The CDC Guidelines for the Treatment of Pain

Treatment depends on the type of pain the patient has.

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Podiatrists treat pain every day. Back in 2016, the Center for Disease Control developed a controversial document concerning the treatment of chronic pain. After much frustration and alleged misunderstanding of the original guideline, the CDC published a new guideline in 2022 that defines three types of pain as:

1) *Acute*, which is pain that has been happening for less than one month;

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2) *Sub-acute,* or pain that lasts from 1-3 months;

3) *Chronic,* which lasts more than 3 months.

This guideline was not meant for board-certified pain control specialists, but more for primary care practitioners who treat pain. Most podiatrists fall into the primary care practitioner category. The new guideline, unlike its predecessor, was meant to clarify "misunderstandings" concerning maximum allowable dosage and tapering of pain medications, the virtual prohibition of prescribing benzodiazepine with opioids, and various administrative bodies mistakenly using this guideline as actual standards of care rather than being "advisory" in nature. Tackling the last problem first… in fact, many state medical boards have used this guideline as a standard of care.

The best way for podiatrists to address this is by using accurate and complete documentation. If your treatment plan consists of any deviation from this guideline, you must be prepared to explain why you are not following the guideline's recommendation. An example of this might include the difficulty in referring certain patients to psychiatric/psychological evaluation due to lack of availability in your geographic area, or a lack of affordability.

So, which pain guideline should be observed? Some states have their own guidelines, including those that have separate guidelines that deal with pain and Workers Compensation. If you're unsure what to use, look for the date that the guideline was published. Generally, if a state published its pain guideline after the 2022 CDC Federal guideline, observe the later one.

Most of the state guidelines are similar to the 2022 CDC guideline, with some differing emphases. Some require use of various pain measuring tools, most of which are available online from individual state health sites. But variation about drug testing frequency still persists.

The Bible has given us the famous 10 Commandments, but the CDC found it necessary to format its guideline into the following 12 "recommendations":

Recommendation 1: Non-opioid therapies are at least as effective as opioids for many common types of acute pain. Consider use of opioids for acute pain only if the benefits outweigh the risks. An example: Patient presents with acute pain at the base of the 5th metatarsal and the lateral ankle. X-rays reveal a Jones fracture with a partial dislocation that needs to be reduced. An assessment might reveal that opioid analgesics are necessary for a short time to control the acute pain. That would not entail prescribing a dosage of Percodan for the next 4-6 weeks. Perhaps a non-displaced fracture of the left 5th toe, proximal phalanx would not entail any use of opioids.

Recommendation 2: Non-opioid therapies are preferred for subacute and chronic pain. These include physical therapy, splinting, biofeedback, acupuncture, and non-opioid medication. Establish treatment goals for pain and restoration of functions. Consider how opioid therapy should be discontinued when/if the benefits of continued use do not outweigh its risks.

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Recommendation 3: When starting opioid therapy for any type of pain, consider using immediate-release opioids instead of extended release and long-acting opioids. If your patient's drug coverage will not adequately cover such a prescription and your patient can only afford an extended release or long-acting option, your chart should state the reason for your prescription for that option.

Recommendation 4: Pay attention to dosage levels in patients who are opioid naïve! They may do better with lower levels of opioids. Prior to increasing any dosage, carefully weigh benefits versus risks. These guidelines usually refer to the dosage risk by comparing morphine equivalent units (MEUs) or morphine milligram equivalents (MMEs). Conversion charts are freely available on various websites.

Recommendation 5: Clarifies the prior CDC Guideline concerning tapering prescribed opioids. Tapering should be done gradually unless there are warning signs of impending overdose, such as the patient exhibiting signs of confusion, sedation, or slurred speech. Tapering becomes more of an issue, due to non-adherence by patients when they have been taking opioids for months or years rather than days or weeks. "Cold turkey" stoppage of opioids may be dangerous and should be generally reserved for patients who must cease any ingestion of opioids immediately.

Recommendation 6: When dealing with acute pain, the provider should only prescribe enough opioids for the expected duration of pain that's severe enough to require opioids, and no longer. Of course, that is assuming that opioids are necessary over other options.

Recommendation 7: Clinicians should evaluate benefits versus risks with patients within 1-4 weeks of initiation of opioid therapy for subacute or chronic pain, or of any dosage escalation. You should regularly re-evaluate benefits and risks of continued opioid therapy with patients, and yes, that means you should document that this is indeed being done. Such documentation is often missing from many reviewed medical records.

Recommendation 8: Work with your patients to incorporate management strategies to mitigate the risk of using opioids. That strategy should include offering naloxone, especially with patients that are taking 50 or more morphine equivalent units per day. Some states require giving a prescription for naloxone so that the patient has it readily available should it be necessary.

Part of pain management strategies involves the prescriber conducting a thorough history and physical. Ask your patient if they have sleep apnea or insomnia. Do they use a sleep apnea mask? In such patients, beware of risks of further respiratory depression and act accordingly when it comes to prescribing any medications, and cross-check your prescriptions with any other provider's prescriptions that might cause further respiratory depression. Additionally, be aware that patients over 65 years old tend to have under-treatment of their pain. Be alert for any patients with decreased renal function, and ascertain whether your patient has any prior history of drug or alcohol abuse.

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Recommendation 9: Access your state's regulated substance prescription databases prior to prescribing or changing a dosage, especially when using opioids and restricted substances. For example, if the patient is also on a benzodiazepine, this places them at increased risk of respiratory depression. Keep in mind that often, such substances, including other opioids, have been prescribed by another healthcare professional. Coordinate and cooperate with the other prescribers.

Recommendation 10: Insist on appropriate toxicology testing for patients on controlled substances. Refer to your state mandates about the type and frequency of these tests, and if they aren't available, review your relevant Medicare LCDs. The appropriate test generally depends on whether your patient is at low, medium, or high risk for abuse of the medication. Some states require specific tools to be used to make this determination. The failure to use them and log them in our medical records can result in professional discipline, fines, and being held liable to return the money for the medication as part of an audit. This is *despite* that fact that you are not the pharmacist and did not pay for the prescription. Remember that when you write the prescription, you are potentially liable for the cost of these medications!

Recommendation 11: This is the section that addresses the use of benzodiazepines with opioids. It wants you to exercise "particular caution" when prescribing opioids if the patient is on a benzodiazepine, whether prescribed by you (less likely as a podiatrist) or by another healthcare provider. However, some patients have been on both and are stable for years. Your medical record should clearly reflect this. This has long been a point of contention with various federal and state agencies. They would frequently cite the 2016 CDC Guideline that, to be charitable, was "unclear" in this area.

Obviously, a patient who has

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sleep apnea has an increased risk of respiratory depression if also on a benzodiazepine and an opioid. You must check your state's prescription database. It will not suffice to claim that YOU did not prescribe the other medications when you prescribed the opioids. Remember that suddenly stopping the use of benzodiazepines can be destabilizing. Consult with or allow the prescriber of that substance to perform the weaning from its use. Work in conjunction with the patient's team of healthcare professionals.

Recommendation 12: Detoxification for patients with opioid use disorder should be performed by an expert, often using other medication to aid in the process. Do not be afraid to refer such a patient to an addiction specialist.

It should also be noted that other treatments, such as physical therapy or non-opioid analgesics, acupuncture, and the like help reduce the need for opioids, or lower their dosage. Plain old good judgment should never be excluded from this equation. Some patients are drug seekers, and you are not required to prescribe opioids out of fear of retribution from such a patient. But once you accept them as a patient, you are required to appropriately treat them in a way that might include opioids.

Other treatments, such as physical therapy or non-opioid analgesics, acupuncture and the like, assist in the ability to keep the need for opioids down, or to lower the dosage of opioids.

By now it should be obvious that writing a thorough and accurate medical record is extremely important in protecting yourself, and in being able to provide the highest level of care to your patients. PM

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