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Editor's Commentary on the Center for Disease Control and Prevention (CDC) Pain Guidelines

As part of this edition, you will find discussed the new CDC guidelines regarding the use of opiate pain medications.

These guidelines are largely intended to heighten the awareness of the abuse potential of opiate pain medications. While this is certainly a generally good idea, several issues have not been dealt with adequately by the CDC in their processes.

The first issue is that practitioners are caught in the middle between those elements forcing pain to be considered as a fifth vital sign, and those regulatory agencies that are sharpening their blades to come after the perceived "bad doctors" that overprescribe pain medications.

Primary care is in the middle of this firestorm and has very difficult choices to make. On one side, manipulative, drug-abusing patients threaten lawsuits and regulatory board actions if physicians do not provide all the narcotics that they request.

On the other side, are the national patient satisfaction initiatives that empower patients to badly score their providers or hospitals if their pain management is not to their liking.

On yet another side, are the legitimate pain patients looking for relief that are being under treated for fear of legal entanglements or discipline.

Several important issues were not adequately addressed by the CDC in their recommendations. First is that persistent, excessive use of the short-acting opiates that have reinforcing qualities that draw drug abusers to them. Hydrocodone and oxycodone derivatives are the most commonly demanded and abused. Once that addiction is established, the misuse of longer-acting opiates fuels the fire. That misuse of excellent medications like methadone, fentanyl, and morphine pave a destructive pathway. Long-acting narcotics that are chosen and prescribed appropriately to the appropriate patients represent a minimal threat.

Second, most pain specialists will relate that it is very unusual for legitimate, well-managed pain patients to become “addicts.” Physical dependence is not the same as addiction, and it is poorly understood and more poorly managed by physicians.

Third, drug abusers abuse drugs. Most of the opiate abusers started with alcohol and marijuana, and have progressed to narcotics. Thus, broad-based drug prevention efforts at early ages could have significant impacts on the narcotic “addicts” of the future.

Finally, these guidelines should have contained a loud and long demand for a national controlled- medication database that all pharmacies and pharmacy benefits managers must be

compelled to cooperate with. So far, these are only state-wide efforts and are fragmented and poorly funded.

Let us all express appreciate for this first step, but we need to make this a national effort to push further.

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A statement from the president of the American Pain Society

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A Message from the President about the CDC Guidelines

On Tuesday afternoon March 15th the CDC released the final version of their 2016 Guideline for Prescribing Opioids for Chronic Pain. (www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm). American Pain Society (APS) members were involved in virtually every step of the development of the guidelines (from literature review, guideline development and formal feedback to CDC on positives and concerns in the two previous drafts of the guideline). As might be expected in a multidisciplinary group such as APS, opinions differ among us on the role of opioids in chronic pain treatment. Unfortunately, due to the absence of any evidence defining both benefits and

risks of long term opioid treatment, experience, more than science, had a primary influence in this guideline's construction. Nonetheless, most of us would agree that guidelines in the area of chronic noncancer pain are important (which is why APS spent considerable time and resources on our own 2009 guidelines on the same topic) and with the primary emphases of the recommendations themselves:

1. Opioids should not be first line monotherapy for chronic pain (and probably not acute pain either - as our recent Guideline for Postoperative pain reinforced)
2. When opioids are prescribed, risks and benefits should be carefully weighed and the lowest effective dose utilized for the shortest time possible (as in every other drug therapy I am aware of).
3. There are some concomitant factors that can increase the risks of opioids (co-administration of sedatives being one factor that is evidence-based and yet commonly seen in practice) and some clinical assessments that MAY reduce risks (e.g., Prescription Drug Monitoring Program checks).
4. Many of the recommendations seem like "mom and apple pie" to most pain experts. Nonetheless, as a guideline targeting primary care practitioners I have listened carefully to numerous primary care APS members who contend that the simple and high profile nature of these guidelines will help primary care colleagues more effectively use their 7 minute appointments to assess and treat people with complex chronic pain.

So what can an evidence-based society such as the APS and its members do with regard to this largely eminence-based guideline? In general, we can all make sure that we have read the guideline and can teach others what they say and what they DO NOT say. For example:

1. The doses and times listed in the guideline are not based on risk/benefit studies but on risk studies alone and thus should not be used by prescribers, insurers or the legal system as limitations on therapy for any one patient – or reason to prescribe for that matter.
2. Despite multiple media reports to the contrary the guideline clearly states that its recommendations regarding acute pain do not refer to pain after trauma or major surgery.
3. The guideline specifically avoids providing guidance for treating pediatric pain – for better or worse.
4. The guideline, similarly, gives no guidance for when to consult a pain expert (or even who a pain expert might be).

In short, it is somewhat embarrassing to realize the large gaps in our knowledge regarding the benefits of long-term opioid treatment for chronic pain after all these years. We, the American Pain Society and its membership encourage support and implementation of studies to fill these gaps. Whether or not we like the opinions expressed in the guidelines we should be at the forefront of gathering data to either change or support those opinions.

Gregory Terman

President, American Pain Society

Acknowledgement

Sincere appreciation to the American Pain Society for allowing us to reprint President Terman's message from their website located at: http://americanpainsociety.org/79-a-message-from-the-president-about-the-cdc-guidelines

Additional References

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2014 National Survey on Drug Use and Health Finds Marijuana Use Continuing to Rise Among Youth