April 6, 2022

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Re: Comments on the 2022 Revised Draft CDC Clinical Practice Guideline for Prescribing Opioids
Docket No. CDC-2022-0024

The U.S. Pain Foundation is pleased to provide comments on the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control (NCIPC)'s Revised Draft Clinical Practice Guideline for Prescribing Opioids. ("2022 Guideline") The U.S. Pain Foundation is a national 501(c)(3) organization for people who live with chronic pain from a myriad of diseases, conditions, and serious injuries. Our mission is to connect, support, educate, and advocate for those living with chronic pain, as well as their caregivers and health care providers.

CDC's Revisions We Support in the Twelve Guideline Statements
We are pleased to see that CDC has made some important and positive changes in the twelve Guideline statements. Chief among them is the removal of specific dosage cautions and limits in Guideline 5, replacing them in the 2022 Guideline statement 4 with "clinicians should prescribe the lowest dosage to achieve expected effects." We are also supportive of the removal of specific days duration of opioid therapy for acute pain in statement 6, replacing them with "clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids."

These dosage and duration limits were arbitrary and unsupported by clinical evidence yet widely implemented across the country and even codified in law in at least 33 states.[1] Prescribers, insurers, and even pharmacies implemented them as strict limits. They have caused the most egregious harms over the past six years including forced tapering, hundreds of documented suicides, sudden loss of access to medication triggering withdrawal, dismissal from physician practices, inability to find medical care, extreme anxiety among pain patients, and loss of function and quality of life.

We are also supportive of repeated cautions added to 2022 Guideline statement 5 to "exercise care," "gradually taper," and "not discontinue abruptly or rapidly" when reducing opioid dosage. The lack of these cautionary phrases regarding opioid therapy cessation and tapering in the 2016 Guideline, led to such widespread and serious harms that the U.S. Food and Drug Administration took the rare step in April of 2019 of issuing a warning and requiring label changes to guide gradual tapering to the nation's prescribers stating that, "The U.S. Food and Drug Administration has received reports of serious harm in patients who are physically dependent on opioid pain medicines suddenly having these medicines discontinued or the dose rapidly decreased. These include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide."[2]

Additional changes in the 2022 Guideline statements we support are easing the directives on patient surveillance and softening the absolute restriction on concurrent prescribing of benzodiazepines. The 2016 Guideline directive to check the state prescription monitoring program "ranging from every prescription to every 3 months" to "when prescribing initial opioid therapy and periodically" thereafter, appropriately leaves monitoring frequency up to the prescribing

[1] Prescribing Policies: States Confront Opioid Overdose Epidemic. National Conference of State Legislatures. June 30, 2019. Available at: https://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx. Accessed April 5, 2022.

[2] https://www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes Accessed April 5, 2022.

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clinician as does the 2022 Guideline statement 10 to "consider toxicology testing" rather than "use urine drug testing before starting opioid therapy and at least annually" thereafter. Constant surveillance of long time patients with no history or signs of misuse or abuse has led to mistrust, erosion of the patient clinician relationship and a perpetuation of damaging stigma for legitimate pain patients. And, Statement 11 changing "avoid" concurrent prescribing of benzodiazepines and opioids to "use extreme caution" now allows some room for cases where co-prescription may still have clinical value when carefully monitored, for example, in patients with chronic pain and spasticity.

Five Guiding Principles Should Be Listed First

Box 1 on page 208 of the 2022 Guideline document lists the 12 Guideline statements followed by five Guiding Principles. We strongly support these Guiding Principles and find them so essential to the practice of good pain management that they should be listed first, ***before*** the Guideline statements in any subsequent listing or publication of the final revised 2022 Guideline.

The five principles we are referring to are:

1. Acute, subacute, and chronic pain need to be appropriately and effectively treated independent of whether opioids are part of a treatment regimen.
2. Recommendations are voluntary and are intended to support, not supplant, individualized, person-centered care. Flexibility to meet the care needs and the clinical circumstances of a specific patient are paramount.
3. A multimodal and multidisciplinary approach to pain management attending to the physical health, behavioral health, long-term services and supports, and expected health outcomes and well-being needs of each person is critical.
4. Special attention should be given to avoid misapplying this updated clinical practice guideline beyond its intended use or implementing policies purportedly derived from it that might lead to unintended consequences for patients.
5. Clinicians, practices, health systems, and payers should vigilantly attend to health inequities, provide culturally and linguistically appropriate communication, and ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for all persons.

Issues We Do Not Support that Require Changes

The U.S. Pain Foundation is concerned that several serious problems in the 2016 Guideline are still present in the 2022 Guideline, and must be changed. These include exclusion of certain pain conditions, clear bias against opioid therapy, a fundamental weakness of evidence upon which the Guideline is based, and continued reference to specific dosage amounts in the accompanying Guideline narrative.

The 2022 Guideline again excludes certain pain conditions—Cancer, Sickle Cell Disease, Palliative Care and End-of-Life Care—as being more worthy of pain control where the stated "risks" and "harms" don't apply. Pain is pain and chronic pain is fundamentally a disease of the nervous system and brain regardless of the etiology. Due to great variation in individual differences regarding disease progression, severity of condition, sensitivity to pain, metabolic variables and more, benefits and risks must be considered on an individual basis rather than exempting everyone with a particular disease or condition. A person with any given pain condition could be in much worse pain for longer duration than a person with one of the excluded conditions. U.S. Pain Foundation strongly recommends eliminating these exclusions.

Despite the positive changes discussed above, the 2022 Guideline still lacks balance in its discussion of opioid therapy for pain and conveys a clear bias against opioid therapy, emphasizing perceived risks and harms and failing to discuss their benefits for pain relief when taken appropriately under medical supervision. The risk and harm the CDC authors are most concerned about is addiction, yet repeated research has shown that the actual risk of addiction in medically

managed chronic pain patients is between less than 1% and 8%.[3] Stated another way, between 99% and 92% of chronic pain patients on opioid therapy do not become addicted to their medication.

In 2015, prior to the release of the 2016 Guideline, the NIH reported that there were between 5 and 8 million Americans on opioid therapy for chronic pain.[4] It is impossible to believe that millions of Americans would continue to take medication for pain relief long-term if the benefits of the medication did not outweigh the risks for those patients. Indeed, as discussed above, after the widespread adoption of the 2016 Guideline, tens of thousands of pain patients on stable doses of opioid medication were force tapered off which led to an inhumane crisis of tremendous pain and suffering, loss of function, anxiety, depression and despair; in many cases, so unbearable as to cause pain patients to take their own lives. The U.S. Pain Foundation has received thousands of calls, e-mails, and letters over the past six years from desperate pain patients who were forced off opioid therapy as a result of the 2016 Guideline and now are so debilitated by unrelenting pain that they are unable to work, sleep, or take care of their families. The Guideline also fails to acknowledge the risks and harms of enduring prolonged pain when other therapies have proven inadequate or contraindicated, especially severe, unremitting, daily pain.

Another area of grave concern about the 12 statements comprising the 2022 Guideline, as was the case in the 2016 Guideline, is the weak body of evidence underlying most of them. Using the GRADE system which rates the strength of the evidence underlying each Guideline statement, seven out of 12 statements have a rating of “4” on a 1 – 4 scale where 4 is the weakest level of evidence considered “very weak.” Three additional statements have an evidence rating of “3” or “weak.” Yet, four out of the 7 statements with very weak evidence were given the strongest “A” level recommendation rating by the CDC Guideline authors, meaning that the recommendation can generally be applied to all persons in the group. Displaying the evidence ratings and strength of the recommendations with letters and numbers rather than the actual words of explanation lacks transparency and raises suspicion around the assignment of strong recommendations. At the very least, CDC should use the descriptive adjectives rather than numbers and letters on each Guideline statement.

While we expressed support for CDC’s removal of specific dosage cautions and limits in the Guideline statements themselves, we are very concerned about the repeated inclusion of cautions and warnings regarding increasing dosages above 50 milligrams morphine equivalence (MME) in many places in the supporting narrative. Since the release of the 2016 Guideline, much has been written about the inappropriate, arbitrary, and unscientific selection of 50-and 90 milligrams morphine equivalent dosage cautions and limits and the widespread harms they have caused. There is wide variation in individual patient characteristics and disease variables that determine the dose of opioids that is optimal for pain relief for any given patient at any specific time. It is inappropriate and harmful for CDC to specify a single dose limit to apply to all patients. Despite comments CDC has made about not implementing Guideline statements as strict limits, it is highly likely that this will occur again. We strongly urge CDC to remove the 50 mg MME cautions throughout the narrative accompanying the Guideline.

Recommendations Regarding Release of Final 2022 Guideline

We have a number of recommendations regarding the release, dissemination and implementation of the final revised 2022 Guideline to ensure that improvements made translate to better care for the millions of Americans living with chronic pain. These include:

[3] Opioid Abuse in Chronic Pain – Misconceptions and Mitigation Strategies https://www.nejm.org/doi/full/10.1056/NEJMra1507771 Accessed April 5, 2022

[4] **National Institutes of Health Pathways to Prevention Workshop: The Role of Opioids in the Treatment of Chronic Pain** Feb 17, 2015. https://www.acpjournals.org/doi/abs/10.7326/m14-2775. Accessed April 5, 2022.

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Clear communication about what exactly has changed and why. For example, highlight that specific dosage cautions and limits and days duration of therapy have been removed because these are not intended to be implemented as strict rules. Clinicians must work with patients to ensure the optimal dosage for that patient. Every person with pain's situation is unique and must be considered on an individual basis.

Include some of the graphics and one page summaries prepared by the HHS Pain Management Best Practices Interagency Task Force (Task Force). The Task Force report provides a comprehensive list of non-opioid therapies for chronic pain across the five broad categories of medication, restorative therapies, interventional procedures, behavioral therapies, and complementary and integrative therapies that front line providers are rarely aware of. These clinicians could benefit from the Task Force materials that reinforce the value of a multimodal, multidisciplinary approach to pain management.

Monitor the effects of the 2022 Guideline on the care of people living with pain, especially those with chronic pain, and work with stakeholder groups to ameliorate problems that arise. There were many signs early on, and soon thereafter many peer-reviewed journal articles, opinion pieces, letters to CDC made public, professional society statements and social media posts about the widespread, detrimental effects that the 2016 Guideline was having on pain patients; but, it has taken six years for any actual changes to be made to the Guideline to lessen those effects. That should never happen again. CDC should publicly commit to opening a portal for patients to report problems, monitoring the effect the new Guideline is having on the care of pain patients, and publicly take steps to ameliorate any problems that result from the implementation of the new Guideline.

Call for Further Scientific Studies of the Effectiveness of All Treatments for Chronic Pain including Opioids
It is clear that the field of chronic pain management lacks more thoughtful, rigorous, longer term effectiveness, and comparative effectiveness studies taking into account the possible confounding factors of dosage variation, co-prescriptions, co-morbidities and combinations of pharmacological and non-pharmacological treatments. An excellent examination of some of these issues can be found in *Opioids and Chronic Pain: An Analytic Review of Clinical Evidence.*[5] If CDC is sincere in its statement on page 4 of the 2022 Guideline that, "It is imperative that people with pain receive the most appropriate and effective pain treatment with careful consideration of the benefits and risks of all treatment options," then it would publicly call for funding of research studies to answer these important questions.

In closing, U.S. Pain Foundation would like to reiterate our longstanding view that opioids are one treatment in the armament of current pharmacological and non-pharmacological treatments for managing chronic pain. They do not help everyone with pain and for those they do help, they do not completely eliminate the pain. However, given our current incomplete understanding of the neurobiology of pain and the lack of truly effective and completely safe options, for tens of thousands and perhaps millions of pain sufferers, their benefits do outweigh their risks. Continuing to demonize and stigmatize these medications and the people who use them safely and appropriately, obfuscate the existing scientific data that underlies examination of benefits and risks and eliminate access to these medications will only unnecessarily prolong the tremendous suffering of millions of Americans.

We hope the CDC will give our recommendations serious consideration as it moves forward with this important work. Should we be able to provide additional information or assist the CDC's efforts in any way, please feel free to contact me using the information listed below.

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[5] Opioids and Chronic Pain: An Analytic Review of Clinical Evidence
https://www.frontiersin.org/articles/10.3389/fpain.2021.721357/full?fbclid=IwAR3UQJ7yzoImB4FGB2yEsv8GeMNsAxBb7pCzkRVZBN4TTYdAioatyh-cMK0 Accessed April 5, 2022.

Sincerely,

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