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.

GOOD PRACTICE STATEMENTS

Acquire informed consent prior to initiating opioid use for chronic noncancer pain. A discussion about potential benefits, adverse effects, and complications will facilitate shared-care decision making regarding whether to proceed with opioid therapy.

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

Clinicians with chronic noncancer 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.

RECOMMENDATION 1

When considering therapy for patients with chronic noncancer pain, we recommend optimization of nonopiod pharmacotherapy and nonpharmacologic therapy, rather than a trial of opioids (strong recommendation).

REMORK: 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.

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 noncancer pain with an active substance use disorder, we recommend against the use of opioids (strong recommendation).

REMORK: Clinicians should facilitate treatment of the underlying substance use disorder if not yet addressed. The studies that identified 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 5

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

REMORK: 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 7

For 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).

REMORK: 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 9

For 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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RECOMMENDATION 10

For patients with chronic noncancer pain who are currently using opioids and have persistent problematic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than keeping the opioid the same (weak recommendation).

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

RECOMMENDATION 2

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, we suggest adding a trial of opioids rather than a trial of nonopioids (strong recommendation).

REMORK: By a trial of nonopioids, we mean initiation, titration and monitoring of response, with discontinuation of nonopioids if important improvement in pain or function is not achieved.

The studies that identified 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 noncancer pain with an active psychiatric 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).

REMORK: Stabilization of psychiatric disorders is 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 6

For patients with chronic noncancer pain who are beginning opioid therapy, we recommend restricting the prescribed dose to less than 90 mg morphine equivalents daily, rather than having no upper limit or a higher limit on dosing (strong recommendation).

REMORK: 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.

RECOMMENDATION 8

For patients with chronic noncancer pain who are currently using opioids, and have persistent problematic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than keeping the opioid the same (weak recommendation).

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For patients with chronic noncancer pain who are currently using opioids and have persistent problematic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than keeping the opioid the same (weak recommendation).

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RECOMMENDATION 12

For patients with chronic noncancer pain who are currently using opioids and have persistent problematic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than keeping the opioid the same (weak recommendation).

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RECOMMENDATION 14

For patients with chronic noncancer pain who are currently using opioids and have persistent problematic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than keeping the opioid the same (weak recommendation).

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RECOMMENDATION 15

For patients with chronic noncancer pain who are currently using opioids and have persistent problematic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than keeping the opioid the same (weak recommendation).

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RECOMMENDATION 16

For patients with chronic noncancer pain who are currently using opioids and have persistent problematic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than keeping the opioid the same (weak recommendation).

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RECOMMENDATION 17

For patients with chronic noncancer pain who are currently using opioids and have persistent problematic pain and/or problematic adverse effects, we suggest rotation to other opioids rather than keeping the opioid the same (weak recommendation).

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