Opioids for Chronic Non-Cancer Pain
Recommendations of an evidence based clinical practice guideline from the McMaster University Michael. G. DeGroote National Pain Centre

Summary

We prioritized 16 guideline questions with our panel and stakeholders, including patient partners, as detailed in Annex 1. For 9 of the 16 questions, we developed 11 formal recommendations with associated remarks where appropriate and 1 Good Practice Statement. For the remaining seven questions, we are drafting clinical statements with our experts as our systematic search of the literature identified insufficient evidence, rendering us uncertain about the effects (benefits and harms) of the interventions in question on patient important outcomes.

The strength of the recommendations is expressed as strong ("the guideline panel recommends...") or conditional ("the guideline panel suggests..."). Annex 2 presents the interpretation of strong and conditional recommendations for patients, clinicians, policymakers, and researchers.

Recommendations and Remarks

Recommendation 1. In people living with chronic non-cancer pain the panel recommends optimizing available nonopioid pharmacotherapy and non-pharmacological therapy prior to considering a trial of opioids **[STRONG recommendation]**

Remarks: There are several non-opioid interventions that may be helpful for people living with chronic pain.

Recommendation 2. In people living with chronic pain without current or past substance use disorder, without other current psychiatric disorders, and without a history of opioid overdose, who have, despite optimized nonopioid therapy, persistent pain they experience as problematic, the panel recommends discussing a trial of opioids **[STRONG recommendation]**

Remarks: This recommendation is consistent with many patients not receiving a trial of opioids. 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 within 2 months.

Recommendation 3. In people with chronic non-cancer pain, who have persistent problematic pain despite optimized nonopioid therapy and have a history of opioid overdose, the panel recommends against offering a trial of opioids **[STRONG recommendation]**

Recommendation 4. In people with chronic non-cancer pain, who have persistent problematic pain despite optimized nonopioid therapy and have an active alcohol use disorder, the panel recommends against offering a trial of opioids **[STRONG recommendation]**

Recommendation 5. In people living with chronic non-cancer pain with a history of any substance use disorder who have persistent problematic pain despite optimized nonopioid therapy, the panel suggests against offering a trial of opioids **[CONDITIONAL recommendation]**

Recommendation 6. In people living with chronic noncancer pain with a history of mental illness or an active mental health disorder, who have persistent problematic pain despite optimized nonopioid therapy, the panel suggests against offering a trial of opioids **[CONDITIONAL recommendation]**

Recommendation 7 and 8. In people living with chronic noncancer pain undergoing a trial of opioids, the panel suggests avoiding doses higher than 80mg morphine equivalents daily **[CONDITIONAL recommendation]** and seldom if ever exceeding doses higher than 150 mg morphine equivalents daily [**STRONG recommendation]**

Remarks: There will be people who would accept the increased risk of harms associated with a dose higher than 80 mg morphine equivalents daily to potentially achieve improved pain control. However, rarely will patients gain important benefit at a dose of more than 150mg morphine equivalents daily. Discussion with a colleague and a documentation of the rationale regarding the possibility of increasing the dose to more than 150mg morphine equivalents daily may therefore be warranted.

Recommendation 9. In people living with chronic non-cancer pain, currently prescribed opioids and experiencing persistent problematic pain and/or problematic side effects, the panel suggests rotation to other opioids **[CONDITIONAL recommendation]**

Remarks: When successful, improved response to opioids should be apparent within 2 months of rotation. In consultation with the patient, rotation may be done in parallel with, and as a way of facilitating, dose reduction.

Recommendation 10. In people living with chronic non-cancer pain on long term stable opioid therapy for chronic non-cancer pain, the panel recommends that clinicians initiate a discussion offering a trial of opioid tapering to the lowest effective dose, potentially including discontinuation and, if the offer is declined, repeating the offer every 6 to 12 months **[STRONG recommendation]**

Remarks: Some patients who agree to opioid tapering may experience 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 and potentially abandoned in such patients.

Good Practice Statement. Patients with chronic non-cancer pain prescribed opioids should not be engaged in forced/involuntary tapering.

Recommendation 11. For people living with chronic noncancer pain who are engaged in voluntary opioid tapering and experiencing challenges, we suggest engagement in multidisciplinary support **[CONDITIONAL recommendation]**

Remarks: Multidisciplinary support may include alternate analgesia; behavior change and active medication management. Health professionals whom physicians can access according to their availability include, but are not limited to, a primary care physician, a nurse, a pharmacist, a physical therapist, a chiropractor, a kinesiologist, an occupational therapist, a substance use disorder specialist, a psychiatrist, and a psychologist.

Annex 1: Guideline questions and output

Guideline question in PIC format	Output
1. Should we offer a trial of Opioids compared to optimizing therapy with non-opioid management options in people with chronic non-cancer pain considering first line therapy for pain?	Formal recommendation #1
2. Should we offer a trial of Opioids compared to continuing established therapy without opioids in people with chronic non-cancer pain, without current or past substance use disorder, without other current serious psychiatric disorders, and without a history of opioid overdose, whose therapy is optimized with non-opioids with persistent problematic pain?	Formal recommendation #2
3. Should we offer a trial of Opioids compared to continuing established therapy without opioids in people with chronic non-cancer pain with an active substance use disorder, or history of opioid overdose, whose non-opioid therapy has been optimized?	Formal recommendation # 3 and #4
4. Should we offer a trial of Opioids compared to continuing established therapy without opioids in people with chronic noncancer pain with an active psychiatric disorder whose non-opioid therapy has been optimized, and who still experience persistent problematic pain?	Formal recommendation #5
5. Should we offer a trial of Opioids compared to continuing established therapy without opioids in people with chronic non-cancer pain with a history of substance use disorder, whose non-opioid therapy has been optimized, who still experience persistent problematic pain?	Formal recommendation #6
6. In people with chronic noncancer pain optimized on non-opioid therapy and naïve to opioids who still experience persistent problematic pain, should we limit a dose of an opioid trial to a particular maximum dose compared to not providing a maximum opioid dose?	Formal recommendation #7 and #8
7. Should we rotate to a different opioid compared to keep the same opioid in people with chronic non-cancer pain with persistent problematic pain and/or problematic side effects?	Formal recommendation #9
8. Should clinicians discuss tapering with patients prescribed opioids for with chronic non-cancer?	Formal recommendation #10
9. Should we recommend a multidisciplinary program for people with chronic non-cancer pain that have agreed to taper their opioids, but are experiencing serious challenges doing so?	Formal recommendation #11

10. Should we restrict the number of opioid tablets prescribed at one time compared to not restrict in people with chronic non-cancer pain prior to starting long-term opioid therapy?	Clinical Statement
11. Should we prescribe controlled compared to immediate release opioids in people with chronic non-cancer pain prior to starting long-term opioid therapy?	Clinical Statement
12. Should we conduct a urine drug screening for baseline substance use compared to not conduct a urine drug screening in people with chronic non-cancer pain prior to starting long-term opioid therapy?	Clinical Statement
13. Should we use formal structured treatment agreements compared to not use formal structured treatment agreements in people with chronic non-cancer pain prior to starting long-term opioid therapy?	Clinical Statement
14. Should we prescribe tamper-resistant formulations of opioids compared to not prescribe tamper-resistant formulations of opioids in people with chronic non-cancer pain prior to starting long-term opioid therapy?	Clinical Statement
15. Should we recommend a fentanyl patch exchange compared to not recommend a fentanyl patch exchange in people with chronic non-cancer pain prior to starting long-term opioid therapy?	Clinical Statement
16. Should we provide take-home naloxone along with opioid prescription compared to not provide take-home naloxone along with opioid prescription in people with chronic non-cancer pain prior to starting long-term opioid therapy?	Clinical Statement

Annex 2: Interpretation of Strong and Conditional Recommendations

The strength of a recommendation is expressed as strong ("the guideline panel recommends...") or conditional ("the guideline panel suggests...") and has the following interpretation:

	Strong Recommendation	Conditional Recommendation
For patients:	Most individuals in this situation would want the recommendation, and only a small proportion would not.	Most individuals would want the suggested course of action, but many would not.
For clinicians:	Most individuals should follow the recommendation. Shared decision making or formal decision aids are unlikely to be needed to support individual patient decision-making consistent with their values and preferences.	Different choices will be appropriate for individual patients, and clinicians must support patients to arrive at a management decision consistent with their personal values and preferences. The use of decision aids may facilitate shared decision making.
For policymakers	The recommendation can be adopted as policy/practice in most situations. Adherence to this recommendation according to the guideline could be used as a quality criterion or performance indicator.	Substantial debate and involvement of various stakeholders will be needed. Performance measures about the suggested course of action should focus on whether an appropriate decision-making process is duly documented.

An evaluation of the conditions and criteria (and the related judgments, research evidence, and additional considerations) that determined the conditional (rather than strong) recommendation will help to identify possible research gaps.