**Pain management is often a challenge** and even more so in the context of the current concerns around opioids. Two decades ago, the prevailing priority was around pain management. Today, the pendulum for many has swung towards patient safety. Both are worthy goals! Sometimes these goals seem to compete and be at odds. Our goal is to pursue a balanced approach.

Much of the current “opioid crisis” is driven by organized crime and illicit manufacturing. However, it is also important to consider fully the potential safety issues around prescription opioids. There is a lot to be learned from recent evidence and our collective clinical experience. Chronic pain is complex as is a potential role for opioids. Opioids offer a net benefit for some, but harm for others. Coordinated strategies and prescribing safeguards will hopefully help protect both patient and society.

It sometimes seems that for every crisis, we create an equal and opposite crisis to deal with it. In the case of the “opioid crisis” there is the risk that an opioid may not be prescribed adequately when it is indicated, such as during initial management of acute injury. Sometimes this is the result of media and societal pressure. Sometimes it is the result of perceived pressure from policy makers and regulating bodies. Sometimes, it is just the result of frustration with the extra hassle. In addition, if patients on high doses are forced to discontinue or taper too rapidly, they may seek illicit opioids to deal with the withdrawal, putting themselves at even greater risk.

The recent 2017 Opioid Prescribing Guideline for Chronic Non-cancer Pain (CNCP), provides 10 recommendations for opioids in CNCP. There are challenges with any attempt to summarize and seek simplicity. Thus attention to the detail, the strength of the recommendation and the qualifying remarks will be essential in getting the whole picture.

To address some of these challenges, our upcoming academic detailing sessions and supporting materials, such as the RxFiles Chronic Pain & Opioids Mini-Book, will try to explore the evidence, clarify a few misunderstandings and discuss potential “best practice” approaches around opioids and pain.

The illicit manufacturing and distribution of opioids, although a major part of the larger “opioid crisis”, is largely beyond the scope of this discussion.
1) Individualize & optimize non-opioid therapy

See the RxFiles CNCP Treatment Colour Chart & supplementary notes. This chart is intended to provide ideas for treatment with considerations of relevant evidence, experience & guidelines.²

Non-pharmacological interventions are essential to long-term success in CNCP. Individualization of a plan is important due to availability, motivation and practicality limitations. Financial coverage will be a barrier for some people. We have provided suggestions and links to support tools/services where available (national, provincial & local).

Wherever possible, involve multidisciplinary team-members to assist in dealing with the complexities & multifaceted nature of CNCP.³

2) In those unresponsive to non-opioid therapy, one may consider an opioid trial

- Opioids have a potential role in patients with inadequate pain relief who have trialed non-drug and drug therapy. See the RxFiles CNCP Treatment Colour Chart & supplementary notes.
  - Opioid therapy may result in a small but important improvement pain (RR 1.25) and function (RR 1.24) compared to standard therapy without an opioid.¹
- Given 1000 patients with chronic pain treated over ≤ 6 months opioid therapy compared to non-opioid therapy:
  - 112 more patients would have a pain reduction of 1/10 on a visual analog scale (over 3-6 months)
  - 102 more patients would have a small but important improvement in function (over 1-6 months)
- The 2017 Canadian CNCP Opioid Guidelines recommend against an opioid trial in patients with an active or a history of substance use disorder or an active psychiatric disorder.
  - These patient populations were excluded from opioid trials showing benefits CNCP, and observational data suggests a higher risk of harm (e.g. addiction, overdose) compared to those without these disorders.

3) Saying “NO” when your instincts send you in that direction.

One physician advisor’s perspective: Sarah Liskowich, MD, CCFP

“Through my experience working with patients with chronic pain, I have learned to stop and listen to my instincts. Although opioid risk tools, guidelines and a plethora of other resources can be useful, they do not replace the expertise gained through your experiences and pattern recognition skills. We regularly use these skills across the domains of medicine to diagnose and treat patients appropriately.

If you feel starting a prescription for an opioid might not be a good idea for your patient at any point in a consultation, you have an opportunity to stop and communicate to the patient your concern and reasons around not initiating opioids. Although it may be uncomfortable at first to say no, in the long run you are doing your patient a great service and practicing compassionate medicine.”
4) When prescribing opioids, include safeguards from the get-go

- Confirm **patient identity** as necessary (e.g., check driver’s license)
- Check **medication profile** (e.g., PIP Profile in SK)
  - Assess previous use of opioids, benzodiazepines
- Introduce as an **“opioid trial”** & discuss **exit strategy** up-front
- Discuss and document **functional goals** (baseline & follow-up)
  - Tools such as the Brief Pain Inventory (BPI) & the Opioid Manager may be useful in assessing & tracking goals
  - Small, incremental gains in function are key
  - Beware of increasing doses without resulting improvement in function, however small the functional gains may be
- Obtain **informed consent / agreement**
  - Be able to discuss potential benefits and harms of opioid use
  - Set boundaries around prescribing in advance
  - Deal with unrealistic expectations around opioid benefits.
  For some, pain scores may only reduce 1-2 points on a 10-point scale; thus for those with scores of 8-9, achieving <6 may be unrealistic. For others, pain scores may not be reduced at all.
- Develop a **prescription writing routine** that helps minimize the chance of forgery/diversion
- Why not include a routine **urinary drug screen** component as part of standard practice?
  - Consider baseline and random at least once yearly thereafter
- Why not avoid **PRNs**? While there will be exceptions to this approach, it is common for CNCP patient to use up all PRNs. For many, structured opioid therapy with minimal or no PRN option lessens the risk of overuse, chemical coping, and dose escalation. (See discussion – Pain Mini-Book, pg ??)
- Take advantage of the various **forms/tools** that are available to provide structure and facilitate process.
  See the Prescribing Opioids Safely chart in the RxFiles Chronic Pain & Opioids Mini-Book, or online http://www.rxfiles.ca/rxfiles/uploads/documents/members/Prescribing%20Opioids%20Safely.pdf

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Documentation is key to successful chronic pain management. The **Opioid Manager** is one form/tool intended to help facilitate. It is also integrated into some EMRs.
5) Contextualize recommended/suggested maximum opioid dosage recommendations from the 2017 Canadian CNCP Opioid Guidelines.¹ Note: MED = Morphine Equivalent Dose.

- The 2017 guideline committee considered available evidence, clinical experience and patient values and preferences. Dosage thresholds require careful understanding in terms of how they will be useful in guiding any particular patient’s therapy.

Let opioid dose guidelines... serve the patient, not the other way around.

1) The dose thresholds of 50 MED and 90 MED are for new, NOT existing patients already on higher doses.

<table>
<thead>
<tr>
<th>Drug</th>
<th>50 MED/day</th>
<th>90 MED/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>50 mg/day</td>
<td>90 mg/day</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>10 mg/day</td>
<td>18 mg/day</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>33 mg/day</td>
<td>60 mg/day</td>
</tr>
</tbody>
</table>

2) The 50 MED/day and 90 MED/day thresholds are NOT absolutes.

- **STRONG Recommendation**: “…recommend restricting...” to <90 MED/d
- **WEAK Recommendation**: “…suggest restricting...” to <50 MED/d

3) Caveat: Some may benefit from higher dose...

- REMARK notes “some patients may gain important benefit...” at a dose > 90 MED/d
  - Referral to a colleague for 2nd opinion...may therefore be warranted in some individuals.

4) Dose restrictions related primarily to evidence for harm, not benefit!

<table>
<thead>
<tr>
<th>FATAL Overdose Rate</th>
<th>Non-fatal Overdose Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 MED/d</td>
<td>0.1%</td>
</tr>
<tr>
<td>20-49 MED/d</td>
<td>0.14%</td>
</tr>
<tr>
<td>50-99 MED/d</td>
<td>0.18%</td>
</tr>
<tr>
<td>&gt;100 MED/d</td>
<td>0.23%</td>
</tr>
</tbody>
</table>


*STRONG recommendations indicate that all or almost all fully informed patients would choose the recommended course of action, and indicate to clinicians that the recommendation is appropriate for all or almost all individuals. Strong recommendations represent candidates for quality of care criteria or performance indicators.

**WEAK recommendations indicate that the majority of 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 to arrive at a decision consistent with their values and preferences. Weak recommendations should not be used as a basis for Standards of Practice (other than to mandate shared decision-making).

Other relevant points...

- While evidence shows that harms are increased with increasing dosages, no overall dose response was found for benefits on pain or function! (Population level)

- The majority of opioid benefit seen in CNCP RCTs have been seen with the relatively lower doses (< 100 MED/day).

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