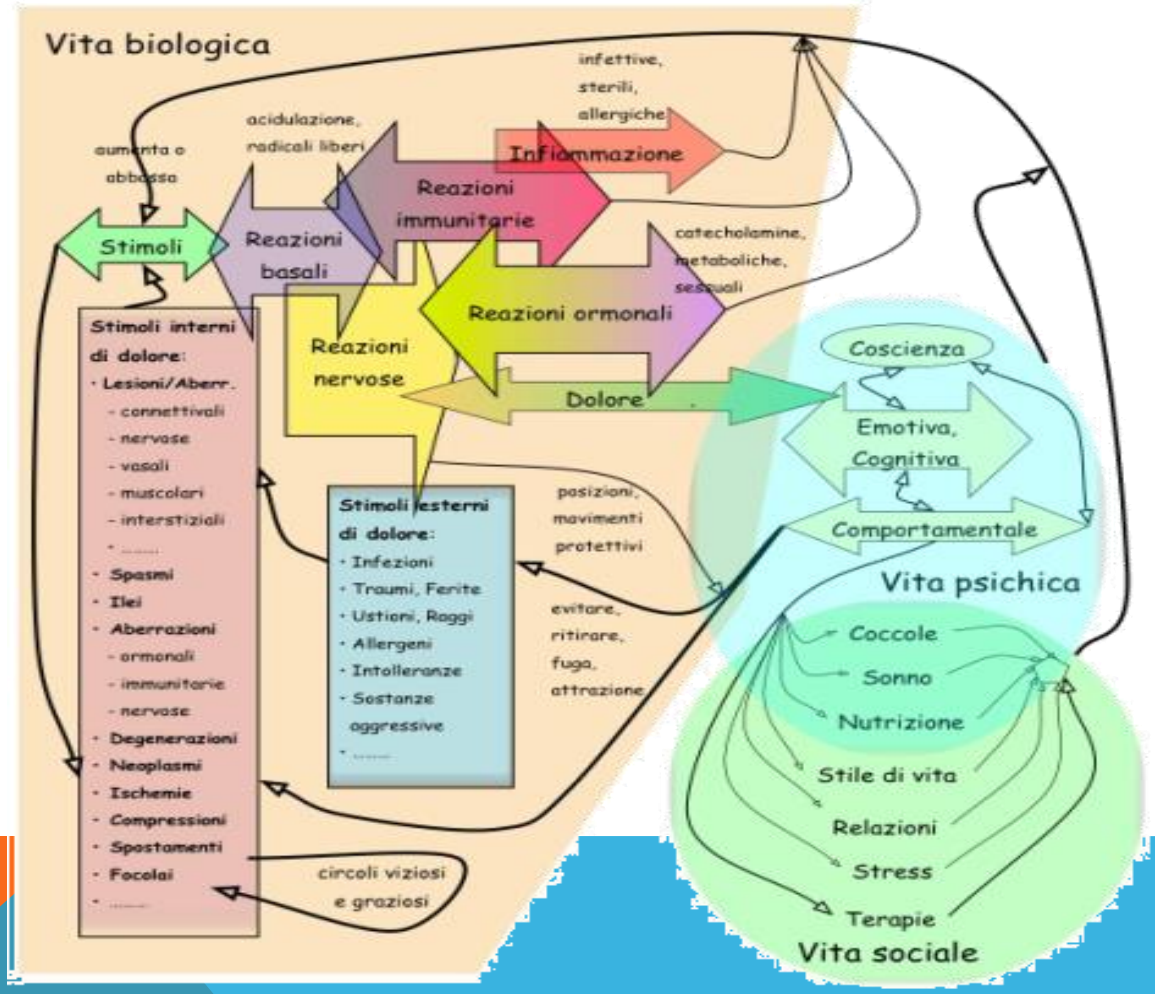
L'appropriatezza: a chi, cosa, come e quando prescrivere un oppioide nel dolore muscoloscheletrico

M.C. Pace

IL DOLORE


Vita biologica
infettive, sterili, allergiche
acidulazione, radicali liberi
aumenta o abbassa
Infiammazione
Reazioni immunitarie
Stimoli
Reazioni basali
catecholamine, metaboliche, sessuali
Reazioni ormonali
Reazioni nervose
Dolore
Stimoli interni di dolore:
· Lesioni/Aberr.
- connettivali
- nervose
- vasali
- muscolari
- interstiziali
· Spasmi
· Ilei
· Aberrazioni
- ormonali
- immunitarie
- nervose
· Degenerazioni
· Neoplasmi
· Ischemie
· Compressioni
· Spostamenti
· Focolai
Stimoli esterni di dolore:
· Infezioni
· Traumi, Ferite
· Ustioni, Raggi
· Allergeni
· Intolleranze
· Sostanze aggressive
posizioni, movimenti protettivi
evitare, ritirare, fuga, attrazione
circoli viziosi e graziosi
Coscienza
Emotiva, Cognitiva
Comportamentale
Vita psichica
Coccole
Sonno
Nutrizione
Stile di vita
Relazioni
Stress
Terapie
Vita sociale

Dolore muscoloscheletrico

Fattori di rischio

- Vita sedentaria
- Età
- Obesità
- Fumo
- Disordini del sonno
- Depressione, ansia
- Lavori manuali

Forme prevalenti

- LBP
- Dolore cervicale
- Osteoartrite
- Artrite reumatoide
- Dolore alla spalla
- Fratture, slogature

Componente neuropatica

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Pain. 2020 September 01; 161(9): 1976–1982. doi:10.1097/j.pain.0000000000001939.

The Revised IASP definition of pain: concepts, challenges, and compromises

Srinivasa N. Raja[1,*], Daniel B. Carr[2], Milton Cohen[3], Nanna B. Finnerup[4], Herta Flor[5], Stephen Gibson[6], Francis Keefe[7], Jeffrey S. Mogil[8], Matthias Ringkamp[9], Kathleen A. Sluka[10], Xue-Jun Song[11], Bonnie Stevens[12], Mark Sullivan[13], Perri Tutelman[14], Takahiro Ushida[15], Kyle Vader[16]

attempt could serve no useful purpose" [23]. Merskey, the chair of the IASP Subcommittee on Taxonomy, recognized that pain was "a psychological concept and not a physical measure" and that the experience of pain had to be distinguished from noxious stimulation

international use [28,33]. As a result of this work, the new edition of the International Classification of Diseases (ICD-11), which the WHO adopted in 2019, includes a chronic pain classification for the first time. In the coming years, ICD-11 will be adopted in several

Pain: An aversive sensory and emotional experience typically caused by, or resembling that caused by, actual or potential tissue injury.

Notes:

- Pain is always a subjective experience that is influenced to varying degrees by biological, psychological, and social factors.
- Pain and nociception are different phenomena: the experience of pain cannot be reduced to activity in sensory pathways.
- Through their life experiences, individuals learn the concept of pain and its applications.
- A person's report of an experience as pain should be accepted as such and respected.
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
- Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a non-human animal experiences pain.

Koechlin *et al. Systematic Reviews* (2019) 8:269
https://doi.org/10.1186/s13643-019-1174-6

Systematic Reviews

PROTOCOL Open Access

The best treatment option(s) for adult and elderly patients with chronic primary musculoskeletal pain: a protocol for a systematic review and network meta-analysis

Helen Koechlin[1,2†], Ben Whalley[3], Nicky J. Welton[4] and Cosima Locher[1,2,3*†]

The ICD-11 defines chronic primary musculoskeletal pain (CPMP) as chronic pain in the muscles, bones, joints, or tendons that is characterized by significant emotional distress (i.e., anxiety, anger, frustration, and depressed mood) or functional disability. CPMP poses a major problem of public health, considering its high prevalence and refractory nature [11]. Low back pain and neck pain con-

Pain Ther (2021) 10:181–209
https://doi.org/10.1007/s40122-021-00235-2

REVIEW

Management of Musculoskeletal Pain: An Update with Emphasis on Chronic Musculoskeletal Pain

Salah N. El-Tallawy · Rohit Nalamasu · Gehan I. Salem · Jo Ann K. LeQuang · Joseph V. Pergolizzi · Paul J. Christo

Common problems in MSK

- Overuse of imaging
- Overuse of opioids
- Overuse of surgery
- Failure to provide education
- Misclassification

Pain Ther (2021) 10:181–209
https://doi.org/10.1007/s40122-021-00235-2

REVIEW

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General recommendations for Musculoskeletal pain management

- Patient's education (non pharmacological strategies)
- Comprehensive patient assessments
- Multimodal and multidisciplinary interventions
- Facilitate early recovery

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REVIEW

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5. If other modalities are ineffective, consider the prescription of opioids by comprehensive assessments and screening for opioid abuse, the effectiveness of long-term opioid therapy, monitoring for adherence and side effects, and discontinue opioids because of lack of response, adverse effects, and abuse [24].

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REVIEW

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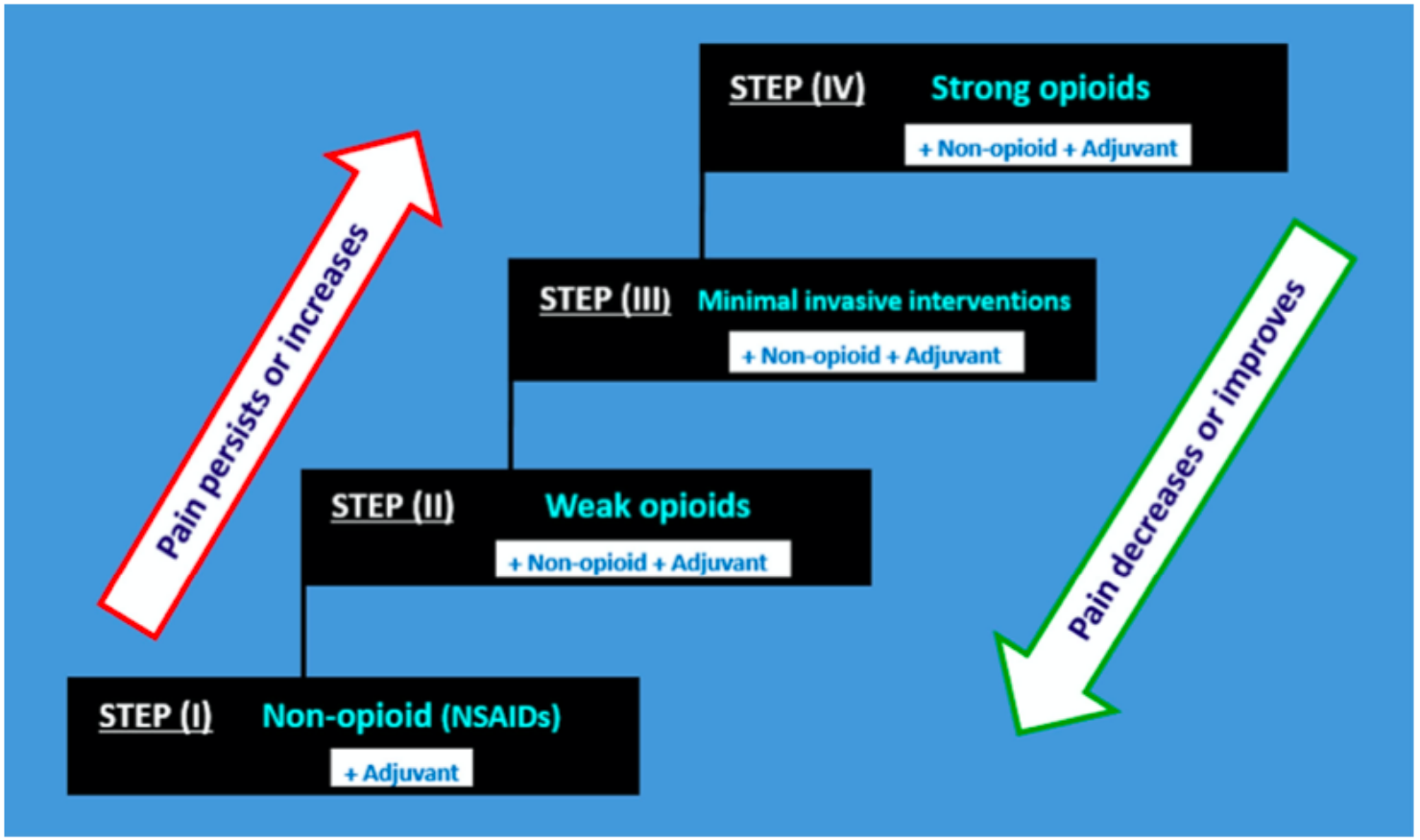

Fig. 2 Updated WHO ladder system

Table 1 Summary of the non-opioid analgesics

Drug	Route	Dose	Duration	Comments
Acetaminophen (paracetamol) [40, 54]	PO/IV	10–15 mg/kg (average 1 g)	6–8 h	Analgesic, anti-pyretic Has a wide safety margin Used for s wide range of painful conditions and in all age groups Overdose may cause hepatic toxicity
NSAIDs: non-selective [36, 40, 43]				
Ibuprofen	PO	400 mg	4–6 h	Analgesic, anti-inflammatory
Lornoxicam (not available in the USA)	PO IV*	8 mg	8 h Maximum daily dose 16–24 mg	Effective for mild-to-moderate pain Ceiling effect to analgesia Gastric upset, renal dysfunction, contraindicated in bronchial asthma
Naproxen	PO	250–500 mg	6–8 h	*Increase intraoperative bleeding
Ketorolac	IV	15–30 mg	6 h	
Diclofenac	Topical 1% or TD 1.3%	Gel: 2-4 g; max 32 g/day/body or 8 g/day/joint Patch: 180 mg	Gel: 4–6 h Patch: 12 h	Effective especially for osteoarthritic pain. Patch used for acute sprains and strains Topical formulation limits systemic side effects
Selective COX-2 inhibitors (COXIBs) [37, 43, 45]				
Celecoxib	PO	200–400 mg	12–24 h	Analgesic, anti-inflammatory
Parecoxib (not available in the USA)	IV*	20–40 mg	12 h	Effective for mild-to-moderate pain Selective COX-2 inhibitors, fewer gastric side effects. Renal dysfunction Not recommended in cardiac and hypertensive patients *May cause allergy

Table 2 Summary of the commonly used opioids

OPIOID	Route	Dose	Onset	Duration	Comments
Morphine [40, 78]	PO	15–60 mg	45 min	4–5 h	Poor oral potency
	MS Contin	30–60	45 min	8–12 h	Histamine release (+)
					Sedation, N/V
	IV	5–15 mg	10 min	3.5–4 h	Respiratory depression
					Active metabolites may accumulate in renal failure
Fentanyl [40, 78]	Sublingual	100–400 mcg	5–10 min	60 min	Rapid onset, short duration
					Respiratory depression+
	IV	5–150 mcg	3–5 min	30–60 min	Very rapid onset, short duration
					Better used by PCA
					Respiratory depression
	TTS	25–100 mcg	17–24 h	72 h	Not suitable for acute pain
					Main indication in cancer pain
Meperidine (pethidine) [40, 78]	IV	50–100 mg	30 min	3–4 h	Effective for visceral pain
					Low safety profile, e.g., more N/V
					High addiction liability, neurotoxic metabolite (norpethidine) in renal impairments
Oxycodone [40, 78]	PO	5–10 mg IR	5–10 min	3–4 h	Good oral analgesic
					Effective for incident pain
	PO	10–20 mg	15–30 min	8–12 h	Good oral analgesic
		CR (Oxycontin)			Rapid onset, long duration
					Effective for visceral and neuropathic pain
					Less N/V
					Respiratory depression
	IV	5–15 mg	3–6 min	4–6 h	Rapid onset, long duration

Table 2 continued

OPIOID	Route	Dose	Onset	Duration	Comments
Tramadol [40, 55, 56]	PO	50–200 mg	40 min	4–6 h	Weak opioid, with additional effects on noradrenergic and serotonergic systems
	IV	50–100 mg	10–15 min	3–4 h	Has an active metabolite
					Effective for moderate pain
					Used in MSK pain when other analgesics are contraindicated or ineffective
					Side effects includes: concerns of addiction, N/V
Codeine [40, 80]	PO	30–60 mg	45 min	3–4 h	Weak opioid. It is inactive prodrug; converted in the liver to morphine by the enzyme CYP2D6
					Sedation, N/V+++
					High side effect profile
Tylenol-3 [40, 80]	PO	Codeine 30–60 mg + paracetamol 300–1000 mg	0.5–1 h	4–6 h	Effective for mild-to-moderate pain
					Risks of opioid addiction, abuse

Table 3 Summary of the adjuvant analgesics

Antidepressants [40, 65, 66]				
Amitriptyline	PO	10–150 mg	24 h	Tricyclic antidepressants
Nortriptyline	PO	25–100 mg	24 h	Mainly used for neuropathic pain, fibromyalgia
				Side effects: drowsiness, anticholinergic actions
Duloxetine	PO	60 mg	24 h	SNRIs
				Mainly used for neuropathic pain, PDPN, fibromyalgia, O.A.
				Not sedative, but causes nausea
Anticonvulsants [40, 65, 66]				
Gabapentin	PO	200–400 mg	TID	Anticonvulsants
Pregabalin	PO	75–300 mg	BID	First-line treatment of neuropathic pain
				May be used for pain
				Cause: drowsiness and sedation
Carbamazepine	PO	400–1200 mg	24 h	Used for trigeminal neuralgia
				It has a narrow therapeutic index: liver toxicity, skin reaction, allergy, anemia
Others				
Dexamethasone [81]	PO/ IV*	4–8 mg	8–12 h	Corticosteroids
				Improves analgesia and reduces opioid requirements
Prednisolone [81]	PO	10–40 mg	BID	* Reduces PONV
Lidocaine (Versatis) [73]	TD	5% patch	12 h on then 12 h off	First-line treatment localized neuropathic pain and PHN
				Selective cases of MSK pain
Capsaicin [74]	TD	8% patch	Analgesia occurs within few days and may last for few months	Peripheral neuropathic pain and PHN
				Burning or itching sensation

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Clinical Practice Guidelines for Pain Management in Acute Musculoskeletal Injury

Joseph R. Hsu, MD, Hassan Mir, MD,† Meghan K. Wally, MSPH,* and Rachel B. Seymour, PhD,**
the Orthopaedic Trauma Association Musculoskeletal Pain Task Force

TABLE 2. Pain Medication Recommended Taper* Following a Major Musculoskeletal Injury Procedure (eg, Operative Fixation of Long Bone or Complex Joint Fracture, Extensive Soft Tissue Injury or Surgery, etc.)

Status	Opioid	Nonopioid
Inpatient	Oxycodone/acetaminophen 5 mg/325 mg 1 tab po q 4 h PRN moderate pain 5 mg/325 mg 2 tabs po q 6 h PRN severe pain (hold next acetaminophen scheduled dose) Hydromorphone 1 mg IV q 3 h PRN for severe breakthrough pain	Ketorolac 15 mg IV q 6 h × 5 doses, followed by ibuprofen 600 mg po q 8 h Gabapentin 100 mg 1 tab po TID Scheduled acetaminophen 500 mg po q 12 h
Postdischarge		
Week 1 (at discharge)	Oxycodone/acetaminophen 5 mg/325 mg 1 tab po q 4 h PRN Dispense #42 (1 time Rx, no refills) Hydrocodone/acetaminophen 5 mg/325 mg or tramadol 50 mg (only if necessary—3 Rx Max)	Ibuprofen 600 mg po q 8 h × 7 d (Rx given) Gabapentin 100 mg 1 tab po TID × 7 days (Rx given) Scheduled acetaminophen 500 mg po q12 h × 7 d (can increase as combined opioid analgesic decreases) NSAIDs PRN as directed Gabapentin if necessary (up to 1800 mg/d)
Week 2	1 tab po q 4 h PRN Dispense #42	Scheduled acetaminophen 500 mg po q12 h (can increase as combined opioid analgesic decreases)
Week 3	1 tab po q6 hours PRN Dispense #28	Scheduled acetaminophen 1000 mg po q12 h (can increase as combined opioid analgesic decreases)
Week 4	1 tab po q8 hours PRN Dispense #21	Scheduled acetaminophen 1000 mg po q8 hours (can increase as combined opioid analgesic decreases)
Weeks 5+		NSAIDs PRN as directed Acetaminophen PRN as directed Gabapentin if necessary (then wean)

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TABLE 3. Pain Medication Recommended Taper* Following a Minor Musculoskeletal Injury Procedure (eg, Operative Fixation of Small Bone or Simple Joint Fracture, Minimal Soft Tissue Injury or Surgery, etc.)

Status	Opioid	Nonopioid
Postdischarge		
Week 1	Hydrocodone/acetaminophen 5 mg/325 mg or tramadol 50 mg 1 tab po q 6 h PRN Dispense #28 (1 time Rx, no refills)	Ibuprofen 600 mg po q 8 h × 7 d (Rx given) Gabapentin 100 mg 1 tab po TID × 7 d (Rx given) Scheduled acetaminophen 1000 mg po q12 h (can increase as combined opioid analgesic decreases)
	Hydrocodone/acetaminophen 5 mg/325 mg or tramadol 50 mg (only if necessary—2 Rx Max)	NSAIDs PRN as directed Gabapentin if necessary (up to 1800 mg/d)
Week 2	1 tab po q 8 h PRN Dispense #21	Scheduled acetaminophen 1000 mg po q8 hours (can increase as combined opioid analgesic decreases)
Week 3	1 tab po q12 h PRN Dispense #14	Scheduled acetaminophen 1000 mg po q8 hours (can increase as combined opioid analgesic decreases)
Weeks 4+		NSAIDs PRN as directed Acetaminophen PRN as directed

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TABLE 4. Pain Medication Recommended Taper* Following a Nonoperative Musculoskeletal Injury (eg, Closed Management of Injury, Laceration Repair, etc.)

Injury Category	Opioid	Nonopioid
Minor injury (eg, small bone fracture, sprain, laceration, etc.)	Tramadol 50 mg (only if necessary—2 Rx Max) 1 tab po q 6 h PRN Dispense #20, then #10	NSAIDs PRN as directed Scheduled acetaminophen 1000 mg po q8 hours, then PRN as directed
Major injury (eg, large bone fracture, rupture, etc.)	Hydrocodone/acetaminophen 5 mg/325 mg or tramadol 50 mg (only if necessary—2 Rx Max) 1 tab po q 6 h PRN Dispense #20, then #10	NSAIDs PRN as directed Scheduled acetaminophen 1000 mg po q12 h, then PRN as directed

Dosage and duration can be less if tolerated

TABLE 1. Best Practice Recommendations* for Alleviation of Acute Pain After Musculoskeletal Injury

Category	Recommendations
Pain medication strategies	Use MMA. MMA may include NSAIDs, acetaminophen, gabapentinoids, and immediate-release opioids.
	Prescribe the lowest effective immediate-release opioid dose for the shortest period possible.
	Do not use extended-release opioids.
	Consider local or regional block anesthesia as part of the postoperative multimodal regimen.
Cognitive strategies	Discuss alleviation of pain, expected recovery course, and patient experience at all encounters.
	Connect patients with pain that is greater or more persistent than expected and patients with substantial symptoms of depression, anxiety, or posttraumatic stress or less effective coping strategies (greater catastrophic thinking and lower self-efficacy) to psychosocial interventions and resources.
	Consider using strategies for optimal mindset such as aromatherapy, music therapy, or approaches based on cognitive behavioral therapy.
Physical strategies	Use immobilization, ice, and elevation appropriately.
	Consider the use of TENS units.
	Consider the use of cryotherapy units.

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Clinical Practice Guidelines for Pain Management in Acute Musculoskeletal Injury

Joseph R. Hsu, MD, Hassan Mir, MD,† Meghan K. Wally, MSPH,* and Rachel B. Seymour, PhD,* the Orthopaedic Trauma Association Musculoskeletal Pain Task Force*

Combination Pharmaceutical Strategies

Multimodal Analgesia

- The panel recommends the use of multimodal analgesia (MMA) as opposed to opioid monotherapy for pain control (strong recommendation, moderate-quality evidence).
- The panel recommends the use of periarticular injections as an adjunct to pain management that improves pain control postoperatively (strong recommendation, moderate-quality evidence).
- The panel cannot recommend specific MMA regimens at this time without further scientific evidence. MMA should be tailored to patients' injuries and medical comorbidities (strong recommendation, very low–quality evidence).

Open Access Research

BMJ Open

Opioid prescribing for chronic musculoskeletal pain in UK primary care: results from a cohort analysis of the COPERS trial

Tomi Ashaye,[1] Natalia Hounsome,[2] Dawn Carnes,[2] Stephanie J C Taylor,[2] Kate Homer,[2] Sandra Eldridge,[2] Anne Spencer,[3] Anisur Rahman,[4] Jens Foell,[2] Martin R Underwood,[5] on behalf of the COPERS Study Team (ISRCTN 24426731).

'Few things a doctor does are more important than relieving pain … pain is soul destroying.'[1] These words from Marcia Angell, former editor in chief of the *New England Medical Journal*, succinctly illustrate the therapeutic need for pain relief. However, prescribers

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the UK.[4] Pain is the main symptom of many musculoskeletal conditions and it is closely associated with depression, anxiety, fatigue and sleep deprivation. The WHO recognises chronic musculoskeletal pain as a global priority and aims to better alert nations to the health and economic costs brought about by musculoskeletal conditions.[5]

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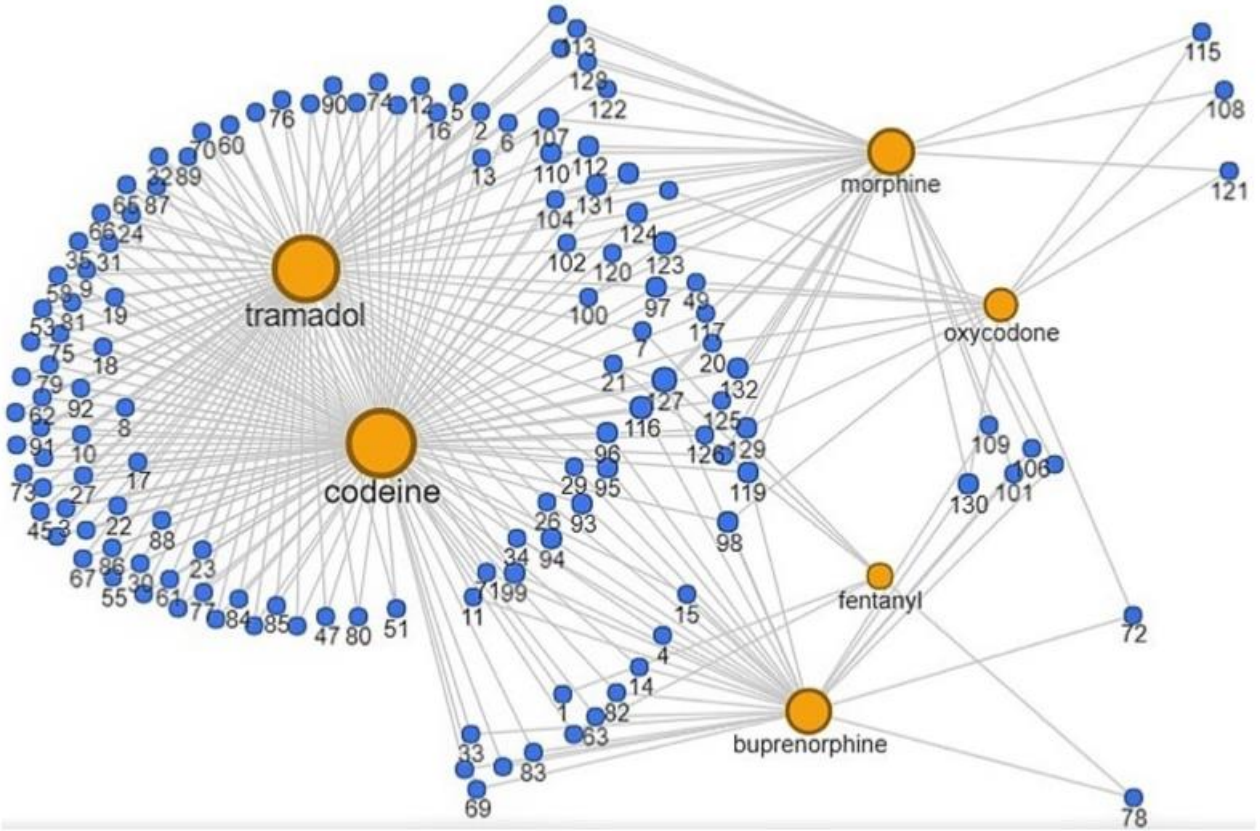

Figure 2 Network plot showing coprescribing of opioids for 132 patients. Patients are indicated by blue circles with numbers, which are linked to prescribed opioids (yellow circles). The size of the circles is proportional to the number of prescribed opioids.

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Table 3 Characteristics of opioid prescriptions in patients receiving strong and weak opioids (n=413)

Prescription characteristics	People receiving strong opioids n=231	People receiving weak opioids n=182
Number of patients prescribed opioids	231 (56%)	182 (44%)
Annual number of prescriptions	2332	987
Annual cost per patient	£174	£24
Average number of prescriptions a year (SD)	10 (9)	5 (5)
Number of patients receiving >3 prescriptions a year	166 (40%)	88 (21%)
Average cost per patient receiving >3 prescriptions a year	£236	£40

BMJ Open

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an opiate drug.[12] The UK guidelines on chronic pain management for people with low back pain and osteoarthritis[13–16] recommend weak opioids as a second-line treatment when the first-line medication (non-steroidal anti-inflammatory drugs, paracetamol or cyclo-oxygenase-2 inhibitors) is ineffective or not tolerated. Strong opioids are to be only prescribed for unremitting cases and even then for short-term use only, stepping patients down to weaker opioids as appropriate, or removing altogether if not effective.[15]

Sleep Medicine Reviews
Volume 65, October 2022, 101672

The short-term effects of opioid and non-opioid pharmacotherapies on sleep in people with chronic low back pain: A systematic review and meta-analysis of randomized controlled trials

James M. Puterflam [a b c], Julian J. Comis [a c], Qianwen Lan [a c], Chen Liu [a c], Adam J. Lipschitz [a], Ronald R. Grunstein [a b d], Paulo H. Ferreira [a c 1], Christopher J. Gordon [a b 1]

Opioid therapies significantly improved sleep quality (SMD = 0.27, 95% CI: 0.17–0.36) and reduced sleep disturbance (SMD = 0.32, 95% CI: 0.25–0.40) compared to placebo-control. These findings show a

Research Paper

PAIN

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Trends in long-term opioid prescribing in primary care patients with musculoskeletal conditions: an observational database study

John Bedson[a,*], Ying Chen[a], Richard A. Hayward[a], Julie Ashworth[a], Kate Walters[b], Kate M. Dunn[a], Kelvin P. Jordan[a]

Guidance from the World Health Organisation and the UK National Institute for Health and Care Excellence (NICE) suggest using opioids as part of a stepped approach to controlling MSK pain.[16,30] This advice advocates incremental

patients.[12,31] Indeed, guidelines suggest using opioids if alternative prescribing strategies have failed, which might prompt doctors to use opioids in patients in whom pain has been difficult to control.[16,30] However, the increasing incidence

Guidelines that are now being incorporated into normal practice[4,6] need to ensure clear messages around appropriate use of opioids, including the correct dosage and indications for continued use. Regular review would also ensure that opioid use is only continued when necessary, reducing the potential for addiction and side effects.

[CLINICAL COMMENTARY]

DAVID B. ANDERSON[1] • CHRISTINA ABDEL SHAHEED[2]

Medications for Treating Low Back Pain in Adults. Evidence for the Use of Paracetamol, Opioids, Nonsteroidal Anti-inflammatories, Muscle Relaxants, Antibiotics, and Antidepressants: An Overview for Musculoskeletal Clinicians

OF THE MEDICATION CATEGORIES DISCUSSED (opioids, paracetamol, NSAIDs, muscle relaxants, antibiotics, and antidepressants), only NSAIDs (selective and nonselective) showed benefits (when compared with placebo) in both acute and chronic LBP. Like paracetamol,

Given the uncertain evidence of benefits (**TABLE 1**) and risk of harms (**TABLE 2**), practice guidelines may need to be updated to reflect the current evidence for each medication type. In general, medicines should not be used as the sole treatment for pain, but rather combined with safe,

TABLE 1 Overview of Pain and Function Outcomes for Each Medication Compared With Control

Medication	Scale[b]	Follow-up	Type	LBP Type	MD (95% CI)	Trials (n)	Quality of Evidence
Pain							
Paracetamol[8,33]	0-100	<2 weeks	Acetaminophen	Acute	1.5 (−1.3, 4.3)	1 (1520)	High
NSAIDs[25]	0-100	≤3 weeks	Nonselective NSAIDs	Acute	−7.3 (−11.0, −3.6)	4 (815)	Moderate
			Nonselective NSAIDs	Chronic	−6.0 (−11.0, −1.0)	4 (847)	Low
			Selective NSAIDs	Chronic	−9.1 (−13.6, −4.7)	2 (507)	Low
Opioids[7]							
Single ingredient	0-100	≤3 months	Mix	Chronic	−10.1 (−12.8, −7.4)	13 (3419)	Moderate
Combination opioid and simple analgesic	0-100	≥3 months, <12 months	Tramadol plus paracetamol	Chronic	−11.9 (−19.3, −4.4)	2 (501)	Moderate
Muscle relaxants[12]	0-100	≤2 weeks	Nonbenzodiazepine	Acute	−7.7 (−12.1, −3.3)	16 (4546)	Very low
			Benzodiazepine	Acute	2.0 (−9.8, 13.8)	1 (112)	Moderate
			Antispastic	Acute	−1.6 (−15.3, 12.1)	1 (103)	Low
		3 to 13 weeks	Nonbenzodiazepine	Acute	0.6 (−4.5, 5.7)	3 (612)	Moderate
			Benzodiazepine	Acute	−1.0 (−10.4, 8.4)	1 (103)	Low
			Antispastic	Acute	4.0 (−7.7, 15.7)	1 (99)	Moderate
			Antispastic	Chronic	−5.4 (−13.7, 2.9)	1 (80)	Very low
Antibiotics[6,31]	0-100	100 days	Amoxicillin/clavulanate	Chronic	−13.0[a]	1 (144)	-
		12 months	Amoxicillin/clavulanate	Chronic	−26.0[a]	1 (144)	-
		12 months	Amoxicillin	Chronic	−0.8 (−1.6, 0.0)	1 (180)	-
Antidepressants[17]	0-100	10 days to 6 months	Mix	Chronic	−4.3 (−6.2, −2.5)	16[c]	Low
Function							
Paracetamol[27]	0-100	<2 weeks	Acetaminophen	Acute	−1.9 (−4.8, 1.0)	1 (1652)	High
		>2 weeks to ≤3 months		Acute	0.4 (−1.7, 2.5)	1 (1652)	High
NSAIDs[16,38]	0-24	≤3 weeks	Selective NSAIDs	Acute	−2.0 (−2.9, −1.2)	2 (437)	High
		4 to 16 weeks	Mix	Chronic	−0.85 (−1.3, −0.4)	4 (1161)	Low
Opioids[7]	0-100	2 weeks	Tramadol	Chronic	−6.3 (−12.2, −0.3)	1 (103)	Very low
Muscle relaxants[12]	0-100	≤2 weeks	Nonbenzodiazepine	Acute	−3.3 (−7.3, 0.7)	7 (2438)	Very low
			Nonbenzodiazepine	Mixed	−19.2 (−27.7, −10.7)	1 (329)	Low
			Benzodiazepine	Acute	0.0 (−13.2, 13.2)	1 (112)	Low
			Antispastics	Acute	2.0 (−15.6, 19.6)	1 (103)	Low
		3 to 13 weeks	Nonbenzodiazepine	Acute	4.3 (−1.4, 10.1)	2 (422)	Moderate
			Benzodiazepine	Acute	−6.9 (−12.1, −1.7)	1 (103)	Moderate
			Antispastics	Chronic	−3.2 (−8.3, 1.8)	1 (80)	Very low
Antibiotics[6,31]	0-24	100 days	Amoxicillin/clavulanate	Chronic	−3.5[a]	1 (144)	-
		12 months	Amoxicillin/clavulanate	Chronic	−7.0[a]	1 (144)	-
		12 months	Amoxicillin	Chronic	−2.3 (−4.2, −0.4)	1 (180)	-
Antidepressants[17]	0-100	10 days to 6 months	Mix	Chronic	−1.3 (−1.0, −1.6)	6[c]	Low

Abbreviations: CI, confidence interval; LBP, low back pain; MD, mean difference; NSAIDs, nonsteroidal anti-inflammatory drugs.

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Guidelines

Responsible, Safe, and Effective Prescription of Opioids for Chronic Non-Cancer Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines

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10.7.1 Recommendation

Opioid therapy must be started with short-acting opioids and should be maintained with low doses due to adverse consequences related to moderate to high dose opioid therapy.

(Evidence: Level II; Strength of Recommendation: Moderate)

NICE National Institute for Health and Care Excellence

NICE guideline

Low back pain and sciatica in over 16s: assessment and management

Pharmacological management of low back pain

1.2.22 Consider oral NSAIDs for managing low back pain, taking into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age. **[2016]**

1.2.23 When prescribing oral NSAIDs for low back pain, think about appropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastroprotective treatment. **[2016]**

1.2.24 Prescribe oral NSAIDs for low back pain at the lowest effective dose for the shortest possible period of time. **[2016]**

1.2.25 Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective. For guidance on safe prescribing of opioids and managing withdrawal, see NICE's guideline on medicines associated with dependence or withdrawal symptoms. **[2016]**

1.2.26 Do not offer paracetamol alone for managing low back pain. **[2016]**

1.2.27 Do not routinely offer opioids for managing acute low back pain (see recommendation 1.2.25). **[2016]**

1.2.28 Do not offer opioids for managing chronic low back pain. **[2016]**

1.2.29 Do not offer selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors or tricyclic antidepressants for managing low back pain. **[2016]**

1.2.30 Do not offer gabapentinoids or antiepileptics for managing low back pain. **[2016, amended 2020]**

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2021

POSITION PAPER

EJP
European Journal of Pain

European* clinical practice recommendations on opioids for chronic noncancer pain – Part 1: Role of opioids in the management of chronic noncancer pain

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Background: Opioid use for chronic non-cancer pain (CNCP) is complex. In the absence of pan-European guidance on this issue, a position paper was commissioned by the European Pain Federation (EFIC).

3.1 | Good clinical practice statements and recommendations

3.1.1 | Part 1: Role of opioids in the management of chronic noncancer pain

1. Optimization of non-opioid treatment. Before considering opioid treatment, we first suggest optimizing non-pharmacological treatments (e.g. exercise, physiotherapy, psychological therapies) and considering non-opioid analgesics. Weak recommendation, strong consensus (16/16; 11/11).

Comment: Optimization of non-pharmacological therapies should include interdisciplinary multimodal pain therapy (Kaiser et al., 2017) – if available – and – in selected patients – invasive procedures such as neuromodulation.

2. When to consider opioids. We suggest considering a trial of opioids if established non-pharmacological treatments and established non-opioid analgesics are:

- *Not effective and/or*
- *Not tolerated and/or*
- *Contraindicated*
- *Not available*

1. Measures prior to opioid initiation

1.1 Case history and clinical status: General case history (including previous substance use disorder), pain-related case history and the physical and psychological status of the patient should be considered and documented. Good clinical practice statement. Strong Consensus (17/17; 17/17).

1.2 Screening for mental disorders: The physician who is thinking about opioid prescribing should consider documentation of psychosocial case history and screening for current and/or past psychiatric disorders. Good clinical practice statement. Strong Consensus (17/17; 17/17).

1.4 Therapeutic goals. Physicians prescribing opioids should consider setting individual and realistic therapeutic goals together with the patient. Good clinical practice statement. Strong Consensus (17/17; 17/17).

1.5 Patient information: Physicians prescribing opioids should consider providing patients with information by means of documented oral or written communication, including information on traffic and workplace aspects relevant to the patient (and potentially to the family and/or caregiver). Good clinical practice statement. Strong Consensus (17/17; 17/17).

1.6 Titration and driving safety: Physicians prescribing opioids should consider informing patient of national legal regulations regarding driving during the titration phase or when their dose is changed and to document the information in the chart. Good clinical practice statement. Strong Consensus (17/17; 17/17).

The daily dosages in the long-term open label extensions studies were as follows: Buprenorphine transdermal (5–40 µg/h; average 14 µg/h); Hydromorphone (8–32 mg/d; average 17 mg/d); Morphine (Maximum 90 mg/d, half of the patients used <60 mg/d); Oxycodone: 20–140 mg/d (mean dosages in studies 44 mg/d); Tapentadol (100–500 mg/d; average 368 mg/d) (Bialas et al., 2020).

5. Initial dose adjustment phase (8–12 weeks)
   a. Start slow, go slow
   b. Monitor and treat side effects if needed
   c. Find the optimal dosage (predefined treatment goals met; no or tolerable/manageable side effects)
   d. Discontinue if
   (i) Predefined treatment goals not reached
   (ii) Intolerable/manageable side effects
   (iii) Non-medical use of prescribed opioids
6. Long-term opioid therapy (>12 weeks)
   a. Regular assessments (at least every 3 months)
   b. Assess four A's: Activity, analgesia, aberrant behaviour, adverse effects
   c. Promote non-pharmacological therapies
   d. Continue if
   (i) Stable dosage
   (ii) Sustained improvement of daily functioning and pain reduction
   (iii) tolerable/manageable side effects
   (iv) No signals of non-medical use of prescribed opioids
   e. Discuss tapering/drug holiday after 6 months with the patient
   f. Discontinue if
   (i) Dose escalation
   (ii) Loss of improvement of daily functioning and of pain reduction
   (iii) tolerable/manageable side effects
   (iv) Signals of non-medical use of prescribed opioids

EXPERT OPINION

SIAARTI

PRO VITA CONTRA DOLOREM SEMPER

Appropriatezza, efficacia e sicurezza dei farmaci oppiacei nella terapia del dolore cronico adulto e pediatrico

Versione del 21 Aprile 2023

Si calcola che circa il 12% dei pazienti ha un dolore cronico correlato ad una diagnosi oncologica; nel rimanente 88% (per lo più di donne e di età compresa tra i 35 ed i 65 anni), il dolore è causato da malattie muscolo-scheletriche ed

Nell'ambito delle terapie farmacologiche, i farmaci oppiacei rappresentano spesso una opzione terapeutica fondamentale nell'ambito di un percorso di cura individualizzato e multimodale per il trattamento del dolore, la cui assunzione, in

I farmaci oppiacei sono infatti caratterizzati da un'ampia variabilità di risposta individuale che in taluni casi può portare anche ad un elevato rischio di gravi effetti collaterali [9]. E' dunque fondamentale una titolazione del farmaco attenta

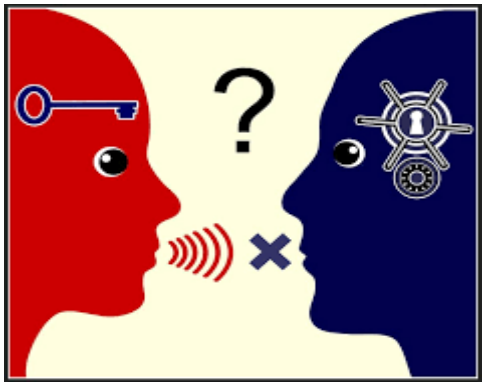
QUINDI?

NON SONO UNA PANACEA

- Pazienti selezionati e ben studiati
- Titrazione
- Per un tempo contingentato
- Controlli ravvicinati
- Come parte di un trattamento multimodale e multidisciplinare

CAMBIARE LINGUAGGIO

- ***Modello biopsicosociale***
- ***Riempire la distanza tra segno e significato***
- ***Multidisciplinarità***
- ***Multimodalità***
- ***Relazione come momento di cura***



Formazione

Grazie!