Response to "Opioids for chronic pain"

In his letter to *CMAJ*, Mr. Ross has engaged in selective citation to support his position that opioids are highly effective for chronic noncancer pain and that development of opioid use disorder is an uncommon consequence of treatment.[1] He also misrepresented the views of one of us (D.J.) about why high-dose opioid therapy is inadvisable.

Current systematic reviews provide a different perspective. Specifically, a 2018 systematic review found that opioids provide statistically significant but small effects for pain relief (weighted mean difference [WMD] –0.69 cm, 95% confidence interval [CI] –0.82 to –0.56 cm on a 10 cm visual analogue scale for pain; minimally important difference [MID] 1 cm; modelled risk difference for achieving the MID 11.9%, 95% CI 9.7% to 14.1%), and improved physical functioning (WMD 2.04, 95% CI 1.41 to 2.68 points on the 100-point SF-36 physical component score; MID, 5 points; modelled risk difference for achieving the MID 8.5%, 95% CI 5.9% to 11.2%).[2]

A 2015 systematic review found that among patients prescribed opioid therapy for chronic noncancer pain, rates of addiction averaged between 8% and 12%.[3] For the 2017 Canadian "Guideline for opioid therapy and chronic noncancer pain," we considered only studies from this review that used a conservative definition of addiction to derive a pooled estimate of 5.5% (95% CI 3.9% to 7.0%).[4]

We share Mr. Ross' concerns about inappropriate tapering of opioids, which subjects patients to opioid withdrawal, itself a dose-dependent harm of opioids.[5] The 2017 guideline explicitly discourages excessively rapid tapering.[4] The 9th recommendation states that patients using high dosages of opioids (≥ 90 mg morphine equivalent dose [MED]/d) should try to decrease their dosage. There are risks associated with tapering, including opioid withdrawal. Moreover, the evidence supporting benefits of reducing dosages of opioids comes from low-quality observational studies. It is thus reasonable for a patient, informed of the benefits and risks and the associated uncertainty, to choose to try lowering their dose. Another might choose to leave well enough alone. Recognizing this as a value- and preference-sensitive decision, the guideline made a weak recommendation in favour of gradually reducing opioid dosages in those patients taking high doses.

A weak recommendation indicates that most informed patients would choose the suggested course of action, but an appreciable minority would not. With weak recommendations, different choices will be appropriate for individual patients, and clinicians should assist patients to arrive at a decision consistent with their values and preferences. The online version of the guideline includes decision aids to help facilitate this process (https://app.magicapp.org/app#/guideline/2849).

An observational study published after our guideline found that 75% (82 of 110) of patients with chronic noncancer pain who were approached agreed to taper their opioids. After 4 months, the 51 participants who completed the study had reduced their median opioid dosage from 288 to 150 mg MED/day, with no significant increase in pain and reduced pain catastrophizing.[6]

Our group is continuing to monitor the emerging literature and plans to update guideline recommendations when new evidence is sufficient to modify the current recommendations.

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References

1. Ross M. Opioids for chronic pain [letter]. *CMAJ* 2018;190:E269.
2. Busse JW, Wang L, Kamaleldin M, et al. Opioids for chronic noncancer pain: a systematic review and meta-analysis. *JAMA* 2018;320:2448-60.
3. Vowles KE, McEntee ML, Julnes PS, et al. Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis. *Pain* 2015;156:569-76.
4. Busse JW, Craigie S, Juurlink DN, et al. Guideline for opioid therapy and chronic noncancer pain. *CMAJ* 2017;189:E659-66.
5. Juurlink DN. Rethinking "doing well" on chronic opioid therapy. *CMAJ* 2017;189:E1222-3.
6. Darnall BD, Ziadni MS, Stieg RL, et al. Patient-centered prescription opioid tapering in community outpatients with chronic pain. *JAMA Intern Med* 2018;178:707-8.

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