FPM
Faculty of Pain Medicine
ANZCA

PS14(PM) Statement on the responsibility of specialist pain medicine physicians for overall opioid management in patients with chronic non-cancer pain who have an intrathecal opioid delivery device in situ 2023

Short title: Responsibility for co-prescription of oral and intrathecal opioids

Introduction

The long-term intrathecal delivery of drugs is an established, evidence-based therapy for the management of refractory spasticity and cancer pain. The role of intrathecal therapy in chronic non-cancer pain is controversial and evidence for long term efficacy and safety is more limited.

The rationale is that drugs delivered directly to the site of action in the central nervous system, can achieve improved effect and fewer adverse effects, at only a small fraction of an equivalent systemic dose. (1,2,3,4) Where alternative routes of drug administration are available and tolerated, there are no firm grounds on which to expect that intrathecal administration would be associated with improved patient outcomes.

This modality of treatment is an invasive intervention, which is costly and labour-intensive, with potential for serious risks and complications: the balance of risk and benefit demands careful consideration.

Education of the patient increases their understanding of the potential benefits, risks and their responsibilities: the patient must be motivated to participate in the management plan, and consent to all aspects of the treatment. Discussion regarding the expectations for reduction in oral opioid with successful intrathecal treatment should occur, and the outcomes documented.

Both physician and patient should be aware of current data relating to safety and potential neurotoxicity of proposed intrathecal medications. (5,6,7)

Intrathecal opioid administration in patients with chronic non-cancer pain (CNCP)

Effective management of intrathecal opioid therapy requires rigorous appropriate patient selection- that should include comprehensive, multidisciplinary assessment of symptoms, disease, psychological and social factors, current and previous treatments and other treatment options.

Patients must have a clear sociopsychobiomedical formulation for their pain for which less-invasive modalities of management (including psychological and physical therapies) have failed.

The treating physician must be experienced with the therapy and device(s) to be utilised and must adhere to PS11 (PM) Procedures in pain medicine clinical care standard. They should preferably have FPM Endorsement for Category 3 procedures.

This modality is optimally initiated, managed and supervised by appropriately trained and experienced specialist pain medicine physicians (SPMPs). However, it is recognised that other craft groups such as neurosurgeons, anaesthetists and palliative care physicians may develop appropriate skills in initiation, supervision, and management, and that some primary care physicians may develop skills in management of this modality.

Allocation and delegation of responsibility

The SPMP who is managing or supervising a patient with an implanted intrathecal analgesic infusion pump or port with attached ambulatory pump has the overall responsibility for all opioid prescriptions for that patient in a shared care model with primary care physicians (GP) and other specialists.

Other clinicians should not initiate or modify opioid therapy in these patients without discussion with the SPMP, including planning of reduction of oral opioids.

Where, by mutual agreement, the actual prescription for oral opioids has been delegated to another treating doctor, the SPMP retains responsibility for the appropriateness of the patient's opioid regimen in the context of an overall pain management program.

It is recognised that other pain conditions and any other acute medical or surgical problems that may arise should be managed according to clinical need. Necessary interventions may include regular and time-limited emergency oral or parenteral analgesic therapy. Timely communication with the responsible SPMP should then occur, once the acute problem has been stabilised.

Ongoing pain-related drug therapy, especially with opioid analgesics, should be discussed with and endorsed by the SPMP.

Real time prescription monitoring should be used, when available, before prescribing any opioid, by any route to a patient on intrathecal opioids.

Local regulatory permits should recognise the shared care context when oral and IT opioid formulations are co-prescribed.

References

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