2017 CANADIAN OPIOID PRESCRIBING GUIDELINE

KEY POINTS

Patients with chronic noncancer pain may be offered a trial of opioids only after they have been optimized on non-opioid therapy, including non-drug measures.

We suggest avoiding opioid therapy for patients with a history of substance use disorder (including alcohol) or current mental illness, and opioid therapy should be avoided in cases of active substance use disorder.

For patients beginning opioid therapy, we recommend restricting to under 90 mg morphine equivalents daily (MED) and suggest restricting the maximum prescribed dose to under 50 mg MED.

Patients already receiving high-dose opioid therapy (≥90 mg MED) should be encouraged to embark on a gradual dose taper, and multidisciplinary support offered where available to those who experience challenges.

GOOD PRACTICE STATEMENTS

Acquire informed consent prior to initiating opioid use for chronic noncancer pain. A discussion about potential benefits, adverse effects, and complications will facilitate shared-care decision making regarding whether to proceed with opioid therapy.

Clinicians should monitor chronic noncancer pain patients using opioid therapy for their response to treatment, and adjust treatment accordingly.

Clinicians with chronic noncancer pain patients prescribed opioids should address any potential contraindications and exchange relevant information with the patient's general practitioner (if they are not the general practitioner) and/or pharmacists.

RECOMMENDATION 1

When considering therapy for patients with chronic noncancer pain, we recommend optimization of nonopioid pharmacotherapy and nonpharmacologic therapy, rather than a trial of opioids (strong recommendation)

RECOMMENDATION 2

For patients with chronic noncancer pain, without current or past substance use disorder and without other active psychiatric disorders, who have persistent problematic pain despite optimized nonopioid therapy, we suggest adding a trial of opioids rather than continued therapy without opioids (weak recommendation)

Remark: By a trial of opioids, we mean initiation, titration and monitoring of response, with discontinuation of opioids if important improvement in pain or function is not achieved. The studies that identified substance use disorder as a risk factor for adverse outcomes characterized the conditions as alcohol abuse and dependence, and narcotic abuse and dependence, and sometimes referred to International Classification of Diseases, 9th revision (ICD-9) diagnoses. The mental illnesses identified in studies as risk factors for adverse outcomes were generally anxiety and depression, including ICD-9 definitions, as well as "psychiatric diagnosis," "mood disorder" and post-traumatic stress disorder.

RECOMMENDATION 3

For patients with chronic noncancer pain with an active substance use disorder, we recommend against the use of opioids (strong recommendation)

Remark: Clinicians should facilitate treatment of the underlying substance use disorders, if not yet addressed. The studies that identified substance use disorder as a risk factor for adverse outcomes characterized the conditions as alcohol abuse and dependence, narcotic abuse and dependence, and sometimes referred to ICD-9 diagnoses.

RECOMMENDATION 4

For patients with chronic noncancer pain with an active psychiatric disorder whose nonopioid therapy has been optimized, and who have persistent problematic pain, we suggest stabilizing the psychiatric disorder before a trial of opioids is considered (weak recommendation)

RECOMMENDATION 5

For patients with chronic noncancer pain with a history of substance use disorder, whose nonopioid therapy has been optimized, and who have persistent problematic pain, we suggest continuing nonopioid therapy rather than a trial of opioids (weak recommendation)

Remark: The studies that identified a history of substance use disorder as a risk factor for adverse outcomes characterized the conditions as alcohol abuse and dependence, and narcotic abuse and dependence, and sometimes referred to ICD-9 diagnoses.

RECOMMENDATION 6

For patients with chronic noncancer pain who are beginning opioid therapy, we recommend restricting the prescribed dose to less than 90 mg morphine equivalents daily, rather than having no upper limit or a higher limit on dosing (strong recommendation)

Remark: Some patients may gain important benefit at a dose of more than 90 mg morphine equivalents daily. Referral to a colleague for a second opinion regarding the possibility of increasing the dose to more than 90 mg morphine equivalents daily may therefore be warranted in some individuals.

RECOMMENDATION 7

For patients with chronic noncancer pain who are beginning opioid therapy, we suggest restricting the prescribed dose to less than 50 mg morphine equivalents daily (weak recommendation)

Remark: The weak recommendation to restrict the prescribed dose to less than 50 mg 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 higher than 50 mg in order to potentially achieve improved pain control.

RECOMMENDATION 8

For patients with chronic noncancer pain who are currently using opioids, and have persistent problematic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than keeping the opioid the same (weak recommendation)

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

RECOMMENDATION 9

For patients with chronic noncancer pain who are currently using 90 mg morphine equivalents of opioids per day or more, we suggest tapering opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy (weak recommendation)

Remark: Some patients may have a substantial increase in pain or decrease in function that persists for more than one month after a small dose reduction; tapering may be paused or potentially abandoned in such patients.

RECOMMENDATION 10

For patients with chronic noncancer pain who are using opioids and experiencing serious challenges in tapering, we recommend a formal multidisciplinary program (strong recommendation)

Remark: In recognition of the cost of formal multidisciplinary opioid reduction programs and their current limited availability/capacity, an alternative is a coordinated multidisciplinary collaboration that includes several health professionals whom physicians can access according to their availability (possibilities include, but are not limited to, a primary care physician, a nurse, a pharmacist, a physical therapist, a chiropractor, a kinesiologist, an occupational therapist, an addiction medicine specialist, a psychiatrist and a psychologist).

COLLABORATING FOR BETTER CARE

National medical organizations have come together to form the Pan-Canadian Collaborative for Improved Opioid Prescribing. This partnership seeks to connect prescribers with educational resources to help address the harms associated with prescription opioids –including addiction, overdose, and death. The Collaborative is also committed to helping ensure Canadians have timely and appropriate access to optimal treatment for acute and chronic pain.

The Collaborative is pleased to disseminate 2017 Canadian Guideline for Opioid Therapy and Chronic Noncancer Pain, coordinated by the Michael G. DeGroote National Pain Centre at McMaster University. The guideline is integral in assisting the practice decisions regarding use of opioids for chronic noncancer pain management based on the latest evidence and expertise.

Health care professionals will have access to an app available at https://www.magicapp.org/public/guideline/8nyb0E that gives easy access to the evidence underpinning the recommendations. There will be a self-directed CME on the guideline and other tools that will be made available online.

These new prescribing guidelines are intended to increase patient safety; however, there may be unintended harms while reducing opioid prescribing levels. Becoming familiar with the risks of abrupt cessation of opioids, strategies for overdose prevention, and resources to guide tapering and assessment of opioid use disorder may mitigate risks associated with reducing opioid prescribing. The work seeks to support physicians and help them get the information they need, how they need it.

The Collaborative organizations will communicate with their members about new resources to support optimal patient care in this important area as they become available.

Canadian Centre on Substance Abuse
Centre canadien de lutte contre les toxicomanies

Association médicale canadienne
Canadian Medical Association

1867–2017 150

The College of Family Physicians of Canada
Le Collège des médecins de famille du Canada

MDcme.ca
Credible. Accessible. Flexible.
Crédible, accessible et souple.

McMaster University

Michael G. DeGroote National Pain Centre

Royal College of Physicians and Surgeons of Canada
Collège royal des médecins et chirurgiens du Canada