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 (MME) and suggest restricting the maximum prescribed dose to under 50 mg MME.

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

Patients with chronic non-cancer pain, we recommend optimization of nonopioid pharmacotherapy and nonpharmacologic therapy, rather than a trial of opioids (weak recommendation)

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)

Remark: By a trial of opioids, we mean initiation, titration and continued therapy without opioids (weak recommendation)

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 2

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

Remark: Clinicians should facilitate treatment of the underlying substance use disorder of an opioid addiction. 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 3

For patients with chronic non-cancer 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 4

For patients with chronic non-cancer pain who are beginning opioid therapy, we recommend restricting the prescribed dose to less than 90 mg morphine equivalents daily (weak recommendation)

Remark: Some patients may gain important benefit at a dose of more than 90 mg morphine equivalents daily. Referal 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 5

For patients with chronic non-cancer 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 6

For patients with chronic non-cancer pain who are currently using opioids, and have persistent problemmatic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than continuing 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 7

For patients with chronic non-cancer 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/capacity, an alternative is a coordinated multidisciplinary collaboration that includes several health professionals whom physicians can access accordingly.

RECOMMENDATION 8

For patients with chronic non-cancer 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 accordingly.

RECOMMENDATION 9

For patients with chronic non-cancer pain who are using opioids, nonopioid pharmacotherapy should be re-examined (weak recommendation)

Remark: Clinicians should monitor chronic non-cancer pain patients using opioid therapy for their response to treatment, and adjust treatment accordingly.

RECOMMENDATION 10

For patients with chronic non-cancer pain who have a history of substance use 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)

Remark: By a trial of opioids, we mean initiation, titration and monitoring of response, with or without discontinuation of opioids if improved pain control.

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 11

For patients with chronic non-cancer pain who are currently using opioids, and have persistent problemmatic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than continuing 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.

GOOD PRACTICE STATEMENTS

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

Clinicians with chronic non-cancer pain patients prescribed opioids should address any potential contradictions and exchange relevant information with the patient’s general practitioner (if they are not the general practitioner) and/or pharmacists.

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

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)

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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 pain care and treatment for acute and chronic pain.

The Cooperative is pleased to disseminate 2017 Canadian Guideline for Opioid Therapy and Chronic Noncancer Pain, coordinated by the Michael G. DeGroat 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.npca.org/en/patients/guide/index.html that gives easy access to the evidence and the recommendations. There will be well-directed CME on the guideline and other tools that will be made available online.

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