Update on the 2022 CDC Clinical Practice Guideline for Pain Management

Diana D. Rivera González, Pharm.D
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Diana Rivera González has no financial relationships with ineligible companies to disclose.

Learning Objectives

At the conclusion of the activity pharmacists should be able to:

- Explain the rationale for updating the 2022 CDC Pain Management Guideline.
- Describe the updates and changes to the updated guideline.
- Identify practical considerations for implementing the guideline in various outpatient and office-based clinical practice settings.
- Place the guidelines in the context of the evolving overdose crisis in the United States and the ongoing need to improve the lives of patients living pain.

Learning Objectives

At the conclusion of the activity pharmacy technicians should be able to:

- Explain the rationale for updating the 2022 CDC Pain Management Guideline.
- Identify the updates and changes to the updated 2022 guideline
- List considerations in the dispensing process that have changed with the CDC 2022 update.
- Describe the role of pharmacy technicians in supporting the pharmacy team.

Self- Assessment

The misapplication of the 2016 CDC Opioid Prescribing Guideline, the risk of different tapering strategies and rapid tapering associated with patient harm have been some of the considerations for the 2022 CDC guideline revision.

a) TRUE
b) FALSE

Self- Assessment

Nonopioid therapies are at least as effective as opioids for many common types of acute pain is one recommendation of the CDC 2022 guideline. Nonopioid therapies are preferred for subacute and chronic pain.

a) TRUE
b) FALSE

Self- Assessment

Several nonopioid pharmacologic therapies (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) are used for painful symptoms in chronic pain conditions.

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Self- Assessment

When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids.

a) TRUE
b) FALSE

Self- Assessment

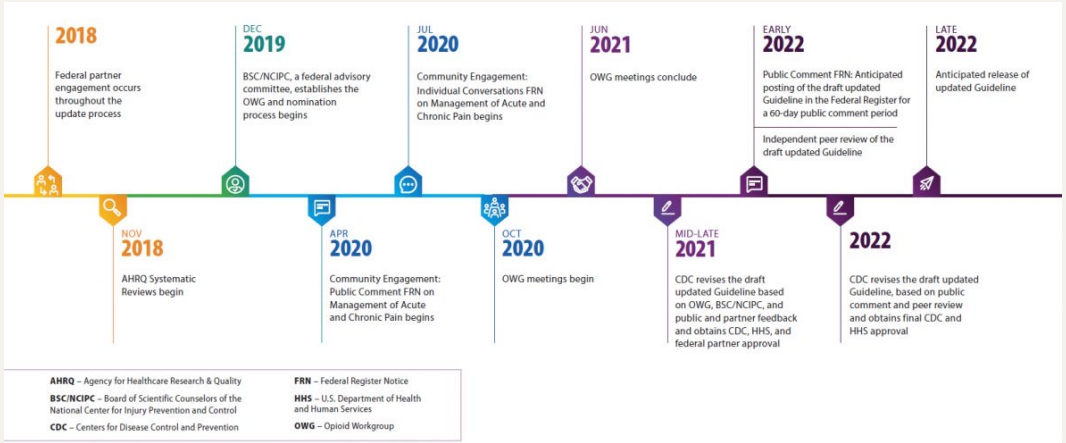
Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.

a) TRUE
b) FALSE

Introduction

Introduction

- Pain can lead to impaired **physical functioning, poor mental health, and a reduced quality of life.**
- Chronic pain is the **leading cause** of disability in the United States.
- CDC provides guidance to clinicians, as well as tools and resources for patients and clinicians, to **help advance comprehensive pain care.**



Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington (DC): National Academies Press (US); 2011.

Three waves of the US Opioid Crisis

1

1990s

Involving prescription opioids

2

2010

Involving heroin

3

2013

Involving synthetic opioids

In 2017, the US Department of Health and Human Services (HHS) declared the opioid epidemic a **public health emergency.**

Understanding the epidemic. CDC. March 17, 2021. Available at: www.cdc.gov/opioids/basics/epidemic.html. Accessed October 4, 2021.
HHS. What is the U.S. opioid epidemic? February 19, 2021. Available at: www.hhs.gov/opioids/about-the-epidemic/index.html. Accessed October 4, 2021.
Encinosa W, Bernard D, Selden TM. Opioid and non-opioid analgesic prescribing before and after the CDC's 2016 opioid guideline [published online ahead of print, 2021 May 8]. Int J Health Econ Manag. 2021:1-52. doi:10.1007/s10754-021-09307-4

CDC Guideline for Prescribing Opioids for Chronic Pain

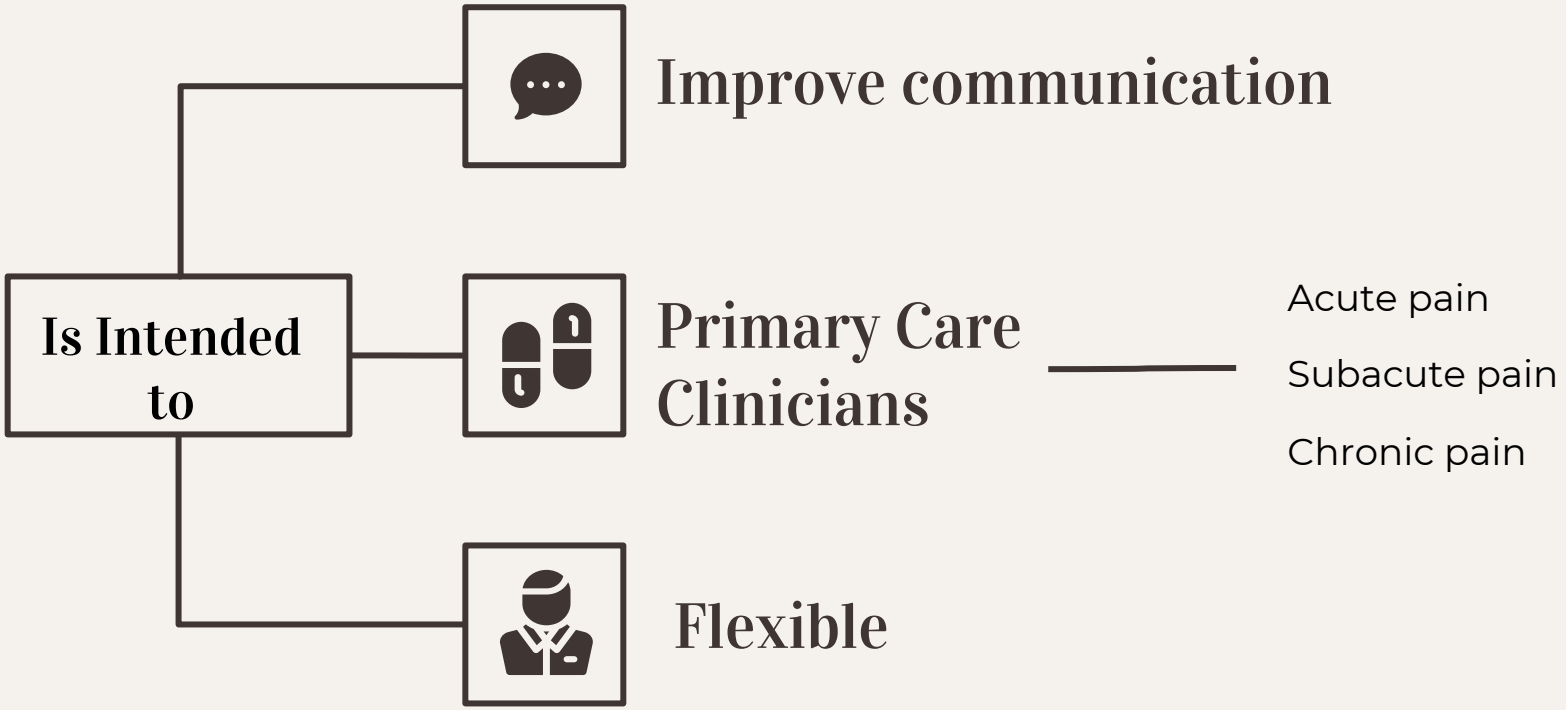
Clinical Concerns

- Rapid guideline uptake resulted in **decreases** in the overall rate of opioid prescribing, the rate of high-dosage opioid prescriptions, and the percentage of patients with concurrent benzodiazepine and opioid prescriptions.

5. When initiating opioids, prescribe the lowest effective dosage. Use caution when prescribing opioids at any dosage, and carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 MME/day, and avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.	The limits on prescription duration and dosing (defined in terms of MME doses) may be misinterpreted as "hard and fast" recommendations, leading to under/overdosing. Abrupt dose reductions increase the risk of opioid withdrawal, undertreatment, and the use of illicit alternatives.
6. For acute pain, prescribe the lowest effective dose of immediate-release opioids and prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed.	

Lawhern RA,PhD, Nadeau SE. Behind the AHRQ Report – Understanding the Limitations of Non-Pharmacological , Non-Invasive Therapies in Chronic Pain. Pract Pain Manage. 2018;(18)7.
Nadeau SE, Wu JK, Lawhern RA. Opioids and Chronic Pain – An Analytic Review of the Clinical Evidence. Front Pain Res. 17 August 2021 [See references 28-32] https://www.frontiersin.org/articles/10.3389/fpain.2021.721357/full

The 2022 Clinical Practice Guideline



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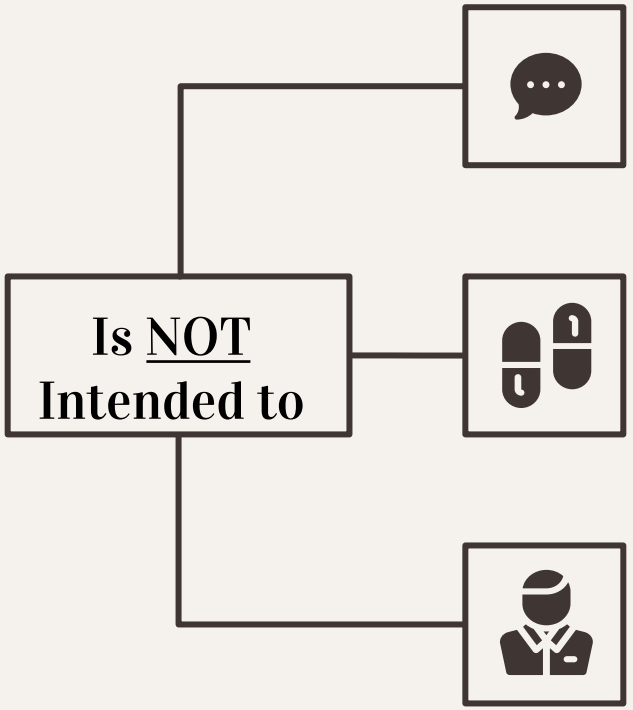
The 2022 Clinical Practice Guideline



Replacement for clinical judgement

Applicable to

- Sickle Cell Disease
- Cancer-related pain
- Palliative or End-of-life care

Inflexible

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About the New Guideline Recommendations

Recommendations 1 and 2

Determining whether or not to initiate opioids for pain

Recommendations 3, 4 and 5

Selecting opioids and determining opioid dosage

Recommendations 6 and 7

Deciding duration of initial opioid prescription and conducting follow up

Recommendations 8, 9, 10, 11 and 12

Assessing risk and addressing potential harms of opioid use

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Determining whether or not to initiate opioids for pain

Recommendations 1 and 2

Determining whether or not to initiate opioids for pain

The first two recommendations address determining **whether to initiate opioids or alternative pain therapies** for acute, subacute, and chronic pain.

- Evaluate patients and diagnosis
- Maximize use of non-pharmacologic and non-opioid therapies
- Consider initiating opioids, when warranted
- Discuss benefits of opioid therapy

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Recommendation 1

Non- opioids medications for acute pain

- When not contraindicated, nonsteroidal anti-inflammatory drugs (NSAIDs) **should be used** for low back pain, painful musculoskeletal injuries, dental pain, postoperative pain, and kidney stone pain.
- Triptans, NSAIDs, or their combinations **should be used** along with antiemetics as needed for acute pain related to episodic migraine.

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Recommendation 1

Opioid medications for acute pain

- Opioid therapy has an important role for acute pain **related to severe traumatic injuries**, **invasive surgeries** typically associated with moderate to severe postoperative pain, and **other severe acute pain** when NSAIDs and other therapies are contraindicated or likely to be ineffective.
- Clinicians should involve patients in decisions about whether to start opioid therapy and ensure that patients are aware of the **expected benefits, common risks, serious risks and alternative to opioids.**

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Recommendation 2

Non- opioids medications for subacute and chronic pain

- Nonopioid therapies are **preferred** for subacute and chronic pain
- Noninvasive nonpharmacologic **can help manage chronic pain**, such as exercise for back pain, fibromyalgia, and hip or knee osteoarthritis.
- Several **nonopioid medications** can be useful for painful symptoms in subacute and chronic pain conditions. For example:
  - Acetaminophen
  - NSAIDs (topical and systemic)
  - Selected antidepressants
  - Selected anticonvulsants

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Recommendation 2

Opioid medications for subacute and chronic pain

- Opioids **should not be considered** first-line or routine therapy for subacute or chronic pain. This does not mean that patients should be required to sequentially "fail" nonpharmacologic and nonopioid pharmacologic therapy.
- It should be determined with patients how functional benefit will be evaluated and establish treatment goals.
- Opioid therapy should not be initiated without consideration of **an exit strategy** to be used if opioid therapy is unsuccessful.

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Selecting opioids and determining opioid dosage

Recommendations 3, 4 and 5

Recommendation 3

When starting opioids

- It should be prescribed **immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids.**
- It is **not recommended** treat acute pain with ER/LA opioids or initiate opioid treatment for subacute or chronic pain with ER/LA opioids.
- It is **not recommended** to prescribe ER/LA opioids for intermittent or as-needed use.
- It is **recommended** to ER/LA opioids for severe, continuous pain.

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Recommendation 3

When starting opioids

Immediate release opioids

Faster acting medication with a **shorter duration** of pain-relieving action.
Examples include morphine, oxycodone, or hydrocodone.

Extended release and long acting opioids

Slower acting medication with a **longer duration** of pain-relieving action.
Examples include methadone, transdermal fentanyl, or extended-release versions of opioids such as oxycodone, hydromorphone, hydrocodone, and morphine.

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Recommendation 4

When starting opioids on naïve patients

- Clinicians should prescribe the **lowest effective dosage.**
- The lowest starting dose for opioid-naïve patients is often equivalent to a single dose of approximately 5–10 MME or a daily dosage of 20–30 MME/day.
- Before increasing total opioid dosage to 50 or greater MME/day, clinicians should pause and carefully reassess evidence of **individual benefits and risks.**

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Recommendation 4

When starting opioids on naïve patients

Table 1: Morphine milligram equivalent doses for commonly prescribed opioids for pain management

Opioid	**Conversion factor**
Codeine	0.15
Fentanyl TDS (in mcg/hr)	2.4
Hydrocodone	1.0
Hydromorphone	5.0
Methadone	4.7
Morphine	1.0
Oxycodone	1.5
Oxymorphone	3.0
Tapentadol	0.4
Tramadol	0.2

Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521–7 and Nielsen S, Degenhardt L, Hoban B, Gisev N. Pharmacoepidemiol Drug Saf 2016;25:733–7.

Recommendation 5

Dosages in patients already in opioid therapy

- If benefits outweigh risks of continued opioid therapy, non-opioid therapies **should be optimized** while continuing opioid therapy.
- If benefits do not outweigh risks of continued opioid therapy, other therapies should be optimized and **gradually taper** to lower dosages or appropriately taper and discontinue opioids.
    - When patients have been taking opioids for longer durations, tapers of **10% per month or slower** are likely to be better tolerated than more rapid tapers.

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Clinical Case

Brenda

Brenda is a 64 years old female diagnosed with severe spinal stenosis after having spinal arthritis in the back for several years. Due to failed conservative treatments and increasing pain, a lumbar laminectomy was performed on the patient yesterday. Patient complains of severe pain not responding to NSAID or acetaminophen

Pertinent social history: retired teacher, no longer active due to pain, no tobacco use, no alcohol and no illicit drug use.

Clinical Case

Brenda

After reassessment done by the doctor, the decision has been made to escalate drug therapy to an opioid medication. The doctor asks for your help with the dose, which of the following do you recommend?

a) 5 mg oxycodone ER once daily for 3 days
b) 5 mg oxycodone IR every 6 hours for 3 days
c) 10 mg oxycodone ER 3x daily for 5 days
d) 15 mg oxycodone IR opioid 3x daily for 5 days

Clinical Case

Brenda

After reassessment done by the doctor, the decision has been made to escalate drug therapy to an opioid medication. The doctor asks for your help with the dose, which of the following do you recommend?

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c) 10 mg oxycodone ER 3x daily for 5 days

d) 15 mg oxycodone IR opioid 3x daily for 5 days

Deciding duration of initial opioid prescription and conducting follow up

Recommendations 6 and 7

Deciding duration of initial opioid prescription and conducting follow up

These recommendations address:

01

Prescribing no greater quantity than needed for the expected duration of pain severe enough to require opioids.

02

Evaluating benefits and risks within 1-4 weeks and regularly after starting long-term opioid therapy for subacute and chronic pain.

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Recommendation 6

Opioid medication for acute pain

- When opioids are needed for acute pain, it should be prescribed 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.

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Recommendation 7

Follow up after initiation of opioids for acute pain

- It should be considered follow-up intervals within the lower end of the range when ER/LA opioids are started or increased or when total daily opioid dosage is ≥50 MME/day.
- Shorter follow-up intervals (every 2–3 days for the first week) should be strongly considered when starting or increasing the dosage of methadone.
- An initial follow-up interval closer to 4 weeks can be considered when starting immediate-release opioids at a dosage of <50 MME/day.

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Assessing risk and addressing potential harms of opioid use

Recommendations 8, 9, 10, 11 and 12

Assessing risk and addressing potential harms of opioid use

Recommendations 8-12 include:

- Evaluating risk for opioid-related harms, discussing risk with patients, and working with patients to incorporate strategies to mitigate risk into the management plan.
- Reviewing prescription drug monitoring program (PDMP) data.
- Considering the benefits and risks of toxicology testing
- Using caution when prescribing opioid pain medication and benzodiazepines concurrently.
- Offering or arranging treatment for OUD, if needed.

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Recommendation 8

Risk mitigation strategies

- Strategies to mitigate risk:
  - Ask patients about their drug and alcohol use
  - Ensure that treatment for depression and other mental health conditions is optimized
  - Offering naloxone
  - Using PDMP data and toxicology screening

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Recommendation 8

Over-the-Counter Naloxone

Will be available by early 2024

Recommendation 8

How to use naloxone nasal spray?

Recommendation 9

Reviewing PDMP data

- PDMP data should be reviewed to determine whether the patient is receiving opioid dosages or combinations that put the patient at **high risk for overdose.**
- At a minimum, PDMP data should be reviewed **before initial opioid prescriptions** for subacute or chronic pain and then **every 3 months or more frequently** during long-term opioid therapy.

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Clinical Case

Peyton

Peyton is a 54 years old male patient with medical history of a torn anterior cruciate ligament (ACL) and inner meniscus diagnosed 1 year ago which required knee reconstruction surgery a few weeks after diagnosis. As of today, he completed the required physical therapy sessions. His pain management regimen includes oxycodone 10mg twice daily.

Pertinent social history: owner of a landscape company, no tobacco use, no alcohol and no illicit drug use

Clinical Case

Peyton

The doctor following up on Peyton's case asks for your help to assess if is appropriate to increase the oxycodone dose. You check the PDMP data, and you found the following information:

- Recent prescription for alprazolam 0.25 mg three times a day for 30 days. Prescribed by James Schultz, M.D.
- Oxycodone 10 mg twice daily, Trey Nelson, M.D.

Clinical Case

Peyton

You ask Peyton about the alprazolam prescription, and he states “Well, I’ve been feeling really anxious about not being able to do the things I used to do. Now, I sit behind the desk all day when I used to be more active and go out and do site estimates and manage my workers. I’m really worried that my business is going to go under because I can’t be onsite. So, I went back to a therapist I used to see, and he prescribed the alprazolam. It does help me sleep, if nothing else, and I think it helps with the anxiety I’m having.”

Clinical Case

Peyton

Considering the amount of pain Peyton is still having and his recent prescription for alprazolam, which option demonstrates the best recommended course of action and plan of care for Peyton?

Clinical Case

Peyton

Option A

- Take Peyton off the alprazolam immediately for his safety.
- Recommend ibuprofen around the clock for pain.
- Devise a tapering plan to discontinue the oxycodone.
- Offer naloxone.

Option B

- Discuss safety concerns with Peyton, including increased risk for respiratory depression and overdose.
- Inform Peyton that you will coordinate care with Dr. Schultz to discuss Peyton's needs, goals, and weigh risks of concurrent benzodiazepine and opioid therapy.
- Offer naloxone.
- Discuss nonopioid options for Peyton's pain.

Clinical Case

Peyton

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- Offer naloxone.
- Discuss nonopioid options for Peyton's pain.

Recommendation 10

Toxicology testing

- Toxicology testing is recommended to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances.

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Recommendation 11

Co-prescribing opioids and other medications

- Caution should be employed when prescribing **opioid pain medication and benzodiazepines.**
- Because other central nervous system depressants can potentiate **respiratory depression** associated with opioids, clinicians should consider **whether benefits outweigh risks** of concurrent use of these medications.
- It should be considered involving **pharmacists as part of the management team** when opioids are co-prescribed with other central nervous system depressants.

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Recommendation 12

Arranging treatment for opioid use disorder

- Detoxification on its own, without medications for opioid use disorder, is **not recommended** for opioid use disorder.
- Medication treatment of OUD has been associated with reduced risk for overdose and overall deaths.
    - Buprenorphine can be prescribed by any clinician with a current, standard DEA registration with Schedule III authority, in any clinical setting.
    - Methadone treatment for OUD can only be provided through a SAMHSA-certified opioid treatment program.
    - Naltrexone can be prescribed in any setting.

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Self- Assessment

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Conclusions

- Pain, particularly chronic pain, can lead to impaired physical functioning, poor mental health, and a reduced quality of life.
- Since 2016, research about noninvasive, nonpharmacological treatment and nonopioid pharmacological treatment of chronic pain has become available.
- As a result of these reviews and feedback from patients with pain, caregivers, clinicians, and partners, CDC determined that an update of the Guideline, was warranted.
- Pharmacist and pharmacy technicians play a vital role in contributing to ensure safe use and appropriate selection of pain treatment plans.

Thank you!

References

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