Opioid rotation in patients initiated on oxycodone or morphine: a register study

Lisa Ericson1
Anneli Ambring2
Ingela Björholt1
Peter Dahm3

1Nordic Health Economics, 2Center of Registers, Region of Vastra Gotaland, 3Department of Anesthesia and Intensive Care and Pain Section, Sahlgrenska University Hospital, Gothenburg, Sweden

Purpose: Strong opioids are recommended for the treatment of moderate to severe pain. However, some patients do not achieve a successful treatment outcome due to intolerable adverse events and/or inadequate analgesia, thus may benefit from switching to another opioid, a procedure known as “opioid rotation.” The type of opioid at treatment initiation may influence the risk of opioid rotation and the objective of this study was to assess such rotation after treatment initiation with two alternative treatments, controlled-release (CR) oxycodone versus CR morphine in patients suffering from non-cancer pain.

Method: The study reported here was a real-life study based on Swedish register data: the Prescribed Drug, National Patient, and Cause of Death registers. The captured data cover the entire Swedish population treated in specialist care. A statistical analysis plan was agreed and signed before data were accessed.

Results: Data from 50,223 cases were included in the analyses. The risk of rotation was 19% higher in patients initiating treatment with morphine compared with oxycodone (hazard ratio 1.19; 95% confidence interval 1.11–1.27; \( P \leq 0.001 \)), after adjusting for such baseline variables that were both significantly correlated with the outcome variable (time to rotation) and significantly different between the groups; age at index date, osteoarthritis and number of pain-related drugs.

Conclusion: Patients with non-cancer pain who initiated treatment with CR morphine had a higher risk of opioid rotation than patients initiated with CR oxycodone.

Keywords: nationwide data, Sweden, drug rotation, non-cancer pain

Introduction
Opioid analgesics are effective in the management of pain relief. Strong opioids such as oxycodone and morphine are recommended for the treatment of moderate to severe pain. Strong opioids are classified as step 3 medications in the World Health Organization (WHO) ladder for cancer pain management.\(^1\)\(^{-}3\) In national and international guidelines for the treatment of chronic non-cancer pain, treatment with strong opioids is recommended when other analgesics have been unsuccessful.\(^4\)

Opioid rotation is discussed as an alternative mainly to avoid development of tolerance, but also when intolerable adverse effects or inadequate analgesia despite dose increases arise.\(^5\)\(^{-}8\) Despite the lack of randomized studies to support the effectiveness of the approach, opioid rotation is generally accepted as clinical practice in such cases\(^9\) and guidelines for the strategy have been developed.\(^10,11\)

The pharmacokinetic profiles of morphine and oxycodone differ in that the oral bioavailability of oxycodone is higher than that of morphine\(^12,13\) and morphine has...
active metabolites that may accumulate and lead to an increased risk of adverse events and toxicity.14-16 The clinical relevance of these differences poses a challenging question, and is as yet unresolved in the available randomized trials.

However, results from a US health care claims-database study on the risk of opioid rotation has shown that non-cancer pain patients treated with controlled-release (CR) morphine or transdermal fentanyl were more disposed to opioid rotation than patients treated with CR oxycodone. The corresponding analyses in cancer patients showed no such differences.17 As register studies always have caveats, we wanted to find out if the results of the US study could be reproduced. In Sweden, the availability of national health care registers offers unique opportunities to perform research on the general population on a nationwide basis, as the registers cover total data for Sweden.

Thus, the objective of our study was to assess opioid rotation after treatment initiation with CR oxycodone versus CR morphine in patients suffering from non-cancer pain using Swedish register data.

Methods
This was a real-life study based on Swedish register data. The study was approved by the regional ethics review board in Gothenburg and performed according to the World Medical Association’s Declaration of Helsinki.

National health care registers
Data on prescribed and dispensed pharmaceuticals at Swedish pharmacies were obtained from the Swedish Prescribed Drug Register, which contains information such as patient age, sex, and personal identification number, as well as information about dispensed products. All drugs are classified according to the Anatomical Therapeutic Chemical classification system. Information about hospital inpatient and outpatient health care was extracted from the Swedish National Patient Register and included patient age, sex, personal identification number, length of hospitalization, consulting visits, dates of admission and discharge, and International Classification of Diseases, tenth revision (ICD-10) diagnoses. Information on the date of a patient’s death was obtained from the Cause of Death Register. Information from the registers was linked by each patient’s unique ten-digit personal identification number. All registers are held at the Swedish National Board of Health and Welfare (NBHW).

Study population

Inclusion and exclusion criteria
Patients eligible for the study should have been dispensed either CR oxycodone or CR morphine at the pharmacy for the first time between January 1, 2006 and December 31, 2008, and diagnosed according to the definitions later in this paper at a hospital visit the year preceding start of treatment. This means that patients diagnosed within the Swedish primary health care system and with no contact with the hospital or specialist care, were not included, since no register encompasses the entire Swedish primary health care system. The date of the first dispensation of CR oxycodone or CR morphine was denoted as the “index” date. To ensure that the patients were naive to strong opioids, no dispensation of any strong opioid was allowed during the 6-month period preceding the index date (pretreatment). Patients were excluded from the study if, at the index date, they were dispensed CR oxycodone tablets of 40 mg or stronger or CR morphine tablets of 60 mg or stronger. These patients were excluded since they were not considered naive to strong opioids as had probably initiated the treatment earlier – for example, while hospitalized.

Population
The population was defined by the ICD-10 diagnosis codes registered in the National Patient Register any time during the year preceding the index date. Diagnoses were selected that possibly could have been indications for opioid use; for example fibromyalgia, low back pain, other spinal pain (excluding low back pain but including neck pain), osteoarthritis, other musculoskeletal pain, or neuropathic pain (a list of all diagnoses is presented in Online supplement A). Patients who before the index date had also been registered with a cancer diagnosis were excluded from the population. If a patient had a cancer diagnosis registered after the index date, the patient was included in the study until the date of the cancer diagnosis, since it was assumed a cancer diagnosis would change the treatment strategy.

Study procedure
A statistical analysis plan was developed and approved by the sponsor, the statistician and the responsible scientist at Nordic Health Economics before the data extracted from the registers were accessed. In the statistical analysis plan, definitions as well as analyses were predefined.

Data extraction
Data were extracted from the Prescribed Drug Register then linked to the National Patient and Cause of Death registers.
using personal identification numbers. Extraction and link- 
age of data were performed by the Department of Statistics, 
Monitoring and Evaluation at the NBHW. All data were ano-
ymized by the NBHW before analyses were performed.

Opioid rotation
Opioid rotation was identified as the first dispensation of 
any other strong CR opioid or strong immediate-release (IR) 
opioid, except IR oxycodone in the CR oxycodone group and 
IR morphine in the CR morphine group. Dispensation of any 
weak opioid that was not dispensed during the 6-month pre-
treatment period was also defined as a rotation, since such a 
therapy change could be due to dissatisfaction with treatment. 
This time point had to occur within 3.5 months following the 
last dispensation of the study medication. Patients were fol-
lowed until the first change in treatment strategy. All opioids 
considered are listed in Online supplement B.

Censoring
“Censoring” was defined as: date of death; date of the last 
dispensation of CR oxycodone/CR morphine plus the number 
of days 25 mg/50 mg daily would last (however, if the last 
dispensation was within the first month following the index 
date, the daily dose was assumed to be 10 mg/20 mg daily); 
if more than 6 months had passed between two dispensa-
tions of the study medication, the treatment was considered 
discontinued and the former of the two dispensations plus 
the number of days the treatment would last according to 
the doses just mentioned was set as the censoring date; and 
a maximum of 3.5 months from the last dispensation.

Concomitant and pain-related medication
The number of concomitant drugs was used as a proxy for 
comorbidity and analyzed by registering the total number of 
drugs dispensed, including dietary supplements and nutrient 
solutions, during the 6-month pretreatment period. In addi-
tion, a separate analysis of the number of pain-related drugs 
dispensed during pretreatment was performed (a list of all 
pain-related drugs is presented in Online supplement C). Each 
substance was counted as one concomitant drug.

Statistical analysis
For comparison between the CR oxycodone and CR morphine 
groups, the Mann–Whitney U-test was used for continuous 
variables and Fisher’s exact test for dichotomous variables.

Patients were followed for 1 year from the index date. Time to opioid rotation was assessed as the number of days 
between the date of each patient’s index date and the date of 
rotation. Treatment stop was treated as the censoring date. All 
analyses of time to opioid rotation between the two groups 
were performed with Poisson regression models adjusted 
for all measured variables significantly correlated with the 
outcome variable (time to opioid rotation) and significantly 
different between the groups (oxycodone versus morphine). 
The time variable in the model was analyzed with a break 
point 30 days after the index date to achieve a better estimate 
of updated time in the study. The unadjusted and adjusted 
hazard ratios (HRs) including 95% confidence intervals 
(CIs) were calculated from Poisson regression models. The 
HRs for age in the Poisson regression models were given 
for 10 years’ change.

Programming of all statistical analyses was performed 
using SAS® (v 9.2; SAS Institute, Cary, NC, USA). All 
significance tests were two-sided and conducted at a 0.05 sig-
nificance level.

Results
Patient characteristics
The dataset included 50,223 patients, 44,917 (89.4%) of 
whom initiated treatment with CR oxycodone and 5306 
(10.6%) with CR morphine. In the oxycodone group, there 
were 6265 (13.9%) patients rotating and the corresponding 
number in the morphine group was 983 (18.5%).

The baseline characteristics are shown in Table 1. Oxycodone patients were younger at the index date 
(mean ± standard deviation: 65.9 ± 16.9 versus 70.9 ± 15.5) and 
had a lower number of concomitant (9.0 ± 5.4 versus 11.0 ± 5.7) 
as well as pain-related (2.4 ± 1.4 versus 2.6 ± 1.4) drugs com-
pared with morphine patients during the 6-month pretreatment 
period. The proportion of patients with a diagnosis of low back 
pain and osteoarthritis was higher in the oxycodone group, 
while patients with a diagnosis of fibromyalgia or neuropathic 
pain were more common in the morphine group.

Baseline predictors
The baseline predictors of time from the index date to 
opioid rotation during the first year after the index date were 
analyzed for oxycodone and morphine together (Table 2). The 
significant predictors were age at index date, sex, osteoarthritis, 
other musculoskeletal pain, and number of pain-related drugs. 
For every 10-year increase in age, the risk of rotation was 3% 
lower, and among patients 65 years or older the risk was 13% 
lower. In addition, female sex was associated with 8% higher 
risk of rotation. Further, osteoarthritis was associated with
Table 1 Baseline characteristics of patients in the controlled-release oxycodone and controlled-release morphine groups

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Oxycodone (n = 44,917)</th>
<th>Morphine (n = 5306)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years), mean ± SD</td>
<td>65.9 ± 16.9</td>
<td>70.9 ± 15.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age category (%)</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>&lt;65 years</td>
<td>42.1</td>
<td>30.1</td>
<td></td>
</tr>
<tr>
<td>≥65 years</td>
<td>57.9</td>
<td>69.9</td>
<td></td>
</tr>
<tr>
<td>Sex (%)</td>
<td></td>
<td></td>
<td>0.18</td>
</tr>
<tr>
<td>Male</td>
<td>40.3</td>
<td>39.3</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>59.7</td>
<td>60.7</td>
<td></td>
</tr>
<tr>
<td>Non-cancer diagnoses (%)</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>10.9</td>
<td>15.5</td>
<td></td>
</tr>
<tr>
<td>Low back pain</td>
<td>22.5</td>
<td>19.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Other spinal pain</td>
<td>2.4</td>
<td>2.5</td>
<td>0.55</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>46.8</td>
<td>38.3</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Other musculoskeletal pain</td>
<td>32.6</td>
<td>33.0</td>
<td>0.58</td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuropathic pain</td>
<td>25.3</td>
<td>35.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Concomitant drugs (n), mean ± SD</td>
<td>9.0 ± 5.4</td>
<td>11.0 ± 5.7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Pain-related drugs (n), mean ± SD</td>
<td>2.4 ± 1.4</td>
<td>2.6 ± 1.4</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Notes: *Patients could have >1 diagnosis; †excluding low back pain and including neck pain; ‡as a proxy for comorbidity.
Abbreviation: SD, standard deviation.

Discussion

This real-life study, based on observational data from Swedish national registers, assessed opioid rotation in non-cancer patients initiated on treatment with CR oxycodone or CR morphine. The analyses included a comprehensive dataset with a large study population of 50,223 patients, of whom 44,917 began treatment with oxycodone and 5306 with morphine.

Our findings show that non-cancer patients initiating treatment with CR morphine rotate more often than those beginning with CR oxycodone. The adjusted result showed that the risk of rotation was 19% higher in the morphine group than in the oxycodone group.

Patients in the morphine group were older and had a higher number of concomitant as well as pain-related drugs during the 6-month pretreatment period, compared with the oxycodone group. In terms of potential indications for treatment, more patients in the morphine group had fibromyalgia and neuropathic pain, while low back pain and osteoarthritis were more common in the oxycodone group.

Influence of the results of age, osteoarthritis, and number of pain-related drugs were controlled for in the analysis, as these baseline variables were not only different between the groups but also predictors for time to rotation. Concomitant medication was used as a proxy for comorbidity to assess the general burden of illness. Such medication was more common in the morphine group, but was not found to be a predictor of outcome. However, there may be other aspects to the general health status of the patients other than the number of drugs taken, and the lack of detailed information in this regard is a limitation of the study. Conversely, it is not intuitively clear in what direction a potential difference in the general burden of illness between the groups would go. Would more diseased patients be more or less likely to undergo opioid rotation? The answer would probably be “more likely” if the diseases were causing pain, but perhaps “less likely” if they were not painful, such as in the case of hypertension and hypercholesterolemia.
The concomitant use of pain drugs was handled as a separate variable and was adjusted for in the analysis. The results showed that for every additional pain-related drug dispensed during the 6-month pretreatment period, the risk of opioid rotation was lower. A possible explanation for this is that the more pain-related drugs a patient had during this period, the fewer options he/she had to change to if rotating pain therapy after initiation with a strong opioid (CR oxycodone or CR morphine).

Pain is a subjective sensation not easy to define, thus difficult to compare between individuals. There are no standard doses for treatment with opioid drugs. Therefore, the goal is to find individual doses that relieve each patient’s pain. Patients who are opioid naive or have moderate previous opioid exposure should start with a low dose, which should then be titrated slowly to minimize the risk of adverse events. In this kind of study, the challenge is to find a dose that could be used for all patients in a particular population or even doses for different subgroups within the populations. The doses used for the calculations of treatment stop in the present study were chosen to reflect clinical practice in Sweden when a maintenance dose has been achieved. In Sweden, opioids are generally prescribed at lower doses compared with in other parts of the world, particularly in non-cancer pain patients. The choice of doses might have affected the length of treatment, as higher doses would have resulted in shorter treatment durations and vice versa. Since patients need to adapt to these kinds of drugs, the oxycodone and morphine doses were assumed lower during the first month of treatment initiation (10 mg and 20 mg, respectively) than during maintenance treatment (25 mg and 50 mg).

As with all register-based studies, the analyses were confined to data available in the registers and limitations of this study include lack of information on the reason for the initial choice of treatment and why patients switched therapy. The former may be due to differences in the characteristics of the patients not evident from data in the registers. However, the size of the patient population should have countered this problem, unless Swedish specialist doctors systematically make similar choices all over the country.

Interestingly, our results support the results of the previous study on 1896 non-cancer pain patients in the USA, in which the risk to rotate was reported to be 64% lower in the CR oxycodone group than in the CR morphine (HR = 0.36, 95% CI 0.27–0.47, P < 0.01). This means that the risk of rotating was 178% higher in the morphine group (HR for CR morphine compared with CR oxycodone = 2.78). Our results showed a more moderate difference between the two drugs (19%), but the findings were still similar to those of Berger et al in that they indicated an increased risk to rotate for those initiated with CR morphine compared with those with CR oxycodone. The reason for this difference remains speculative, but it lends further support to the notion that the more favorable pharmacokinetic profile of oxycodone provides clinical advantages over morphine in everyday health care practice.

**Conclusion**

Patients with non-cancer pain initiated on treatment with CR morphine had 19% higher risk of opioid rotation than patients initiated with CR oxycodone in a nationwide Swedish population.

**Acknowledgments**

The authors thank Mundipharma (Gothenburg, Sweden) for sponsoring the study. Mundipharma approved the study design, but did not participate in data collection, data analysis, or manuscript preparation. The decision to publish the study was stipulated in the Research Agreement, signed before initiating the study.

The statistical analyses were carried out by Aldina Pivodic at Statistiska Konsultgruppen in Gothenburg, Sweden.

**Author contributions**

All authors contributed to the design of the study and the interpretation of data. Lisa Ericson and Ingela Björholt drafted the manuscript and all coauthors revised it critically for intellectual content. All authors approved the final version of the manuscript for publication.

**Disclosure**

Peter Dahm has been periodically engaged as a lecturer and has participated in clinical studies funded by different pharmaceutical companies, including Mundipharma. Nordic Health Economics is an independent research and consultancy group carrying out projects funded by companies, county councils, public authorities, and academic institutions. Anneli Ambring was employed at Nordic Health Economics when the study was carried out. The authors declare no other conflicts of interest in relation to this work.

**References**


Supplementary materials

Online supplement A Non-cancer pain diagnoses

**Fibromyalgia**
M79.0, M79.1, M79.6, M79.7, R52.1, R52.2, R52.9

**Low back pain**
M40, M41, M42, M43, M45, M46, M47.9K, M48.0K, M48.8K, M49.5, M51.0, M51.1K, M51.2, M51.3, M51.8, M51.9, M53.2, M53.3, M53.8, M53.9, M54.4, M54.5, M54.8, M54.9, M80.0K, M84.1K, M84.2K, M96.0K, M96.1K, M96.6K, M99.1K

**Other spinal pain (excluding low back pain but including neck pain)**
M48.0A, M48.09, M48.4A, M48.4J, M48.8A, M48.8J, M50, M51.0J, M51.1J, M53.0, M53.1, M53.4, M53.6, M80.0J, M84.0A, M84.0J, M84.1A, M84.2A, M84.2J, M95.3, M95.4, M96.0A, M96.0J, M96.1A, M96.1J, M96.6A, M96.6j, M99.1A, M99.1J

**Osteoarthritis**
L40.5, M00–M03, M05–M09, M11, M13, M15–M19, M25.0, M25.5, M36, M84.1B–M84.1H, M96.0B–M96.0H

**Other musculoskeletal pain**
M00–M99 (except the codes already mentioned)

**Neuropathic pain**
E10–E14, E85, G00–G99, B02.2

Online supplement B Strong and weak opioids

<table>
<thead>
<tr>
<th>ATC code</th>
<th>Substance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong opioids</strong></td>
<td></td>
</tr>
<tr>
<td>N02AA01</td>
<td>Morphine</td>
</tr>
<tr>
<td>N02AA03</td>
<td>Hydromorphone</td>
</tr>
<tr>
<td>N02AA05</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>N02AA51</td>
<td>Bupivacaine hydrochloride + morphine hydrochloride</td>
</tr>
<tr>
<td>N02A55</td>
<td>Oxycodone + naloxone</td>
</tr>
<tr>
<td>N02AB</td>
<td>Ketobemidone, meperidine, fentanyl</td>
</tr>
<tr>
<td>N02AE</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td>N02AF</td>
<td>Nalbuphine</td>
</tr>
<tr>
<td>N02AG</td>
<td>Opioids in combination with antispasmodics</td>
</tr>
<tr>
<td>N07BC02</td>
<td>Methadone</td>
</tr>
<tr>
<td><strong>Weak opioids</strong></td>
<td></td>
</tr>
<tr>
<td>M01AE51</td>
<td>Ibuprofen + codeine</td>
</tr>
<tr>
<td>N02AAS9</td>
<td>Codeine + acetaminophen or acetylsalicylic acid and caffeine</td>
</tr>
<tr>
<td>N02AC04</td>
<td>Dextropropoxyphene</td>
</tr>
<tr>
<td>N02AX02</td>
<td>Tramadol</td>
</tr>
<tr>
<td>N02BE51</td>
<td>Acetaminophen + codeine</td>
</tr>
<tr>
<td>R05DA04</td>
<td>Codeine</td>
</tr>
</tbody>
</table>

Abbreviation: ATC, Anatomical Therapeutic Chemical.

Online supplement C Pain-related drugs

<table>
<thead>
<tr>
<th>ATC code</th>
<th>Substance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corticosteroids</strong></td>
<td></td>
</tr>
<tr>
<td>H02AB01</td>
<td>Betamethasone</td>
</tr>
<tr>
<td>H02AB06</td>
<td>Prednisolone</td>
</tr>
<tr>
<td><strong>Analgesics</strong></td>
<td></td>
</tr>
<tr>
<td>M01A</td>
<td>Non-steroidal anti-inflammatory drugs</td>
</tr>
<tr>
<td>M02A</td>
<td>Topical products for joint and muscular pain</td>
</tr>
<tr>
<td>N02A</td>
<td>Opioids</td>
</tr>
<tr>
<td>N02B</td>
<td>Other analgesics and antipyretics</td>
</tr>
<tr>
<td>N07BC02</td>
<td>Methadone</td>
</tr>
<tr>
<td>R05DA04</td>
<td>Codeine</td>
</tr>
<tr>
<td><strong>Local anesthetics</strong></td>
<td></td>
</tr>
<tr>
<td>N01BB02</td>
<td>Lidocaine</td>
</tr>
<tr>
<td>N01BB20</td>
<td>Lidocaine + prilocaine</td>
</tr>
<tr>
<td>N01BX04</td>
<td>Capsaicin</td>
</tr>
<tr>
<td><strong>Antiepileptics</strong></td>
<td></td>
</tr>
<tr>
<td>N03AF01</td>
<td>Carbamazepine</td>
</tr>
<tr>
<td>N03AF02</td>
<td>Oxcarbazepine</td>
</tr>
<tr>
<td>N03AX09</td>
<td>Lamotrigine</td>
</tr>
<tr>
<td>N03AX12</td>
<td>Gabapentin</td>
</tr>
<tr>
<td>N03AX16</td>
<td>Pregabalin</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td></td>
</tr>
<tr>
<td>N05AA02</td>
<td>Levoemepromazine</td>
</tr>
<tr>
<td><strong>Antidepressants</strong></td>
<td></td>
</tr>
<tr>
<td>N06AA04</td>
<td>Clomipramine</td>
</tr>
<tr>
<td>N06AA09</td>
<td>Amitriptyline</td>
</tr>
<tr>
<td>N06AA10</td>
<td>Nortriptyline</td>
</tr>
<tr>
<td>N06AB04</td>
<td>Citalopram</td>
</tr>
<tr>
<td>N06AX11</td>
<td>Mirtazapine</td>
</tr>
<tr>
<td>N06AX16</td>
<td>Venlafaxine</td>
</tr>
<tr>
<td>N06AX21</td>
<td>Duloxetine</td>
</tr>
</tbody>
</table>

Abbreviation: ATC, Anatomical Therapeutic Chemical.