PAIN EPIDEMIC
• +100 million people in the U.S. experienced pain in 2011
• Pain has a significant impact on quality of life and is a leading cause of disability
• 50 million (20.4%) adults in the U.S. have chronic pain (2016)
• 19.6 million (8%) adults in the U.S. had high-impact chronic pain, which limits life or work activities on most days or every day in the previous six months (2016)
• Chronic pain has an estimated annual cost of $560-630 billion

OPIOID CRISIS
• 47,600 (68%) of the 70,200 drug overdose deaths in the U.S. involved an opioid (2017)
• Overdose deaths involving opioids (including prescription opioids¹ and illegal opioids like heroin and illicitly manufactured fentanyl) are six times higher than in 1999
• 130 Americans die every day from an opioid overdose; 46 of those are related to prescription opioids¹
• There has been a significant increase in heroin (2010) and fentanyl (2013) overdose deaths
• Illicit fentanyl analogues (including carfentanil) are 100 to 10,000 times more potent than morphine and have been found in other drugs such as heroin and cocaine, and counterfeit opioid tablets
• Approximately 41% of patients receiving chronic opioid therapy for pain may develop an opioid use disorder

MANAGING PAIN
The management of pain requires an interdisciplinary, biopsychosocial and multimodal approach.
• Nonopioid treatment approaches are recommended as first-line and preferred for chronic pain
  - Nonpharmacologic therapy:
    • Chiropractic care, acupuncture, massage
    • Behavioral: Mindfulness, meditation, cognitive-behavioral therapy
    • Movement: Exercise, physical therapy, yoga, tai chi
  - Nonopioid pharmacotherapy: Acetaminophen; Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) (e.g. ibuprofen, naproxen, meloxicam, celecoxib, etc.); Topicals (e.g. methyl salicylate/menthol, capsaicin, and lidocaine); Tricyclic Antidepressants (TCAs) (e.g. amitriptyline and nortriptyline); Selective Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs) (e.g. duloxetine and venlafaxine); and Anticonvulsants (e.g. gabapentin and pregabalin)
  - Opioids¹ are NOT recommended for first-line or routine therapy for chronic pain (excluding cancer-related or end-of-life pain) and have NOT been shown to be superior to nonopioid pharmacotherapy for improving pain-related function
  - Providers should review the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain (2016); also consider use of the quick reference, Checklist for prescribing opioids for chronic pain
  - Providers should avoid high risk opioid prescribing such as high dose opioid therapy (greater than 90 morphine equivalent daily dose (MEDD)), concurrent use of opioids and benzodiazepines¹, and with patients that have a history of significant mental health or substance use disorder
  - Patients should receive opioid overdose education with the consideration of co-prescribing naloxone for at risk patients

For more information, visit www.f4cp.org
• Medication-assisted treatment (MAT) with buprenorphine/naloxone (Suboxone®), methadone, or naltrexone in combination with behavioral therapies is recommended for managing OUD.

TAPERING OPIOID THERAPY

Opioid therapy has significant risks and limited benefit for the management of chronic pain. Clinicians should consider slowly decreasing opioid dosage while maximizing nonopioid treatment approaches. Patient-centric tapers are recommended; reducing the opioid dose by 5-10% every four weeks will help prevent withdrawal and support the patient while changing pain care. Patients should be assessed for co-occurring mental health and substance use disorders to include OUD, and referred for treatment as appropriate.

REFERENCES

1. Institute of Medicine Report from the Committee on Advancing Pain Research, Care, and Education: Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research. The National Academies Press; 2011.

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