Navigating the Complexities of Opioid Prescribing for Chronic Pain

PANELISTS

Dr. Suzanne Turner • Dr. Mel Kahan • Dr. Andrea Furlan

WITH

Dr. Stephanie Zhou • Dr. Carrie Bernard

Ontario College of Family Physicians — *Thriving Family Physicians in a Healthy Ontario*

Family & Community Medicine, University of Toronto | Mental Health and Addictions

Please introduce yourself in the chat!

Your name,
Your community,
Your X (Twitter) handle

@OntarioCollege
#PractisingWell

Your Panelists: Disclosures

Dr. Suzanne Turner

Relationships with financial sponsors (including honoraria):

- OCFP Practising Well CoP speaker

Dr. Mel Kahan

Relationships with financial sponsors (including honoraria):

- OCFP Practising Well CoP speaker
- Indivior (honorarium for Oct 2024 presentation on opioid agonist treatment)
- Alberta Ministry of Health (honorarium for expert panel member, Centre of Recovery)

Dr. Andrea Furlan

Relationships with financial sponsors (including honoraria):

- OCFP Practising Well CoP speaker, Google Inc.
- WSIB (Membership on advisory boards or speakers' bureaus)
- CIHR, Ontario Health, Health Canada, Canadian Generic Product Association (Funded grants, research or clinical trials)
- Opioid Manager App, Opioid Manager Book (Patents for a drug or device)
- 8 Steps to Conquer Chronic Pain (All other investments or relationships)

Your Moderator and Co-Host: Disclosures

Dr. Stephanie Zhou @stephanieyzhou

Relationships with financial sponsors (including honoraria):

- Ontario College of Family Physicians – Practising Well Scientific Planning Committee
- Canadian Medical Association – Honoraria for practice management lectures
- Department of Family and Community Medicine (University of Toronto)
- Toronto Public Health – Board of Directors member

Dr. Carrie Bernard

Relationships with financial sponsors (including honoraria):

- OCFP– Practising Well Scientific Planning Committee
- OCFP – Practising Well CoP Speaker
- University of Toronto – Stipend to supervise learners (students and residents) for the Department of Family and Community Medicine
- University of Toronto – Stipend for role in the Division of Mental Health and Addictions
- McMaster University –Stipend to supervise residents
- College of Family Physicians of Canada – Board Member

Mitigating Bias

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Potential conflicts

N/A

Mitigating potential bias

The Scientific Planning Committee (SPC) has control over the choice of topics and speakers.

Content has been developed according to the standards and expectations of the Mainpro+ certification program.

The program content was reviewed by the SPC.

Practising Well Self-Learning Program

The Practising Well CoP is certified for self-learning credits!

Earn **1-credit-per-hour** for reviewing the recording and resources from **past CoP sessions**. The self-learning program is certified for up to 63 Mainpro+ credits.

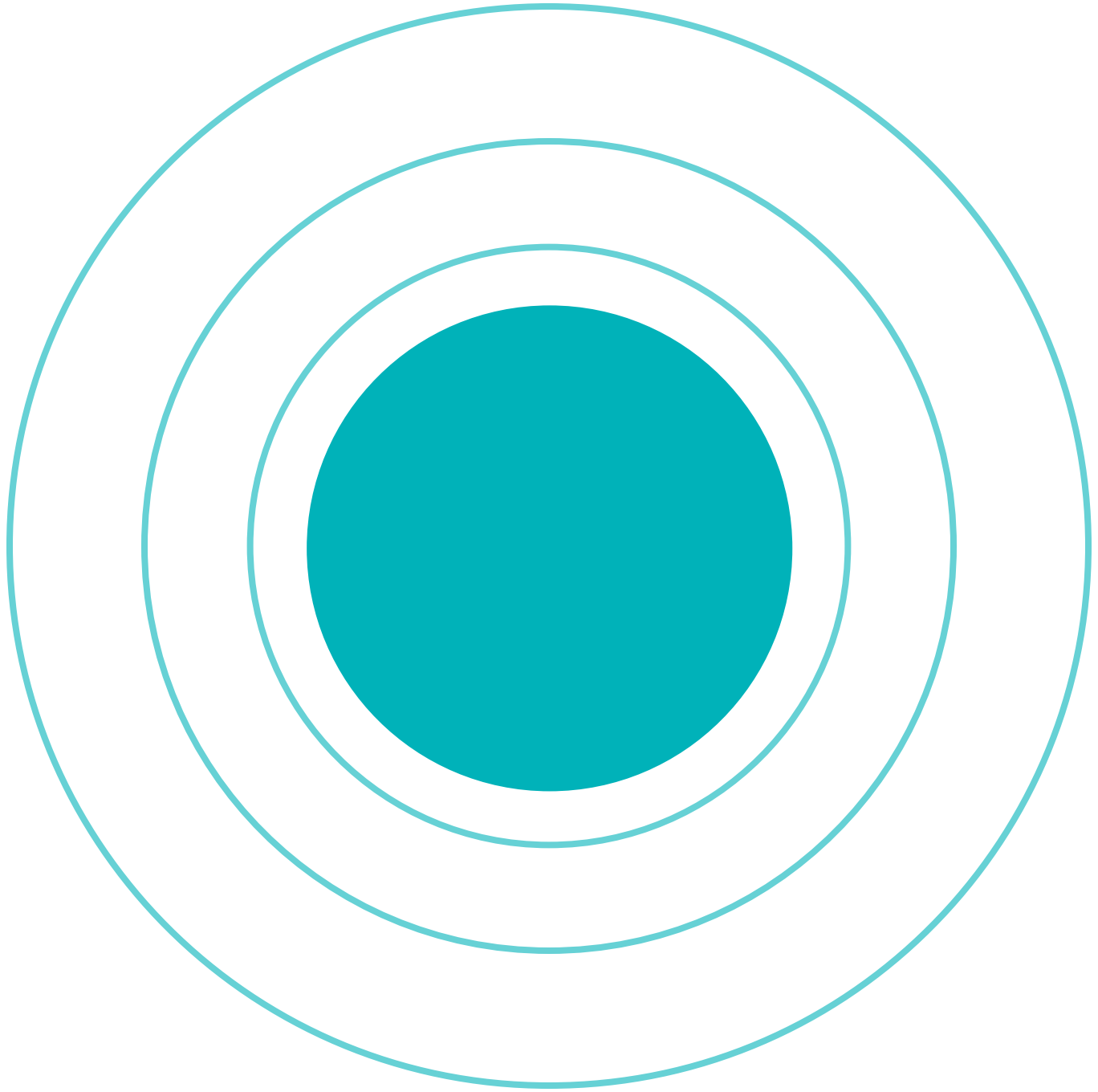
Learn More and Participate

Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCM recognizes that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCM respects that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.



Your Panelists

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Dr. Mel Kahan

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Navigating the Complexities of Opioid Prescribing for Chronic Pain

2013: 50-year-old patient with diabetic neuropathy

- 2013: Take over a practice of 1000 patients
  - Inherited Pam on oxyneo 40 mg BID + 2 percocets TID
  - Fibromyalgia and full body pain, worst in shoulders and knees
  - Patient used to getting 3 months of meds at a time
  - Resistant to coming in for appointments as she has "always just got her meds"
  - Asking for fax renewals
- MEq:
  - Oxycodone: 40 mg x 2 times daily + 2 x 5mg x 3 times daily=110 mg
  - Morphine: 110 mg x 1.5 = 165 mg

What should we do?

- Insist on an in-person appointment
- Reviewed CPP, investigations
- 5 As of chronic pain management
  - Analgesia – what happens before/after her dose, pain scale
  - Activity – how do the meds help her maintain function, what functions does she not have and how could she improve them
  - Adverse effects – constipation, sweating, falls, hypogonadism\
  - Aberrant behaviours – running out early, dose escalations, using more than one prescriber
  - Affect – impacts on mood, mental health
- All was well, improved functioning – can play with grandkids, wash dishes, mood great, not running out early
- Given prescription for 3 months at a time x 2 (total of 6 mo) as was previously prescribed
- Signed a narcotic agreement and patient saw me twice a year moving forward

2017: 55 year old patient with neuropathy

- 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain
  - Ceiling of 90 mg MEq for those "grand-fathered" in taper recommendations
  - Urine drug screens as risk mitigation
  - Seems like stronger recommendation for an opioid contract
- How do these changes impact Pam?

2017: 55-year-old patient with neuropathy

- Urine drug screen done in the office at the next routine visit
- Pam is "offended" but does a urine drug screen
- Sent off to local lab for assessment and comes back in about a week

	Result
BARBITURATES	neg
BENZODIAZEPINES	neg
CANNABINOIDS(THCA)	pos
COCAINE METABOLITE	neg
ETHANOL	neg
METHADONE	neg
METHADONE METABOLITE	neg
OPIATES	pos
OXYCODONE	pos

Urine Drug Screens

- The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain includes guidance on urine drug screening (UDS) as a "**risk mitigation strategy"**
- Clinicians may repeat UDS annually and more frequently if a patient is at elevated risk or exhibiting aberrant drug-related behaviors
  - Baseline, once per year and more frequently if risk factors
- About 30% of UDS results may be aberrant, often due to prescribed opioid non-detection or the presence of THC (1)
  - Ensure know how to test for the opioid present (ie fentanyl, oxycodone, morphine may need separate tests)
  - If only on short-acting may not be picked up depending on the half life **
  - Clinicians vary greatly in how they change opioid prescribing with respect to urine drug screens (2)
  - "Erroneous provider interpretation of UDT results, infrequent documentation of interpretation, lack of communication of results to patients, and prescription refills "despite inaccurate interpretations are common. Expert assistance with urine toxicology interpretations may be needed to improve provider accuracy when interpreting toxicology results"
- Clinicians should be aware of potential false positives and negatives and consider using confirmation testing GC/MS
  - Confirmatory testing may be difficult to access depending on where you are location

(1) https://cep.health/download-file/1612201407.867819-272/#:~:text=Amphetamines,and%20renal%20or%20liver%20impairment

(2) Morasco BJ, Krebs EE, Adams MH, Hyde S, Zamudio J, Dobscha SK. Clinician Response to Aberrant Urine Drug Test Results of Patients Prescribed Opioid Therapy for Chronic Pain. Clin J Pain. 2019 Jan;35(1):1-6.

(3)Chua I, Petrides AK, Schiff GD, Ransohoff JR, Kantartjis M, Streid J, Demetriou CA, Melanson SEF. Provider Misinterpretation, Documentation, and Follow-Up of Definitive Urine Drug Testing Results. J Gen Intern Med. 2020 Jan;35(1):283-290.

2017: 55-year-old patient with neuropathy

- Mention that the new guidelines probably mean we should fill out a new narcotic agreement
- Patient wants to know why this is different than the one we signed in 2013 and what the use is "anyways"

- "A written treatment agreement may, however, be useful instructuring a process of informed consent around opioid use,clarifying expectations for both patient and physician, andproviding clarity regarding the nature of an opioid trial withendpoints, goals, and strategies in event of a failed trial"

Treatment Agreements

- Issues with treatment agreements – very limited evidence and mostly to support consent (3)
  - CPSO prescribing guidelines say treatment agreements may be useful in establishing expectations and promote adherence (4)
- Agreements are negatively associated as time-consuming and minimally effective in reducing opioid misuse (1)
- Most reviewed are written far above recommended reading levels and serve primarily to convey consequences of non-compliance (1)
- In large studies only used in about 50% of cases and more associated with patients with substance-use risk factors and limited impact on non-adherence to rules (2)

(1)Laks J, Alford DP, Patel K, Jones M, Armstrong E, Waite K, Henault L, Paasche-Orlow MK. A National Survey on Patient Provider Agreements When Prescribing Opioids for Chronic Pain. J Gen Intern Med. 2021 Mar;36(3):600-605.
(2)Pacheco S, Nguyen LMT, Halphen JM, Samy NN, Wilson NR, Sattler G, Wing SE, Feng C, Paulino RAD, Shah P, Addimulam S, Patel R, Wray CJ, Arthur JA, Hui D. Adherence to Opioid Patient Prescriber Agreements at a Safety Net Hospital. Cancers (Basel). 2023 May 27;15(11):2943.
(3) McAuliffe Staehler TM, Palombi LC. Beneficial opioid management strategies: A review of the evidence for the use of opioid treatment agreements. Subst Abus. 2020;41(2):208-215.
(4) https://www.cpso.on.ca/en/physicians/policies-guidance/policies/prescribing-drugs/advice-to-the-profession-prescribing-drugs#:~:text=Prescription%20treatment%20agreements%20(sometimes%20called,diversion%2C%20such%20as%20prescription%20opioids.

2022: 50-year-old patient with neuropathy

- 2017: Reminder on Oxyneo 40 mg BID + Percocet 2 tabs TID
- Trial of opioid rotation to MS Contin goes horribly wrongly as supposed to "taper" to < 90 mEq
- As of 2018 on MS-contin 30 mg BID + Statex 10 mg TID
- Was an epic failure with destabilization of her pain management and more worrisome her function
- She presents asking if there are any other medications she can try

Korownyk CS, Montgomery L, Young J, Moore S, Singer AG, MacDougall P, Darling S, Ellis K, Myers J, Rochford C, Taillefer MC, Allan GM, Perry D, Moe SS,Ton J, Kolber MR, Kirkwood J, Thomas B, Garrison S, McCormack JP, Falk J, Dugré N, Sept L, Turgeon RD, Paige A, Potter J, Nickonchuk T, Train AD, WereschJ, Chan K, Lindblad AJ. PEER simplified chronic pain guideline: Management of chronic low back, osteoarthritic, and neuropathic pain in primary care. CanFam Physician. 2022 Mar;68(3):179-190. doi: 10.46747/cfp.6803179.

	OSTEOARTHRITIS	CHRONIC LOW BACK PAIN	NEUROPATHIC PAIN
Foundation of treatment	**Physical activity** is the foundation of a treatment plan for osteoarthritis and chronic low back pain.		
Add-on option	**Psychological therapy** is an option for patients with any of these conditions.		
	Placebo or control: 40%	Placebo or control: 40%	Placebo or control: 29%
Additional treatments with clear evidence of benefit	Intra-articular corticosteroids: 70% SNRIs: 61% Oral NSAIDs: 58% Topical NSAIDs: 51%	Oral NSAIDs: 58% Spinal manipulation: 55% TCAs: 53% SNRIs: 50%	Gabapentinoids: 44% SNRIs: 42% Rubefacients (e.g. capsaicin): 40%
Treatments with unclear benefit	Glucosamine Chondroitin Viscosupplementation	Acupuncture Rubefacients (e.g. capsaicin)	TCAs Cannabinoids Topical nitrates
Treatments with evidence of no benefit	Acetaminophen	Corticosteroids (epidural)	Acupuncture Topical ketamine, amitriptyline, doxepin or combinations
Treatments with harms that exceed benefit	Opioids Cannabinoids	Opioids Cannabinoids	Opioids Topiramate Oxcarbazepine

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Navigating the Complexities of Opioid Prescribing for Chronic Pain

Managing patients on higher doses of opioids

OCFP Practising Well

June 25

METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

Context: Backlash arising from OxyContin crisis

- Canadian Pain Guideline 2017: Opioid doses above 90 mg morphine equivalent per day are associated with a higher risk of overdose
- Guideline recommended tapering, while minimizing risks
- Reports of physicians
  - Tapering and discontinuing opioids
  - Refusing to continue opioids for patients whose physicians had left practice
- Climate of fear among prescribers: Concerns about CPSO investigation, and about prescribing opioids to patients who are addicted

Need for a balanced view…

- Opioids can improve quality of life and relieve suffering for some patients with chronic pain
- Some patients need doses above 90 mg MED, especially if they have neuropathic pain or other severe organic pain syndromes
- High doses are generally safe if they carefully titrated, the patient doesn't use benzos or alcohol, and doesn't have an Opioid Use Disorder

Three questions re patients on doses > 90 mg

1. Is the opioid providing satisfactory pain relief?
2. Is the opioid causing adverse effects that negate its analgesic benefits?
3. Does the patient have an opioid use disorder?

Does the opioid provide satisfactory pain relief?

- Opioids are much more effective for acute pain than for chronic pain
- Reduction in pain intensity of at least two points on a ten point scale, for at least several hours after the dose
- Improvement in function – more active, able to do daily tasks
- An opioid is ineffective if the patient has severe pain and pain-related disability despite a higher opioid dose
- The prescriber should taper, or switch to a different opioid

Is the opioid causing side effects?

- Sedation, fatigue, depression, lower daily function
- These side effects are associated with the dose of the opioid, and the concurrent use of benzodiazepines, alcohol
- Other side effects: sexual dysfunction, falls, exacerbation of sleep apnea, constipation and other GI side effects
- Opioid switching lowers the dose, helping with dose-related side effects
- Tapering sedating drugs may also help

Switching (rotating) opioids

- Patients who haven't responded or had side effects with one opioid will sometimes do better with a different opioid
- The patient hasn't developed tolerance to the analgesic effect of the new opioid so it may be more effective
- There is good evidence that opioid rotation can improve pain control, and it is a recommendation of the Canadian Guideline

Wong AK, Klepstad P, Rubio JP, et al Palliat Med. 2023 Nov 14. doi: 10.1089/jpm.2023.0541.

Protocol for switching

- Calculate the equianalgesic dose of the current opioid
- Oral oxycodone is 1.5 x as potent as morphine; hydromorphone is 5 x as potent as morphine
- Start the new opioid at 50-75% of the equianalgesic dose of the original opioid
- 50% if the dose is higher (> 200 mg MED) or the patient is on sedating drugs
- Lower dose because patient is not fully tolerant to the effects of the new opioid

Opioid tapering

- Weaker evidence of benefit for tapering than for switching
- Tapering can cause:
  - Worsening pain (even if pain is poorly controlled on higher dose)
  - Depression and anxiety
  - Suicidal ideation
  - Illicit opioid use or alcohol use

Olivia E, Bowe T, Manhapra A et al. Associations between stopping prescriptios for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation. BMJ 2020; 368: m283

Yarborough BJH, Stumbo SP, Schneider JL, Ahmedani BK, Daida YG, Hooker SA, Negriff S, Rossom RC, Lapham G. Impact of Opioid Dose Reductions on Patient-Reported Mental Health and Suicide-Related Behavior and Relationship to Patient Choice in Tapering Decisions. J Pain. 2023 Nov 10:S1526-5900(23)00614-4.

Indication for tapering

- Patient is on a high dose and suffering complications e.g. fatigue, GI
- Patient does not have an opioid use disorder – opioid agonist treatment is best for OUD
- Switching has not worked
- Patient is willing to taper; forced tapers generally don’t work

Approach to tapering

- Taper is slow, flexible with joint decision making
- End point of the taper is dose reduction, not necessarily cessation
- Slower tapers especially if patient has been on opioids a long time
- Hold or reverse the taper if the patient experiencing persistent worsening pain, mood or function

Nosyk B, Sun H, Evans E, Marsh DC, Anglin MD, Hser YI, Anis AH. Addiction. 2012 Sep;107(9):1621-9.

Clinical features of prescription opioid use disorder (POUD)

- Rapid dose escalation, dose much higher than usual for the pain condition
- Poor function and poor mood
- Still reports severe pain, but resists attempts to lower the dose or switch
- Runs out early, acquires opioids from other sources
- Current or past history of problematic use of alcohol or other substances
- Anxiety or mood disorder or PTSD
- Withdrawal symptoms at the end of a dosing interval: myalgias, dysphoria, insomnia, marked increase in pain

Buprenorphine/naloxone: First line treatment for prescription opioid use disorder

- 2 mg/0.5 mg and 8 mg/2 mg tablet and film,covered as a general benefit
- Relieves withdrawal and cravings without sedation or euphoria
- Partial opioid agonist with ceiling effect: does not suppress respiratory center even in high doses
- Slow onset of action so less reinforcing and euphoric effect
- Long duration of action: Relieves withdrawal symptoms and cravings for a full 24 hours
- High receptor affinity: Blocks the effects of other opioids e.g. oxycodone, hydromorphone

Buprenorphine: A good choice for OUD and chronic pain

- Is effective for both OUD and chronic pain
- Patients usually experience marked improvement in mood, function and pain
- Compared to a specialized addiction clinic, patients who receive buprenorphine from their family physician receive better screening, identification and management of acute and chronic illnesses

Korownyk C, Perry D, Ton J, Kolber MR, Garrison S, Thomas B, Allan GM, DugréN, Finley CR, Ting R, Yang PR, Vandermeer B, Lindblad AJ. Opioid use disorder in primary care: PEER umbrella systematic review of systematic reviews. Can Fam Physician. 2019 May;65(5):e194-e206.

One approach to buprenorphine dosing: Microdosing

- Because of its high receptor affinity, buprenorphine displaces other opioids from the receptor, precipitating withdrawal

Microdosing: gradual dose increase while maintaining the other opioid

  - Day 1: 0.5 mg buprenorphine; Day 2: 0.5 mg bid; Day 3: 1 mg bid; Day 4: 2 mg bid ; Day 5: 3 mg bid; Day 6: 4 mg bid
  - Day 7: 12 mg OD – stop other opioid, increase by 2-4 mg up to 32 mg

- Optimal dose relieves withdrawal symptoms and cravings for 24 hours

- Randhawa PA, Brar R, Nolan S. Buprenorphine-naloxone "microdosing": an alternative induction approach for the treatment of opioid use disorder in the wake of North America's increasingly potent illicit drug market. CMAJ. 2020 Jan 20;192(3):E73.

Summary: Management of patients on a high opioid dose

- If inadequate pain relief: Switch to a different opioid
- If side effects eg fatigue, depression: Switch to a different opioid, and taper benzodiazepines and other sedating drugs
- Pain plus prescription opioid use disorder: Buprenorphine/naloxone; titrate dose through microdosing protocol
- If trial of tapering: Slow, flexible, joint decision making with patient, hold or reverse taper if patient has persistent worsening of pain, mood or function

META:PHI resources

- Information on buprenorphine for community providers;
- https://www.metaphi.ca/wp-content/uploads/ED_OUD_CommunityProvider.pdf
- Patient handout on microdosing buprenorphine:
- https://www.metaphi.ca/wp-content/uploads/ED_OUD_MicrodosingInfo.pdf
- Handbook: Primary care management of substance use
- https://www.metaphi.ca/wp-content/uploads/Guide_PrimaryCareManagement.pdf
- Or, search META:PHI website by topic
- www.metaphi.ca

Your Panelists

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Dr. Mel Kahan

Dr. Andrea Furlan

Navigating the Complexities of Opioid Prescribing for Chronic Pain

Practising Well Community of Practice

Navigating the Complexities of Opioid Prescribing for Chronic Pain

Andrea D. Furlan MD PhD
Professor, Division of Physiatry, University of Toronto
TAPMI – UHN site – Rehabilitation Pain Service

Getting the best from a Pain Clinic Consult

Referral to the Pain Clinic

Please see this lovely 59-year-old woman with chronic back pain on opioids since 2014. Please suggest some options to opioids.

Patricia

Getting the best from a Pain Clinic Consult

Referral to the Pain Clinic

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Attachments

- Neck MRI (2018 and 2021)
- Lumbar MRI (2021)
- EMG NCS (2019), normal
- Rheum consult (2017), nothing
- PMHx (depression, HTN, Diabetes)
- Current medications

Current medications

- Venlafaxine 75 mg PO daily
- Tramacet 1-2 tabs PO TID PRN
- Tramadol ER 200 mg PO HS
- Gabapentin 1200 mg PO TID
- Baclofen 20 mg PO HS
- OTC acet/methocarb ES 2 tabs PO PRN
- OTC ibuprofen ES PO PRN
- Cannabis edibles
- Cuvitru SC 3/7
- Insulin glargine 130 units SC HS
- Insulin aspart SS AC
- Dexlansoprazole 60 mg PO BID
- Vit D
- Magnesium
- Glucosamine/Chondroitin
- Symbicort/Ventolin BID PRN

What is going on?

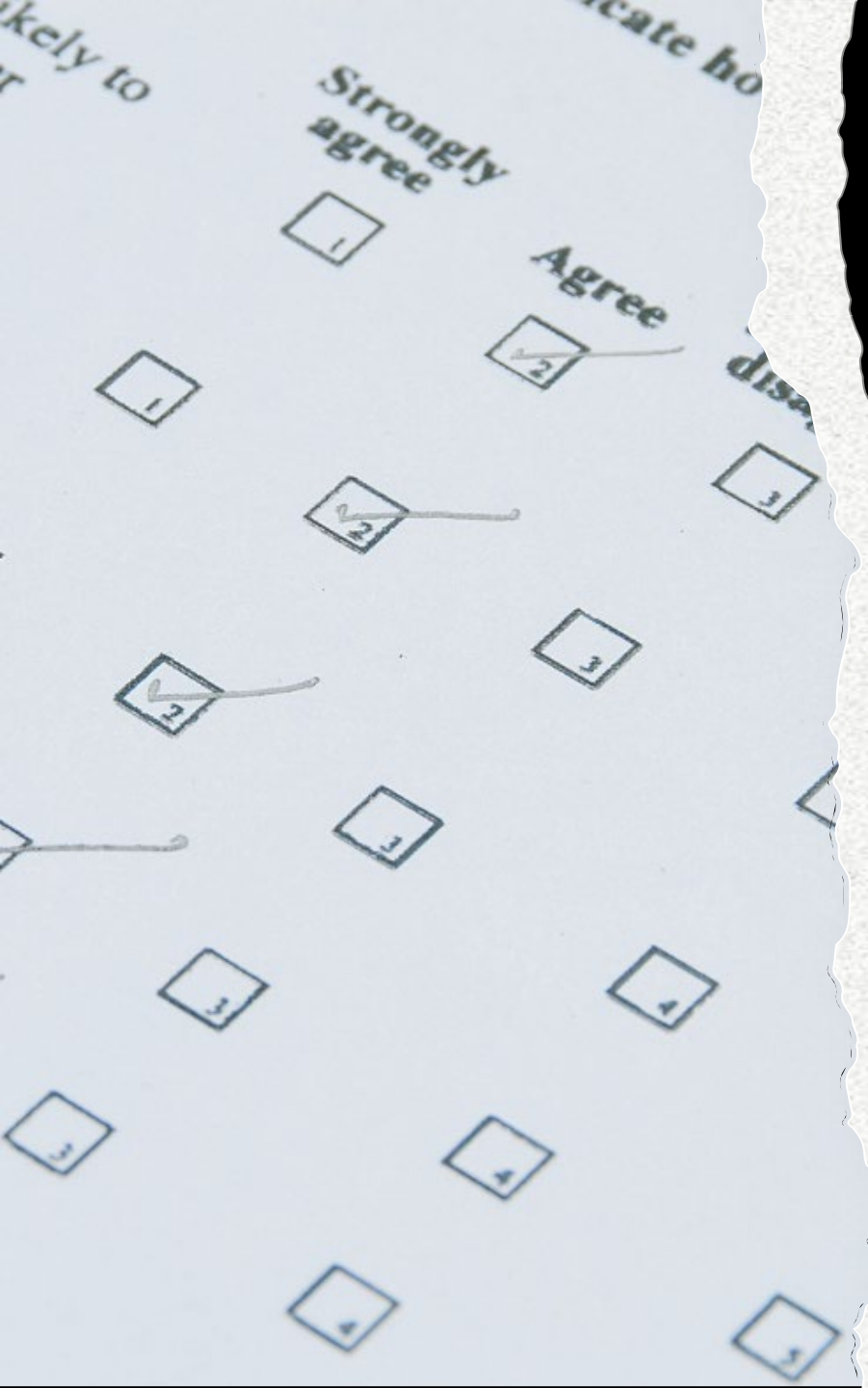
Major differences between you and us

Primary Care

1. Ongoing relationship
2. Knowledge of the social context
3. Collateral information about how they got here
4. Rapport and trust with your patient
5. See the person with a multitude of symptoms.
6. Your client is the patient

Specialist

1. One visit and a few follow-ups
2. Limited knowledge of their social context
3. Our source of information is what you send us and what the patient tells us
4. We are strangers to your patient
5. See the symptom (pain) the person has, and the problem you want us to solve (opioid).
6. Our clients: the patient and the referring primary care professional



Patricia at the pain clinic

- Multiple questionnaires
- Registration desk
- RPN, meds, vitals, gown
- Resident/Clinical fellow: history and PE
- The specialist: the plan

Pain is a bio-psycho-social event

Tousignant-Laflamme 2017

Rehabilitation management of back pain

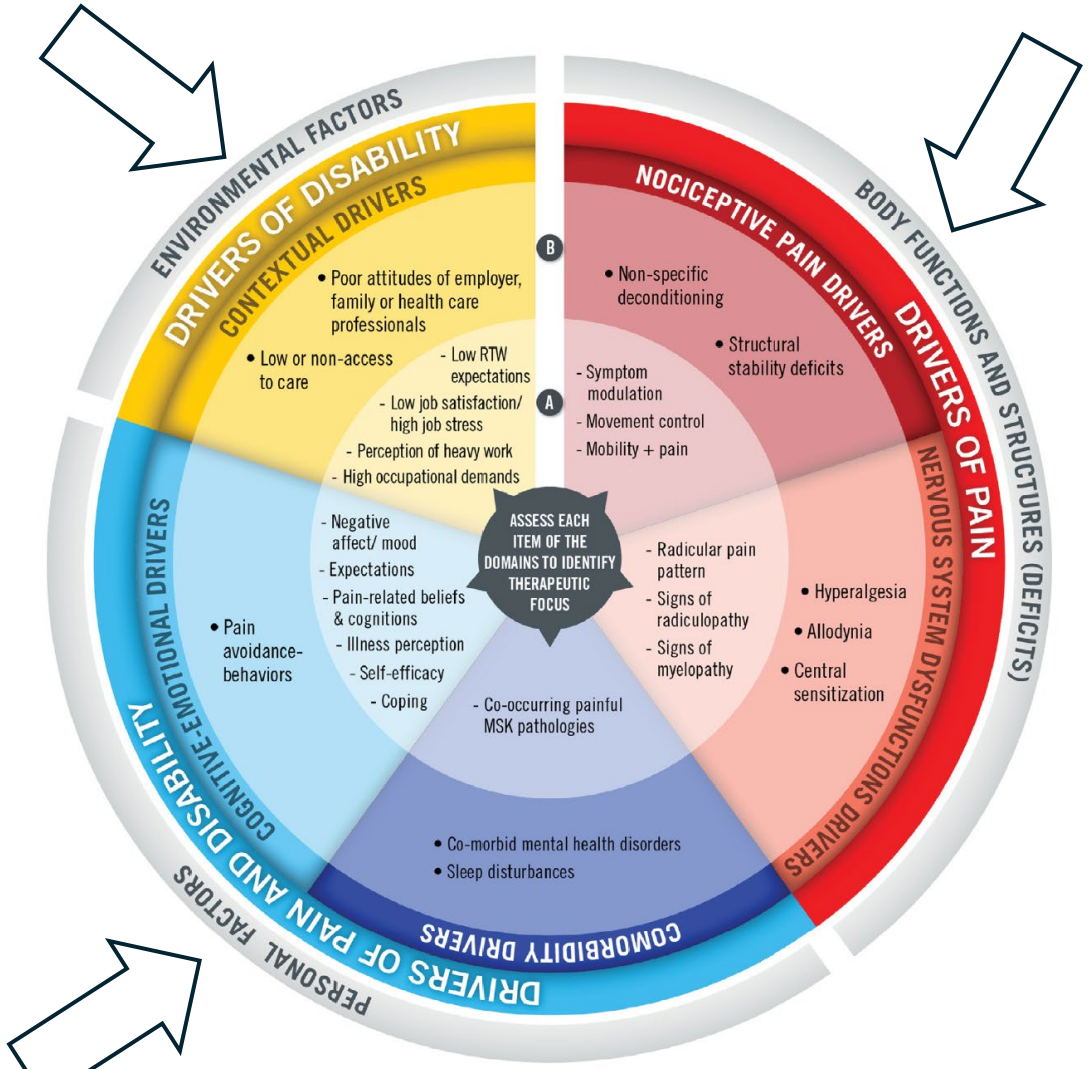
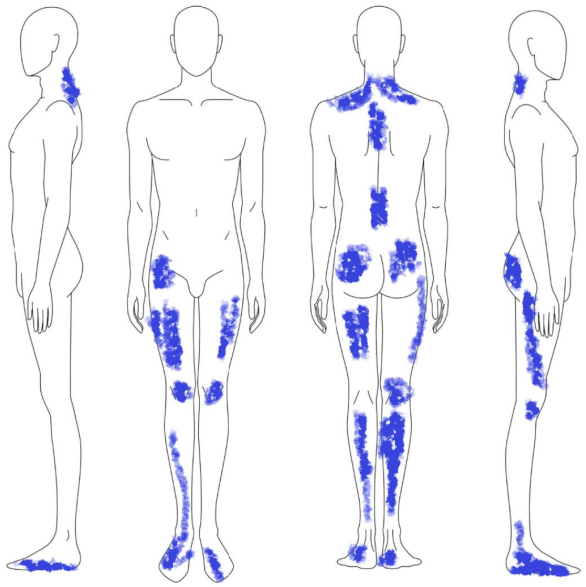


Figure 1 ain and disability driver management model. (**A**) refers to more common and/or modifiable elements; (**B**) refers to elements that are more complex and less modifiable, and that will prompt more aggressive or require interdisciplinary care to effectively address the problematic domain.
Abbreviations: RTW, return to work; MSK, musculoskeletal.

Pain Clinic: questionnaires and forms

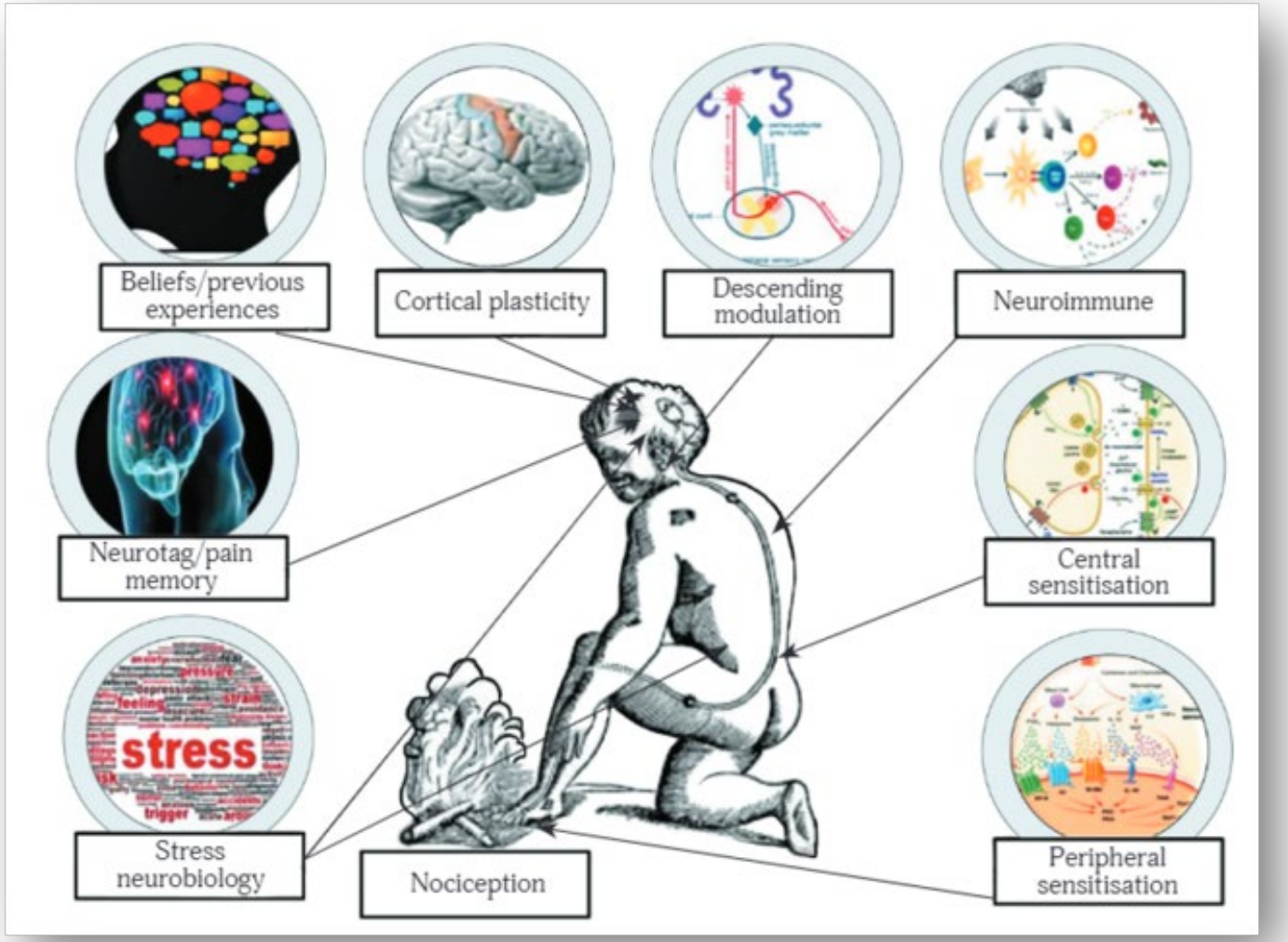


Pain intensity 8/10

- Brief Pain Inventory
- Pain intensity
- Pain Catastrophizing Scale
- Injustice Experience Questionnaire
- PHQ-9, GAD 7, DN-4
- Central Sensitization Inventory
- Fibromyalgia Diagnostic Criteria
- Somatization Inventory
- Childhood Adversity
- Substance Use Questionnaires
- Sleep Quality
- Tampa Scale of Kinesiophobia

Pain Clinic: Physical Exam

- Gait
- Mental status
- Mood
- MSK
- Neurological
- Sensory exam



Patricia

Drivers of Disability	A	B
Nociceptive		
Neuropathic - Nociplastic		✓
Comorbidity		✓
Cognitive-Emotional	✓	✓
Contextual	✓	✓

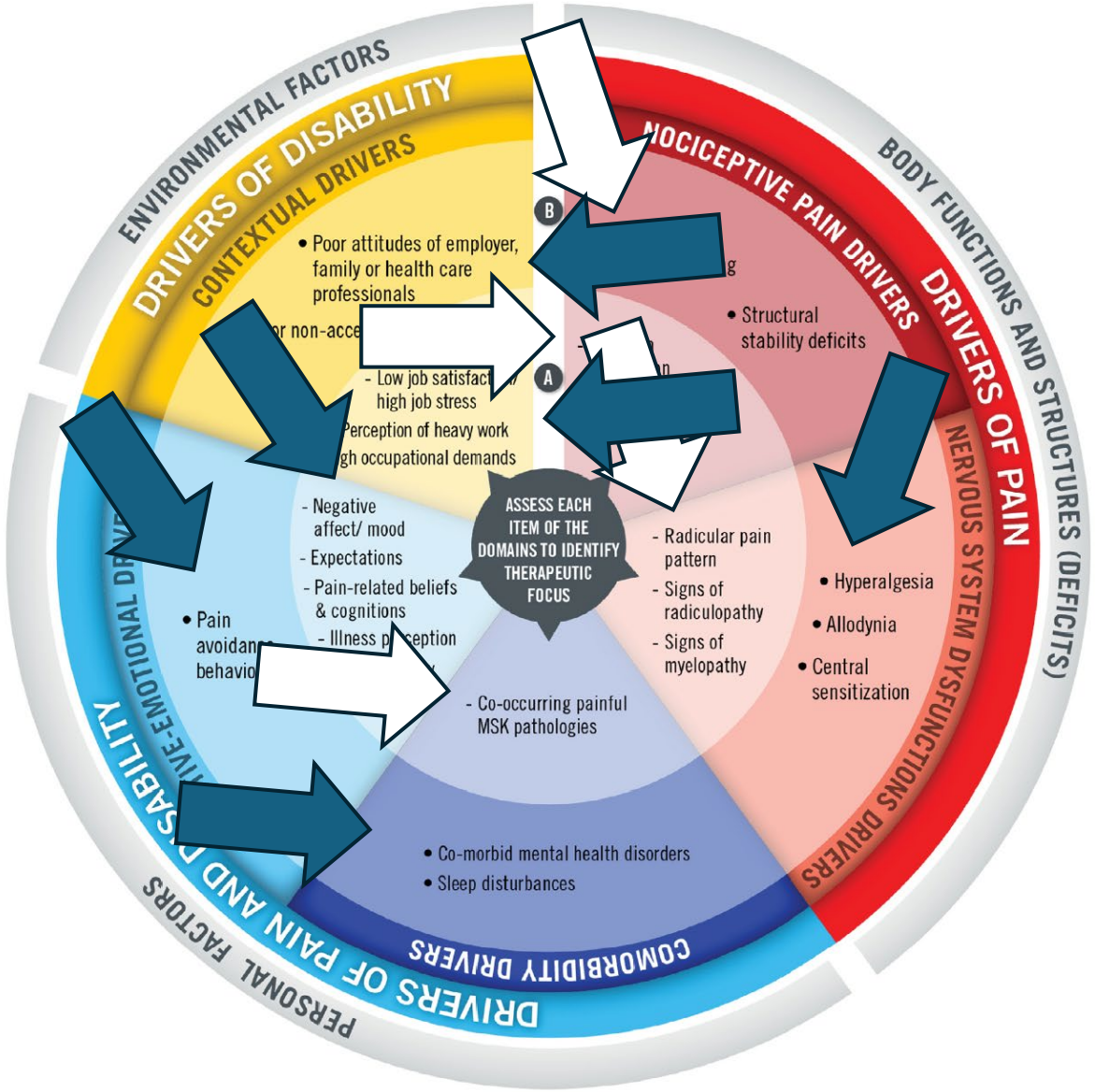


Figure 1 Pain and disability driver management model. (**A**) refers to more common and/or modifiable elements; (**B**) refers to elements that are more complex and less modifiable, and that will prompt more aggressive or require interdisciplinary care to effectively address the problematic domain.

Chronic Back pain
Opioid problem

Chronic Nociplastic Pain, Fibromyalgia
Central Sensitization
Opioid-induced hyperalgesia
Irrational polypharmacy
Opioid dependence
Low self-efficacy
Poor sleep quality
Poor dietary habits, obesity, diabetes
Early childhood adversities
Depression
Work disability, Fear avoidance

Getting the best from a Pain Clinic Consult

Referral to the Pain Clinic

Please see this lovely 59-year-old woman with chronic back pain on opioids since 2014. Please suggest some options to opioids.

Pain Clinic Management Plan

- Patient education (OIH, FM, CS)
- Brain retraining (fear-avoidance)
- Emotional Awareness (ACES)
- Sleep efficiency
- Healthy diet and physical activity
- Activation of modulatory pain pathways → her inner pharmacy
- Resources available to her (Youtube videos, POP portal, online peer-led groups)
- Motivation for a change
- Stop baclofen and gabapentin, opioid tapering (tramadol)

JAMA®

QUESTION Among patients with chronic pain, does a multicomponent intervention consisting of group meetings, education, individual support, and skill-based learning reduce opioid use and improve pain interference with daily activities compared with usual care?

CONCLUSION This randomized clinical trial found that compared with usual care, a group-based educational intervention significantly reduced opioid use but had no effect on perceived pain.

POPULATION

362 Women
242 Men

Adults taking strong opioids to treat chronic nonmalignant pain

Mean age: **61** years

LOCATION

191
Primary care centers in England

INTERVENTION

608 Patients randomized

305

Education and support
3-Day–long group sessions on skill-based learning and education and 1-on-1 support for 12 months plus usual care

303

Usual care
Self-help booklet on pain, opioids, and opioid tapering plus a relaxation CD

PRIMARY OUTCOMES

Patient-Reported Outcomes Measurement Information System Pain Interference Short Form 8a (PROMIS-PI-SF-8a) score (T-score range, 40.7-77; 77 indicates worst pain interference; minimal clinically important difference, 3.5) and proportion of participants who discontinued opioids at 12 months

FINDINGS

PROMIS-PI-SF-8a score and opioid discontinuation rate

	PROMIS-PI-SF-8a score	Opioid discontinuation
Education and support	**−4.1** (95% CI, −4.98 to −3.22)	**29%** 65 of 225 patients
Usual care	**−3.17** (95% CI, −4.10 to −2.24)	**7%** 15 of 208 patients

Between-group difference in PROMIS-PI-SF-8a score,
−0.52 (95% CI, −1.94 to 0.89)

Absolute difference in opioid discontinuation,
21.7% (95% CI, 14.8% to 28.6%)

Sandhu HK, Booth K, Furlan AD, et al. Reducing opioid use for chronic pain with a group-based intervention: a randomized clinical trial. *JAMA*. Published May 23, 2023. doi:10.1001/jama.2023.6454

2024 CANADIAN OPIOID PRESCRIBING GUIDELINE

GOOD PRACTICE STATEMENT: Patients with chronic non-cancer pain prescribed opioids should not be engaged in forced/involuntary tapering.

RECOMMENDATION 1

In people living with chronic non-cancer pain the panel recommends optimizing available nonopioid pharmacotherapy and non-pharmacological therapy prior to considering a trial of opioids

[STRONG recommendation]

Remarks:
There are several non-opioid interventions that may be helpful for people living with chronic pain.

RECOMMENDATION 2

In people living with chronic pain without current or past substance use disorder, without other current or past psychiatric disorders, and without a history of opioid overdose, who have, despite optimization of available nonopioid therapy, persistent pain they experience as problematic, the panel recommends discussing a trial of opioids

[STRONG recommendation]

Remarks:
This recommendation is consistent with many patients not receiving a trial of opioids. 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 within 2 months.

RECOMMENDATION 3

In people with chronic non-cancer pain, who have persistent problematic pain despite optimization of available nonopioid therapy and have a history of opioid overdose, the panel recommends against offering a trial of opioids

[STRONG recommendation]

RECOMMENDATION 4

In people with chronic non-cancer pain, who have persistent problematic pain despite optimization of available nonopioid therapy and have an active alcohol use disorder, the panel recommends against offering a trial of opioids

[STRONG recommendation]

RECOMMENDATION 5

In people living with chronic non-cancer pain with a history of any substance use disorder who have persistent problematic pain despite optimization of available nonopioid therapy, the panel suggests against offering a trial of opioids

[CONDITIONAL recommendation]

Remarks:
A conditional recommendation conveys the importance of considering patient's unique situation and represents a mandate for shared decision-making to ensure all decisions are consistent with each individual patient's values and preferences.

RECOMMENDATION 6

In people living with chronic noncancer pain with a history of mental illness or an active mental health disorder, who have persistent problematic pain despite optimization of available nonopioid therapy, the panel suggests against offering a trial of opioids

[CONDITIONAL recommendation]

Remarks:
A conditional recommendation conveys the importance of considering patient's unique situation and represents a mandate for shared decision-making to ensure all decisions are consistent with each individual patient's values and preferences.

RECOMMENDATION 7 & 8

In people living with chronic noncancer pain undergoing a trial of opioids, the panel suggests avoiding doses higher than 80mg morphine equivalents daily

[CONDITIONAL recommendation]

and seldom if ever exceeding doses higher than 150 mg morphine equivalents daily

[STRONG recommendation]

Remarks:
- A conditional recommendation conveys the importance of considering patient's unique situation and represents a mandate for shared decision-making to ensure all decisions are consistent with each individual patient's values and preferences.
- There will be people who would accept or not the increased risk of harms associated with a dose higher than 80 mg morphine equivalents daily to potentially achieve improved pain control.
- Rarely will some patients gain important benefit at a dose of more than 150mg morphine equivalents daily. Discussion with a colleague and a documentation of the rationale regarding the possibility of increasing the dose to more than 150mg morphine equivalents daily may be warranted.
- These recommendations do not apply to people already receiving long term opioid therapy.

RECOMMENDATION 9

In people living with chronic non-cancer pain, currently prescribed opioids and experiencing persistent problematic pain and/or problematic side effects, the panel suggests rotation to other opioids

[CONDITIONAL recommendation]

Remarks:
- A conditional recommendation conveys the importance of considering patient's unique situation and represents a mandate for shared decision-making to ensure all decisions are consistent with each individual patient's values and preferences.
- When successful, improved response to opioids should be apparent within 2 months of rotation. In consultation with the patient, rotation may be done in parallel with, and as a way of facilitating, dose reduction.

RECOMMENDATION 10

In people living with chronic non-cancer pain on long term stable opioid therapy for chronic non-cancer pain, the panel recommends that clinicians initiate a discussion offering a trial of opioid tapering to the lowest effective dose, potentially including discontinuation and, if the offer is declined, repeating the offer every 6 to 12 months

[STRONG recommendation]

Remarks:
Some patients who agree to opioid tapering may experience 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 and potentially abandoned in such patients.

RECOMMENDATION 11

For people living with chronic noncancer pain who are engaged in voluntary opioid tapering and experiencing challenges, we suggest engagement in multidisciplinary support

[CONDITIONAL recommendation]

Remarks:
- A conditional recommendation conveys the importance of considering patient's unique situation and represents a mandate for shared decision-making to ensure all decisions are consistent with each individual patient's values and preferences.
- Multidisciplinary support may include alternate analgesia; behavior change and active medication management. Health professionals whom physicians can access according to their availability include, but are not limited to, a primary care physician, a nurse, a pharmacist, a physical therapist, a chiropractor, a kinesiologist, an occupational therapist, a substance use disorder specialist, a psychiatrist, and a psychologist.

McMaster University
Michael G. DeGroote NATIONAL PAIN CENTRE

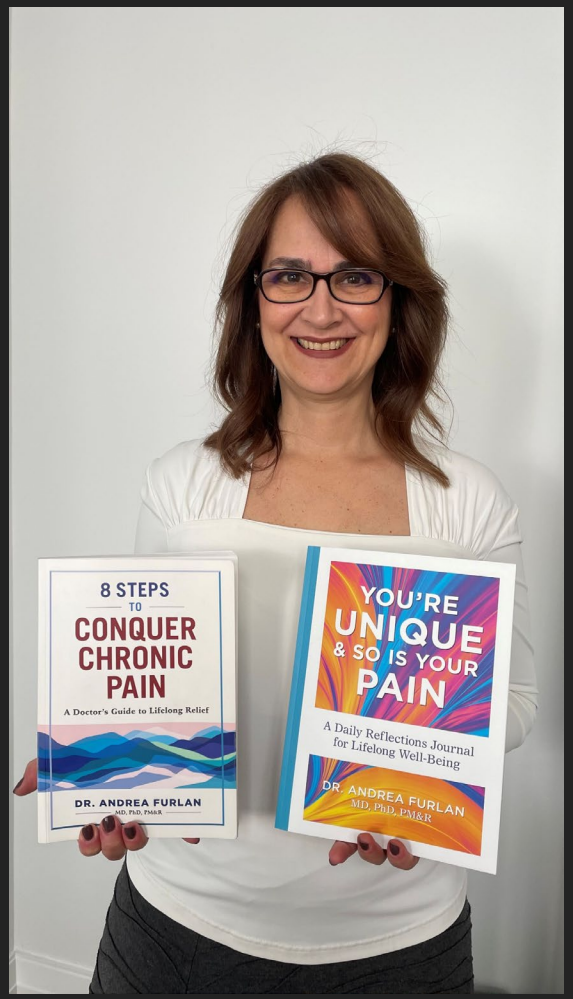
Recommendation 10

In people living with chronic non-cancer pain on long-term stable opioid therapy for chronic non-cancer pain, the panel recommends that clinicians initiate a discussion offering a trial of opioid tapering to the lowest effective dose, potentially including discontinuation and, if the offer is declined, repeating the offer every 6 to 12 months

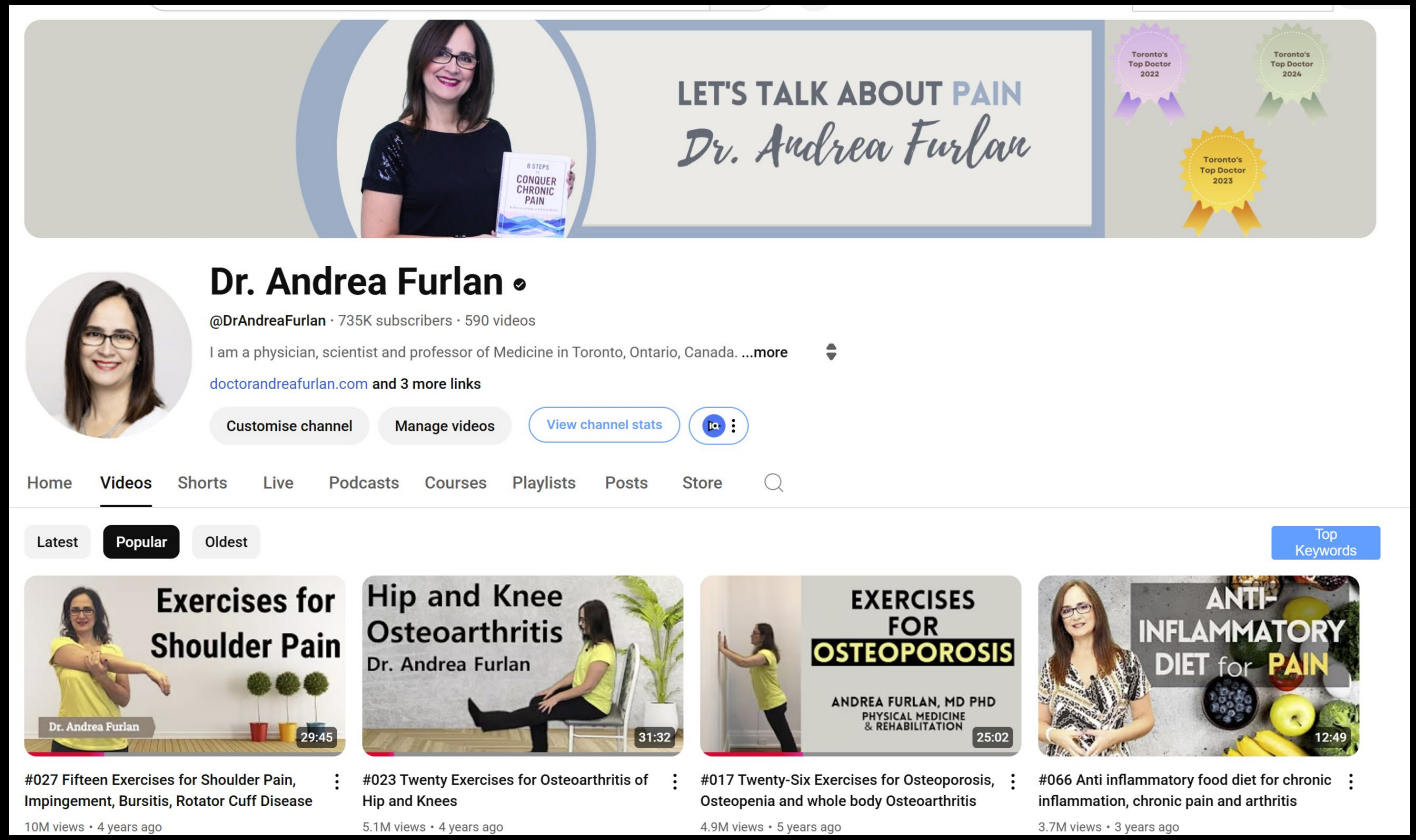
[STRONG recommendation]

Remarks:

Some patients who agree to opioid tapering may experience 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 and potentially abandoned in such patients.



youtube.com/@DrAndreaFurlan



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https://www.youtube.com/@DrAndreaFurlan

INDEX

Resources

Tools

Links to resources shared today will be sent to participants following the session.

Tools and Resources

Resource	Link
Information on Buprenorphine for Community Providers	https://www.metaphi.ca/wp-content/uploads/ED_OUD_CommunityProvider.pdf
Patient Handout on Microdosing Buprenorphine	https://www.metaphi.ca/wp-content/uploads/ED_OUD_MicrodosingInfo.pdf
Handbook: Primary Care Management of Substance Use	https://www.metaphi.ca/wp-content/uploads/Guide_PrimaryCareManagement.pdf
META:PHI – Search by Topic	www.metaphi.ca
2024 Canadian Opiod Prescribing Guideline	https://npc.healthsci.mcmaster.ca/wp-content/uploads/2024/06/2024-Opioid-Prescribing-Guideline-Web.pdf
YouTube – Dr. Andrea Furlan	youtube.com/@DrAndreaFurlan
Health Quality Ontario – Opioid Prescribing for Acute Pain	https://www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/opioid-prescribing-for-acute-pain
Health Quality Ontario – Opioid Prescribing for Chronic Pain	https://www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/opioid-prescribing-for-chronic-pain
Health Quality Ontario – Opioid Use Disorder (Opioid Addiction)	https://www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/opioid-use-disorder
Centre for Effective Practice – Urine Drug Screening	https://cep.health/download-file/1612201407.867819-272/#:~:text=Amphetamines,and%20renal%20or%20liver%20impairment

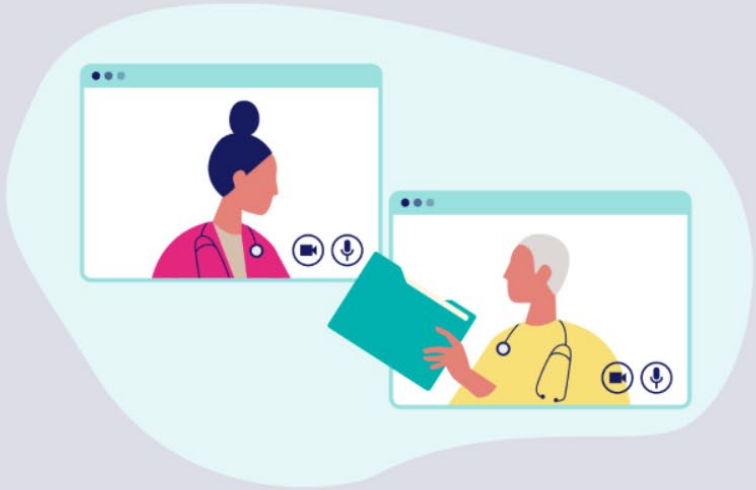
Resources

Education

Links to resources shared today will be sent to participants following the session.

Peer Connect

Enabling you to connect, share and learn from your fellow family physicians.



Mentorship Program - Connect with a Peer Guide!

An opportunity to partner with another family physician, **one-to-one or in a small group**, for support as you **explore clinical complexity and increase your confidence** caring for patients with mental health challenges, substance use, and chronic pain. A focus can be on your well-being as you engage in this challenging work.

Peer Connect

practisingwell@ocfp.on.ca

Upcoming Community of Practice

Best Practices for Nicotine Cessation

with Drs. Peter Selby, Osnat Melamed, Milan Khara

July 23, 2025
8:00am – 9:00am

Register Now

practisingwell@ocfp.on.ca

This one-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 1 Mainpro+ credit. The Practising Well Community of Practice includes a series of planned live, interactive sessions. Each session is worth 1 Mainpro+ credits, for up to a total of 12 credits.