# New CDC Opioid Guideline Targets Overprescribing for Chronic Pain

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Nonopioid therapy is the preferred approach for managing chronic pain outside of active cancer, palliative, and end-of-life care, according to a new guideline released today by the Centers for Disease Control and Prevention.

The 12 recommendations included in the guideline center around this principle and two others: using the lowest possible effective dosage when opioids are used, and exercising caution and monitoring patients closely when prescribing opioids.

Specifically, the guideline states that "clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient," and that "treatment should be combined with nonpharmacologic and nonopioid therapy, as appropriate."

The guideline also addresses steps to take before starting or continuing opioid therapy, and drug selection, dosage, duration, follow-up, and discontinuation. Recommendations for assessing risk and addressing harms of opioid use are also included.

The CDC developed the guideline as part of the U.S. government's urgent response to the epidemic of overdose deaths, which has been fueled by a quadrupling of the prescribing and sales of opioids since 1999, according to a CDC press statement. The guideline's purpose is to help prevent opioid misuse and overdose.

"The CDC Guideline for Prescribing Opioids for Chronic Pain, United States, 2016 will help primary care providers ensure the safest and most effective treatment for their patients," according to the statement. The CDC's director, Dr. Tom Frieden, noted that "overprescribing opioids – largely for chronic pain – is a key driver of America's drug-overdose epidemic."

In a CDC teleconference marking the release of the guideline, Dr. Frieden said it has become increasingly clear that opioids "carry substantial risks but only uncertain benefits, especially compared with other treatments for chronic pain.

"Beginning treatment with an opioid is a momentous decision, and it should only be done with full understanding by both the clinician and the patient of the substantial risks and uncertain benefits involved," Dr. Frieden said. He added that he knows of no other medication "that's routinely used for a nonfatal condition [and] that kills patients so frequently.

"With more than 250 million prescriptions written each year, it's so important that doctors understand that any one of those prescriptions could potentially end a patient's life," he cautioned.

A 2015 study showed that 1 of every 550 patients treated with opioids for noncancer pain – and 1 of 32 who received the highest doses (more than 200 morphine milligram equivalents per day) – died within 2.5 years of the first prescription.

Dr. Frieden noted that opioids do have a place when the potential benefits outweigh the potential harms. "But for most patients – the vast majority of patients – the risks will outweigh the benefits," he said.

The opioid epidemic is one of the most pressing public health issues in the United States today, said Sylvia M. Burwell, secretary of the Department of Health & Human Services. A year ago, she announced an HHS initiative to reduce prescription opioid and heroin-related drug overdose, death, and dependence.

"Last year, more Americans died from drug overdoses than car crashes," Ms. Burwell said during the teleconference, noting that families across the nation and from all walks of life have been affected.

Combating the opioid epidemic is a national priority, she said, and the CDC guideline will help in that effort. "We believe this guideline will help health care professionals provide safer and more effective care for patients dealing with chronic pain, and we also believe it will help these providers drive down the rates of opioid use disorder, overdose, and ... death," she said.

The American Medical Association greeted the guideline with cautious support.

"While we are largely supportive of the guidelines, we remain concerned about the evidence base informing some of the recommendations," noted Dr. Patrice A. Harris, chair-elect of the AMA board and chair of the AMA Task Force to Reduce Opioid Abuse, in a statement.

The AMA also cited potential conflicts between the guideline and product labeling and state laws, as well as obstacles such as insurance coverage limits on nonpharmacologic treatments.

"If these guidelines help reduce the deaths resulting from opioids, they will prove to be valuable," Dr. Harris said in the statement. "If they produce unintended consequences, we will need to mitigate them."

Of note, the guideline stresses the right of patients with chronic pain to receive safe and effective pain management, and focuses on giving primary care providers – who account for about half of all opioid prescriptions – a road map for providing such pain management by increasing the use of effective nonopioid and nonpharmacologic therapies.

It was developed through a "rigorous scientific process using the best available scientific evidence, consulting with experts, and listening to comments from the public and partner organizations," according to the CDC statement. The organization "is dedicated to working with partners to improve the evidence base and will refine the recommendations as new research becomes available.

"In conjunction with the release of the guideline, the CDC has provided a checklist for prescribing opioids for chronic pain, and a website with additional tools for implementing the recommendations within the guideline.

# Prescriber's dozen -- The CDC's opioid recommendations

The Centers for Disease Control and Prevention's new opioid prescription guideline includes 12 recommendations. Here they are, modified slightly for style:

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Providers should only consider adding opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks.

2. Before starting opioid therapy for chronic pain, providers should establish treatment goals with all patients, including realistic goals for pain and function. Providers should not initiate opioid therapy without consideration of how therapy will be discontinued if unsuccessful. Providers should continue opioid therapy only if there is clinically meaningful improvement in pain and function.

3. Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy, and patient and provider responsibilities for managing therapy.

4. When starting opioid therapy for chronic pain, providers should prescribe immediate-release opioids instead of extended-release/long-acting opioids.

5. When opioids are started, providers should prescribe the lowest effective dosage. Providers should use caution when prescribing opioids at any dosage, should implement additional precautions when increasing dosage to 50 or more morphine milligram equivalents (MME) per day, and generally should avoid increasing dosage to 90 or more MME per day.

6. When opioids are used for acute pain, providers should prescribe the lowest effective dose of immediate-release opioids. Three or fewer days often will be sufficient.

7. Providers should evaluate the benefits and harms with patients within 1-4 weeks of starting opioid therapy for chronic pain or of dose escalation. They should reevaluate continued therapy's benefits and harms every 3 months or more frequently. If continued therapy's benefits do not outweigh harms, providers should work with patients to reduce dosages or discontinue opioids.

8. During therapy, providers should evaluate risk factors for opioid-related harm. Providers should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose – such as history of overdose, history of substance use disorder, or higher opioid dosage (50 MME or more) – are present.

9. Providers 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 high opioid dosages or dangerous combinations that put him or her at high risk for overdose. Providers should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, providers should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications, as well as other controlled prescription drugs and illicit drugs.

11. Providers should avoid concurrent prescriptions of opioid pain medication and benzodiazepines whenever possible.

12. Providers should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.