WHAT IS NEW IN CHRONIC NON CANCER PAIN CONTROL: THE PROS & CONS OF THE CDC GUIDELINES FOR SAFE OPIOID PRESCRIBING

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OBJECTIVES

• At the end of this presentation, the participant will be:
  • Able to discuss the 12 recommendations of CDC Guidelines for safe Opioid Prescribing in Chronic Noncancer Pain (CNCP)
  • Able to assess the place of the Guidelines in the treatment of CNCP
  • Able to discern the quality of evidence used to develop the Guidelines
  • Able to discuss what the Guidelines ARE & what the Guidelines ARE NOT
• Pain as the 5th vital sign
  • Starting in 2001, the Joint Commission has now officially recognized that pain is a major health problem and "patients have the right to appropriate assessment and management of pain"
SETTING THE STAGE: A BALANCING ACT

- Patient Expectations
  - of being pain free
  - of “magic bullet” medications
  - of unlimited supply of medications
    - opioids
  - of not having to do any work
    - physical therapy
    - behavioral health
  - of no consequences for their decisions
    - “being honest”
SETTING THE STAGE: A BALANCING ACT

• Provider’s realities
  • the incidence of alcoholism and addiction in the general population is 5%-10
  • one addict affects 7-10 people
  • the prevalence of current or past substance use disorders in patients receiving chronic opioids for CNCP may be ~ 40% or higher
  • the principles of chronic medication management are often forgotten when managing opiate medication
    • clash of providers & patient’s values

CDC GUIDELINES

• Primary Care Providers
  • Family medicine, Internal medicine
  • Physicians, nurse practitioners, physician assistants
• Treating patients ≥18 years with chronic pain
  • Pain longer than 3 months or past time of normal tissue healing
• Outpatient settings
• Does not include active cancer treatment, palliative care, and end-of-life care
CDC GUIDELINES: GRADE METHOD

- Standard for guideline development
- Transparent approach for conducting systematic review, rating quality of evidence, and determining strength of recommendations
- Used by > 100 organizations (including Advisory Committee on Immunization Practices)
- Recommendations based on:
  - Quality of evidence
  - Balance between benefits and harms
  - Values and preferences
  - Cost

CDC GUIDELINES: GRADE EVIDENCE TYPES

- Evidence Types:
  - Type 1: Randomized controlled trials (RCTs); overwhelming observational studies
  - Type 2: RCTs (limitations); strong observational
  - Type 3: RCTs (notable limitations); observational
  - Type 4: RCTs (major limitations); observational (notable limitations) clinical experience
CDC GUIDELINES: EVIDENCE SUMMARY

- Effective nonpharmacologic therapies: exercise, cognitive behavioral therapy (CBT), interventional procedures
- Effective nonopioid medications: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), anticonvulsants, antidepressants
- Opioid-related overdose risk is dose-dependent
- Factors that increase risk for harm: pregnancy, older age, mental health disorder, substance use disorder, sleep-disordered breathing
- Providers lack confidence in ability to prescribe safely and are concerned about opioid use disorder
- Patients are ambivalent about risks/benefits and associate opioids with addiction
- Introduction clearly states these are ONLY guidelines

CDC GUIDELINES: CONCEPTUAL FRAMEWORK

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use
DETERMINE WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

- Recommendation #1
  - Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.
  - Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
  - If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

(Recommendation category A: Evidence type: 3)

WHAT DOES THIS MEAN

- There is insufficient evidence to determine the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms, such as overdose, mortality, and possibly fractures and cardiovascular events...

- No therapeutic guideline for any condition that has CNCP endorses opioids as 1st line treatment
DETERMINE WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

• Recommendation #2
  • Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.
  • Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

(Recommendation category A: Evidence type: 4)

WHAT DOES THIS MEAN

• Non opioid medication maximized
• SOAPP R screening test
• Controlled Substance Agreement (CSA)
• Review of PMP report
• Baseline UDM
• Discuss risks and benefits of using controlled substances w/ patient
• Use of Visual Analogue Scales (0-10); *30% = clinically meaningful improvement
• Pause & think
DETERMINE WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

• Recommendation #3
  • Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

(Recommendation category A: Evidence type: 3)

WHAT DOES THIS MEAN

• Realistic expectations
  • never state medications will take ALL of pain away
  • Emphasize increase in function over decrease in pain
• 4 A’s of monitoring therapy
  • analgesia
  • activities of daily living
  • adverse effects
  • aberrant drug-related behaviors
OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

• Recommendation #4
  • When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

(Recommendation category A: Evidence type: 4)

WHAT DOES THIS MEAN

• Start low and go slow
• Start on short acting (SA) opioid
• Reassess in ~ 2 weeks
• Methadone & fentanyl are rarely chosen as medications for opioid naive patients
• LA opioids may be associated with higher risk of respiratory depression
  • what to do w/ patients on LA & SA opioids (?)
• Pause & think
OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

• Recommendation #5
  • When opioids are started, clinicians should prescribe the lowest effective dosage.
  • Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to $\geq 50$ morphine milligram equivalents (MME)/day, and should avoid increasing dosage to $\geq 90$ MME/day or carefully justify a decision to titrate dosage to $\geq 90$ MME/day.

(Recommendation category A: Evidence type: 3)

WHAT DOES THIS MEAN

• Start with lowest effective dosage and increase by the smallest practical amount.
• If total opioid dosage $\geq 50$ MME/day
  • reassess pain, function, and treatment
  • check PMP, urine drug monitoring, evaluate compliance
  • increase frequency of follow-up; and
  • consider offering naloxone.
• Avoid increasing opioid dosages to $\geq 90$ MME/day.
• If escalating dosage requirements
  • discuss other pain therapies with the patient
  • consider working with the patient to taper opioids down or off
  • consider consulting a pain specialist.
WHAT DOES THIS MEAN

• If patient is currently on > 90 MME/Day consider:
  • Offer established patients already taking >90 MME/day the opportunity to re-evaluate their continued use of high opioid dosages in light of recent evidence regarding the association of opioid dosage and overdose risk.
  • For patients who agree to taper opioids to lower dosages, collaborate with the patient on a tapering plan.
  • Offer buprenorphine for pain (?)
  • If patient has been stable and w/o any aberrant behavior, consider no change at all (?)

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

• Recommendation #6
  • Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
  • 3 days or less will often be sufficient; more than 7 days will rarely be needed.

(Recommendation category A: Evidence type: 4)
WHAT DOES THIS MEAN

• Opioids for acute pain
  • Prescribe the lowest effective dose.
  • Prescribe amount to match the expected duration of pain severe enough to require opioids.
  • Often \( \leq 3 \) days and rarely more than \( 7 \) days needed. What does this mean for post-surgical patients(?)
  • Do not prescribe additional opioids “just in case”.
  • Re-evaluate patients with severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly.
  • Do not prescribe ER/LA opioids for acute pain treatment.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

• Recommendation #7
  • Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
  • Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
  • If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

(Recommendation category A: Evidence type: 4)
WHAT DOES THIS MEAN

• Reassessment of opioid regiment
  • within 1-4 weeks of starting long-term therapy or of dosage increase
  • at least every 3 months or more frequently.
  • Goals met?; Benefits > risks?
  • Is medication strong enough?
    ✓ If Not strong enough & Not lasting long enough
    ✓ ↑ dose
    ✓ Does medication last long enough?
    ✓ If Strong enough but Not lasting long enough
    ✓ ↓ dose interval
  • ALWAYS Pause & think
  • Consider adherence

WHAT DOES THIS MEAN

• Or should opioids be decreased or discontinued
  • Work with patients to taper opioids down or off when
    • no sustained clinically meaningful improvement in pain and function
    • opioid dosages ≥ 50 MME/day without evidence of benefit
    • concurrent benzodiazepines that can’t be tapered off
    • patients request dosage reduction or discontinuation
    • patients experience overdose, other serious adverse events, warning signs.
  • Taper slowly enough to minimize opioid withdrawal
    • A decrease of 10% per week is a reasonable starting point
  • Access appropriate expertise for tapering during pregnancy
  • Optimize nonopioid pain management and psychosocial support
ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

• Recommendation #8
  • Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
  • Clinicians 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, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

(Recommendation category A: Evidence type: 4)

WHAT DOES THIS MEAN

• Co-morbid conditions can increase risk of adverse effects of opioid medication
  • moderate or severe sleep-disordered breathing or obstructive sleep apnea
  • depression
  • hypothyroid
  • pregnancy
  • hepatic or renal dysfunction
  • > 65 y/o
ASSESSING RISK AND ADDRESSING HARMs OF OPIOID USE

• Recommendation #9
  • Clinicians should review the patient’s history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose
  • Clinicians 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.

(Recommendation category A: Evidence type: 4)

WHAT DOES THIS MEAN

• If PMP reveals prescriptions from multiple sources, high dosages, or dangerous combinations, or evidence of medication related aberrant behavior, then
  • Discuss safety concerns with patient (and any other prescribers they may have), including increased risk for overdose.
  • For patients receiving high total opioid dosages, consider tapering to a safer dosage, or offering a safer opioid such as buprenorphine, or consider offering naloxone.
WHAT DOES THIS MEAN

• If you suspect evidence of medication related aberrant behavior, or opioid use disorder, then
  • shorter time between visits, w/ less medication dispensed; 2 weeks vs. 4 weeks
  • increased urine drug testing
  • increased monitoring of PMP
  • random pill counts
  • consultation w/ a pain and/or addiction specialist
  • do not “fire” patient

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

• Recommendation #10
  • When prescribing opioids for chronic pain, clinicians 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.

(Recommendation category B; Evidence type: 4)
WHAT DOES THIS MEAN

• Clinician should become familiar with urine drug testing panels, the difference between immunoassay & GC-MS, LC-MS/MS, and how to interpret results.
• Don’t test for substances that wouldn’t affect patient management.
• Before ordering urine drug testing
  • explain to patients that testing is intended to improve their safety
  • explain expected results; and
  • ask patients whether there might be unexpected results.
• Discuss unexpected results with local lab and patients.
• Verify unexpected, unexplained results using specific test.
• Do not dismiss patients from care based on a urine drug test result.

WHAT DOES THIS MEAN: URINE DRUG TESTING

<table>
<thead>
<tr>
<th>Immunoassay Presumptive Screen</th>
<th>GC-MS or LC-MS/MS Definitive Quantitative</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-office, point-of-care, or lab-based IA test</td>
<td>Laboratory test</td>
</tr>
<tr>
<td>Less specific and sensitive</td>
<td>Highly specific and sensitive</td>
</tr>
<tr>
<td>Results within minutes</td>
<td>Results in hours to days</td>
</tr>
<tr>
<td>Detects drug classes and few meds, illicit substances</td>
<td>Measures concentrations of all medications, illicit substances, and metabolites</td>
</tr>
<tr>
<td>Guidance for preliminary treatment decisions</td>
<td>Definitive identification and analysis</td>
</tr>
<tr>
<td>Cross-reactivity common: More false positives</td>
<td>False-positive results rare</td>
</tr>
<tr>
<td>Higher cutoff levels: More false negatives</td>
<td>False-negative results rare</td>
</tr>
</tbody>
</table>
WHAT DOES THIS MEAN: WINDOWS OF DETECTION

<table>
<thead>
<tr>
<th>Drug/Drug Class</th>
<th>Approximate Window of Detection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>3-5 days</td>
</tr>
<tr>
<td>THC*</td>
<td>3-5 days</td>
</tr>
<tr>
<td>Benzodiazepines*</td>
<td>1-3 days</td>
</tr>
<tr>
<td>Opioids*</td>
<td>~3 days</td>
</tr>
<tr>
<td>Cocaine (benzoyleucgonine metabolite)</td>
<td>2-3 days</td>
</tr>
</tbody>
</table>

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

- Recommendation #11
  - Clinicians should avoid prescribing opioid pain medication and benzodiazepines (carisoprodol) concurrently whenever possible.

(Recommendation category A: Evidence type: 3)
WHAT DOES THIS MEAN

- Carisoprodol (Meprobamate)
- Carisoprodol probably potentiates the inhibitory effects of GABA at the GABA-A receptor in the medulla similar to benzodiazepines.
- Benzodiazepines facilitate inhibitory effects of GABA on the respiration at the GABA-A receptor in the medulla.
- “HOLY TRINITY” (DEA) = CARISPRODOL (Soma®) + Benzodiazepine + Opioid → ↑ risk of death drastically!!
- Taper benzodiazepines gradually.
- Offer evidence-based psychotherapies for anxiety.
  - cognitive behavioral therapy
  - specific anti-depressants approved for anxiety
  - other non-benzodiazepine medications approved for anxiety
- Coordinate care with mental health professionals.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

- Clinicians 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 (OUD).

(Recommendation category A; Evidence type: 2)
WHAT DOES THIS MEAN

• If OUD is suspected
• Discuss with your patient and provide an opportunity to disclose concerns.
• Assess for OUD using DSM-5 criteria. If present, offer or arrange MAT.
  • Buprenorphine through an office-based buprenorphine treatment provider or an opioid treatment program specialist
  • Methadone maintenance therapy from an opioid treatment program specialist
  • Oral or long-acting injectable formulations of naltrexone (for highly motivated non-pregnant adults)
• Consider obtaining a waiver to prescribe buprenorphine for OUD (see http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management)

IMPACT OF THE GUIDELINES

• The Guidelines themselves state that they ARE ONLY GUIDELINES
  • however some states have used these Guidelines to enforce opioid prescribing laws
  • insurance companies have restricted limits
  • possible use for monitoring providers
• While the Guidelines are a summary of the best available data, most of the Guidelines are of low quality data; ie: Evidence type 4
• Increase of a “Chilling Effect” on opioid prescribing
EXAMPLE OF HOW TO INTERPRET & IMPLEMENT THE GUIDELINES

• The Centers for Disease Control (CDC) released its CDC Guideline for Prescribing Opioids for Chronic Pain in March of this year. The stated purpose of the Guideline is “to improve communication between primary care clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death.”

• The Council recognizes that the use of long-term opioid therapy for the treatment of chronic non-cancer pain is a balancing act requiring careful consideration to (a) ensure pain patients have access to medications that improve and maintain their quality of life, yet at the same time, (b) address the public safety and health consequences of opioid abuse and misuse.

EXAMPLE OF HOW TO INTERPRET & IMPLEMENT THE GUIDELINES

• The Council supports the CDC Guideline in the context of its stated purpose, recognizing that the levels of recommendation by the CDC are mainly based on expert opinion and the quality of data (types 3 and 4) is rated as limited to little confidence of the effect estimates. The Council supports ongoing research aimed at reducing pain, optimizing function and minimizing adverse effects in patients with pain.

• The Guideline is not intended to override a healthcare provider’s individual judgement, but rather serve to guide skillful and appropriate pain management. The Guideline should not be used by licensing boards to set strict policy or enforce practice standards, and is not to be used by insurance companies to set dose or medication supply limitations.
SUMMARY

- **Pro**
  - Summary of best available data
  - Introduction of Guidelines state that the recommendations are guidelines only
  - Provide guidance on the maximum dose of opioids to prescribe
  - Implementation of the Guidelines may help to decrease opioid OD deaths
  - Can be used as a document to teach providers
  - Provides guidance on safe opioid prescribing

- **Con**
  - Data is of low quality
  - The Guidelines have been used as a basis of legislation for opioid prescribing
  - The maximum recommended dose of opioids in the Guidelines has been implemented as a rigid line
  - States w/ limits on maximum opioid doses do not have lower opioid OD rates
  - May actually decrease thought process when prescribing opioids; ie: 90MME/day is the only point retained
  - Has led to a “Chilling Effect” on opioid prescribing thereby decreasing access to appropriate medication for patients w/ CNCP