Illinois Health and Hospital Association

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New CDC Guidelines on Opioid Use in Treatment of Chronic, Non-Cancer Pain

In March 2016, the Centers for Disease Control and Prevention (CDC) issued guidelines on opioid use to treat chronic, non-cancer pain. Chronic pain not caused by cancer is a prevalent and debilitating medical condition. It is also among the most controversial and complex to manage. The widespread use of the opioid drugs for chronic pain has resulted in a national epidemic of opioid overdose deaths and addiction. The CDC guidelines contain 12 recommendations, summarized below.

Determining When to Initiate or Continue Opioids for Chronic Pain

- Non-pharmacologic therapy or non-opioid therapy is preferred for chronic pain. Approaches include weight loss, physical therapy, NSAIDs, acetaminophen and steroid injections.
- Establish treatment goals with patients that include realistic goals for pain and function. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- Periodically address risks and realistic benefits of opioid therapy in patients with chronic pain. Discuss side effects and risk. Continue opioid therapy only if meaningful improvement in pain and function that outweighs risk to patient safety.

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

- Start therapy with Immediate Release (IR) instead of Extended Release (ER)/Long-Acting (LA) formulations.
- Start with lowest effective dose: Re-evaluate when patent at ≥50 MME/day (MME = Morphine Mg Equivalents). A strong reason and good documentation is needed to get to ≥90 MME/day or higher.
- For acute pain, start with the lowest effective dose of IR: Three days or less is recommended. Seven or more days is rarely needed.
- Review benefits and risks at one to four weeks after use for chronic pain. Revisit benefits and risks every three months. Work to optimize other therapies and taper opioids when possible.

Clinicians and patients who set a plan in advance will clarify expectations regarding how opioids will be prescribed and monitored, as well as situations in which opioids will be discontinued or doses tapered to improve patient safety (e.g., if treatment goals are not met, opioids are no longer needed or adverse events put the patient at risk).

Assessing Risk and Addressing Harms of Opioid Use

- Before starting and during periodic assessment of continuation of opioid therapy:
    - Evaluate for risks of adverse reactions such as sleep apnea, age ≥65, mental health conditions, substance abuse disorder, history of prior non-fatal overdose; and
    - Consider addition of home naloxone for patients at increased risk for harm.
- Regularly review of patient history through the Prescription Drug Monitoring Program, www.ilpmp.org.
- Use urine drug screens (UDS) before starting chronic opioid therapy and consider regular UDS, at least annually.
- Avoid prescribing BZP and opioids concurrently whenever possible.

Treatment for Abuse

- Clinicians should offer or refer patients who develop opioid abuse disorders to evidence-based treatment, such as Medication Assisted Treatment (MAT) in conjunction with behavioral therapy.