

Opioid Use and Chronic Pain: VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain (2022)

About the Guideline

- This guideline was developed to provide a foundation for evaluating and managing patients with chronic pain who are currently receiving or who will be considered for opioids for pain management.
- The development team and working group included physicians and other professionals from the following institutions:
 - Department of Veterans Affairs
 - Department of Defense
 - VA Evidence Based Practice, Office of Quality and Patient Safety, Veterans Health Administration
 - Clinical Quality Improvement Program, Defense Health Agency
 - The Lewin Group
 - ECRI
 - Sigma Health Consulting
 - Duty First Consulting
- The Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology was utilized to determine the strength and quality of the literature.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline, especially if you work in an acute care setting or with patients suffering from chronic pain.

Background

- The opioid epidemic is a national crisis that affects public health, social, and economic welfare, and chronic pain being the most common, costly, and disabling chronic medical condition in the United States.
- The misuse of prescription opioids costs an estimated \$78.5 billion annually.
- The ill effects of long-term opioid use include the following:
 - Increased mortality
 - Opioid use disorder (OUD)
 - Overdose
 - Sexual dysfunction
 - Fractures
 - Myocardial infarction
 - Constipation
 - Sleep-disordered breathing
 - New-onset depression
- Approximately 50.2 million adults experience chronic pain on most days, or every day.
- Pain is defined by the International Association for the Study of Pain (IASP) as “an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.” The following should be considered regarding individuals in pain:

- Pain is a personal experience, influenced by biological, psychological, and social factors.
- There is a difference between pain and nociception; pain cannot be assumed only from activity in sensory neurons.
- Individuals learn the concept of pain through life experiences.
- An individual's pain experience should be respected.
- Pain may have adverse effects on function, and social and psychological well-being.
- Expression of pain is not limited to verbal communication and may be expressed by several behaviors.
- **Chronic pain is defined as persistent or recurring pain lasting longer than 3 months. IASP classifies chronic pain into the following seven groups:**
 - Chronic primary pain
 - Chronic cancer pain
 - Chronic post-traumatic and postsurgical pain
 - Chronic neuropathic pain
 - Chronic headache and orofacial pain
 - Chronic visceral pain
 - Chronic musculoskeletal pain
- **A comprehensive pain assessment should be performed, including a focused physical exam and a biopsychosocial interview that incorporates the following elements:**
 - Pain assessment
 - Onset
 - Location
 - Duration
 - Exacerbating factors
 - Relieving factors
 - Radiation
 - 24-hour pain pattern
 - Quality of pain
 - History of previous treatments and their effect on pain
 - Impact of pain on activities of daily living and quality of life
 - Functional goals
 - Evaluation of psychological and/or behavioral factors that may affect treatment
 - Evaluation of social factors that may affect treatment
 - Current and past co-occurring conditions
 - Physical exam
 - Confirmation of diagnosis
 - Consideration of consultations and referrals
 - Discussion of beliefs and understanding of the cause of the pain, individual preferences, and perceived efficacy of various treatment options

Initiation and Continuation of Opioids

- For the management of chronic, non-cancer pain, initiation of opioid therapy is not recommended.
 - Consideration should be made for individuals experiencing acute pain conditions, an acute pain condition in addition to chronic pain, or an acute exacerbation of chronic pain.

- Long-term opioid therapy is not recommended for individuals in younger age groups, as younger adults who are treated with long-term opioids are at increased risk of OUD, opioid misuse, and drug overdose.
- Long-term opioid therapy is not recommended for patients with chronic pain who also have a substance use disorder (SUD). However, each patient should be treated individually, and SUD should not be considered a contraindication to long-term opioid therapy.
- When considering the use of methadone, buprenorphine, or extended-release naltrexone injection, no recommendation is made in selecting one of these medications over another for patients with chronic pain and co-occurring OUD.
- The use of buprenorphine is suggested instead of full-agonist opioids for patients receiving daily opioids for treatment of chronic pain.
 - Pain reduction with buprenorphine was similar when compared with pain reduction provided by other opioids.
 - Buprenorphine may be considered as a first-line agent in adults with chronic pain over the use of moderate- to high-dose, full-agonist opioids.
 - Buprenorphine is first-line treatment for OUD and has shown to cause less euphoric effects.
- Concurrent use of benzodiazepines and opioids for chronic pain is not recommended.
 - Concurrent use increases the risk of overdose and overdose death.
 - Benzodiazepines should not be initiated in patients being treated with opioids, and conversely, patients already receiving benzodiazepines should not be started on long-term opioids.
 - For individuals currently receiving benzodiazepines and opioids, tapering of one or both medications should be considered to avoid serious adverse effects.

Dose, Duration, and Taper of Opioids

- When prescribing opioids, using the lowest dose, as indicated by patient-specific risks and benefits, is recommended.
- Reevaluation of patient-specific risks and benefits, and monitoring for adverse events (including OUD and the risk of overdose) is recommended if considering an increase in opioid dosage.
- When prescribing opioids, the shortest duration as indicated is recommended.
- After initiating opioid therapy, reevaluation should be performed at 30 days (or sooner). Frequent follow-up visits should be performed if opioids are to be continued.
 - Longer durations of therapy with opioids are associated with a higher risk of needing treatment for OUD and a higher risk of a fatal opioid overdose.
 - Prior to starting opioid therapy, an individualized assessment of risks and benefits should be performed.
 - Follow-up visits should include reevaluating the need to continue opioids and assessing the patient for changes in co-occurring conditions, diagnoses, medication and functional status.
- Prescribing long-acting opioids is not recommended for acute pain, as an as-needed medication, or when initiating long-term opioid therapy due to the risk of OUD, overdose, and death.
- A collaborative, patient-centered approach is suggested when tapering opioids.
- There is no recommendation for or against any specific tapering strategy.

Screening, Assessment, and Evaluation

- Assessing the risk for suicide and self-directed violence is recommended when initiating, continuing, changing, or discontinuing long-term opioid therapy, and at each patient contact.
 - Some patients may threaten suicide when clinicians recommend discontinuing opioids; however, continuing opioids to prevent patient self-harm is not recommended as this increases overall risk.
 - The use of buprenorphine may be considered as a bridge to gradually titrating long-term opioids and may help relieve distress surrounding titration.
- When considering long-term opioid therapy for patients with chronic pain, assessing for conditions associated with a higher risk of harm, such as behavioral health conditions, a history of traumatic brain injury, and psychological factors is recommended.
- When opioids are being considered for patients with acute pain, screening for pain catastrophizing and co-occurring behavioral health conditions is recommended to identify those at higher risk for negative outcomes.
 - These individuals are at an increased risk of mortality, potentially obtaining inappropriate prescriptions, opioid dependence, and overdose.
- For patients receiving opioids, an ongoing reevaluation of the benefits and harms of continued use based on individual risk factors is suggested.
 - An increased risk of harm is associated with socioeconomic status, age, dose, opioid formulation, and the use of other prescriptions.

Risk Mitigation

- Urine drug testing is suggested for patients receiving long-term opioids to ensure the appropriate use of prescription opioids.
- An interdisciplinary plan of care is suggested to address pain and/or behavioral health problems, including SUDs, for patients with high-risk or aberrant behavior.
- Providing preoperative opioid and pain management education to patients is suggested to decrease the risk of prolonged opioid use for postsurgical pain.

Reference

VA/DoD Clinical Practice Guideline. (2022). *Use of Opioids in the Management of Chronic Pain Work Group*. Washington, DC: U.S. Government Printing Office. <https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPG.pdf>