> 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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2. Busse J, editor. *The 2017 Canadian guideline for opioids for chronic non-cancer pain*. Hamilton, ON: National Pain Centre, McMaster University; 2017. Available from: **http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf**. Accessed 2018 Apr 6.
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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

and opioid therapy may be initiated with immediate release alone. The benefit and safety of controlled release or sustained release over immediate release preparations is not clearly established. Some patients, when switching from immediate release to comparable dose sustained release, require larger doses in order to acquire a similar analgesic effect. The release profile of all sustained or controlled release preparations is not the same and may vary for the same drug among patients. Individuals misusing opioids favour immediate release opioid preparations, regardless of the route of administration.[2]

Regarding the last point, a structured survey of 8304 individuals entering treatment for opioid use disorder found that only 4% selected extended-release opioids as their preferred formulation, while 66% favoured short-acting opioids; the remainder (30%) had no preference.[3]

Dr Persaud suggests that differences between the Canadian guideline and the Centers for Disease Control and Prevention (CDC) guideline[4] are owing to bias. Dr Persaud might well be right: The CDC panel was largely restricted to experts who have been critical of opioid use for chronic noncancer pain. In addition, the CDC guideline, relative to ours, had limited involvement of patients, excessive restrictions on selection of evidence (eg, insisting on studies with a follow-up of 1 year or more excluded every randomized controlled trial of treatment with opioids), suboptimal application of the GRADE (Grading of Recommendations Assessment, Development and Evaluation) rating system to address evidence quality, excessive use of strong recommendations in the face of low-quality evidence, and vagueness in some recommendations.[5] These factors, in addition to bias as a function of restricting panelists largely to those who were already on record as being critics of opioid use, explain differences between the 2 guidelines.

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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Correction

In the article "Pathways to rural family practice at Memorial University of Newfoundland," published in the March issue of *Canadian Family Physician*, an error appears in the Methods section within the discussion on the L&L (Learners and Locations) database.[1] The statement "Smaller centres with less than 50% commuting flows to larger centres were categorized in accordance with the larger centre" should have read as follows:

> Smaller centres with more than 50% commuting flows to larger centres were categorized in accordance with the larger centre.

Canadian Family Physician apologizes for this error and any confusion it might have caused.

Reference

1. Rourke J, O'Keefe D, Ravalia M, Moffatt S, Parsons W, Duggan N, et al. Pathways to rural family practice at Memorial University of Newfoundland. *Can Fam Physician* 2018;64:e115-25. Available from: **www.cfp.ca/content/cfp/64/3/e115.full.pdf**. Accessed 2018 Mar 23.

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