Evidence-Based Clinical Practice Guideline for Deprescribing Opioid Analgesics

Draft for Public Consultation
Feedback Template

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OR

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Name of individual and/or organisation represented: The Society of Hospital Pharmacists of Australia (SHPA) – Collated from SHPA's Pain Management Specialty Practice Group and Surgery and Perioperative Medicine Specialty Practice Group

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Recommendation / Guideline Section / Page	**Feedback**
Glossary	Deprescribing: Members report that although the reference for this definition is given, it does not truly reflect that reference and the agreed definition for deprescribing, which is '*Deprescribing is the process of withdrawal of an inappropriate medication*, *supervised by a health care professional with the goal of managing polypharmacy and improving outcomes*'. [1] When discussing tapering, weaning, withdrawing of opioids, the aim by necessity differs with the individual circumstances. This definition (i.e., aim to cease) is used throughout but it is felt that it is not reflected in the information and recommendations it contains. Deprescribing Plan: As above, members recommend that it should be mentioned in the definition that the plan is to facilitate dose *reduction OR cessation* Opioid Use Disorder (OUD): Two criteria are 'tolerance' and 'experiencing withdrawal'. Members ask if these are two aspects of same state, i.e. adaption? Members report that if these two are present, then is OUD suggested? They question if these are more so physical signs, compared with the OUD definition and recommend at least one further criterion required before OUD can be implied. Taper: *'The gradual dose reduction of a medication for the purpose of discontinuation'*. Members question whether tapering implies discontinuation is the overall aim or purpose.
Acronyms	oMEDD: Although oMEDD is written in full here, it is not defined, which would be useful as some GPs may not be aware of what it means without explanation. 'MME' is then used throughout the recommendations, which implies there is a different meaning to those who are unsure. Would be useful to include both of these in the 'Acronym' list and possibly, both in the definitions.

	'MED' is also used in table, so it might be useful to add that as well, just to quickly provide some definition so that GPs are reassured they are not missing something.
Executive Summary: How to use this guideline	Reference 24 is meta-analysis by Busse et al. [2] Please check this is the correct reference as only vomiting is mentioned as an adverse effect in that reference. Members report that perhaps the CDC guidelines are meant to be referred to here for reference 23. [3]
Summary of Recommendations	Consensus Recommendation 1: Add '*or when first reviewed by the GP'* (e.g., following transitions of care). Suggest to add this as a qualifier, as GPs are the target audience for these guidelines. Consensus Recommendation 4 d: Should this be qualified with *'or proportionately lower, if at risk of harm due to age, frailty, CKD etc.'* See earlier point re: oMEDD. Supporting information refers to 'MME'. Conditional Recommendation 10: Add after non-pharmacological 'and non-opioid'
Background	Page 21, last paragraph: Remove 'with aim to cease'
Guiding Principles	Page 24, first paragraph: Remove 'with aim to cease' Page 25, first paragraph: To support member feedback above, re: removing 'aim to cease', after advising to restart 'at the previous minimum effective dose.' This point reinforces that reduction in dose also constitutes 'deprescribing', as the dose has been reduced to a more suitable one when considering benefit and harm.

Recommendation 1	Members agree with this recommendation and add that it is always important that prescribers have an 'escape' route prepared whenever a medication is prescribed.
	Additional points to consider:
	- After 'Avoid repeat prescribing for acute conditions', add:
	  o Prescribe small pack sizes.
	  o Provide specific patient opioid information (e.g., the PSA handout - suggest that a copy is included in these guidelines or a similar patient resource)[4]
	  o Consider commencing an 'Opioid agreement' if the patient requests a repeat after an acute episode

	There are three plans/patient documents mentioned in this recommendation: 1. Agreed pain management plan (i.e., includes other modalities, strategies and aims of treatment) 2. An opioid deprescribing plan (may not be required if the first – the pain management plan- does not rely on opioids) 3. An opioid 'agreement' (also known as a 'treatment agreement' or 'prescriber agreement') which can support both of the above but is neither a 'deprescribing', or a 'pain management' plan. It is introduced as a concept in the 'Research Evidence Summary' but not discussed prior to that point. Research Evidence Summary, page 38: As above, the research evidence summary appears to mix these three plans up a bit. Perhaps speak to each plan/document independently and be clear where the recommendation fits in. "The recommendation to initiate a deprescribing plan at this stage (initiation) is based on...." Last sentence: '*This highlights the importance of discussions surrounding the intended duration of use and deprescribing early in the opioid prescribing process.'* In practice, the time for this to occur would be when the GP is called upon to prescribe opioids after a transition from acute care for treatment to acute pain from surgery or trauma. At the point of transfer of prescribing to the GP, the issue of dose reduction should be discussed, and a plan agreed to. This could be more specific: 1. Assess (and discuss) the expected time of pain requiring opioid analgesia. 2. Prescribe small quantities of opioid 3. Provide specific opioid information for the patient 4. If this is a repeat prescription, consider an agreement with caveats around future prescribing 5. Co-prescribe non-opioid and non-pharmacological option, and laxatives.
Recommendation 2 Page 40 – Research Evidence Summary	Members agree with this recommendation. This has been present in opioid patient contracts for some time but very rarely taken up and used by GPs Includes the point that there is low certainty (consistent) evidence that mean pain scores and functional measures improve or do not change in people with CNCP who have REDUCED or discontinued opioids. It must be acknowledged that the aim of deprescribing is to reduce and *perhaps* cease the opioid.

	Second-last sentence of paragraph will need clarification. Should there be 'compared to' in the sentence or a 'smallER' proportion?
Recommendation 4	Members believe this should be rewritten to reflect current evidence. Members report that there is a lack of evidence to support deprescribing opioids to patients with sleep apnoea and COPD with limited evidence outside of an anaesthetic setting. Members question deprescribing opioids to patients with prescribed doses of OMEDD of 60mg. Would that in turn mean that for it to qualify as opioid deprescribing, you must maintain opioid doses on chronic use to <100mg/day?
Recommendation 5	Members feel that this is excluding some of the target population (those in end-of-life care) identified in the beginning of the document.
Recommendation 6	Members agree, however this could discriminate against pain sufferers who don't have an opioid use disorder. Page 45: Perhaps introduce the definition here of OUD that has been used earlier (in glossary) so that 'severe' is distinct from having just two features. (See earlier point re: OUD glossary)
Recommendation 7	Members agree and suggest that this is where most of the deprescribing risks appear from. However it was added that some GPs may not have the resources (time, correct skill set) to do this safely. Members require clarification if a deprescribing plan requires the patient to reduce and cease their opioids or recommending deprescribing to an OMEDD dose of <100mg? The evidence provided by Fishbain (2019) and Mackey (2020) demonstrate the gains made by patients taking OMEDD >100mg but the gains for OMEDD >60mg were more modest. Members agreed that if patient has been on short-term opioids then the plan should be to discontinue the opioid if possible, and added that most of the acute withdrawal symptoms, especially the sympathomimetic symptoms can be adequately managed. Page 47: "If a person has been using opioids short term (e.g. <1 week) or has been using opioids infrequently, opioids may be discontinued without gradual tapering." The caveat here should discuss the daily dose used. Whilst the sector is moving away from SR opioids, if a patient was on for example, oxycodone/naloxone 20/10mg twice daily for 3 days or less than 7 days, they should still be tapered rather than ceased, as per rapid taper practices in hospitals[5].

Recommendation 8	Opioid deprescribing should involve consideration of a person's starting dose and the available opioid dosage forms - is there any role for the use of IR release formulations in the management of CNCP. If patients can manage their pain on these only then I think they should generally be ceased. Opioid equianalgesic calculators may not be helpful in deprescribing because they don't take into account the lack of cross tolerance between opioid analgesics and the opioid equivalence of tapentadol, for example, does not seem to work well. Page 49: Members suggest input, if possible, from a pharmacist. This can be a general practice pharmacist but also through a HMR as an initial consultation can be provided, then two follow-up HMRs if highlighted in the first report. Especially good timing if the opioid is commenced during a hospital stay and the person is discharged to the GP with opioids and an expectation to manage. It would be good to have this promoted as many GPs are not familiar with this HMR allowance and it provides the ideal opportunity for involving a pharmacist in these processes. It may be of interest to a local pharmacist to get involved. Practice points, fourth major dot point: Additional factor to consider is tapering process of uneven doses when doses are taken more than once dose daily. Discussion with patient about the best timing to have the lower dose, means that they have contributed to the decision and therefore is a more patient-centred approach. Practice Points, sixth major dot point: Considering concomitant medications. It may be appropriate to commence withdrawal of another medicine before withdrawing the opioid (especially if they have been taken concurrently for some time). Examples of these are gabapentinoids (common concomitant medication needing tapering) or a benzodiazepine. Practice points, last dot point: When referring to oral morphine equivalents, might be a good time to bring in the initials previously used (oMEDD, MME, MED) and an explanation as to what it is. For example 'for comparison, an opioid dose is often estimated by converting it to the oral morphine equivalent daily dose, a method to standardise the dose based on the knowledge that different opioids with varying potency may produce a similar analgesic effect.'.[6] Page 50, first line: Typo 'of the Australian AND New Zealand College…'

Recommendation 9	Monitoring should assess pain and function, however there are no physical or psychological functional tools listed. Members suggest the Pain Self Efficacy Questionnaire (PSEQ)[7] and a DASS psychological assessment tool (DASS-21).[8]
Recommendation 10	Members feel that the GP would benefit from the support of other members of the healthcare team before deprescribing opioids. The patient must feel that they can access a member of this team very easily and it is felt that it may not be something most GPs can undertake. A group of individuals is therefore required and could consist of a clinic or practice nurse, a pharmacist, a psychologist, a psychiatrist and the prescriber. Close communication within the team is essential to maintain treatment integrity and a common message.
Recommendation 11	Members feel that co-interventions are essential and were surprised to see very low level of evidence for this. It was noted in that in some member pain clinics, MBSR and physical activity such as walking and aquatic physiotherapy were offered as adjuncts to opioid deprescribing.
Clinical Considerations	Page 85, table 7: History of gastritis: perhaps advise to consider current precautions, e.g., GI problems when there was a history of positive helicobacter is not a reason to avoid NSAID now. The use of “simple” when describing analgesics may be problematic. Members would prefer to avoid terminology such as 'simple' as this gives the wrong message to patients as it is an adjunct analgesic, which has a role. It was added that it may be best to avoid use of this in a document describing a context in which language is so important and might be repeated by GPs or pharmacists when talking to patients.
Other comments	Some members were surprised to see the target population including patients taking opioids for cancer-related or end of life pain as opioids have been recognised as justifiable in this patient group for ongoing opioid therapy. Key Clinical Question 1: Some members argue that the evidence suggests that deprescribing can be harmful in some situations.[9] [10] [11] While the principles of patient centred care and opioid reduction are stated, if there is no indication that the patient wishes to stop their opioid analgesics and without informed consent, some may argue that deprescribing opioids is unethical. [12] Members believe that patient engagement is really important to the success of deprescribing.[13] Guideline Development Group (GDG): GDG membership lacks a Pain Specialist Clinician (Member/Fellow of Faculty of Pain Management, ANZCA) and someone representing Palliative Care clinicians. There was representation from addiction specialists who might take a

	different view to those who are treating patients with Chronic Non-Cancer Pain (CNCP).It was noted that there was a consumer representative but not one from a group supporting Persistent Pain patients such as Chronic Pain Australia. Hyperlinks change with time. Perhaps include some firm advice or summarise the key concepts, so that some of target audience (GPs) do not have to negotiate hyperlinks continually. (This point refers to the whole of the guideline document.) Note that a date was missing from the Mathieson reference (reference 84), it was 2020. Despite the evidence that is often presented there are some patients who are able to utilise long term opioids without developing opioid use disorders or developing the long term harms. Some other, mainly legacy, patients have no other treatments and acquire some QoL from their opioid analgesia. Paediatrics: One deficiency is that there is not much reference to opioid reduction in paediatric and adolescent patients. While literature concerning deprescribing in the paediatric and adolescents may be lacking, there are times when members may we have to address the issue, particularly if GPs have initiated opioids for acute or chronic pain management. They feel that this group should be acknowledged/recognised and referred to specialist services.

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