

CDC Develops Guideline for Opioid Prescribing

Key Points for Practice

- Chronic pain should be managed primarily with nonpharmacologic therapy or with medications other than opioids.
- Physicians should routinely discuss the risks and benefits of therapy and the mutual responsibility to mitigate risk with patients who are receiving opioids.
- When opioids are prescribed, they should be titrated to the lowest effective dosage.
- Treatment should be offered or arranged for patients with opioid use disorder.

From the AFP Editors

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Opioids have increasingly been offered to patients in an effort to minimize the substantial impact chronic pain has on daily function. The prevalence of chronic pain among adults in the United States is estimated at approximately 11%, with one report suggesting that the percentage of adults who experience daily pain may be as high as 43%. Since 2007, an upward trend in the number of opioid prescriptions written by primary care physicians has been noted, whereas consensus regarding optimal strategies for treating chronic pain with these potentially harmful medications has remained largely absent.

A recently released guideline aims to establish patient-centered approaches to initiating, managing, and discontinuing opioid use. The recommendations from the Centers for Disease Control and Prevention (CDC) emphasize the serious risks and harms associated with opioids. Long-term studies have not provided rigorous evidence on the effects of long-term opioid use in adults with noncancer pain of at least three months' duration.

Recommendations Based on Higher-Quality Evidence

The CDC advises that chronic pain primarily be treated with nonpharmacologic therapy or with medications other than opioids. The recommendation is based on data from

observational studies, as well as randomized clinical trials with notable limitations. Opioids should be considered only if expected benefits are likely to outweigh risks. Nonpharmacologic and nonopioid pharmacologic therapies are recommended as appropriate as part of a regimen to improve pain even if a decision to prescribe opioids has been made.

Because of the adverse effects and risks associated with opioids, patient involvement is critical when initiating or determining whether to continue opioid therapy. Physicians should routinely engage patients who are receiving opioids in discussions about therapy, including its risks and realistic expected benefits, and about the responsibilities of the physician and patient to mitigate risk. These conversations should occur at least every three months.

According to the CDC, which reviewed studies that included one randomized controlled trial with notable limitations, opioids should initially be titrated to the lowest effective dosage. The risks and benefits of dosing with 50 morphine milligram equivalents or greater per day should be carefully evaluated, with avoidance or cautious justification of doses greater than or equal to 90 morphine milligram equivalents per day. Support for prescribing high dosages is lacking, especially because of an increased risk of overdose and known challenges associated with tapering of opioids.

Increased risk of potentially fatal overdose due to reduced respiratory function has also been reported in patients who use opioids in conjunction with benzodiazepines. This class of medications should be avoided in nearly all patients receiving opioid therapy.

In addition to potentially fatal overdose, hazardous outcomes associated with opioid use include physical and psychological dependence and tolerance. Randomized clinical trials and observational studies support the treatment of opioid use disorder.

Buprenorphine, methadone, and behavioral therapies have been proven effective in reducing opioid misuse and preventing relapse. Physicians may need to obtain certification or a waiver, if applicable, to administer buprenorphine. If an opioid use disorder is suspected, concerns should be discussed and a diagnosis can be made using the criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition. Asking persons with substance use disorder or suspected substance use disorder to leave their physician's practice may be perceived as abandonment and jeopardizes patient safety.

Additional Recommendations

Using evidence gathered via clinical expertise, observational studies with important limitations, or randomized clinical trials with several major limitations, the CDC has concluded that treatment goals should be clearly outlined before initial therapy with opioids begins. Standards for determining when to discontinue opioids are also necessary; patient safety should never be compromised in pursuit of improved pain and function. Goals should be reestablished in patients who are seeking care from a new physician but are already receiving opioids. Assessing all patients for psychological comorbidities that may diminish the effects of pain relief is necessary for ensuring optimal treatment.

Whether a patient's pain requires acute or long-term care, immediate-release opioids are a safer option than extended-release/long-acting opioids. The latter are more prone to abuse and have been relabeled by the U.S. Food and Drug Administration for use in severe, long-term cases when other options, including immediate-release opioids, are ineffective or not tolerated after a one-week trial. Opioids are hazardous in any amount—even in the typical three-day regimen that is sufficient for most cases of acute pain—and initial dosages should always be prescribed at the lowest effective level. Long-term opioid use may originate from a brief period of use for an acute condition.

Patients should be required to return for follow-up evaluation within one to four weeks of receiving an initial prescription for opioids or a prescription to titrate their previously established dosage. An assessment of the harms and benefits of therapy is recommended at least every three months. When the harms of opioid use outweigh the benefits, physicians may consider tapering or

discontinuing therapy and pursuing preferred nonopioid interventions for pain management instead. Individual risk factors for opioid overdose should be evaluated on an ongoing basis; the presence of certain risk factors may indicate a need to offer a patient naloxone to prevent fatality resulting from an overdose.

Most states have prescription drug monitoring programs to maintain information on the amount and types of controlled substances a patient has received. When available, individual records should be reviewed by physicians before starting patients on opioid therapy, and patients' records should be rechecked throughout the course of therapy as part of routine follow-up practices. Prescription drug monitoring programs may be incomplete or inaccessible depending on state law; however, search results may prompt action that directly enhances patient safety.

The CDC has deemed its recommendations, including all of the above, appropriate for most adult patients across evidence categories. Although limited evidence also supports the role of urine drug testing to screen for unreported use of illicit drugs or the use of medications that may be contraindicated with opioids, the CDC proposes that physicians determine when and for whom urine testing is appropriate on an individual basis. Urine drug testing may present a burden for patients and physicians because of the cost and time involved in ordering the tests and interpreting the results. If a physician views urine drug testing as a necessary element in the management of opioid therapy, experts contend that a reasonable approach includes screening prior to initiating therapy and once per year thereafter.

Guideline source: Centers for Disease Control and Prevention

Evidence rating system used? Yes

Literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? No

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Available at: http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?s_cid=rr6501e1_w

This guideline was reviewed by the AAFP and received an Affirmation of Value: <http://www.aafp.org/patient-care/clinical-recommendations/all/opioid-prescribing.html>

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