CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Recommendation 1

Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and pt and only consider opioid tx for acute pain if benefits are anticipated to outweigh risks to the pt. Before prescribing opioid tx for acute pain, clinicians should discuss w/ pts the realistic benefits and known risks of opioid tx (recommendation category: B; evidence type: 3).

Implementation Considerations

- Nonopioid tx at least as effective as opioids for many common acute pain conditions, including LBP, neck pain, pain related to other musculoskeletal injuries (e.g., sprains, strains, tendonitis, and bursitis), pain related to minor surgeries typically assoc w/ minimal tissue injury and mild post-op pain (e.g., simple dental extraction), dental pain, kidney stone pain, and headaches incl episodic migraine.

- Maximize use of nonopioid pharmacologic (e.g., topical or oral NSAIDs, acetaminophen) and nonpharmacologic (e.g., ice, heat, elevation, rest, immobilization, or exercise) tx as appropriate for specific condition.

- Opioid tx has an important role for acute pain related to severe traumatic injuries (including crush injuries and burns), invasive surgeries typically assoc w/ moderate to severe post-op pain, and other

severe acute pain when NSAIDs and other therapies contraindicated or likely to be ineffective.

- When dx and severity of acute pain warrant use of opioids, prescribe IR opioids at lowest effective dose and for no longer than expected duration of pain severe enough to require opioids.

- Prescribe and advise opioid use only as needed (e.g., hydrocodone 5 mg/acetaminophen 325 mg, 1 tablet not more frequently than q4h prn for moderate to severe pain) rather than on a scheduled basis (e.g., 1 tablet q4h) and encourage and recommend an opioid taper if opioids are taken around the clock for more than a few days.

- If pts already receiving opioids long term require additional medication for acute pain, nonopioid meds should be used when possible and, if additional opioids are required (e.g., for superimposed severe acute pain), they should be continued only for the duration of pain severe enough to require additional opioids, returning to the pt's baseline opioid dosage ASAP, incl a taper to baseline dosage if additional opioids were used around the clock for more than a few days.

- Ensure that pts are aware of expected benefits of, common risks of, serious risks of, and alternatives to opioids before starting or continuing opioid tx; involve pts meaningfully in decisions about whether to start opioid tx.