CDC Issues New Opioid-Prescribing Guidelines

Seeking Balance Between Pain Relief and Safety

William Renthal, MD, PhD

Pain is a symptom common to numerous physical and psychiatric ailments and can often be managed by treating the underlying condition. However, in approximately 20 million patients each year, chronic pain persists despite treatment.\(^1,2\) Chronic pain is complex, heterogeneous, and poorly understood. Patients with chronic pain experience a decreased quality of life and increased risk for multiple comorbidities, costing society billions of dollars in reduced productivity annually. Therefore, equipping physicians with effective tools and guidelines for chronic pain management is of paramount importance.

Chronic pain can be managed with both pharmacologic and nonpharmacologic options, such as behavioral and physical therapy. Unfortunately, insurance coverage for multidisciplinary pain management is limited, which places much of the responsibility for treating chronic pain on primary care and prescription medications. Multiple pharmacologic options are available, including nonsteroidal anti-inflammatory drugs, antidepressants, anticonvulsants, and opioids, but it is rarely possible to predict the safest and most effective medication for a given patient. Moreover, there is a paucity of clinical trials to guide physicians in treating chronic pain. In some cases, opioids are the only class of medications to which a patient responds, but because of dangerous adverse effects, including respiratory depression, unintentional overdose, and addiction, it is important for physicians, especially those in primary care, to be confident with prescribing them safely.

The clinical decision to prescribe opioids must also be made in the setting of increases in opioid prescriptions and prescription opioid-related deaths, which now exceed 200 million prescriptions and 16000 deaths per year (Figure). About half of those who died had an active opioid prescription; the other half obtained opioids through pill diversion.\(^2\) Notably, among diverted opioid prescriptions, more than 50% are obtained freely from a family member or friend with a valid prescription. This reality forces prescribing physicians to simultaneously address the risk for opioid overdose in their own patients, as well as the risk of prescriptions being diverted and harming others.

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**REFERENCES**


**Figure. Opioid Prescriptions and Opioid-Related Deaths From 1999-2013**

Data compiled from National Institute on Drug Abuse, 2014,\(^3\) and National Prescription Audit, 1997-2013.\(^4\)

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The challenge of effective pain management, coupled with exponentially rising opioid-related deaths, is further compounded by inadequate physician education regarding opioid prescribing. A multifaceted federal effort aims to address this crisis through significant increases in funding to multiple opioid-related programs and opioid-prescribing educational initiatives targeting 540,000 physicians within the next 2 years. In step with these goals, this week’s JAMA features the final Centers for Disease Control and Prevention (CDC) guidelines for opioid prescribing for noncancer, nonpalliative chronic pain.

Driven by the strong federal push to improve opioid education and safety, the CDC recommendations consolidate and build on opioid-prescribing guidelines from multiple professional medical societies, the goal of which is to provide primary care physicians with a resource for safe opioid prescribing.

The guidelines initially focus on when to initiate or continue opioids for chronic pain. Because of the dangerous adverse effect profile of opioids, nonpharmacologic and non-opioid medications are recommended as first-line therapy. If opioids are deemed necessary, the CDC emphasizes the importance of regularly communicating expectations, risks, and benefits with patients, at least as frequently as every dose adjustment. The guidelines particularly emphasize the importance of safe storage and disposal of opioids in the home, as this may help reduce accidental ingestion or drug diversion.

The guidelines additionally provide direction on opioid selection, follow-up, and discontinuation. The CDC recommends initiating opioid therapy with immediate release rather than extended-release/long-acting opioids, with an effort to titrate use to the lowest effective dose with the shortest duration of therapy. Finally, the recommendations focus on assessing the risk and addressing the harms of opioid use. The guidelines highlight a need to consider comorbid conditions that increase the risk for overdosing, such as hepatic insufficiency, high opioid doses, benzodiazepine use, depression, or substance abuse. In such populations, physicians are recommended to supply patients with emergency naloxone.

In addition to safe opioid-prescribing recommendations for pain, the CDC also provides guidance for reasonable prevention of prescription drug abuse. Throughout the course of opioid treatment, the CDC suggests that physicians review their state’s prescription drug monitoring program to determine whether a patient is concurrently receiving controlled substances from other physicians. For select patients, urine drug testing is recommended prior to initiation of therapy, and at least annually thereafter, to detect the presence of other controlled substances and to confirm the patient is taking his or her prescribed opiates. The CDC also gives guidance on addressing opioid use disorder in the primary care setting through referral to substance abuse specialists or offering medication-assisted treatment with buprenorphine or methadone. Together, these final CDC guidelines and excellent web resources provide a central and up-to-date resource for primary care physicians prescribing opioids.

Despite these prudent recommendations, there are few well-controlled clinical studies on opioid-prescribing methods for chronic pain. While the guidelines will be updated as new data become available, concerns may be raised that appropriate access to opioids could be negatively affected by federal guidelines based on admittedly weak data. However, it is important to note that the CDC guidelines are in this respect, an iteration of well-accepted medical principles of drug prescribing: to use the lowest effective dose for the shortest possible duration. Furthermore, many of these concerns were recently addressed in an eloquent article by the US Food and Drug Administration, which endorsed the CDC guidelines and emphasized taking a balanced approach between the needs of patients with chronic pain and the public health risks of opioid overprescribing.

As the pendulum swings away from the current environment of opioid overprescribing, improvements to patient and physician education, controlled substance tracking, abuse treatment programs, and better research in patient outcomes will all play important roles in achieving this balance. However, in the long-term, our continued investment in basic science research and the development of safer next-generation analgesics may be the ultimate solution to this considerable clinical and societal problem.

REFERENCES