Navigating the New Opioid Guidelines

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Faculty Disclosure

- **Faculty:** Kulvir Badesha MD, FRCPC

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Learning Objectives

- At the conclusion of this activity participants will be able to:

  - ✓ Appreciate the historical context and current magnitude of the current opiate crisis
  - ✓ Understand the limitations of "chronic pain" as a definition
  - ✓ Appreciate the current guidelines regarding the use of opiates in chronic pain
  - ✓ Be able to formulate reasonable care plans for patients with chronic pain

Alarming Canadian Statistics

- 15-19% of Canadian adults suffer from Chronic Non Cancer Pain (CNCP)
  - ✓ ~50% of these patients will suffer for > 10 years
  - ✓ ~25% of these patients will suffer for > 20 years

- Opioid related deaths
  - ✓ ~ 2800 deaths nationally in 2016; probably an underestimate
  - ✓ ~ 69 deaths in Manitoba in 2016
  - ✓ More deaths than the height of the HIV epidemic
  - ✓ Potential years of life lost far greater than any other disease

How did we get here….

- WHO Pain Ladder
- Pain is the fifth vital sign; no upper limit to prescribing opiates
- Oxycontin wave with aggressive marketing and significant addiction potential
- Second highest per capita consumption of prescribed opiates in the world
- No significant training in medial school regarding opiates and addictions medicine

How did we get here….

- Federation of Medical Regulatory Authorities of Canada as well as provincial and territorial medical regulatory authorities forms the National Opioid Use Guideline Group in 2007; Guideline in 2010

- Health Canada funded researchers at Michael G. DeGroote National Pain Centre (McMaster University) as an expanded focus of the National Anti-Drug Strategy to include prescription misuse; updated Guidelines in 2017

National Opioid Use Guideline Group

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Part A: Executive Summary and Background
Part B: Recommendations for Practice

PART B

— Recommendations for Practice —

Published by the
National Opioid Use Guideline Group (NOUGG)

University of Manitoba

CNCP 2010

By Pain Condition

Examples of CNCP conditions for which opioids *were shown to be effective* in placebo-controlled trials*		Examples of CNCP conditions that *have NOT been studied* in placebo-controlled trials
Tramadol only	Weak or strong opioid	
Fibromyalgia	• Diabetic neuropathy • Peripheral neuropathy • Postherpetic neuralgia • Phantom limb pain • Spinal cord injury with pain below the level of injury • Lumbar radiculopathy • Osteoarthritis • Rheumatoid arthritis • Low-back pain • Neck pain	• Headache • Irritable bowel syndrome • Pelvic pain • Temporomandibular joint dysfunction • Atypical facial pain • Non-cardiac chest pain • Lyme disease • Whiplash • Repetitive strain Injury

Chronic Pain

Classification of Pain

- Type
  - ✓ Nociceptive
  - ✓ Neuropathic pain
- Temporal
  - ✓ Acute pain
  - ✓ Chronic pain
- Location
  - ✓ Soft tissue
  - ✓ Bones/joints
  - ✓ Visceral pain

Acute Pain: What is it?

- ✓ Generally agreement on pain lasting < 3-6 months
- ✓ Pain that does not persist past normal tissue healing
- ✓ Pain that has biological value

Chronic Pain: What is it?

- ✓ No universally accepted definition
- ✓ Temporal definitions; vary from 3-6 months but don't encapsulate the complete clinical picture
- ✓ Pain without apparent biological value
- ✓ Pain persisting beyond normal tissue healing time
- ✓ Persistent pain that is not amenable, as a rule, to treatments based on specific remedies

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

Main editor

Jason Busse

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Panel Composition

- 4 member steering group
- 15 member guideline panel composed of 13 clinicians; 2 patient representatives
- 13 member multidisciplinary clinical expert committee with expertise in chronic pain management had an advisory role to the panel
- 16 member patient advisory committee had an advisory role to the panel

GRADE Approach to Recommendations

Table 1: The GRADE approach's interpretation of strong and weak guideline recommendations

Implications for:	Strong recommendation	Weak recommendation
Patients	All or almost all informed individuals would choose the recommended course of action, and only a very small proportion would not.	The majority of informed individuals would choose the suggested course of action, but an appreciable minority would not.
Clinicians	All or almost all individuals should receive the intervention. Formal decision aids are not likely to be needed to help individual patients make decisions consistent with their values and preferences.	Recognize that different choices will be appropriate for individual patients and that clinicians must help each patient arrive at a management decision consistent with his or her values and preferences. Decision aids may be useful in helping individuals to make decisions consistent with their values and preferences.
Policy makers	The recommendation can be adopted as policy in most situations. Adherence to this recommendation according to the guideline could be used as a quality criterion or performance indicator.	Policymaking will require substantial debate and involvement of various stakeholders.

Potential Benefits: Pain

- 2250 patients from 13 RCTs
- Compared optimization with NSAIDs with a trial of opioids
- Outcomes measured by Visual Analogue Scale (0-10cm)
- Follow up period between 1-6 months
- Median Difference was only 0.49 cm
  - CI (1.24cm reduction – 0.26cm gain)
- Quality of evidence: low, due to inconsistency and imprecision
- Summary: opioid therapy may result in little or no difference in pain compared to NSAIDs

Potential Benefits: Physical Function

- 1972 patients from 8 RCTs
- Compared optimization with NSAIDs with a trial of opioids
- Outcomes measured by SF-36 (0-100 point scale)
- Follow up period between 1-4 months
- Median Difference was only a reduction of 1.5
  - CI 95% (3.08 reduction – 0.08cm gain)
- Quality of evidence: moderate, serious imprecision
- Summary: opioid therapy likely results in little or no difference in physical function compared to NSAIDs

Potential Harms: Addiction

- Based on data from 22 278 patients in 9 studies
- Compared optimization with NSAIDs with a trial of opioids
- Follow up period not reported
- Risk of opioid addiction is 5.5%; ~1:20 patients
  - CI 95% (3.91 – 7.03%)
- Quality of evidence: Moderate, due to serious inconsistency
- Summary: opioid therapy likely results in an important risk of addiction

Potential Harms: Fatal Overdose

- Based on data from 285 520 patients from a single study
- Compared optimization with NSAIDs with a trial of opioids
- Median follow up period 2.6 years
- Annual risk of fatal overdose are dose related:
  - 0.1%; ~1000 patients receiving <20mg ME daily
  - 0.23%; 1:400 patients receiving >100mg ME daily
- Quality of evidence: High
- Summary: opioid therapy results in a rare but important risk of fatal overdose

Case 1

- John T
- 36 male construction worker
- PMHx: Previous fracture involving his left elbow in his youth
- He now gets a dull ache with excessive use, as well as changes in humidity and cold weather
- What should we do?

Case 1: Questions

- Should we prescribe opiates?
- If so, what dosages?

Recommendation 1

- When considering therapy for patients with chronic non-cancer pain
- We recommend optimization of non-opioid therapy, and non-pharmacological therapy, rather than a trial of opioids
- Strong Recommendation

Case 1: Conclusion

- Non Pharmacological Therapies
  - ✓ Sleep hygiene
  - ✓ Local warmth, neoprene support
  - ✓ Intermittent TENS
  - ✓ Physiotherapy
  - ✓ Activity modification
  - ✓ Change in employment

- Pharmacological Therapies
  - ✓ Acetaminophen PRN
  - ✓ Scheduled acetaminophen when needed
  - ✓ NSAID PRN
  - ✓ NSAID scheduled when needed

CADTH Non Opioid Therapy for CNCP

Practical Info

Table 2 lists some of the specific treatments available for management of chronic non-cancer pain and the evidence for each of the treatments.

Table 2: Non-opioid therapies for chronic non-cancer pain

Chronic non-cancer pain condition(s)	Quality of Evidence	Therapies with some evidence of effectiveness
Chronic low back pain	Moderate to high	NSAIDS, duloxetine, and benzodiazepines are more effective than placebo, sham, no treatment, usual care, or wait list*[41]*
Rheumatoid arthritis, osteoarthritis, fibromyalgia, low back pain, intermittent claudication, dysmenorrhoea, mechanical neck disorder, spinal cord injury, post-polio syndrome, and patellofemoral pain	Low	Physical activity reduced the severity of pain and improved physical function. Harms included muscle soreness.*[71]*
Fibromyalgia	Moderate	Regular physical exercise probably reduces pain in patients with fibromyalgia.*[168]*
Chronic low back pain	Low to moderate	Evidence of small to moderate short-term benefits for Tai chi, mindfulness based-stress reduction, exercise, multidisciplinary rehabilitation, spinal manipulation, massage therapy, and acupuncture. Effects on function were generally smaller than effects on pain.*[41] [40]*
Back pain, knee osteoarthritis, neck pain, fibromyalgia, severe headaches or migraines	Low or very low	Acupuncture, yoga, massage therapy, spinal manipulation, osteopathic manipulation, Tai Chi, and relaxation approaches may help some patients manage pain.*[149]*

CADTH has compiled the best available evidence to inform decisions on non-opioid therapies for chronic non-cancer pain. Find the evidence at www.cadth.ca/opioids and www.cadth.ca/pain.

Case 2

- Mildred O; 76 female
- PMHx: HTN, CHF, CKD, right hip osteoarthritis
- Ongoing right hip pain limiting quality of life
- Currently taking acetaminophen 650mg scheduled every 6 hours
- Does not prefer operative management
- What should we do?

Case 2: Questions

- Should we prescribe opiates?
- Should we tell her that opiates are on the Beers List and we should not use them?
- Should we tell her we do not prescribe opiates?

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

Case 2: Conclusion

- Mildred O

- Non Pharmacologic Therapies
  - ✓ Activity Modification
  - ✓ Weight loss
  - ✓ Non weight bearing exercise: cycling, warm pool exercises
  - ✓ Physiotherapy

- Pharmacologic Therapy
  - ✓ Discussion of the potential risks and benefits of an opioid trial
  - ✓ Discuss various opiates with benefits and risks
  - ✓ Hydromorphone 0.5 mg every 4 hours PRN

Case 3

- Karen A; 32 female
- PMHX: Opiate Use Disorder; previous oxycontin, now hydromorphone
- Presents to your clinic with chronic mechanical low back pain, without neurological features
- She would like prescription for hydromorphone contin
- What should we do?

Case 3: Questions

- Should we prescribe opiates?
- Should we tell her she is showing signs of addiction and drug seeking and therefor we wont be giving her any opioids?
- Should we tell her we do not prescribe opiates?

Recommendation 3

- For patients with chronic non-cancer pain with an active substance use disorder
- We recommend against the use of opioids
- Strong Recommendation; Against

Case 3: Conclusion

- Karen A
- Patient-Centered history
  - ✓ Function: how is this affecting her life?
  - ✓ Ideas: what does she think is going on?
  - ✓ Fears: is there anything she is afraid of?
  - ✓ Expectations: what does she hope this visit will achieve?
- Addictions History
- Social History
- Explore stage of change
- Engage in treatment
- Reduce harms

Case 4

- Daniel D; 52 male with a past medical history of HTN
- Presenting symptom is non specific low back pain without red flags
- Lost his job in customer service 2 years ago and is currently going through a divorce with his partner of 20 years
- Has been taking acetaminophen regularly with no benefit; his friend uses a fentanyl patch and he would like to try the same
- What should we do?

Case 4: Questions

- Should we consider a fentanyl patch?

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

Case 4: Conclusion

- Daniel D

- Non Pharmacological Therapy
  - ✓ Social supports and activities
  - ✓ Encourage physical activity
  - ✓ Sleep Hygiene
  - ✓ Employment services
  - ✓ Low cost counseling; CBT

- Pharmacological Therapy
  - ✓ SSRI
  - ✓ SNRI

Case 5

- Mary P; 46 female
- PMHx: Opiate use disorder, oral consumption of oxycodone after MVA 10 years ago; no active substance use disorder for the past 5 years
- Presenting with ongoing symptoms of chronic neck pain without red-flags or neurological features
- Currently taking acetaminophen scheduled and NSAIDs PRN. She has been thinking about taking opiates however she is concerned given her history.

- What should we do?

Case 5: Questions

- Should we prescribe opiates?
- Should we tell her she is showing signs of addiction and that we wont be giving her any opioids?
- Should we tell her that opiates cause addiction and that given her addiction history she should never receive opiated again?
- Should we tell her we do not prescribe opiates?

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

Case 5: Conclusion

- Open and honest discussion regarding chronic pain including expected benefits with additional pharmacotherapy
- Open and honest discussion about the risks of awakening addiction circuitry given past medical history
- Consider multidisciplinary optimization at a clinic specializing in chronic pain management

Case 6/7

- Garry K; 58 male
- Past medical history of Class II obesity as well significant trauma to left knee from a football injury at 18 years of age
- Currently of disability with early CPP
- Maximal non opioid pharmacological and non pharmacological therapy is currently being done; he has followed by the pain clinic
- He would like to consider opiate therapy. What should we do?

Case 6/7: Questions

- Should we prescribe opiates?

- Should we tell him we do not prescribe opiates?

Recommendation 6

- For patients with chronic non-cancer pain who are beginning long term opioid therapy
- We recommend restricting the prescribing dose to less than 90mg of 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 recommend restricting the prescribing dose to less than 50mg of morphine equivalents daily
- Weak Recommendation

Case 6/7: Conclusion

- Discuss risks and benefits of opiate therapy
- Potential Risks
  - ✓ Addiction
  - ✓ Fatal and Non Fatal Overdose
  - ✓ Constipation
- Potential Benefits
  - ✓ Reduction in pain by 20% in 50% of patients ?
  - ✓ Bridge to knee arthroplasty
- Start low as PRN
- Titrate slowly over time if necessary
- Discuss dosing and dispensing
- Consider a formal opiate contract

Case 8

- Ronald R; 76 male with chronic low back pain secondary to degenerative joint disease and spinal stenosis
- Currently taking hydromorphone contin 27mg po TID
- He presents to clinic with his wife due to increasing confusion and myoclonus with worsening low back pain
- Admitted to the local community hospital under your care. There are no red flags nor cause for the delirium
- What should you do?

Case 8: Questions

- What are the diagnostic possibilities?

Recommendation 8

- For patients with chronic non-cancer pain who are currently using opioids, and have persistent problematic pain and/or problematic adverse events

- We suggest rotation to other opioids rather than keeping the opioid the same

- Weak Recommendation

Case 8

Table B Appendix 8.1 Oral Opioid Analgesic Conversion Table

	Equivalence to oral morphine 30 mg:	To convert to oral morphine equivalent multiply by:	To convert from oral morphine multiply by:
Morphine	30 mg	1	1
Codeine	200 mg	0.15	6.67
Oxycodone	20 mg	1.5	0.667
Hydromorphone	6 mg	5	0.2
Meperidine	300 mg	0.1	10
Methadone and tramadol	Morphine dose equivalence not reliably established.		

Case 8: Conclusion

- Recognize opioid induced hyperalgesia risks starts to increase significantly at doses > 240mg morphine equivalents daily
- Recognize opioid induced neurotoxicity
- Manage effective opioid rotation with the principles of morphine equivalency and incomplete cross tolerance
- Hydromorphone 27mg x TID = 81mg HM daily
- HM 81mg x 5 (potency) = 405 mg of morphine equivalents (ME)
- Dose reduction 25% for incomplete cross tolerance = 300mg ME
- Fentanyl Patch 25mcg ~ 90mg ME
- Ask for assistance from someone familiar with these situation when necessary; palliative care or pain specialist.

Case 9

- Ronald R
- Followed in your community clinic.
- Continues to do well with better pain control than he has had over the past year.
- He hospitalization frightened him and he wants to know if he should still be on so much medication
- What should we do?

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 the opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy

- Weak Recommendation

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 the opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy

- Weak Recommendation

Learning Objectives

- At the conclusion of this activity participants will be able to:

  - ✓ Appreciate the historical context and current magnitude of the current opiate crisis
  - ✓ Understand the limitations of "chronic pain" as a definition
  - ✓ Appreciate the current guidelines regarding the use of opiates in chronic pain
  - ✓ Be able to formulate reasonable care plans for patients with chronic pain

References

- http://www.iasp-pain.org/
- http://www.cadth.ca/evidence-bundles/opioid-evidence-bundle
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TRAILBLAZER ADVENTURER

INNOVATOR DEFENDER CHALLENGER

ADVENTURER TRAILBLAZER DEFENDER VISIONARY

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