Evidence-to-Decision table 4.1		
In adults (including older persons) and adolescents with cancer-related pain, what is the evidence for certain dosing regimens or interventions in order to effectively and safely cease opioids?		
POPULATION:	Adults (including older persons) and adolescents with cancer-related pain	**Background:** Patients undergoing the cessation of opioids may experience withdrawal symptoms if they have developed physical dependence on opioids. How to cease opioids quickly and appropriately while avoiding withdrawal symptoms is an area of interest. **Current WHO recommendation**: If the cause of pain is addressed by anticancer treatment, the use of opioids can be stopped. To avoid withdrawal symptoms, the dose should be decreased gradually. After an abrupt reduction in pain (e.g. after nerve block or neuroablative procedure), the dose should be reduced to 25% of the original dose. If the procedure has been successful, the dose can be reduced further every 2-3 days and stopped completely if the pain does not recur.
INTERVENTION:	Opioid dosing regimen (for cessation)	
COMPARISON:	Other opioid dosing regimen	
MAIN OUTCOMES:	• Effective cessation of opioid • Pain relief speed • Pain relief maintenance • Quality of life (QoL) • Functional outcomes • Confusion (adverse event) • Gastrointestinal adverse event	
STRATIFICATIONS:	• Age (adults, older persons, adolescents, children) • History of substance abuse • Refractory pain	
SETTING:	All	
PERSPECTIVE:	Population	

	CRITERIA	SUPPORTING EVIDENCE & ADDITIONAL CONSIDERATIONS
PROBLEM	**Is the problem a priority?**	**Research Evidence** None **Additional considerations** Patients undergoing the cessation of opioids may experience withdrawal symptoms if they have developed physical dependence on opioids. How to cease opioids quickly and appropriately while avoiding withdrawal symptoms is an area of interest.

BENEFITS & HARMS	**Do the desirable effects outweigh the undesirable effects?** Yes ☐ No ☐ Uncertain ☒ Yes	• **No randomized controlled trials** compared opioid dosing regimens with the goal of opioid cessation. **BENEFITS and HARMS** • **No trial** reported on **effective cessation of opioid**. • **No trial** reported on **pain relief speed**. • **No trial** reported on **pain relief maintenance**. • **No trial** reported on **QoL**. • **No trial** reported on **functional outcomes**. • **No trial** reported on **confusion**. • **No trial** reported on **gastrointestinal adverse event**. **STRATIFICATIONS** • Studies conducted in adults with a wide age range, without stratification into adolescent, non-older persons, and older persons. • Studies provide no data regarding history of substance abuse. • Studies provide no data regarading refractory pain. **SUMMARY** No eligible trials were found that address this sub-question.

ACCEPTABILITY & PREFERENCES	**Is there important uncertainty or variability about how much people value the options?** Major variability [ ] Minor variability [ ] Uncertain [Yes] **Is the option acceptable to key stakeholders?** Yes [ ] No [ ] Uncertain [Yes]	**<u>Research Evidence</u>** None **<u>Additional considerations</u>** None

FEASIBILITY ./ RESOURCE USE	**How large are the resource requirements?** Major ☐ Minor ☐ Uncertai Yes **Is the option feasible to implement?** Yes ☐ No ☐ Uncertain Yes	**Research Evidence** None **Additional considerations** None
	Would the option improve equity in health? Yes ☐ No ☐ Uncertai Yes	**Research Evidence** None **Additional considerations** None

Recommendation	**Current recommendation:** If the cause of pain is addressed by anticancer treatment, the use of opioids can be stopped. To avoid withdrawal symptoms, the dose should be decreased gradually. After an abrupt reduction in pain (e.g. after nerve block or neuroablative procedure), the dose should be reduced to 25% of the original dose. If the procedure has been successful, the dose can be reduced further every 2-3 days and stopped completely if the pain does not recur. **New (draft) recommendation:** None
Strength of Recommendation	**None**
Quality of Evidence	**None**
Justification	There was no eligible evidence on which to base a recommendation.
Subgroup considerations	
Implementation considerations [incl. M&E]	
Research priorities	