Pain and Opioid Management: The CDC Guidelines

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Accessed from:
https://www.cdc.gov/drugoverdose/prescribing/guideline.html
Disclaimers

• Methadone provider, WSU SOM
• Medical Director, Dawn Farm
• Vivitrol Provider
• Buprenorphine Provider
• Consultant, DOJ/DEA/BCBSM
• No financial relationships to disclose.
How Did They Do It?

- **Grading of Recommendations Assessment, Development, and Evaluation**: GRADE

- Driven by the “degree of confidence of the evidence”.
  - **Type 1**: can be very confident that the true effect lies close to the estimate;
  - **Type 2**: likely to be close but there is a possibility that it is substantially different;
  - **Type 3**: confidence in the effect estimate is limited and the true effect might be substantially different from the estimate of the effect;
  - **Type 4**: very little confidence in the effect estimate, and the true effect is likely to be substantially different from the estimate.
  - **NO studies**: evidence is considered to be insufficient.
How Did They Do It?

• Type 1: RCT or overwhelming evidence from observational studies
• Type 2: RCT with important limitations or exceptionally strong evidence from observational studies
• Type 3: observational studies or randomized clinical trials with notable limitations
• Type 4: clinical experience and observations, observational studies with important limitations, or RCT with several major limitations.
How Did They Do It?

• **Category A** recommendations apply to all persons in a specified group and indicates that most patients should receive the recommended course of action.
  • Can be based on type 3 or 4 evidence when risk outweighs harm.

• **Category B** recommendations indicate that there should be individual decision making: different choices will be appropriate for different patients. Clinicians must help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.
  • When risk and benefits are more balanced.
How Did They Do It?

• The available evidence is “low in quality” (type 3 or 4!)

• So they also used “Contextual Evidence”: “complementary information that assists in translating the clinical research findings into recommendations.”

• They did this for the following areas:
  • Effectiveness of non-pharmacologic therapy;
  • Benefits and harms of opioid therapy;
  • Clinician and patient values and preferences; and
  • Resource allocation (cost)
How Did They Do It?

• Core Expert Group: chosen by the CDC; no conflicts of interest.
  • Were shown the guidelines and commented, were not allowed to vote or come to a consensus.
  • Were not given the final guideline for comment.
  • Were NOT considered to be a FDA Advisory Committee

• Federal Partner Engagement: SAMHSA, NIDA, VA, DOD, ONCHT, CMS ONDCP, AHRQ.

• Stakeholders: medical societies; hospital systems, community orgs.

• Constituent Engagement: clinicians and patients

• Peer /Review: three more experts!

• Public Comment
The CDC Guidelines for Opioids

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The CDC Guidelines for Opioids: These Findings “Drove” the Guidelines (p15):

• No evidence shows a long term benefit of opioids in terms of pain and function at 1 year. Most studies are 6 weeks or less in duration.

• Extensive evidence shows the possible harms of opioids, including addiction, overdose and MVAs.

• Extensive evidence suggests some benefits of non-pharmacologic treatments, with less harm than opioid therapy.
CDC Guidelines: Three Sections

• Determining when to initiate or continue opioids for chronic pain
  • Opioid selection, dosage duration, follow up and discontinuation
  • Assessing risk and addressing harms of opioid use.
Determining when to initiate or continue opioids for chronic pain: Guideline 1

• Non-pharmacologic therapy and non opioid pharmacologic therapy are preferred for chronic pain.

• Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

• If opioids are used, the should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

• Evidence grade: 3
What is “Chronic Pain”

• Pain present > 3 months OR:
• After tissue healing has completed
• Mechanism not understood
• Evidence overall shows poor response to opioids
Guideline 1: nonpharmacologic therapies

- Exercise therapy for OA: immediate benefits for hip and knee pain (reference 99, 100)
- Aerobic, aquatic and/or resistance exercises (reference 176)
- Exercise therapy for fibromyalgia (reference 98, 101)
- Multimodal therapies
- Multidisciplinary approaches
- Arthrocentesis & steroid injections for RA (reference 117) or OA (reference 118)
  - Risks of repeated steroid injections not fully determined (reference 118)
Guideline 1: nonopioid pharmacologic therapies

- NSAIDs and acetaminophen
- Antidepressants: Tricyclics and SNRIs
- Pregabalin, gabapentin and carbamezepine: FDA approved neuropathic agents
- Pregablin: approved for fibromyalgia.
- Overdoses and deaths from non-opioids are “a fraction” of opioids.

Guideline 1: nonopioid pharmacologic therapies

• Toxicities of non-opioids:
  • NSAIDs: GI and renal; cardiovascular (reference 111, 112); platelets (reference 179)
  • Acetaminophen: hepatic; avoid with chronic liver disease or alcohol use.
Guideline 1: opioid pharmacologic therapies

• Insufficient evidence whether pain relief, function or QOL improves with long-term opioid therapy.
• Risks are “clearer and significant”.
• Increased risks for Opioid Use Disorder (OUD), OD, MI, MVI.
• Deaths since 1999: 165,000
Guideline 1: integrated pain management

• Requires coordination of care (and specialist services)
• ”Not always” covered by insurance or available locally.
• Can use partial approach with limited access:
  • No difference in LBP when randomized to aerobics or individual PT sessions (rrr 181)
• CBT can be integrated into primary care visits (reference 179); free or low cost “self help” groups may be available.
Guideline 1: confirm the diagnosis!

- Perform a FOCUSED history including standard questions (FOLDCARTS, etc)
- Focused physical exam
- Imaging or other diagnostics ONLY IF INDICATED:
  - Severe or progressive neurologic deficits
  - Pain consultation for complex pain syndromes
  - Specialty consultation for underlying conditions (DM, RA)
Guideline 1: what kind of pain is it?

- Nocioceptive: OA, LBP
  - NSAIDs are recommended for exacerbations of chronic pain
- Neuropathic: PHN, diabetic neuropathy, FM
  - Antidepressants, anticonvulsants-can take weeks or more

- Toxicities of each should be considered
  - Medical toxicities
  - Risks of falls and injuries with sedating meds.
Guideline 1: when should opioids be added?

• CDC guidelines do not address end-of-life care, palliative care, or active cancer care.
• Patients should not be required to fail all non-pharmacologic and non-opioid therapies before being offered opioids.
• They should be offered in the context of uncertain benefits and certain risks.
• LEAST indicated in chronic/central pain syndromes.
• MOST indicated if continued with non-opioid and non-pharmacologic therapies.
Determining when to initiate or continue opioids for chronic pain: Guideline 2

• Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.

• Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

• Evidence level: type 4
Determining when to initiate or continue opioids for chronic pain: Guideline 2

• Overall, there is insufficient evidence for long term benefits of opioid therapy.
• There is, however, evidence of dose-dependent harms (see later).
• Evidence for risk-assessment tools is inconsistent.
• In a Cochrane review, there was “weak evidence” for pain relief if patients could continue > 6 months. There was no evidence of increased function.

Noble M et al. Long term opioid management for chronic noncancer pain. in: Cochrane database of systematic reviews (Online) · January 2010
DOI: 10.1002/14651858.CD006605.pub2 · Source: PubMed
Determining when to initiate or continue opioids for chronic pain: Guideline 2

• BEFORE opioid therapy is started, treatment goals should be established:
  • Improvement in function
  • 30% or greater decrease in pain
  • Obviously, patients may be motivated to report these goals!
  • DO THIS before writing an opioid prescription for more than 30 days.

• Although there is no good evidence for opioid agreements, they can provide a basis for tapering in case of opioid failure or abuse.
Determining when to initiate or continue opioids for chronic pain: Guideline 2

• Quality of Life (QOL) = pain relief plus functional improvement
• Clinically important improvement in both: 30% (187)
• Depression should be monitored and treated if needed.
• When is improvement in function not significant?
  • Diseases with progressive neurologic involvement
  • Catastrophic injuries
Determining when to initiate or continue opioids for chronic pain: Guideline 3

• Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioids therapy and patient and clinician responsibilities for managing therapy.

• Evidence level: 3
Determining when to initiate or continue opioids for chronic pain: Guideline 3

• Patients may be naive about the risks and benefits of opioids.

• Patients should be involved in the decision making process; not simply informed of a “change in government policy”.
  • This should be balanced against the psychological effects of opioids on patients who are already on them or are seeking them.
Determining when to initiate or continue opioids for chronic pain: Guideline 3

- Be explicit and realistic about expect benefits! (no long term data)
- Function is a goal, not just pain relief!
- Advise about side effects and risks (constipation as well as overdose)
- Advise regarding dangerous situations (driving, etc)
- Discuss OUD, respiratory depression, death.
- Recommend against use with alcohol and sedatives.
- Risks to household members.
- Plan for periodic assessment.
Determining when to initiate or continue opioids for chronic pain: Guideline 3

- Discuss universal monitoring!
- Evaluate for ability to manage their own medications
- Minimum interval for evaluation: at least every 3 months.
CDC Guidelines: Three Sections

• Determining when to initiate or continue opioids for chronic pain

• **Opioid selection, dosage duration, follow up and discontinuation**

• Assessing risk and addressing harms of opioid use.
Opioid selection, dosage duration, follow up and discontinuation: Guideline 4

• When starting opioid therapy for chronic pain, clinicians should prescribe immediate releases opioids instead of extended-release/long-acting (ER/LA) opioids.

• Evidence level: 4
Opioid selection, dosage duration, follow up and discontinuation: Guideline 4

- ER/LA opioids include Fentanyl, methadone, long acting morphine and oxycodone, and long acting hydrocodone.

- There is evidence that there is increased risk for OD when starting with ER/LA opioids. (77)

- There is no good evidence that ER/LA opioids are more effective than immediate release opioids (KQ3).

- The FDA modified labelling of ER/LA opioids in 2014 requiring moderate to severe, around the clock pain.
Patients should be “opioid tolerant” to be on ER/LA opioids:

- 60 mg oral morphine/day
- 25 mcg transdermal fentanyl/hr
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day
- “An equianalgesic dose of another opioid”.

https://www.scopeofpain.com/
http://www.er-la-opioidrems.com/IwgUI/rem/home.action
Opioid selection, dosage duration, follow up and discontinuation: Guideline 4

- Patients should be “opioid tolerant” to be on ER/LA opioids:

- The use of scheduled daily opioids may result in a higher M.E.D.
- In addition, the safety of adding immediate release opioids for breakthrough pain hasn’t been established.
- In contextual reviews, methadone was found to have an excessive risk compared to other ER/LA opioids.
- Expert review found that Fentanyl prescribed to naïve patients or prescribers without experience in these medications.
- NO recommendations can be made regarding abuse-deterrent formulations.
Opioid selection, dosage duration, follow up and discontinuation: Guideline 5

- When opioids are started, clinicians should prescribe the lowest effective dosage.
- Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing doses to ≥ 50 morphine milligram equivalents dose (M.E.D.) per day, and should avoid increasing dosage to ≥ 90 M.E.D. per day or carefully justify a decision to titrate dosage to ≥ 90 M.E.D.

- THIS DOES NOT PROHIBIT THE CLINICIAN FROM DOSES HIGHER THAN 100 MED!

- Evidence level: 3
Opioid selection, dosage duration, follow up and discontinuation : Guideline 5

• There are not studies showing benefit of dose escalation (84)
• There is evidence for harm at higher opioid doses.
• Relative risk: (M.E.D.)
  • 1-20: 1
  • 50 -100: 1.9 to 4.6
  • >100: 2.0 - 8.9
• “opioid doses should not be increased to >90 M.E.D. without careful justification”. 
Opioid selection, dosage duration, follow up and discontinuation: Guideline 5

- Opioids should be started at the lowest starting doses on product labeling.
- Use increased care if age > 65; renal/hepatic insufficiency.
- Wait at least 5 half-lives before increasing dose.
- Before proceeding with further increases, evaluate for changes in pain, function and risks.
- CONSIDER NALOXONE if M.E.D. > 50.
- “carefully justify” > 90 M.E.D.
Opioid selection, dosage duration, follow up and discontinuation: Guideline 5

- * if patients do not get improvement in pain and function with > 90 M.E.D.; consider taper! (see below)
- Higher doses may require use of pain specialty consultants (Washington state) (30)
- Use of sedatives, including muscle relaxants, “sleepers” and benzodiazepines, significantly increases the risk! (see below).
Opioid selection, dosage duration, follow up and discontinuation: Guideline 5

- What To Do When Patients Are Already on High Dose Opioids:
  - Explain RR of taking high dose opioids.
  - Discuss concepts of tolerance, withdrawal and possible opioid induced hyperalgesia (see below).
  - Maximize other treatment options, including non-pharmacologic and anesthetic interventions.
  - Consider referral for difficult tapers (see below)
Opioid selection, dosage duration, follow up and discontinuation: Guideline 6

• Long term opioid use often begins with treatment acute pain.

• When opioid are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release (IR) opioid and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioid.

• Three days or less will often be sufficient; more than seven days will rarely be needed.

• Evidence level: 4
Opioid selection, dosage duration, follow up and discontinuation: Guideline 6

• A significant number of patients who start opioids for treatment for acute pain will progress to long term opioid use (KQ5).
• Guidelines recommend either <3, <7 or < 14 days of opioids for acute pain.
• These guidelines do not apply to postoperative pain or trauma.
• Always look for potentially serious underlying causes! (i.e., claudication masking as arthritis).
• Do not prescribe ER/LA opioids for treatment of acute pain!
• (Suggestion from author): start using Electronic Prescribing of Controlled Substances (EPCS)!!
FIGURE 1. One- and 3-year probabilities of continued opioid use, by duration of first episode in weeks (base case)

Duration is expressed in terms of weeks (1-26) with increments of 1 week. Discontinuation is defined as 180 opioid-free days and allowable gap to assess continuous opioid use in first episode was 30 days. One-week duration is defined as having an episode lasting 7 or more days.

MMWR, March 17, 2017/66 (10); 265-269
Opioid selection, dosage duration, follow up and discontinuation : Guideline 7

• Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.

• Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.

• If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

• Evidence level: 4
Opioid selection, dosage duration, follow up and discontinuation: Guideline 7

- The use of opioids for more than 3 months increases the incidence of opioid use disorder (OUD) (KQ2)
- Risk of overdose is highest during the first 2 weeks of treatment (KQ3)
- If your patient doesn’t get relief at one month, success isn’t likely.
- Risk of overdose increases during 3-7 days after dosage increase; especially with methadone.
Opioid selection, dosage duration, follow up and discontinuation: Guideline 7

• Evaluate harms and benefits within “one to four weeks”. Consider the “low end” when:
  • Opioids are first started.
  • M.E.D. goes over 50.

• Should use an assessment tool such as the PEG Assessment scale or assessing for improvement in function (not just analgesia).

• Assess for common side effects (constipation and drowsiness)

• Assess for dangerous side effects (sedation or slurred speech).

• DOES THE PATIENT WANT TO CONTINUE?
1. What number best describes your **pain on average** in the past week:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Pain as bad as you can imagine</td>
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</tbody>
</table>

2. What number best describes how, during the past week, pain has interfered with your **enjoyment of life**?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not interfere</td>
<td>Completely interferes</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

3. What number best describes how, during the past week, pain has interfered with your **general activity**?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not interfere</td>
<td>Completely interferes</td>
<td></td>
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</tr>
</tbody>
</table>
# Treatment of Opioid Induced Constipation (OIC)

<table>
<thead>
<tr>
<th>Agent</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulk Forming (Metamucil®)*</td>
<td>Flatuence, distension; may not be appropriate for OIC</td>
</tr>
<tr>
<td>Polyethylene glycol (Miralax®)</td>
<td>Diarrhea, dehydration, electrolytes</td>
</tr>
<tr>
<td>Surfactants (Docusate, Colace)</td>
<td>minimal</td>
</tr>
<tr>
<td>Cathartics (Senna, Senekot®)</td>
<td>Laxative bowel</td>
</tr>
<tr>
<td>Methylnaltrexone (Relistor®)</td>
<td>Needs SQ administration, $$$</td>
</tr>
<tr>
<td>Naloxegol (Movantik®)</td>
<td>cyp3A4 substrate</td>
</tr>
<tr>
<td>Oral naloxone (2 to 4 mg)</td>
<td>Can be absorbed --&gt; withdrawal</td>
</tr>
<tr>
<td>Naltrexone (low dose) (Rivea®)</td>
<td>Could induce withdrawal</td>
</tr>
<tr>
<td>Lubiprostone (Cl channel activator), Amitiza®</td>
<td>N/V</td>
</tr>
</tbody>
</table>

Source: UpToDate
Opioid selection, dosage duration, follow up and discontinuation: Guideline 7

- Regularly assess all patients at LEAST every 3 months
- As before, assess for efficacy, adverse effects, and signs of OUD (see below)
- Assess for sustained improvement in BOTH pain and function.
- Possible dose decrease or discontinuation of opioids
- If virtual visits are used, need face to face at least once yearly.
- ACT when there are signs of OUD or signs of sedation/overdose or diversion!
- Opioid tapering: see below.
CDC Guidelines: Three Sections

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage duration, follow up and discontinuation
- **Assessing risk and addressing harms of opioid use.**
Assessing risk and addressing harms of opioid use: Guideline 8

• Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.

• Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioids overdose, such as history of overdose, history of substance use disorder (SUD), higher opioids dosages (≥ 50 M.E.D./day), or concurrent benzodiazepine use, are present.
Naloxone formulations:
Assessing risk and addressing harms of opioid use: Guideline 8

- No good evidence for tools to identify risk of abuse.
- Questionnaires such as Opioid Risk Tool (ORT) are widely used.
- Several risk factors are “self evident”:
  - History of SUD
  - Pregnancy
  - Alcohol & sedative use (see below)
  - M.E.D. > 50
  - Risk for sleep-disordered breathing: CHF, obesity, OSA.
Assessing risk and addressing harms of opioid use: Guideline 8. Pregnancy:

- Inconsistent but documented claims of: stillbirth, growth restriction, preterm delivery, birth defects.
- Neonatal withdrawal syndrome has been documented, dose relationship has not.
- Recommend Maternal Fetal Medicine consultation before INITIATING opioid therapy during pregnancy**
- If SUD is identified during pregnancy, refer to specialist for medication assisted therapy (buprenorphine or methadone)
- Codeine should be used with caution in breastfeeding due to "overactive" CYP 2D6. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2776794/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2776794/)
Assessing risk and addressing harms of opioid use: Guideline 8. Renal and Hepatic Insufficiency:

• Evaluate each drug for warnings about decreased GFR/increased LFTs
• Therapeutic ratio may be decreased
• Methadone may be the best drug to use with liver/renal failure but should be administered by an expert! **
Assessing risk and addressing harms of opioid use: Guideline 8. Patients > 65 years

• As with patients with hepatic and renal disease, have narrow therapeutic window.
• May also have cognitive impairment, leading to medication errors
• Frequently receive sedatives-contradindicated by the BEERS criteria
• Increased fall risk
Assessing risk and addressing harms of opioid use: Guideline 8. Mental Health Conditions:

• Since pain is worsened by depression, use the GAD-7 or PHQ-9 or PHQ-4 to screen.
• Incidence of SUD is increased in patients with co-occurring mental illness, as well as OD risk.
• Do not initiate opioids during acute “psychiatric instability” (31)
• Consider BH consultation for anyone with a history of suicide attempt.
• Consider Tricyclics or SNRI in patients with co-occurring depression and CP.
Assessing risk and addressing harms of opioid use: Guideline 8. History of SUD

- Clinical evidence review found little support for any single questionnaire.
- See Module 1 of this Webinar series for addiction eval.
- A “single question” interview can be used: how many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? (206, 207)
- Use MAPS and urine drug screen!!
- If positive results are obtained, consider addiction evaluation before proceeding or continuing**
- Offer naloxone if you offer opioids!
## Risk Assessment Tools

### Patients considered for long-term opioid therapy:

<table>
<thead>
<tr>
<th>Tool</th>
<th># of items</th>
<th>Administered By</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORT Opioid Risk Tool</td>
<td>5</td>
<td>patient</td>
</tr>
<tr>
<td>SOAPP® Screener &amp; Opioid Assessment for Patients w/ Pain</td>
<td>24, 14, &amp; 5</td>
<td>patient</td>
</tr>
<tr>
<td>DIRE Diagnosis, Intractability, Risk, &amp; Efficacy Score</td>
<td>7</td>
<td>clinician</td>
</tr>
</tbody>
</table>

### Characterize misuse once opioid treatments begins:

<table>
<thead>
<tr>
<th>Tool</th>
<th># of items</th>
<th>Administered By</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMQ Pain Medication Questionnaire</td>
<td>26</td>
<td>patient</td>
</tr>
<tr>
<td>COMM Current Opioid Misuse Measure</td>
<td>17</td>
<td>patient</td>
</tr>
<tr>
<td>PDUQ Prescription Drug Use Questionnaire</td>
<td>40</td>
<td>clinician</td>
</tr>
</tbody>
</table>

### Not specific to pain populations:

<table>
<thead>
<tr>
<th>Tool</th>
<th># of items</th>
<th>Administered By</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAGE-AID Cut Down, Annoyed, Guilty, Eye-Opener Tool, Adjusted to Include Drugs</td>
<td>4</td>
<td>clinician</td>
</tr>
<tr>
<td>RAFFT Relax, Alone, Friends, Family, Trouble</td>
<td>5</td>
<td>patient</td>
</tr>
<tr>
<td>DAST Drug Abuse Screening Test</td>
<td>28</td>
<td>patient</td>
</tr>
<tr>
<td>SBIRT Screening, Brief Intervention, &amp; Referral to Treatment</td>
<td>Varies</td>
<td>clinician</td>
</tr>
</tbody>
</table>


# Opioid Risk Tool (ORT)**

**gender specific**

Mark each box that applies

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family Hx of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Illegal drugs</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Prescription drugs</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal Hx of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Illegal drugs</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Prescription drugs</td>
<td>5</td>
</tr>
<tr>
<td>3. Age between 16 &amp; 45 yrs</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. Hx of preadolescent sexual abuse</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5. Psychologic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ADD, OCD, bipolar, schizophrenia</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>1</td>
</tr>
</tbody>
</table>

**Administer**

- On initial visit
- Prior to opioid therapy

**Scoring (risk)**

- 0-3: low
- 4-7: moderate
- ≥8: high

**Scoring Totals:**

Assessing risk and addressing harms of opioid use: Guideline 8. History of Overdose

- If a patient experiences an overdose, "work with them to reduce dosage and to discontinue opioids when possible"
- If you decide to continue opioids, offer naloxone
- Would obtain addiction and psychiatric consultation if you decide to continue**
Assessing risk and addressing harms of opioid use: Guideline 8. Offering Naloxone

- Serious events have been reported but are rare.
- The recent increase in fentanyl contaminated heroin has led to the marketing of 4 mg and 2 mg naloxone (Narcan®) Nasal Spray.
- Indications per CDC:
  - History of OD or addiction
  - Patients taking benzodiazepines with opioids
  - Patients who have “lost” their opioid tolerance (i.e., released from hospital, treatment or prison)
  - M.E.D. > 50.
- More info available at Prescribe to Prevent (http://prescribetoprevent.org)
Assessing risk and addressing harms of opioid use: Guideline 9

• Clinicians should review the patient’s history of controlled Substance (CS) prescriptions using prescription drug monitoring program (Michigan Automated Prescription System, MAPS) to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose.

• Clinicians should review MAPS data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
Assessing risk and addressing harms of opioid use: Guideline 9

- The veracity of the MAPS information should be confirmed with the patient:**

- Currently, the MAPS system relies on first initial and last name and birthdate; errors can occur.

- MAPS entries may occur when a prescription is presented but not filled.

- The MAPS system also lists whether prescriptions were paid for by insurance or cash.

- Use of the MAPS may help document “due diligence” to law enforcement and the DEA.
Assessing risk and addressing harms of opioid use: Guideline 9

- “Clinicians should discuss safety concerns....with patients found to be receiving opioids from more than one prescriber” or “receiving medications that increase risk when combined with opioids” and consider offering naloxone.

- AVOID PRESCRIBING OPIOIDS AND BENZODIAZEPINES WHENEVER POSSIBLE.....coordinate care if necessary.
  - Consider the possibility of a SUD!

- If diversion (sharing or selling) is suspected, “consider” urine drug testing to assist...whether opioids can be discontinued without causing withdrawal (see below).
Assessing risk and addressing harms of opioid use: Guideline 9

• Experts agreed that clinicians should not dismiss patients from their practice on the basis of PDMP information.

• Doing so can adversely affect patient safety, could represent patient abandonment, and could result in missed opportunities to provide potentially lifesaving information (e.g., about risks of opioids and overdose prevention) and interventions (e.g., safer prescriptions, nonopioid pain treatment [see Recommendation 1], naloxone [see Recommendation 8], and effective treatment for substance use disorder [see Recommendation 12]) (see below for additional information)**
Assessing risk and addressing harms of opioid use: Guideline 10

• When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug screens (testing) at least **annually** to assess for prescribed medications as well as other CS and illicit drugs.

• Evidence level: 4
Assessing risk and addressing harms of opioid use: Guideline 10

• Urine drug testing (UDT) should be done at the beginning of therapy.
• Testing can be either immunoassay screening or with confirmation by GC/MS. (see later).
• Testing should be done at least “annually” or more often, based on risk assessment.
• ????????
Assessing risk and addressing harms of opioid use: Guideline 10

- Testing can be either immunoassay screening or with confirmation by GC/MS. (see later).
- In comparison, MAPS reports (which are free) should be initially and then at least every 3 months; up to every time a patient is seen for a prescription.
Assessing risk and addressing harms of opioid use: Guideline 10

• A negative urine drug test for a prescribed opioid indicates: **

1. A false negative test
2. Abuse (taking more than prescribed)
3. Hoarding
4. Diversion (selling or sharing)
Assessing risk and addressing harms of opioid use: Guideline 10

• In most situations, initial urine drug testing can be performed with a relatively inexpensive immunoassay panel for commonly prescribed opioids and illicit drugs.

• Patients prescribed less commonly used opioids might require specific testing for those agents. The use of confirmatory testing adds substantial costs and should be based on the need to detect specific opioids that cannot be identified on standard immunoassays or on the presence of unexpected urine drug test results.
Clinicians should be familiar with the drugs included in urine drug testing panels used in their practice and should understand how to interpret results for these drugs. For example, a positive "opiates" immunoassay detects morphine, which might reflect patient use of morphine, codeine, or heroin, but this immunoassay does not detect synthetic opioids (e.g., fentanyl or methadone) and might not detect semisynthetic opioids (e.g., oxycodone). However, many laboratories use an oxycodone immunoassay that detects oxycodone and oxymorphone.

In some cases, positive results for specific opioids might reflect metabolites from opioids the patient is taking and might not mean the patient is taking the specific opioid for which the test was positive. For example, hydromorphone is a metabolite of hydrocodone, and oxymorphone is a metabolite of oxycodone. (30)
Assessing risk and addressing harms of opioid use: Guideline 10

• Clinicians should not test for substances for which results would not affect patient management or for which implications for patient management are unclear.

• For example, experts noted that there might be uncertainty about the clinical implications of a positive urine drug test for tetrahydrdocannabinol (THC).
Assessing risk and addressing harms of opioid use: Guideline 10

- In addition, restricting confirmatory testing to situations and substances for which results can reasonably be expected to affect patient management can reduce costs of urine drug testing, given the substantial costs associated with confirmatory testing methods. Before ordering urine drug testing, clinicians should have a plan for responding to unexpected results.
Assessing risk and addressing harms of opioid use: Guideline 10

• Clinicians should explain to patients that urine drug testing is intended to improve their safety and should also explain expected results (e.g., presence of prescribed medication and absence of drugs, including illicit drugs, not reported by the patient).

• Clinicians should ask patients about use of prescribed and other drugs and ask whether there might be unexpected results. This will provide an opportunity for patients to provide information about changes in their use of prescribed opioids or other drugs.
• Clinicians should discuss unexpected results with the local laboratory or toxicologist and with the patient.

• Discussion with patients prior to specific confirmatory testing can sometimes yield a candid explanation of why a particular substance is present or absent and obviate the need for expensive confirmatory testing on that visit.

• For example, a patient might explain that the test is negative for prescribed opioids because she felt opioids were no longer helping and discontinued them.

• If unexpected results are not explained, a confirmatory test using a method selective enough to differentiate specific opioids and metabolites (e.g., gas or liquid chromatography/mass spectrometry) might be warranted to clarify the situation.
Assessing risk and addressing harms of opioid use: Guideline 10

• Clinicians should use unexpected results to improve patient safety (e.g., change in pain management strategy [see Recommendation 1], tapering or discontinuation of opioids [see Recommendation 7], more frequent re-evaluation [see Recommendation 7], offering naloxone [see Recommendation 8], or referral for treatment for substance use disorder [see Recommendation 12], all as appropriate).

• If tests for prescribed opioids are repeatedly negative, confirming that the patient is not taking the prescribed opioid, clinicians can discontinue the prescription without a taper.
Assessing risk and addressing harms of opioid use: Guideline 10

• Clinicians should not dismiss patients from care based on a urine drug test result because this could constitute patient abandonment and could have adverse consequences for patient safety, potentially including the patient obtaining opioids from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.
Assessing risk and addressing harms of opioid use: Guideline 11

• Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
FDA requires strong warnings for opioid analgesics, prescription opioid cough products, and benzodiazepine labeling related to serious risks and death from combined use

Action to better inform prescribers and protect patients as part of Agency’s Opioids Action Plan
Assessing risk and addressing harms of opioid use: Guideline 11

• Benzodiazepines and opioids both cause central nervous system depression and can decrease respiratory drive. Concurrent use is likely to put patients at greater risk for potentially fatal overdose.

• Because of greater risks of benzodiazepine withdrawal relative to opioid withdrawal, and because tapering opioids can be associated with anxiety, when patients receiving both benzodiazepines and opioids require tapering to reduce risk for fatal respiratory depression, it might be safer and more practical to taper opioids first (see Recommendation 7).
Assessing risk and addressing harms of opioid use: Guideline 11

• Clinicians should taper benzodiazepines gradually if discontinued because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death (contextual evidence review).

• A commonly used tapering schedule that has been used safely and with moderate success is a reduction of the benzodiazepine dose by 25% every 1–2 weeks (213,214).

• CBT increases tapering success rates and might be particularly helpful for patients struggling with a benzodiazepine taper(213).

• If benzodiazepines prescribed for anxiety are tapered or discontinued, or if patients receiving opioids require treatment for anxiety, evidence-based psychotherapies (e.g., CBT) and/or specific anti-depressants or other nonbenzodiazepine medications approved for anxiety should be offered.
Assessing risk and addressing harms of opioid use: Guideline 12

• Clinicians should offer or arrange evidence-based treatment (usually medication assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.
Assessing risk and addressing harms of opioid use: Guideline 12

- Clinicians should not dismiss patients from their practice because of a substance use disorder because this can adversely affect patient safety and could represent patient abandonment.

- Identification of substance use disorder represents an opportunity for a clinician to initiate potentially life-saving interventions, and it is important for the clinician to collaborate with the patient regarding their safety to increase the likelihood of successful treatment.
Assessing risk and addressing harms of opioid use: Guideline 12

• In addition, although identification of an opioid use disorder can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance use disorder require ongoing pain management that maximizes benefits relative to risks.

• Clinicians should continue to use nonpharmacologic and nonopioid pharmacologic pain treatments as appropriate (see Recommendation 1) and consider consulting a pain specialist as needed to provide optimal pain management.
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