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

Recommendation 2

Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and pt and only consider initiating opioid tx if expected benefits for pain and function are anticipated to outweigh risks to the pt. Before starting opioid tx for subacute or chronic pain, clinicians should discuss w/ pts the realistic benefits and known risks of opioid tx, should work w/ pts to establish tx goals for pain and function, and should consider how opioid tx will be discontinued if benefits do not outweigh risks (recommendation category: A; evidence type: 2).

Implementation Considerations

- To guide pt-specific selection of tx, clinicians should evaluate pts and establish or confirm the dx.

- Recommend appropriate noninvasive nonpharmacologic approaches to help manage chronic pain, such as exercise (e.g., aerobic, aquatic, or resistance exercises) or exercise tx (a prominent modality in physical tx) for back pain, fibromyalgia, and hip or knee OA; weight loss for knee OA; manual therapies for hip OA; psychological tx, spinal manipulation, low-level laser tx, massage, mindfulness-based stress reduction, yoga, acupuncture, and multidisciplinary rehab for LBP; mind-body practices (e.g., yoga, tai chi, or qigong), massage, and acupuncture for neck pain; CBT, myofascial release massage, mindfulness practices, tai chi, qigong,

acupuncture, and multidisciplinary rehab for fibromyalgia; and spinal manipulation for tension headache.

- Low-cost options to integrate exercise include walking in public spaces or use of public recreation facilities for group exercise. PT can be helpful, particularly for pts who have limited access to safe public spaces or public recreation facilities for exercise or whose pain has not improved w/ low-intensity physical exercise.

- Health insurers and health systems can improve pain mgmt and reduce med use and associated risks by increasing reimbursement for and access to noninvasive nonpharmacologic therapies w/ evidence for effectiveness.

- Review FDA-approved labeling, including boxed warnings, and weigh benefits and risks before initiating treatment w/ any pharmacologic tx.

- When pts affected by OA have an insufficient response to nonpharmacologic interventions such as exercise for arthritis pain, topical NSAIDs can be used in pts w/ pain in a single or few joints near the surface of the skin (e.g., knee). For pts w/ OA pain in multiple joints or incompletely controlled w/ topical NSAIDs, consider duloxetine or systemic NSAIDs.

- Use NSAIDs at the lowest effective dose and shortest duration needed; use w/ caution, particularly in older adults and in pts w/ CV comorbidities, chronic renal failure, or previous GI bleeding.

- When pts w/ chronic LBP have had an insufficient response to nonpharmacologic approaches such as exercise, consider NSAIDs or duloxetine for pts w/o contraindications.

- Tricyclic, tetracyclic, and SNRI antidepressants; selected anticonvulsants (e.g., pregabalin, gabapentin enacarbil, oxcarbazepine); and capsaicin and lidocaine patches can be considered for neuropathic pain. In older adults, decisions to use TCAs should be made judiciously on a case-by-case basis because of risks for confusion and falls.

- Duloxetine and pregabalin are FDA-approved for the treatment of diabetic peripheral neuropathy, and pregabalin and gabapentin are FDA-approved for treatment of postherpetic neuralgia.

- In pts w/ fibromyalgia, tricyclic (e.g., amitriptyline) and SNRI antidepressants (e.g., duloxetine, milnacipran), NSAIDs (e.g., topical diclofenac), and specific anticonvulsants (i.e., pregabalin and gabapentin) are used to improve pain, function, and QoL. Duloxetine, milnacipran, and pregabalin are FDA-approved for the treatment of fibromyalgia. In older adults, decisions to use TCAs should be made judiciously on a case-by-case basis because of risks for confusion and falls.

- Pts w/ co-occurring pain and depression might be especially likely to benefit from antidepressant med.

- Opioids should not be considered first-line or routine tx for subacute or chronic pain. This does not mean that pts should be required to sequentially fail nonpharmacologic and nonopioid pharmacologic tx or be required to use any specific treatment before proceeding to opioid tx. Rather, expected benefits specific to the clinical context should be weighed against risks before initiating tx. In some clinical contexts (e.g., serious illness in a pt w/ poor prognosis for return to previous level of function, contraindications to other therapies, and clinician and pt agreement that the overriding goal is pt comfort), opioids might be appropriate regardless of previous therapies used. In other situations (e.g., headache or fibromyalgia), expected benefits of initiating opioids

are unlikely to outweigh risks regardless of previous nonpharmacologic and nonopioid pharmacologic therapies used.

- Opioid tx should not be initiated w/o consideration by the clinician and pt of an exit strategy to be used if opioid tx is unsuccessful.

- Before opioid tx is initiated for subacute or chronic pain, determine jointly w/ pts how functional benefit will be evaluated and establish specific, measurable treatment goals.

- For pts w/ subacute pain who started opioid tx for acute pain and have been treated w/ opioid tx for ≥30 days, ensure that potentially reversible causes of chronic pain are addressed and that opioid prescribing for acute pain does not unintentionally become long-term opioid tx simply because meds are continued w/o reassessment. Continuation of opioid tx at this point might represent initiation of long-term opioid tx, which should occur only as an intentional decision that benefits are likely to outweigh risks after informed discussion between the clinician and pt and as part of a comprehensive pain mgmt approach.

- Clinicians seeing new pts already receiving opioids should establish treatment goals, including functional goals, for continued opioid tx. Avoid rapid tapering or abrupt D/C of opioids.

- Pt education and discussion before starting opioid tx are critical so that pt preferences and values can be understood and used to inform clinical decisions.

- Review available low-cost options for pain mgmt for all pts and particularly for pts who have low incomes, do not have health insurance, or have inadequate insurance.

- 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 and should involve pts in decisions about whether to start opioid tx.