Debating the opioid guidelines: corrections

We must correct errors in the commentary of Drs Gallagher and Hatcher[1] in the debate regarding the *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain*.[2]

Drs Gallagher and Hatcher advise that the guideline's recommendations will be applied to patients with cancer-related pain, acute pain, and pain at the end of life. We wish to emphasize that this should not occur. Under the section "What this guideline does not address," we state,

> This guideline does not address the use of opioids to manage the following: cancer-related pain, opioid addiction or opioid use disorder, acute or sub-acute pain (pain lasting less than 3 months), [and] pain or suffering associated with end-of-life care.[2]

They suggest that harms associated with nonsteroidal anti-inflammatory drugs (NSAIDs) are equivalent, or perhaps greater, than harms associated with long-term opioid therapy for chronic noncancer pain. They are not. Solomon and colleagues found that older adults with arthritis who were prescribed opioids had nearly twice the risk of out-of-hospital cardiac death as did comparable patients prescribed non-selective NSAIDs.[3] Moreover, opioids are associated with dependence, addiction, and diversion[2]; NSAIDs are not. Many other adverse effects of opioids are subtle and often not attributed to therapy, including motor vehicle collisions, reduced libido, falls, and depression.

They argue that our second recommendation (a weak recommendation in favour of a trial of opioids 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) should have been a strong one. According to the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach, a strong recommendation in favour of an intervention requires confidence that the desirable effects of an intervention outweigh its undesirable effects. Opioids, when added to nonopioids, achieve on average modest improvements in pain and function. Adverse effects include relatively frequent constipation, nausea and vomiting, sedation, opioid use disorder, and a small but important risk of unintentional overdose, which can be fatal. A guideline panel makes a strong recommendation using GRADE if they believe that all, or almost all, fully informed patients would choose the recommended intervention. The small benefit with opioids in the face of adverse effects struck the panel, and continues to strike us, as a value- and preference-sensitive decision, which using the GRADE approach warrants a weak recommendation.

They argue that the guideline denies a trial of opioids to patients with a history of substance use disorder or an active psychiatric illness. It does not. We made weak recommendations against a trial of opioids for these patient populations owing to their increased risk of opioid use disorder and nonfatal and fatal overdose. As we have indicated, a weak recommendation indicates most informed patients would choose the suggested course of action, but an appreciable minority would not. With weak recommendations, clinicians should recognize that different choices will be appropriate for individual patients and should assist patients in arriving at a decision consistent with their values and preferences.

Drs Gallagher and Hatcher suggest that the evidence for a dose-response effect for opioids and overdose is based on a poster. This is incorrect. These data derive from large observational studies.[4,5] They further suggest that recommendations 6 and 7 will result in many patients having their doses cut; however, these recommendations only apply to new trials of opioid therapy and not to legacy patients.

They state that the guideline limits a 90-mg morphine equivalent dose as "the absolute highest dose."[1] It does not. The remark associated with recommendation 6 states,

> 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.[2]

They suggest that "there is no mention in the guideline"[1] regarding inappropriate tapering of opioids. This is false. The remark associated with recommendation 9 states,

> Some patients are likely to experience significant 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.[2]

They suggest that recommendation 10 (strong recommendation for a formal multidisciplinary program for patients with chronic noncancer pain who are using opioids and experiencing serious challenges in tapering) is impractical. We agree that this recommendation is resource dependent, which is why the guideline provides the following associated remark:

> Recognizing 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, a substance use disorder specialist, a psychiatrist, and a psychologist).[2]

The Canadian guideline is available here in an interactive, multi-layered format, with patient decision aids for all weak recommendations: **www.magicapp.org/public/guideline/8nyb0E**.

We reiterate our view that, if followed, the 2017 Canadian guideline will promote evidence-based prescribing of opioids for chronic noncancer pain.

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Competing interests

All authors were members of the steering committee for the Canadian opioid guideline. **Dr Juurlink** has received payment for lectures and medicolegal opinions regarding the safety and effectiveness of analgesics, including opioids. He is a member of Physicians for Responsible Opioid Prescribing, a volunteer organization that seeks to reduce opioid-related harm through more cautious prescribing practices. **Dr Buckley** reports grants from Purdue Pharma and Janssen Inc outside the submitted work.

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Debating the opioid guidelines: context

We wish to respond to the commentary of Dr Persaud[1] in the debate regarding the *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain*.[2]

Dr Persaud takes our statement regarding controlled-release versus short-acting opioids out of context. The full statement is as follows:

> In patients with continuous pain including pain at rest, clinicians can prescribe controlled release opioids both for comfort and simplicity of treatment. Activity related pain may not require sustained release treatment