The New CDC Opioid Prescribing Guideline for Treatment of Pain

Documenting the rationale for use of these drugs is key.

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I. Are Podiatrists Governed By This Guideline?

In November of 2022, the CDC made available their "new and improved" guideline concerning the use of opioids and pain. It states that since its original guideline on this topic, new evidence has come to the fore. Additionally, it addresses several "misinterpretations" of the 2016 guideline. However, as this is a journal that is read mostly by podiatrists, the first question should be: does the guideline apply to DPMs?. The answer is: if the podiatrist treats pain, at least some of the time, by prescribing opioids, it does apply. As few podiatrists treat chronic pain with opioids, for the most part, we are talking about patients who are status-post surgery, with fractures and other traumatic injuries to the foot and ankle.

Unlike the 2016 guideline, the new guideline includes acute and subacute pain: the type seen in surgical and trauma patients. Acute pain is defined as a pain for a duration of less than one month. Sub-acute pain is defined as pertaining to patients in pain for one to three months. Having more than three months of pain is defined as chronic.

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This guideline does not pertain to the pain specialist. Few podiatrists are board certified by a recognized board in the treatment of pain. Some states mention by name various board certifications that would qualify the provider as a specialist in the treatment of pain. You do not qualify as a pain specialist by merely taking the required three to four-hour course to be able to prescribe opioids in your state. This guideline does not pertain to pediatric podiatric patients.

In virtually every state, it is required, if you are prescribing a controlled medication, to access your state-controlled substance data bank. This way, you are able to ascertain if other practitioners are prescribing controlled substances to your patient.

To review: as a podiatrist, with a DEA number, who prescribes opioids for pain, as a non-pain specialist, this guideline applies to you.

II. Acute Pain

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tive patients, or patients who sustained some kind of fracture or acute pain to their foot or ankle. Certain patients with neuropathic pain are also included. The CDC, in the new guideline, lists a total of 12 "recommendations". The first one impacts on treatment of acute pain:

"Non-opioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of non-pharmacologic and non-opioid pharmacologic therapies as appropriate for the specific condition and patient. They should only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy."

The guideline goes on to point out that, specifically for conditions such as bursitis, tendonitis, as well as sprains and strains, non-opioid therapies are often as effective as opioids. They recommend the use of topical or oral NSAIDs such as acetaminophen, as well as non-pharmacologic therapy such as ice, heat, rest, exercise, immobilization, as appropriate. Crush injuries and burns may require the use of opioids, as might your surgical patients.

Most patients that will be considered in acute pain will be post-operative patients, or patients who sustained some kind of fracture or acute pain to their foot or ankle.

When it is appropriate to use opioids, you should prescribe immediate-release opioids at the lowest effective dose, and for no longer than you expect the acute pain will persist. Please note that some insurance will not pay the extra money for the immediate-release opioids. If the patient cannot afford it, please note that as the reason you did not prescribe that type of medication to your patient.

Podiatrists and other healthcare providers should only use the minimum efficacious dosage to treat the patient's acute pain. That is not to say that each patient must be titrated up from the minimum possible dosage to the point of efficaciousness. Start the patient with the minimum effective dosage that your experience, and the science, dictates. If that is not effective, titrate the dosage upwards, being careful to correctly discover the underlying source of pain. Do not be shy about referring patients to other appropriate healthcare providers on your medical team.

Always make sure that your patient is very aware of the common and serious risks and alternatives to starting opioid therapy. Determine if your patient is opi-

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oid-naïve. Is there a history of use or abuse of opioids? That does not mean that after a bunionectomy, TENS treatments should be given in lieu of opioids. Your experience and evidenced-based knowledge dictate the appropriate treatment.

III. 50 Is the New 90

In the prior set of "Opioid Guidelines", the CDC arbitrarily used 90 morphine equivalent units (MEUs) as the upper limit that non-pain specialist practitioners should

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be using to treat intractable pain. Frankly, many practitioners found this to be an unworkable number, not sufficiently supported by evidence-based studies.

Healthcare providers who treated pain often "inherited" patients on MEUs much higher than 90. The older CDC "recommendations" seemed to imply that if a patient was on MEUs at or above 90, a rapid taper was in order. Many patients and practitioners faced a daunting situation with such tapers. A very rapid taper can place the health of the patient in jeopardy. Additionally, it caused some patients to seek street drugs when they were insufficiently medicated. In response to this, a couple of years ago, the CDC issued a "clarifying" letter advocating a slow taper for such patients.

In the new guideline, the CDC uses the lower number of 50 MEUs as a signpost. Unlike its predecessor, 50 MEU is not meant to be any kind of maximum dosage. It simply asserts that studies have shown that at, or above, that dosage, more complications of opioid therapy tend to occur at greater frequency.

At that number, 50 MEUs, it is best to stop, look, and listen. Be very aware of your patient's reaction to their dosage; especially in the realm of respiratory changes. Use of sleep studies, in cases of possible apnea, can be a very wise choice. Sit the patient down, and go over (again) the various complications that might be seen with the use of opioids. Consider, if possible, a slow taper. A slow taper might take many months. Chart your goals. Chart your patient's attitude to your goals.

The new guideline does not advocate the immediate dismissal of a patient who violates the way you prescribed opioids, even if they took an increased number of pills, or took street drugs. This is so for patients who failed a urine screening or just admitted it. It recognizes that the patient is better off under the care of a trained healthcare provider as opposed to being cast off. Use the violation as an educating moment. Reassure the patient you are in their corner. However, continue to monitor

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them for any violations. That is not to say that you can never dismiss a patient from your practice for continued abuse of opioids.

Under the prior guideline, many state medical and podiatric boards used the 90 MEUs, as well as taking medication not as recommended, as hard standards, that sometimes led to professional discipline. As it has just been issued, it is yet to be seen how the state boards will use the new CDC guideline. Due to this question mark, you should document, document, document!

Of note, the CDC states that the goal of treatment with opioids for pain is the reduction of pain, not its elimination.

IV. Non-invasive Non-pharmacologic Approaches to Acute Pain

The guideline touts using various types of heat therapy, manipulations, acupressure, massage, electric modulation, and other non-pharmacologic therapies for the treatment of acute pain. It does not suggest that you must try them if, in your professional clinical judgment, pharmacologic intervention alone is indicated. Keep in mind that non-opioid pharmacologic intervention is also an option. Additionally, keep in mind that the non-invasive non-pharmacologic therapies can be used in conjunction with pharmacologic treatment of acute pain. The goal is to reduce the amount of opioid therapy. Also consider ice and elevation as part of the treatment of acute foot and ankle pain, when appropriate to the diagnosis.

The guideline cites the American Academy of Family Physicians when asserting that acupressure might be useful in some patients with acute musculoskeletal pain. Again, this is cited as part of the guideline, not as a standard of care. The use of acupressure for the treatment of pedal musculoskeletal pain is not mandated by this guideline, just to be considered.

The guideline is also aware that certain non-invasive therapies are not covered by patients' medical insurance coverage. It is also aware of the unavailability of certain types of treatment in rural areas; so too with areas where transportation is not available for certain types of patients. As an aside, should your patient fall into these categories, be sure to record the reasons why certain types of treatment or therapies could not be attempted.

V. Non-opioid Pharmacologic Treatment

The guideline does not address the use of medical cannabis in the treatment of acute pain. The reason is simply that federal law still considers it an illegal substance. However, if your state allows for the medical use of cannabis, and you are certified to suggest it, you should at least consider its use. Many pain control specialists have found that its use decreases, or even eliminates, the amount of opioids needed to treat a patient in acute or sub-acute pain.

The guideline suggests that oral NSAIDs, such as diclofenac, might be useful in the treatment of acute pain. Topical NSAIDs may also be useful. Depending on the etiology of the pain, gabapentin may be helpful in the treatment of acute pain; so might the use of muscle relaxants. Attention to side-effects such as gastrointestinal distress must be dealt with. The patient must be made aware of this. Patients may have contraindications for use of NSAIDs or medications like gabapentin. If considered and rejected due to such a contra-indication, it should be noted in the patient's medical record. The most obvious reasons would be various pre-existing gastrointestinal ailments in patients point to avoiding the use of NSAIDs as well as kidney damage pre-existing in a patient as well as the avoidance of the use of gabapentin.

Consider using capsaicin or lidocaine patches, when appropriate, in conjunction with other therapy, or alone, to treat acute and sub-acute pain. Also, consider using Duloxetine and pregabalin for the treatment of diabetic peripheral neuropathy.

VI. Sub-acute Pain

Opioids are not considered the first choice for treatment of sub-acute pain. The guideline does point out that you do not have to try each non-opioid therapy prior to using opioids in appropriate cases. The key is that the expected benefit must outweigh the risks of your treatment of the patient in sub-acute pain.

VII. Conclusion

Of note, the CDC states that the goal of treatment with opioids for pain is the reduction of pain, not its elimination. You may or may not agree with that, but that is what it states. You should record how your treatment for pain is proceeding. How effective is it? Specifically, what can your patient do that they could not do prior to the prescription, or any change of treatment or dosage? Can they now walk three blocks instead of one block?

It is important to remember that the CDC has written an updated guideline for the treatment of pain. It guides you, not orders you. However, if you decide to go outside the guideline in your care and treatment of a patient, please note your rationale in your patient records. **PM**

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