Review of The CDC Guidelines for Prescribing Opioids for Chronic Pain

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Faculty Disclosure

- Dr. Todd Woodard discloses no relevant financial conflicts of interest with regard to this activity

Learning Objectives

- At the conclusion of this application-based presentation, the learner should be able to:
  - Demonstrate the appropriate use of the 2016 CDC Prescribing Guidelines for chronic pain management
  - Identify patients who should be prescribed opioid overdose treatment medication and understand differences in current formulations

Pre-Test Question 1

- About how many individuals in the US have an Opioid Use Disorder?

a) 1 million
b) 2 million
c) 3 million
d) 4 million

Pre-Test Question 2

- Which is not a symptom of an opioid overdose?

a) Respiratory Depression
b) Sedation
c) Mydriasis
d) Miosis

Pre-Test Question 3

- What is the most expensive Buprenorphine based Medication Assistant Treatment?

a) Suboxone Film
b) Butrans
c) Probuphine
d) Belbuca

Pre-Test Question 4

- Prescribers and Pharmacists do not have a role in mitigating the Opioid Epidemic

a) True
b) False

Background of the Opioid Epidemic

- Opioid Epidemic
  - What is the opioid epidemic
  - DSM-V criteria for opioid use disorder
  - DSM-V criteria for opioid overdose
  - Initiatives for resolution of the opioid epidemic

Prevalence of the Opioid Use Disorder

- Opioid Use Disorder
  - **~4 million** people in the US have used prescription pain relievers for nonmedical reasons
  - **~2 million** people in the US have an opioid use disorder
  - **~16 million** people worldwide have an opioid use disorder
  - Mortality rates are **13 times higher** compared with non-users

Prevalence of the Opioid Overdose

- Opioid Overdose
  - Since 1999, the number of overdose deaths involving opioids quadrupled
  - Since 1999, the amount of prescription opioids sold in the U.S. nearly quadrupled w/o an overall change in the amount of pain reported.
  - From 2000 to 2015 more than half a million people died from drug overdoses
  - **91** Americans die every day from an opioid overdose.

CDC Guidelines Recommendations

1st Recommendation

- Nonpharmacologic and nonopioid pharmacologic therapy are preferred for chronic pain

2nd Recommendation

- Before starting opioid therapy, treatment goals should be established

3rd Recommendation

- Before starting and during opioid therapy, risk vs benefits of opioid therapy should discussed along with patient and providers role in managing therapy

4th Recommendation

- Immediate-release opioids should be used first when prescribing opioid therapy

Patient Case 1

- AM is 40 year old male who presents to his family physician regarding continued pain in his left knee. His past medical history is positive for sports related knee injury X 2 years ago and mild hypertension. His x-ray shows degenerative changes with osteophyte formation in his left knee. A diagnosis of left knee osteoarthritis is made. AM pain level is 5 out of 10 and he is ready to start medical management. His current medications include HCTZ for HTN and occasional use of OTC APAP 500mg BID. He notes that his current OTC APAP regimen is not working.
- Answer Questions 1-3

Question 1

- What is the recommended next step in managing AM's left knee osteoarthritis?

a) Tramadol 50mg 1 q 4-6 hours
b) Diclofenac sodium 50mg BID
c) Diclofenac potassium 50mg TID
d) APAP 1000mg QID and physician directed exercise program or PT

Question 2

- AM continues having pain upon next office visit 1 month later. What do you recommend as the next course of therapy?

a) A trial of an intra-articular steroid injection
b) Oxycodone/APAP 5/325 1-2 q 4-6 hours prn
c) A trial of an intra-articular viscosupplementation
d) A trial of an intra-articular steroid injection and Naproxen 500 BID

Question 3

- AM is now having mild to moderate pain and previous treatments have continued to fail. What would be the next course of action?

a) Morphine Sulfate ER 15mg BID plus continued PT/exercise
b) Oxycodone ER 20mg BID plus continued PT/exercise
c) Tramadol 50mg 2 q 6 hours prn and PT/exercise
d) Tramadol 50mg 1 q 6 hours prn, APAP 1g QID, and PT/exercise

5th Recommendation

- Lowest effective dose of opioids should be prescribed
- Risk vs benefit should be considered before exceeding

≥50 MME/D

- Doses should not exceed >90 MME/D

Opioid Equianalgesic Dosing Chart

	Equianalgesic Doses (mg)	
Drug	Parenteral	Oral
Morphine IR	10	30
Morphine ER	N/A	30
Oxycodone IR	N/A	20-30
Oxycodone ER	N/A	20-30
Hydrocodone IR	N/A	30-45
Oxymorphone IR	1	10
Oxymorphone ER	N/A	10

6th Recommendation

- Providers should use the lowest effective dose of immediate-release opioid for acute pain for the shortest duration

7th Recommendation

- Benefits vs Risks should be evaluated 1 to 4 weeks after starting opioid therapy for chronic pain or dose escalation and every 3 months for continued therapy

8th Recommendation

- Evaluate risks of opioid related-harm before and during therapy along with discussing risk reduction strategies and offering naloxone to high risk patients

Patient Case 2

- BF is 45 year old overweight female who presents for a follow-up appt with her physician assistant regarding pain related to migraine headaches. Her past medical history is positive for migraine headaches X 6 months and newly diagnosed neuropathic pain. Her headache diary consists of 10 headache days per month with increasing # of headaches over the last month. Sumatriptan is not resolving acute headaches. She is a current smoker and enjoys having a glass of wine daily with her meals. BF pain level is 6 out of 10 and she is ready to start prophylactic medication. Her current medications include daily butalbital/APAP/caffeine and sumatriptan 50mg (using 3 x/week) for migraines.
- Answer Questions 1-3

Question 1

- What should be the first recommendation for BF regarding her current treatment?

a) Start a trial of low dose immediate-release opioids and D/C smoking
b) Start a trial of pregabalin to treat neuropathic pain and headaches and D/C wine
c) Increase dose of sumatriptan to 100mg and immediately stop butalbital/APAP/caffeine and D/C smoking and wine
d) Reduce dose of sumatriptan and taper to discontinued butalbital/APAP/caffeine, D/C smoking and wine

Question 2

- After a last visit and recommendations, patient continued to have chronic migraines with 8 migraine headache days per month. What would be the next course of treatment?

a) Start a trial of tramadol
b) Start a trial of amitriptyline
c) Start a trial of divalproex sodium
d) Start a trial of onabotulinumtoxinA

Question 3

- After following the previous recommended treatment from the last office visit patient is still having trouble aborting acute headaches and has newly diagnosed stage 2 hypertension. PA-C wants to start a trial of an immediate-release opioid. What is recommended to be done before treatment?
  a) Assess risk vs benefit of opioid treatment and re-evaluate use after 5 weeks
  b) Assess risk vs benefit of opioid treatment and re-evaluate use after 6 weeks
  c) Assess risk vs benefit of opioid treatment and re-evaluate use after 2 months
  d) Assess risk vs benefit of opioid treatment and re-evaluate use after 1 month

9th Recommendation

- Providers should check their states prescription drug monitoring program (PDMP) when prescribing opioids

GA PDMP website:https://gdna.georgia.gov/georgia-prescription-drug-monitoring-program

10th Recommendation

- Urine drug screens (UDS) should be done prior to and at least annually for chronic opioid use

11th Recommendation

- Prescribing opioids concomitantly with benzodiazepines should be **avoided**

12th Recommendation

- Medication-assisted treatment (MAT) along with behavioral therapy should be offered for patients with opioid use disorder

Patient Case 3

- JT is 29 year old male and is having an appt with his new family physician for continued back pain after back surgery 4 months ago. His pain continues despite around the clock hydrocodone/APAP 1-2 tabs q 4 hours. JT pain level is 7 out of 10 and he complains that current therapy is not working. His past medical history includes chronic back pain, depression, and anxiety. Currently taking hydrocodone/APAP, sertraline, and alprazalam.
- Answer Questions 1-3

Question 1

- Before starting or continuing opioid therapy what should the prescriber do?

a) Check the PDMP, complete UDS, complete opioid risk assessment tools, and discuss provider and patient expectations
b) Check PDMP and complete UDS
c) Check the PDMP, complete UDS, complete opioid risk assessment tools, and complete pain contract, and discuss provider and patient expectations
d) No further assessment is needed as this patient is friends with provider

Question 2

- JT's physician is agreeing to start additional therapy since all assessments are favorable and wants to change regimen to Oxycodone. He consults with his on-site clinical pharmacist for recommendations on a new regimen. What should the clinical pharmacist recommend?
  a) Change hydrocodone/APAP to Oxycodone IR, add Ibuprofen 800mg TID, and prescribe naloxone
  b) Change hydrocodone/APAP to Oxycodone IR, add Ibuprofen 800mg TID
  c) Change hydrocodone/APAP to Tramadol, add Ibuprofen 800mg TID, and prescribe naloxone
  d) Change hydrocodone/APAP to Oxycodone IR, add Ibuprofen 800mg TID, and prescribe naloxone, and consider consultation with physician prescribing alprazalam to decide on its continued use

Question 3

- On follow-up visit prescriber has learned from patient's insurance company that patient now has opioid use disorder. What recommendation should be made?
  a) Taper to discontinue opioids, ensure patient has naloxone available, refer patient to appropriate provider for Medication Assisted Treatment
  b) Immediately discontinue opioids, ensure patient has naloxone available, refer patient to appropriate provider for Medication Assisted Treatment
  c) Taper to discontinue opioids and ensure patient has naloxone available
  d) Taper to discontinue opioids, ensure patient has naloxone available, continue Ibuprofen, and refer patient to appropriate provider for Medication Assisted Treatment

Summary

- Use and optimize nonopioid therapy and adjunctive medications
- Identify appropriate/inappropriate use of opioids
- Identify patients at risk for opioid misuse
- Reduce risk of overdose
- Provide naloxone
- Educate patients about opioid safety
- Ensure proper follow-up
- Taper, discontinue, and/or refer to specialist if needed

Practice Exercise

Convert the following Opioids

1.) Hydrodone IR 10mg q 6 hours to Oxycodone IR

Answer:_____

2.) Oxycodone ER 40 mg BID to Morphine Sulfate ER

Answer:_____

Questions

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