AVANOS

NEW OPIOID GUIDELINES: A BACK TO BASICS APPROACH

By Peter S. Staats, MD, MBA, ABIPP, FIPP, National Spine and Pain Centers

It isn't possible to write a unique treatment algorithm for every kind of pain, in every kind of setting. Treatment strategies for headaches are going to be different from complex regional pain syndrome, which will be different from pain due to spinal stenosis. Moreover, patients with chronic medical disorders or psychiatric disorders require specific approaches that others may not. As physicians, we start with the history and physical examination, make a diagnosis and devise a treatment algorithm based on a specific diagnosis for that specific patient with that specific set of comorbidities.

The treatment algorithm for patients with osteoarthritis (OA) pain includes short-term and long-term solutions such as:

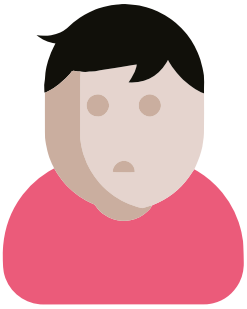
- Anti-inflammatory medications that only last a few hours
- Prescription opioids that only provide a few hours of relief
- Steroid injections that only provide a few months of relief
- Physical therapy that only provides a few months of relief
- Hyaluronic acid injections that only provides a few months of relief
- Surgery that can provide years of pain relief

I currently am the chief medical officer of the largest pain practice in the United States, National Spine and Pain Centers, and in the past, served as the president of the American Society Of Interventional Pain Physicians. This organization has worked for decades setting guidelines for advanced pain treatment. One set of guidelines we recently wrote involved the management of opiates, and provides guidance for interventional pain physicians to think about opioids. The Centers for Disease Control and Prevention (CDC) recently released new guidelines[1] for primary care physicians on appropriate opiate management.

These guidelines suggest that once the prescription of opioids hits 50 milligrams a day of morphine-equivalents–when incidents of death and other significant morbidity increases–the primary care doctor should get a consultation from a pain physician, or discontinue the opiates. These new proposed CDC guidelines[2] have been met with great concern by primary care physicians and patients alike in that they recommend limits on prescribing and could eventually create new legal and regulatory burdens for these primary care physicians. Patients may subsequently be sent to a pain physician for further management. These same guidelines were not intended for the advanced pain physician and the implications for this group of physicians are not clear.

As an interventional pain management physician, I view the CDC guidelines as a positive. For doctors, they are

an attempt to get back to the basics. Once a diagnosis is made, interventional therapies and treatment strategies are both considered, as opposed to just interventional strategies, with the goal of limiting the amount of opioids or stopping them completely.



Interventional pain management procedures are becoming more popular because they are non-narcotic, minimally invasive and modify pain transmission. Thermal radiofrequency ablation procedures are one class of procedures that are highly effective. However, the government has decreased reimbursement for these interventional treatments in an ambulatory surgery center or office setting, but covers them at a much greater rate in hospital settings.

In a time of sky rocketing healthcare costs, we should be driving costs to the lower-cost environment. Unfortunately, there are a number of reasons for this apparent inconsistency. Sadly, as a result of changes in policies and penalties for readmission, hospital-acquired conditions, and the changing impact of electronic health record payments, we are pushing patients into the hospital for this care.[3] As guidelines continue to change, the underlying metrics for patient success will remain the same, such as pain scores.

PAIN SCORES ARE STILL NEEDED TO UNDERSTAND BETTER TREATMENT ALGORITHMS

The usual method for measuring pain improvement throughout the patient experience –pain scores–can be complex. For example, in some disorders, patients don't inform their doctors that their pain problem has improved over time, something that may be at odds with the treatment algorithm. This may be because patients increase their activity level, or for secondary gain issues.

Pain scores are important, and it is equally important to consider function such as the ability of the patients to complete daily tasks: doing the dishes, going grocery shopping or something more complex such as caring for a child, or returning to work. Pain caused by OA may lead to health-related decreased quality of life, diminished cognitive function, limitations in activities of daily living, reduced productivity, and increased anxiety and depression.

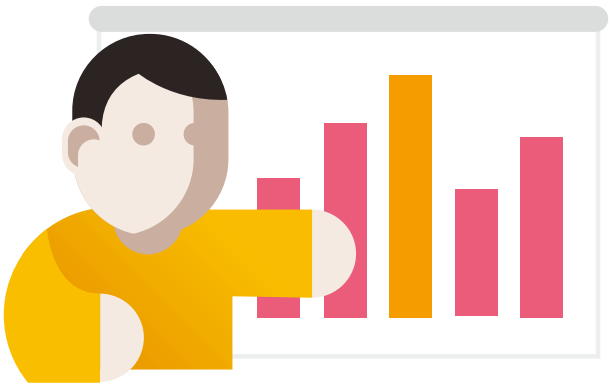
I was the principle investigator on a paper published in JAMA in 2004 which showed a drug isolated from snails found in the Philippines. When delivered intrathecally, this drug can profoundly turn off pain[4]. Other unique avenues of pain treatment and research are needed to broaden the offerings from physicians to patients seeking pain relief. In our practices, we try to offer minimally invasive alternative treatment options to patients with chronic pain, and not just when the data says their pain score is still a nine.

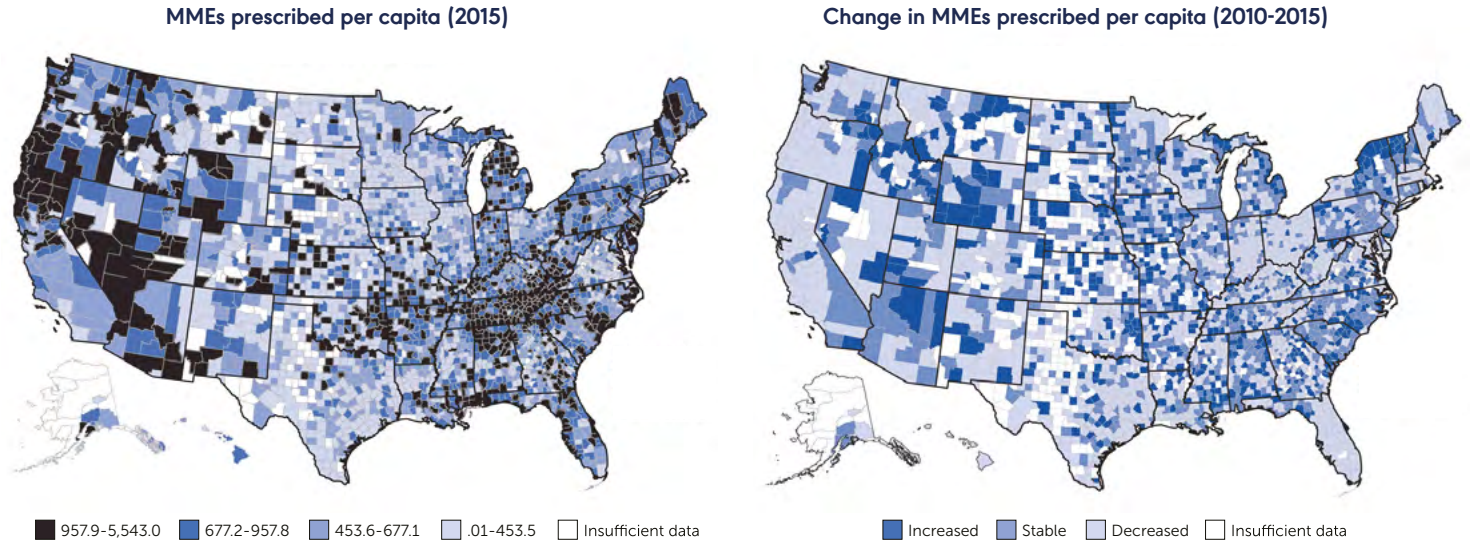
THE PRESCRIPTION TREND OVER TIME

Refer to maps on following page.

As guidelines and policies continue to rise in prominence across the United States, they can have a real impact on the average clinician. A recent CDC report captured changes in prescribing trends, which reflected the potential effects of raised awareness.[5]

The advanced clinician today has to understand all available options. If physicians are prescribing opioids in more than half of the 1.14 million nonsurgical hospital admissions, as research has found[6], it will take an effort to offer patients treatment strategies other than opioids for complex pain problems. There are new approaches coming out every day: epidural injections, facet





Morphine milligram equivalents (MMEs) of opioids prescribed per capita in 2015 and change in MMEs per capita during 2010–2015, by county – United States, 2010–2015. Image via Centers for Disease Control and Prevention[5]

injections, or non-narcotic treatment options like a spinal cord stimulator. Newer treatment strategies such as cooled radiofrequency (RF) can denervate pain-causing sensory nerves, keeping the strength intact.

Prescribing opioids isn't the answer for every patient, and physicians should feel empowered to take a second look at the chronic pain treatment algorithm. There is more that can be done to improve long-term patient satisfaction and it starts with getting back to the basics of treatment, and knowing what will work best for your patient's pain relief.

Peter S. Staats MD, MBA, has a consulting/speaking/financial relationship with Avanos Medical, Inc.

1. Centers For Disease Control And Pre. Guideline for Prescribing Opioids for Chronic Pain. Journal of Pain & Palliative Care Pharmacotherapy. 2016Jun2;30(2). http://dx.doi.org/10.15585/mmwr.rr6501e1.
2. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1-49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1.
3. How Medicare Has Pushed Outpatient Costs Higher - InsideSources. (2016, April 26). Retrieved November 18, 2017, from http://www.insidesources.com/how-medicare-has-pushed-outpatient-costs-higher/
4. Staats PS, Yearwood T, Charapata SG, Presley RW, Wallace MS, Byas-Smith M, Fisher R, Bryce DA, Mangieri EA, Luther RR, Mayo M, McGuire D, Ellis D. Intrathecal Ziconotide in the Treatment of Refractory Pain in Patients With Cancer or AIDSA Randomized Controlled Trial. JAMA. 2004;291(1):63-70. doi:10.1001/jama.291.1.63 https://jamanetwork.com/journals/jama/fullarticle/197939
5. Morbidity and Mortality Weekly Report (MMWR) [Internet]. Centers for Disease Control and Prevention. Centers for Disease Control and Prevention; 2017 [cited 2017 Oct 25]. Available from: https://www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm#T1_down
6. Herzig SJ, Rothberg MB, Cheung M, Ngo LH, Marcantonio ER, Opioids and Opioid Related Adverse Events. J. Hosp. Med2014;2;73-81. doi:10.1002/jhm.2102 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3976956/

There are inherent risks in all medical devices. For more detail on indications, cautions, warnings and contraindications, **click here**.

AVANOS

avanospainmanagement.com