The Updated 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

Guidelines at a Glance for Applying and Implementing Recommendations

The 2022 Clinical Practice Guideline (updated from 2016) were developed because the Centers for Disease Control and Prevention (CDC) recognized that clinicians needed current recommendations for prescribing opioids to improve pain management and patient safety. The updated guidelines include twelve recommendations that can be summarized by the following four actions:

1. **determining whether to initiate opioids for pain**
2. **selecting opioids and determining opioid dosages**
3. **deciding duration of initial opioid prescription and conducting follow-up**
4. **assessing risk and addressing potential harms of opioid use**

The guidelines focus on pain care for outpatients aged 18 years or older with acute pain (duration less than 1 month), subacute pain (duration of 1-3 months), or chronic pain (duration of more than 3 months).

Determining Whether to Initiate Opioids for Pain
Nonopioid therapies are at least as effective as opioids for many common types of acute pain. However, there is an important role for opioid therapy for acute pain related to severe traumatic injuries (such as crush injuries and burns) and invasive surgeries. Nonopioid therapies are also preferred for subacute and chronic pain. Nonopioid therapies include:

- Medications such as acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), and selected antidepressants (duloxetine) and anticonvulsants (gabapentin)
- Physical treatments (heat therapy, acupressure, spinal manipulation, remote electrical neuromodulation, massage, exercise therapy, weight loss)
- Behavioral treatment (cognitive behavior therapy, mindfulness-based stress reduction). Clinicians should maximize the use of these therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient

Selecting Opioids and Determining Opioid Dosages
If opioids are deemed to be clinically necessary for acute, subacute, or chronic pain, clinicians should initially prescribe immediate-release opioids (morphine, oxycodone, or hydrocodone) instead of extended-release (methadone or transdermal fentanyl) and long-acting (ER/LA) opioids. Since the benefits and the risks of opioid therapy change over time for an individual, use should be re-evaluated periodically. If opioids are continued for subacute or chronic pain, clinicians should be aware that many patients do not experience benefit in pain or function from increasing opioid dosages to ≥50 morphine milligram equivalents (MME) per day. Clinicians should carefully weigh the benefits and risks and exercise care when changing opioid dosages,

forms, or products and regularly assess benefits and risks.

Deciding Duration of Initial Opioid Prescription and Conducting Follow-up
It is important to note that opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages. Longer durations of previous opioid therapy might require longer tapers. The rate of tapering should be individualized based on the patient's clinical situation. Tapers of approximately 10% per month or slower are likely to be better tolerated than more rapid tapers when patients have been taking opioids for longer durations (≥1 year). When patients have taken opioids for shorter durations (weeks to months), a decrease of 10% of the original dose per week or slower (until approximately 30% of the original dose is reached, followed by a weekly decrease of approximately 10% of the remaining dose) is less likely to trigger withdrawal symptoms.

Assessing Risk and Addressing Potential Harm of Opioid Use
Before starting and during continuation of opioid therapy, providers should periodically evaluate risk for opioid-related harm and discuss risks with patients. Clinicians should regularly review the patient's history of controlled substance prescriptions using state prescription drug monitoring program data. Individuals can be at significantly higher risk for sedation side effects leading to falls/accidents/respiratory depression events when receiving benzodiazepines (alprazolam, diazepam, etc.) or muscle relaxants (Carisoprodol, Cyclobenzaprine, etc.) concurrently with opioid treatment. However, this does not mean opioid treatment should be withheld from patients already taking medications that depress the central nervous system. Clinicians should offer naloxone (Narcan® nasal spray) when prescribing opioids, particularly to patients at increased risk for overdose. It is important for the provider to educate patients on overdose prevention and naloxone use. It is also critical to provide education to members of their households. Patients must be told to inform family, roommates, caregivers, friends, and others around them where they keep the Narcan® nasal spray and how and when to use it.

Bottom Line: The new 2022 Clinical Practice Guideline emphasizes flexibility and encourage individualized opioid and nonopioid options to promote overarching principles of safe and effective pain treatment rather than focusing on specific dosage thresholds.
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References:

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