# Management of Pain - A Comparison of Current Guidelines

The Centers for Disease Control and Prevention (CDC) released a guideline in 2016 regarding the prescribing of opioids for chronic non-cancer pain (CNCP).[1] Although similar to guidelines from other organizations for CNCP, there are some notable differences that should be recognized.

**Introduction:**

"The CDC Guideline for Prescribing Opioids in Patients with Chronic Pain – United States, 2016" is intended to provide recommendations to primary care providers on safe opioid prescribing practices.[1] The CDC guideline does not provide recommendations for treating pain that is related to palliative care, active cancer, or end-of-life care. It is noted that primary care providers are accountable for about 50% of opioid prescriptions.[2] The CDC stresses the importance of open communication and provider-to-patient education on the risks and benefits of opioids for pain treatment.[1]

The guideline includes 12 recommendations that are grouped into 3 areas for consideration:[1]

A. Determining when to initiate or continue opioids for chronic pain
B. Opioid selection, dosage, duration, follow-up and discontinuation
C. Assessing risk and addressing harms of opioid use

## The 12 recommendations:[1]

### A. Determining when to initiate or continue opioids for chronic pain

1. Non-pharmacologic and non-opioid pharmacologic therapies to modulate pain should be recommended first (before opioids).
2. Treatment goals should be established before initiating opioid therapy for chronic pain.
    - Realistic goals should be established for pain and improvement in function.
    - Goals should address how therapy will be discontinued and if the risks outweigh the benefits.
3. When initiating, and periodically during, opioid therapy, providers should weigh the potential risks versus benefits of opioids and discuss them with the patient.

## B. Opioid selection, dosage, duration, follow-up and discontinuation

4. When starting opioid treatment**,** immediate-release formulations are preferred over extended-release or long-acting formulations.
5. When initiating an opioid, it is important to administer the lowest effective dose and titrate slowly. Patients should be monitored for improvement in pain and function, especially when increasing the dosage to ≥50 morphine milligram equivalents (MME)/day.
    - Dosages ≥90 MME/day should generally be avoided when possible.
        - There should be clear documentation as to the medical necessity if this threshold is exceeded.
6. When treating acute pain, it is important to prescribe the lowest effective dose of immediate-release opioids and not to prescribe opioids for longer than necessary. Three days or less will often be sufficient; >7 days is rarely needed.
    - To reduce overprescribing of opioid medications, initial opioid prescribing for acute pain is limited to 7 days per New York State (NYS) Public Health Law Section 3331, 5. (b), (c).
        - Acute pain is defined as pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the practitioner reasonably expects to last only a short period of time.
7. When initiating opioid therapy, patients should be evaluated within 1 to 4 weeks and the risks versus benefits should be evaluated.
    - For patients utilizing opioids for longer durations, patients should be evaluated every 3 months or more frequently if required.

## C. Assessing risk and addressing harms of opioid use

8. Before initiating and periodically during opioid therapy, patients should be screened for risk factors for opioid-related harms. For patients with a history of drug overdose, history of substance use disorder (e.g., drug and/or alcohol), opioid dosages ≥50 MME/day or concomitant benzodiazepine use, **naloxone should be offered.**
9. Prescribers should review the patient's controlled substance prescription history in the state's Prescription Monitoring Program (PMP).
    - The NYS Internet System for Tracking Over-Prescribing (I-STOP) - PMP should be checked when prescribing a Schedule II, III, or IV controlled substance.
    - For patients requiring longer therapy for chronic pain, the PMP should also be monitored regularly.
    - The PMP provides a history of controlled substance prescriptions dispensed to patients in NYS.
10. For patients utilizing opioids for chronic pain, urine drug screens should be conducted when initiating therapy and then annually at a minimum.
11. Benzodiazepines, when co-prescribed with opioids, increase the possibility of harmful adverse effects, such as respiratory distress and death. Other central nervous system depressants (e.g., muscle relaxants and hypnotics), when used concomitantly with opioids, can potentiate the central nervous system depression and prescribers should consider whether the benefits outweigh the risks when prescribing the 2 agents concurrently.
12. If a patient develops an opioid use disorder, provide the patient with the proper tools to seek treatment.
    - The NYS Office of Alcoholism and Substance Abuse Services (OASAS) operates a toll-free, anonymous and confidential service that offers help to patients with alcoholism, drug abuse and gambling problems.
        - The HOPELINE contact number is 1-877-8-HOPE-NY or text HOPENY.

**Comparison of Selected Opioid Guidelines:**

After reviewing various guidelines[3-8] for treating CNCP, it was found that there are several similarities compared to the CDC recommendations. Guidelines were issued by the following organizations:

- American Academy of Neurology (AAN 2014[3])
- American College of Occupational and Environmental Medicine (ACOEM 2014[4])
- American Pain Society (APS 2009[5])
- American Society of Interventional Pain Physicians (ASIPP 2017[6])
- Veterans Affairs/Department of Defense (VA/DoD 2017[7])
- Washington State Agency Medical Directors' Group (WA State AMDG 2015[8])

The CDC and the organizations listed above agree that:[1,3-8]

**Non-pharmacologic and non-opioid pharmacologic treatments should be considered before initiating opioid therapy for pain management. Patients should also be assessed for risks versus benefits of opioid treatment before initiating opioids. During treatment, pain and functionality should be assessed in comparison to baseline.**

While there are similarities among the guidelines, the CDC makes some recommendations that differ from these other organizations.[1,3-8] Table 1 highlights some of these differences.

Table 1. Guideline recommendations on opioid use for CNCP.

| Potential issues in opioid prescribing | AAN 2014[3] | ACOEM 2014[4] | APS 2009[5] | ASIPP 2017[6] | CDC 2016[1] | VA/DoD 2017[7] | WA State Agency Medical Directors' Group 2015[8] |
|---|---|---|---|---|---|---|---|
| Indication for opioid treatment | Benefits outweigh risks | Other evidence-based approaches have failed and function is impaired by pain | Pain is negatively affecting function or quality of life and benefits outweigh risks | Medical necessity established. Non-opioid and non-pharmacological therapies failed | Expected benefit outweighs risk for both pain and function improvement | Failure to respond to self-management strategies, other non-pharmacological therapy, and non-opioid therapies | Non-opioid and non-pharmacologic therapies have failed and no relative contraindications |
| Highest recommended dose (MME per day) | 80-120 | 50 | Not addressed | 91 | 90 | 90 | 120 |
| Initial opioid treatment | Not addressed | Lowest effective dose | Individualized to the patient's health status, prior opioid use, and therapeutic goals | Low dose, short-acting | Short-acting | Lowest dose of opioids as indicated by patient-specific risks and benefits | Short-acting, low dose |
| Initial duration of therapy | Not addressed | Up to 4 weeks, for acute pain | Several weeks to several months, for chronic pain | Evaluation of the stratification of risk for misuse and abuse, knowledge of opioid and titration during an 8- to 12-week period | 3 days or less, for acute pain | For acute pain use a short-acting opioid and reassess therapy in 3-5 days<br><br>For opioid therapy, 1 week for initial prescription; no more than 3 months total | Shortest duration for acute pain. Usually less than 14 days |
| Evaluation of pain therapy | At every visit; frequency not specified | Weekly follow-ups. Every 3-6 months during maintenance therapy | Periodically | Regular follow-up visits; frequency not specified | Initially, after 1-4 weeks; then, at least every 3 months after | Follow-up frequently based on patient risk factors (e.g., 1-4 weeks with any dose change; up to every 3 months without dose change if clinically and functionally stable) | Every 6 months for low-risk patients. Every 3 months for moderate risk. Every month for high-risk patients[a] |

| Potential issues in opioid prescribing | AAN 2014[3] | ACOEM 2014[4] | APS 2009[5] | ASIPP 2017[6] | CDC 2016[1] | VA/DoD 2017[7] | WA State Agency Medical Directors' Group 2015[8] |
|---|---|---|---|---|---|---|---|
| Opioid rotation/ tapering[b] | Not addressed | MME should be 50% of previous dose | 25-50% reduction in MME | Not addressed | Not addressed | 5-20% dose reduction every 4 weeks to allow time for neurobiological, psychological, and behavioral changes | Not addressed |
| Treatment goals | 20-30% improvement in pain and function (test not specified) | Improvement in function and pain | Not addressed | 30% improvement in pain or functional status without adverse consequences | 30% improvement on PEG test | Utilize a patient-centered approach and set goals for improvement in function and pain that are tailored to the patient's capabilities, needs, prior treatment experience, and preferences | Improvement in function and pain from baseline |
| Characteristics of patients at high risk for opioid abuse/misuse | Severe depression or anxiety, history of substance abuse, concomitant sedative or benzodiazepine | Psychiatric disorders (several listed, including depression, anxiety, personality disorder), benzodiazepine or alcohol use, sleep disorders | Psychiatric conditions, history of drug or alcohol abuse, younger age, repeated dose escalation | Widespread pain without objective signs and symptoms involving ≥3 regions of the body, unwilling to try multimodal therapy, psychiatric disorders, high levels of pain exacerbation and lack of coping strategies, history of SUD, <45 years of age, HIV-related pain, not functioning close to a near normal lifestyle | Mental health disorders (depression, anxiety), history of overdose, concurrent benzodiazepine use, higher opioid dosages (>50 MME/day) | Risk of suicide, active or history of SUD, unstable mental health disorders, medical conditions that acutely increase opioid risks (e.g., compromised or worsening of cognitive or cardiopulmonary status), recent overdose, current sedation, or recent motor vehicle accident | Mental health disorders (PTSD, depression), history of SUD, concurrent benzodiazepine or sedative use |

| Potential issues in opioid prescribing | AAN 2014[3] | ACOEM 2014[4] | APS 2009[5] | ASIPP 2017[6] | CDC 2016[1] | VA/DoD 2017[7] | WA State Agency Medical Directors' Group 2015[8] |
|---|---|---|---|---|---|---|---|
| Management of patients at high risk for overdose | Not addressed | Not addressed | Not addressed | Adherence monitoring by UDT and PMP | Naloxone recommended | Overdose education and naloxone distribution, UDT, PMP, and face-to-face follow-up with frequency determined by risks | Overdose prevention brochure provided |
| Monitoring the PMP[c] | Check initially, then periodically | Not addressed | Not addressed | Check initially, then monitor regularly | Check initially, then periodically | At least quarterly | Check at least annually for low-risk patients; biannually for moderate-risk; tri-annually/quarterly for high-risk[a] |

AAN=American Academy of Neurology; ACOEM=American College of Occupational and Environmental Medicine; APS=American Pain Society; ASIPP=American Society of Interventional Pain Physicians; CDC=Centers for Disease Control and Prevention; MME=morphine milligram equivalents; PEG=Pain average, interference with Enjoyment of life, and interference with General activity; PMP=Prescription Monitoring Program; PTSD=post-traumatic stress disorder; SUD= substance use disorder; UDT=urine drug test; VA/DoD=Veterans Affairs/Department of Defense; WA=Washington

[a]Risk is for adverse outcomes of therapy. Risk factors may include history of alcohol or substance use disorder, advanced age, or renal or hepatic dysfunction.

[b]Opioid rotation refers to a switch from 1 opioid to another. This is an option if the patient develops intolerable adverse effects to an opioid or if an opioid does not provide adequate therapeutic effect. When switching, dose reduction is recommended due to incomplete cross-tolerance between opioids.

[c]Disclaimer: guidelines may have been published prior to PMP (i.e., I-STOP) availability in NYS.

**Review of NYSMPEP CNCP Key Messages**

**Key Message 1:**

- CNCP is commonly defined as pain that persists for 3-6 months or longer, or beyond the period of expected healing.
- Treatment goal: improvement of pain and functional status.
- First-line treatment for CNCP should include a combination of non-pharmacologic and non-opioid analgesic pharmacologic therapies.

**Key Message 2:**

- Patients with CNCP who continue to experience moderate-to-severe pain despite an adequate trial of non-pharmacologic and non-opioid therapies should be evaluated to determine if a SHORT-TERM trial of a Short-Acting Opioid (SAO) would be appropriate.
- Prescriptions for a trial of SAO should be written for the shortest time possible; *7-day trial per New York State Public Health Law Section 3331, 5. (b), (c)*.
- Patients started on opioids should be reevaluated every 1-4 weeks. A baseline risk assessment for potential opioid misuse should be performed when patients start opioid therapy and then periodically thereafter.

**Key Message 3:**

- Long-Acting Opioids (LAO) should NOT be used for:
  - Treatment of acute pain
  - On an as-needed basis
  - Initiation of opioid therapy for CNCP
- Patients with CNCP should NEVER be on more than 1 LAO at a time.
- When initiating long-term opioid therapy, the total daily Morphine Milligram Equivalent (MME) dose should be calculated and should generally not exceed ≥90 MME/day.

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