# The 2017 Draft Recommendations for Use of Opioids in Chronic Non-Cancer Pain

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**Disclaimer**

The draft recommendations in this guideline are presented to encourage public review and comment. The direction ('for' or 'against') and strength ('weak' or 'strong') of each recommendation has been established by a 15-member guideline panel of clinicians, methodologists and patients, and are unlikely to change unless compelling evidence emerges that was not considered by the panel. All feedback received regarding the wording of recommendations and associated text, and/or important considerations (please see Feedback Form), will be carefully considered by the guideline steering committee and used to inform the drafting of the final guideline document.

This guideline was an investigator-initiated study, supported by grants from the Canadian Institutes of Health Research and Health Canada. The funders had no role in the design and conduct of the study; collection, analysis, and interpretation of the data; or preparation, review, or approval of the guideline. Health Canada personnel provided non-binding feedback during the study. Final decisions regarding the protocol and issues that arose during the guideline development process were the purview of the guideline steering committee.

# 1 - Initiation and Dosing of Opioids in Patients with Chronic Non-Cancer Pain

## Recommendation #1

### When considering first-line therapy for patients with chronic non-cancer pain

Strong Recommendation

We recommend optimization of non-opioid pharmacotherapy and non-pharmacological therapy, rather than a trial of opioids

#### Rationale

Opioids, when added to non-opioids achieve, on average, modest improvements in pain and function at the cost of very frequent dependence, frequent addiction, and rare non-fatal unintentional overdose and death. A variety of non-opioid therapies as first-line treatment for patients with chronic non-cancer pain achieve a similar magnitude of improvement in pain and function but without the problems of dependence, addiction, and non-fatal overdose

## Recommendation #2

### Patients with chronic non-cancer pain with persistent problematic pain despite optimized non-opioid therapy, without current or past substance use disorder or current serious psychiatric disorder

Weak Recommendation

We suggest a trial of opioids rather than continued non-opioid therapy

*By a trial of opioids, we mean initiation, titration, and diligent monitoring of response, with discontinuation of opioids if important improvement in pain or function is not achieved*

#### Rationale

Opioids, when added to non-opioids achieve, on average, modest improvements in pain and function. Adverse effects include relatively frequent constipation, nausea and vomiting, cognitive changes, dependence, and addiction, and rare death and non-fatal unintentional overdose

## Recommendation #3

### Patients with chronic non-cancer pain with an active substance use disorder and chronic non-cancer pain

Strong Recommendation AGAINST

We recommend against the use of opioids

*Clinicians should, if not yet addressed, facilitate treatment of the underlying substance use disorders*

#### Rationale

Low quality evidence suggests a possible substantial increase in the very serious adverse outcomes of unintentional non-fatal overdose and death in patients with active substance abuse disorder using opioids

## Recommendation #4

### Patients with chronic non-cancer pain with a current serious psychiatric disorder whose non-opioid therapy has been optimized, and who still experience persistent problematic pain

Weak Recommendation

We suggest stabilization of the psychiatric disorder before considering a trial of opioids

#### Rationale

Low quality evidence suggests a possible large increase in the very serious adverse outcomes of unintentional non-fatal overdose and death in patients with serious psychiatric disorder using opioids

## Recommendation #5

### Patients with chronic non-cancer pain with a history of substance use disorder, whose non-opioid therapy has been optimized, and who still experience persistent problematic pain

Weak Recommendation

We suggest continuing non-opioid therapy rather than a trial of opioids

#### Rationale

Low quality evidence suggests a possible appreciable increase in the very serious adverse outcomes of unintentional non-fatal overdose and death in patients with using opioids

## Recommendation #6

### Patients with chronic non-cancer pain beginning long term opioid therapy

Weak Recommendation

We suggest restricting the prescribed dose to under 50mg morphine equivalents daily, rather than a dose of 50 to below 90 mg

*The weak recommendation to restrict the prescribed dose to under 50mg morphine equivalents daily acknowledges that there are likely to be some patients who would be ready to accept the increased risks associated with a dose over 50mg to potentially achieve improved pain control*

#### Rationale

Observational study results provide moderate quality evidence of a progressive increase in the likelihood of unintentional non-fatal overdose or death as the prescribed dose of opioids increases. These serious outcomes are very rare in those prescribed less than 50 morphine equivalents daily, but increase in those prescribed doses of 50 to 90, and though still rare, are very concerning in those prescribed doses of over 90

## Recommendation #7

Strong Recommendation

We recommend restricting the prescribed dose to under 90mg morphine equivalents daily rather than no upper, or a higher limit on dosing

*Some patients may gain important benefit over 90mg morphine equivalents, but not on lower doses. Referral to a colleague for a second opinion regarding the possibility of increasing above 90mg morphine equivalents daily may therefore be warranted in some individuals*

### Rationale

Observational study results provide moderate quality evidence of a progressive increase in the likelihood of unintentional non-fatal overdose or death as the prescribed dose of opioids increases. These serious outcomes are very rare in those prescribed less than 50 morphine equivalents daily, but increase in those prescribed doses of 50 to 90, and though still rare, are very concerning in those prescribed doses of over 90

## 2 - Rotation and Tapering of Opioids, for Patients with Chronic Non-Cancer Pain

### Recommendation #8

**For patients with chronic non-cancer pain currently using 90 mg morphine equivalents of opioids per day or more, with persistent problematic pain and/or problematic side-effects**

Weak Recommendation

We suggest rotation to other opioids rather than keeping the opioid the same

*Rotation in such patients may be done in parallel with, and as a way of facilitating, dose reduction*

#### Rationale

Low quality evidence suggests that substitution of an alternative opioid can reduce pain and adverse effects in patients with chronic non-cancer pain using opioids

### Recommendation #9

**For patients with chronic non-cancer pain currently using 90 mg morphine equivalents of opioids per day or more, with persistent problematic pain and/or problematic side-effects**

Weak Recommendation

We suggest tapering opioids to the lowest possible dose, including discontinuation, rather than no change in opioid therapy

*Some patients are likely to experience significant increase in pain or decrease in function that persist more than one month after a small dose reduction; tapering may be paused and potentially abandoned in such patients*

#### Rationale

Reduction in opioid dose may reduce adverse effects including cognitive impairment and the likelihood of non-fatal or fatal unintentional overdose. Reduction, particularly if not done very slowly, may cause increased pain, decreased function, or highly aversive symptoms of opioid withdrawal

### Recommendation #10

**Patients with chronic non-cancer pain using opioids and experiencing serious challenges in tapering**

Strong Recommendation

We recommend a formal multidisciplinary opioids reduction program

*Recognizing the cost of formal multidisciplinary opioid reduction programs and their current limited availability/capacity, an alternative is a coordinated multidisciplinary collaboration including several health professionals (possibilities include, but are not limited to, a primary care physician, a pharmacist, a physical therapist, a kinesiologist, a psychiatrist, and a psychologist)*

#### Rationale

Studies provide moderate quality evidence that, in patients desiring a reduction or discontinuation of opioid therapy but experiencing serious challenges in tapering or discontinuing therapy, multi-disciplinary programs can substantially increase the likelihood of successful reduction or discontinuation