ECHO IDAHO:
Opioids, Pain & Substance Use Disorders

CDC Guidelines on Prescribing Opioids

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Disclosures

None

Learning Objectives

- Chronic pain management tenets
- Review opioid treatment data
- Outline CDC prescribing guidelines
- Review applicability of guidelines

Chronic Pain

Up to 30% of people worldwide

Unlike acute pain, which carries survival value, chronic pain might be best considered to be a disease, with treatment and psychological implications.

Many experts consider pain classification as a continuum of nociceptive, neuropathic, and nociplastic.

Biopsychosocial model of pain presents physical symptoms as the culmination of a dynamic interaction between biological, psychological, and social factors

Chronic Pain Treatment

- Factors promoting resilience (emotional support systems and good health) can promote healing and reduce pain chronification.
- Effective pain management can reduce neuroplastic changes.
- Guidelines typically include personalized multimodal approach:
  - Pharmacotherapy
  - Psychotherapy
  - Integrative treatments
  - Invasive procedures

Opioid treatment for Chronic Non-Cancer Pain

- Opioids do not eliminate chronic pain, initial pain relief is around 30% in most studies
- The results of RCT's cannot be generalized because clinical trials do not include CNCP patients with multiple pain complaints, anxiety, depression or other psychiatric comorbidities – the type of patient most likely to be on long-term and high dose opioid therapy
- There is no controlled study that has evaluated long term efficacy for pain and function
- Studies show a high attrition rate over time (typically declining analgesia vs drug related adverse effects)
- Opioid analgesics are not superior to NSAIDs, tricyclic antidepressants or anticonvulsants in reducing pain.

Dunn et al. 2010

- Compared with <20 MME, HR for overdose:
  - 20-<50 MME/d---------- 1.88
  - 50-<100 MME/d---------- 4.63
  - ≥100 MME/d---------- 7.18

Bohnert et al. 2011

- Compared with <20 MME, HR for overdose death:
  - 20-<50 MME/d---------- 1.4
  - 50-<100 MME/d---------- 3.7
  - ≥100 MME/d---------- 8.9

The 2022 Clinical Practice Guideline is intended to help clinicians:

- Improve communication with patients about the benefits and risks
- Improve the safety and effectiveness of pain treatment
- Mitigate pain
- Improve function and quality of life
- Reduce risks (opioid use disorder, overdose, death)

The practice guideline

IS NOT applicable to:

- Sickle cell disease
- Cancer-related pain
- Palliative care
- End-of-life care

IS NOT focused on opioids prescribed for opioid use disorder.

4 categories

12 recommendations

Category 1

Determine whether to initiate opioids for chronic pain

Category 1: Determine whether to initiate opioids for chronic pain

Recommendation 1: Acute pain

- Nonopioid therapies are at least as effective as opioids for acute pain.
- Maximize use of nonpharmacologic and nonopioid pharmacologic therapies first
- Before prescribing, discuss the benefits and risks.

Category 1: Determine whether to initiate opioids for chronic pain

Recommendation 2: Chronic pain

- Maximize nonpharmacologic and nonopioid pharmacologic therapies first and only consider opioid therapy if expected benefits for pain and function outweigh risks to the patient.
- Discuss benefits and risks.
- Work with patients to establish treatment goals for pain and function, and plan how opioid therapy will be discontinued if benefits do not outweigh risks.

Category 2

Selecting Opioids and Determining Opioid Dosages

Recommendation 3

- Prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids.

Category 2: Selecting Opioids and Determining Opioid Dosages

Recommendation 4

- Use the lowest effective dosage.
- Evaluate benefits vs risks when considering increasing dose

Recommendation 5: Patients already on opioids (legacy patients)

- When considering opioid dosage:
  - If *benefits outweigh risks*, optimize nonopioid therapies while continuing opioid therapy.
  - If *benefits do not outweigh risks*, optimize other therapies and appropriately taper and discontinue opioids.
- Opioid therapy should not be discontinued abruptly.

Category 3:

Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up

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Recommendation 6: Acute pain

- Prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

Category 3: Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up

Recommendation 7: Subacute/chronic pain

- Evaluate benefits and risks with patients within 1–4 weeks of starting opioids or increasing dose
- Regularly reevaluate benefits and risks of continued opioid therapy with patients.

Category 4:

Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation 8

- Before starting and throughout duration of opioid therapy, evaluate risk for opioid-related harms and discuss with patients.
  - Risk tools (DIRE, ORT)
  - Ask patients about drug, alcohol and other substance use
  - Screen and assess mental health
- Naloxone

Category 4: Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation 9

- Review state prescription drug monitoring program (PDMP) data

Recommendation 10

- Consider toxicology testing to assess for prescribed medications and other substances

Recommendation 11

- Use caution when prescribing opioids and benzodiazepines (or other CNS depressants) concurrently
  - Consider whether benefits outweigh risks
  - Consider dose schedule

Recommendation 12

- Offer treatment for patients with opioid use disorder.
- Detoxification on its own **is not recommended** for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.

Opioid prescribing for CNCP:

- Optimize non-opioid treatments
- Identify conditions in which to avoid opioids
- Evaluate for opioid risk
  - Patient risk factors
  - Risk tools
  - PDMP
  - Compliance history
  - Concurrent medications

Risk Tools

- **ORT**: A score of 3 or below suggests a low risk for future opioid abuse, while a score of 4 to 7 indicates moderate risk. A score of 8 or greater suggests a high risk of future abusive drug-related behavior.
- Webster et al: For those patients with a risk category of low, 17 out of 18 (94.4%) did not display an aberrant behavior. For those patients with a risk category of high, 40 out of 44 (90.9%) did display an aberrant behavior.
- **ORT-r**: takes out the gender differences, superior in predicting the development of OUD in patients with CNMP on long-term opioid therapy

Opioid prescribing for CNCP:

- Review risks, side effects
- Toxicology testing
- Outline goals and expected benefits (baseline function scale)
- Use lowest effective dose of short acting medication
- Follow up within 1 month of initiation or change
- Plan for tapering if not effective in meeting goals

Opioid prescribing for CNCP:

- For new patients on chronic opioids
  - Follow same guidelines if continuing
  - Don’t continue risky regimens to “tie-over” to a pain clinic
  - Taper slowly if tapering, consider opioid replacement

Take home points for prescribing clinicians

Get used to having discussion regarding chronic pain and opioids

Use risk tools

Use EMR based check lists

Take home points for non-prescribing professionals

Chronic pain is not effectively treated with opioids

References

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