Summary: CDC Guidelines for Treating Pain with Opioids

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(Please note that the full document contains a wealth of evidence-based information and guidance regarding opioid prescribing and opioid use disorder (OUD). To read in its entirety, go to http://dx.doi.org/10.15585/mmwr.rr7103a1).

Determining Whether or Not to Initiate Opioids for Pain

Recommendation 1 – Acute Pain

Nonopioid therapies are at least as effective as opioids for many common acute pain conditions, including low back pain, neck pain, pain related to other musculoskeletal injuries (e.g., sprains, strains, tendonitis, bursitis), pain related to minor surgeries, dental pain, kidney stone pain, and headaches including episodic migraine. Clinicians should maximize non-opioid treatments and only consider opioid therapy for acute pain if the benefits are anticipated to outweigh the risks. If opioids are prescribed, use immediate-release opioids at the lowest effective dose taken as needed for no longer than the anticipated duration of the acute pain.

Pharmacologic treatments

Musculoskeletal injuries (e.g., sprains, strains, whiplash) topical NSAIDS provided the greatest benefit-harm ratio, followed by oral NSAIDs or acetaminophen with or without diclofenac.

NSAIDS are more effective than opioids for surgical dental pain and kidney stone pain, and as effective as opioids for low back pain.

Non-pharmacologic treatments likely effective for acute pain include:

Low back pain - heat therapy, massage, acupuncture, spinal manipulation
Acute musculoskeletal injuries – acupressure, transcutaneous electrical neurostimulation
Episodic migraine – remote electrical neuromodulation
Post-operative pain – massage

Recommendation 2 – Subacute and Chronic Pain

Nonopioid therapies are preferred for subacute and chronic pain, and should be maximized before considering opioid therapy. Before starting opioid therapy, clinicians should discuss the realistic benefits and known risks and work with the patient to establish treatment goals and opioid discontinuation plans.

Pharmacologic treatments

Osteoarthritis – NSAIDS (topical and oral), duloxetine
Chronic low back pain – NSAIDS, duloxetine
Neuropathic pain – Tricyclic, tetracyclic, and SNRI antidepressants; selected anticonvulsants; limited evidence for topical lidocaine and capsaicin
Diabetic neuropathy, Postherpetic neuralgia – SNRIs, duloxetine, pregabalin, gabapentin, enacarbil, oxcarbazepine

Fibromyalgia – SNRIs (ep duloxetine, milnacipran), topical NSAIDs, pregabalin, gabapentin; limited evidence for amitriptyline

Non-pharmacologic treatments likely effective for subacute and chronic pain include:
Back pain – exercise therapy, spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, acupuncture
Neck pain – mind-body practices, massage, acupuncture
Hip/knee osteoarthritis – exercise therapy, cognitive behavioral therapy (CBT)
Fibromyalgia – exercise therapy, CBT, myofascial release massage, mindfulness practices, tai chi, qigong, acupuncture
Tension headache – spinal manipulation

Selecting Opioids and Determining Opioid Dosages

Recommendation 3 – Starting Opioid Therapy
When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids, not extended release (ER) or long acting (LA) opioids. ER/LA opioids should be reserved for severe, continuous pain.

Recommendation 4 – Starting Opioid Therapy
When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effect dosage. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients.

The lowest starting dose for opioid naïve patients is often equivalent to a single dose of 5 – 10 MME or a daily dose of 20 – 30 MME/day. Many patients do not experience benefit in pain reduction or improved function from increasing opioid dosages to 50 MME/day or above.

MME equivalency for common opioids (multiply dose by conversion factor for MME):
Codeine – 0.15
Fentanyl transdermal – 2.4
Hydrocodone – 1.0
Hydromorphone – 5.0
Methadone – 4.7
Morphine – 1.0
Oxycodone – 1.5
Oxymorphone – 3.0

Recommendation 5 – Changing Dosage
Clinicians should carefully weigh risks and benefits, and exercise care, when changing opioid dosage. Clinicians should work closely with patients to optimize available non-opioid therapies. If benefits do not outweigh risks of continuing opioid therapy, clinicians should work closely

with patients to gradually taper to a lower dosage. There may be times that opioids should be tapered and discontinued. *Unless there are indication of a life-threatening issue, opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.*

Longer duration of previous opioid therapy might require a longer taper. Tapers can be completed over several months to years and should be individualized based on patient goals and concerns.

Tapers of 10%/month or slower are likely to be better tolerated than more rapid tapers.

Tapers may have to be paused and restarted again when the patient is ready and might have to be slowed as patients reach low dosages.

Clinicians should collaborate with the patient on the tapering plan, including patients in decisions such as how quickly tapering will occur and when pauses in the taper might be warranted.

Clinicians should follow up at least monthly with patients who are tapering.

Clinicians should advise patients of an increased risk of overdose on abrupt return to a higher dose because of loss of tolerance. Opioid overdose education should be provided, and naloxone offered.

At times, clinicians and patients might not be able to agree on whether or not tapering is necessary. Clinicians should acknowledge this discordance, express empathy, and seek to implement treatment changes in a patient-centered manner *while avoiding patient abandonment.*

Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up

Recommendation 6 – Initial Duration for Acute Pain

When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

Patients should be evaluated at least every 2 weeks if they continue to receive opioids for acute pain. If opioids are continued for more than 4 weeks, clinicians should ensure that potentially reversible causes of chronic pain are addressed. Continuation of opioid therapy after 4 weeks should represent an intentional decision that considers the risks and benefits of longer-term opioid therapy.

Recommendation 7 – Follow-Up Frequency for Subacute and Chronic Pain

Clinicians should evaluate benefits and risks with patients within 1-4 weeks of starting opioid therapy or increasing opioid dosage for subacute and chronic pain.

Clinicians should regularly reevaluate with patients the benefits and risks of continued opioid therapy.

Assessing Risk and Addressing Potential harms of Opioid Use

Recommendation 8 – Evaluating and Discussing Risks/Harms

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.

Clinicians should screen for and ensure that mental health conditions are being treated.

Clinicians should ask patients about their (and family) drug and alcohol use.

Patients with a prior opioid overdose have a substantially increased risk of future overdose. This risk increases as MME/day prescribed increases. These patients should be assessed for opioid use disorder.

If opioids are prescribed for a patient with a prior opioid overdose, the increased risk of overdose should be discussed with the patient and strategies to mitigate increased risk should be incorporated into the management plan.

Practices should educate patients (and family) about overdose prevention and naloxone use. Naloxone should be offered.

Clinicians should use additional caution and increased monitoring for patients with renal or hepatic insufficiency and patients 65 and older.

Recommendation 9 – Use of State Prescription Drug Monitoring Programs (PDMPs; CURES in CA)

CURES data should be reviewed prior to initial opioid prescribing and prior to each opioid refill.

PDMP information should be utilized to enhance safety and inform care. Clinicians should not dismiss patients from their practice on the basis of PDMP information.

***PLEASE NOTE – AT THIS TIME, MEDICATIONS RECEIVED THROUGH AN OPIOID TREATMENT PROGRAM (OTP) DO NOT SHOW UP ON PDMPs BECAUSE OF ADDITIONAL PRIVACY PROTECTIONS FOR INDIVIDUALS RECEIVING MAT THROUGH AN OTP. The program, however, can see regulated medications you have prescribed.

Recommendation 10 – Toxicology Testing

Toxicology testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Clinicians should not dismiss patients from care on the basis of a toxicology test result.

Before starting opioids, and periodically (at least annually) during opioid therapy, clinicians should consider benefits and risks of toxicology testing to assess for prescribed opioids and other prescription and non-prescription controlled substances that increase risk of overdose when combined with opioids.

Clinicians should explain to patients in advance that toxicology testing is intended to improve safety and that results will not be used to dismiss patients from care.

On a toxicology test day, clinicians should ask patients in a nonjudgmental manner about use or prescribed and other drugs and whether there might be unexpected results.

Clinicians should be familiar with the drugs covered by their toxicology panel and understand how to interpret the results. Examples: a positive opiate immunoassay detects morphine, which could be from morphine, codeine, or heroin. It does not detect synthetic opioids, and may not detect semi-synthetic opioids. A benzodiazepine immunoassay generally does not detect lorazepam and may or may not detect clonazepam.

In addition, urine creatinine (a result of muscle metabolism) averages 125 mg/dL. People with high muscle mass should have higher urine creatinine, elderly people with lower muscle mass have lower urine creatinine. Water loading, an attempt to dilute drug metabolites to undetectable levels, will lower urine creatinine. Levels less than 20 mg/dL usually indicate tampering. (Loop diuretics can result in lower urine Cr levels, but levels still usually exceed 20 mg/dL.) Levels above 20 mg/dL do not preclude tampering. Urine creatinine less than 5 mg/dL is not within the physiologic capability of the human kidney.

Confirmatory testing, usually in the form of gas chromatography/mass spectrometry, should be used when toxicology results inform major decisions with regard to patient care.

Recommendation 11 – Opioids in Patients Utilizing Benzodiazepines or Other CNS Depressants

Clinicians should use caution when prescribing opioid pain medication and benzodiazepines due to increased risk of significant central nervous system depression.

There are circumstances where it may be appropriate to prescribe opioid pain medication to a patient also prescribed benzodiazepines (e.g., severe acute pain in a patient on long-term, stable low-dose benzodiazepine therapy), caution should be used. In specific situations, benzodiazepines can be beneficial, and stopping them can be destabilizing.

Clinicians should consider whether benefits outweigh risks for concurrent use of opioid with other CNS depressants (e.g., muscle relaxants, nonbenzodiazepine sedative hypnotics, and potentially sedating anticonvulsant medications such as gabapentin and pregabalin).

Buprenorphine and methadone for OUD should not be withheld from patients taking benzodiazepines or other medications that depress the CNS.

Recommendation 12 – Clinicians Should Offer or Arrange Treatment with Evidence-Based Medications to Treat Patients with Opioid Use Disorder

Clinicians should not dismiss patient from their practice because of OUD because this can adversely affect patient safety.

Detoxification on its own, without medications for OUD, is not recommended for OUD because of increased risks for resuming drug use, overdose, and overdose death.

Stigma can reduce the willingness of persons with opioid use disorder to seek treatment. However, OUD is a chronic, treatable disease from which people can recover and lead healthy lives.

Clinicians who suspect OUD should discuss their concerns with the patient in a nonjudgmental manner and provide an opportunity for the patient to disclose related concerns or problems.

Identification of OUD represents an opportunity for a clinician to initiate potentially life-saving interventions. The clinician should collaborate with the patient regarding their safety to increase the likelihood of successful treatment.

Pregnant women with OUD should begin methadone or buprenorphine as soon as possible to prevent harms to both the patient and the fetus.

Based on: Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022. MMWR Recomm Rep 2022; 71(No. RR-3):1-95. DOI http://dx.doi.org/10.15585/mmwr.rr7103a1