Choosing Wisely Australia
An initiative of NPS MedicineWise

FPM FACULTY OF PAIN MEDICINE ANZCA

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.

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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.

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SUPPORTING EVIDENCE

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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.

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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

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