Oxycodone: how did we get here and how do we fix it?

Since oxycodone became available in New Zealand in the early 2000s, its use has increased exponentially. The misuse and addiction issues that have occurred in other countries with oxycodone have now become apparent in New Zealand. Oxycodone is a strong opioid, which should be used second-line, after morphine, for patients with acute, moderate to severe pain. Opioids should be used at the lowest effective dose, for the shortest possible time. Strong opioids are also often used for patients with malignant pain. However, the use of strong opioids for chronic non-malignant pain is controversial.

The heavy marketing of oxycodone, along with its rapid rise in popularity, means that many aspects of its pharmacology and general use may have been misunderstood. These include that oxycodone:

- Is not the same as codeine or a "gentle analgesic" – it is approximately twice as potent as morphine, i.e. 10 mg of oxycodone is equivalent to 15-20 mg of morphine
- Has significant addictive potential that the literature suggests is higher than that of morphine
- Is not considered a safe option for patients with renal impairment, due to accumulation of active metabolites
- Has a similar overall adverse event profile to morphine

Secondary care prescribing is the predominant source of oxycodone prescriptions. Between April 2013 and March 2014, 72% of dispensed oxycodone originated from prescriptions written by clinicians outside of general practice. Of these prescriptions, 17% were then continued in general practice.

There are a number of strategies that should be considered to reduce the use of oxycodone and strong opioids, including that:

- Morphine is the first-line treatment when a strong opioid is indicated for moderate to severe pain; this applies in any setting
- Oxycodone is not an appropriate analgesic for mild to moderate pain
- If patients are discharged from hospital with a strong opioid, the prescription should cover a short time period only and the patient should have a treatment plan for tapering use of analgesics
- Primary care clinicians do not need to repeat a prescription for patients discharged from hospital on oxycodone or another strong opioid
- Pain can be managed by maximising non-opioid treatments
- The decision to prescribe oxycodone, or any strong opioid, should take into account the predicted net benefits from treatment, weighed up with the risks of adverse effects, misuse and addiction
- Opioids should be considered a treatment of last resort for patients with chronic non-malignant pain

Peer group discussion points:

1. Have you initiated a patient on oxycodone? If so, in what clinical scenario(s) and why was oxycodone selected?
2. Can you describe your experience with patients being discharged from hospital on oxycodone: is this an issue in your practice? Do you provide follow up for these patients in the community? Do you write repeat prescriptions for oxycodone?
3. Do you think that patients understand the potency, addictive potential and adverse effects associated with oxycodone? Do you educate patients about these aspects?
4. Have you ever felt pressure to initiate or continue a prescription for oxycodone at the request of a patient? What factors influenced your decision to prescribe or not to prescribe?
5. Are you aware of any problems among your patients in terms of oxycodone misuse or addiction?
6. If you identified a patient who was addicted to oxycodone, how would you manage this?