Helping patients cope with chronic non-malignant pain: it's not about opioids

Opioid analgesics have traditionally been used for the treatment of patients with chronic non-malignant pain despite a lack of evidence supporting their long-term use. Given this lack of evidence, along with issues associated with opioids such as misuse and addiction, non-pharmacological treatments are preferred for the management of patients with chronic non-malignant pain, where possible. If pharmacological treatments are required, non-opioid analgesics should be considered before opioids, and used in combination with non-pharmacological treatments.

Managing patients with chronic pain can be complex and time-consuming as treatment strategies need to incorporate both physical treatments and acknowledgement of the patient's pain and emotional wellbeing. A "collaborative partnership" between the patient and clinician is considered the best way to help the patient deal with their pain, improve their outlook on life, and help them with any struggles they may be experiencing.

Maximising the use of non-pharmacological treatments, and non-opioid analgesics when necessary, is the key concept when dealing with these patients, as treatment approaches that combine non-pharmacological and non-opioid analgesics have been shown to be the most effective. Trials of different treatments are essential for finding the best combination that suits the patient. There are a wide range of non-pharmacological options that can be considered, including:

- Cognitive behavioural therapy (formal and/or internet-based self-help)
- Exercise, pilates, yoga and Tai Chi
- Acupuncture and nerve stimulation techniques
- Massage, hot and cold compresses

When pharmacological treatment is required, there are a number of non-opioid analgesics that can be considered including paracetamol, NSAIDs, tricyclic antidepressants and neuromodulators, e.g. gabapentin.

Opioid treatments should only be considered after other treatment options have failed. Weaker opioids, e.g. codeine or tramadol, should be used before morphine, and all opioids administered for the shortest possible time at the lowest possible dose. When prescribing opioids, it is recommended that a set of guiding principles, such as the 10 Universal Precautions approach, are used to minimise the adverse effects and misuse issues associated with them. An opioid treatment agreement between clinician and patient, which is part of the universal precautions approach, should be used to help ensure that opioid analgesics are used appropriately. Whenever a patient is started on an opioid, there should also always be a plan for stopping.

Peer group discussion points

1. Do you prescribe opioid analgesics for patients with chronic non-malignant pain? If so, what opioid do you usually select?
2. If you prescribe oxycodone, has reading this series of articles on oxycodone and managing pain changed the way you will prescribe oxycodone in the future?
3. Have you observed aberrant behaviour, misuse or addiction in patients taking opioids long-term?
4. Have you experienced difficulties in ceasing opioid treatment in patients with chronic non-malignant pain?
5. Do you recommend non-pharmacological treatments in patients with chronic non-malignant pain? How effective are they?
6. What non-opioid analgesic treatments have you found most effective in patients with chronic non-malignant pain?
7. How much emphasis do you place on managing the patient's psychological aspects of chronic pain? What techniques do you use to help patients deal with these issues?