This is a corrected version of the department that appeared in print.

Lown Right Care

Reducing Overuse and Underuse

Appropriate Use of Opioids for Chronic Pain

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Case Scenario

Mrs. H is a 76-year-old woman with hypertension and type 2 diabetes mellitus complicated by stable chronic kidney disease. Mrs. H also has a degenerative joint disease of the knees and walks with a cane. Her mobility and quality of life are significantly limited by knee pain. Physical therapy, heat, acupuncture, and steroid injections have provided insufficient relief. Nonsteroidal anti-inflammatory drugs (NSAIDs) were discontinued because of kidney disease. Several years ago, Mrs. H's family physician prescribed 5 mg of oxycodone every six hours as needed, and a standing dose of 650 mg of acetaminophen every six hours. This regimen, with range of motion exercises and application of heat, has improved pain and function without adverse effects. Mrs. H takes two to four oxycodone doses per day and has not needed more than the 100 pills prescribed each month. At a recent visit, her physician told her that because of the opioid epidemic and scrutiny by the state medical licensure board, he is no longer comfortable prescribing opioids for her chronic pain. He refers Mrs. H to a pain management specialist. However, when Mrs. H calls several pain specialists' offices, she is told that they no longer accept new patients, only do interventional procedures, or no longer prescribe opioids.

Clinical Commentary

The opioid epidemic in the United States coincided with a steady increase in national opioid prescriptions, peaking in 2012 at more than 255 million, or a rate of 81.3 prescriptions per 100 people.[1] Opioid prescribing declined between 2012 and 2017 to 191 million, or 58.7 prescriptions per 100 people.[1] In 2017, more than 70,000 people died from drug overdoses (47,600 involving opioids), making it the leading cause of injury-related death in people 25 to 64 years of age.[2,3] Contributing causes include aggressive pharmaceutical industry marketing, indiscriminate prescribing by clinicians, pressure from regulatory agencies to control pain and improve patient satisfaction, patient misuse and diversion, and increased use of illicit drugs such as heroin and fentanyl.[4]

Chronic pain is pain that has lasted for longer than three months or the time of normal tissue healing.[5,6] Nonpharmacologic treatment options include physical therapy, manipulative medicine, acupuncture, and cognitive behavior therapy. Pharmacologic approaches include opioid and nonopioid analgesics in addition to adjuvant medications such as anticonvulsants, antidepressants, and muscle relaxants.[7] The use of nonopioid medications is often restricted by limited effectiveness or adverse effects, such as bleeding, strokes, and cardiovascular and renal disease with NSAIDs.[8] Adjuvant medications such as gabapentin (Neurontin) have been used for nonapproved indications (e.g., bone and joint pain) with little evidence of effectiveness.[9] These medications are also associated with numerous adverse effects, drug-drug interactions, and the potential for misuse.[10]

In 2016, the Centers for Disease Control and Prevention (CDC) published guidelines for prescribing opioids for chronic noncancer pain based on an Agency for Healthcare Research and Quality systematic review and expert opinion.[11,12] These guidelines were intended for primary care clinicians, who account for approximately one-half of all opioid prescriptions.[13] The American Academy of Family Physicians gave the guidelines an Affirmation of Value but did not fully endorse them because of the limited or insufficient evidence to support some recommendations.[14]

In response to the CDC guidelines, media attention, and increased regulatory scrutiny, many physicians have stopped prescribing opioids for chronic pain. Abrupt opioid discontinuation has left patients with the inability to function, led to opioid withdrawal or pain crises, and caused some to seek relief from illicit opioids.[15,16] In 2019,

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CME **This clinical content** conforms to AAFP criteria for CME. See CME Quiz on page 333.

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TAKE-HOME MESSAGES FOR RIGHT CARE

- A patient-centered shared decision-making approach is essential for the management of chronic pain.
- Clinicians should use nonpharmacologic approaches and nonopioid analgesics such as acetaminophen and nonsteroidal anti-inflammatory drugs, in addition to adjuvant medications such as anticonvulsants and antidepressants, in patients with chronic pain and continue these treatments if effective.
- When opioids are indicated, assess benefits and harms, prescribe the lowest possible dose, and implement mitigation strategies to decrease the potential for misuse.
- Avoid rapid tapering and arbitrary dose limits for patients already on chronic opioid therapy. A slow tapering of opioids with close monitoring should be discussed when goals of therapy are not achieved or if harms outweigh benefits.

the lead authors of the CDC guidelines clarified that their intention was not to set hard limits on daily opioid doses or cause clinicians to abruptly taper or stop prescribing opioids to patients with chronic pain.[17]

A systematic and commonsense approach to pain management is essential. Appropriate treatment of acute pain, including the use of short-acting opioids when indicated in the lowest possible dose for less than seven days, may decrease the risk of chronic opioid use.[11] The use of nonpharmacologic, nonopioid, and adjunctive medications should be the first-line treatment in a comprehensive approach to chronic pain management.[10] When these therapies are inadequate to relieve pain or improve function, low doses of short-acting opioids may be added.[18] A patient-focused shared decision-making discussion should include careful risk-benefit analysis and establish realistic goals. Opioid harms should be reviewed, and risk mitigation strategies should be implemented, such as the use of prescription drug monitoring programs, periodic urine drug testing, prescribing of naloxone when appropriate, and the avoidance of the coadministration of benzodiazepines when possible.[10,16] Pain, function, and adverse effects should be continuously assessed during the first one to four weeks of opioid therapy, and then at least every three months after.[10]

The CDC recommends reassessing the risk-benefit analysis when the dosage approaches 50 morphine milligram equivalents (MME) per day and to avoid using greater than 90 MME per day. If higher dosages are necessary, close patient oversight and monitoring for increased risks are needed.[17,18] Opioid therapy may be continued if there has been a meaningful improvement in function or pain control. Tapering or discontinuation may be considered if the goals of therapy are not achieved, if the patient requests it, or if risks outweigh the benefits of continued therapy.[19-21] Most patients receiving long-term opioid therapy require a slow taper of approximately 10% each month with close monitoring for worsening pain, deteriorating function, and withdrawal symptoms. Opioids should never be abruptly discontinued except in emergencies (e.g., drug overdose). Medication-assisted treatment is typically necessary only for patients with opioid use disorder and should not be based on the dosage of medication required to treat chronic pain.[19-21]

A National Institutes of Health Pathways to Prevention Workshop consensus statement concluded that "patients, providers, and advocates all agree that there is a subset of patients for whom opioids are an effective treatment method for their chronic pain, and that limiting or denying access to opioids for these patients can be harmful."[22] The judicious use of opioids for acute and chronic pain in conjunction with nonopioid pharmacologic and nonpharmacologic therapy, and with careful monitoring and risk reduction strategies, is a patient-centered care approach.[5,10,18,19,23]

Patient Perspective

We appreciate the call for shared decision-making with patients who are being treated with opioids to control pain. There is excellent patient-oriented information available on the risks and benefits of opioids that is helpful for patients to read before shared decision-making commences.[24] The patient should also be aware of the risk of interactions with other drugs (e.g., benzodiazepines).[25] It is disturbing that a patient's longtime primary care physician would refuse to continue an effective pain regimen and would not feel obligated to verify that another clinician was able to take over the patient's care. In most cases, fear of prescribing opioids has been due to an overly stringent interpretation of CDC guidance. All family physicians should be aware of the CDC's updated advice that these guidelines be interpreted using a patient-centered approach.[17]

Attempts to completely discontinue long-term opioid therapy for chronic pain have sometimes resulted in anguish and desperation, not because of opioid use disorder but because, for some, nothing else seems to work. It is advisable to try other options and to discontinue opioids when possible. However, physicians sometimes fail to emphasize, and patients often are oblivious, to the risks and sometimes questionable effectiveness of nonopioid pain relievers, especially over-the-counter medications. As part of shared decision-making, patients should be made aware of concerns about long-term use of acetaminophen causing liver damage or use of NSAIDs causing cardiovascular, bleeding, or gastrointestinal effects.[26,27] The limited effectiveness and known adverse effects of repurposed drugs such as anticonvulsants and antidepressants should be made clear. The physician should also ensure that the patient has a safe place at home to store medications

that is not accessible to children.[28] As always, one of the most important safety precautions is a complete medication review to check for potential interactions and redundant or unneeded medications.[29]

Resolution of Case

With the help of a friend, Mrs. H was able to find a new primary care physician willing to manage her chronic pain. After performing a thorough physical examination and history, including a review of past treatments and diagnostic testing, the physician determined that the previous pain management regimen was appropriate. They agreed that the benefits of improving her function outweighed the risks, and they would continue to evaluate the option to taper therapy in the future. The new physician educated Mrs. H on the safe use of her opioid medication and the need to continue nonopioid and nonpharmacologic approaches for her pain.

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