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Centre universitaire
de médecine générale
et santé publique · Lausanne

Vignette F

Alexandre Gouveia

Jeudi d'Unisanté

Avancées scientifiques 2023

18 janvier 2024

Vignette clinique

- Monsieur M, 45 ans, plombier
- Consulte pour lombalgie apparue suite à un accident dans le contexte de son activité professionnelle
- Après investigations et 2 semaines de traitement antalgique, la douleur est actuellement à 6/10 et le patient aimerait une antalgie plus efficace, comme p.ex. un opioïde

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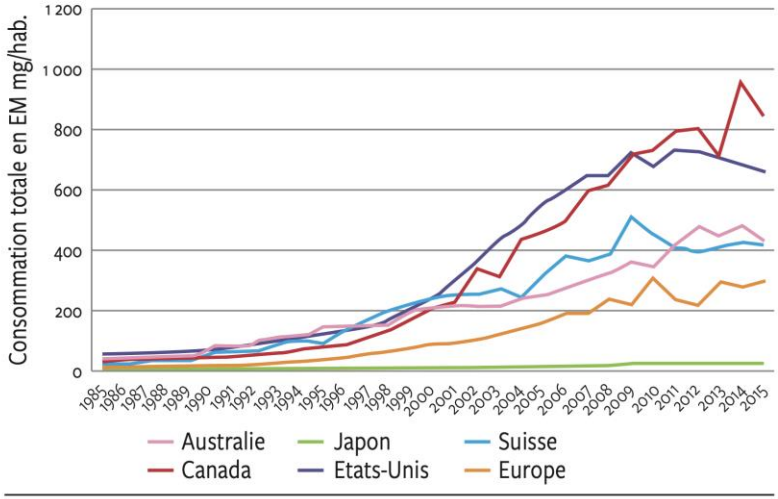
Contexte

FIG 1 **Consommation totale d'opioïdes en équivalent morphinique de 1985 à 2015**



Ruchat, D., Suter, M., R., Rodondi, P., Berna, C., Consommation d'opioïdes entre 1985 et 2015 : chiffres suisses et mise en perspective internationale, Rev Med Suisse, 2018/612 (Vol.4), p. 1262–1266

Contexte

Suisse Modifié le 2 mai 2023 à 11:58

La prescription d'opioïdes a fortement augmenté en dix ans en Suisse

Les médecins suisses prescrivent beaucoup plus d'opioïdes qu'il y a dix ans / La Matinale / 1 min. / le 2 mai 2023

Les médecins suisses prescrivent beaucoup plus d'opioïdes qu'il y a dix ans. Une étude menée par l'hôpital de Baden a analysé les données de la SUVA. Elle montre que ces médicaments sont souvent proposés même pour des cas bénins.

BASES SCIENTIFIQUES POUR LA PRÉVENTION
DES MALADIES NON TRANSMISSIBLES ET DES ADDICTIONS

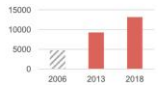
Fiche d'information

Évolution de la prescription d'analgésiques et de somnifères en Suisse

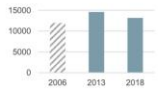
Mandatés par l'Office fédéral de la santé publique (OFSP), l'Hôpital universitaire de Berne et l'Université de Zurich ont étudié les changements observés en matière de prescription d'analgésiques et de somnifères. Pour ce faire, les achats remboursés par la compagnie d'assurance maladie Helsana en 2013 et 2018 ont été analysés. L'étude montre que la prescription d'opioïdes puissants continue d'augmenter fortement. Les opioïdes faibles sont plus rarement prescrits. Des somnifères tels que les benzodiazépines sont prescrits plus rarement et moins longtemps.

CHIFFRES CLÉS

Opioïdes puissants



Opioïdes faibles



Nombre d'achats d'opioïdes pour 100 000 habitants

Remarque : Les valeurs mesurées en 2006 proviennent d'une étude précédente (cf. Wertli et al. 2017). La méthode a évolué entre-temps.

5 achats sur 6
concernant des
opioïdes puissants
ne sont pas associés à une
maladie tumorale active

PRINCIPALES CONCLUSIONS

Évolution de la prescription d'opioïdes puissants et faibles

L'utilisation de médicaments antidouleur augmente à l'échelle mondiale. Des opioïdes faibles sont employés lorsque des médicaments sans opioïdes n'agissent plus sur une douleur légère ou modérée. Des opioïdes puissants sont prescrits pour soulager les très fortes douleurs.

L'étude montre que le nombre des prescriptions d'opioïdes puissants a augmenté (+42,2 %) entre 2013 et 2018. Comparé aux résultats d'une précédente étude datant de 2006, la hausse s'est atténuée. Le nombre de prescriptions d'opioïdes faibles a chuté (-9,8 %). Entre 2006 et 2013, on notait encore une augmentation pour ces produits.

Comparé au nombre d'achats, le nombre de jours de traitement relatif aux opioïdes puissants a aussi augmenté, bien qu'un peu plus modérément (+13,7 %). Les personnes qui achètent des opioïdes puissants sont en moyenne dix ans plus âgées que celles qui prennent des opioïdes faibles.

Concernant les opioïdes faibles, le nombre d'achats de médicaments contenant le principe actif tapendatol a fortement augmenté bien que le tramadol demeure le principe actif le plus utilisé. Concernant les opioïdes puissants, les achats d'oxycodon et d'hydromorphon ont particulièrement augmenté.

Arrière-plans de la prescription d'opioïdes puissants

14,2 % des achats d'opioïdes puissants sont à mettre en relation avec une maladie tumorale active, en particulier dans le cadre de thérapies anticancéreuses. La majorité des prescriptions concerne des personnes qui ne sont pas atteintes d'une maladie tumorale active (85,8 %). Dans ces cas, les opioïdes sont utilisés par exemple pour traiter de fortes douleurs chroniques en relation avec un accident ou une opération. Le contexte des prescriptions non liées à des tumeurs n'a pas été examiné dans le cadre de cette étude. Vu leur grand nombre, elles devront être clarifiées au cours de recherches ultérieures.

Évolution de la prescription de somnifères

Les analyses concernant les somnifères montrent qu'ils sont moins achetés qu'il y a quelques années (-9,4 %) et en particulier que le nombre de jours de traitement est en baisse (-17,2 %).

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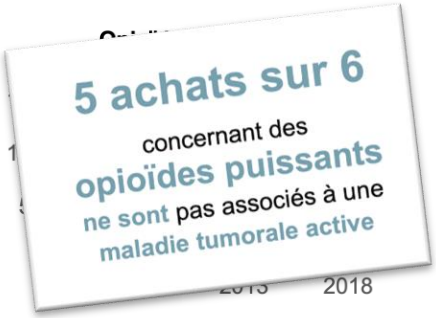
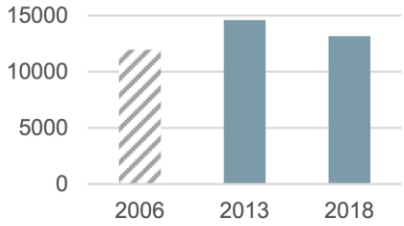


Opioïdes faibles



Nombre d'achats d'opioïdes pour 100 000 habitants

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Quelle est la sécurité et l'efficacité d’un traitement de courte durée par un analgésique opioïde pour la lombalgie et la cervicalgie aiguë?

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Articles

Opioid analgesia for acute low back pain and neck pain (the OPAL trial): a randomised placebo-controlled trial

Caitlin M P Jones, Richard O Day, Bart W Koes, Jane Latimer, Chris G Maher, Andrew J McLachlan, Laurent Billot, Sana Shan, Chung-Wei Christine Lin, on behalf of the OPAL Investigators and Coordinators*

Summary

Background Opioid analgesics are commonly used for acute low back pain and neck pain, but supporting efficacy data are scarce. We aimed to investigate the efficacy and safety of a judicious short course of an opioid analgesic for acute low back pain and neck pain.

Methods OPAL was a triple-blinded, placebo-controlled randomised trial that recruited adults (aged ≥18 years) presenting to one of 157 primary care or emergency department sites in Sydney, NSW, Australia, with 12 weeks or less of low back or neck pain (or both) of at least moderate pain severity. Participants were randomly assigned (1:1) using statistician-generated randomly permuted blocks to guideline-recommended care plus an opioid (oxycodone–naloxone, up to 20 mg oxycodone per day orally) or guideline-recommended care and an identical placebo, for up to 6 weeks. The primary outcome was pain severity at 6 weeks measured with the pain severity subscale of the Brief Pain Inventory (10-point scale), analysed in all eligible participants who provided at least one post-randomisation pain score, by use of a repeated measures linear mixed model. Safety was analysed in all randomly assigned eligible participants. The trial was registered with the Australian New Zealand Clinical Trials Registry (ACTRN12615000775516).

Findings Between Feb 29, 2016, and March 10, 2022, 347 participants were recruited (174 to the opioid group and 173 to the placebo group). 170 (49%) of 346 participants were female and 176 (51%) were male. 33 (19%) of 174 participants in the opioid group and 25 (15%) of 172 in the placebo group had discontinued from the trial by week 6, due to loss to follow-up and participant withdrawals. 151 participants in the opioid group and 159 in the placebo group were included in the primary analysis. Mean pain score at 6 weeks was 2·78 (SE 0·20) in the opioid group versus 2·25 (0·19) in the placebo group (adjusted mean difference 0·53, 95% CI −0·00 to 1·07, p=0·051). 61 (35%) of 174 participants in the opioid group reported at least one adverse event versus 51 (30%) of 172 in the placebo group (p=0·30), but more people in the opioid group reported opioid-related adverse events (eg, 13 [7·5%] of 174 participants in the opioid group reported constipation *vs* six [3·5%] of 173 in the placebo group).

Interpretation Opioids should not be recommended for acute non-specific low back pain or neck pain given that we found no significant difference in pain severity compared with placebo. This finding calls for a change in the frequent use of opioids for these conditions.

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See Online for appendix

Introduction

Low back pain and neck pain are very prevalent,[1] with low back pain being the largest contributor to years lived with disability globally, and neck pain being the fourth largest.[2,3] Low back pain and neck pain also impose the highest direct costs of any medical condition.[4] The economic burden is even greater when the indirect costs are also considered.[5]

Clinical guidelines recommend opioid analgesics for people with acute low back or neck pain only when other pharmacological treatments are contraindicated or have not worked.[6] Despite these guidelines, as high as two-thirds of people in Australia receive an opioid as first-line treatment when presenting for care with low back pain and neck pain.[7] In the USA, opioid prescription rates have decreased in the previous decade, but were still dispensed at a rate of 43·3 prescriptions per 100 people in 2020.[8] The use of opioids for the management of acute low back pain and neck pain is not supported by direct and robust evidence.[9] A further concern regarding opioid use is the risks of adverse events, which can be serious (eg, dependency, misuse, and overdose) and could lead to increased mortality.[10,11] There have been recent calls to reduce the use of opioids, including guidelines from the US Centers for Disease Control and Prevention, the National Institute for Health and Care Excellence in the UK, the Stanford–*Lancet* Commission, and the Australian Commission on Safety and Quality in Healthcare.[12–14]

The aim of this research was to investigate the efficacy and safety of a judicious short course of an opioid analgesic for the management of acute non-specific low back pain and neck pain.

Opioid analgesia for acute low back pain and neck pain (the OPAL trial): a randomised placebo-controlled trial

Jones CMP, Day RO, Koes BW, Latimer J, Maher CG, McLachlan AJ, Billot L, Shan S, Lin CC; OPAL Investigators Coordinators

Lancet. 2023 Jul 22;402(10398):304-312.

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Jones CMP, Day RO, Koes BW, Latimer J, Maher CG, McLachlan AJ, Billot L, Shan S, Lin CC; OPAL Investigators Coordinators. Opioid analgesia for acute low back pain and neck pain (the OPAL trial): a randomised placebo-controlled trial. Lancet. 2023 Jul 22;402(10398):304-312.

Méthodologie

Population	Adultes se présentant dans des établissements de soins primaires ou des services d'urgence à Sydney, Australie, souffrant de douleurs lombaires ou cervicales (ou les deux) d'une durée de 12 semaines ou moins:
Intervention	
Contrôle	
Outcome	
Design	

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Jones CMP, Day RO, Koes BW, Latimer J, Maher CG, McLachlan AJ, Billot L, Shan S, Lin CC; OPAL Investigators Coordinators. Opioid analgesia for acute low back pain and neck pain (the OPAL trial): a randomised placebo-controlled trial. Lancet. 2023 Jul 22;402(10398):304-312.

Résultats

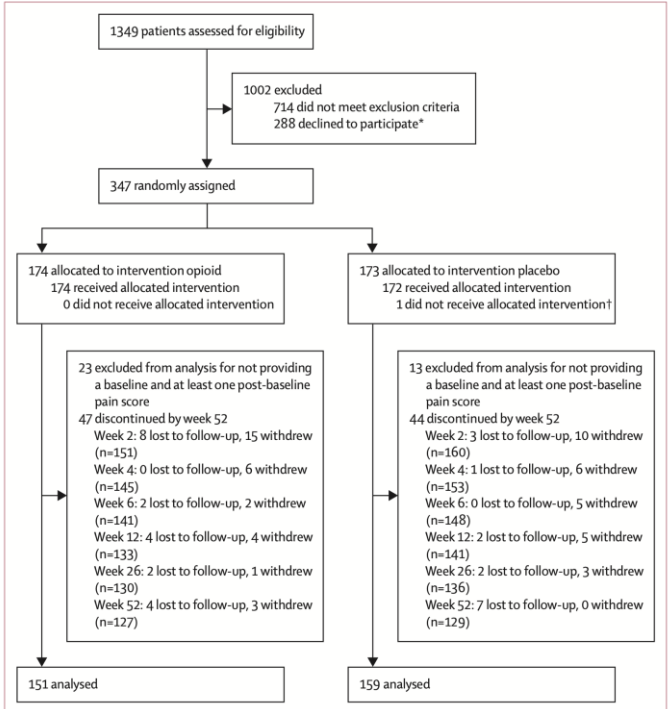

Figure 1: **Trial profile**
Participants who were lost to follow-up were those whom we were unable to contact; those who withdrew had advised trial staff they no longer wished to participate. *Reasons were collected when possible (appendix pp 10–11). †Excluded after randomisation due to a diagnosis of bony metastases.

	Opioid (n=174)	Placebo (n=172)
Sex		
Female	93/174 (53%)	77/172 (45%)
Male	81/174 (47%)	95/172 (55%)
Age		
n	172	169
Mean (SD), years	44·0 (15·5)	45·4 (16·1)
BMI		
n	139	151
Mean (SD), kg/m²	28·4 (7·3)	28·9 (6·1)
Pain location		
Low back	136/174 (78%)	141/171 (83%)
Neck	22/174 (13%)	16/171 (9%)
Both	16/174 (9%)	14/171 (8%)
Worse pain in participants with both low back and neck pain		
Low back	7/16 (44%)	9/14 (64%)
Neck	8/16 (50%)	4/14 (29%)
Unable to determine	1/16 (6%)	1/14 (7%)
Low back pain extends to leg		
Yes	88/142 (62%)	88/145 (61%)
No	54/142 (38%)	57/145 (39%)
Neck pain extends to arm		
Yes	21/30 (70%)	11/20 (55%)
No	9/30 (30%)	9/20 (45%)
Pain duration*		
n	171	164
Mean (SD), days	21·1 (56·36)	15·9 (19·71)
Median (IQR), days	7·0 (3·0–21·0)	7·0 (3·0–21·0)

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Jones CMP, Day RO, Koes BW, Latimer J, Maher CG, McLachlan AJ, Billot L, Shan S, Lin CC; OPAL Investigators Coordinators. Opioid analgesia for acute low back pain and neck pain (the OPAL trial): a randomised placebo-controlled trial. Lancet. 2023 Jul 22;402(10398):304-312.

Résultats

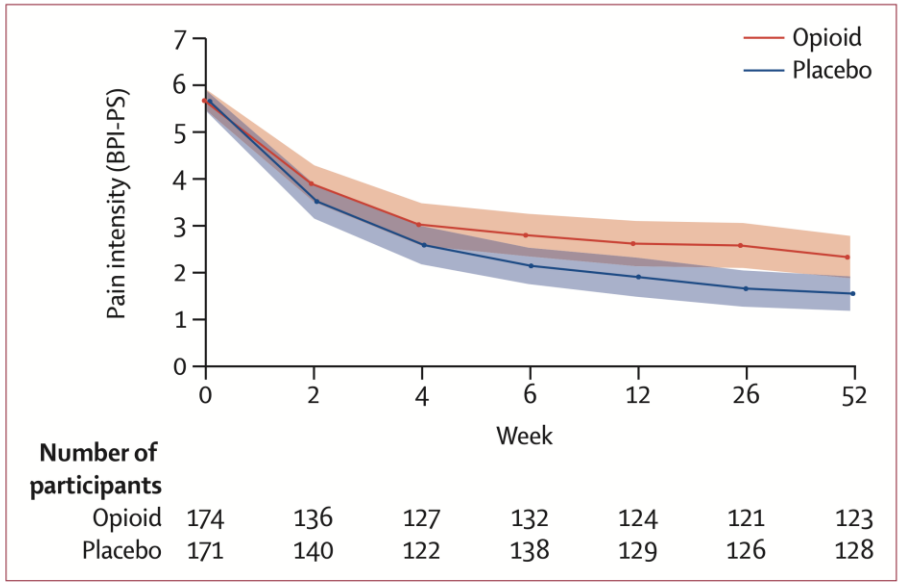

Figure 2: **Longitudinal plot of mean pain severity score**
Datapoints show mean scores at each timepoint, and the shaded areas show 95% CIs. Estimates are raw values (not modelled). BPI-PS=Brief Pain Inventory, pain severity subscale.

	Opioid (n=174)		Placebo (n=172)		Mean difference (95% CI)	p value
	n	Mean (SE)	n	Mean (SE)		
Pain severity (BPI-PS)						
Week 2	136	3·81 (0·19)	140	3·54 (0·19)	NA	NA
Week 4	127	3·08 (0·20)	122	2·73 (0·20)	NA	NA
Week 6	132	2·78 (0·20)	138	2·25 (0·19)	0·53 (–0·00 to 1·07)	0·051
Week 12	124	2·58 (0·20)	129	2·10 (0·19)	0·48 (–0·06 to 1·02)	0·083
Week 26	121	2·67 (0·20)	126	1·87 (0·19)	NA	NA
Week 52	123	2·37 (0·20)	128	1·81 (0·19)	0·57 (0·02 to 1·11)	0·041
Quality of life, physical score (SF-12v2)						
Week 2	119	39·24 (0·85)	125	40·00 (0·81)	NA	NA
Week 4	112	41·44 (0·86)	113	42·28 (0·84)	NA	NA
Week 6	119	43·78 (0·85)	117	44·62 (0·83)	–0·84 (–3·17 to 1·50)	0·48
Week 12	111	45·27 (0·86)	118	45·66 (0·82)	–0·40 (–2·74 to 1·95)	0·74
Quality of life, mental score (SF-12v2)						
Week 2	119	47·46 (0·87)	125	48·50 (0·82)	NA	NA
Week 4	112	48·65 (0·88)	113	50·46 (0·86)	NA	NA
Week 6	119	48·01 (0·86)	117	51·26 (0·85)	–3·25 (–5·63 to –0·87)	0·0075
Week 12	111	48·24 (0·88)	118	51·91 (0·84)	–3·67 (–6·07 to –1·27)	0·0028

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Conclusions

- Même une utilisation prudente et à court terme d'un opioïde n'a pas apporté de bénéfices en termes de réduction de la douleur et a conduit à une légère augmentation de la douleur à moyen et long terme par rapport au placebo
- Le groupe opioïde a eu des scores de qualité de vie et de santé mentale inférieurs à ceux du groupe placebo
- Le groupe placebo a obtenu de meilleurs résultats dans certains autres critères, bien que les différences n'aient pas été significatives
- Bien qu'aucune différence n'ait été trouvée dans le temps global de récupération, davantage de personnes dans le groupe placebo se sont rétablies dans les 14 premiers jours par rapport à celles du groupe opioïde

Forces et faiblesses

Forces :

- Premier essai randomisé avec opioïde contrôlé par placebo
- Setting (médecine de première ligne, services d'urgence)
- Critères d'évaluation sur la qualité de vie et sécurité sur 12 mois

Faiblesses :

- Presque 25% de données manquantes
- Absence de précision sur les soins de base recommandés
- Adhésion au traitement rapportée par seulement 58% des participants

Implications pour la pratique

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STATE OF THE ART REVIEW

Opioids for low back pain

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doi: 10.1136/bmj.g6380

ABSTRACT

Back pain affects most adults, causes disability for some, and is a common reason for seeking healthcare. In the United States, opioid prescription for low back pain has increased, and opioids are now the most commonly prescribed drug class. More than half of regular opioid users report back pain. Rates of opioid prescribing in the US and Canada are two to three times higher than in most European countries. The analgesic efficacy of opioids for acute back pain is inferred from evidence in other acute pain conditions. Opioids do not seem to expedite return to work in injured workers or improve functional outcomes of acute back pain in primary care. For chronic back pain, systematic reviews find scant evidence of efficacy. Randomized controlled trials have high dropout rates, brief duration (four months or less), and highly selected patients. Opioids seem to have short term analgesic efficacy for chronic back pain, but benefits for function are less clear. The magnitude of pain relief across chronic non-cancer pain conditions is about 30%. Given the brevity of randomized controlled trials, the long term effectiveness and safety of opioids are unknown. Loss of long term efficacy could result from drug tolerance and emergence of hyperalgesia. Complications of opioid use include addiction and overdose related mortality, which have risen in parallel with prescription rates. Common short term side effects are constipation, nausea, sedation, and increased risk of falls and fractures. Longer term side effects may include depression and sexual dysfunction. Screening for high risk patients, treatment agreements, and urine testing have not reduced overall rates of opioid prescribing, misuse, or overdose. Newer strategies for reducing risks include more selective prescription of opioids and lower doses; use of prescription monitoring programs; avoidance of co-prescription with sedative hypnotics; and reformulations that make drugs more difficult to snort, smoke, or inject.

thebmj.com
Use our interactive graphic as a guide to prescribing opioids for low back pain. See www.bmj.com/content/350/bmj.g6380/infographic

Introduction

Back pain affects most adults, is a leading cause of activity limitation and work disability worldwide, and is among the most common reasons for seeking healthcare.[1 2] It has an enormous impact on individuals, healthcare systems, and national economies, and treatment approaches have important consequences for patients, clinicians, and society.

In the United States, the prescription of opioids for low back pain has increased.[3] Insurance claims data suggest that the opioids are the most commonly prescribed class of drug for back pain,[4] and more than half of regular opioid users report back pain.[5] Unfortunately, increased drug misuse, complications, and fatal overdoses have accompanied this rise in opioid use.[6] Clinicians must therefore weigh the possible analgesic benefits of opioid therapy against the risks.

The aims of this review are to examine trends and variations in the use of opioids for back pain; assess the evidence for opioid efficacy in acute and chronic back pain; summarize new data on the adverse effects of long term opioids; and make recommendations for judicious prescribing. The review is interspersed with commentary from a patient with back pain and extensive experience with opioid therapy.

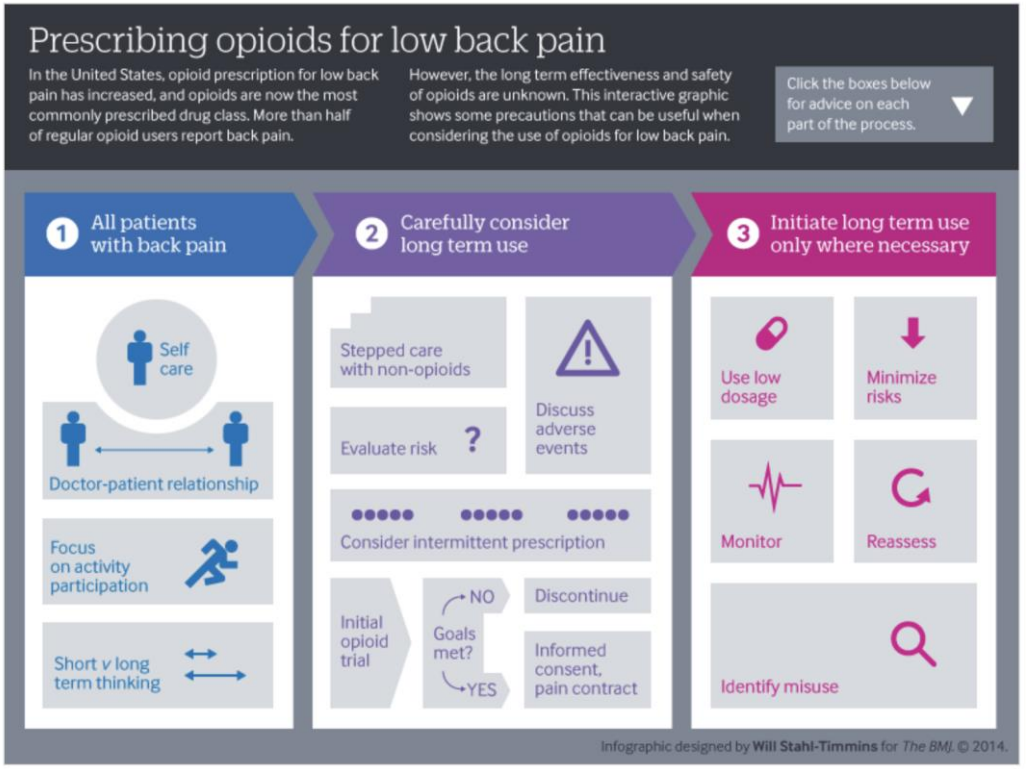
Despite some evidence from randomized controlled trials (RCTs) on the efficacy of opioids in the short term treatment of low back pain, little evidence is available on long term efficacy and safety.[7] Because clinical trials in this area may not generalize well to routine care and provide no evidence on long term use, we also considered selected observational data.

Sources and selection criteria

We identified reviews of opioid efficacy for back pain published between 2000 and April 2014 in the PubMed database using the search terms low back pain and opioids, with a filter for systematic reviews. Because efficacy may differ for back pain relative to other pain conditions (such as neuropathic pain, headache, and fibromyalgia), we focused on reviews that separated back pain from other causes.

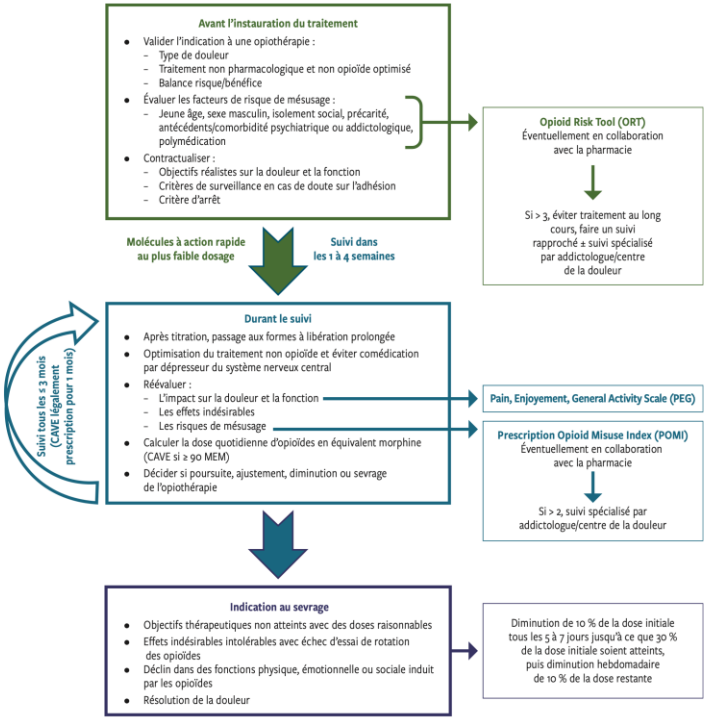
Patients with mood disorders or a history of substance misuse are often excluded from RCTs of opioids, but they are more likely to receive opioids in routine care.[10 11] No RCTs of opioids for back pain have lasted for more than four months,[3] although many patients receive treatment for longer. Thus, we also examined relevant cohort studies from primary care or employed populations.

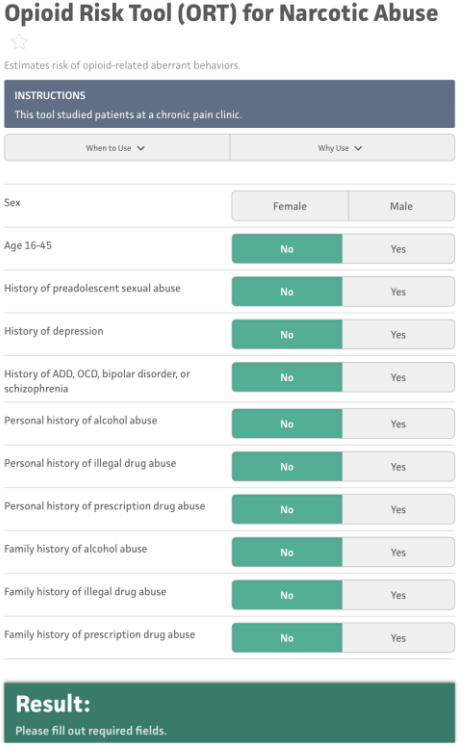
Relevant RCTs have been too small, brief, and selective to adequately assess less common complications, those occurring with long term use, and those related to comorbid conditions or drug interactions. We therefore conducted a separate PubMed search for studies on the prevalence of



Deyo RA, Von Korff M, Duhrkoop D. Opioids for low back pain. BMJ. 2015 Jan 5;350:g6380.

Implications pour la pratique





https://www.mdcalc.com/calc/1757/opioid-risk-tool-ort-narcotic-abuse

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Nicollier, L., Pasquier, S., D., Berger, J., Gouveia, A., Prescription des opioïdes en médecine générale pour les douleurs chroniques non cancéreuses, Rev Med Suisse, 2022/796 (Vol.8), p. 1761–1766.
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