

Erratum

Macintyre PE, Jamcotchian MA, Stevens JA. Calling time on the use of modified-release opioids for acute pain. *Med J Aust* 2024; <https://doi.org/10.5694/mja2.52417>

In “The opioid prescription” section in the Box, the statement “Coprescription of naloxone is suggested” was missing. In addition, in the last section of this Box, the text on the left column should be “Recognition of OIVI”. The updated “Titration of immediate-release opioids prescribed for the treatment of acute pain” Box is shown below. ■

Requirements for individualised opioid titration regimens

The opioid prescription	<ul style="list-style-type: none"> • The initial dose range of opioid prescribed should vary according to the age of the patient (for opioid-naïve patients) and the severity of the anticipated pain: <ul style="list-style-type: none"> ▶ Age is a better predictor of opioid requirements than patient weight ▶ Increasing age is associated with decreased opioid requirements and this appears to be primarily due to pharmacodynamic rather than pharmacokinetic factors; that is, increased sensitivity of the central nervous system with ageing rather than the changes in metabolism and excretion of the drug that might also be seen in older patients ▶ The initial opioid dose range prescribed should be lower in patients with moderate pain than those with severe acute pain; lower doses may also be safer where appropriate monitoring is not reliable • Subsequent doses may need to be adjusted according to patient response (analgesic effectiveness and adverse effects) • Prescribe an appropriate dose interval (the interval within which additional doses should not be given): <ul style="list-style-type: none"> ▶ In some settings (eg, where there is 24-hour medical cover and experienced nursing staff and appropriate monitoring are available) it may be reasonable to order an IR opioid “every two hours as needed”; in other settings “every four hours as needed” may be safer • Order “as needed” only and not on a regular (time-contingent) basis; write maximum 24-hour dose as “sedation score less than 2” • Coprescription of naloxone is suggested • The IR opioid should be used for the shortest time possible and in decreasing doses over a short time. Deprescribing starts in hospital and requires involvement of nurses, doctors, ward pharmacists and the patient: <ul style="list-style-type: none"> ▶ This requires regular patient review ▶ The opioid prescription may need to be rewritten to allow for or assist with decreasing opioid dose trajectories, sometimes on a daily basis
Assessment of analgesic effectiveness	<ul style="list-style-type: none"> • Unidimensional pain scores are commonly used in the acute pain setting to determine analgesic effectiveness and guide opioid titration: <ul style="list-style-type: none"> ▶ Do not adjust analgesic regimens, including opioid doses, based on a patient’s pain scores alone ▶ Predictors of high pain scores include psychological comorbid conditions (eg, anxiety, catastrophising), pre-existing chronic pain, and tolerance to opioids, and therefore high scores do not always mean that an opioid — or more opioid — is needed ▶ A patient’s pain score trajectory (plotting a patient’s pain scores over time) is a more useful indicator of patient progress and can allow identification of psychological distress, the presence of non-opioid-responsive pain and post-operative/post-trauma complications; pain score trajectories that do not decrease over the first few days are also good predictors of chronic post-surgical pain. Patients whose pain score trajectories are not decreasing require review ▶ “Chasing” pain scores with opioids to achieve an arbitrarily defined acceptable level of pain or zero pain can lead to increases in the risk of OIVI and PPOU • Include an assessment of patient function (eg, using functional activity scores). One example of a functional activity score is: <ul style="list-style-type: none"> • A — no limitation of relevant activity due to pain (relative to baseline) • B — mild limitation of activity due to pain • C — unable to complete activity due to pain
Recognition of OIVI	<ul style="list-style-type: none"> • Increasing sedation is a more reliable indicator of developing OIVI than a decrease in respiratory rate: <ul style="list-style-type: none"> ▶ Respiratory rate can remain within acceptable limits even when OIVI is severe ▶ Record sedation scores (along with pain scores and functional activity scores) at time of administration of the IR opioid and when peak effect is expected (ie, about one hour after administration of an oral IR opioid) • One suggested sedation scoring system is: 0 = wide awake, 1 = easy to rouse (and can stay awake), 2 = easy to rouse but unable to remain awake, and 3 = difficult to rouse: <ul style="list-style-type: none"> ▶ Titrate opioids so that sedation score is always < 2 • Hypoxaemia may be a very late sign of hypoventilation, especially if the patient is receiving supplemental oxygen • Immediate intervention is required if a patient has a sedation score of 2 or 3, regardless of the patient’s respiratory rate

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