E2 LANGUAGE

Practice test 2

READING SUB-TEST – TEXT BOOKLET: PART A

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Opioid dependence

Text A

Identifying opioid dependence

The International Classification of Disease, Tenth Edition [*ICD-10*] is a coding system created by the World Health Organization (WHO) to catalogue and name diseases, conditions, signs and symptoms.

The *ICD-10* includes criteria to identify dependence. According to the *ICD-10*, opioid dependence is defined by the presence of three or more of the following features at any one time in the preceding year:

- a strong desire or sense of compulsion to take opioids
- difficulties in controlling opioid use
- a physiological withdrawal state
- tolerance of opioids
- progressive neglect of alternative interests or pleasures because of opioid use
- persisting with opioid use despite clear evidence of overtly harmful consequences.

There are other definitions of opioid dependence or 'use disorder' (e.g. the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, [*DSM-5*]), but the central features are the same. Loss of control over use, continuing use despite harm, craving, compulsive use, physical tolerance and dependence remain key in identifying problems.

Text B

WHY NOT JUST PRESCRIBE CODEINE OR ANOTHER OPIOID?

Now that analgesics containing codeine are no longer available OTC (over the counter), patients may request a prescription for codeine. It is important for GPs to explain that there is a lack of evidence demonstrating the long-term analgesic efficacy of codeine in treating chronic non-cancer pain. Long-term use of opioids has not been associated with sustained improvement in function or quality of life, and there are increasing concerns about the risk of harm.

GPs should explain that the risks associated with opioids include tolerance leading to dose escalation, overdose, falls, accidents and death. It should be emphasised that OTC codeine-containing analgesics were only intended for short-term use (one to three days) and that longer-term pain management requires a more detailed assessment of the patient's medical condition as well as clinical management.

New trials have shown that for acute pain, nonopioid combinations can be as effective as combination analgesics containing opioids such as codeine and oxycodone. If pain isn’t managed with nonopioid medications then consider referring the patient to a pain specialist or pain clinic.

Patient resources for pain management are freely available online to all clinicians at websites such as:

- Pain Management Network in NSW - www.aci.health.nsw.gov.au/networks/pain-management
- Australian and New Zealand College of Anaesthetists Faculty of Pain Medicine - www.fpm.anzca.edu.au

Text C

TABLE 2. COMPARISON OF MEDICATION APPROACHES FOR SHORT-TERM MANAGEMENT OF OPIOID WITHDRAWAL (OVER SEVEN TO 10 DAYS)[8-16]

Medication	Regulatory requirements	Requires off-label use	Strength of evidence	Advantages	Disadvantages	Notes on dosage
Buprenorphine–naloxone (sublingual)	Permit before treatment; patient registered as drug dependent in some jurisdictions	Indicated for opioid dependence (off-label for pain)	Multiple well-conducted RCTs demonstrate efficacy and safety[8]	• A large evidence base (e.g. Cochrane reviews) shows it is the most effective option for opioid taper[16]	• More restrictive than other options (regulatory requirements and supervised dosing) • Indicated only for opioid dependence, not for chronic pain in the absence of opioid dependence	• See sample withdrawal regimen (Box 8) or refer to state and national guidelines
Tramadol (oral)	Only those that apply to S4 medications	Yes (indicated for pain not opioid dependence)	Low – a small number of RCTs demonstrate efficacy and safety[9-12]	• A small number of studies examined a one-week tramadol taper, with outcomes comparable with those of other opioid tapers and superior to clonidine	• May produce serotonergic side effects, known drug interactions, use with caution in the elderly • Use is off label • Risk of seizures, even at usual doses • Variable metabolism through CYP P450, similar to codeine	• 100 to 300 mg sustained-release formulation twice a day for one week • Supervised dosing and daily dispensing may be indicated
Buprenorphine (transdermal patch)	Permit before treatment if patient is drug dependent	Yes (indicated for pain not opioid dependence)	None – no RCTs or published cases	• Good safety profile	• Dose likely to be insufficient for patients with clear evidence of opioid dependence	• 5, 10 or 20 mcg weekly patches are available • A single patch should be sufficient for taper from oral codeine
Symptomatic medications	Only those relating to S4/OTC medications	No (if use is consistent with product indication)	Moderate to high – well-conducted RCTs demonstrate efficacy; however, poorer outcomes than buprenorphine or tramadol[15]	• Fewer prescribing restrictions • Relatively safe in outpatient setting	• Shown to be less effective than buprenorphine and tramadol • Multiple medications can be confusing • Caution using sedative medications in outpatient setting • Clonidine can cause severe hypotension	• See Table 1

Abbreviations: OTC = over the counter; RCT = randomised controlled trial.

Text D

Preparation for tapering

As soon as a valid indication for tapering of opioid analgesics is established, it is important to have a conversation with the patient to explain the process and develop a treatment agreement. This agreement could include:

- time frame for the agreement
- objectives of the taper
- frequency of dose reduction
- requirement for obtaining the prescriptions from a designated clinician
- scheduled appointments for regular review
- anticipated effects of the taper
- consent for urine drug screening
- possible consequences of failure to comply.

Before starting tapering, it needs to be clearly emphasised to the patient that reducing the dose of opioid analgesia will not necessarily equate to increased pain and that it will, in effect, lead to improved mood and functioning as well as a reduction in pain intensity. The prescriber should establish a therapeutic alliance with the patient and develop a shared and specific goal.

END OF PART A
THIS TEXT BOOKLET WILL BE COLLECTED