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

Rec 6

When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids (rec category: A; evidence type: 4).

Implementation Considerations

- Nontraumatic, nonsurgical acute pain can often be managed w/o opioids.

- Opioids are sometimes needed for treatment of acute pain. When the dx and severity of acute pain warrant use of opioids, prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. For many common causes of nontraumatic, nonsurgical pain, when opioids are needed, a few days or less are often sufficient, and shorter courses can minimize the need to taper opioids to prevent withdrawal sx at the end of a course of opioids. However, durations should be individualized to the pt's clinical circumstances.

- Generally avoid prescribing additional opioids to pts just in case pain continues longer than expected.

- For post-op pain related to major surgery, procedure-specific opioid prescribing recs are available w/ ranges for amounts of opioids needed (on the basis of actual use and refills and on consensus).

- To minimize unintended effects on pts, clinicians, practices, and health systems should have mechanisms in place for the subset of pts who experience severe acute pain that continues longer than the expected duration. These mechanisms should allow for timely reevaluation to confirm or revise the initial dx and adjust pain mgmt accordingly. Clinicians, practices, and health systems can help minimize disparities in access to and affordability of care and refills by ensuring all pts can obtain and afford additional evaluation and treatment, as needed.

- Longer durations of opioid tx are more likely to be needed when the mechanism of injury is expected to result in prolonged severe pain (e.g., severe traumatic injuries).

- Pts should be evaluated at least q2wks if they continue to receive opioids for acute pain.

- If opioids are continued for ≥1 mo, ensure that potentially reversible causes of chronic pain are addressed and that opioid prescribing for acute pain doesn't 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 discussion between the clinician and pt and as part of a comprehensive pain mgmt approach.

- If pts already receiving long-term opioid tx require additional opioids for superimposed severe acute pain (e.g., major surgery), opioids should be continued only for the duration of pain severe enough to require additional opioids, returning to the pt's baseline opioid dosage ASAP, including a taper to baseline dosage if additional opioids were used around the clock for more than a few days.

- If opioids are used continuously (around the clock) for more than a few days for acute pain, clinicians should prescribe a brief taper to minimize withdrawal sx on D/C of opioids.

- If a taper is needed, taper durations might need to be adjusted depending on the duration of the initial opioid prescription.

- Tapering plans should be discussed w/ the pt before hospital discharge and w/ clinicians coordinating the pt's care as an outpt.