

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Promoting Patient Care and Safety

THE US OPIOID OVERDOSE EPIDEMIC

The United States is in the midst of an epidemic of prescription opioid overdoses. The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported by Americans hasn't changed. This epidemic is devastating American lives, families, and communities.



More than 40 people die every day from overdoses involving prescription opioids.¹



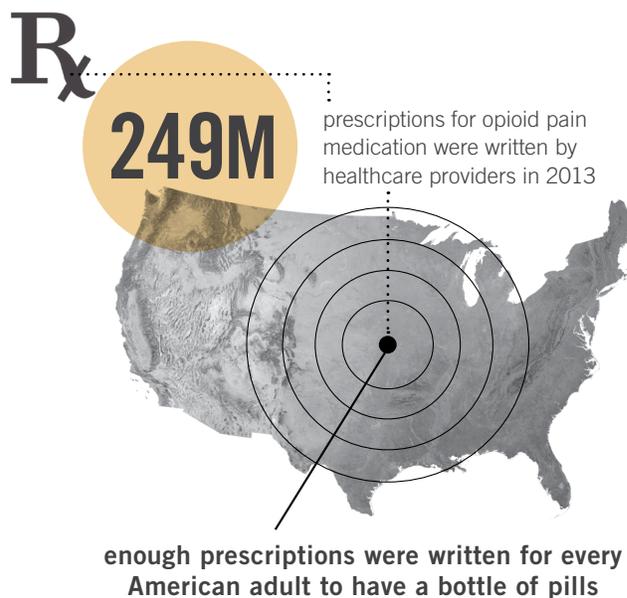
Since 1999, there have been over 165,000 deaths from overdose related to prescription opioids.¹



4.3 million Americans engaged in non-medical use of prescription opioids in the last month.²

PRESCRIPTION OPIOIDS HAVE BENEFITS AND RISKS

Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don't have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use.



¹ Includes overdose deaths related to methadone but does not include overdose deaths related to other synthetic prescription opioids such as fentanyl.

² National Survey on Drug Use and Health (NSDUH), 2014



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html
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WHAT CLINICIANS CAN DO TO HELP

KEY PRACTICES & ACTIONS



1. Use non-opioid treatment as the first line for acute or chronic pain



In a systematic review, **opioids did not differ from nonopioid medication in pain reduction**, and nonopioid medications were better tolerated, with greater improvements in physical function



2. If opioids are needed, start prescribing at the lowest effective dose



Studies show that high dosages ≥ 100 MME/day are associated with **2 to 9 times the risk of overdose** compared to < 20 MME/day.



3. Use available PDMP Data to determine if patients have previously filled prescriptions for opioids or other controlled medications



Check data for high dosages and prescriptions from other providers. A study showed patients with **one or more risk factors** (4 or more prescribers, 4 or more pharmacies, or dosage > 100 MME/day) accounted for **55% of all overdose deaths**.



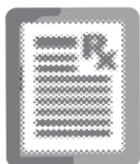
4. Ensure patients' safety by avoiding concurrent prescribing of opioids with other sedating drugs



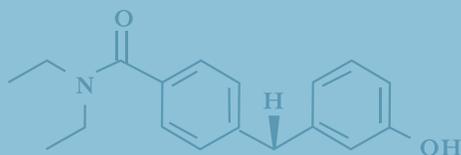
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5. Offer treatment for patients with Opioid Use Disorder (OUD), including medication-assisted treatment (MAT).



A study showed patients prescribed high dosages of opioids long-term (> 90 days) had **122 times the risk of opioid use disorder** compared to patients who were not prescribed opioids.



RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

LOW BACK PAIN

Self-care and education in all patients; advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First-line: acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs)
- Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

NEUROPATHIC PAIN

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

OSTEOARTHRITIS

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First-line: Acetaminophen, oral NSAIDs, topical NSAIDs
- Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

FIBROMYALGIA

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

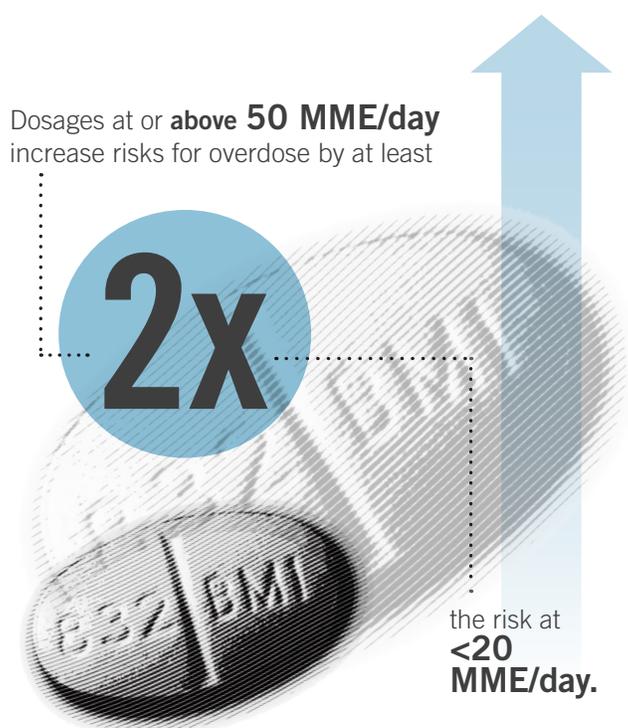
- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin



CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)



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