Cautious, Evidence-Based Opioid Prescribing

Despite low-quality evidence supporting practice change,[1-6] use of chronic opioid therapy (COT) for chronic non-cancer pain increased dramatically over the past two decades.[34-36] Concurrently, opioid analgesic overdose deaths, addiction, misuse and diversion have increased markedly.[20,37]

COT may provide modest, variable short-term pain relief for some patients with chronic pain. Long-term benefits of COT for chronic pain have not been established. Potential medical and behavioral harms of opioids are an important concern, particularly at higher dosage levels and in higher risk or medically complex patients. While COT at lower doses may be a useful treatment for some patients, it should only be considered for carefully evaluated, closely monitored patients when a cautious, structured and selective approach is employed, and clear benefits for pain and function are documented. COT always entails risks for patients, their families and the community, so vigilance and caution are essential.

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Myths and Facts about Chronic Opioid Therapy (COT)

Myth: COT for chronic pain is supported by strong evidence.	**Fact:** Evidence of long-term efficacy for chronic non-cancer pain (≥16 weeks) is limited,[1,2,3] and of low quality.[4,5] Opioids are effective for short-term pain management. But, for many patients with chronic pain, analgesic efficacy is not maintained over long time periods.[6]
Myth: Physical dependence only happens with high doses over long periods of time.	**Fact:** With daily opioid use, physical dependence and tolerance can develop in days or weeks.[7,8]
Myth: Patients who develop physical dependence on opioids can easily be tapered off.	**FACT:** Successfully tapering chronic pain patients from opioids can be difficult – even for patients who are motivated to discontinue opioid use.[33]
Myth: Addiction is rare in patients receiving medically prescribed COT.	**Fact:** Estimates vary. Between 4% and 26% of patients receiving COT have an opioid use disorder.[9-12] Among patients without an opioid use disorder, more than one in ten misuse opioids by: intentional over-sedation; concurrently using alcohol for pain relief; hoarding medications; increasing dose on their own; and borrowing opioids from friends.[9,15]
Myth: Addiction is the main risk to be concerned about when prescribing opioids.	**Fact:** Opioids have significant risks besides addiction and misuse.[18,19] These risks include respiratory depression and unintentional overdose death;[20,21] serious fractures from falls;[22,23] hypogonadism and other endocrine effects that can cause a spectrum of adverse effects;[24] increased pain sensitivity,[25] sleep-disordered breathing,[26] chronic constipation and serious fecal impaction,[27,28] and chronic dry mouth which can lead to tooth decay.[29]
Myth: Extended-release opioids are better than short-acting opioids for managing chronic pain.	**Fact:** Extended-release opioids have **not** been proven to be safer or more effective than short-acting opioids for managing chronic pain.[30]
Myth: Prescribing high-dose opioid therapy (≥120 mg morphine equivalents/day) is supported by strong evidence that benefits outweigh risks.	**Fact:** No randomized trials show long-term effectiveness of high opioid doses for chronic non-cancer pain. Many patients on high doses continue to have substantial pain and related dysfunction.[32] Higher doses come with increased risks for adverse events and side effects including overdose, fractures, hormonal changes, and increased pain sensitivity.[18-26]
Myth: Opioid overdoses only occur among drug abusers and patients who attempt suicide.	**Fact:** Patients using prescription opioids are at risk of unintentional overdose and death.[20] This risk increases with dose and when opioids are combined with other CNS depressants like benzodiazepines and alcohol.[21]
Myth: Dose escalation is the best response when patients experience decreased pain control.	**Fact:** When treating chronic pain, dose escalation has **not** been proven to reduce pain or increase function, but it can increase risks.[32]

Do's & Don'ts for Acute Pain Management

DO explain that opioids are for time-limited use. With the first opioid prescription, set expectations that opioids should be discontinued when the pain problem is no longer acute.

DON'T stock your patients' medicine cabinets with unused opioids. Limit all initial and refill prescriptions for acute pain. A 30-day supply is often excessive – many patients only take a pill or two then leave the rest in their medicine cabinet. This increases the risk of diversion, which in turn increases the risk of addiction and fatal overdose in families and communities. For those patients who use the medicine daily for several weeks, physiologic dependence develops within days or weeks. Due to risks of accidental poisoning, it is important to store opioids in a medication lock box and flush unused opioids down a sink or toilet.

DON'T start long-term use of opioids by accident. Long-term opioid prescribing should only occur after careful patient evaluation, discussion of risks and realistic expectations of benefits, and clear explanation of rules for safe use. Routine authorization of refills may cause patients to expect the prescription to continue indefinitely.

DON'T prescribe extended-release opioids for acute pain or to opioid-naïve patients. Extended-release opioids are not appropriate for managing acute pain and should never be prescribed to an opioid-naïve patient.

Do's & Don'ts for Chronic Pain Management

DON'T initiate chronic opioid therapy (COT) before considering safer alternatives such as primary disease management, cognitive-behavioral therapy (CBT), participating in pleasant and rewarding life activities, physical therapy, non-opioid analgesics and exercise.

DO screen patients for depression and other psychiatric disorders before initiating COT. Patients with depression and other mental health problems often present with pain problems. They may not know that mental health problems can contribute to chronic pain. These patients are at higher risk of opioid addiction. They may be better served by mental health treatment.

DO talk with patients about therapeutic goals, opioid risks, realistic benefits, and prescribing ground rules. Therapeutic goals should include increased activity and improved quality of life, not just pain relief. Patients should understand the full range of opioid risks and the limited benefits they can reasonably expect. The rules for safe and appropriate use of opioids need to be explicit, preferably documented in a written treatment agreement.

DO realize that patients are reluctant to disclose a history of substance abuse. A history of substance abuse indicates greater risk of opioid addiction, but getting an accurate picture of past and current drug use can be difficult. If a patient denies past or current substance abuse, recognize that they may be afraid to tell you the truth. Consult the medical record, a prescription drug monitoring database, and third parties as needed.

DO perform a thorough medical evaluation and a urine drug screen before initiating COT. Starting chronic opioid therapy should be an affirmative decision based on adequate assessment of risk, urine drug screening, and use of a treatment agreement. Because it can be difficult to know if a patient is seeking opioids for addiction or diversion purposes, COT should only be considered by a physician who has an ongoing relationship with the patient. The prescribing physician should be willing to continue working with the patient if problems arise.

DO explain to patients that discontinuing opioids may be difficult. Some patients find it difficult to taper off of opioids, particularly from higher dose regimens, even when they are eager to do so. Patients can experience increased pain, insomnia, or anxiety when tapering from opioids. These unpleasant withdrawal symptoms can last for several weeks. Do not abandon chronic pain patients after discontinuing opioids.

DO perform random urine drug screens on patients receiving COT. Urine drug screening helps identify patients using illicit drugs or not taking the medicine as prescribed.

DON'T continue COT with patients who show no progress toward treatment goals defined by increased function and reduced pain.

DON'T assume patients know how to use opioids safely. Opioids are powerful drugs that patients sometimes use in unsafe ways. Risks of unsafe use increase with prescribed dose and are greater for extended-release medications with long half-life. Patients often do not understand that it can be unsafe to take extended-release opioids "as-needed for pain." Take time to talk with patients about how they are using opioids. Ask patients about their problems and concerns.[17]

DON'T assume patients use opioids as you intend. Many patients vary their dose and use combinations of other CNS depressant drugs or alcohol in ways that you may not know about. Patients may also sell their medications or share them with others. Opioid misuse often occurs among patients who do not have an opioid use disorder.[9,15] Vigilance for unsafe use is essential.

DON'T start a treatment that you are not prepared to stop. Don't initiate COT without benchmarks for stopping, a procedure for tapering that you are willing and able to use, and an approach to managing physical and psychological withdrawal symptoms. If substance abuse is identified, taper opioids and make arrangements for substance abuse treatment.

DON'T assume patients are doing well with COT without careful evaluation. Careful and compassionate interviewing about opioid use and misuse, questions about your patients' problems and concerns,[17] screening questionnaires, urine drug screening, and information from prescription drug monitoring databases often reveal problems with prescription opioids that would otherwise be missed.

DON'T abandon patients with a prescription drug problem. For patients who are misusing or addicted to prescription opioids, offer help or referral to someone who can treat substance abuse.

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