Update on Guidelines for Prescribing Opioids for Chronic Pain

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Outline

Historical view

Evolving guidelines

Take-home points

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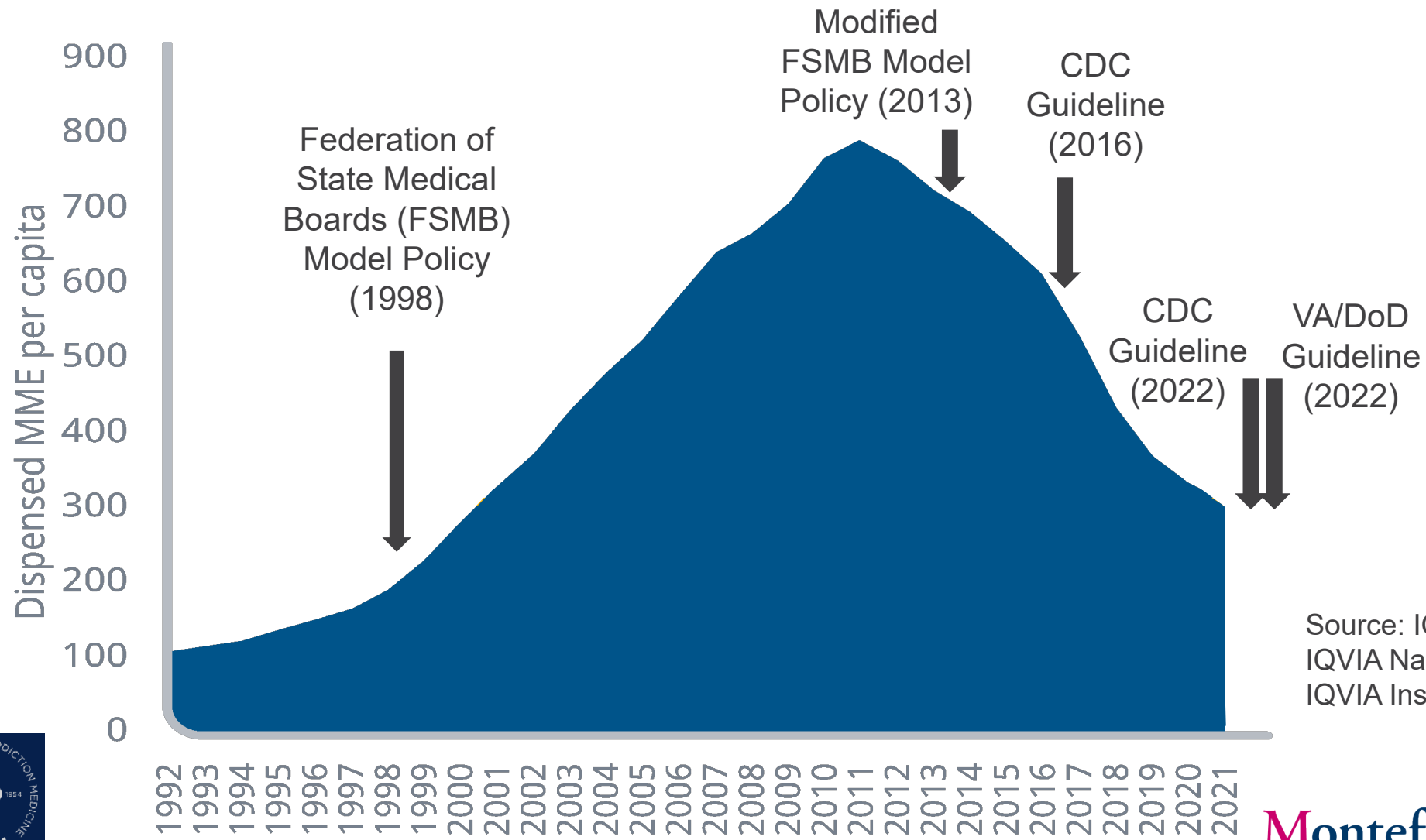
Epidemiology of opioid prescribing



Source: IQVA Xponent, Mar 2020; IQVIA National Prescription Audi; IQVIA Institute, Nov 2020).

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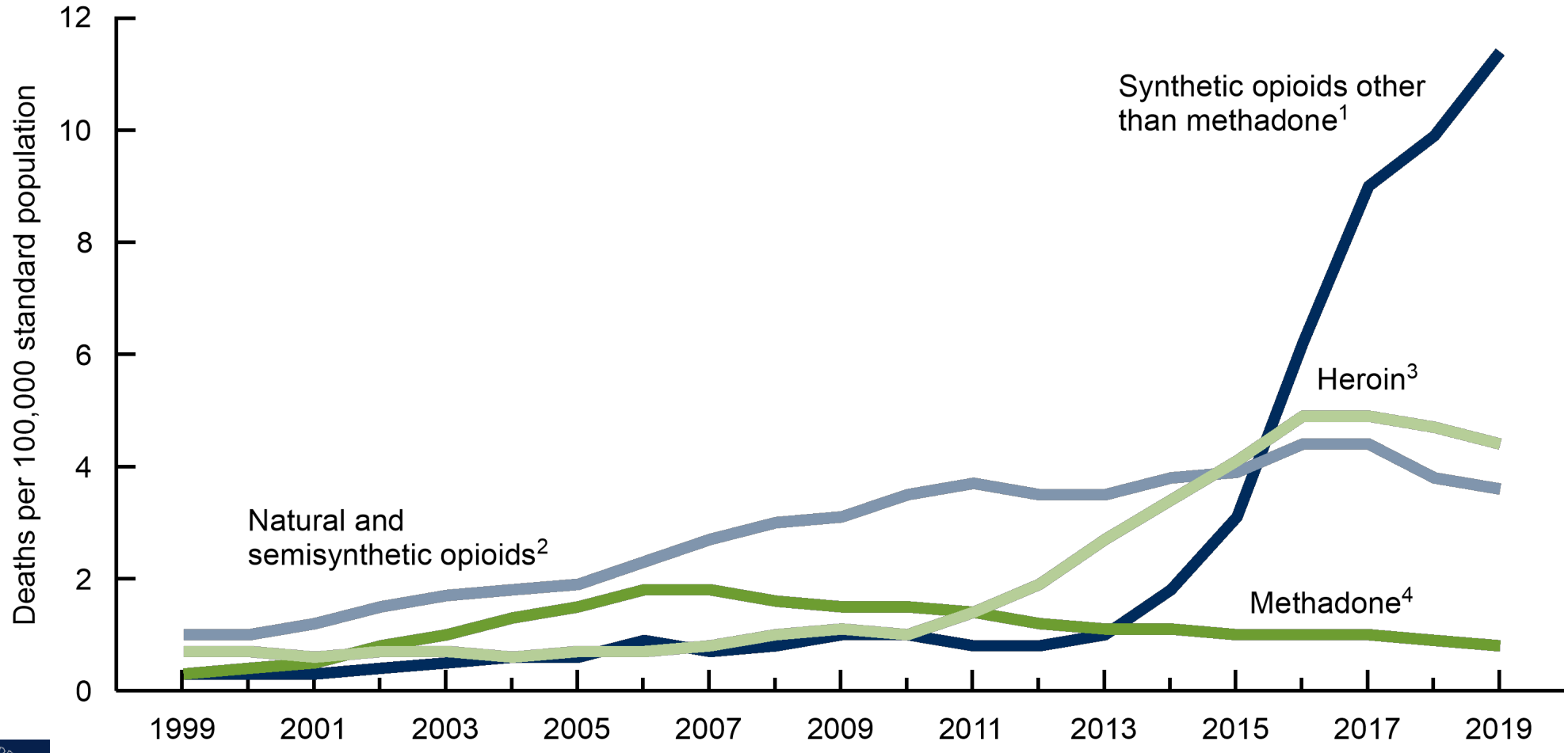
Opioid overdose death



Source: National Center for Health Statistics, National Vital Statistics System, Mortality

Clinical guidelines for opioid prescribing (2016)

- **When to prescribe opioids for chronic pain**
  - Non-pharmacologic and non-opioid therapies are preferred
  - Establish functional treatment goals
  - Discuss risks/benefits of opioids, and patient/provider responsibilities
- **How to prescribe opioids for chronic pain**
  - Start with immediate release (not long-acting) formulations
  - Prescribe lowest effective opioid dose (avoid and justify >90 MME)
  - For acute pain, not more than 3 to 7 days' supply
  - Regularly reassess; taper if pain and functional benefits do not outweigh risks
- **Assessing and mitigating harms**
  - Use the prescription drug monitoring program, urine drug testing, give naloxone
  - Avoid concurrent benzodiazepine use when possible
  - If OUD, provide or refer for OUD treatment ★

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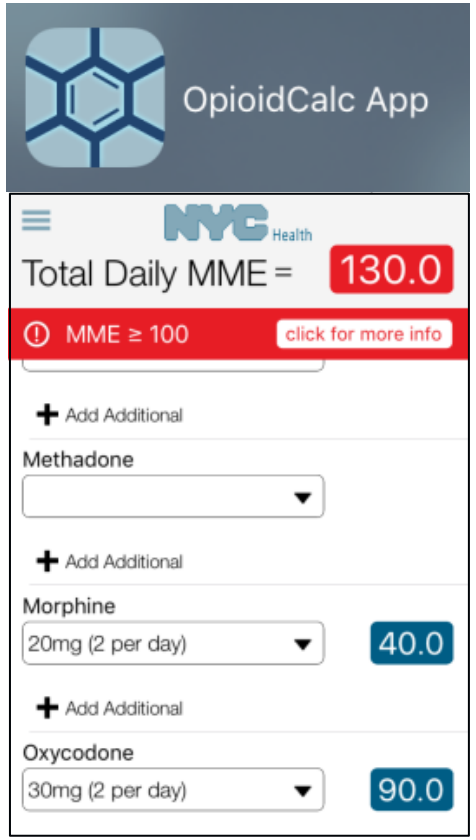
90 MME

- MME = morphine milligram equivalents
  - 90 MME is ~65 mg oxycodone
- CDC (2016): “Avoid” or “carefully justify” increasing to ≥90 MME/day
  - Arbitrary threshold
  - Did not say to taper all patients to below 90 MME

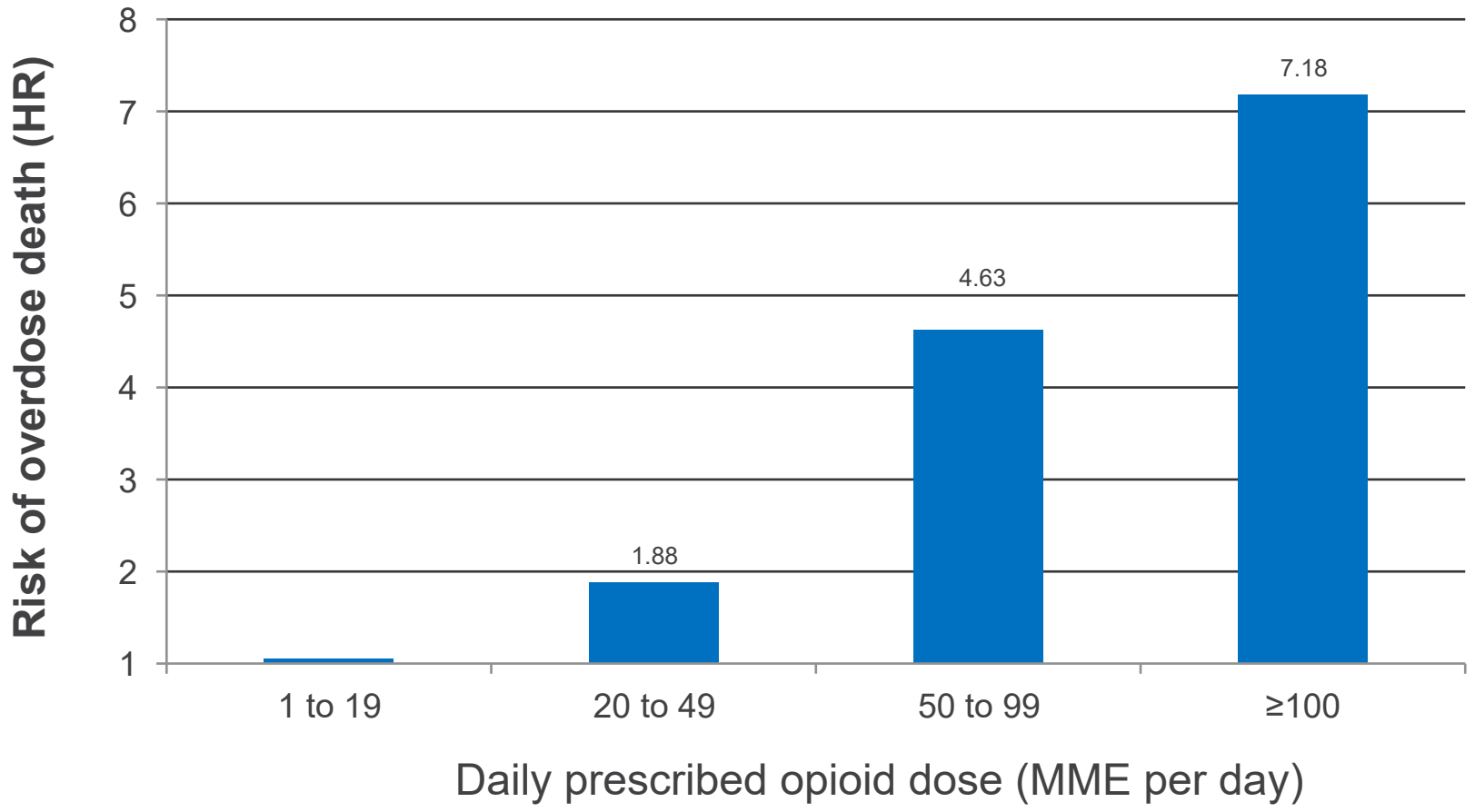


No clear benefit to escalating opioid dose

- No difference in chronic pain or function with increasing opioid dose
  - RCT of stable dose (mean 40 MME) vs. liberal dose escalation[1]
- No improvement in chronic pain or function with opioids for chronic pain
  - RCT of opioids vs. non-opioids for chronic back or OA pain[2]

[1]Naliboff BD et al., J Pain (2011); [2]Krebs EE et al., JAMA (2018)

Overdose death increases with opioid dose



Bohnert AS et al., JAMA 2011

Benefits of tapering

Annals of Internal Medicine

REVIEW

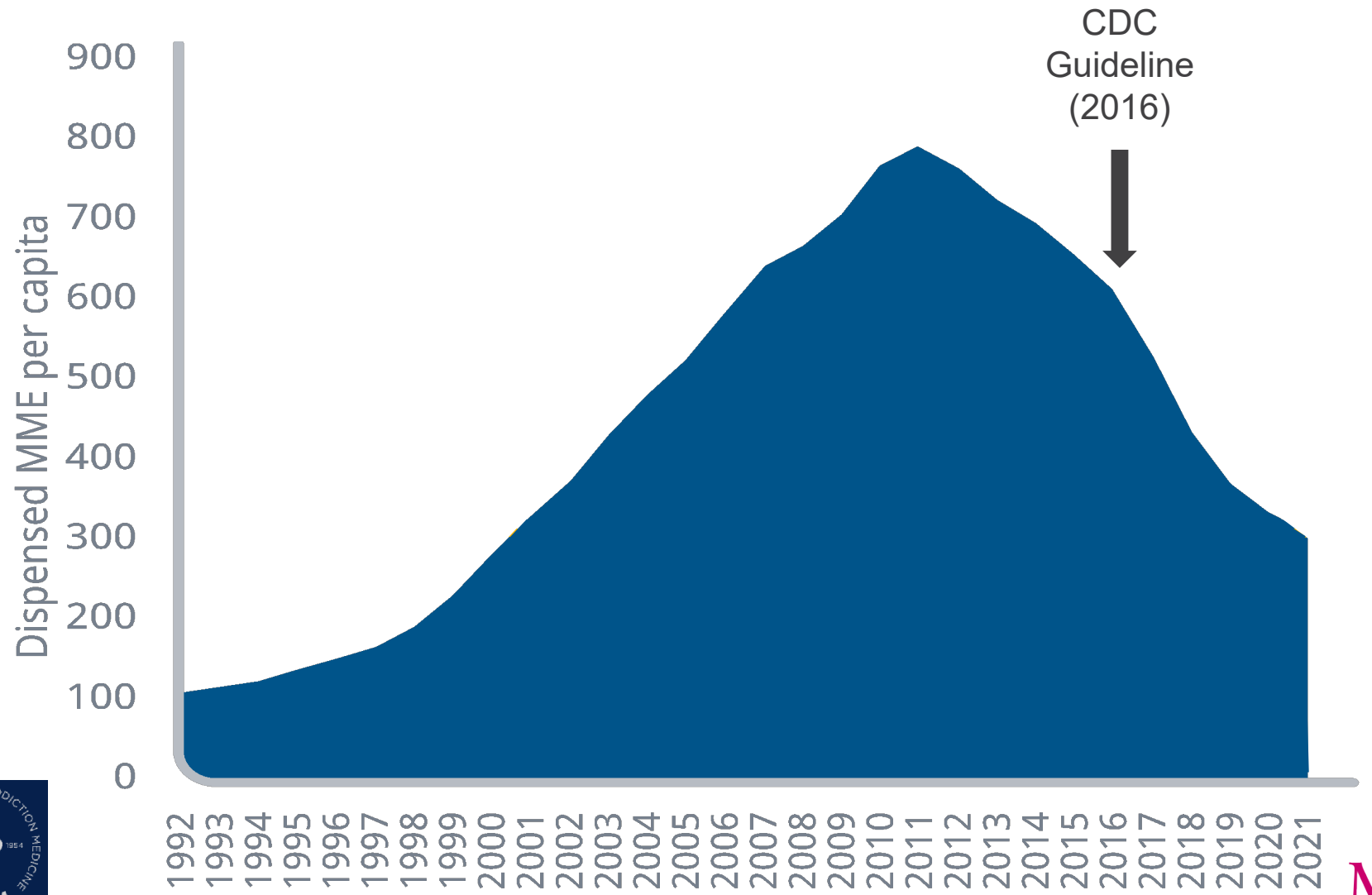
Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy

A Systematic Review

- 67 studies, very low-quality evidence overall
- Fair-quality evidence suggesting:
  - Improvement in pain severity
  - Improvement in function
  - Improvement in quality of life
- Limited ability to conclude effects on:
  - Opioid withdrawal symptoms
  - Substance use
  - Adverse events
- Most studies were in multimodal pain care programs

Frank J, 2017

What happened?



Source: IQVA Xponent, Mar 2020; IQVIA National Prescription Audi; IQVIA Institute, Nov 2020).

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Providers turning patients away

- 43% of PCP clinics surveyed unwilling to prescribe to a new patient on long-term opioids

- Why?
  - Stigma of chronic pain or opioid use
  - Fear of liability and regulatory burden
  - Payor and pharmacy barriers

Lagisetty P et al. Assessing reasons for decreased primary care access. Pain (2021)

Inequities in opioid prescribing and de-prescribing

- Compared with white patients, Black patients are:
  - Less likely to be prescribed opioids, and prescribed fewer or lower dose[3]
  - More likely to have prescription opioids tapered[1]
  - More closely monitored, including more urine drug testing[2]
- Similar and less pronounced trends for Latinx vs. white non-Hispanic
- Compared with men, women are:
  - Less likely to be prescribed opioids, and prescribed lower dose[6]
  - More likely to have prescription opioids tapered[5]
- Notably, Black and female patients have *lower* risk for prescription opioid death than white and male patients

[1]Buonora M et al., Pain Medicine (2019); [2]Becker WC et al., Ann Family Med (2011), Hausmann LR et al. Pain (2013); [3]Pletcher MJ et al., JAMA (2008), Joynt M et al, JGIM (2013), Todd KH Ann Emerg Med (2000), Wisniewski AM et al., J Addict Med (2008), Morasco BJ et al., Pain (2010); [4] Hoffman KM et al., PNAS (2016); [5]Buonora M et al., Pain Medicine (2019); [6]Kaplovitch E, et al. PLoS One (2015), Wisniewski AM et al, J Addict Med (2008)

Harms of rapid taper or discontinuation

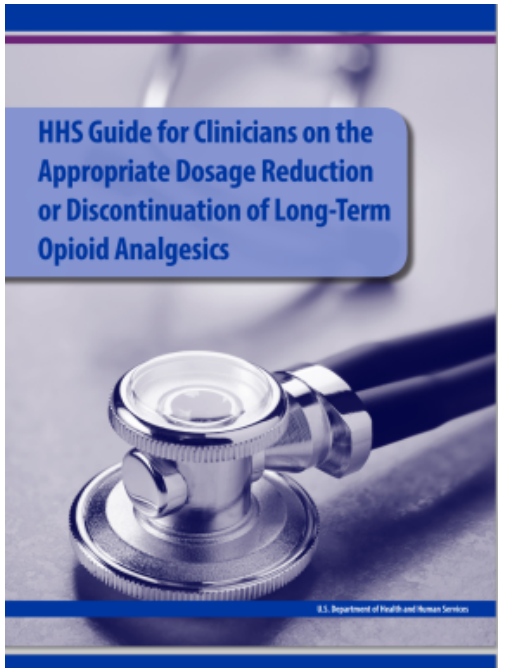
- Opioid withdrawal
- Exacerbation of pain
- Psychological distress, suicidality, and death[1]
- Termination of chronic medical care[2]
- Illicit opioid use[3]
- Opioid-related hospitalization and ED visits[4]
- Overdose and overdose death[5]
  - Possible explanations: Decreased tolerance after tapering, non-prescribed opioids, suicidality, confusion about change in prescription

[1]Demidenko MI et al., Genl Hosp Psych (2017), Oliva EM et al., BMJ (2020); [2] Perez HE et al., JGIM (2019); [3] Binswanger IA et al., DAD (2020), Coffin PO et al., Plos One (2020); [4]Mark TL et al., JSAT (2019); [5]James JR et al., JGIM (2019), Glanz JM et al., JAMA Network Open (2019)

Reaction to overzealous opioid de-prescribing

U.S. Department of Health and Human Services Guideline (2019)

- Opioids should not be tapered rapidly or discontinued suddenly
  - Except if there is a life-threatening issue, such as impending overdose



CDC (2022)

- "Misapplication [of the 2016 guideline] including inflexible application of recommended dosage and duration thresholds, **contributed to patient harms…**These experiences underlined the need for an updated guideline reinforcing the importance of **flexible**, **individualized**, **patient-centered** care."

Dowell D et al. NEJM (2022), CDC website

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Updated 2022 CDC guideline

My summary of key changes:

- Less paternalistic, more collaborative
- More room for individualized care rather than algorithmic (removed 90 MME threshold, 3-7 days for acute pain, less “avoid” language)
- Emphasized provider responsibility to provide care
- Loads of new guidance in “implementation considerations”
- Clarified that the guideline is not for payors, health systems, or regulators to set rigid standards and they “should ensure that policies do not result in rapid tapers or abrupt discontinuation”

Dowell D et al. NEJM (2022), CDC website

Some highlights of the revised CDC recommendations

- New guidance on non-opioid treatments for acute, chronic, and sub-acute pain
  - Acute: ice, heat, NSAIDS, triptans, etc. Chronic: PT, CBT, SNRIs, etc.
  - Be intentional if transition from acute event to long-term treatment
- Still, prescribe the lowest effective dose of opioids for chronic pain
  - Avoid increasing dosage above levels likely to yield diminishing returns in benefits:risks
- Regarding tapering: "If benefits do not exceed risks, *work closely with patients to gradually* taper or lower doses…"
  - Follow up at least monthly, 10% per month or slower is likely to be better tolerated
  - Need for taper if opioid treatment > a few days

Operationalizing tapering “if benefits do not outweigh risks”

High risk

- Adverse effects
- Overdose
- Risky use or misuse
- High dose opioids or concurrent sedatives (e.g., benzodiazepines)
- OUD -> switch to OUD treatment

Low benefit

- Persistent or worsening pain
- Poor function

Also consider:

- **Risks/benefits of <u>tapering</u> too**
- **<u>Patient</u> (not only provider) perspectives**

New CDC Guideline: In situations where benefits and risks of continuing opioids are considering to be close or unclear, **shared decision-making** with patients is particularly important.”

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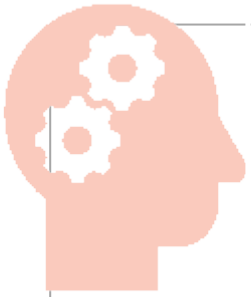
Applying harm reduction principles to opioid prescribing and de-prescribing

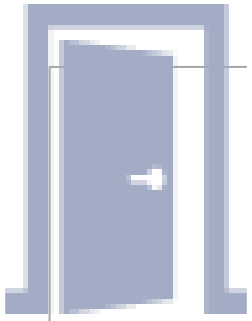


Respecting the rights of people prescribed opioids

- Individualized care
- No forced withdrawal

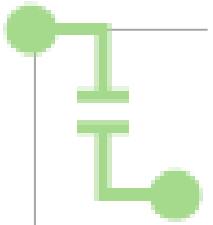
Acknowledging a spectrum of use and problems

- Sometimes benefits exceed risks
- People may not be able to taper off



Providing non-judgmental, low-threshold services

- Do not refuse care



Meeting people where they are

- Shared decision-making
- Slow taper

Patients have told us this is what they need.

Matthias M et al., J of Pain (2017); Ritchie CS et al., The Gerentologist (2020); Goesling J et al., Pain (2019); Dassieu L et al., Canadian J of Pain (2021); Perez HE et al., AMERSA abstract (2019); Henry S et al., J of Pain (2019).

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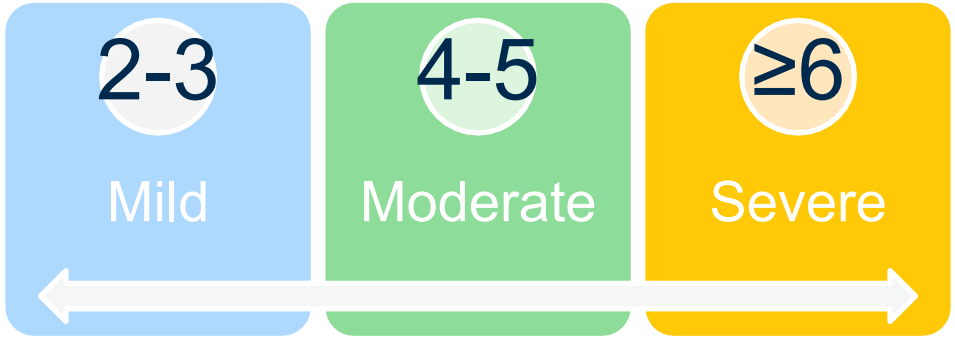
Diagnosing OUD when opioids are prescribed

Diagnostic criteria

- ❑1. Taking more or for longer than intended
- ❑2. Unsuccessful efforts to stop or cut down
- ❑3. Spending a great deal of time obtaining/using/recovering
- ❑4. Craving
- ❑5. Failure to fulfill major role obligations due to use
- ❑6. Continued use despite resulting social or interpersonal problems
- ❑7. Important activities reduced because of use
- ❑8. Recurrent use in hazardous situations
- ❑9. Continued use despite resulting physical or psychological problems
- ❑10.Tolerance*
- ❑11. Withdrawal symptoms*



*Tolerance and withdrawal don't contribute if taken under medical supervision

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If your patient meets criteria for OUD

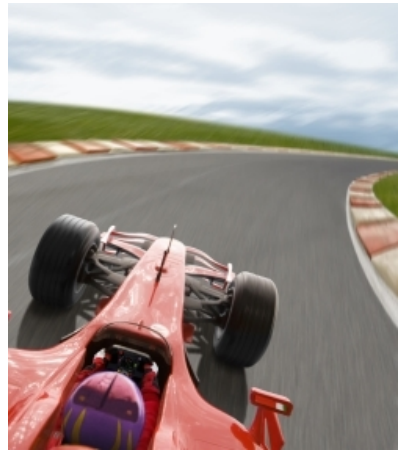
- If moderate or severe OUD
  - Connect them with evidence-based treatment with methadone or buprenorphine
- If mild OUD
  - Offer transition to buprenorphine (particularly if prior unsuccessful taper)
  - Less evidence to guide treatment; may be reasonable to attempt taper
- It is not always clear
  - Ongoing assessment, additional criteria may emerge
  - Even if no OUD but risks>benefits and unable to taper, may benefit from buprenorphine per CDC

Veterans Affairs/Department of Defense Guideline (2022)

- “Paradigm shift” in pain care towards more patient-centered, whole health approaches
- Largely consistent with updated CDC recommendations with notable exceptions:
  1. Assess and address mental health in patients with chronic pain
     - Depression, PTSD, traumatic brain injury
     - Increased risk of suicidality after opioid tapering[1]
  2. New recommendation #5: “For patients receiving daily opioids for the treatment of chronic pain, we suggest the use of buprenorphine instead of full agonist opioids due to lower risk of overdose and misuse.” [weak evidence for]
     - Evidence is limited, but strong safety profile over other long-acting opioids
     - Note that sublingual buprenorphine/naloxone is FDA-approved for OUD and is used off-label for pain management

[1]Demidenko MI et al. Gen Hosp Psychiatry 2017.

Questions and considerations in expanding buprenorphine for chronic pain without OUD



- Are we going too fast again?
  - Will use of opioids for chronic pain expand because safer option?
  - Not enough evidence to guide implementation
- For opioid-naïve patients:
  - Low-dose dose buccal or transdermal probably best
  - In conflict with recommendation not to start with long-acting opioid
- For opioid-tolerant patients:
  - Remaining lack of clarity about when to switch, e.g. only if high risk/unsuccessful taper?
  - More likely to need higher doses, such as sublingual bupe/naloxone, but this is off-label
  - Many providers will need help with induction and dosing
- Public health perspective: We still need to identify and track OUD

Cunningham C and Starrels JL. Guideline Promoting Buprenorphine for Treatment of Chronic Pain: Transformative Yet Underdeveloped. Annals of Int Med; 2023.

Take-home points

- The prescription opioid landscape and guidance continue to evolve
- Apply harm reduction principles for opioid prescribing and deprescribing and consider each individual's whole health
- Be mindful of biases and equity in pain and opioid management
- Buprenorphine is a safer alternative to full agonists and seems like the future, but questions remain
- Stay tuned!