

Correspondence

Re: Effectiveness of Long-Term Opioid Therapy for Chronic Low Back Pain

To the Editor: In Licciardone et al, attention is appropriately given to the important question of whether long-term opioid therapy (LTOT) has measurable benefits for those with chronic low back pain.¹ The primary finding in this observational study is that a cohort of individuals with chronic low back pain who are already taking LTOT have no better pain control or functioning over 12 months compared with a propensity score-matched cohort of individuals with chronic low back pain not taking opioids. Yet the authors conclude that their findings add support to the notion that “clinicians should consider tapering opioid dosage among long-term opioid therapy users in accordance with clinical practice guidelines.” While this is a reasonable statement on its own, the study design and results of this study do not support this conclusion.

Primary care clinicians face 2 distinct questions surrounding LTOT for chronic pain. The first question is whether starting opioid-naïve individuals with chronic pain syndromes on LTOT will result in benefit compared with nonopioid therapies. The authors note the small but growing body of literature that suggests only modest, if any, benefit of this approach over the long-term for pain control and functioning.^{2,3}

A second, separate question is whether tapering or stopping LTOT in opioid-dependent individuals will result in benefit. To our knowledge, there are no randomized trials assessing this question. Observation data from multiple studies find associations of increased harms with tapering.^{4,5} These studies have notable limitations and should not stop clinicians from discussing with patients the issue of tapering LTOT, as there remain risks associated with LTOT continuation.⁶ Neither should they dissuade considerations to transition from full agonists to buprenorphine, an approach that is likely to reduce risks associated with continuation or tapering of full agonists.⁷ This question is not addressed by the study design in Licciardone et al, yet the authors conclude that their findings indicate that clinicians should consider tapering opioid dosage among long-term opioid therapy users in accordance with clinical practice guidelines. This statement risks adding unmerited confidence to a clinical scenario that remains nuanced.

Whether to initiate LTOT in opioid-naïve individuals with chronic pain seems increasingly clear: the limited benefits with noted risks make this pathway one that should be rarely taken, and when done so, guidelines suggest buprenorphine as the safest opioid.⁸ The data presented by Licciardone et al do not offer signals to suggest otherwise. Yet the questions of whether and

when to recommend tapering LTOT or transitioning full agonist LTOT to buprenorphine are not addressed in Licciardone et al, are ones in need of more evidence, and for now, should be approached with careful nuance and individualization by primary care clinicians.

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