PROP
Physicians for Responsible Opioid Prescribing

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Robert R. Redfield, M.D.
Director
Centers for Disease Control and Prevention
1600 Clifton Road NE
Atlanta, GA 30329

Re: Docket No. CDC-2020-0029- Management of Acute and Chronic Pain

Submitted Electronically

Dear Dr. Redfield:

Physicians for Responsible Opioid Prescribing (PROP) appreciates the opportunity to submit a comment to Docket No. CDC-2020-0029- Management of Acute and Chronic Pain. PROP's members include clinicians and researchers in the fields of Primary Care, Pain Medicine, Addiction Medicine, Anesthesiology, Physical Medicine and Rehabilitation, Emergency Medicine, Public Health, Internal Medicine, Rheumatology and other specialties.

The CDC first alerted the nation to the alarming increase in prescription opioid overdose deaths in 2006, increases that were in direct relationship to increases in opioid analgesic sales.[1] By 2016, after extensive examination of the factors that contributed to the US opioid addiction epidemic, the CDC published a guideline for the use of opioids by primary care physicians for the treatment of chronic pain.[2] The CDC's focus on primary care physicians and chronic pain was based on evidence that this was the area where opioid use was least beneficial and most harmful. By many accounts, primary care physicians have found the guideline tremendously helpful. Data accumulated since its publication have shown desired downward trends in inappropriate prescribing, and in prescription opioid related morbidity and mortality. Even so, the United States continues to have much higher rates of opioid prescribing than any other developed country in the world, so it is not accurate to depict current practice as overly restrictive.

For many pain patients who are physiologically dependent on opioids, the shift away from the excessive use of high opioid doses unique to the United States has been difficult. The 2016 guideline envisioned dose reduction or discontinuation achieved gradually through shared decision making with patients. For a variety of reasons, this goal proved difficult to achieve. Some patients using opioids long-term now have difficulty finding clinicians willing to continue them on a risky treatment lacking evidence of effectiveness. Many of these patients are fearful of losing access to opioids and believe they are being unfairly penalized for opioid misuse, as evidenced by anecdotes submitted to this docket. We believe that the problems these patients have experienced can be avoided without returning to the ineffective and unsafe opioid prescribing practices that resulted in hundreds of thousands of needless deaths and millions becoming addicted to medically prescribed opioids. Both the CDC[3] and HHS[4] have now published new guidance on how and when to taper chronic opioid pain treatment. At the same time,

several trials are underway to assess best practices for helping patients receiving opioids at unsafe doses. Changes in current guidelines should be informed by emerging scientific evidence on how best to meet the needs of patients dependent on opioids.

Primary care physicians find the management of chronic pain difficult, particularly when patients are taking high doses of opioids. Without help and resources, these patients take considerable time and energy in increasingly busy primary care practices with limited resources. The answer is not to abandon these patients, but to provide much needed resources so that primary care can cope. Most importantly, recommendations to successfully engage, assess, implement effective treatment pathways (eg, maintain and monitor, taper, transition to buprenorphine), and provide effective health system changes will be required to provide effective support and to successfully address the concerns of these patients.[5]

While the US opioid epidemic unfolded before our eyes, neuroscientists have increasingly identified mechanisms whereby opioid medications cause adaptations in the brain that run counter to the drugs intended or initial effects.[6,7] These so-called drug opposite effects are established much earlier than was previously thought, and explain why people taking opioids over long periods often experience loss of analgesia and extreme difficulty tapering. Tapering exposes these aversive changes, that include not only worsening pain, but intolerable negative mood changes. For some patients, continued opioid use is necessary not because it effectively manages the pain that prompted opioid prescribing initially, but because continued use averts the negative effects of opioid discontinuation.

We know from clinical experience and from controlled studies that opioids are rarely beneficial for chronic pain. The downward trends in new starts of chronic opioid treatment achieved by the 2016 guideline should be seen as a positive development that will encourage people to find alternative means of controlling chronic pain, which though harder to employ than the prescription pad, will ultimately result in better outcomes and less distress. In efforts to manage patients currently using opioids long-term, it would be a tragic mistake to alter prescribing guidance in ways that made it easier for a new generation of persons with chronic pain to receive opioids long-term.

Now is not the time to reverse the gains of the 2016 guideline. The focus now should be twofold: to find better ways to help people already on opioids and improve access to better means than opioids to treat chronic pain.

Respectfully submitted,

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REFERENCES

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