Will the new opioid guidelines harm more people than they help?

YES — Romayne Gallagher MD CCFP(PC) FCFP Lydia Hatcher MD FCFP CHE DCAPM
NO — Nav Persaud MSc MD CCFP

YES The dominant narrative over the past decade has been that the increase in opioid-related harms, including opioid overdose deaths, has been directly caused by an increase in opioid prescribing by physicians. *The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* (developed in 2010 and updated in 2017)[1] will not resolve the public health issue, but will broaden the collateral damage to patients with chronic pain, a substantial part of the Canadian population (19% to 25%).[2] While the guidelines are aimed at patients with chronic noncancer pain, many physicians will apply them to patients with active cancer, those with acute pain, and those at the end of life because of fear of harm and regulatory sanctions.

Limitations of the recommendations

Optimize nonopioid pharmacotherapy and nonpharmacologic therapy rather than trial opioids (recommendation 1). Inadequate coverage of nonopioid and nonpharmacologic therapies is a considerable obstacle.

The guideline says opioids have more side effects than nonsteroidal anti-inflammatory drugs (NSAIDs) do, despite similar efficacy for pain, but the reference cited[3] ignores the hospitalization of 2 patients taking NSAIDs for gastrointestinal bleeding and severe pancreatitis. Are NSAID-related harms and deaths[4] more acceptable because they occur in older adults and are less visible than sudden deaths in young adults? Or is it because they are not tracked by regulators?

For patients without current or past substance use disorder (SUD) and without active psychiatric disorders who have persistent pain, a trial of opioids is suggested (recommendation 2). Despite high-quality evidence showing small statistically significant improvements in pain and physical function in many studies, the guideline focuses on the rare possibility of an opioid overdose (0.10%) and only rates this as a weak recommendation.[1] What counts is prevention of opioid overdose and not prevention of suffering due to pain.

Chronic noncancer pain and SUD (recommendations 3 and 5). There is no question that patients who have an active SUD based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition,[5] should not be given opioids or controlled substances for chronic noncancer pain. While there is considerable evidence that patients with a clinically significant history of substance misuse should not be prescribed opioids, to deny use of any opioids to somebody with a remote history is punitive. Knowing that approximately 80% of Canadian teenagers have consumed alcohol and nearly 50% have consumed illicit drugs[6] potentially denies opioids to more than half our population.

Chronic noncancer pain and serious psychiatric disorders (recommendation 4). Many of our patients suffer multiple comorbidities and managing their mental health issues is vital. While anxiety and depression make pain worse, the reciprocal relationship is also seen.[7] This suggests that both pain and mental illness must be treated together. A blanket no to opioids in those with mental illness will adversely affect the mental health of patients.

Restrict the prescribed dose to 50 mg of a morphine-equivalent dose (MED) daily (weak recommendation) and less than 90 mg MED daily (strong recommendation) (recommendations 6 and 7). These recommendations are based on a poster presentation (not a published paper) showing that the risk of fatal overdose rises from 0.10% with doses of less than 20 mg MED daily to 0.23% with doses of more than 100 mg MED daily,[8] and a non-significant regression analysis showing no dose response for pain or function improvement in patients in 6 studies who tried a single opioid.[1] This is later called "high-quality evidence."[1]

Genetic variables affecting opioid pharmacokinetics can result in unpredictable analgesia and adverse effects.[9] That is why one would not expect a linear dose-response curve in multiple patients tried on a single opioid.

How these recommendations are interpreted by physicians and regulatory bodies is key. If 90 mg MED daily is the absolute highest dose, many patients will have their doses cut or will never reach a dose that has the potential to work for their pain. What can we offer them to treat their pain if nonopioid and nonpharmacologic therapies fail? If they are older adults with multiple comorbidities or with severe, crippling osteoarthritis we can now offer medical assistance in dying.[10] Will it be easier to request medical assistance in dying than it will be to achieve adequate pain management?[11]

Rotation and tapering of opioids (recommendation 8 and 9). Opioid rotation seems, at first blush, to be about improving pain and reducing side effects rather than reducing the use of opioids. But the guideline recommends rotation as a method to reduce opioid dose by overlapping a steep reduction (10% to 30%) of the current opioid while adding a new opioid at the lowest possible daily dose available. The current opioid is reduced

and stopped over the next 3 to 4 weeks while the new one is only increased by 10% to 20% each week. A patient switched from a high dose of one opioid to very low doses of another opioid could develop serious harms such as withdrawal, hyperalgesia, loss of function, and possibly hospitalization. This method is not referenced.

With regard to tapering of opioids, we have seen many patients prescribed sudden decreases in dosing (up to 50%) to completely stopping opioids, despite no history of aberrant behaviour. Many physicians are unaware of the negative physical and emotional effects of withdrawal. Some patients will look for pain medications from the "street" or from friends—not to get high, but just to feel better. Older patients end up in the emergency department where the admission might be recorded as an opioid-related harm! The values and preferences statement does acknowledge that harm might come from tapering and that it might have to be halted, but there is no mention in the guideline. Capable physicians are being singled out for regulatory reviews because these hard-to-taper patients that others have not been able to manage are referred to them.

Multidisciplinary opioid-reduction programs (recommendation 10). This recommendation is laudable but highly impractical, as Canada lacks multidisciplinary programs for pain, let alone opioid reduction. Timely access to addiction and mental health treatment is absent across the country.

Conclusion

Have multiple guidelines reduced harm from opioids? The Centers for Disease Control and Prevention in the United States has documented reduced prescribing of opioids since 2010,[12] and there have been similar reductions in Canada.[13] However, the opioid-related overdose deaths have continued to climb in both countries owing to illicit opioid–related deaths. Guidelines will do nothing to reduce these opioid-related deaths[14] nor will they help to diminish the stigma of chronic pain where patients can end up doctorless and in precarious physical and mental health, with nowhere to turn.

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Competing interests
Dr Gallagher accepts honoraria for educational talks from Purdue Pharma.
Dr Hatcher has been an advisory board or committee member for Purdue Pharma, Lilly, AstraZeneca, Tilray, and Paladin and has received honoraria or speaker fees from Purdue Pharma, Lilly, Tweed, Catalytic Health, Tilray, Knight Therapeutics, CME AWAY, mdBriefCase, and the College of Physicians and Surgeons of Ontario. She was an expert panel member for the 2017 Canadian opioid guideline update.

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Cet article se trouve aussi en français à la **page 105**.

CLOSING ARGUMENTS — YES

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- *The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* are biased toward reducing the use of opioids and provide insufficient evidence to support this bias.
- The guidelines make recommendations that will harm patients mentally and physically.
- Prescribing of opioids has reduced considerably in the past 5 years, yet opioid-related deaths continue to rise.
- The guidelines will harm more people than they help.

The parties in these debates refute each other's arguments in rebuttals available at **www.cfp.ca**. Join the discussion by clicking on "Respond to this article" at **www.cfp.ca**.

NO Falsehoods caused the opioid crisis and falsehoods keep it going. Worries that the 2017 Canadian opioid guideline[1] will *cause* harm show how far away from appropriate practice we have been tugged by misinformation.

Purdue Pharma executives pleaded guilty in the United States to inappropriately promoting opioid products.[2] The admittedly illegal activities include falsely claiming that long-acting opioids have a lower abuse