An Agenda for Development of Pain Management Best Practices
Presentation to HHS Inter Agency Task Force on Best Practices in Pain Management

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Your Task 1: Rewrite 2016 CDC Opioid Prescription Guidelines

- There is no relationship between State by State rates of opioid prescribing and rates of overdose deaths or ER visits.*

*Data Source: US CDC Wonder Database, 2018*
Realities of Pain Management Practice

- Opioid analgesics are not the first therapy of choice.
  - Many pts do not tolerate opioids well.
  - Other analgesics may be effective for some pts and disorders
    - NSAIDs also have mortality risks.
- In many patients, opioid analgesics are effective and safe for acute or chronic pain
  - Risk of opioid-related death similar to blood thinners (~0.025% - 0.05%/yr).
  - Optimum therapeutic dose from 50 to 1000 MMED due to genetic polymorphism affecting μ-receptors or individual metabolism. (1)
  - Tolerance may develop; but no medical evidence for “opioid induced hyperalgesia” in other than animal models.
  - Dependency may develop with long term use and is an expected, accepted and manageable outcome for people otherwise in agony. (2)
  - Opioid abuse (opioid “use” disorder) is rare in medically managed pts. (3)

(1) Clinical experience of Stephen E Nadeau MD, author of >100 peer reviewed articles in medical literature.
Likewise note: ~1.6 million seniors now maintained on >90 MMED (source: HHS/CMS and CDC Surveillance Reports)
(2) “Dependence” characterized by withdrawal symptoms if tapering is too fast. Different from “addiction”.
Realities of Pain Management Practice (2)

- Incidence of opioid abuse diagnosis or chronic prescribing is less than 0.6% in post-surgical patients treated with opioids (1, 2)
  - Fewer than 1% of post-surgical pts continue prescriptions beyond 13 weeks
  - Incidence of abuse only weakly sensitive to doses 20-120 MMED
  - Many OUD diagnoses made by poorly trained doctors who fail to recognize emergence of chronic pain due to failed surgeries.

- No controlled trials have shown that alternative therapies can substitute for opioid therapy in severe pain.
  - Medical trials literature is very weak
  - We do not know if alternative therapies are more effective than placebo (3)
  - If used, non-analgesic therapies should be viewed as adjuncts, not replacements

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There is no validated body of medical evidence to support a single “one size fits all” threshold of risk for bad outcomes from opioid therapy versus dose.
- Variability between patient metabolism and medical conditions treated
- No body of trials data taken under representative conditions of pain management practice

There are alternatives to the 2016 opioid prescription guidelines
- Federation of State Medical Boards “Guidelines for Chronic Use of Opioid Analgesics”, April 2017
- Other Guidelines from Medical Specialties, Associations and Academies
- Whatever guidelines the Task Force proposes must be patient-centered and evidence-based. Stakeholder input should be embraced and integrated by the Task Force.