Prescribing Opioids for Chronic Pain: The CDC Guideline in Practice

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CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
Objectives

- By the end of this module, the participant will be able to:
  - Apply the 2016 CDC Guideline in clinical practice
  - Differentiate clinical situations in which the guideline may or may not be applicable
  - Use CDC resources to provide an informed, systems based approach to prescribing opioids for chronic pain
The Guideline

- Released by Centers for Disease Control and Prevention (CDC) March 2016
- Recommendations for primary care clinicians treating:
  - Adult outpatients with pain > 3 months duration
  - Non-cancer and non-palliative pain management
- Developed through a systematic review
  - Recommendation category (A or B)
  - Evidence Type (1-4)
Rationale

- Pain is a common presenting symptom in clinical practice
- Opioids are commonly prescribed in pain management
- The CDC guideline was developed to:
  - Reduce variation in prescribing opioids for chronic pain
  - Provide a resource for prescriber education
  - Decrease risks for overdose and addiction
CDC Guideline for Prescribing Opioids for Chronic Pain - United States 2016

- Determining When to Initiate or Continue Opioids for Chronic Pain
  - Three recommendations

- Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation
  - Four recommendations

- Assessing Risk and Addressing harm
  - Five recommendations
Section I: Determining When to Initiate or Continue Opioids for Chronic Pain

1. Opioids Are Not First-Line Therapy

2. Establish Goals for Pain and Function

3. Discuss Risks and Benefits
Recommendation 1
Opioids Are Not First-Line Therapy

- Nonpharmacologic and Nonopioid therapy preferred for chronic pain
- Consider opioid therapy if expected benefits for both pain and function outweigh risks to patient
  - Benefits should be specific to diagnosis and clinical context
- If opioids are used, combine with non-opioid therapies
- [CDC Nonopioid Treatments for Chronic Pain](https://www.cdc.gov/pain/)
Recommendation 2
Establish Goals for Pain and Function

- Consider realistic goals before starting therapy
- Function can include psychological, social, and physical goals
- Use PEG Assessment Scale to track outcomes
  - Establish baseline function
  - Consider using a systems approach to assessment
- Only continue therapy if there is meaningful improvement in pain and function
Pain, Enjoyment, General Activity (PEG) Scale

In the past week, what number best describes...

Your **Pain** on average

No pain  
As bad as you can imagine

How pain has interfered with **Enjoyment of life**

Does not interfere  
Completely interferes

How pain has interfered with **General activity**

Does not interfere  
Completely interferes
Recommendation 3
Discuss Risks and Benefits

- Before starting therapy discuss:
  - Explicit and realistic benefits
  - Advise about common effects
    - Nausea, constipation, physical dependence, difficulty stopping
  - Advise about serious adverse effects
    - Overdose and opioid use disorder
  - Discuss reassessment and monitoring
  - Discuss safety concerns
    - Safe storage, Naloxone for high dose opioid prescribing
Case: Arthur Jones

- 63 year old man with chronic bilateral foot pain from diabetic peripheral neuropathy
  - Type 2 diabetes diagnosed at 43 years
  - Hypertension
  - Former tobacco smoker, quit at age 50

- Current medications
  - Lisinopril, metformin, canaglifozin
  - Pregabalin, 100 mg TID

- BMI 30.1; HA1C 7.8%
Case: Arthur Jones

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Requesting stronger medication for pain

- Determining when to initiate (or continue) opioids
  - Not first line therapy
  - Establish goals for pain and function
  - Discuss risks and benefits
Case: Arthur Jones
Determining when to initiate opioids

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Requesting stronger medication for pain

- Not first line therapy
  - Review evidenced based therapies

- Prior therapies
  - Gabapentin
  - Duloxetine
  - Amitriptyline
  - Topical capsacian
Case - Determining when to initiate opioids

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Requesting stronger medication for pain

Establish Goals for Pain and Function

Works as a chef
- **Physical:** 8 – pain has limited activity, particularly walking
- **Social:** 7 – feels more irritable at work
- **Psychological:** 8 – distressed by poor sleep
Case: Arthur Jones

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Requesting stronger medication for pain

Discuss risks and benefits of opioid therapy
- Limitations of medications
- Common side effects
  - Nausea, Constipation, Tolerance
- Serious risks
  - Overdose, Opioid use disorder

Discuss your approach to monitoring for safety
Section II: Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. Use Immediate-Release Opioids When Starting

5. Use the Lowest Effective Dose

6. Prescribe Short Durations for Acute Pain

7. Evaluate Benefits and Harms Frequently
Recommendation 4
Use Immediate-Release Opioids When Starting

- Start with immediate-release (IR) opioids
- In general, avoid combining IR and ER (extended-release) opioids
- Methadone and transdermal fentanyl should not be used first line, and only prescribed by clinicians familiar with unique risks
Immediate Release Opioids

- Morphine
- Codeine
- Oxycodone
- Hydrocodone
- Hydromorphone
- Tramadol *

Morphine molecular structure
Source: Wikimedia Commons
https://goo.gl/images/6Vgsb5
Recommendation 5
Use the Lowest Effective Dose

- Start with lowest effective dosage
- Increase by smallest practical amount
- Risk for serious harm increases with dosages
- If pain and function do not improve, discuss tapering, discontinuing or other approaches
- Consider consulting a pain specialist for dosages over 90 MME
- Reevaluate patients who are already on high dosages
Immediate Release Opioids:
Starting oral doses

- Morphine: 15 mg q4hr PRN
- Codeine: 15-30 mg q4-6hr PRN
- Oxycodone: 5-10 mg q4-6hr PRN
- Hydromorphone: 2-4 mg q4-6hr PRN
- Hydrocodone/acetaminophen: 5mg hydrocodone q4-6hr PRN
- Tramadol*: 25 mg at first dose, followed by 25-50 mg q4-6hr PRN

* Not a typical opioid, but should be managed like other typical opioids
Recommendation 6
Prescribe Short Durations for Acute Pain

- Acute pain: start with lowest effective doses of immediate-release opioids
- Prescribe no more than needed for acute episode
  - Three days or less often sufficient
  - More than seven days rarely needed
- Physical dependence may occur after a few days
- Avoid ER/LA opioids for acute pain
- Reevaluate patient if treatment needed longer than expected
Recommendation 7
Evaluate Benefits and Harms Frequently

- Evaluate patients within 1-4 weeks of starting opioid therapy for chronic pain
- Reevaluate patients after dose escalation
- Assess patients at least every three months
  - More frequent follow-up if dose > 50 MME
- Taper opioids if:
  - Benefits not sustained
  - High doses without benefit
  - Evidence of risk > benefit or harm
Case: Arthur Jones

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Requesting stronger medication for pain
- Agrees to trial of opioids for pain management

- Use an immediate release opioid
- Use the lowest effective dose
- Prescribe short durations for acute pain
- Evaluate the benefits and harms frequently
Case – Use an immediate release opioid at lowest effective dose

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Requesting stronger medication for pain
- Agrees to trial of opioids for pain management

- Trial of tramadol 50 mg planned
  - 50 mg at bedtime daily
  - 25 mg after work, PRN
- Instructed not to take before driving or during work until after next visit
- Plan return visit in 2 weeks
- Prescribed #30 tablets
Section III: Assessing Risk and Addressing Harms of Opioid Use

8. Use Strategies to Mitigate Risk
9. Review PDMP Data
10. Use Urine Drug Testing
11. Avoid Concurrent Opioid and Benzodiazepine Prescribing
12. Offer Treatment for Opioid Use Disorder
Recommendation 8
Use Strategies to Mitigate Risk

- Evaluate for potential risk before starting opioids
  - Use Checklist for prescribing opioids for chronic pain
- Assess for opioid related harms during therapy
- Incorporate risk mitigation into management plan
  - Consider naloxone for patients with history of overdose, substance used disorder, higher opioid dosages (> 50 MME), or concurrent benzodiazepines
- Caution in sleep-disordered breathing, pregnancy, age > 65 y, anxiety, depression, substance use disorders
Recommendation 9
Review PDMP Data

- Review state prescription drug monitoring program (PDMP) data
  - Know expectations in your state
  - Look for dangerous combinations or other prescribers

- Check before starting opioid therapy and periodically afterwards

- Aberrant behavior is opportunity for intervention, rather than dismissal of patient from practice
**Recommendation 10**

**Use Urine Drug Testing**

- Use urine drug testing before starting opioid therapy for chronic pain
- Consider interval testing based on risk assessment, at least annually: *individualize*
- Understand test characteristics and interpretation for your practice
- Have an intervention plan for unexpected results
  - Discuss with lab, toxicologist, medical review officer
  - Refer for treatment if needed
Recommendation 11 - Avoid Concurrent Opioid and Benzodiazepine Prescribing

- Avoid concurrent opioid and benzodiazepine prescribing whenever possible
  - Increased risk for overdose
- Avoid prescribing opioids and CNS depressants (e.g. muscle relaxants, hypnotics) whenever possible
- Communicate with mental health professionals to coordinate care
Recommendation 12
Offer Treatment for Opioid Use Disorder

- Offer or arrange evidence-based treatment for patients with opioid use disorders (OUD)
  - Refer, rather than dismiss patients from practice
- Assess for OUD using DSM-5 criteria
  - Discuss your concerns with patient
- Consider obtaining waiver to allow you to prescribe buprenorphine treatment
  - Offer treatment with buprenorphine or naltrexone
- Consider referral to an Opioid Treatment Program
Case: Arthur Jones

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Requesting stronger medication for pain
- Trial of tramadol with follow up in 2 weeks

8. Use Strategies to Mitigate Risk
9. Review PDMP Data
10. Use Urine Drug Testing
11. Avoid Concurrent Opioid and Benzodiazepine Prescribing
12. Offer Treatment for Opioid Use Disorder
Case: Arthur Jones

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Tried tramadol, 25 mg on four occasions; experienced severe nausea and dizziness with each dose

Use Strategies to Mitigate Risk

- Any changes in health status?
- Any harms or adverse events?
Case: Arthur Jones

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Tried tramadol, 25 mg on four occasions; experienced severe nausea and dizziness with each dose

- Use Strategies to Mitigate Risk
- Review PDMP Data
- Use Urine Drug Testing
- Avoid Concurrent Opioid and Benzodiazepine Prescribing
- Offer Treatment for Opioid Use Disorder
Case – Review of PDMP and Testing

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Tried tramadol, 25 mg on four occasions; experienced severe nausea and dizziness with each dose

- PDMP shows no other sources of controlled substances
- Urine drug testing shows tramadol and no other non-prescribed drugs
- Plan for trial of hydrocodone, 5 mg at bedtime and after work, PRN, #15 with 2 week f/u
Case: Arthur Jones, 6 months later

- 63 year old man with chronic pain from diabetic peripheral neuropathy
- Pregabalin, 100 mg TID
- Hydrocodone has improved sleep, work and physical activity
- Taking hydrocodone 7.5 mg BID and 10 mg at bedtime

- Use CDC Checklist
- Reassess PEG: 5 in each domain
- Evaluate for harm and misuse
- Check PDMP
- Calculate MME (morphine milligram equivalent) = 25 mg
- Continue regular follow-up
Section 3: Assessing Risk and Addressing Harms of Opioid Use

8. Use Strategies to Mitigate Risk

9. Review PDMP Data

10. Use Urine Drug Testing

11. Avoid Concurrent Opioid and Benzodiazepine Prescribing

12. Offer Treatment for Opioid Use Disorder
Offer Treatment for Opioid Use Disorder

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- Assess for OUD using DSM-5 criteria
  - Discuss your concerns with patient
- Consider obtaining waiver to allow you to prescribe buprenorphine treatment
  - Offer treatment with buprenorphine or naltrexone
- Consider referral to an Opioid Treatment Program
Referral to Treatment

- **SAMHSA Behavioral Health Treatment Services Locator**

  https://findtreatment.samhsa.gov/
Putting it all together

- Treating chronic pain is common in primary care
  - Most chronic pain does not require opioids
  - When opioids are required, following the guideline will help reduce the risks of therapy

- A practice-wide, systems-based approach can improve satisfaction for patients, practitioners, and office staff in managing patients prescribed opioids for chronic pain
Additional Resources from the CDC

- Materials for Patients
  - https://www.cdc.gov/drugoverdose/patients/materials.html

- Information for Providers
  - https://www.cdc.gov/drugoverdose/providers/index.html

- Additional Provider Training Resources
  - https://www.cdc.gov/drugoverdose/training/index.html

The overarching goal of PCSS is to train a diverse range of healthcare professionals in the safe and effective prescribing of opioid medications for the treatment of pain, as well as the treatment of substance use disorders, particularly opioid use disorders, with medication assisted treatments.