

Editorials

Prescribing Opioids for Chronic Pain: Unintended Consequences of the 2016 CDC Guideline

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See related Practice Guideline at <https://www.aafp.org/afp/2016/0615/p1042.html>.

In 2016, the Centers for Disease Control and Prevention (CDC) released a clinical practice guideline to help guide the use of opioid pain relievers for chronic noncancer pain.¹ The guideline was structured around a series of 12 recommendations based on evidence and expert consensus; one recommendation focused on the treatment of acute pain because chronic pain often starts with the treatment of acute pain. The American Academy of Family Physicians (AAFP) reviewed the guideline and assigned it an affirmation of value, meaning that it provides useful information but does not meet the criteria for full endorsement. One of the concerns raised by the AAFP was that the guideline’s strong clinical recommendations were based on limited or insufficient evidence.²

Since the CDC guideline was released, there has been a significant reduction in opioid prescribing, and the guideline has been adopted by state Medicaid agencies, insurers, and others.^{3,4} Widespread implementation of the guideline has had unintended consequences that have negatively affected clinicians and patients. Rigid application of the 90-morphine milligram equivalent (MME) prescribing limit and policies that limit the duration of opioid therapy or that require abrupt tapering or discontinuation of opioid therapy⁵ have resulted in limited access to opioids for postsurgical patients and patients who have cancer. It has also resulted in physicians’ offices limiting or dismissing patients who are seeking or already receiving these medications. The authors of the CDC guideline recently sought to clarify their intent and limit the negative effects from implementation of the guideline.⁶

Family physicians should recognize that patients transitioning from acute to chronic pain treatment are the primary focus of the guideline. It does not completely address the “legacy” patient who has been on long-term opioid therapy, often in combination with benzodiazepines and hypnotics. The guideline addresses best practices for general pain care, such as patient

assessment, optimizing assessments of risks vs. benefits, using the lowest effective dosage for pain relief and functional improvement, and monitoring patients with periodic drug screens, state prescription drug monitoring programs, and functional assessment tools.

The two recommendations subject to greatest misapplication are the 90-MME prescribing limit and avoidance of the combined use of opioids and benzodiazepines. Although escalation of opioid dosing to more than 90 MME per day should be avoided when possible in patients transitioning to long-term opioid therapy, this does not mean that patients who are already receiving dosages greater than 90 MME must be rapidly tapered or that their opioid therapy should be discontinued. Discontinuation or rapid tapering in patients who depend on opioids for pain control will precipitate opioid withdrawal and may lead patients to turn to illicit drugs that increase their risk of overdose or acquiring bloodborne diseases.

Similarly, the recommendation to limit the combined use of opioids and benzodiazepines does not warrant abruptly discontinuing or rapidly tapering one or both categories of medications. For patients who are already receiving high-dose opioids or opioid-benzodiazepine combinations, physicians should consider the risks vs. benefits of continuing therapy and of maximizing adjunctive nonopioid pharmacologic treatments (e.g., antidepressants, anticonvulsants) and nonpharmacologic treatments (e.g., acupuncture, manipulative therapy). Then via a shared decision-making process, physicians should work with the patient to taper one or both therapies. This will likely take months or years to accomplish, and periodic pauses in the tapering process may be necessary. Resources available to aid clinicians in the opioid tapering process include free online continuing medical education modules (e.g., <https://online.stanford.edu/courses/som-ycme0022-how-taper-patients-chronic-opioid-therapy>), a Curbside Consultation in *American Family Physician*,⁷ and the recently released tapering guide from the U.S. Department of Health and Human Services.⁸

Finally, in implementing the CDC guideline in practice, remember it is just that: a guideline to help you make decisions about patients with chronic pain. Except in cases of diversion or other misuse, abrupt discontinuation or

changes in therapy should be avoided, and you should work with your patient using the tools mentioned above, as well as others you may be using in practice. Patients with chronic pain should never be abandoned while receiving long-term opioid therapy. If you are not able to continue chronic pain care because of relocation or retirement, the patient should be transitioned to another physician, leaving adequate time for the patient to reestablish care based on area resources. Above all, do no harm, and document your actions and conversations with patients who have chronic pain.

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