An Update on Pain Medication Guidelines

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Disclosures/Conflicts of Interest

• None
About the Speaker

Family
Food
Morel hunting
Frisbee (Ultimate)
Basketball
Overview

- Review of CDC controlled substance guidelines
  - 12 recommendations (majority of time)
- Changes since the last update
- Questions?
Why?
Background on CDC report 2016

<table>
<thead>
<tr>
<th>Increase in</th>
<th>Increase in</th>
<th>Need</th>
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</thead>
<tbody>
<tr>
<td>Fourfold increase in opioid prescription 1999-2010</td>
<td>Fourfold increase in opioid related deaths</td>
<td>Need for national guideline on pain management</td>
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<tr>
<td></td>
<td></td>
<td>• Improve appropriate opioid prescribing</td>
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<td></td>
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<td>• Minimize opioid-related risks</td>
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Aftermath: Good and Bad

- Decline in opioid prescriptions (most significantly high-dose)
- Temporary increase in non-opioid medications
- About half of states limited initial opioid prescriptions for acute pain to a ≤7-day supply
- Rigid application of MME thresholds
- Extension to other groups (i.e. cancer and palliative care)
- Duration limits by insurers
- Rapid tapers, discontinuation and patient abandonment
2022 Update Includes

• New evidence:
  • Benefits and risks of prescription opioids for both acute and chronic pain
  • Comparisons with non-opioid pain treatments
  • Dosing strategies
  • Opioid dose-dependent effects
  • Risk mitigation strategies
  • Opioid tapering and discontinuation
Uses

• Acute (<1 month), Subacute (1-3 months), and Chronic
• Age 18+
• Improve communication with patients
• Improve effectiveness and safety
• Not to be applied to sickle cell disease, cancer of palliative/end-of-life care
• Not an inflexible standard
Four Principles, Twelve Recommendations

1. Determining whether or not to initiate opioids for pain (1,2)
2. Selecting opioids and determining opioid dosages (3,4,5)
3. Deciding duration of initial opioid prescription and conducting follow-up (6,7)
4. Assessing risk and addressing potential harms of opioid use (8,9,10,11,12)
Determining whether or not to initiate opioids for pain
Recommendation 1

- Nonopioid therapies are at least as effective as opioids for **acute** pain.
- **Maximize** nonpharmacologic and nonopioid therapy first.
- Before prescribing opioid therapy for acute pain, clinicians should **discuss** with patients the realistic **benefits** and known **risks** of opioid therapy.
Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain

The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH\textsuperscript{1,2}; Amy Gravely, MA\textsuperscript{1}; Sean Nugent, BA\textsuperscript{1}; et al

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<table>
<thead>
<tr>
<th>Nonopioid Medications</th>
<th>Nonpharmacologic Treatments</th>
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<tbody>
<tr>
<td>Acetaminophen</td>
<td>Hot/cold compress</td>
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<tr>
<td>NSAID’s (oral or topical)</td>
<td>Stretching</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>Exercise</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>TENS</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>Spinal manipulation</td>
</tr>
<tr>
<td>Muscle relaxants</td>
<td>Acupressure</td>
</tr>
<tr>
<td>Oral steroid (limited use)</td>
<td>Acupuncture (including BFA)</td>
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<tr>
<td>Local anesthetic</td>
<td>Mindfulness techniques</td>
</tr>
<tr>
<td>Topical anesthetic</td>
<td>Dry Needling</td>
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<tr>
<td>Topical Capsaicin (decrease substance P)</td>
<td>Trigger point injections</td>
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<tr>
<td></td>
<td>Interventional pain medicine techniques</td>
</tr>
<tr>
<td></td>
<td>Regenerative medicine (PRP, Prolo, BMAC)</td>
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</tbody>
</table>
Noninvasive Nonpharmacologic Approaches to Acute Pain

Noninvasive nonpharmacologic approaches to acute pain have the potential to improve pain and function without risk for serious harms (10). Clinical evidence reviews found that some nonpharmacologic treatments were likely effective for acute pain, such as heat therapy for acute low back pain; several others might be effective for specific acute pain conditions, such as spinal manipulation for acute back pain with radiculopathy, a cervical collar or exercise for acute neck pain with radiculopathy, acupressure for acute musculoskeletal pain, massage for postoperative pain (10), and remote electrical neuromodulation for acute pain related to episodic migraine (11).
Recommendation 2

• Nonopioid therapies are preferred for subacute and chronic pain

• Only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks

• Clinicians should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.
Selecting opioids and determining opioid dosages
Recommendation 3

• When **starting** opioids, clinicians should prescribe immediate-release opioids (tramadol, morphine, hydrocodone, oxycodone etc.) instead of extended-release and long-acting opioids (morphine ER, methadone, transdermal fentanyl etc.)
• In opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage.

• If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients.
Recommendation 4 (continued)

- The lowest starting dose for opioid-naïve patients is often equivalent to a single dose of approximately 5–10 MME or a daily dosage of 20–30 MME/day.

### Table. Morphine milligram equivalent doses for commonly prescribed opioids for pain management

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Conversion factor*</th>
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<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td>2.4</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1.0</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>5.0</td>
</tr>
<tr>
<td>Methadone</td>
<td>4.7</td>
</tr>
<tr>
<td>Morphine</td>
<td>1.0</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3.0</td>
</tr>
<tr>
<td>Tapentadol†</td>
<td>0.4</td>
</tr>
<tr>
<td>Tramadol§</td>
<td>0.2</td>
</tr>
</tbody>
</table>
• For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage.
  • If benefits outweigh risks of continued opioid therapy, optimize nonopioid therapies while continuing opioid therapy.
  • If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages.

• Unless there are indications of a life-threatening issues such as warning signs of impending overdose opioid, therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.
Recommendation 5 (continued)

• Unless there are indications of life-threatening issues such as warning signs of impending overdose opioid, therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.
Deciding duration of initial opioid prescription and conducting follow-up
Recommendation 6

- When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
  
  - Consider 1-140 MME total for first dose
Recommendation 7

• Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation.

• Clinicians should regularly reevaluate benefits and risks of continued opioid therapy with patients.
Assessing risk and addressing potential harms of opioid use
Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients.

Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.
Recommendation 8 (continued)

• Ask patients about their drug and alcohol use and use validated tools or consult with behavioral specialists to screen for and assess mental health and substance use disorders.
When prescribing initial opioid therapy and periodically during opioid therapy for chronic pain, clinicians should **review the patient’s history of controlled substance prescriptions** using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose.
• When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances.
Recommendation 11

• Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently.
• Consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.
• Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder.

• Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.

• FDA approved medications: Buprenorphine, methadone, and naltrexone

• Other medications for withdrawal symptoms such as hydroxyzine and or clonidine
Questions?
References


