CDC Guidelines for Prescribing Opioids for Chronic Pain

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Disclosures

- I have no relationship with any industry or person(s) that could be construed as a conflict of interest in presenting this material.
- No off-label therapies or products will be discussed in this presentation.

Objectives

- Describe the impact of opioids in America.
- Summarize the CDC Guidelines for Prescribing Opioids for Chronic Pain.

Quiz

In 2012, the amount of opioids prescribed in America were:

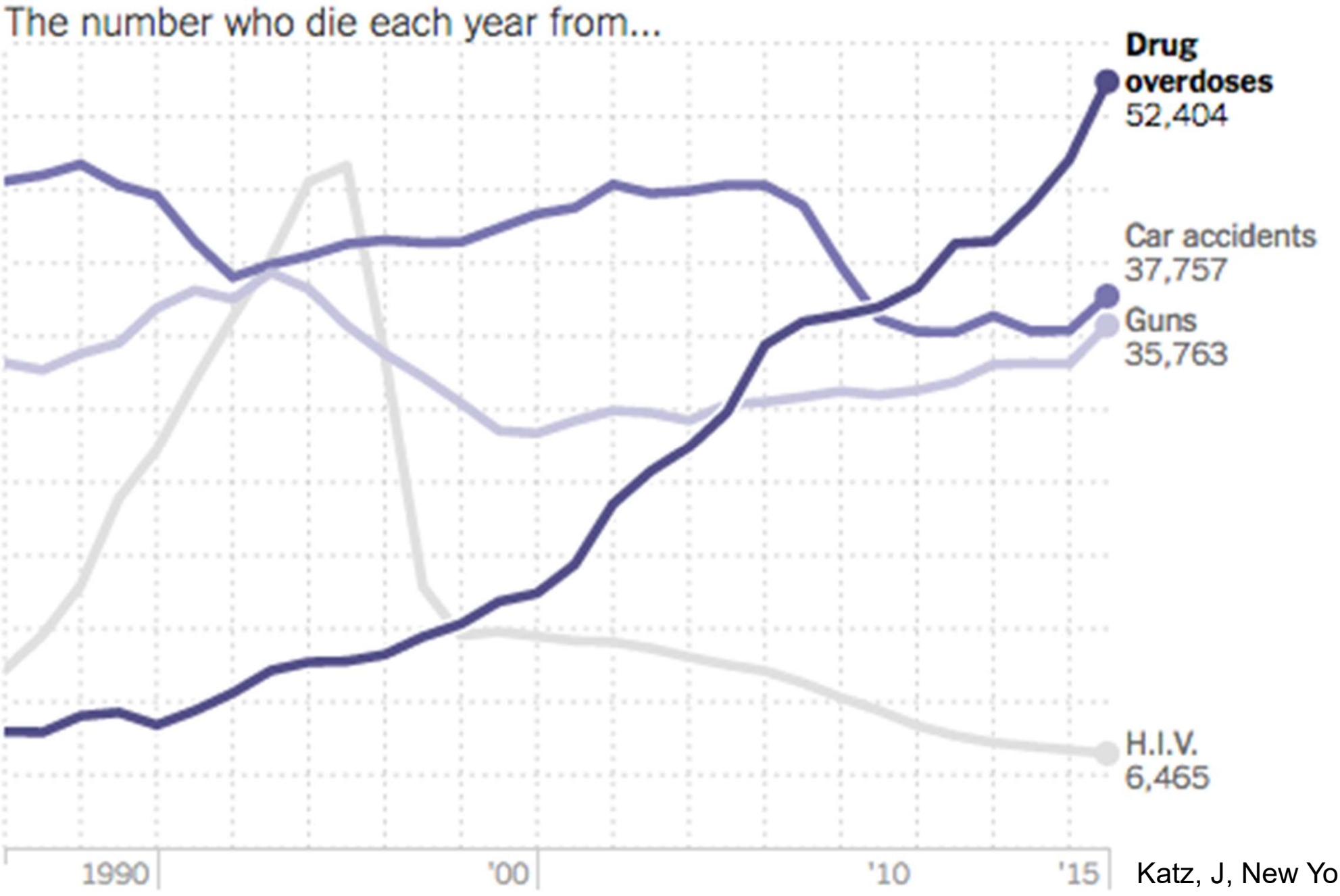
A. Peaking

B. Enough for every adult to have a bottle

C. Too few

D. Enough for some people to test positive on a drug screen just from opioid exposure in the drinking water

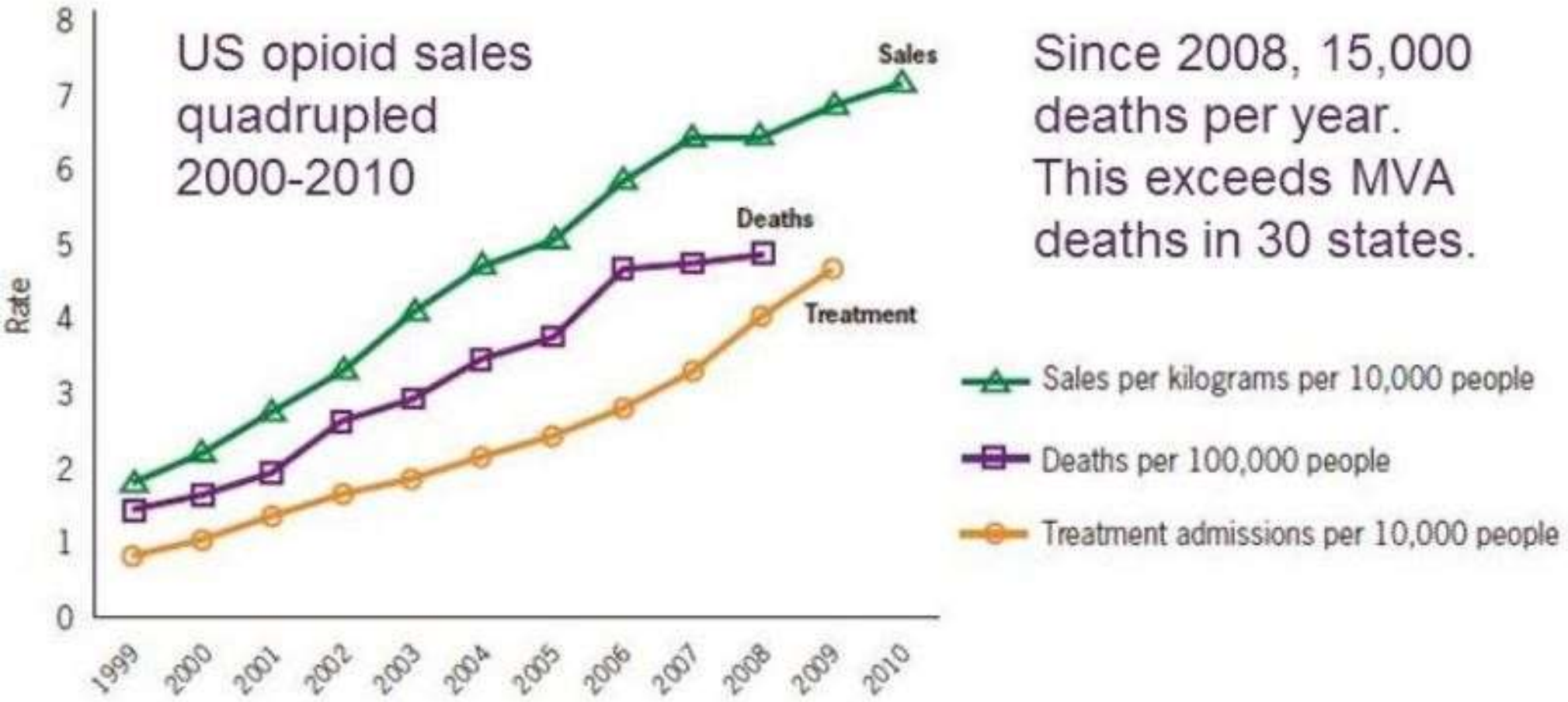
The Opioid Epidemic



Katz, J, New York Times, 10-26-17

Opioid Prescriptions

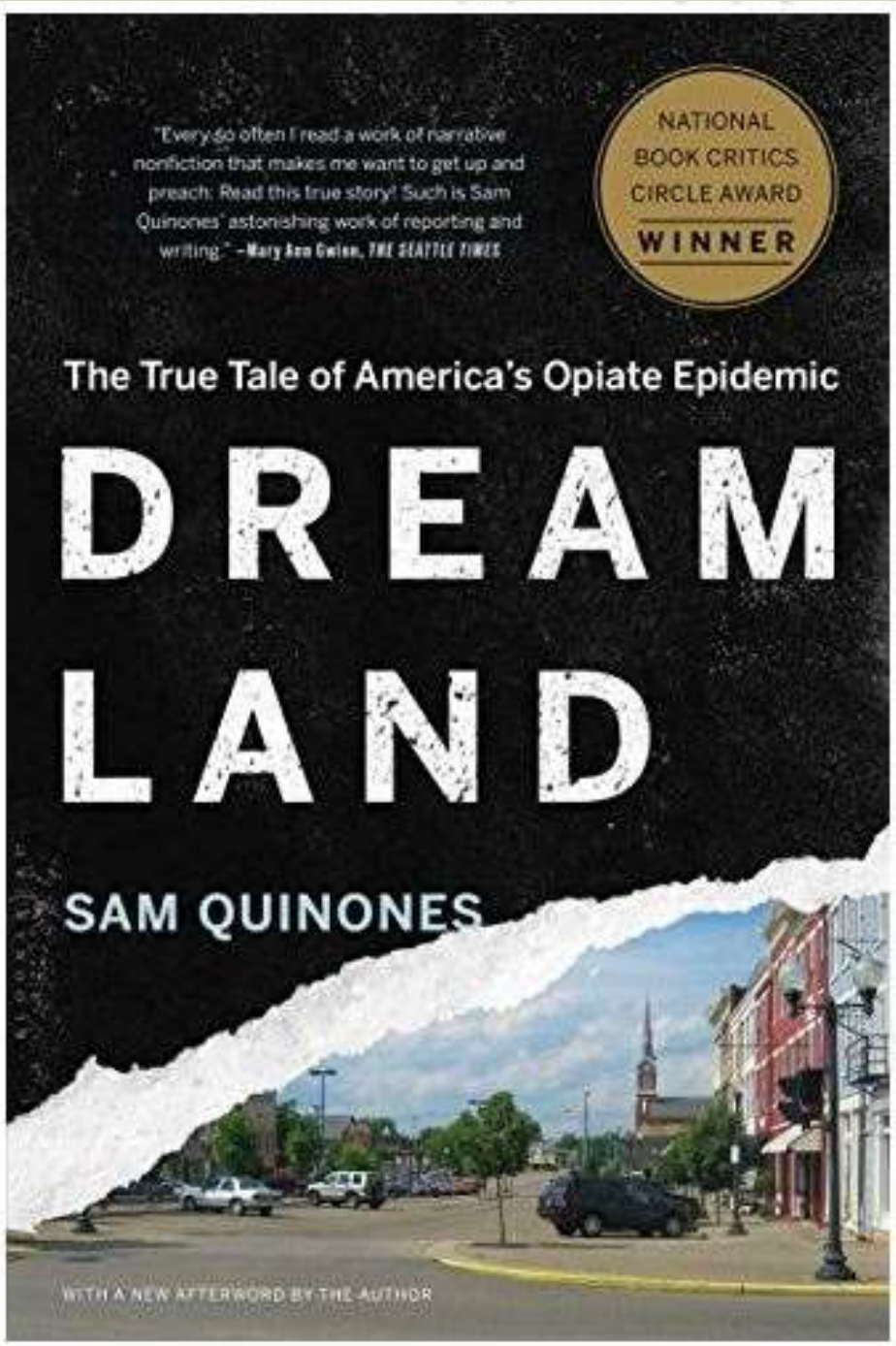
Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)



SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

Slide source: Mark Sullivan & PCSS Training for Opioid Therapy

Dreamland


"Every so often I read a work of narrative nonfiction that makes me want to get up and preach: Read this true story! Such is Sam Quinones' astonishing work of reporting and writing." —Mary Ann Gwinn, THE SEATTLE TIMES
NATIONAL BOOK CRITICS CIRCLE AWARD
WINNER
The True Tale of America's Opiate Epidemic
DREAM LAND
SAM QUINONES
WITH A NEW AFTERWORD BY THE AUTHOR

Chronic Pain

- Pain lasting >3 months or beyond normal tissue healing time
- Due to medical condition, injury, medical treatment, inflammation, or an unknown cause
- ~15% of US adults
- US: Enough opioids prescribed in 2012 for every US adult to have a bottle

CDC MMWR 2016

CDC Guidelines

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

SEARCH

CDC A-Z INDEX

Opioid Overdose

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  - **Guideline Overview**
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CDC > Opioid Overdose > Information for Providers

CDC Guideline for Prescribing Opioids for Chronic Pain

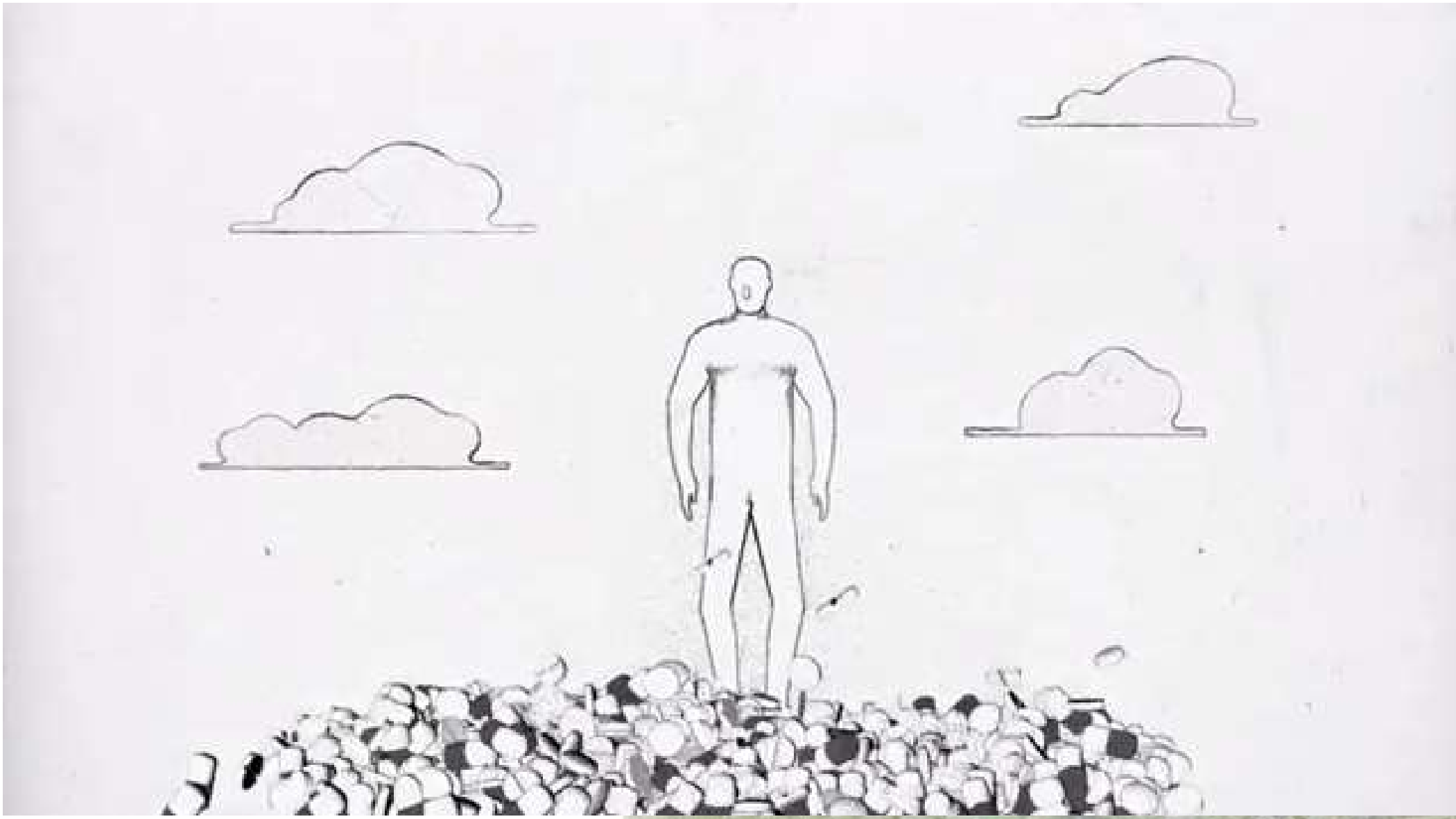
Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

CDC developed and published the *CDC Guideline for Prescribing Opioids for Chronic Pain* to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings.

Guideline Recommendations

Guideline for Prescribing Opioids for Chronic Pain: Recommendations [PDF - 674 KB]

Current Response



CDC ... nes

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

TO LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline

Determining When to Initiate or Continue Opioids for Chronic Pain

Quiz

Which of the following is a good goal to have if prescribing opioids for chronic pain?

A. Absence or near absence of pain
B. Improved relationships
C. Improved daily functioning
D. Improved oratory skills

Initiation?

- Nonpharmacologic therapy and nonopioid medications preferred
- Benefits for improved pain and function should outweigh risks

Initiation

- Establish treatment goals
- Establish a discontinuation plan

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
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Q1: *What number from 0–10 best describes your **pain** in the past week?*

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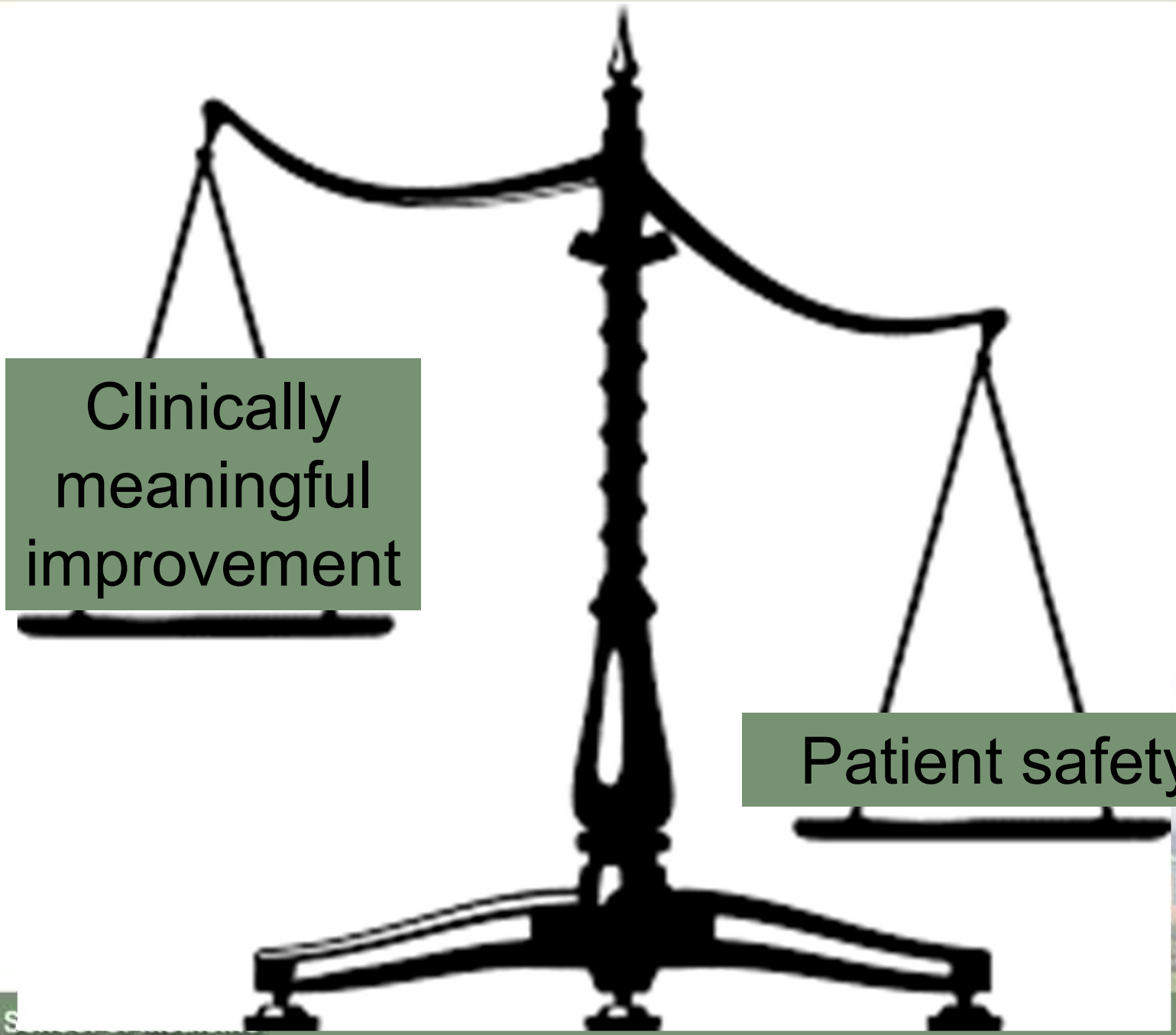
Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*

0="not at all", 10="complete interference"

Initiation and Continuation

- Patients and clinicians should discuss their responsibilities for managing therapy.
- Informed consent discussion:
  - Helpful for acute pain, no evidence of improvement for chronic pain
  - Complete relief of pain is unlikely
  - Common and serious side effects

Continuation



Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

Quiz

For acute pain, opioid prescriptions over _____ days are rarely needed.

A. 1

B. 7

C. 14

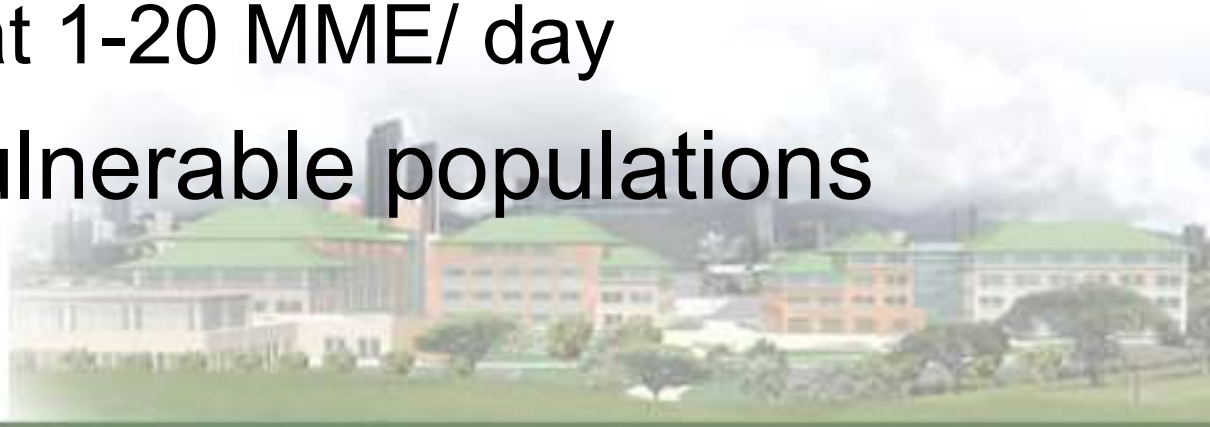
D. 30

Selection

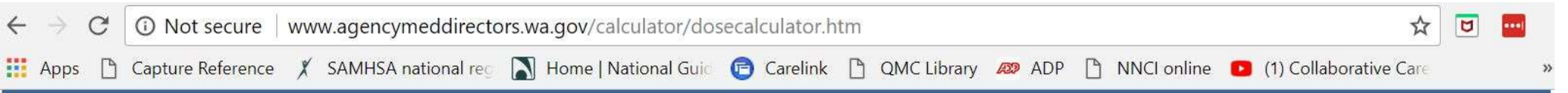
- Choose immediate-release over extended-release formulations
  - Higher overdose risk on ER/LA formulations
  - No evidence of benefit of scheduled vs. intermittent use
  - ER/LA should only be used for opioid tolerant patients
  - ER/LA for “daily, around-the-clock, long-term treatment”

Dosage

- Prescribe lowest effective dosage
  - No evidence of improved benefit at higher doses, but good evidence of increased dose-dependent risks
- Reevaluate when ≥50 MME/ day
- Avoid ≥ 90 MME/ day
  - ≥100 MME/ day with overdose OR 2-8.9 times the risk at 1-20 MME/ day
- Caution with vulnerable populations



Dosage in MME



Opioid Dose Calculator

← Back to AMDG Home

Instructions: Fill in the mg per day* for whichever opioids your patient is taking. The web page will automatically calculate the total morphine equivalents per day.

Patient's Name:
Today's Date: April 19, 2018

Opioid (oral or transdermal):	mg per day:*	Morphine equivalents:
Codeine		0
Fentanyl transdermal (in mcg/hr)		0
Hydrocodone		0
Hydromorphone		0
Methadone†		0
Morphine		0
Oxycodone	15	22.5
Oxymorphone		0
Tapentadol		0
Tramadol		0
	Total	**22.5**

Duration

- Prescribe lowest effective dose, lowest quantity, for the shortest duration of time
- Long-term use often starts with acute pain
- 3 days or less is typically sufficient
- More than 7 days is rarely needed

Duration

- Reevaluate benefits and harms 1-4 weeks after change
  - If no benefit after 1 month, unlikely to become more beneficial afterwards
- Reevaluate benefits and harms at least every 3 months with continued therapy
  - More than 3 months use substantially increases risk of an opioid use disorder

Assessing Risks and Addressing Harms of Use

Quiz

Which of the following is not a risk factor for harm from opioid use?

A. Obstructive sleep apnea
B. Renal impairment
C. Concurrent benzodiazepine use
D. Gout

Assessing Risk & Addressing Harm

- Assess risk factors and create management plan inc. naloxone when needed
- Higher risk patients
  - Sleep disordered breathing
  - Renal or hepatic impairment
  - Mental health or substance use disorders
  - Pregnant
  - ≥ 65 years old

Assessing Risk & Addressing Harm

- Assess risk factors and create management plan inc. naloxone when needed
- Consider naloxone for those with
  - History of overdose or substance use disorder
  - Concurrent benzodiazepine prescriptions
  - ≥ 50 MME/ day

Assessing Risk & Addressing Harm

- Clinicians should review a patient's substance use history and use a prescription monitoring database when available
  - Check every prescription up to every 3 months
  - In Hawai‘i, more frequently

Assessing Risk & Addressing Harm

- Clinicians should use urine drug testing prior to initiating opioid therapy and consider at least annual testing
  - Checking to ensure that no other substances are being used
  - Checking to ensure that prescribed opioid is being used

Assessing Risk & Addressing Harm

- Clinicians should avoid prescribing concurrent opioid and benzodiazepine therapy whenever possible
  - Cohort study found near 4x risk of overdose death if concurrent benzo use

Assessing Risk & Addressing Harm

- Clinicians should offer or arrange evidence-based treatment, usually medication assisted treatment in combination with behavioral therapies, whenever possible
  - Opioid dependence in primary care settings with pts with chronic pain on opioids 3-26%
  - buprenorphine- naltrexone
  - methadone

Further Training