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CORRESPONDENCE

Reassessing opioid conversion guidelines: narrow consensus and clinical challenges

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To the Editor,

The MASCC-ASCO-AAHPM-HPNA-NICSO guideline on opioid conversion in adults with cancer proposes a much-needed framework for transitioning between opioids and routes of administration in complex cancer pain scenarios [1]. However, a closer look at the reported margins of consensus raises concerns about how these recommendations will be implemented in everyday practice. Although 58 of 84 statements reached or surpassed the 75% threshold, the percentage of agreement in certain critical areas hovered around 78–80%, reflecting the minimal clearance of the established consensus bar. For instance, recommendations about specific opioid choices under renal or hepatic dysfunction reached only 78.9% agreement [2], while the use of buprenorphine in "stop-start" conversions narrowly exceeded consensus at 79.4% [1]. These figures, although technically meeting the criteria, do not convey a robust or uniform endorsement among experts.

The underlying reliance on the Delphi consensus methodology is understandable, given the limited availability of high-quality randomized trials. However, this method can amplify expert biases, especially when differences of opinion are only faintly reconciled to reach the 75% cutoff [3]. These borderline outcomes serve more as indications of persistent clinical uncertainty than as definitive statements of best practice. Another key issue is the conspicuous absence of robust, prospective data to validate the morphine equivalent daily dose (MEDD) approach [4, 5]. While MEDD calculations are frequently used, their inaccuracy at higher doses can lead to unsafe conversions, underscoring the tenuous foundation on which some consensus recommendations stand.

Moreover, by excluding patients with comorbidities such as opioid use disorder or advanced organ dysfunction, the guideline may not reflect the most challenging real-world cases [6]. Oncologists and palliative care clinicians routinely contend with patients whose renal, hepatic, or psychiatric status complicates straightforward opioid conversion ratios—yet these subsets remain largely underrepresented [7]. Failing to account for these nuances can perpetuate suboptimal pain control or, conversely, heighten the risk of toxicity.

From a clinical standpoint, these tight margins of expert agreement may encourage clinicians to interpret the guidelines cautiously.

In particular, methadone conversion stands out as a point of contention [8]. The recommendation that only experienced prescribers should manage this practice is warranted, yet it effectively narrows the scope of clinicians capable of safely implementing the guideline. Similarly, the modest consensus around fentanyl dose adjustments—coupled with the panel's inability to agree on an automatic dose reduction strategy when switching opioids—illustrates the many unresolved details that practitioners must navigate [1].

Additionally, several proposed statements with specific conversion ratios failed to achieve the 75% agreement threshold, indicating significant uncertainty. For example, the suggestion that clinicians cannot assume the same ratio for morphine-to-hydromorphone versus hydromorphone-to-morphine achieved only 60.5% agreement; the proposed ratio of oral morphine to transdermal fentanyl reached just 68.4%; and attempts to establish clear dose conversions between transdermal fentanyl and methadone resulted in 57.5% agreement. Such borderline or below-threshold levels reflect the unsolved practical complexities, further emphasizing the need for more robust data. In many low-resource

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settings, morphine, methadone, and fentanyl remain among the few accessible opioids and are recognized by the World Health Organization (WHO) as essential medicines for the management of cancer pain [9].

Ultimately, this guideline fulfills a significant role in highlighting the complexities and risks of opioid conversion. However, the fine margins in expert voting illustrate how much we still do not know. Without additional prospective data and detailed guidance for patients with complex clinical profiles, the narrow consensus may offer only limited reassurance for frontline providers. Providing clear and well-defined guidelines for clinicians working in settings with limited resources is particularly crucial, as these practitioners often have even fewer therapeutic options. Future efforts should prioritize large-scale, prospective research incorporating diverse patient populations to strengthen the evidence base underlying these crucial recommendations.

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Declarations

Competing interests The authors declare no competing interests.

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