

2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

Patient Centered Medicine 4 Course

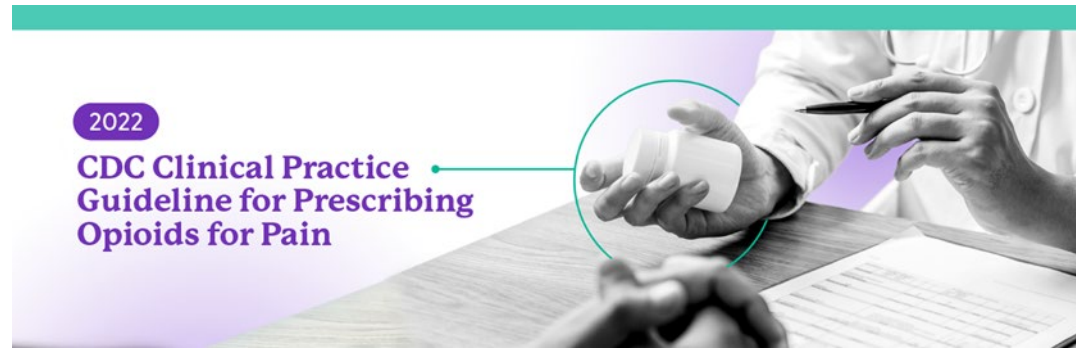
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STRITCH
SCHOOL *of* MEDICINE

Goal of this session:

- Be prepared to take the best care of your patients with acute, subacute and chronic pain



Objectives

- Summarize the role of a clinical practice guideline
- Explain the rationale for the development of the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain
- List commonly used non-opioids for the management of pain and the side effects of the non-opioids
- Utilizing the 2022 Clinical Practice Guideline for Prescribing Opioids for Pain develop appropriate strategies to mitigate risk to patients if initiating or continuing opioids
- Summarize best practices for opioid tapering and discontinuation
- Describe the role of a prescription drug monitoring database
- Explain how urine drug testing can help in risk assessment and decision making when prescribing opioids

What is a Clinical Practice Guideline?

- Statements that include recommendations
 - To optimize patient care
 - Informed by systematic review of evidence
 - Informed by assessment of benefits and harms of alternative care option

Institute of Medicine

- Challenge of creating guidelines: treatments are based on averages
 - what will help most patients with fewest side effects
 - require clinical judgment as to how a recommendation applies to each patient.

American Heart Association

Clinical Practice Guidelines

- Intended to help clinicians take better care of patients
- Not “rules”
 - Individual patients may be managed differently than guideline
 - biologic differences, comorbidities, availability of resources, cultural preferences, patient preferences

IDSA Practice Guideline Highlights & Status



Listed below is a summary of 2021, 2022, and 2023 highlights for IDSA guidelines as well as guidelines endorsed by IDSA.

| Guideline | Publication Date | Journal |
|--|------------------|--|
| Guidelines Released in 2023 | | |
| <i>IDSA Guidelines</i> | | |
| Antimicrobial Resistance Update | 6/2023 | <i>IDSA and Clinical Infectious Diseases</i> |
| Hepatitis C Guidance Update | 5/2023 | <i>IDSA and Clinical Infectious Diseases</i> |
| SHEA/IDSA/APIC Compendia Update for: | | |
| <ul style="list-style-type: none"> Prevent Healthcare-associated Infections through Hand Hygiene Clostridioides difficile Infections Surgical Site Infections Methicillin-Resistant <i>Staphylococcus aureus</i> | Ongoing | <i>Infection Control & Hospital Epidemiology</i> |
| Updates to COVID-19 guidelines: Treatment and Management Diagnostics: Antigen Testing Diagnostics: Molecular | Ongoing | <i>IDSA and Clinical Infectious Diseases</i> |
| Guidelines Released in 2022 | | |
| <i>IDSA Guidelines</i> | | |
| Updated Guidance on Antimicrobial-Resistant Gram-Negative Infections, v1.1 : ESBL-E, CRE, and <i>Pseudomonas aeruginosa</i> with Difficult-to-Treat Resistance | 3/2022 | <i>IDSA and Clinical Infectious Diseases</i> |



LIST OF TITLES — OCTOBER 2023

Clinical Consensus documents provide recommendations on focused clinical issues based on a careful examination of available scientific data, supplemented with expert opinion when the evidence is limited.

Committee Opinions provide ACOG committee assessments of emerging issues in obstetric and gynecologic practice.

Committee Statements address issues related to the practice of obstetrics and gynecology, such as ethics and access to care for underserved populations.

Clinical Practice Guidelines provide clinical management recommendations that are developed through assessment of the benefits and harms of care options based on a systematic review of the evidence.

Practice Bulletins are evidence-based documents that summarize current information on techniques and clinical management issues for the practice of obstetrics and gynecology.

Obstetric Care Consensus documents are developed jointly with the Society for Maternal-Fetal Medicine and include high-quality, consistent, and concise clinical recommendations for practicing obstetricians and maternal-fetal medicine subspecialists.

Technology Assessments provide an overview of technology in obstetrics and gynecology.

ACOG documents are reviewed routinely for accuracy and continued relevance. The "reaffirmed date" in the list below indicates when the document was last reviewed.

No titles have been withdrawn from circulation this month.

| Number | Title | Publication Date | Reaffirmed Date |
|--------|-------|------------------|-----------------|
|--------|-------|------------------|-----------------|



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Patient Education

CHEST's areas of focus are carefully chosen and center on the subspecialties and disease states where we can make the biggest difference in helping clinicians provide evidence-based patient care.

Airway Disorders

Get expert-backed strategies for the prevention of acute exacerbations of COPD, a major cause of morbidity and mortality around the world.

Chest Infections

Learn about the administration and monitoring of immunosuppressive drugs in patients with lung disease and lung transplant recipients.

Clinical Pulmonary

This collection aids clinical decision-making for the diagnosis and management of chronic and acute cough, plus associated complications.

Critical Care

See evidence-based guidance for caring for critically ill patients during pandemics, as well as methods for liberating patients from mechanical ventilation.

Interstitial Lung Disease

Our recommendations provide consensus-derived guidance for improving individual diagnostic decision-making for hypersensitivity pneumonitis.

Interventional Pulmonary

These guidelines examine flexible bronchoscopy, endobronchial ultrasound transbronchial needle aspiration, and transbronchial cryobiopsy.

Pulmonary Vascular

Explore our reviews of the management of pulmonary arterial hypertension and the use of antithrombotic therapy for VTE disease, thrombosis, and atrial fibrillation.

Thoracic Oncology

Read our recently updated guideline on lung cancer screening, and see our recommendations for treating high-risk patients with non-small cell lung cancer.

Learn how our guidelines are created

CDC Pain/Opioid Guideline



- EPIDEMIC of prescription opioid overdose and death
- As many as 1 in 4 people receiving prescription opioids long term in primary care setting struggles with addiction
- 2016 CDC Practice Guideline for Prescribing Opioids for Chronic Pain
 - Developed for Primary Care Providers treating patients with chronic pain
 - excludes patients undergoing active cancer treatment, palliative care, at end of life

Total number and rate of opioid prescriptions dispensed, United States, 2006–2020

| Year | Total Number of Prescriptions | Opioid Dispensing Rate/100persons |
|------|-------------------------------|-----------------------------------|
| 2006 | 215,917,663 | 72.4 |
| 2020 | 142,816,781 | 43.3 |

Prescription Opioid Deaths

2019 - Prescription opioids involved in 28% of all opioid overdose deaths

2018-2019 - Nearly 7% decrease in prescription opioid-involved deaths

2016 CDC Guideline – “Misapplications”

- Applied to populations outside of guidelines’ scope
- Guideline’s dosage recommendations resulted in hard limits or “cutting off” opioids
 - “ ≥ 90 MME/day”
- “Opioids cannot be prescribed for non-cancer chronic pain”
- “Opioids should be stopped in patients with non-cancer chronic pain”

In November, the agency eased the guidelines for prescribing opioids for pain, allowing physicians more flexibility.



— People like Rheba Smith, of Atlanta, say they have struggled to get opioid prescriptions written and filled the past few years. Guidelines from the Centers for Disease Control and Prevention in 2016 inspired laws cracking down on opioid prescribing practices. *Andy Miller / KHN*

2022

CDC Clinical Practice Guideline for Prescribing Opioids for Pain



2016 → 2022

2016

- Primary Care Clinicians

2022

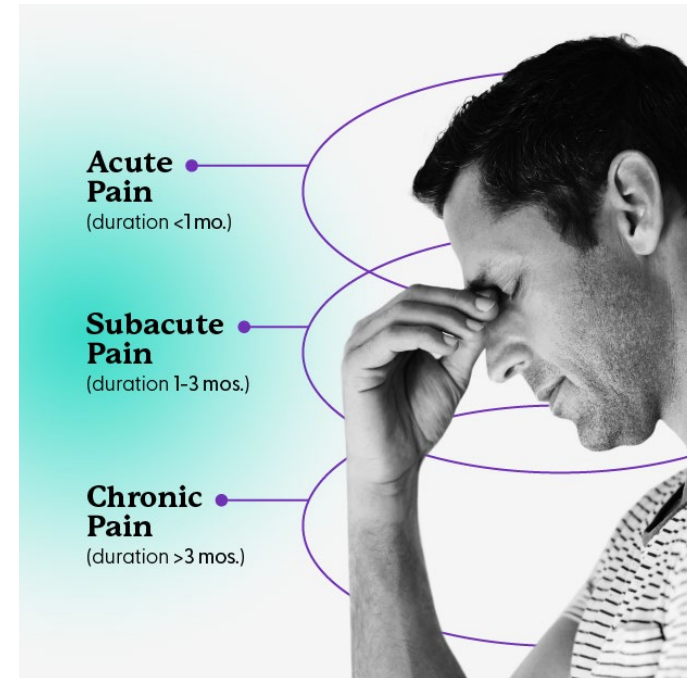
- Primary Care Clinicians
- Dental and other oral health clinicians
- Emergency clinicians providing pain management for patients being discharged from emergency departments
- Surgeons
- Occupational medicine physicians
- Physical medicine and rehabilitation physicians
- Neurologists
- Obstetricians and gynecologists

2016 → 2022

2016

- **Management of Chronic pain**
 - *excludes patients undergoing active cancer treatment, palliative care, end of life*

2022



- *Patients >18 years old*
- *does not apply to pain management related to sickle cell disease, cancer-related pain treatment, palliative care, or end-of-life care.*

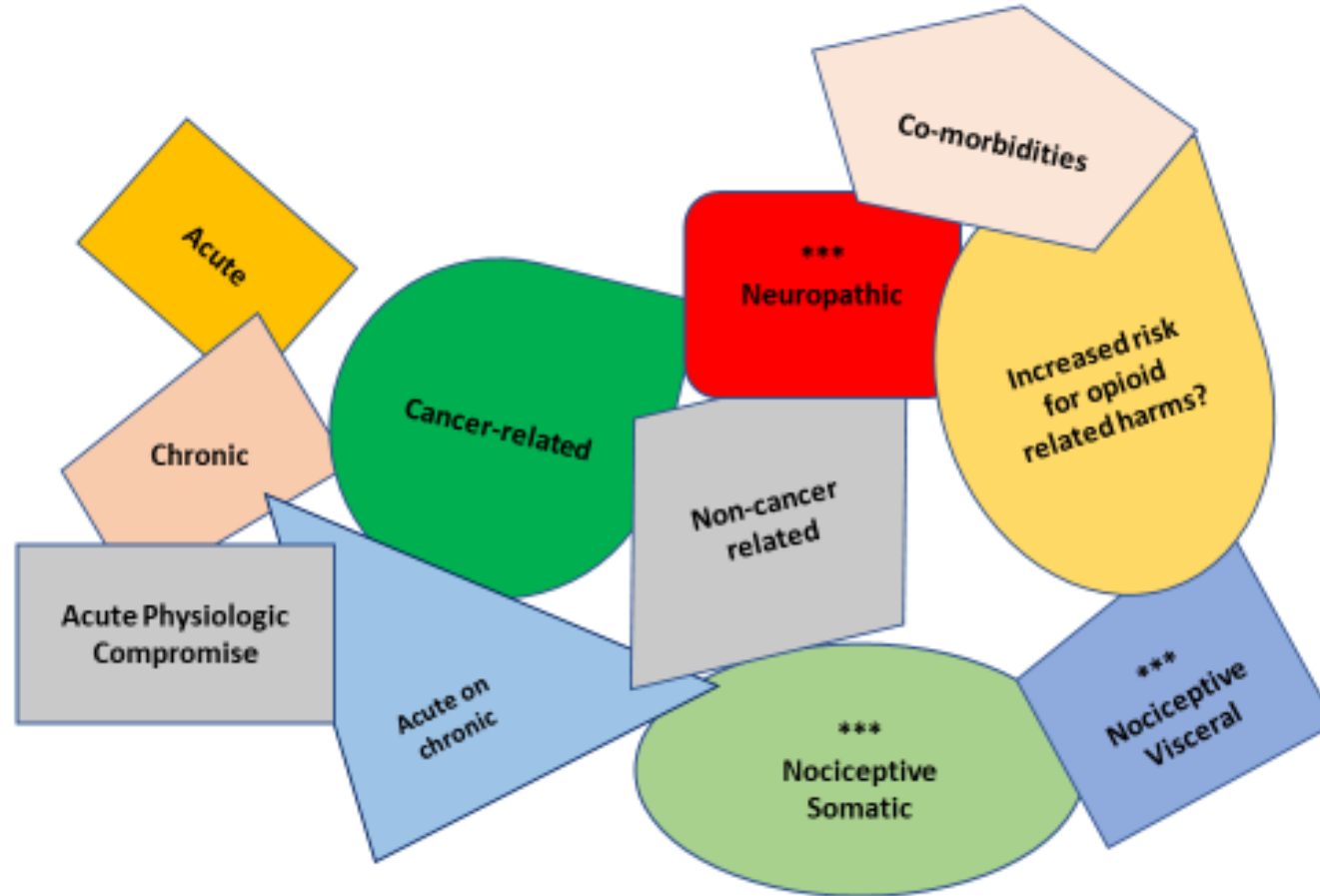
2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

- Twelve Recommendations

- Four Areas

- Determining whether or not to initiate opioids (recs 1,2)
 - Selecting opioids and determining opioid dosages (recs 3,4,5)
 - Deciding duration of initial opioid prescription and conducting follow-up (recs 6,7)
 - Assessing risk and addressing potential harms of opioid use (recs 8-12)

Most Important - Obtain a thorough Hx and PE



...And appropriate diagnostic testing if needed

Recommendation 1 – ACUTE pain

Nonopioid therapies are at least as effective as opioids for many types of acute pain

Use nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the condition and patient

Evidence-based Guidelines

| Condition | Recommendations |
|---|--|
| Acute low back pain | American College Physicians: <u>Nonpharmacologic</u> : superficial heat, massage, acupuncture, or spinal manipulation <u>Pharmacologic</u> : NSAIDs or skeletal muscle relaxants <u>Opioids</u> : insufficient evidence for effectiveness of opioids and recommends nonopioid medications |
| Acute musculoskeletal injury (aside from acute low back pain) | American Academy Family Physicians: <u>Nonpharmacologic</u> : acupressure, electrical nerve stimulation <u>Pharmacologic</u> : topical NSAIDs with or without menthol gel (first-line therapy); Oral NSAIDs, oral acetaminophen <u>Opioids</u> : Suggest against treating patients with acute pain from musculoskeletal injuries with opioids |

A Few Notes on “Muscle Relaxants” Antispasmodics

| | Cyclobenzaprine | Methocarbamol |
|----------------------|--|--|
| Mechanism of Action | Poorly understood inhibition of muscle-stretch reflex in spinal cord, Reduction in hyperactive muscle reflexes 5HT2 receptor antagonist Related to TCAs Antimuscarinic effects | General CNS depressant |
| Clinical Indications | Acute spasm due to muscle injury, inflammation | Acute muscle spasm Dental: acute TMJ |
| Toxicities | Strong antimuscarinic Effects: sedation, confusion, visual hallucinations Serotonin syndrome | CNS depressant: confusion, sedation Fall risk in older adults |
| Initial Dosing Adult | 5mg PO tid (including dose qhs) | 500mg PO tid |

ACUTE pain

Nonopioid therapies at least as effective as opioids for many types of acute pain

Use nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the condition and patient

Only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient.

Before prescribing opioid therapy for acute pain, discuss with patients realistic benefits and known risks of opioid therapy

ACOG: Recommendations for Pain Management for Pregnant and Postpartum Persons



- Postpartum period: stepwise, multimodal, shared decision-making, incorporating pharmacologic treatments that might include opioids
 - Vaginal delivery: acetaminophen or NSAIDs, and if needed, adding opioid
 - Cesarean delivery: oral and parenteral medications such as acetaminophen, NSAIDs, or low-dose, low-potency, short-acting opioids
 - duration of opioid use limited to shortest reasonable course expected for treating acute pain
- *Recommend counseling persons who are prescribed opioids about the risk for central nervous system depression in the postpartum person and in the breastfed infant*

Recommendation 2 -Subacute and Chronic Pain

Nonopioid therapies preferred for subacute and chronic pain

Maximize nonpharmacologic and nonopioid pharmacologic therapies

Before starting opioid therapy

Discuss realistic benefits, known **risks** of opioid therapy
Establish treatment **goals** for pain and function
Consider how opioid therapy will be **discontinued** if benefits do not outweigh risks

Realistic goals for pain AND

function

*Function can improve even when pain is
still present*

Nonpharmacologic Therapies

- Exercise (e.g., aerobic, aquatic, or resistance exercises)
- Exercise therapy
- Psychological therapy
- Spinal manipulation
- Low-level laser therapy
- Massage
- Mindfulness-based stress reduction
- Yoga
- Acupuncture
- Mind-body practices (e.g., yoga, tai chi, or qigong), massage
- Accupressure
- Cognitive behavioral therapy
- Walking in public spaces
- Use of public recreation facilities for group exercise
- Physical therapy



Problem.....

Acupuncture

Medicare only covers acupuncture (including dry needling) for chronic low back pain. Medicare covers up to 12 acupuncture visits in 90 days for chronic low back pain defined as:

- Lasting 12 weeks or longer
- Not having an identifiable cause (for example, not an identifiable disease like cancer that has spread, or an infectious or inflammatory disease)
- Pain that isn't associated with surgery or pregnancy

Transportation challenges

Live in Rural Areas

Foot Massage

30 min. | \$30
45 min. | \$45
60 min. | \$55

Chair Massage

10 min. | \$15
20 min. | \$30
30 min. | \$40

Body Massage

30 min. | \$40
45 min. | \$55
60 min. | \$65
90 min. | \$95

Cupping

Foot | \$12
Body | \$28

Combination Massage

20 min foot + 20 min body | \$50
30 min foot + 30 min body | \$65
40 min foot + 40 min body | \$85

Non-opioid Pharmacologic Agents

Osteoarthritis

Topical NSAIDs (few joints near skin)

Duloxetine

Systemic NSAIDs

Chronic low back pain

NSAIDs

Duloxetine

Fibromyalgia

Tricyclic antidepressants

SNRI antidepressants

NSAIDs (e.g., topical diclofenac)

Specific anticonvulsants (i.e., pregabalin and gabapentin).

Duloxetine, milnacipran, and pregabalin FDA-approved

Neuropathic pain

Tricyclic, SNRI antidepressants; Selected anticonvulsants (e.g., pregabalin, gabapentin)

Capsaicin and lidocaine patches

•Peripheral diabetic neuropathy:
Duloxetine, pregabalin FDA-approved

•Post herpetic neuralgia:
pregabalin, gabapentin FDA-approved.

Adverse Effects of Non-opioids

| | Side effects | 2023 AmericaGO Geriatrics Society Beers Criteria® for potentially inappropriate medication use in older adults. |
|-------------|---|---|
| Oral NSAIDs | Kidney injury, GI injury, Coronary events | Avoid chronic use unless other alternatives are not effective and the patient can take a GI protective agent; strong recommendation |
| Pregabalin | blurred vision, cognitive effects, sedation, weight gain, dizziness, peripheral edema | |
| Gabapentin | blurred vision, cognitive effects, sedation, and weight gain | |
| Duloxetine | Nausea, sedation | |
| Tricyclics | Anticholinergic side effects, sedating, orthostatic hypotension | Avoid; strong recommendation |

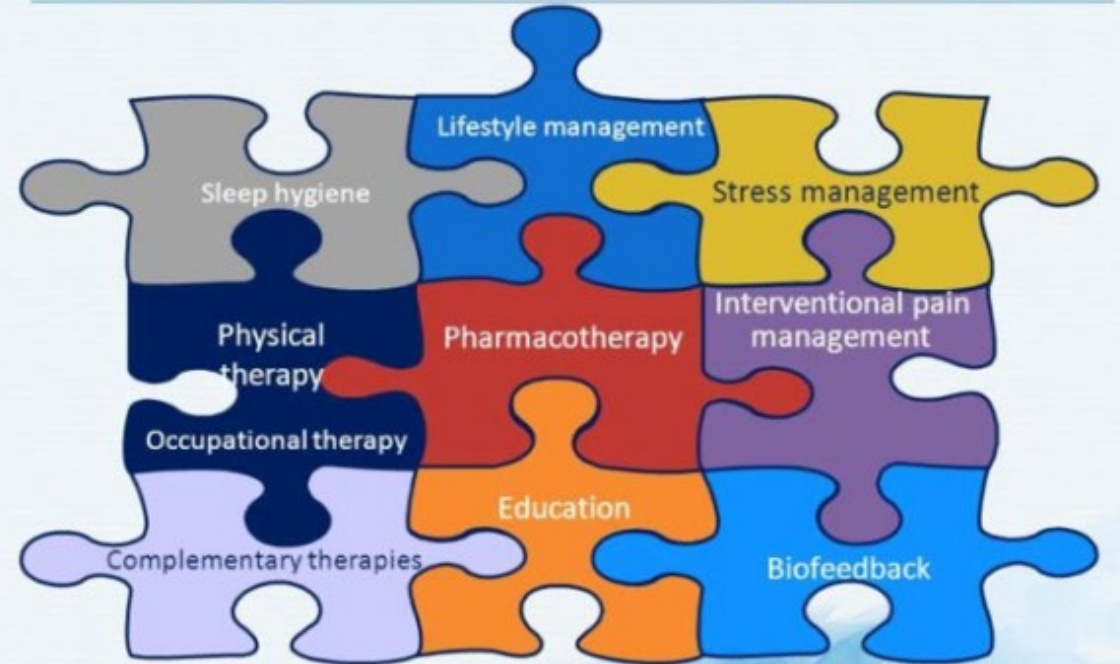
Why not opioids?

- **Insufficient evidence** to determine long-term benefits of opioid therapy for chronic pain
- Increased risk **serious harms** related to long-term opioid therapy
 - appears to be dose dependent
- Evidence - **improvement in pain reduced** with longer duration of opioid therapy

Subacute and Chronic Pain Management



Multimodal Treatment of Pain Based on Biopsychosocial Approach



Recommendation 3 - Selecting Opioids and Determining Opioid Dosages

- When starting opioid therapy for acute, subacute, or chronic pain:
 - **prescribe immediate-release opioids**
 - not extended-release and long-acting (ER/LA) opioids



Reminder: Immediate Release Oral Opioids

- Administered as
 - single agents
 - Morphine, oxycodone, hydromorphone, tramadol
 - combination products
 - Hydrocodone/acetaminophen (5/325; 10/325)
 - Oxycodone/acetaminophen
 - Codeine/Acetaminophen
- Peak analgesic effect occurs in 60-90 minutes
- Expected total duration of analgesia of 3-4 hours
- Generally q 4 hour PRN dosing intervals

Reminder: Extended-release Opioids

- Scheduled (not intermittent) dosing
- Dosed q 12, 24, 72 hours (product specific)

Extended-release Opioids

- Morphine
 - Morphine ER, MS Contin, Kadian, Avinza
- Oxycodone
 - Oxycodone ER, Oxycontin
- Fentanyl
 - Transderm patch (Duragesic)
- Hydrocodone
- Hydromorphone
- Methadone

When starting opioid tx prescribe IMMEDIATE RELEASE instead of extended release/long acting opioid

- Why?

- No evidence scheduled ER/LA opioid is more effective or safer
- Potential higher risk of overdose
 - particularly during initial weeks of therapy
- No evidence that risk of opioid addiction is decreased

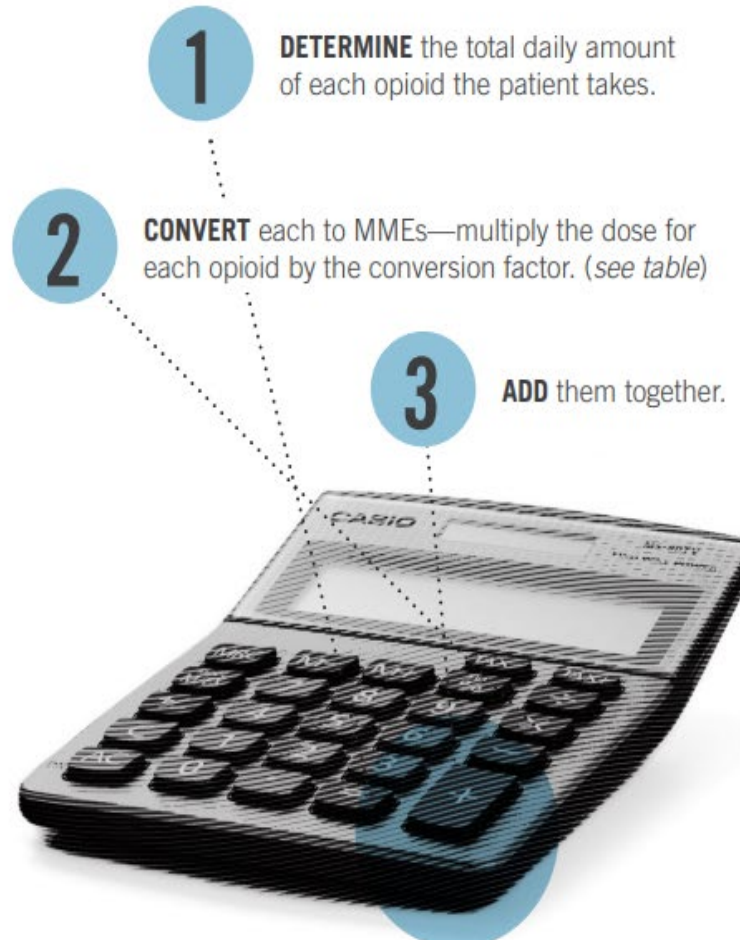
Recommendation 4 - acute, subacute, or chronic pain

- When initiating opioids for opioid-naïve patients **prescribe lowest effective dosage.**
- If continuing opioids
 - use caution at any dose
 - evaluate diminishing return on pain benefits vs risks/side effects with increasing doses

• Standard Morphine Milligram Equivalents (MME)

- 5-10 MME starting dose
- 20-30 MME/day

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?



Calculating morphine milligram equivalents (MME)

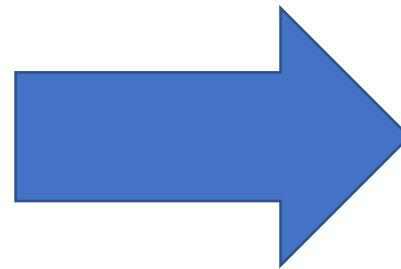
| OPIOID (doses in mg/day except where noted) | CONVERSION FACTOR |
|---|-------------------|
| Codeine | 0.15 |
| Fentanyl transdermal (in mcg/hr) | 2.4 |
| Hydrocodone | 1 |
| Hydromorphone | 4 |
| Methadone | |
| 1-20 mg/day | 4 |
| 21-40 mg/day | 8 |
| 41-60 mg/day | 10 |
| ≥ 61-80 mg/day | 12 |
| Morphine | 1 |
| Oxycodone | 1.5 |
| Oxymorphone | 3 |

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

Guide: ORAL Starting Doses

- | | |
|--------------------------|----------|
| • Codeine | 30 mg |
| • Tramadol | 25-50 mg |
| • Morphine = Hydrocodone | 5 mg |
| • Oxycodone | 3 mg |
| • Hydromorphone | 1 mg |

- Abnormal renal function?
- Abnormal hepatic function?
- Multiple comorbidities?
- Frail?
- Elderly?



Lower dose may be effective

How high can an opioid be titrated?

- Benefits of high-dose opioids for pain not well established
- Few trials evaluated opioid dosages of ≥ 90 MME/day
- Opioid dosages of 50–90 MME/day associated with minimally greater improvement in mean pain intensity compared with dosages of < 50 MME/day
 - No difference in mean improvement in function
- Analyses of placebo-controlled trials found some evidence of plateauing effect at ≥ 50 mg MME/day
- Increased risks with increased doses

Recommendation 5 – Patient already on opioid therapy

Increasing Dose of Opioid?
Weight risks/benefits

Benefit > risk of continuing
opioid

Maximize non-opioid therapies
Continue opioid



Risk > benefit of continuing opioid

Maximize other therapies

Taper opioid to lower dose or taper
until discontinued

- **Opioid Risks/Adverse Effects**

- Potentially fatal respiratory depression
- Potentially life long opioid use disorder
- **Constipation**, sedation, dry mouth, weight gain, memory deficits, loss of appetite, fatigue, nausea/vomiting, pruritus, dizziness, urinary retention
- Opioid endocrinopathy
 - Adrenal insufficiency
 - Infertility
- Affect on ability to safely operate vehicle
- Risk to household members/others if intentionally/unintentionally shared

Opioid Tapering

- Individualized plan
- Minimize symptoms and signs of withdrawal
- Opioid use > 1year
 - 10% dose decrease per month, or slower
- Opioid use weeks to months
 - Decrease of 10% of original dose per week or slower
 - Once ~ 30% of original dose is reached → weekly decrease of ~10% of remaining dose
- Maximize other pain therapies
- Psychosocial support

- 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.**

Recommendation 6 – Acute Pain

- When opioids needed for acute pain, prescribe no greater quantity than needed for expected duration of pain severe enough to require opioids
 - Ensure reliable follow-up

Study

246 patients with ACUTE pain
discharged from ED with opioid prescription



Patients taking opioids continued them for
median of 4 days

Back pain 6 days

Fractures 6 days

Renal colic 2 days

Musculoskeletal injury 5.5 days

Other dx 3 days

92.5% patients reported having leftover pills

52.2% of pills unused overall

Opioid-Prescribing Guidelines for Common Surgical Procedures: An Expert Panel Consensus

J Am Coll Surg. 2018 October ; 227(4): 411–418.

Table 1.

Johns Hopkins Expert Panel Recommendations for Ideal Range of Oxycodone 5-mg Tablets to Prescribe to Opioid-Naïve Patients on Discharge after Undergoing Select Procedures

| Procedure | Range (minimum-maximum) |
|---|--------------------------------|
| General surgery | |
| Laparoscopic cholecystectomy (procedure 1) * | 0–10 |
| Laparoscopic inguinal hernia repair, unilateral (procedure 2) * | 0–15 |
| Open inguinal hernia repair, unilateral (procedure 3) * | 0–10 |
| Open umbilical hernia repair | 0–15 |
| Breast surgery | |
| Partial mastectomy without sentinel lymph node biopsy (procedure 4) * | 0–10 |
| Partial mastectomy with sentinel lymph node biopsy (procedure 5) * | 0–15 |
| Thoracic surgery | |
| Video-assisted thoracoscopic wedge resection | 0–20 |
| Orthopaedic surgery | |
| Arthroscopic partial meniscectomy | 0–10 |
| Arthroscopic ACL/PCL repair | 0–20 |
| Arthroscopic rotator cuff repair | 0–20 |
| ORIF of the ankle | 0–20 |
| Gynecologic surgery and obstetric delivery | |
| Open hysterectomy | 0–20 |
| Minimally invasive hysterectomy | 0–10 |
| Uncomplicated cesarean delivery | 0–10 |
| Uncomplicated vaginal delivery | 0 |
| Urologic surgery | |

Recommendation 7 - subacute or chronic pain

- Evaluate patient within 1–4 weeks of starting opioid therapy
- Regularly reevaluate benefits and risks of continued opioid therapy



Recommendation 8

- Before starting and periodically during continuation of opioid therapy, evaluate risk for opioid-related harms and **discuss** risk with patients
- Incorporate into management plan strategies to mitigate risk, including offering **naloxone**

Assess for

- Drug and alcohol use
- Signs of opioid misuse or opioid use disorder
 - difficulty controlling use, cravings, work, and social or family problems related to opioid use
- Depression and other mental health disorders
- Sleep disordered breathing
- Safety critical jobs
- History of opioid overdose

Study

- History of opioid overdose
 - cohort study of commercially insured patients found that **opioids were dispensed to 91% of patients who had a previous overdose**
 - substantial percentage experienced repeated opioid overdose
 - cumulative incidence at 2 years:
 - 17% among patients receiving ≥ 100 MME/day
 - 15% among those prescribed 50–100 MME/day
 - 9% among those prescribed < 50 MME/day
 - 8% among those prescribed no opioids

When to Offer Naloxone to Patients

Only 1 naloxone prescription is dispensed for every 70 high-dose opioid prescriptions. As a healthcare professional, you play a critical role in ensuring patients receive naloxone.¹



Fact Sheet: Clinicians

Some situations and conditions may make an opioid overdose more likely. The following factors increase risk of opioid overdose:²

- A history of overdose
- Patients with sleep-disordered breathing
- Patients taking benzodiazepines with opioids
- Patients at risk of returning to a high dose for which they have lost tolerance (e.g., patients undergoing tapering or recently released from prison)
- Patients taking higher dosages of opioids (e.g., ≥ 50 MME/day)
- A history of substance use disorder

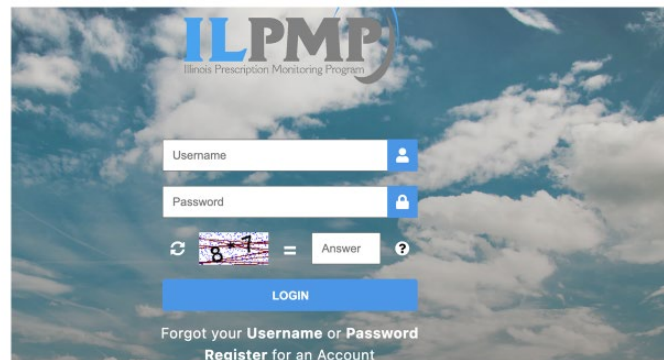


Recommendation 9 - PDMP

- Review patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data
 - PDMP = State-based databases that collect information on controlled prescription drugs dispensed by pharmacies

Role of PDMP Review

- Determine whether patient receiving opioid doses or dangerous combinations that put him/her at high risk for overdose
- Review PDMP data
 - When prescribing initial opioid therapy for acute, subacute, or chronic pain,
 - Periodically during opioid therapy for chronic pain





Medication Dispense History (from 1/9/2021 to 7/7/2021)

[Expand All](#) [Collapse All](#)

Cyclobenzaprine HCl

Gabapentin

HYDROcodone-Acetaminophen

| | Dispensed | Written | Strength | Quantity | Refills | Days Supply | Provider | Pharmacy |
|-------------------------------------|------------|------------|-------------|----------|---------|-------------|------------|---------------------------|
| HYDROCODON-ACETAMINOPHEN | 06/23/2021 | 06/21/2021 | 5MG-325MG | 40 | 0 | 10 | [REDACTED] | WAL-MART PHARMACY 10-1779 |
| HYDROCODON-ACETAMINOPHEN | 06/14/2021 | 06/14/2021 | 5MG-325MG | 60 | 0 | 10 | [REDACTED] | WAL-MART PHARMACY 10-1779 |
| HYDROCODONE BITARTRATE-ACETAMINOPHE | 06/11/2021 | 06/11/2021 | 7.5MG-325MG | 15 | 0 | 3 | [REDACTED] | WAL-MART PHARMACY 10-1779 |
| HYDROCODONE BITARTRATE-ACETAMINOPHE | 06/03/2021 | 06/01/2021 | 7.5MG-325MG | 40 | 0 | 7 | [REDACTED] | WAL-MART PHARMACY 10-1779 |

Morphine Sulfate

traMADol HCl

- Mark as Reviewed and Close
- Mark as Unable to Review and Close
- Close

Never reviewed

If prescriptions from multiple sources, high doses, dangerous combinations

- Discuss PDMP findings with patient
 - PDMP can have inaccurate data
 - Address safety concerns
 - Consider possibility of substance use disorder; discuss with pt
-
- Do not dismiss patients from practice
 - Use opportunity to provide potentially lifesaving information and interventions

Recommendation 10

- When prescribing opioids for subacute or chronic pain
 - consider benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances



- Urine Drug Testing
 - GOAL = improve patient safety

Urine Drug Screen

- Recommend urine drug testing before starting opioids for subacute or chronic pain and at least annually
- Can provide information about drug use not reported by patients
- Can assist in identifying when patient not taking opioids prescribed for them
 - might indicate diversion
 - might indicate difficulties with adverse effects
- Does not provide accurate information about how much or what dose of opioids or other drugs a patient took

| IMMUNOASSAY | GAS CHROMATOGRAPHY, MASS SPECTROMETRY |
|--|---|
| Less expensive, fast, easy to use | More expensive, labor intensive |
| Most frequently used technique in all settings, including hospital labs | Requires advanced laboratory services. |
| Used commonly as screening test. | Used primarily to confirm positive immunoassay result. |
| Engineered antibodies bind to drug metabolites | Measures drugs and drug metabolites directly. |
| Qualitative testing-- positive or negative | Quantitative testing |
| Screens for presence of drugs or a panel of drugs: amphetamine, marijuana, PCP, cocaine, natural opiates (morphine/ codeine/thebaine but without differentiation). Heroin is metabolized to morphine and can therefore be detected; a separate screening assay specific to heroin is also available. | Identifies specific drugs and their metabolites |
| Does not differentiate various natural opiates | Differentiates all opioids |
| Typically misses semisynthetic (e.g. hydrocodone and oxycodone) and synthetic opioids (e.g. fentanyl and tramadol). Assays specific for these drugs must be requested. | More accurate for semisynthetic and synthetic opioids--methadone, propoxyphene, fentanyl, meperidine, hydrocodone, oxycodone, hydromorphone, oxymorphone, buprenorphine, heroin |
| Often has high cut- off levels, giving false negative results | Very sensitive, detects low levels of drug, minimizes false negatives |
| Will show false positives: poppy seeds, quinolone antibiotics, over-the-counter medications | Very specific, less cross-reactivity, minimizes false positives |

Source: Adapted from "Urine Drug Testing in the Management of Chronic Pain," at <https://www.drugabuse.gov/sites/default/files/files/UrineDrugTesting.pdf>

Unexpected Results on UDS?



Unexpected Results on UDS?

- Opportunity to improve patient safety
 - discuss taper, discontinue opioids
 - more frequent re-evaluation
 - offer naloxone
 - refer for treatment for substance use disorder

- Do not dismiss patient from care based on a urine drug test result
 - Potential adverse consequences
 - abandonment
 - patient obtains opioids from alternative sources
 - missed opportunities to facilitate treatment for substance use disorder

Recommendation 11

- CAUTION prescribing benzodiazepines with opioids
 - Increased risk of CNS depression

Recommendation 12

- Offer/arrange treatment with evidence-based medications to treat patients with opioid use disorder
 - Buprenorphine, methadone, or naloxone + behavioral therapies

Summary

Specifically, the [2022 Clinical Practice Guideline](#) is intended to help clinicians:

- Improve communication with patients about the benefits and risks of pain treatments, including opioid therapy for pain
- Improve the safety and effectiveness of pain treatment
- Mitigate pain
- Improve function and quality of life for patients with pain
- Reduce the risks associated with opioid pain therapy (including opioid use disorder, overdose, and death)

Final Comments

Honest, Difficult Conversations

I just need relief. Are you not going to do anything for me?

- “I am confident that together we will find safe and effective options.”
- “Let’s talk more about you, aside from your pain experience. I know there are things in your life that are really important to you. Let’s work so that you can be more engaged in these.”
- “Now let’s talk about your pain and how it impacts your ability to do those things so we can figure out which options may be best for you.”
- “I am committed to working with you so you are not in terrible pain and can have a meaningful life. I believe we can accomplish this and lower your dose.”

I cannot go to work/get out of bed/handle my daily responsibilities without this medicine. Do you want me to lose my job/my home/not be able to live my life?

- “I want you to have safe and effective pain control, and it is my medical opinion that your current medicine can no longer give you that.”
- Pain can be an overwhelming experience. And I understand that you are upset.”
- “In order to help you, I need to know more about you, aside from your pain experience. Tell me more about your daily responsibilities and activities.”
- “I understand your concern and making sure you can continue your current functions is our priority. That is why I want our goal to be to keep you functional, or even improve your function.”
- “We do not have anything in our toolbox that will make your pain go away entirely, but we can help make it manageable so you can work and do other things that matter to you.”
- “We share your goals.”
- “You may be surprised to find that you are as able to do all the things you want as well or better with less opioids.”



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Rectangular Snip

Perspective
DECEMBER 27, 2018

Harder to Treat Than Leukemia — Opioid Use Disorder in Survivors of Cancer

Alison Wakoff Loren, M.D., M.S.C.E.

Ms. M. was a 24-year-old with chronic myeloid leukemia in blast phase who received an allogeneic hematopoietic cell transplant from an unrelated donor. She developed acute graft-

versus-host disease (GVHD) of the gastrointestinal tract that evolved into overlap syndrome with severe chronic GVHD of the skin, connective tissues, and joints. Her pain was debilitating and led to prescriptions for first morphine and oxycodone, and ultimately hydromorphone. Ill equipped to

trist frequently. She agreed to obtain prescriptions only from me, which I confirmed with her internist.

But trouble continued to simmer: her pain was mitigated by immunosuppression, yet she insisted she could not tolerate lower opioid doses. She manipulated

transplantation. I finally found a facility that accepted her insurance, but they rejected her when they heard her medical history. “She’s too complicated for us. We can’t take care of her here,” they said.

As the opioid epidemic rages, much energy has been devoted to understanding how addiction begins. The path often starts with a prescription for opioids, and people who study or create policy on this issue usually add that these prescriptions are provided

For many people with cancer, there is now indeed a tomorrow — one that should be free of opioid addiction.

Total Pain

- Physical
- Emotional
- Social
- Spiritual

Cicely Saunders



Treating pain is an ethical imperative

Balancing safety and harms of treatment regimens is critical

Our understanding of pain and its management continues to evolve



Thank you for your attention

Wishing you the best in your ongoing M4 studies

Please email me with any questions

Proceed to the required quiz

Resources

- 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>.
- Difficult Opioid Conversations, Flip the Script, Department of Human Services