**Summary of European clinical practice recommendations on opioids for chronic noncancer pain**

* Up to a quarter of Europeans report on chronic pain and, in around 80% of those cases, the pain is not related to cancer. This pain is called chronic non-cancer pain (CNCP).
* Opioid prescriptions have increased over the past decade in some European countries which has caused concerns.
* To provide European guidance on the role of opioids in CNCP, the European Pain Federation published an evidence- and consensus-based position paper which was peer reviewed by international experts. The position paper was developed by eight scientific societies and one patient organisation.
* The new recommendations aim to provide safer and more effective care for people with CNCP, give guidance to doctors on appropriate opioid use, as well as decrease harmful opioid use.

**Key Recommendations**

* Opioids should not be used as a first line care option for any chronic non-cancer pain. First line care for chronic non-cancer pain should consist of trialling non-pharmacological treatments (e.g. exercise, physiotherapy, psychological therapies) and/or non-opioid analgesics.
* Opioid treatment can be considered as part of second line care, only if non-pharmacological treatments and/or non-opioid analgesics trialled are ineffective, not tolerated, or contraindicated.
* Opioids should not be used for primary pain syndromes. Chronic primary pain is pain that lasts more than three months, causing significant emotional distress or functional disability, but which cannot be explained by another specific medical condition. Examples include fibromyalgia, chronic migraine, irritable bowel syndrome and non-specific low-back pain.
* Opioids can be considered for the chronic secondary pain, as a second- or third-line option. Chronic secondary pain is pain due to a defined medical condition, such as following surgery or injury, internal diseases, diseases of the muscles, bones or joints, or nerve damage.
* When selecting an opioid treatment, one should consider the type of chronic non-cancer pain (primary or secondary pain syndrome), the comorbidities of the patient (e.g., mental health issues, history of addiction), contraindications, patient preferences, treatment goals, benefits and harms of treatments and the benefit-risk ratio of available pharmacological alternative treatment options.
* If starting an opioid treatment, closely monitor patients, and the treatment should only continue if there is clinically meaningful improvement in pain and daily function that outweigh harms and side effects.
* If starting an opioid treatment, starting low and go slow. At the outset, one should prescribe the lowest effective dose: less than 50 morphine milligram equivalents (MME) a day. One should also avoid increasing the dosage above 90 MME/day, or carefully justify any decision to do so.
* Opioid therapy should stop if the goals agreed at the beginning of the treatment are not being met, if intolerable adverse events happen, if goals can be achieved through non-opioid treatments, or due to concerns about a patient becoming dependent.
* Read the full paper here: <https://onlinelibrary.wiley.com/doi/full/10.1002/ejp.1736>

The new clinical recommendations for opioid use in treating CNCP have been endorsed by:

* European Pain Federation (EFIC)
* European Academy of Neurology (EAN)
* European Federation of Addiction Societies (EUFAS)
* European Federation of Psychologists’ Associations (EFPA)
* European Psychiatric Association (EPA)
* European Region - World Confederation of Physical Therapy (ER-WCPT)
* European Society of Anaesthesiology and Intensive Care (ESAIC)
* European Society of Physical and Rehabilitation Medicine (ESPRM)
* European Society of Regional Anaesthesia & Pain Therapy (ESRA)
* Pain Alliance Europe (PAE)