**Opioid use and associated factors in 1,676 inflammatory bowel disease patients: A multicentre quality improvement project**

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**Abstract**

**Objective:** Despite its association with poorer outcomes, opioid use in inflammatory bowel disease (IBD) is not well characterised in the United Kingdom (UK). We aimed to examine the extent of opioid use, the associated factors and the use of mitigation techniques such as pain-service review and opioid weaning plans among individuals with IBD.

**Methods:** Data was collected from consecutive patients attending IBD outpatient appointments at 12 UK hospitals. A pre-defined questionnaire was used to collect data including patient demographics, IBD history, opioid use in the past year (>2 weeks) and opioid-use mitigation techniques. Additionally, consecutive IBD-related hospital stays leading up to July 2019 were reviewed with data collected regarding opioid use at admission, discharge and follow-up as well as details of the admission indication.

**Results:** In 1,352 outpatients, 12% had used opioids within the past 12 months. Over half of these individuals were taking opioids for non-IBD pain and less than half had undergone an attempted opioid wean.

In 324 hospitalised patients, 27% were prescribed opioids at discharge from hospital. At 12 months post-discharge, 11% were using opioids. Factors associated with opioid use in both cohorts included female sex, Crohn’s disease and previous surgery.

**Conclusions:**

One in ten IBD patients attending outpatient appointments were opioid-exposed in the past year while a quarter of inpatients were discharged with opioids, and 11% continued to use opioids 12 months after discharge. IBD services should aim to identify patients exposed to opioids, reduce exposure where possible and facilitate access to alternative pain management approaches.

**What is already known on this topic** – Opioid-exposure is on the rise in the UK general population and previous findings suggest opioid-exposure is greater in IBD than in the general population. Studies from North America show individuals with IBD are frequently prescribed opioids, however data relating to Europe is lacking.

**What this study adds** – One tenth of outpatients with IBD were exposed to opioids in the previous year and a quarter of hospitalised IBD patients were discharged on opioids. Over half of opioid use is related to non-IBD pain, mostly musculoskeletal. Almost three quarters of patients discharged on opioids had no opioid weaning plan.

**How this study might affect research, practice or policy** – There is a significant risk of opioid-exposure among IBD patients. This risk may be reduced by the wider use of opioid weaning plans and appropriate referral to pain services. These measures should be evaluated in future quality improvement initiatives.

**Introduction:**

Most individuals with inflammatory bowel disease (IBD) experience pain and this is associated with poorer quality of life, increased healthcare utilisation and worse clinical outcomes.1 While opioid medications are used to relieve cancer-related pain, there is little evidence that they are helpful for the relief of chronic pain2 and opioids are associated with many side effects including nausea, narcotic bowel syndrome, paradoxical exacerbation of pain, increased disease flares and increased mortality in IBD.3–6 For this reason, using opioids to treat chronic pain is discouraged in IBD, NICE and intercollegiate pain guidelines.7–9

Opioid-exposure in IBD patients in the UK had increased three-fold between the trienniums 1990-1993 and 2010-2013 however contemporary data since updated guidelines is lacking.8-10 Studies documenting opioid-exposure in IBD predominantly originate from North America where patterns of prescribing differ markedly from the UK.10–12 In the UK, overall opioid-exposure in the general population has risen by 127% over the past decade13 and previous findings indicate the IBD population have substantially greater opioid-exposure than matched non-IBD individuals.14,15

We therefore aimed to define the prevalence of opioid-use among those accessing IBD services in the UK by performing a multi-centre questionnaire-based analysis of opioid-use in both outpatients and inpatients. Secondarily, we aimed to define indications for opioid-use, to identify associated risk factors and to examine the use of measures to reduce exposure including alternative analgesic prescribing, the use of opioid weaning schedules and the use of specialist pain services.

**Methods**

*Development of online data collection tool*

Questionnaires to review opioid use in inpatients and outpatients were developed by a multidisciplinary steering committee (see Supplementary Information 1 and 2) and data was entered anonymously by clinicians between October 2021 and March 2022 using an online platform on an academic NHS server.

*Study centres and patient recruitment*

The questionnaires were piloted in a single centre and following this, the study was expanded to include twelve sites across the UK, selected for data collection based on previous participation and engagement with IBD quality and improvement studies (see Supplementary Information 3 for list of sites). Sites included both general hospitals and regional IBD centres.

Consecutive patients with a confirmed diagnosis of IBD reviewed in gastroenterology and IBD clinics between October 2021 and March 2022 were included. Patient demographics, IBD-related information and details of opioid-use were obtained (see Supplementary Information 1). Additional details were obtained from those with more than 2 weeks of opioid-use in the previous 12 months, including details of opioid used, other analgesic use, comorbidities, disease activity, use of pain services and opioid weaning attempts. This data was collected from interrogation of hospital issued prescriptions, general practice prescriptions, clinic records where available, and patient recall.

Consecutive patients with a confirmed diagnosis of IBD and an IBD-related admission comprised the inpatient cohort; twenty-five consecutive admissions per site were included, regardless of pre-admission opioid use, working backwards from July 2019 to reduce the impact of the COVID-19 pandemic on the analysis. Collected data comprised basic demographics, IBD-related information, pre-admission opioid-use, admission details (including surgery type) and opioids prescribed at hospital discharge (see Supplementary Information 2). Further data was collected at 3-6 months and 12 months regarding follow up, ongoing opioid use, weaning plans, pain service referral and physician global assessment of disease severity.

*Definition of terms*

“Weak opioids” included codeine and dihydrocodeine with or without paracetamol and “strong opioids” were all other opioid medications, including tramadol, morphine and fentanyl, in line with The Misuse of Drugs Regulations 2001 and British National Formulary definitions.16,17

We classified patients as having undergone disease reassessment if magnetic resonance imaging, computed tomography imaging or lower GI endoscopy were performed within the past year. “Other pain modulating drugs” included non-steroidal anti-inflammatory drugs (NSAIDs), antidepressants and gabapentin or pregabalin. “Medical optimisation” was defined as commencement of new IBD medications or dose alterations of current therapy.

In this study, opioid-use greater than 2 weeks was chosen by the consensus panel of experts as a time that represented a clinically meaningful prescription period longer than normally required for relief of an acute pain event.

*Statistical analysis*

For inpatients, all patients were included in the denominator for calculation of ongoing opioid-use regardless of whether they were lost to follow-up. In all other cases of missing data, we excluded patients from relevant analyses. Age data was collected in 5-year intervals to preserve anonymity, and further categorised for analysis into 3 age ranges; 18-40, 41-60 and >60 years.

An adjusted multivariable logistic regression model was developed to identify factors associated with opioid-use. Variables of interest were identified a priori and a univariable analysis identified those significantly associated with opioid use (see Supplementary Information 4). These were analysed in the multivariable regression model and results are presented as odds ratios (OR) with 95% confidence intervals (95% CI). Data was analysed using R version 4.2.1.18

*Ethical approval and consent exemption*

The study was performed as a quality improvement project following SQUIRE guidelines.19 The online survey platform has been approved as compliant with the General Data Protection Regulation by the Leeds Teaching Hospital NHS Trust Caldicott Guardian. All data was anonymised at the point of data entry.

**Results**

*Baseline characteristics and demographics*

Data was collected for 1,352 outpatients of whom 715(52.9%) were female, 647(47.9%) had CD, 653(48.3%) had UC, 33(2.4%) had IBD-unclassified and the median age group was 41-45 years (see Table 1).

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Opioid use in the past year †** | | **All patients** |
| No (N=1191) | Yes (N=161) | Total (N=1352) |
| **Age (Years)** | | | |
| <40 | 555 (46.6%) | 58 (36.0%) | 613 (45.3%) |
| 40-60 | 354 (29.7%) | 59 (36.6%) | 413 (30.5%) |
| >60 | 282 (23.7%) | 44 (27.3%) | 326 (24.1%) |
| **Sex** | | | |
| Male | 587 (49.3%) | 50 (31.1%) | 637 (47.1%) |
| Female | 604 (50.7%) | 111 (68.9%) | 715 (52.9%) |
| **IBD type** | | | |
| Ulcerative colitis | 610 (51.2%) | 43 (26.7%) | 653 (48.3%) |
| Crohn’s disease | 533 (44.8%) | 114 (70.8%) | 647 (47.9%) |
| IBD-unclassified | 30 (2.5%) | 3 (1.9%) | 33 (2.4%) |
| IBD-not specified | 18 (1.5%) | 1 (0.6%) | 19 (1.4%) |
| **Previous Surgery** | | | |
| No | 963 (80.9%) | 89 (55.3%) | 1052 (77.8%) |
| Yes | 228 (19.1%) | 72 (44.7%) | 300 (22.2%) |
| **Duration of disease (Years)** | | | |
| 0-5 | 412 (34.6%) | 42 (26.1%) | 454 (33.6%) |
| 6-15 | 465 (39.0%) | 59 (36.6%) | 524 (38.8%) |
| >16 | 303 (25.4%) | 57 (35.4%) | 360 (26.6%) |
| Missing | 11 (0.9%) | 3 (1.9%) | 14 (1.0%) |
| **Physician Global Assessment**‡ | | | |
| Remission | 678 (56.9%) | 69 (42.9%) | 747 (55.3%) |
| Mild | 308 (25.9%) | 48 (29.8%) | 356 (26.3%) |
| Moderate | 174 (14.6%) | 38 (23.6%) | 212 (15.7%) |
| Severe | 31 (2.6%) | 6 (3.7%) | 37 (2.7%) |

**Table1. Opioid exposure by cohort characteristics: Outpatients**

† Exposure to any opioid containing medicine for more than 2 weeks within the past 12 months

‡The Physician Global Assessment is an assessment of inflammatory bowel disease severity taking into account the daily record of abdominal discomfort, functional assessment and other observations such as physical findings, and the patient’s performance status.

Data was collected for 324 patients with a hospital admission (see Table 2), 163 (50.3%) of whom were female with a median age group of 36-40 years. IBD type was CD in 177 (54.6%), UC in 132 (40.7%) and IBD-unclassified (IBD-U) in 11 (3.4%).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Opioid prescribed at hospital discharge †** | | | **All patients** | | |
| No (N=235) | | Yes (N=89) | Total (N=324) | | |
| **Age (Years)** | |  | |  |  | | |
| <40 | | 132 (56.2%) | | 51 (57.3%) | 183 (56.5%) | | |
| 40-60 years | | 69 (29.4%) | | 27 (30.3%) | 96 (29.6%) | | |
| >60 years | | 34 (14.5%) | | 11 (12.4%) | 45 (13.9%) | | |
| **Sex** | |  | |  |  | | |
| Male | | 114 (48.5%) | | 47 (52.8%) | 161 (49.7%) | | |
| Female | | 121 (51.5%) | | 42 (47.2%) | 163 (50.3%) | | |
| **IBD type** | |  | |  |  | | |
| Ulcerative colitis | | 119 (%0.6%) | | 13 (14.6%) | 132 (40.7%) | | |
| Crohn’s disease | | 104 (44.3%) | | 73 (82.0%) | 177 (54.6%) | | |
| IBD-unclassified | | 8 (3.4%) | | 3 (3.4%) | 11 (3.4%) | | |
| IBD-not specified | | 4 (1.7%) | | 0 (0%) | 4 (1.2%) | | |
| **Previous surgery** | |  | |  |  | | |
| No | | 180 (76.6%) | | 37 (41.6%) | 217 (67.0%) | | |
| Yes | | 55 (23.4%) | | 52 (58.4%) | 107 (33.0%) | | |
| **Duration of disease (years)** | | | |  |  | | |
| 0-5 | | 127 (54.0%) | | 36 (40.4%) | 163 (50.3%) | | |
| 6-15 | | 70 (29.8%) | | 32 (36.0%) | 102 (31.5%) | | |
| >16 | | 35 (14.9%) | | 18 (20.2%) | 53 (16.4%) | | |
| Missing | | 3 (1.3%) | | 3 (3.4%) | 6 (1.9%) | | |
| **Pre-admission opioids** ‡ | | | |  |  | | |
| No | 206 (87.7%) | | | 52 (58.4%) | 258 (79.6%) | | |
| Yes | 29 (12.3%) | | | 37 (41.6%) | 66 (20.4%) | | |
| **Reason for admission** § | | | |  |  | | |
| Bowel obstruction | 16 (6.8%) | | 14 (15.7%) | | | 30 (9.3%) |
| Elective surgery | 26 (11.1%) | | 23 (25.8%) | | | 49 (15.1%) |
| Abscess/phlegmon | 11 (4.7%) | | 6 (6.7%) | | | 17 (5.2%) |
| IBD flare | 166 (70.6%) | | 23 (25.8%) | | | 189 (58.3%) |
| Perianal disease flare | 3 (1.3%) | | 7 (7.9%) | | | 10 (3.1%) |
| Stoma/Postoperative | 10 (4.3%) | | 13 (14.6%) | | | 23 (7.1%) |
| Missing | 3 (1.3%) | | 3 (3.4%) | | | 6 (1.9%) |
| **Admitting specialty¶** |  | |  | | |  |
| Medicine | 162 (68.9%) | | 22 (24.7%) | | | 184 (56.8%) |
| Surgery | 73 (31.1%) | | 67 (75.3%) | | | 140 (43.2%) |

**Table 2. Opioid exposure and cohort characteristics: Inpatients**

†Exposure to any opioid containing medication at discharge from hospital

1. Exposure to opioids in the 3 months prior to hospital admission
2. Primary reason for admission to hospital

¶ Specialty under which the individual was admitted i.e., surgical or medical

140 patients (43.2%) were admitted under a surgical team and 184 (56.8%) under a medical team with admission indications of inflammatory IBD flare (n=189, 58.3%), elective surgery (n=49, 15.1%), bowel obstruction (n=30, 9.3%), stoma/post operative (n=23, 7.1%), abscess/phlegmon (n=17, 5.2%) and perianal disease flare (n=10, 3.1%).

*Outpatients*

The prevalence of opioid-use among IBD patients attending clinic was 161/1352(11.9%) with a range 4.5-17.8% across hospital sites. The opioid type was documented for 152/161(94.4%) individuals, with 68/161(42.2%) patients using strong opioids. The most frequently used opioid was tramadol (n=27, 16.8%), followed by morphine (n=25, 15.5%), oxycodone (n=10, 6.2%), buprenorphine (n=7, 3.7%) and fentanyl (n=5, 3.1%). While 130/161(80.7%) individuals used one opioid, 16.2% used 2 and 5(3.1%) individuals used 3 or more.

Opioid-exposed outpatients had a median of 1 comorbidity and a maximum of 5. The most common comorbidity was inflammatory arthritis accounting for 46/161(28.6%) of the total opioid-exposed cohort followed by osteoarthritis (n=27/161, 16.8%) of the opioid-exposed cohort.

The stated indication for opioid-use was IBD in 68/161(42.2%) with the remaining individuals either using opioids for a non-IBD indication (n=85, 52.8%) or unsure of the indication (n=8, 5.0%) (See Figure 1). The most common non-IBD indication was musculoskeletal symptomatology.

In those who indicated that IBD was the reason for their opioid use, objective disease activity assessment was carried out in 47/68(69.1%) (See Figure 1).

Other pain modifying drugs were co-prescribed to 62/161(38.5%) opioid-exposed individuals; antidepressants to 34/161(20.4%), gabapentin or pregabalin to 21/161(13.0%) and NSAIDs to 12/161(7.5%).

A specialist pain service referral had been made for 41/161(25.5%) opioid exposed individuals with a range of 0-100% across sites. An opioid wean was attempted in 69/161(42.9%) opioid exposed individuals with a range of 23-94% across sites. At 3-6 months, 75.0% individuals referred to pain services had an attempted opioid wean compared to 14.7% of those not referred and at 12 months this was 50.0% vs 17.2% respectively.

Multivariable logistic regression analysis (Table 3) of the outpatient cohort demonstrated factors associated with opioid-use were female sex, Crohn’s disease, PGA score of mild or moderate, previous or current biologic or small molecule use and previous IBD-related surgery.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Outpatients** | | | | **Inpatients** | | | |
| **Predictor** | **N=1352** | **Odds Ratio** | **95% Confidence Interval** | **p value** | **N= 324**  **(Inpatients)** | **Odds Ratio** | **95% Confidence Interval** | **p value** |
| **Sex (Female)** | 715 | 2.16 | 1.52 – 3.09 | **<0.001** | 163 | 0.84 | 0.52 – 1.37 | 0.490 |
| **IBD type (CD)** | 647 | 2.24 | 1.50 – 3.37 | **<0.001** | 177 | 6.44 | 3.48 – 12.78 | **<0.001** |
| **Previous surgery** | 300 | 2.28 | 1.53 – 3.42 | **<0.001** | 107 | 3.14 | 1.80 – 5.53 | **<0.001** |
| **PGA**† |  |  |  |  |  |  |  |  |
| **Mild** | 356 | 1.55 | 1.04 – 2.30 | **0.029** | - | **-** | **-** | **-** |
| **Moderate** | 212 | 2.31 | 1.49 – 3.56 | **<0.001** | - | **-** | **-** | **-** |
| **Severe** | 37 | 1.91 | 0.70 – 4.47 | 0.163 | - | **-** | **-** | **-** |
| **Biologic use**‡ | 694 | 1.86 | 1.27 – 2.75 | **0.002** | - | **-** | **-** | **-** |
| **Preadmission opioids** § | **-** | **-** | **-** | **-** | 66 | 3.71 | 1.97 – 7.06 | **<0.001** |
| **Surgery during admission** | **-** | **-** | **-** | **-** | 97 | 4.65 | 2.60 – 8.40 | **<0.001** |

**Table 3. Multivariable regression analysis**

Predictors associated with exposure to any opioid containing medication; for >2 weeks in the past year (Outpatients)/ at discharge from hospital (Inpatients). Significant p values shown in bold.

† The Physician Global Assessment is an assessment of inflammatory bowel disease severity taking into account the daily record of abdominal discomfort, functional assessment and other observations such as physical findings, and the patient’s performance status. Reference group for physician global assessment is the “remission” group.

‡Previous or current biologic or small molecule use

§ Opioid prescription in the 3 months prior to admission

*Inpatients*

A total of 89/324(27.5%) individuals were discharged with an opioid prescription, 52/324(16.0%) of whom had not used opioids in the 3 months prior to admission and were therefore ‘new’ users. Opioids were prescribed at discharge to 22/184(12.0%) of patients admitted under a medical team and 67/140(47.9%) of those admitted under a surgical team.

At 3-6 months after discharge, 300 (92.6%) patients were followed up (See Supplementary Information 5) with 42/324(13.0%) using opioids at this time point, 23(7.1%) of whom were using strong opioids. At 12 months 294(90.7%) individuals were followed up (See Supplementary Information 5) and 35(10.8%) of these individuals were using opioids, 23(7.1%) of whom were using strong opioids. There was no significant difference in patient characteristics between those patients who were followed up and those that were lost to follow up (See Supplementary Information 6).

Opioids were used by 66/324(20.4%) individuals within the 3-month period prior to admission, and this was higher in the subgroup who had previously undergone surgery (n=40/107, 37.4%).

There was no opioid weaning plan for 65/89(73.0%) patients discharged with opioids; 17(77.3%) medical patients and 48(71.6%) surgical patients, with a range of 0-66.6% across sites. A specialist pain service assessment took place in 8/42(19.0%) of those using opioids at 3-6 months and 6/35(17.1%) of those using opioids at 12 months with a range of 0-100% across sites at both time points. At 3-6 months, 6/8(75.0%) individuals referred to pain services had an attempted opioid wean compared to 14.7% of those not referred and at 12 months this was 50.0% vs 17.2% respectively.

Multivariable regression analysis (Table 3) identified Crohn’s disease, pre-admission opioids, previous IBD-related surgery and surgery during admission as factors associated with opioid-use at discharge.

**Discussion**

The recent increase in the global use of opioids highlights the need for accurate data in patients with IBD, yet despite a recent increase in their use among the general population13 and updates to national guidelines,2,7,9 analysis of opioid use among IBD patients in the UK is lacking. Chronic opioid use is associated with serious infections, early biologic discontinuation and mortality5,6,20 and in this UK multicentre study of opioid-use in IBD we found that more than a tenth of individuals received at least 2 weeks of opioids in a single year and more than a quarter of inpatients were discharged with opioids, a tenth of whom continued for at least 12 months. Over half of outpatients with opioid-use were using opioids to treat non-IBD pain, mostly for musculoskeletal indications and less than half had an opioid weaning plan.

*Findings in context*

Our reported opioid-use prevalence among outpatients was 11.9%. This compares to 11% reported in a Canadian study as the prevalence of use in the first month of IBD diagnosis, this study found prevalence fell to 5.8-7.7 % in the following year, compared with a point prevalence 2-3% in controls.14 A far lower prevalence of 3.4% was reported by Gao et al for IBD patients with more than 30 days’ opioid-exposure in a 5 year period.21 One systematic review reported an overall prevalence of opioid-use of 21% in IBD outpatients, however, there was significant heterogeneity in the definitions of opioid-use, and most studies were conducted in North America.22 Differences in opioid-use and prescribing patterns between the USA and the UK mean that this review’s findings do not necessarily reflect opioid use in the UK. This is confirmed by a study comparing the yearly prevalence of opioid-use among non-cancer patients in the USA, Canada, Taiwan and UK which ranged from 1.8-6.6%.10

*Strengths and limitations*

Our study is the first contemporary review of current opioid-use among IBD patients in the UK since the publication of NICE and intercollegiate pain guidelines.2,7–9 9We included both district and regional IBD centres across the UK with a varied sociodemographic and geographical mix.

Details of specialist pain services input and opioid weaning attempts allowed us to highlight areas for improvement in clinical practice.

We acknowledge a number of limitations to our study. We relied on patient recall to determine opioid-use and the indication for this, and whilst we mitigated against recall bias by concurrent examination of patient records, opioid use may have been missed if prescribed by a general practitioner (GP) where GP records were not accessible and a patient additionally did not declare the prescription. We did not collect data regarding the opioid indication at inpatient follow-up as the aim of the project was to identify patients with opioid use, and thus increased risk of complications, regardless of the opioid indication.

In this study 45% of the outpatient population were current users of biologic or small molecule immune therapy, which is slightly higher than 43.8% and 16.2% of CD and UC patients respectively prescribed biologics in a 2015 USA drug database review.23 Changes in the pattern of IBD prescribing since 2015 and/or over-representation of individuals with unremitting or active disease may explain this. Only 2.6% of individuals had a physician’s global assessment of disease severity of “severe disease” suggesting the latter was likely not the case but high rates of biologic use may have resulted in higher overall opioid-use in our study, given the demonstrated association between biologic use and increased opioid use.

We focused on the duration of opioid-use (> 2 weeks) rather than the dose of opioid prescribed, as duration has been shown to be more strongly associated with misuse.24

Some codeine may have been used as an anti-motility agent to manage stool frequency or high stoma output, although the questionnaire specifically directed data collectors to record patients’ pain medication. Even when codeine use was excluded there remained a significant proportion of patients exposed to opioids.

Those with opioid exposure have poorer clinic attendance, possibly leading to loss of follow up and an underestimate of opioid exposure. Drop out numbers were low and the majority of inpatients were followed up for the entire duration of the study (92.6% at 3-6 months and 90.7% at 12 months [See Supplementary Information 5]) reducing this risk. Conversely, complex patients requiring analgesia are followed up more regularly therefore opioid-use could appear higher through selection bias however, there were no significant differences between individuals with follow up and those without (See Supplementary Information 6).

A number of variables, including age, duration of disease and severe PGA were not significantly associated with increased opioid use however, had the sample size been larger, these may have shown significance. Future work with larger datasets could explore these associations further. Formal multiple testing adjustments were not made in the multivariable analysis.

Finally, we recorded referrals to pain services for the outpatient cohort but we do not have prospective data to review the impact; this is assessed for the inpatient cohort.

*Implications*

Almost three quarters of patients exposed to opioids at 12 months after discharge were also exposed to opioids in the 3 months prior to admission, suggesting that chronic pain is an important factor in continued opioid-use. Chronic pain is poorly controlled by opioids2 and hospital admission offers an opportunity to identify persistent opioid-exposure and to liaise with primary care regarding opioid weaning regimens, alternative analgesics and referral to specialist pain services so better pain control can be achieved.

Over half the opioid-exposed outpatient cohort used opioids for non-IBD indications, particularly musculoskeletal pain. Of the 19 inpatients using strong opioids at 12 months, 13 were in remission or had mild disease and 5 had not been discharged with opioid medications, suggesting opioid-use at this point may not relate to their admission, or IBD. Unfortunately, opioids are not beneficial in the management of long-term musculoskeletal pain or chronic pain and thus are not recommended in UK guidelines.9,25–27 A holistic approach to assessing pain in IBD should include assessment of other painful conditions that contribute to the risk of opioid-exposure.

More than half of outpatients with opioid-use had active disease on reassessment and 6/19 inpatients using strong opioids at 12 months had a moderate or severe PGA, indicating measures to control disease activity may reduce opioid requirements. New and persistent opioid use has been reported in a third of patients following disease flares in one study from the USA.28

Following admission to hospital, the discharge opioid prescription should include a weaning plan to mitigate against the risk of persistent use.24 Intercollegiate guidelines recommend documenting the dose and duration to ensure that acute opioid use does not progress to chronic exposure8 and adherence to prescribing guidelines is associated with increased opioid discontinuation.29 We found almost three quarters of patients were discharged without a weaning plan. Our study underscores the need to clearly document the indication for opioid use and the opioid weaning plan for primary care colleagues on discharge.

Fewer than 1 in 5 opioid exposed patients were referred to a pain specialist, with great variation across sites yet those who were referred to pain services were more likely to attempt a wean of opioids. Ease of access to pain services varied, as did the capacity and the integration of pain services within the multi-disciplinary IBD team.

Pain management continues to be an unmet need for patients with IBD that cannot be resolved by disease control alone, given 20-50% of IBD patients continue to experience pain in remission.30,31 Pain management should be patient-centred, including the use of non-pharmacological approaches such as behavioural therapies and lifestyle modifications. The role of guided self-management as an additional, accessible approach will be revealed with the impending results of the IBD BOOST research project.32 Invaluable resources for clinicians include “*Opioids Aware: Tapering and Stopping*”,33 “*Surgery and Opioids: Best Practice Guidelines 2021*”8 and Macintyre et al.’s “*An international* *multidisciplinary consensus statement on the prevention of opioid-related harm in adult surgical patients*”34 while localised primary care guidelines such as “*Dorset CCG Opioid Prescribing for Chronic Pain: Resource Pack 2018*”35 and Oxford University Hospital NHS Foundation Trust’s “*Guidance for opioid reduction in primary care*”36 are tailored to include local resources and support.

*Conclusion*

A significant proportion of IBD patients are exposed to opioids, which may persist, particularly following hospital admission for surgery. Risk of exposure may be reduced by the wider use of opioid weaning regimens and the use of pain services which are currently under-utilised.

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