Provider Considerations for Chronic Pain

Rethinking the Appropriateness of Opioids

The U.S. is undergoing a cultural transformation in the way pain is viewed and treated. Experts agree that opioids should not be considered first line or routine therapy for chronic pain, outside of active cancer, palliative, and end-of-life care. (p. 7)[1]

The following set of provider considerations summarize the 2022 Veterans Affairs (VA)/Department of Defense (DOD) Clinical Practice Guideline (CPG) for the Use of Opioids in the Management of Chronic Pain recommendations as they apply to initiating or continuing opioid therapy for patients experiencing chronic pain.

Evidence from systematic reviews of randomized control trials suggests that the use of opioids for the management of chronic pain is mixed, and the balance between the risks versus benefits is questionable in whether [the use of opioids for chronic pain management] will result in a meaningful benefit for the patient while also increasing adverse events as compared to controls. (p. 35)[1]

For patients receiving daily opioids for the treatment of chronic pain, **we suggest** the use of buprenorphine instead of full agonist opioids due to lower risk of overdose and misuse. (p. 43)[1]

For patients receiving medication for OUD, there is **insufficient evidence to recommend for or against** the selection of any one of the following medications over the other for the management of their co-occurring chronic pain: methadone, buprenorphine, or extended-release naltrexone injection. Treat the OUD according to the VA/DOD CPG for the Management of Substance Use Disorders[5]. (p. 41)[1]

We recommend **against** the initiation of opioid therapy for the management of chronic non-cancer pain (for non-opioid treatments for chronic pain, see the VA/DOD CPGs for Low Back Pain,[2] Headache,[3] and Hip and Knee Osteoarthritis[4]). (p. 35)[1]

Age should be considered in the risk-benefit determination for initiating and continuing long-term use of opioids, as it is inversely correlated with opioid use disorder (OUD) and overdose. We recommend **against** long-term opioid therapy, particularly for younger age groups, as age is inversely associated with the risk of OUD and overdose. (p. 38)[1]

We recommend **against** long-term opioid therapy, particularly for patients with chronic pain who have a substance use disorder (refer to the VA/DOD CPG for the Management of Substance Use Disorders[<?>5]). (p. 39)[1]

We recommend **against** the concurrent use of benzodiazepines and opioids for chronic pain (refer to Recommendation 10 in the VA/DOD CPG for the Management of Substance Use Disorders[<?>5] for further guidance related to tapering one or both agents). (p. 33)[1]

Note: It is important to make considerations for certain subsets of patients, including those experiencing acute pain conditions, acute pain conditions who also have chronic pain, or an acute exacerbation of a chronic pain condition. These patients should be treated according to best medical evidence for the acute condition, including opioids, if clinically appropriate. In these cases, a short-term opioid prescription may be appropriate. Evidence for the use of opioids for acute pain is not addressed in this CPG. (p. 36)[1]

Optimize Non-Opioid Treatments for Chronic Pain

- Self-management to promote health and wellness (e.g., ice and heat at home on the patient's own schedule; breaking up daily activities into shorter periods with breaks so pain does not worsen)
- Non-opioid pharmacologic pain treatments
- Non-pharmacologic pain treatments:
  - Behavioral therapies (e.g., cognitive behavioral therapy)
  - Physical/movement-based therapies (e.g., physical therapy)
  - Manipulative therapies (e.g., chiropractic care)
  - Complementary and integrative health treatments (e.g., acupuncture)
- Interventional pain care (e.g., joint injection, radiofrequency ablation)
- Realistic expectations and limitations of medical treatment
- Refer to the low back pain, osteoarthritis, and headache Clinical Practice Guidelines for further condition-specific guidance (p. 25)[1]

References

1 Veterans Affairs and Department of Defense (2022). *VA/DOD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain. Version 4.0. https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPG.pdf*

2 Veterans Affairs and Department of Defense (2022). *VA/DOD Clinical Practice Guideline for the Diagnosis and Treatment of Low Back Pain. Version 3.0. https://www.healthquality.va.gov/guidelines/Pain/lbp/VADoDLBPCPGFinal508.pdf*

3 Veterans Affairs and Department of Defense (2020). *VA/DOD Clinical Practice Guideline for the Primary Care Management of Headache. Version 1.0. https://www.healthquality.va.gov/guidelines/pain/headache/VADoDHeadacheCPGFinal508.pdf*

4 Veterans Affairs and Department of Defense (2020). *VA/DOD Clinical Practice Guideline for the Non-surgical Management of Hip and Knee Osteoarthritis. Version 2.0. https://www.healthquality.va.gov/guidelines/CD/OA/VADoDOACPG.pdf*

5 Veterans Affairs and Department of Defense. (2021). *VA/DOD Clinical Practice Guideline for the Management of Substance Use Disorder. Version 4.0. https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPG.pdf*

What if after regular follow-up and treatment optimization, our treatment plan was not effective in managing chronic pain and optimizing function?

You can:

- ✓ Complete an opioid risk assessment
- ✓ Refer for interdisciplinary pain and specialty consultations as appropriate (p. 25)[1]