AAPM 34th Annual Meeting

April 25-29, 2018 | Vancouver, Canada

Opioid Prescribing: Current Guidelines and Best Practices

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Disclosure

- Working Group for the Center for Disease Control Guidelines for Chronic Pain
- Off-label use will not be discussed in this presentation.

Self-Assessment Question 1

The CDC Guidelines for prescribing opioids for chronic pain are primarily intended for which of the following?

A. Improve communication between providers and patients about risk/benefits and to improve safety and effectiveness
B. Guide pain specialists on the use of opioids to treat chronic pain
C. Cancer treatment, palliative care and end-of-life care
D. Establish Standard of Care for the chronic use of opioids to treat pain

Self-Assessment Question 2

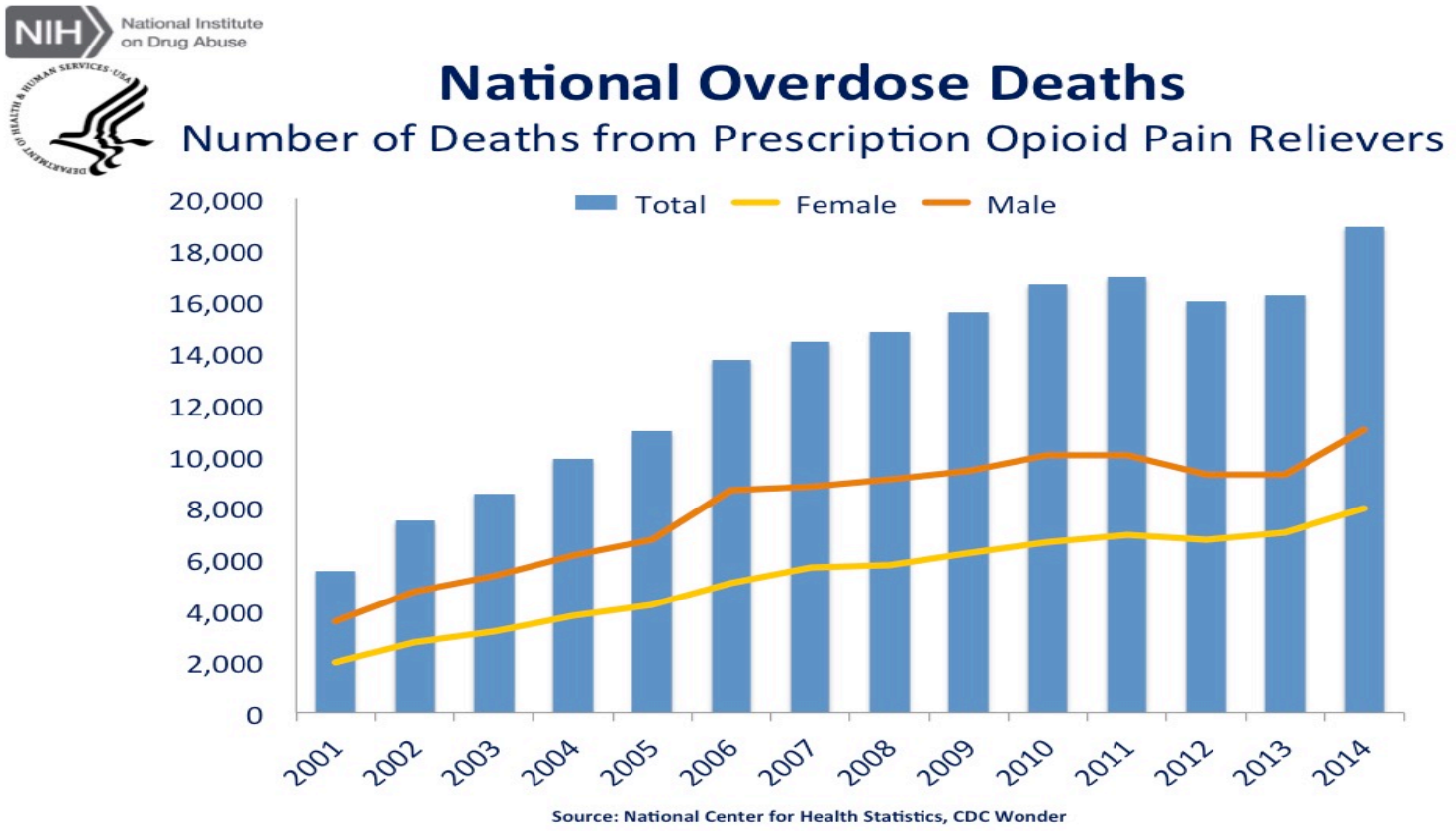
Which of the following one of the CDC guidelines is true?

A. Always start with a long acting or extended release opioid
B. There is no upper limit for opioid dose as long as you properly select and monitor the patient
C. It is OK to prescribe additional opioids for acute pain in case the pain continues longer than expected
D. Monitor the Prescription Drug Monitoring Program for the patient at least every 3 months

Learning Objectives

- Review the impetus for developing the CDC guidelines
- Discuss the 12 CDC guidelines, reasoning and recommendations for use in clinical practice.

Prescription Opioid Deaths Continue to Rise



CDC Guidelines for Prescribing Opioids for Chronic Pain

- Improve communication between providers and patients about risks/benefits and to improve safety and effectiveness
- Primarily targeted at Primary Care Physicians
- Not intended for patient who are in active cancer treatment, palliative care, or end-of-life care
- Not intended to dictate Standard of Care

Interpretation of Recommendation Categories and Evidence Type

- Recommendation Categories
  - Category A applies to all persons, most should receive the recommeded course of action
    - 11 out of 12 of the guidelines
  - Category B Individual decision making needed; different choices will be appropriate for different patients
    - 1 out of the 12 guidelines

Interpretation of Recommendation Categories and Evidence Type

- Evidence Type
  - Type 1: Randomized clinical trials or overwhelming evidence from observational studies (0/12)
  - Type 2: Randomized clinical trials with important limitations or exceptionally strong evidence from observational studies (1/12)
  - Type 3: Observational studies or randomized clinical trials with notable limitations (4/12)
  - Type 4: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations (7/12)

Guideline #1

- Nonpharmacological and nonopioids preferred and should be tried first (Recommendation category A, evidence type 3)
  - Most insurances will not approve these therapies to treat chronic pain

Guideline #2

- Establish treatment goals with consideration on how to D/C if unsuccessful (Recommendation category A; evidence type 4)
  - May use validated assessment instruments
    - CDC suggest the Pain average, interference with Enjoyment of Life, and interference with General activity (PEG) Assessment Scale*
  - Document exit strategy

*Krebs EE, et al. J Gen Intern Med, 24:733, 2009

Guideline #3

- Discuss risks and realistic benefits (Recommendation category A; evidence type 3)
  - Evidence for harm greater than evidence for benefits
    - Chou R, et al. Effectiveness and risk of long term opioid treatment in chronic pain. AHRQ Evidence Reports/Technology Assessments, 2014

Opioid Risks

- Sedation
- Confusion
- Nausea
- Dizziness
- Constipation
- Gonadal suppression
- Respiratory suppression
- Sleep apnea
- Death (over 19,000 cases annually)

- Tolerance
- Physical Dependence
- Addiction
- Withdrawal

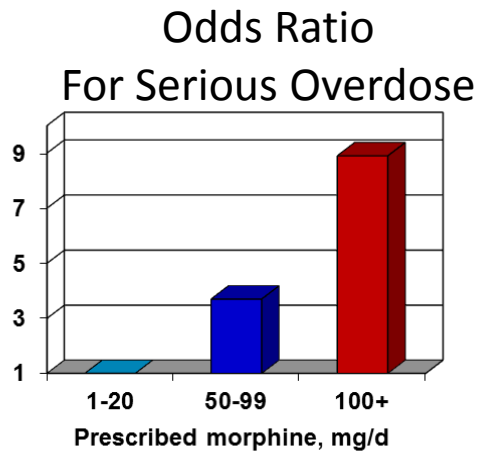
What about Societal Risks?

Guideline #4

- Start with immediate-release opioids (Recommendation category A; evidence type 4)
  - Most deaths associated with long-acting opioids
  - Methadone not first choice
    - appears to be involved in approximately one third of all prescription opioid-related deaths, exceeding hydrocodone and oxycodone despite being prescribed one-tenth as often
  - Transdermal fentanyl should only be used by clinicians familiar with properties

Guideline #5

- Use caution with any dose, additional precautions ≥50 MME, generally avoid ≥90 MME (Recommendation category A; evidence type 3)
  - ≥50 MME associated with overdose
    - Dilokthornsakul P, et al. Risk Factors of Prescription Opioid Overdose Among Colorado Medicaid Beneficiaries. J Pain 17:436, 2016
  - ≥90 MME associated with a 9 fold increase in overdose
    - Dunn KM et al. Ann Intern Med. 2010;152(2):85-92



Guideline #5 continued

- What about transfer patients on high dose opioids?
  - Offer opportunity to reevalute their continued use given recent evidence of overdose risk and poor evidence on benefit
  - Consider tapering plan
    - Should be slow enough to avoid withdrawal

Guideline #6

- For acute pain, prescribe lowest effective dose with immediate-release, minimum quantity needed, usually no more than 3 or fewer days for most non-traumatic pain or minor surgery, more than 7 days rarely needed.
  (Recommendation category A; evidence type 4)
  - A significant number of chronic opioid users start with use for acute pain
  - Do not prescribe additional opioids to patients “just in case” pain continues longer than expected
  - Do not use LA/ER opioids

Guideline #7

- Evaluate benefits and harms within 1-4 weeks of starting. At least every 3 months for continued therapy. (Recommendation category A; evidence type 4)
  - Consider visits in the lower end of range when using ER/LA opioids, dose > 50 MME, using methadone, high risk patients

Guideline #8

- Incorporate plans to mitigate risks (ie. Naloxone) for ≥50 MME or other risk factors (Recommendation category A; evidence type 4)

Guideline #9

- Monitor PDMP at least every 3 months (Recommendation category A; evidence type 4)
  - In California (Effective 10/2/18)
    - Must consult CURES prior to prescribing II, III, IV for the first time and at least every 4 months thereafter
      - Exceptions: Use for inpatients; ER if quantity < 7days; Postop if quantity < 5 days; Receiving hospice care
  - Not all states have functioning PDMP programs
  - Studies are showing that PDMP programs are not affecting prescription trends
      - Deyo et al, J Pain, 2018

Guideline #10

- UDT before starting and at least annually
  (Recommendation category B; evidence type 4)
  - Try and use less expensive screening assays (immunoassay)
  - Do not test for non-meaningful substances
  - If positive/negative, send for confirmatory GC/mass spec
  - Explain to patient that UDT is for their safety
  - Use results wisely

Guideline #11

- Avoid co-administration of benzodiazepines whenever possible (Recommendation category A; evidence type 3)
  - Also consider other central nervous system depressants (muscle relaxants, hypnotics)
  - Check PDMP and make sure they are not taking substances not disclosed
  - If taking benzodiazepines for anxiety, consider psychotherapies (i.e. CBT)

Guideline #12

- Offer or arrange evidence-based treatment (buprenorphine or methadone with behavioral therapies) for patients with opioid use disorder (Recommendation category type A; evidence type 2)
  - In communities without sufficient treatment capacity, consider obtaining a waiver from SAMHSA that allows use of buprenorphine

Summary: Ground Rules for Prescribing Opioid Analgesics

REMEMBER!

- Proper patient selection is *THE* key
- Proper patient assessment is mandatory
- Opioid analgesics are but one component of a comprehensive treatment plan
- Prescribing opioids on a trial basis *MUST* be monitored
- Patient reassessment is *KEY* to ongoing monitoring of opioid therapy
- Any medical treatment can be continued, discontinued, or modified

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