European Journal of Cancer (2012) **48**, 946–947

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Letter to the Editor

Reply to Professor Mercadante: Stop and go strategy for opioid switching requires flexibility

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To the Editor: We are grateful for the interest and response from Mercadante. This study was a randomized, phase II study, and we agree that there were obvious limitations, as discussed in the article. No firm conclusions could be made. However, it was more drop-outs, three serious adverse events (SAEs) and a trend of more pain in the stop and go strategy should not replace the more careful 3-days switch (3DS) in such frail patients. No clinically significant difference >2[1] (11 point scale) in pain intensity or adverse effects were found during the first week after the switch. The protocol was strict during the first five days; however, the patients were allowed to take rescue (morphine/oxycodone) as needed.

Mercadante referred to successful switches with the SAG strategy, and that a more flexible strategy than used in our study would be a better choice. We agree on this when referring to expert settings, or in a different patient population like the patients included in the study by Mercadante[2]; in which the majority used opioid doses below 300 mg/day. Moreover, their patients were not on anticancer treatment, and subjects with poor liver/kidney function and brain metastases were excluded. This underlines the importance of classifying the cohorts in clinical cancer pain studies, and that a common system needs to be agreed upon. Studies using the SAG strategy have observed the patients only in a few days after the switch, which might be too short to detect the adverse events that might arise later because of methadone's long terminal elimination half life.

In the present study we compared two protocols that might be relevant also in the non-expert setting. In addition, frail patients on high opioid doses were included, and they were observed for 14 days after the switch. The safety concerns regarding SAG patients were obvious in the present study, with three SAEs and a greater dropout rate compared to the 3DS group. To stop the previous opioid, and under expert supervision, to change the doses of methadone according to the clinical response, using dose dependent ratios[3,4] as used in this study, might be the best choice. A recent systematic review on opioid switching concluded that the level of evidence for opioid switching is still low.[5]

Conflict of interest statement

None declared.

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0959-8049/$ - see front matter
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