



5 THINGS

CLINICIANS AND CONSUMERS SHOULD QUESTION

Developed by the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists

1 **Avoid prescribing opioids (particularly long-acting opioids) as first-line or monotherapy for chronic non-cancer pain (CNCP)**

The true place of opioids in chronic non-cancer pain (CNCP) is unknown. Most trials of their efficacy have been of less than twelve weeks duration and have shown only modest effects. By contrast opioid use in CNCP has been associated with increased distress, poorer self-rated health, inactivity during leisure, unemployment, higher healthcare utilisation and lower quality of life, suggesting failure to appreciate the complex nature of these conditions.

Opioids should not be used alone or as analgesics of first choice in patients with CNCP. A trial of opioid may be indicated in some patients, according to published guidance. If such an opioid trial is undertaken, then a long-acting preparation should be prescribed, in conjunction with non-drug therapies – physical, behavioural and cognitive – that promote functional restoration, reduce distress and potentially lower pain intensity.

2 **Do not continue opioid prescription for chronic non-cancer pain (CNCP) without ongoing demonstration of functional benefit, periodic attempts at dose reduction and screening for long-term harms**

Comprehensive assessment of patients with CNCP is essential before prescribing an opioid. An opioid ‘contract’ should describe the purpose of the prescription and would include agreed criteria for functional improvement, risks and side-effects of opioid analgesics, and ground rules regarding their use and cessation. There should be a single prescriber (and a deputy) to take responsibility for opioid prescription, in accordance with the regulatory requirements of the relevant jurisdiction.

3 **Avoid prescribing pregabalin and gabapentin for pain which does not fulfil the criteria for neuropathic pain**

The IASP definition of neuropathic pain (2011) requires demonstration of a lesion or disease of the somatosensory system. In effect, that means demonstration of neurological signs. Descriptors that may suggest the pain may be neuropathic, such as burning, painful cold, electric shock-like etc., on their own do not meet this criterion.

Pregabalin has a restricted PBS authority for ‘neuropathic pain’. Although the definition being applied is not stated in the PBS Authority listing, use of the 2011 IASP definition is recommended. As with any pharmacotherapy used in pain medicine, the outcome of a trial of pregabalin or of gabapentin should be judged by improvement in everyday physical, emotional and cognitive functioning, including activity, sleep, absence of adverse effects, and improvement in quality of life.

4

**Do not prescribe
benzodiazepines for low
back pain**

Lifetime prevalence of low back pain in Australia is reported to be as high as 80% with one in ten experiencing significant activity limitation.

Although benzodiazepines continue to be commonly prescribed as ‘muscle relaxants’ for low back pain (LBP), there is an absolute lack of evidence of benefit for this indication. Only one RCT has been conducted on diazepam in acute LBP during the last 40 years, and it showed no additional benefit when added to NSAID therapy alone. A recent systematic review found no additional studies to support the use of benzodiazepines in treating acute or chronic back pain.

Well-described risks are associated with benzodiazepine usage, including abuse, addiction, tolerance and overdose. Accidental death from pharmaceutical benzodiazepines in Australia were highest in the 40-49 and 30-39 year age groups. The number of deaths in the older age groups also remains high.

There is no place for use of benzodiazepine for low back pain.

5

**Do not refer axial lower
lumbar back pain for
spinal fusion surgery**

Chronic low back pain (CLBP) that is not due to underlying disease (infection, cancer) and is not associated with neurological signs is a common problem that is difficult to treat.

Historically, lumbar spinal fusion was used for the treatment of demonstrated spinal instability following trauma or cancer. More recently, lumbar spinal fusion has been used for leg pain attributed to an underlying structural change such as spinal stenosis or spondylolisthesis.

Spinal fusion has been proposed as a treatment for uncomplicated axial CLBP. The rationale for it is elusive, as accurate determination of a single source of the pain, especially when central sensitisation may have occurred, is not usually possible. Though some positive studies have been reported, pooled data from multiple randomised trials do not provide support for performing spinal fusion surgery in preference to non-operative treatment.

In the absence of adequate rationale and compelling new evidence, lumbar spinal fusion is not recommended for treatment of uncomplicated axial CLBP.

SUPPORTING EVIDENCE

1.

Eriksen J, Sjøgren P, Bruera E, et al. Critical issues on opioids in chronic non-cancer pain: An epidemiological study. *Pain* 2006; 125:172-9.

Dowell D, Haegerich T, Chou R. CDC Guidelines for prescribing opioids for chronic pain – United States, 2016. *JAMA* 2016; 315(15):1624-45.

Chou R, Fanciullo G, Fine PG, et al. Clinical Guidelines for the use of chronic opioid therapy in chronic non-cancer pain. *The Journal of Pain* 2009; 10(2):113-30.

Busse J, Craigie S, Juurlink DN, et al. Guideline for opioid therapy and chronic noncancer pain. *CMAJ* 2017; 189(18):E659-66.

Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) Guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2 – Guidance. *Pain Physician* 2012; 15:S67-116.

International Association for the Study of Pain, IASP Taxonomy, 2017 [cited 2018 Jan]

2.

Royal Australasian College of Physicians. Prescription opioid policy: improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use. Sydney, Australia: The Royal Australasian College of Physicians 2009.

Dowell D, Haegerich T, Chou R. CDC Guidelines for prescribing opioids for chronic pain – United States, 2016. *JAMA* 2016; 315(15):1624-45.

Chou R, Fanciullo GJ, Fine PG, et al. Clinical Guidelines for the use of chronic opioid therapy in chronic noncancer pain. *The Journal of Pain* 2009; 10(2):113-30.

Busse J, Craigie S, Juurlink DN, et al. Guideline for opioid therapy and chronic noncancer pain. *CMAJ* 2017; 189(18):E659-66.

Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) Guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2 – Guidance. *Pain Physician* 2012; 15:S67-116.

3.

Neuropathic pain – pharmacological management. NICE Clinical Guideline 173; 2017.

Finnerup NB, Attal N, Haroutounian S, et al. Pharmacotherapy for neuropathic pain in adults: a systematic review and meta-analysis. *Lancet Neurol* 2015; 14:162-73.

Finnerup NB, Haroutounian S, Kamerman P, et al. Neuropathic pain: an updated grading system for research and clinical practice. *Pain* 2016; 157(8):1599-606.

International Association for the Study of Pain, IASP Taxonomy, 2017 [cited 2018 Jan]

Jensen TS, Baron R, Haanpää M, et al. A new definition of neuropathic pain. *Pain* 2011; 152(10):2204-5.

The Pharmaceutical Benefits Scheme, Pregabalin, [cited 2018 Jan]

4.

Briggs AM, Buchbinder R. Back pain: a national health priority area in Australia? *Med J Aust* 2009; 190(9):499-502.

Chou R, Huffman LH. Medications for Acute and Chronic Low Back Pain: A Review of the evidence for an American Pain Society/American College of Physicians Clinical Practice Guideline. *Ann Intern Med* 2007; 147(7):505-14.

Friedman BW, Irizarry E, Solórzano C, et al. Diazepam is no better than placebo when added to naproxen for acute low back pain. *Ann Emerg Med* 2017; 70(2):169-76.

Penington Institute. Australia's Annual Overdose Report 2017.

Shaheed AC, Maher CG, Williams KA, et al. Efficacy and tolerability of muscle relaxants for low back pain: Systematic review and meta-analysis. *Eur J Pain* 2016; 21(2):228-37.

5.

Briggs AM, Buchbinder R. Back pain: a national health priority area in Australia? *Med J Aust* 2009; 190(9):499-502.

Gore M, Sadosky A, Stacey BR, et al. The burden of chronic low back pain: clinical comorbidities, treatment patterns, and health care costs in usual care settings. *Spine (Phila Pa 1976)* 2012; 37(11):E668-77.

Eck JC, Sharan A, Ghogawala Z, et al. Guideline update for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 7: Lumbar fusion for intractable low-back pain without stenosis or spondylolisthesis. *J Neurosurg Spine* 2014; 21(1):42-7.

Bydon M, De la Garza-Ramos R, Macki M, et al. Lumbar fusion versus nonoperative management for treatment of discogenic low back pain: a systematic review and meta-analysis of randomized controlled trials. *J Spinal Disord Tech* 2014; 27(5):297-304.

Fritzell P, Hägg O, Wessberg P, et al. 2001 Volvo Award Winner in Clinical Studies: Lumbar fusion versus nonsurgical treatment for chronic low back pain: a multicentre randomized controlled trial from the Swedish Lumbar Spine Study Group. *Spine (Phila Pa 1976)* 2001; 26(23):2521-34.

HOW THIS LIST WAS MADE

The Faculty of Pain Medicine (FPM) established a working group to develop a preliminary list of pain medicine related practices that were identified, using current clinical evidence, as having possible limited benefit, no benefit or which may potentially cause harm to patients. An online survey tool was used to survey all FPM fellows and trainees inviting them to rank these recommendations and to provide any comment related to them. This engagement facilitated consensus and informed the Fellows and trainees about FPM's involvement with the Choosing Wisely campaign.

FPM's final list of 5 Choosing Wisely recommendations reflects those that were the most broadly supported by the clinicians and which were considered to be the most relevant to community practice.

Last reviewed: February 2018

About Choosing Wisely Australia

Choosing Wisely Australia® is enabling clinicians, consumers and healthcare stakeholders to start important conversations about tests, treatments and procedures where evidence shows they provide no benefit and in some cases, lead to harm. This initiative is being led by Australia's medical colleges, societies and associations and is facilitated by NPS MedicineWise.

About the Faculty of Pain Medicine, ANZCA

The Faculty of Pain Medicine is a faculty of the Australian and New Zealand College of Anaesthetists and is the professional organisation for specialist pain medicine physicians (Fellows) and specialist pain medicine physicians in training (trainees). The Faculty is responsible for the training, examination and specialist accreditation of specialist pain medicine physicians and for the standards of clinical practice for pain medicine in Australia and New Zealand. Formed in 1998, the Faculty is the first multidisciplinary medical academy in the world to be devoted to education and training in pain medicine.

About NPS MedicineWise

Independent, not-for-profit and evidence based, NPS MedicineWise enables better decisions about medicines and medical tests. Visit www.nps.org.au



Reasonable care is taken to provide accurate information at the time of creation. This information is not intended as a substitute for medical advice and should not be exclusively relied on to manage or diagnose a medical condition. Choosing Wisely Australia® disclaims all liability (including for negligence) for any loss, damage or injury resulting from reliance on or use of this information. Read the full disclaimer at www.choosingwisely.org.au
