# Pain Management: 2022 Update

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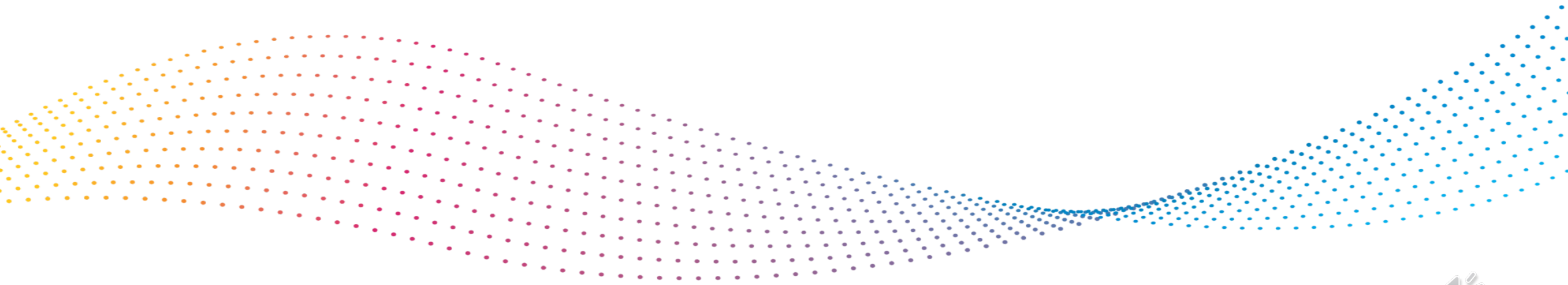


# Objectives:

1. Pain overview & prevalence
2. Types of Treatment therapies
3. World Health Organization pain ladder
4. Overview of 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain
5. 12 guideline recommendations
6. New updates and modifications to the guideline

# Pain

"An unpleasant Sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."

# Types of Pain

Fibromyalgia

Neuropathic Pain

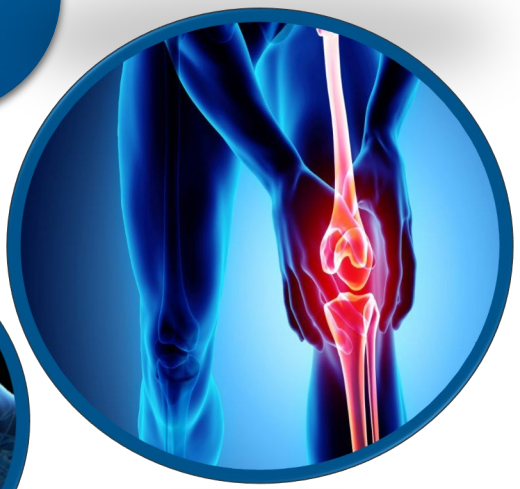
Neuropathic pain

Nociceptive Pain

Acute Pain

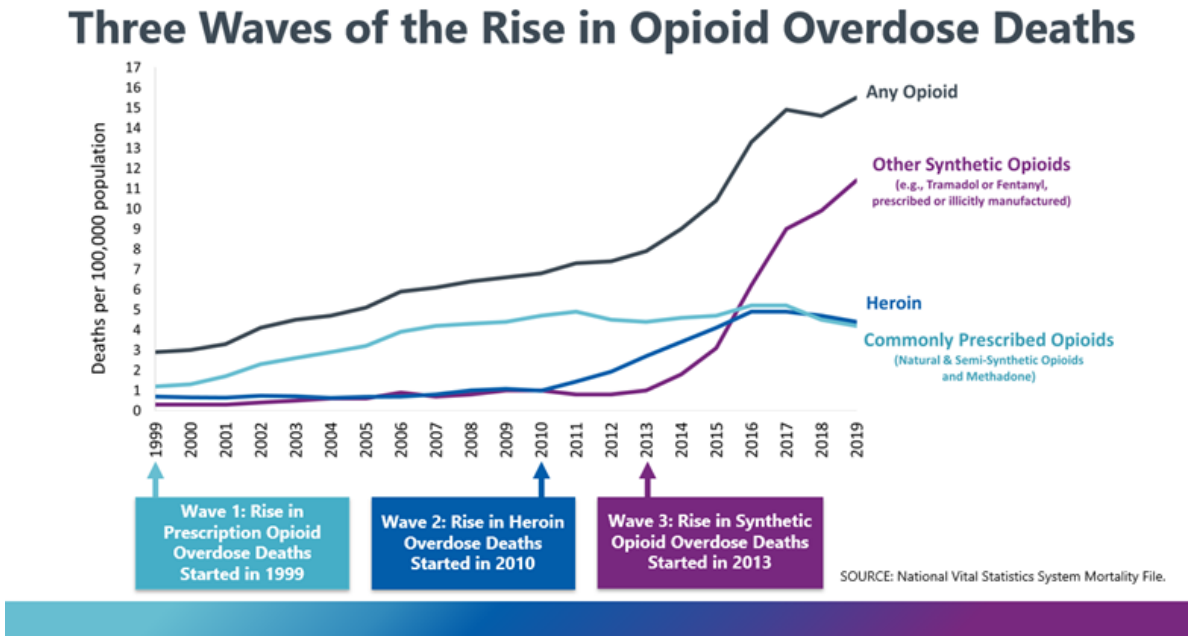
Diabetic Neuropathy

Chronic Pain



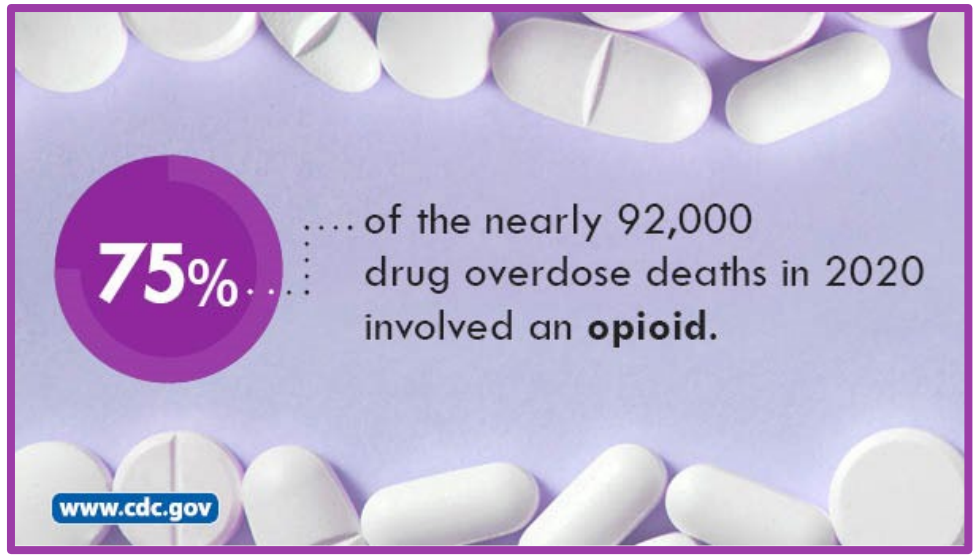
# Prevalence of Pain

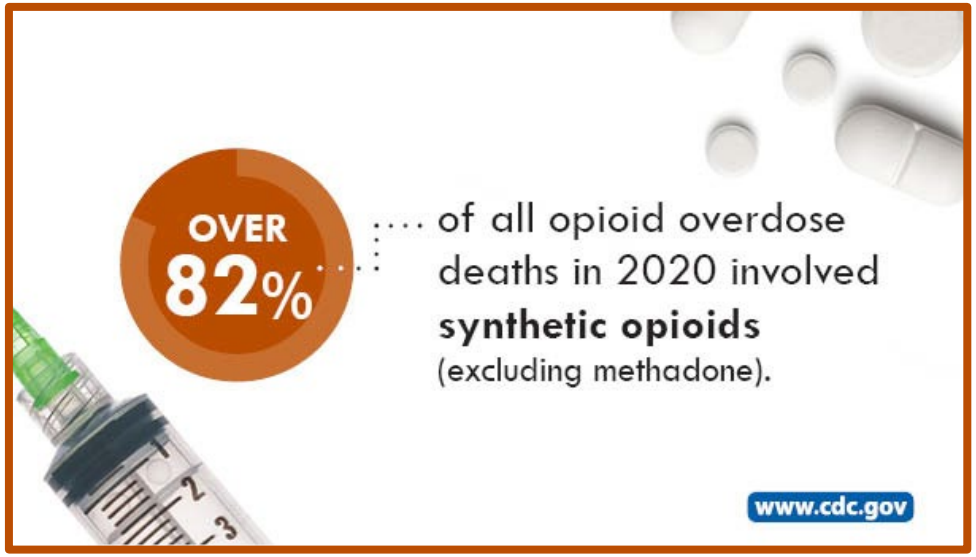
- **1 in 5** U.S. adults had chronic pain in 2019
- **1 in 14** adults experienced "high-impact" chronic pain.
- About ≥ **9%** of suicide decedents had evidence of having chronic pain at the time of death.




- **In 2020…**
  - Approx. 143 million opioid prescriptions were dispensed from pharmacies in the U.S.
  - Prescription opioids remained the most commonly misused prescription drug in the U.S.
  - Among those reporting misuse during the past year,
    - **64.6%** reported the main reason for their most recent misuse was to "relieve physical pain"
    - **11.3%** to "feel good or get high"
    - **2.3%** "because I am hooked or have to have it"

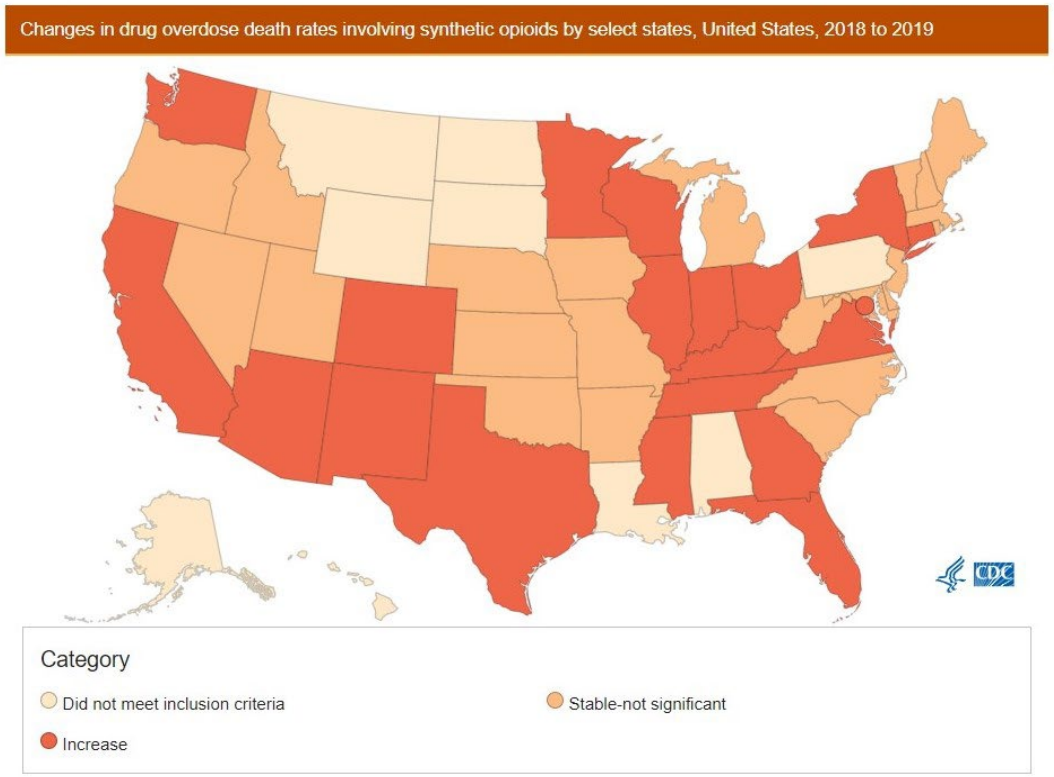

187
PEOPLE
die every day from an opioid overdose
(including Rx and illicit opioids).
www.cdc.gov


75%
of the nearly 92,000 drug overdose deaths in 2020 involved an opioid.
www.cdc.gov

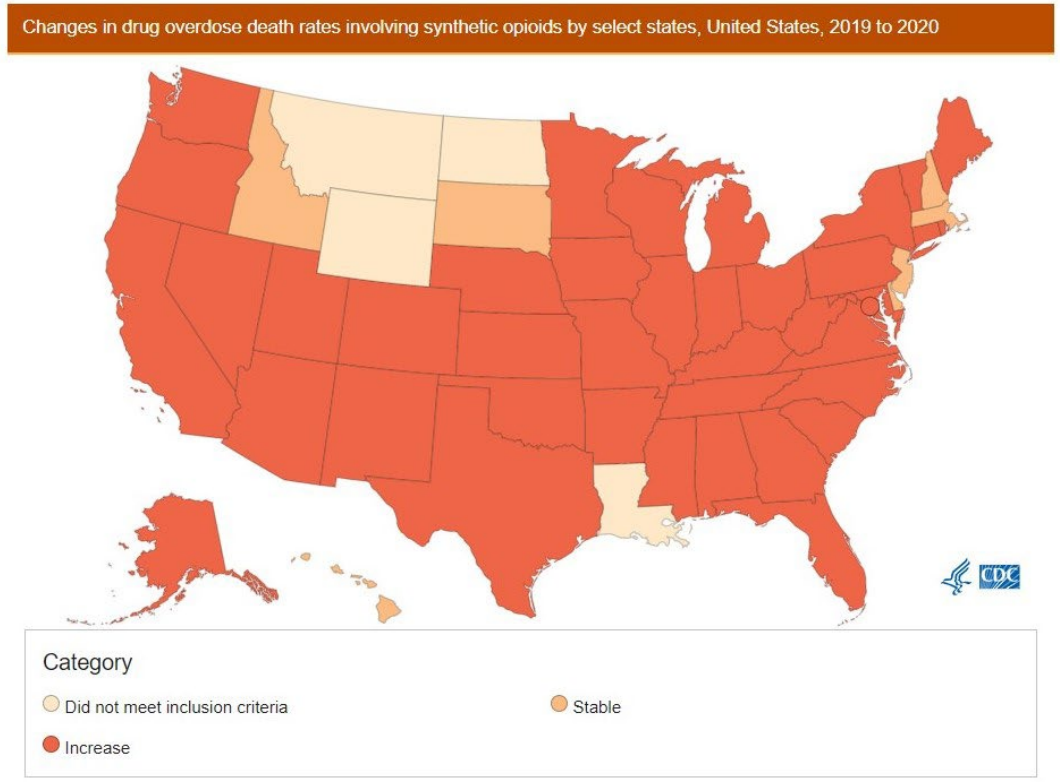

OVER
82%
of all opioid overdose deaths in 2020 involved synthetic opioids
(excluding methadone).
www.cdc.gov


44
PEOPLE
die every day from overdoses involving prescription opioids.
www.cdc.gov

2018-2019




2019-2020




# Changes in Drug Overdose Death Rates in the US





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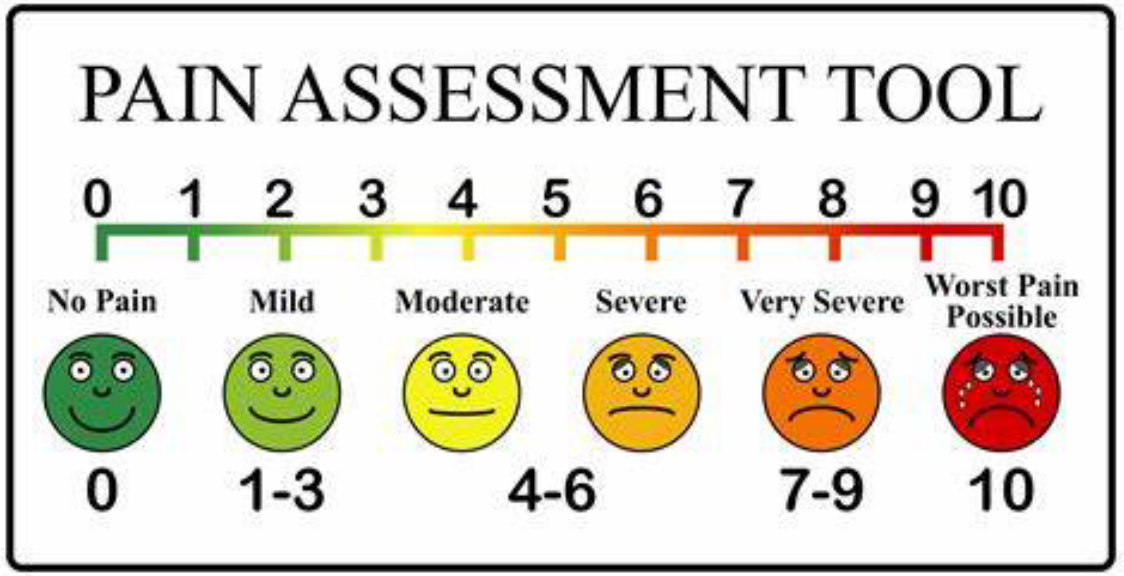
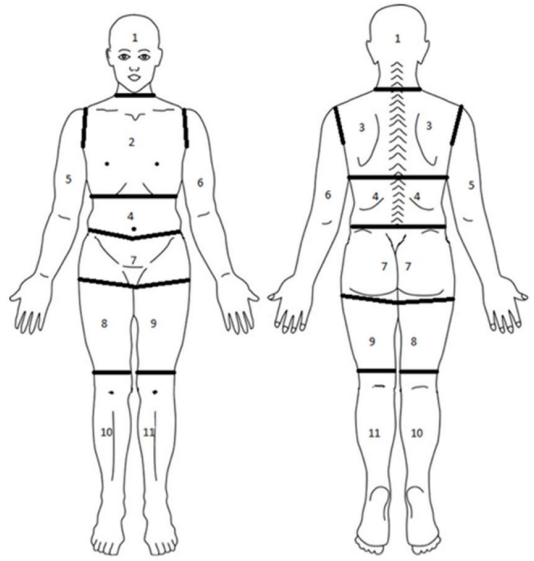
# Pain Assessment Tools

- ❑ Numerical Rating Scales
- ❑ Visual Analog Scales
  - Wong-Baker Faces Rating Scale
- ❑ PEG
  - Pain, Enjoyment of life, Generalized activity scale
- ❑ Pain Diaries
- ❑ Pain Drawings
- ❑ CPOT



# Pharmacological Treatment Options

## NSAIDS

- Ibuprofen
- Diclofenac
- Naproxen

## Opioids

- Morphine
- Oxycodone
- Oxymorphone
- Fentanyl
- Hydromorphone
- Tramadol

## Antidepressants

- TCA's
- SNRI's

## Antiepileptics

- Gabapentin
- Pregabalin
- Topiramate

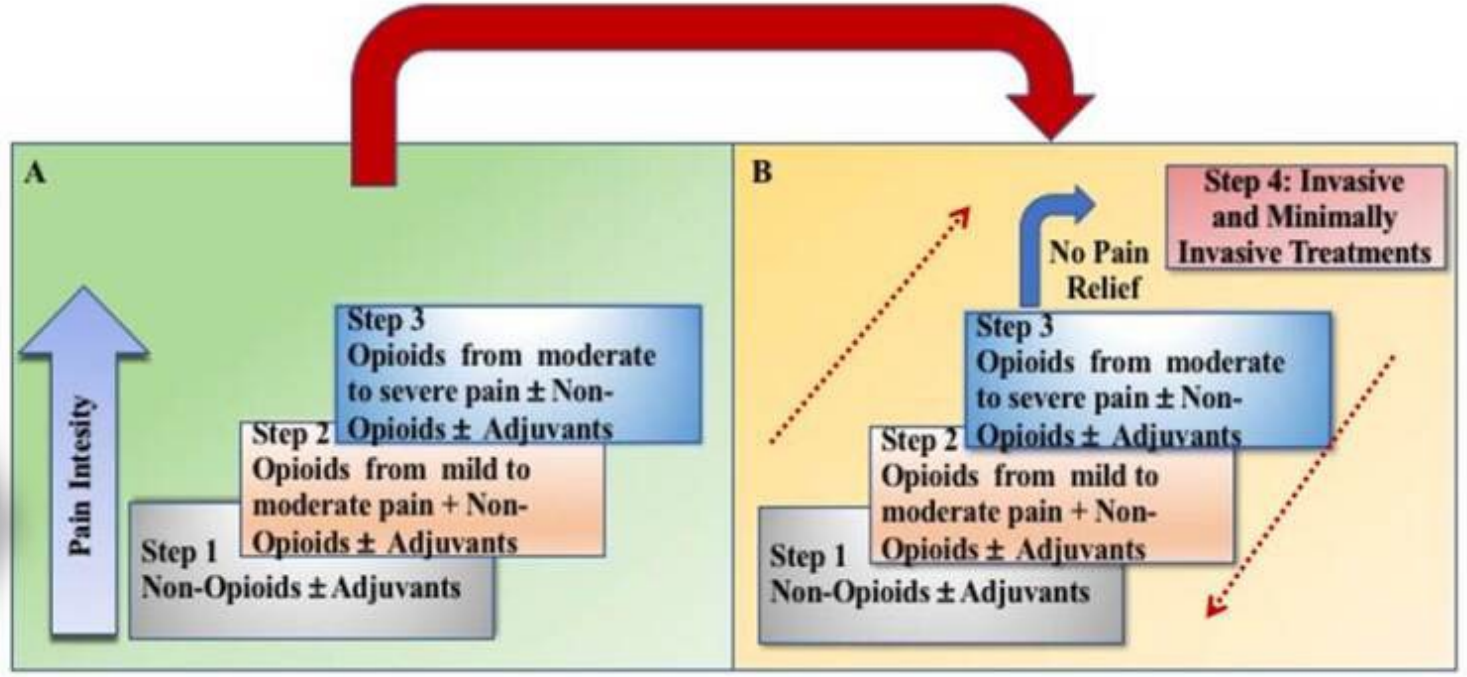
## Transdermal Products

- Lidocaine patch
- Diclofenac

## Muscle Relaxants

- Cyclobenzaprine
- Baclofen

# World Health Organization (WHO) Updated Ladder




Transition from the original WHO three-step analgesic ladder (**A**) to the revised WHO fourth-step form (**B**). The additional step 4 is an "interventional" step and includes invasive and minimally invasive techniques. This updated WHO ladder provides a bidirectional approach.

# 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

- A clinical **tool** which allows clinicians and patients cooperate to make a patient-centered decision in pain management.

- It is intended to…
  - Improve communication with patients regarding the benefits and risks of pain treatments, including opioid therapy for pain.
  - Improve efficacy and safety of pain treatment
  - Mitigate pain
  - Improve quality of life for those with pain
  - Reduce risks that are associated with the use of opioids for pain therapy (e.g., opioid use disorder, overdose, death)

# 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

- The guideline includes **12** recommendations grouped into **4** areas of consideration

Determining whether or not to initiate opioids for pain:

- Recommendations 1, 2

Selecting opioids and determining opioid dosages:

- Recommendations 3,4,5

Deciding duration of initial opioid prescription and conducting follow-up:

- Recommendations 6,7

Assessing risk and addressing potential harms of opioid use:

- Recommendations 8,9,10,11,12

# Recommendation 1

- Maximize use of **non-pharmacological and non-opioid pharmacological therapies** as appropriate for the specific condition and patient.
  - Consider opioid therapy for acute pain if benefits outweigh risks.

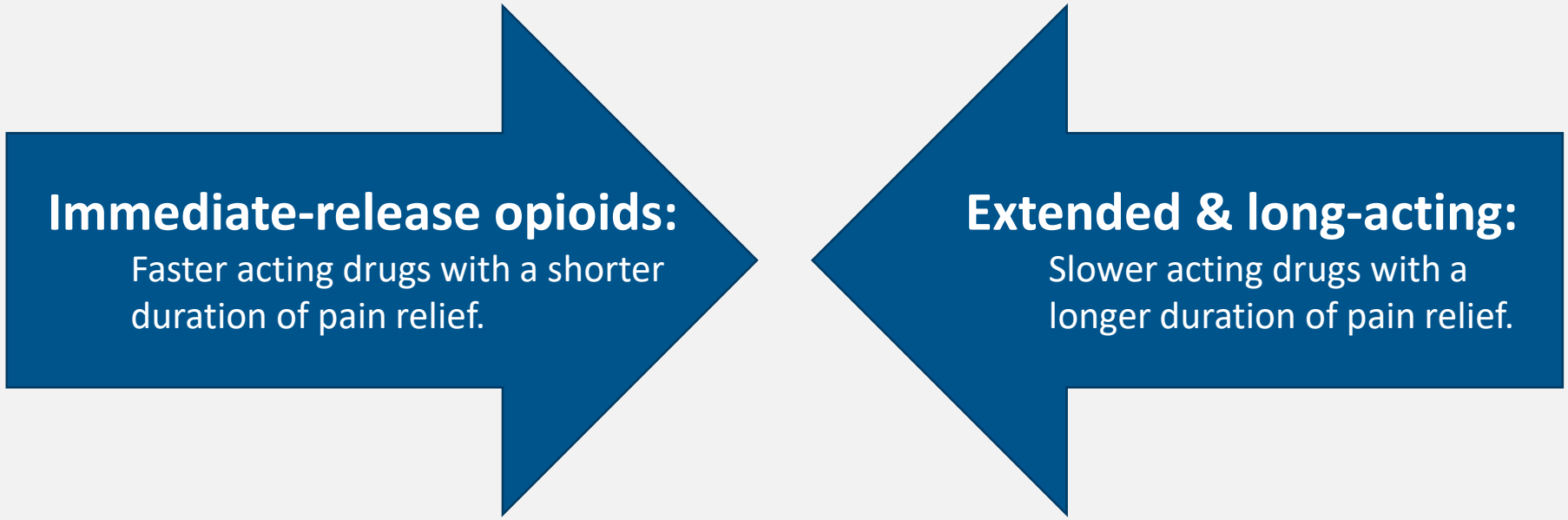
✓ Non-opioid Meds → NSAIDs, Acetaminophen, selected antidepressant, anticonvulsants
✓ Physical treatments → heat therapy, acupressure, massage, weight loss, etc.
✓ Behavioral treatments → cognitive behavioral therapy, etc.

# Recommendation 2

- **Non-opioid therapies are preferred for subacute and chronic pain.**
- Before initiating opioid therapy for subacute or chronic pain, discuss realistic risks and benefits of opioid therapy with patients.

# Recommendation 3

- When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release and long-acting opioids.



# Recommendation 4

- When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe **the lowest effective dosage.**
  - The lowest starting dose for opioid-naïve patients is often equivalent to a single dose of approx. **5–10 MME** or a daily dosage of **20–30 MME/day.**

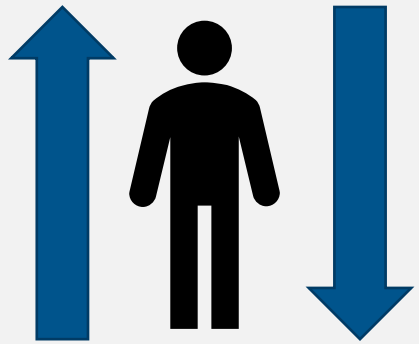
TABLE. Morphine milligram equivalent doses for commonly prescribed opioids for pain management Return

| Opioid | Conversion factor* |
|---|---|
| Codeine | 0.15 |
| Fentanyl transdermal (in mcg/hr) | 2.4 |
| Hydrocodone | 1.0 |
| Hydromorphone | 5.0 |
| Methadone | 4.7 |
| Morphine | 1.0 |
| Oxycodone | 1.5 |
| Oxymorphone | 3.0 |
| Tapentadol† | 0.4 |
| Tramadol§ | 0.2 |

# Recommendation 5

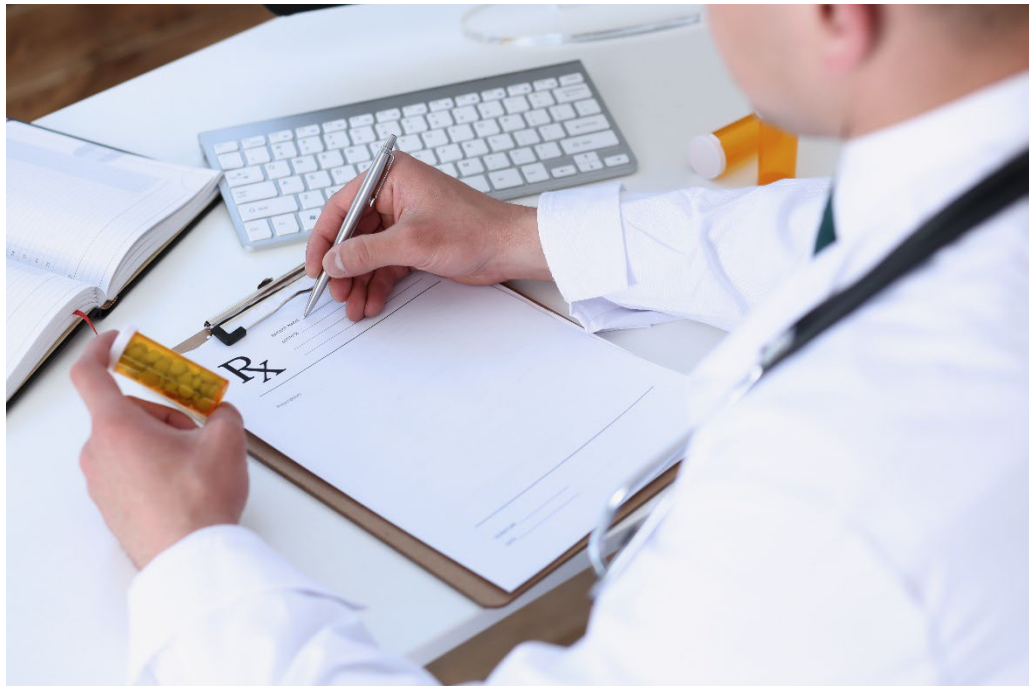
- For patients who are already receiving opioid therapy, clinicians should carefully weigh benefits and risks when **changing opioid dosage.**
  - If benefits do not outweigh risks of continued opioid therapy, clinicians should closely work with patients **to gradually taper to lower dosages** or appropriately taper to discontinue opioids.

Do **NOT** discontinue abruptly.



# Recommendation 6

- When opioids are needed to acute pain, clinicians should prescribe **no greater quantity than needed for the expected duration of pain severe enough to require opioids.**



# Recommendation 7

- Evaluate benefit and risks with patients within **1-4 weeks** of starting opioid therapy for subacute or chronic pain or dosage escalation. Clinicians should **regularly reevaluate benefits and risks** of continued opioid therapy with patients.

# Recommendation 8

- Evaluate risk for opioid-related **harms** and discuss risk with patients. Clinicians should work with patients to incorporate into the management **plan strategies to mitigate risk, including offering naloxone.**

  - Additional strategies to Mitigate Risk…
    - Assess drug and alcohol use with validated tools or consult with behavioral specialists to screen for mental health and substance use disorder.
    - Use PDMP data and toxicology screening as appropriate to assess for concurrent controlled substance use that might place patients at higher risk for opioid disorder.

# Recommendation 9

- When prescribing opioid therapy for pain, clinicians should **review the patient's history** of controlled substance prescriptions using PDMP to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose.

# Recommendation 10

- Consider the benefits and risks of **toxicology testing** to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.


# Recommendation 11

- Use caution when prescribing **opioid pain medication and benzodiazepines concurrently** and consider whether benefits outweigh risks of concurrent prescribing of opioids and other CNS depressants.

**Title** Opioid Agonists / CNS Depressants

**Risk Rating** D: Consider therapy modification

**Summary** CNS Depressants may enhance the CNS depressant effect of Opioid Agonists. **Severity** Major **Reliability Rating** Fair

# Recommendation 12

- Clinicians should offer treatment with evidence-based medications for patients with opioid use disorder.
- Detoxification by itself, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.

# What's New?

- Guiding principles for implementing recommendations
- New data to expand content on prescription opioids for acute pain
- New guidance on subacute pain
- Health equity and disparities in the treatment of pain

# What's Changed?

1. **Clinical Audience:**
   - The 2022 guideline broadens the scope of physicians whose practice include prescribing opioids.

| Primary Care Clinicians | Outpatient Clinicians |
|---|---|
| • Family physicians<br>• Nurse practitioners<br>• Physician assistant<br>• Internists | • Dental and other oral health clinicians<br>• Emergency Clinicians providing pain management for patients being discharged from emergency departments<br>• Surgeons<br>• Occupational medicine physicians<br>• Physical medicine and rehabilitation physicians<br>• Neurologists<br>• Obstetricians and gynecologist |

# What's Changed?

2. **Proper initiation and continuation of opioid therapy**
3. **Opioid Tapering (Recommendation 5)**
   - Determining when and how to taper opioids
   - Pain management during tapering
   - Behavioral health support during tapering
   - Tapering rate
   - Management of opioid withdrawal during tapering
   - Challenges to tapering
   - Continuing high-dosage tapering
4. **Considerations for opioid dosages**

# What's Changed?

## 5. Non-opioid Therapies

### Non-opioid Pharmacologic Therapies

- Topical or oral NSAIDs

### Nonpharmacologic Therapies

- Ice
- Heat
- Elevation
- Immobilization and/or exercise

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Thank you!