Guideline Review: "The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain"

Kevin Hamilton

Faculty/Presenter Disclosure

- **Faculty:** Kevin Hamilton

- **Relationships with commercial interests:**
  - **Grants/Research Support:** None
  - **Speakers Bureau/Honoraria:** None
  - **Consulting Fees:** None
  - **Other:** None

Mitigating Potential Bias

- Not applicable

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Questions

1. What is the maximum recommended dose of opioids, or "watchful dose" in *morphine equivalents*?
2. What is our overall goal in the treatment of CNCP patients?

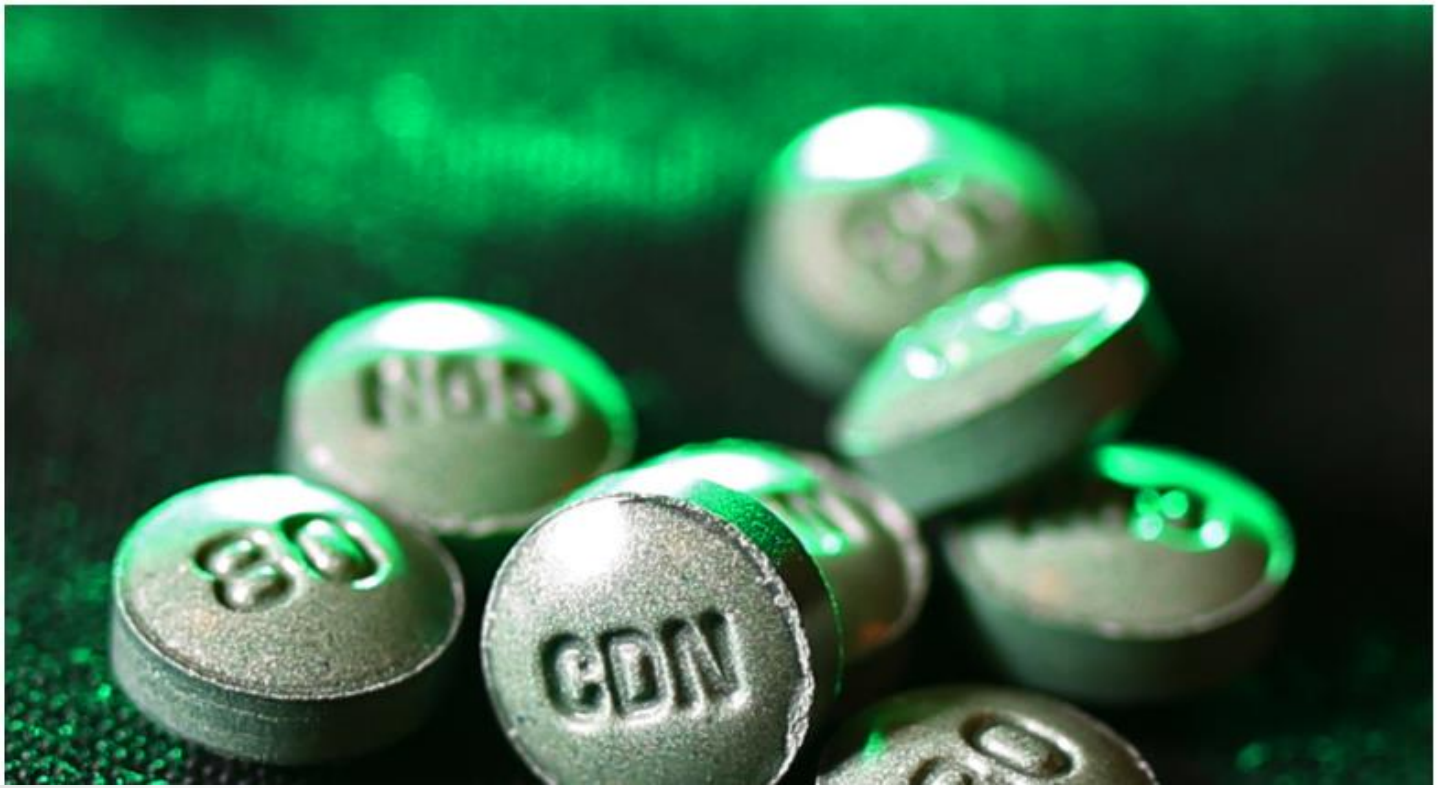
Objectives

1. Recall the 10 updated guidelines for the treatment of chronic non-cancer pain
2. Understand the evidence base that supports the guidelines
3. Apply the guiding principals to your patient's care plan

NATIONAL POST

Doctors' reckless prescribing of fentanyl largely to blame for deadly overdoses: expert

Dr. David Juurlink says a new study showing half of all prescriptions for fentanyl patches are unsafe reflects dangerous prescribing habits



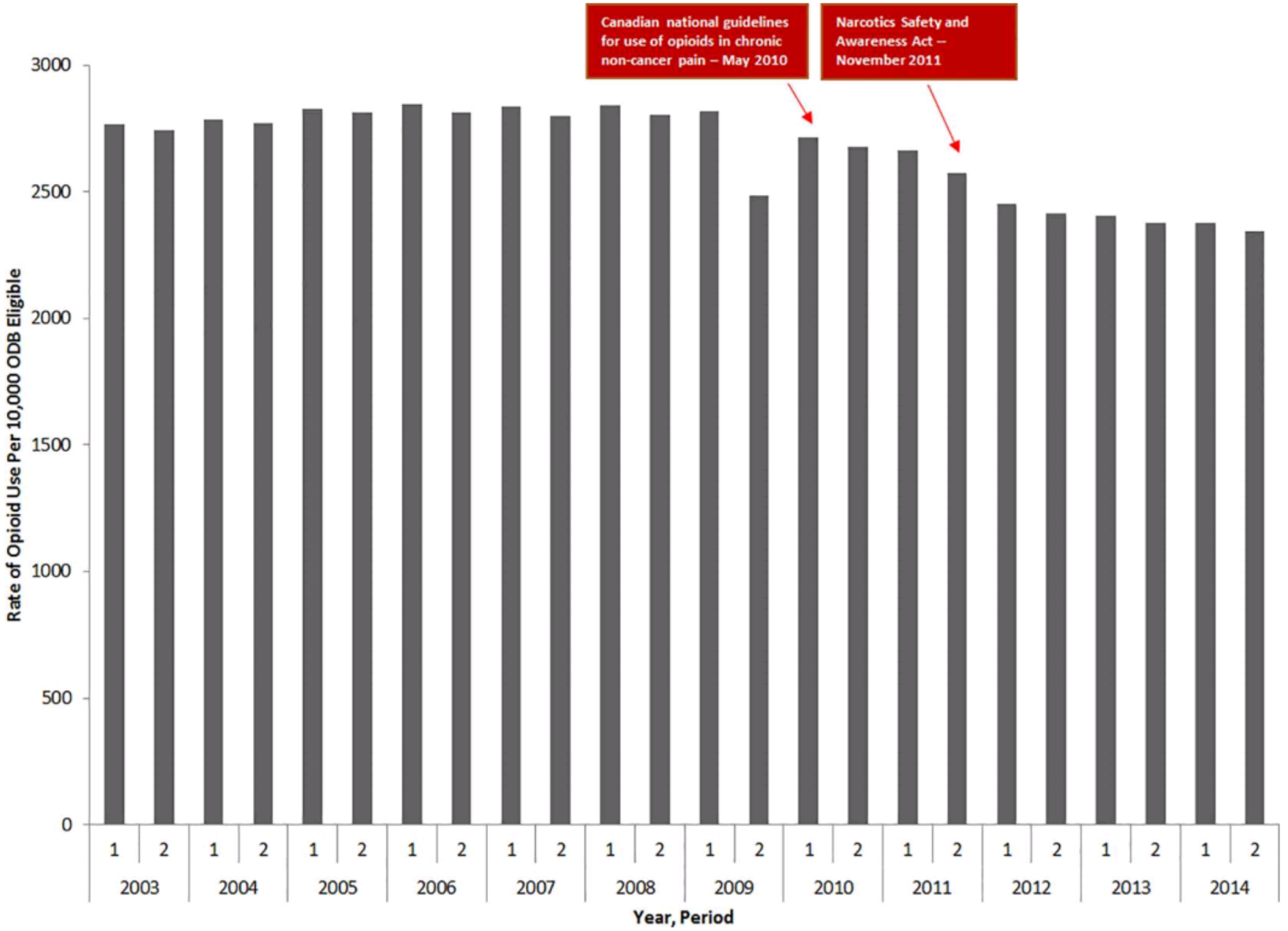


Fig 2. Rate of opioid users (per 10, 000 ODB eligible persons) between 2003 and 2014.

PLoS One. 2016; 11(12): e0167479

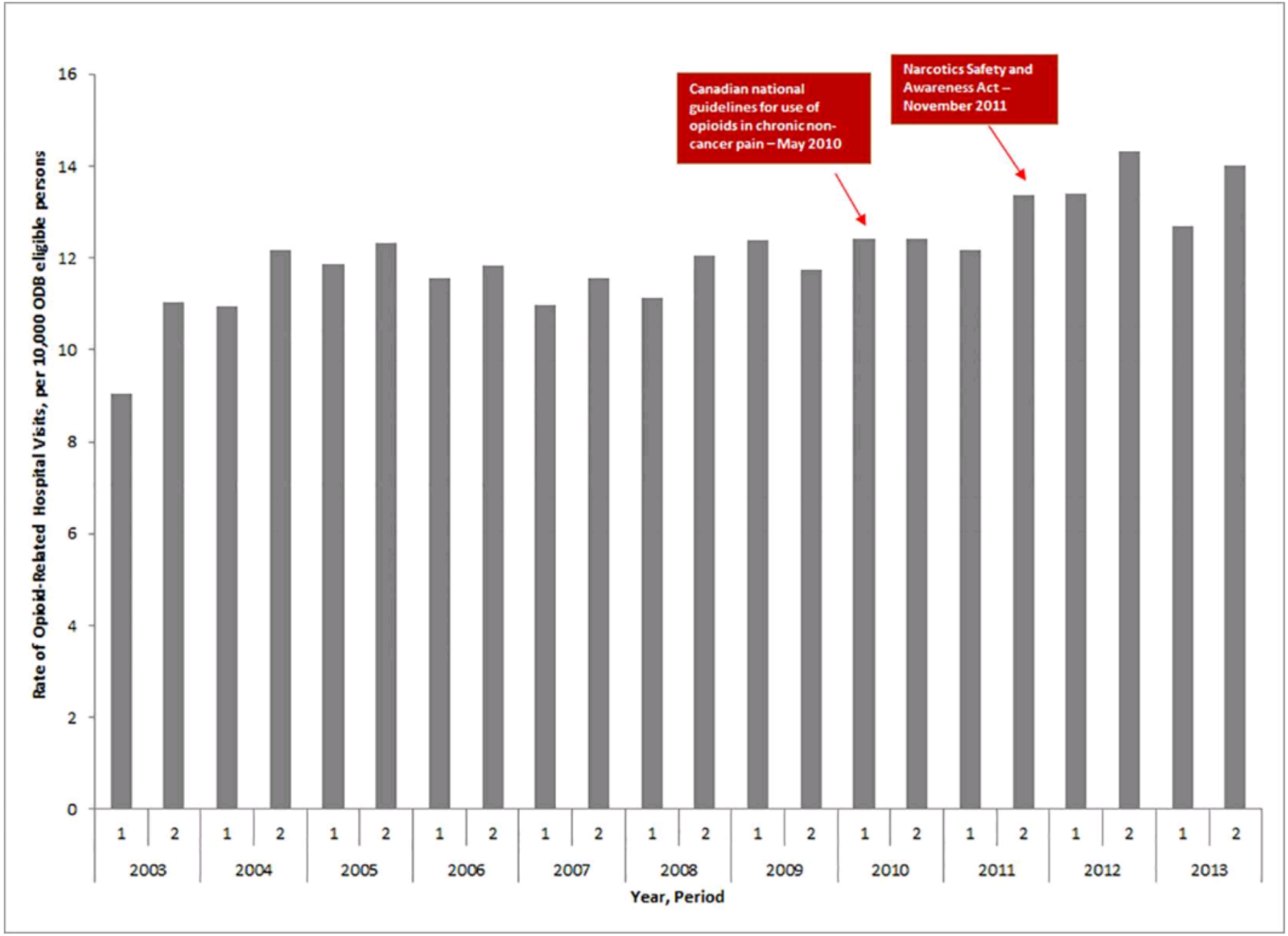


Fig 4. Rate of opioid related hospital or emergency room admissions (per 10,000 ODB eligible persons) between 2003 and 2013.

PLoS One. 2016; 11(12): e0167479

Law Suits Against Purdue Pharma

for misbranding OxyContin as not being addictive

Joint Statement of Action to Address the Opioid Crisis

November 19, 2016

Canada faces a serious and growing opioid crisis. We see its consequences in the rates of addiction, overdoses, and deaths across the country. This is a complex health and social issue with devastating consequences for individuals, families, and communities.

The response to this crisis needs to be comprehensive, collaborative, compassionate and evidence-based.

On November 18, 2016, we heard a number of perspectives on this crisis: from people who use drugs, from families, healthcare providers, first responders, educators and researchers. Today, we have come together to identify specific actions to address this crisis and publicly commit to taking these actions.

This Joint Statement of Action to Address the Opioid Crisis reflects our combined commitment to act on this crisis. We have agreed to work within our respective areas of responsibility to improve prevention, treatment and harm reduction associated with problematic opioid use through timely, concrete actions that deliver clear results and we commit to reporting on our progress in delivering those results.

As Health Ministers, our focus today is on the important actions being taken by players in the health community. We recognize that this is just the beginning. Much work is already underway separately in the areas of law enforcement, corrections, education and elsewhere. We will invite leaders in these communities to join us as we build on the commitments made today.

The Honourable Jane Philpott
Federal Minister of Health

The Honourable Eric Hoskins
Ontario Minister of Health and Long-Term Care

CPD

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

PROGRAMS AND PRACTICE SUPPORT

MAINPRO+®

THE 2017 CANADIAN GUIDELINE FOR OPIOIDS FOR CHRONIC NON-CANCER PAIN

CPD PROVIDERS AND PLANNERS

SELF LEARNING™

CFP MAINPRO+®

PEARLS™

PREVENTION IN HAND

LINKING LEARNING EXERCISES

ALARM – ADVANCES IN LABOUR AND RISK MANAGEMENT

The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain

The College of Family Physicians of Canada (CFPC), as part of the **Pan-Canadian Collaborative on Education for Improved Opioid Prescribing**, and in response to Health Canada's **2016 Joint Statement of Action to Address the Opioid Crisis**, is partnering to provide educational resources for opioid prescribers. The Collaborative aims to address the harms associated with prescription opioids—including addiction, overdose, and death—while ensuring Canadians have timely and appropriate access to optimal treatments for acute and chronic pain.

The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, developed by the Michael G. DeGroote National Pain Centre at McMaster University, will assist health care providers in making practice decisions about the safe and effective use of opioids for chronic non-cancer pain management.

The CFPC is committed to providing its members with timely educational resources that promote safer prescribing and high quality patient care.

Links and Resources

The **2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain**

The **2017 Canadian Opioid Prescribing Guideline – Summary of Recommendations**

The guideline is also a **https://www.magicapp.org/app#/guideline/1857**
This is an interactive, dynamic app that features decision aids and facilitates decision making between patients and providers.

Guideline NOT meant for…

- Cancer related pain
- Opioid addiction or opioid use disorder
- Acute or subacute pain (pain <3 mos.)
- Pain or suffering associated with end-of-life care

Recommendation #1

When considering therapy for patients with chronic non-cancer pain

- We recommend optimization of non-opioid pharmacotherapy and non-pharmacological therapy, rather than a trial of opioids

Strong recommendation

Comparator	Absolute difference (0-10 VAS)	Quality of Evidence	Summary
NSAIDs	Mean diff =0.49↓ (1.24↓ - 0.26 ↑)	low	Opioids may result in little or no difference in pain compared to NSAIDS
Anticonvulsants	Mean diff =0.9↓ (1.65↓ - 0.14 ↓)	low	Opioids may result in a small but important improvement in pain compared to anticonvulsants
TCAs	Mean diff =0.15↓ (1.04↓ - 0.74 ↑)	low	Opioids may result in little to no difference in pain compared to TCAs
Nabilone	Mean diff =0.13↓ (1.04↓ - 0.77 ↑)	low	Opioids may result in little to no difference in pain compared to nabilone
?SNRI	Not addressed in this guideline but appears similar to TCAs		
? naltrexone	Not addressed		

Additional Considerations

- Rare fatal & non-fatal overdose
  - At low doses (<20 Meq/day)
    - 0.1% fatal
    - 0.2% non-fatal
- “Very frequent” physical dependence
  - 5% - 24%*
- Addiction
  - 5.5% (95% CI 4-7%)

J R Soc Med. 2004 Feb; 97(2): 62–65.

Recommendation #2

For patients with chronic non-cancer pain, without current or past substance use disorder and without other active psychiatric disorders, who have persistent problematic pain despite optimized non-opioid therapy

- We suggest adding a trial of opioids rather than continued therapy without opioids

Weak recommendation

Risk vs benefit

- Clinically significant ↓in pain
  - 12%
- Important ↑ in function
  - 10%
- ↑ in GI adverse events
  - 64 more per 1000 patients treated

Opioids NOT to Consider 1st

- Methadone
  - Requires special training
    - PK tricky, drug interactions
- Fentanyl (transdermal)
- Meperidine
  - Limited effectiveness
  - Toxic metabolite accumulation

Opioids NOT to Consider 1st

- Pentazocine
  - Limited effectiveness
  - ↑ incidence of dysphoria
- ?buprenorphine
  - No greater efficacy vs other opioids
  - Claims of ↓ ADRs not substantiated
  - $ and not covered

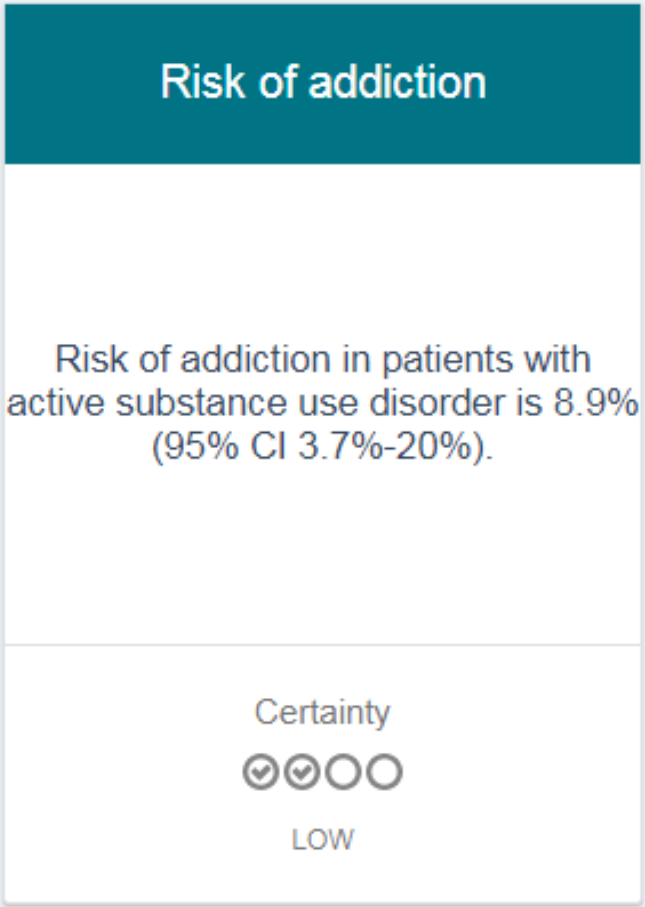
Recommendation #3

For patients with chronic non-cancer pain with an active substance use disorder

- We recommend against the use of opioids

Strong recommendation

Among a 1000 patients like you, on average with Trial of opioids



Among a 1000 patients like you, on average with Trial of opioids

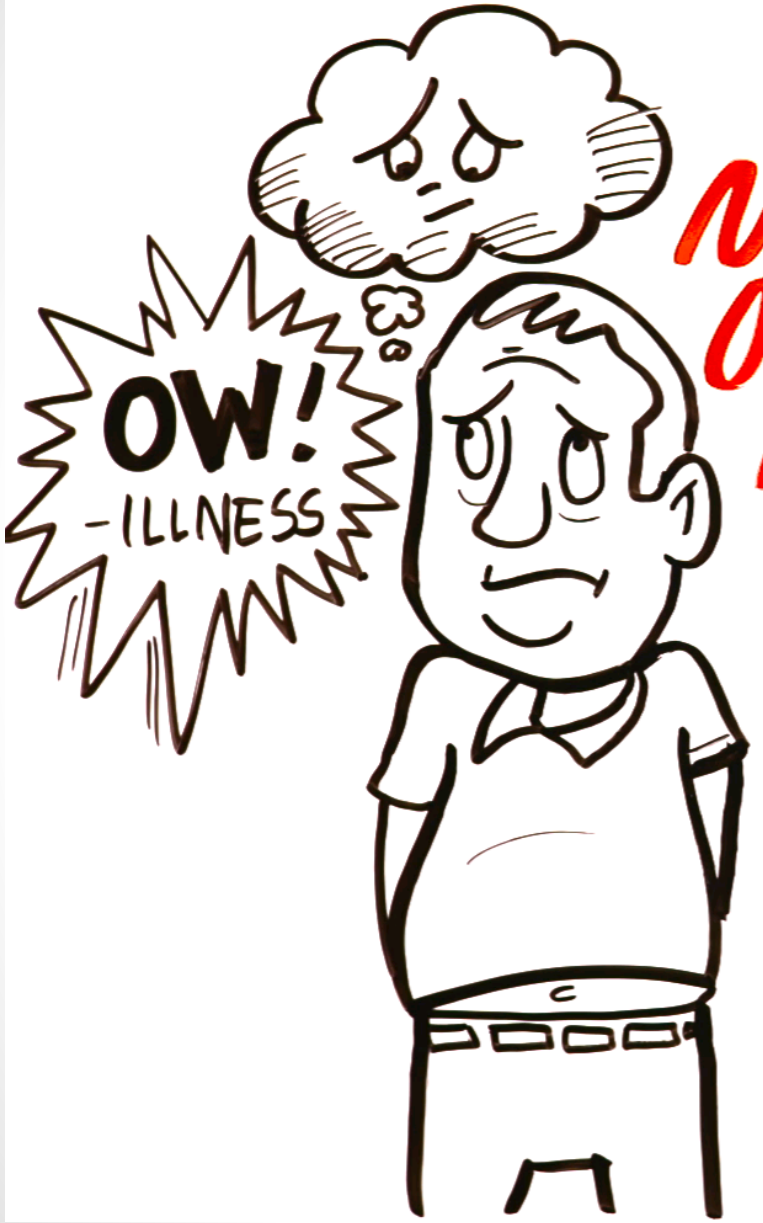
Risk of addiction	Risk of addiction
Risk of opioid addiction is 5.5% (95% CI 3.91-7.03%)	Risk of addiction in patients with active substance use disorder is 8.9% (95% CI 3.7%-20%).
Certainty ⊘⊘⊘○ MODERATE	Certainty ⊘⊘○○ LOW

Recommendation #4

For patients with chronic non-cancer pain with an active psychiatric disorder whose non-opioid 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



your ATTITUDE

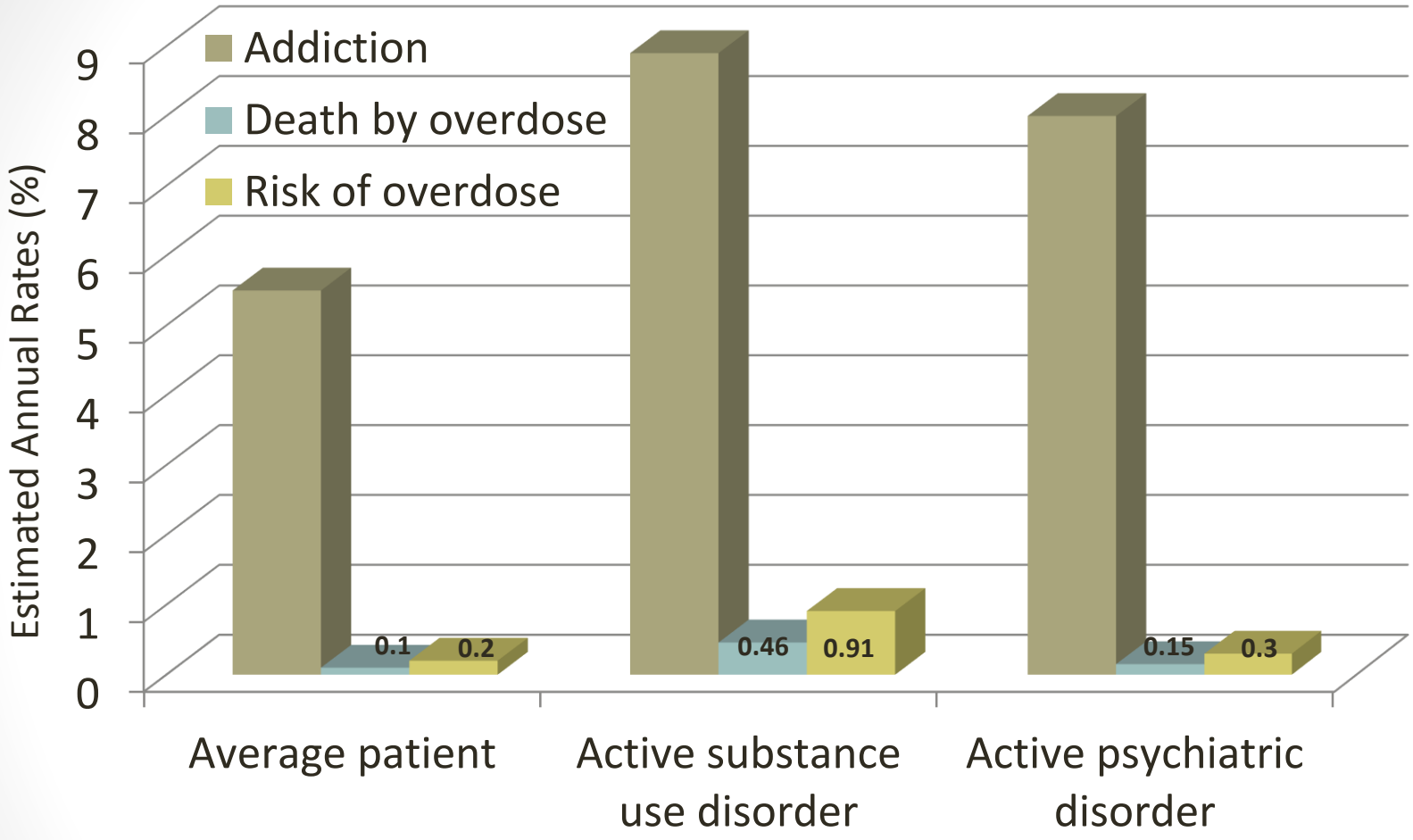
... "I'D BETTER STOP EXERCISING..."

Recommendation #5

For patients with chronic non-cancer pain with a history of substance use disorder, whose non-opioid therapy has been optimized, and who have persistent problematic pain

- We suggest continuing non-opioid therapy rather than a trial of opioids

Weak recommendation



Risk of addiction and overdose grouped by patient population

Recommendation #6

For patients with chronic non-cancer pain who are beginning long term opioid therapy

- We recommend restricting the prescribed dose to less 90mg morphine equivalents daily rather than no upper limit or a higher limit on dosing

Strong recommendation

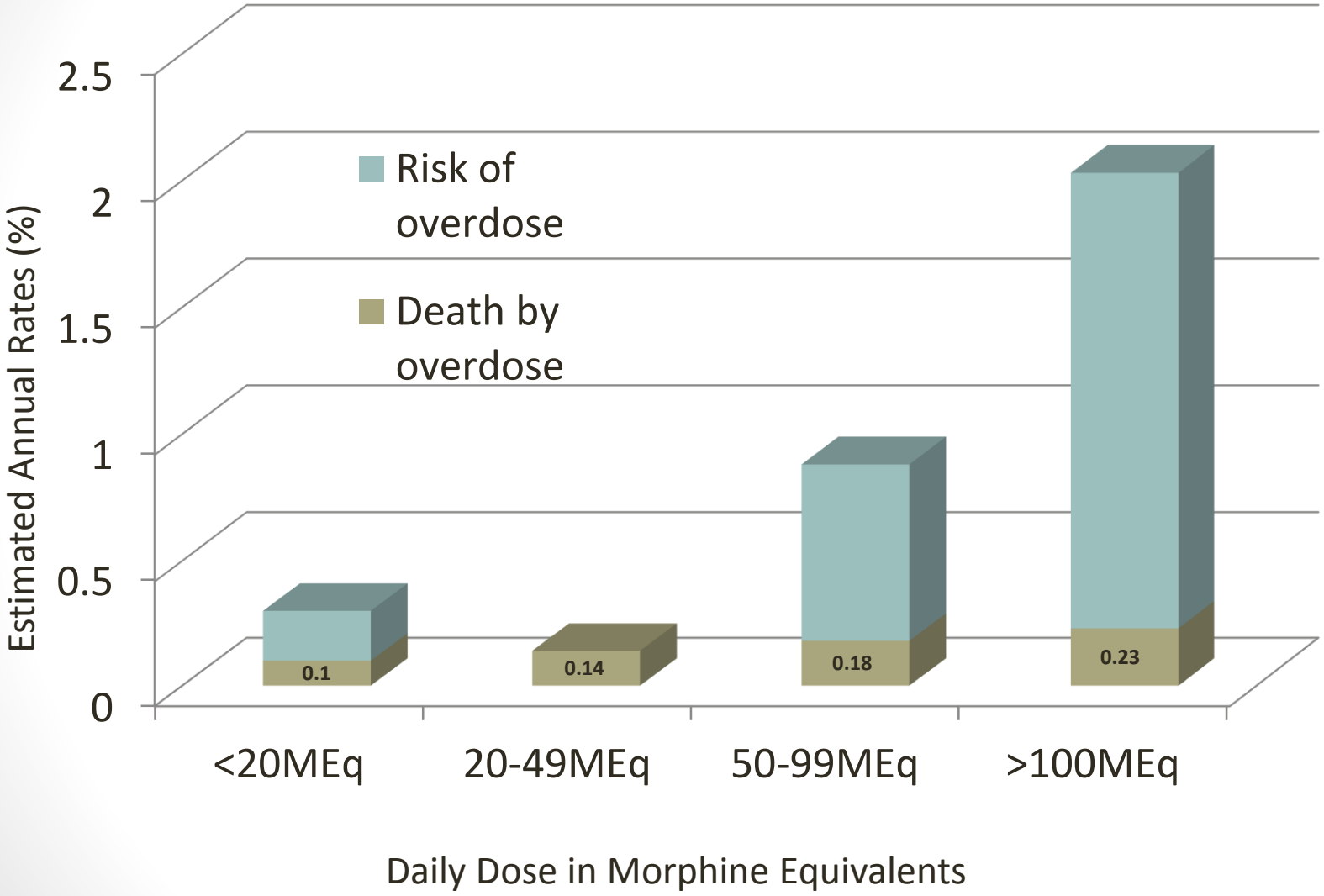
Recommendation #7

For patients with chronic non-cancer pain who are beginning long term opioid therapy

- We suggest restricting the prescribed dose to less than 50mg morphine equivalents daily

Weak recommendation

Outcome Timeframe	Absolute effect estimates No maximum dose	 Threshold dose	Plain text summary
Pain 3 months	Within-study comparisons found no evidence for a dose-response effect on pain (meta-regression p-value=0.49).		Limiting opioid dose to a particular maximum dose results in little or no difference in pain.
Physical function 3 months	Within-study comparisons found no evidence for a dose-response effect on physical function (meta-regression p-value=0.22).		Limiting opioid dose to a particular maximum dose results in little or no difference in physical function.
Gastrointestinal side effects 3 months	Within-study comparisons found no evidence for a dose-response effect on gastrointestinal side effects (meta-regression p-value=0.09).		Limiting opioid dose to a particular maximum dose results in little or no difference in gastrointestinal side effects.
Addiction	Risk of opioid addiction is 5.5% (95% CI 3.91-7.03%)		Limiting opioid dose to a particular maximum dose likely results in little or no difference on the risk of addiction.
Fatal overdose median 2.6 years	Estimated annual fatal overdose rates were 0.10%, 0.14%, 0.18% , and 0.23% in patients receiving <20 mg morphine equivalent per day, 20-49 mg/day, 50-99 mg/day, and >100 mg per day respectively.		Limiting opioid dose to a particular maximum dose results in a reduction in the risk of fatal overdose.
Non-fatal overdose up to 10 years	Estimated annual overdose rates were 0.2%, 0.7%, and 1.8% among patients receiving less than 20 mg/d, 50 to 99 mg/d, and more than 100 mg/d of opioids, respectively.		Limiting opioid dose to a particular maximum dose likely results in a reduction in the risk of non-fatal overdose.
Diversion 1 year	Among US adults, the prevalence of nonmedical use of prescription opioids was 4.9% (95% CI 4.58-5.22%) in 2013.		Limiting opioid dose to a particular maximum dose likely results in little or no difference in the risk of diversion.


2.5
2
1.5
1
0.5
0
Estimated Annual Rates (%)
Risk of overdose
Death by overdose
0.1
0.14
0.18
0.23
<20MEq
20-49MEq
50-99MEq
>100MEq
Daily Dose in Morphine Equivalents

KEY MESSAGE

The evidence base around a watchful dose threshold for morphine or equivalent opioid dosing was limited in both quality and quantity.

The evidence to support a watchful dose of morphine or morphine equivalent opioid dosing of greater than 200 mg/day in chronic non-cancer pain (CNCP) is limited in both quality and quantity; however, there is also little evidence to support a lower threshold dose.

The paucity of evidence for watchful dosing is likely reflective of larger gaps in evidence in the topic of CNCP management in general, including around the appropriate use of opioids.

Recommendation #8

For patients with chronic non-cancer 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

Advanced Opioid Converter

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DISCLAIMER
Recently updated: [April 2013] - Improved handling of methadone with additional feedback and new dosing schemes.
Check out the NSAID Selection Calculator NEW

Converting From:

Select an opioid analgesic to convert ▾ (Total daily dose in mg)

Hint: Fentanyl patch equivalents | Popup calculator

Additional drugs to convert if present:

Select an opioid analgesic to convert ▾ (Total daily dose in mg)

Select an opioid analgesic to convert ▾ (Total daily dose in mg)

Converting To:

Select the FINAL opiate ▾

Reduction for incomplete cross tolerance:

Do not reduce dose ▾ ?

Review if converting 'FROM' or 'TO' I.V. or transdermal fentanyl

Optional section::

Converting FROM transdermal fentanyl: 0.36 ▾

Converting TO transdermal fentanyl: 0.3 ▾

Converting FROM IV fentanyl: 0.25 ▾

Converting TO IV fentanyl: 0.1 ▾

Global RPh Advanced Opioid Converter

Table 5: Opioid conversion table

Opioids*	To convert to oral morphine equivalent, multiply by:	To convert from oral morphine, multiply by:	50 MED equivalent dose	90 MED equivalent dose
Oral preparations (mg/d)				
Codeine	0.15 (0.1-0.2)	6.67	334 mg/d	600 mg/d
Hydromorphone	5.0	0.2	10 mg/d	18 mg/d
Morphine	1.0	1	50mg/d	90mg/d
Oxycodone	1.5	0.667	33 mg/d	60 mg/d
Tapentadol	0.3-0.4	2.5-3.33	160	300
Tramadol	0.1 -0.2	6	300	540**

Recommendation #9

For patients with chronic non-cancer pain who are currently using 90mg 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

Other Reasons to Taper

- Lack of improvement in pain/function
- Nonadherence to treatment plan
- Signs of misuse
- Serious adverse events
- Patient request

Rationale

- Opioid benefits can attenuate
  - Tolerance, hyperalgesia
  - Interdose withdrawal
- Long term harms
  - Depression
  - Hormonal disturbance
  - Sleep disturbance
  - Cognitive impairment

Risks/Benefits of Tapering

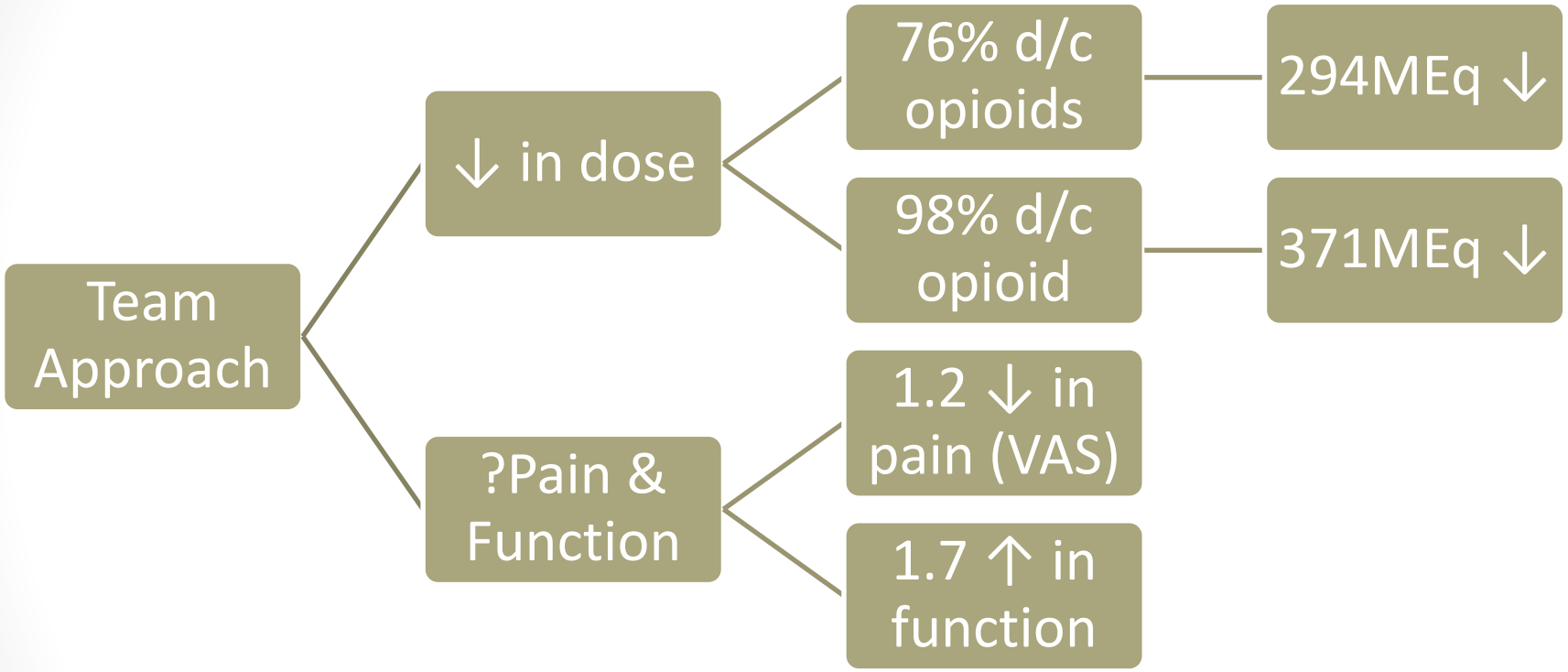
- Pain reduction
  - 4.7 pt ↓ over 6 mos.
  - 40% reported ↓, 28% no change, 33% ↑
- ↓ risk of A/E
- ↓ risk of overdose
- Withdrawal
- Sustained ↓ in function and or ↑ in pain
  - >4 weeks

Journal of opioid management 2006;2(5):277-82
Pain medicine 2015;16(10):1975-81

Recommendation #10

For patients with chronic non-cancer pain who are using opioids and experiencing serious challenges in tapering

- We recommend a formal multidisciplinary program


Team Approach
↓ in dose
?Pain & Function
76% d/c opioids
98% d/c opioid
294MEq ↓
371MEq ↓
1.2 ↓ in pain (VAS)
1.7 ↑ in function

Responses from question #1

Responses from question #2

Guidance Statement #1

Restrict the amount of opioids prescribed

- Variability in restriction suggestions
- Should be flexible for patients travelling
  - Caution of early refills
  - Treat your medication like money

Guidance Statement #2

Immediate vs Controlled Release

- Safety and benefits not clear
- Controlled Release
  - Convenient
  - Reduces pill taking behaviour
    - Psychological dependence

Guidance Statement #3

Co-prescribing with opioids

- Conflicting studies with benzos
  - 3 found↑ harm, 2 did not
- Expert perspective
  - Opioids and benzos should very rarely be prescribed together

Guidance Statement #4

Sleep apnea

- “Clinicians may have a statutory duty to report to governmental licensing authorities”

1. Reduce opioid dose
   - Only for opioid induced central sleep apnea, not OSA
2. Treat sleep apnea
   - Various positive airway pressure options or mandibular repositioning device
3. Both
   - If dose reduction didn’t resolve

Guidance Statement #5

Hypogonadism

- ↑ prevalence of 2° hypogonadism
- Treat with dose taper
- If unsuccessful (or declined)
  - Offer testosterone

Guidance Statement #6

Urine drug screening

- Consider
  - Baseline UDS
  - Annual UDS
    - Or more frequently if high risk or aberrant drug behaviours

Guidance Statement #7

Treatment agreement

- Can be useful to:
  - Structure process of informed consent
    - Goal setting
    - Clarifying expectations
  - Strategies for failed trials
- No reduction in opioid misuse

Guidance Statement #8

Tamper resistant formulations

- Less favoured by people who misuse
- More costly and impact unclear
- Unique risks
  - Particulate induce cardiac valve injury

Guidance Statement #9

Fentanyl patch exchange

- Required by law in Ontario
- Reduce diversion
  - Removes used patches from circulation
- Draws attention to risks of the medication

Guidance Statement #10

Naloxone

- Not beneficial to co-prescribe with all opioids
- Evidence in support of:
  - Opioid rotation
  - Opioid addiction/recreational users
    - For admin by family/friends

Case study

- 57 year old female
- “I’m fed up with my back pain”
- New patient to you
  - Moved from Winnipeg
    - On long term disability
    - Previous health care aid

Case study

- L4/L5 posterolateral disc herniation
  - Laminectomy & discectomy 2004
- 1° concern is diffuse low back pain
  - does have radicular pain down legs
    - no weakness/sensory loss
- No red flags, serious spinal pathology has been excluded

Case study

Medical History

- Anxiety
  - Well controlled
- Insomnia
- HTN
  - 140/75 in office today

Medications

- acetaminophen 500mg 2 tabs qid
- ibuprofen 400mg bid prn
- venlafaxine 150mg od
- clonazepam 0.25mg hs
- hydromorph contin 12mg tid
- ramipril 2.5mg hs
- nabilone 1mg hs
- Docusate Na 100mg hs
- Sennakot hs

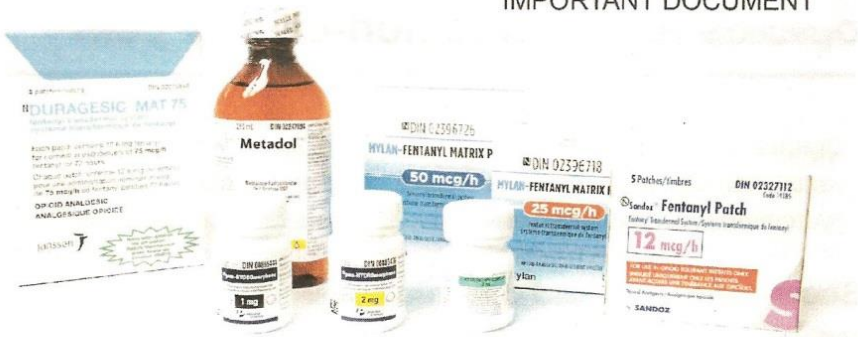
Case study

- Gabapentin
  - Too sleepy
- TCA
  - Pharmacist said it interacted with my Effexor – didn't fill
- Not sure what is helping
  - Does get relief with each opioid ↑
  - Nabilone helped with sleep

Case study

What do we do?

IMPORTANT DOCUMENT



You may be at risk if you are taking

opioids/narcotics for chronic pain

You are taking the following opioid medication:

Codeine (Tylenol NO. 1®, NO. 2®, NO. 3®)

Manitoba

Canadian Deprescribing Network

Did you know?

1 week

is all it takes before some people become physically or psychologically addicted to opioids.

— Centers for Disease Control and Prevention, 2016

4770+ people

were hospitalized in Canada for harmful effects of opioids in 2014-2015, and most cases were accidental. This equals 13 people every day.

— Canadian Institute for Health Information (CIHI), 2016

Seniors have the highest rate of opioid pain reliever use.

— Canadian Centre on Substance Abuse, 2015

1 in 4 seniors hospitalized because of opioids were taking them as directed.

— CIHI, 2016

Canada ranks 2nd

behind the United States for highest per capita use of prescription opioids.

— International Narcotics Control Board, 2015

2500+ deaths

in Canada were from opioid overdoses during 2016. This surpasses yearly car accident deaths by 35%.

— Public Health Agency of Canada, 2017

Taking opioid medications along with drugs like cocaine or heroin, alcohol or **sleeping pills increases the risk of death**.

Since the year 2000, 75% of people taking illegal/non-prescription opioids, including heroin, started via prescription medications. — Cicero *et al.*, 2014

DRAFT: NOT FOR DISTRIBUTION

Outcomes

- Complete cessation
- Dose reduction ≥25%
- Proportion of patients who reduce below 90mg OME
- Therapeutic switch
  - Other opioids
  - Other analgesics

Questions