

Jan. 27, 2017

Draft Recommendations for the 2017 Canadian Opioid Guideline

1. When considering first-line therapy for patients with chronic non-cancer pain, we recommend optimization of non-opioid pharmacotherapy and non-pharmacological therapy, rather than a trial of opioids (**Strong recommendation, Low quality evidence**).*

2. For patients with chronic non-cancer pain, without current or past substance use disorder and without other current serious psychiatric disorders who still experience persistent problematic pain despite optimized non-opioid therapy, we suggest a trial of opioids rather than continued non-opioid therapy. (**Weak recommendation, Moderate quality evidence**).

Remark: 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.

3. For patients with chronic non-cancer pain with an active substance use disorder we recommend against the use of opioids (**Strong recommendation, Low quality evidence**).*

Remark: Clinicians should, if not yet addressed, facilitate treatment of the underlying substance use disorders.

4. For 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, we suggest stabilization of the psychiatric disorder before considering a trial of opioids (**Weak recommendation, Low quality evidence**).

5. For 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, we suggest continuing non-opioid therapy rather than a trial of opioids (**Weak recommendation, Low quality evidence**).

6 & 7. For patients with chronic non-cancer pain beginning long term opioid therapy, we suggest restricting the prescribed dose to under 50mg morphine equivalents daily (**Weak recommendation, Moderate quality evidence**). We recommend restricting the prescribed dose to under 90mg morphine equivalents daily rather than no upper, or a higher limit on dosing (**Strong recommendation, Moderate quality evidence**).

Remark: 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. Further, 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.

8. For patients with chronic non-cancer pain currently using 90mg morphine equivalents of opioids per day or more, with persistent problematic pain and/or problematic side-effects, we suggest rotation to other opioids rather than keeping the opioid the same (**Weak recommendation, Low quality evidence**).

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

9. For patients with chronic non-cancer pain currently using 90mg morphine equivalents of opioids per day or more, we suggest tapering opioids to the lowest possible dose, including discontinuation, rather than no change in opioid therapy (**Weak recommendation, Low quality evidence**).

Remark: 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.

10. For patients with chronic non-cancer pain using opioids and experiencing serious challenges in tapering, we recommend a formal multidisciplinary program (**Strong recommendation, Moderate quality evidence**).

Remark: 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).

* In general, GRADE discourages strong recommendations when the quality of evidence for critical outcomes is low or very low. There are, however, five paradigmatic situations in which strong recommendations may be warranted despite low or very low quality of evidence. One of these is when low quality evidence suggests equivalence of two alternatives, but high quality evidence suggests greater harm of one. For recommendation 1, low quality evidence, much of it indirect, suggests equivalence of opioid therapy and a number of other interventions, and high quality evidence demonstrates greater harm. Another situation is when when high quality evidence

suggests modest benefits and low or very low quality evidence suggests possibility of catastrophic harm. For recommendation 3, high quality evidence suggests modest benefit and low quality evidence suggests an elevated risk of serious harm.