**RCoA and BJA joint webinar - Chronic Opioid use: the other pandemic**

**Additional questions and answers**

**EMCDD reported that opioid contributed to more than 80% of Drug related deaths, why is it still prescribed?**

I am not familiar with the EMCDD but often drug deaths (and non-fatal overdose) with opioids include non-prescribed drugs (e.g. heroin). Important to separate those out, and only use prescribed opioids with careful monitoring and control.

**What influence do pharmaceutical companies have on chronic opioid use or abuse? In particular the USA versus the UK?**

They probably influenced early prescribing in both. I think because of the healthcare system in the US they were able to have a greater influence ( direct marketing to patients/ easier to "doctor shop"/ limited national prescription monitoring) The demise of the American Pain Society due to pharma links is a loss, but we should learn from it

**In some of the Scottish guidelines, oxycodone is second line. Do you think that this should be more universal?**

I think type of strong opioid is less important than whether used at all, dose and duration. We need more research on long term efficacy - still only that one study (SPACE trial, n=240) - need better phenotyping/ genotyping to understand what determines individual response and when opioids can be used appropriately and safely.

**Massive congratulations on the new MHRA guidelines on opioid. How do you think that this be deprescribing plan from the get go, can be rolled out?**

Thanks! Still limited evidence about how best to reduce opioids - will be interesting to see what the iWOTCH study shows when it reports. From clinical experience, managing anxiety around dose reduction and early/ intense treatment of physical withdrawal (often not recognised as that by patient)

**How do you think that the deprescribing plan from the get go, can be rolled out?**

Challenging - especially in COVID times. We need to have a robust way to manage distress/ provide community based support or we will end up with issues such as seen in the US

**Is permanent regional nerve block with catheter more effective than long term opioid use?**

Hard to separate out pain/ sensation block which would be important in long term use, but this selective approach may be promising in future developments

**The issue is how to wean patients who we inherit and who are on MME> 50 but stable. They have had a full cohort of Rx but want to keep on opioids.**

I think that involves a risk/ benefit approach on a case by case basis - stable low dose opioid that allows patient to work/ function may be better than severe uncontrolled pain impacting on ability to function. I think we need more research on long term efficacy: the SPACE trial was good, but only with 240 patients, who actually had relatively low pain/ interference scores (much lower than we would see in our pain clinics)

**How much link is there between availability of alternative treatment options and prescriptions? Supported activity, social prescribing, psychological techniques etc**

Good question. I think a major concern at the moment - will be very interesting to see what happens to prescribing during/ post covid. We are using a lot of online resources - but access (or not) to this may increase inequalities of care

**the question if opioids have to be used in chronic pain needs rephrasing, it can be used on selected patients fora short term if everything else fails**

To some extent I agree with Dave Lambert's conclusion - "don't throw the baby out with the bathwater"! We need to better understand who will respond to opioids without significant harm - will need more research on phenotyping/ genotyping, using a precision medicine approach