Managing non-cancer pain in the care of American Indians and Alaska Natives

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Evidence-based strategies to reduce opioid use

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These are general recommendations only; specific clinical decisions should be made by the treating clinician based on an individual patient's clinical condition.

These materials were created by Alosa Health, a nonprofit educational organization which accepts no funding from any pharmaceutical company. They were distributed through a program with the Indian Health Service.

All materials were reviewed by the Indian Health Service National Committee on Heroin, Opioids, and Pain Efforts (HOPE). Links to these and other resources available at IHS.gov/opioids

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Activity Start Date: October 30, 2023
Activity Termination Date: October 29, 2026

This activity offers CE credit for:

1. Medicine (AMA)
2. Nurses (ANCC & CBRN)
3. Pharmacists (ACPE)
4. Other

All other attendees will receive a Certificate of Attendance

Activity Overview:

The primary goal of this educational program is to address the challenge of effectively managing patients with non-cancer pain. It focuses on setting functional goals, optimizing management with a combination of evidence-based options, both pharmacologic and non-pharmacologic, and understanding the latest recommendations regarding opioid prescribing and strategies to reduce specific risks, such as prescribing naloxone.

The educational program includes a written evidence report (print monograph) and several non-CME/CE components:

1. Summary document of top 4-5 key messages
2. “Academic detailing” educational sessions in clinicians’ offices with trained outreach educators (pharmacists, nurses, physicians) who present the material interactively
3. Reference cards for easy access to key materials
4. Patient education information (brochure/tear off sheets)

This program synthesizes current clinical information on this topic into accessible, non-commercial, evidence-based educational material, which is taught interactively to providers by specially trained clinical educators.

Learning Objectives:

After completing this activity, participants will be able to:

- Define clear functional goals and realistic expectations as part of a comprehensive pain management plan for American Indian and Alaska Native patients.
- Utilize multiple treatment modalities, including non-pharmacologic and non-opioid pharmacologic options.
- When prescribing opioids, assess the risks and benefits of therapy.
- Recommend naloxone for patients with risk factors for possible overdose.
- Discuss tapering and discontinuing opioids whenever the risks outweigh the benefits of treatment.

Financial Support:

There is no commercial support associated with this activity.

Target Audience:

The educational program is designed for physicians, including general internal medicine doctors, family practice physicians, nurse practitioners, physician assistants, nurses, pharmacists and all other clinicians caring for American Indian or Alaska Native patients who have pain.

Credit Information:

In support of improving patient care, this activity has been planned and implemented by CME Outfitters, LLC and Alosa Health. CME Outfitters, LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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> **California Residents:** This continuing nursing education activity was approved by the California Board of Registered Nursing. CME Outfitters LLC's provider number is CEP15510.
>
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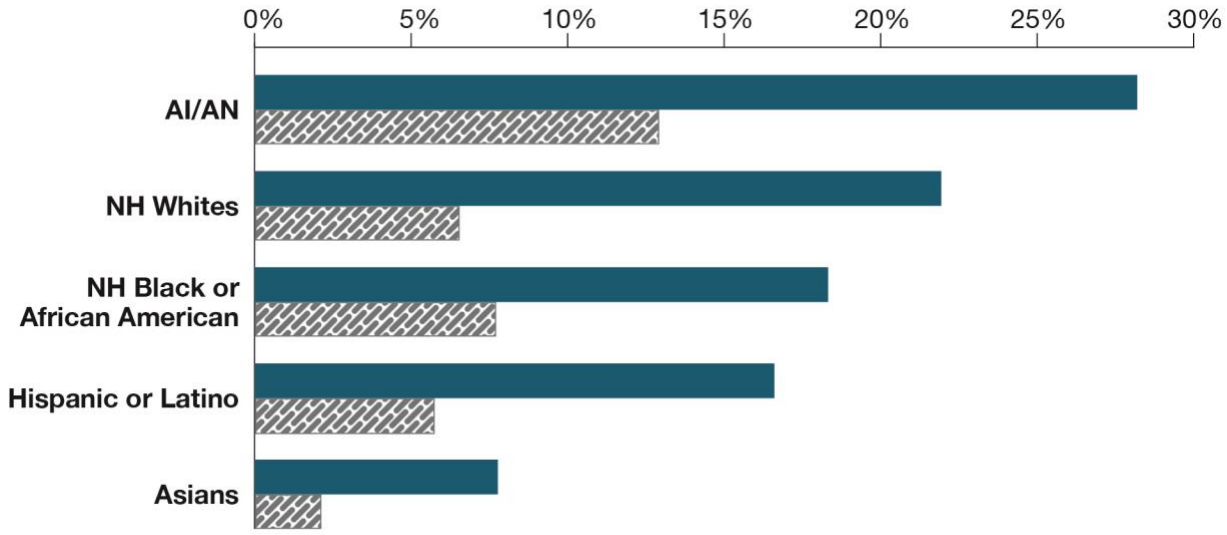
Introduction

In the most recent data from the Center for Disease Control and Prevention (CDC) American Indians and Alaska Natives (AI/AN) reported the highest levels of chronic pain in the past 3 months (28.0%), followed by Whites (21.8%) Blacks (18.8%), Hispanic or Latino (16.5%), and Asians (7.8%) (Figure 1).[1] Treating such a high level of chronic pain in the AI/AN population is made more challenging by a host of factors including high levels of poverty (25.4% for AI/AN people vs. 13.4% of the general population) lower levels of education, higher rates of trauma, and higher-than-average rates of certain physical problems such as diabetes and cardiovascular disease.[2] AI/AN populations experience disparities in access to healthcare services, funding, quality and quantity of services, health education and prevention services relative to other groups.[2]

Figure 1: Prevalence of chronic pain and high-impact chronic in the past 3 months by race/ethnicity 2019-2021[1]



Fortunately, chronic pain *can* be effectively treated, despite the complexities involved. Healthcare providers can help patients recover functioning they have lost to pain, and they can do this while avoiding the many risks that attend the use of opioid pain medications, which have been at the center of an intense national debate due to high ongoing levels of opioid-related overdoses.[3] Strong evidence now exists showing that opioids are not very effective for relieving chronic pain and, in fact, may be associated with *increased* pain and/or reduced functioning.[4,5] Unfortunately, many clinicians may not be aware of the expanding range of both non-opioid medications and non-pharmacological therapies shown to be effective in reducing many common pain conditions.

This document discusses the management of pain, with a detailed look at five common pain syndromes accounting for most chronic pain in adults: osteoarthritis, chronic low back pain, diabetic neuropathy, fibromyalgia, and migraine. It reviews evidence and strategies for treating pain without opioids when possible, and ways to reduce the potential harm of opioids in the relatively rare occasions when these agents may be necessary as part of a chronic pain treatment program.

The information conveyed in this Evidence Document is aligned with the principles of "Opioid Stewardship"[6] as articulated by the Indian Health Service (IHS). Opioid stewardship is a multi-faced approach to pain management and opioid use that encompasses the whole patient – their mind and body, and their preferences, experiences, needs, and goals. IHS has adopted this approach in order to improve outcomes for patients diagnosed with chronic pain syndrome or opioid use disorder (OUD) (see a separate evidence document about treating OUD). Effective opioid stewardship strategies emphasize leadership support, team-based care, and the kinds of safe opioid prescribing practices detailed in this document.

Describing pain

Acute versus chronic pain

Acute pain typically has an abrupt onset due to an obvious cause, such as an injury or other process that is not ongoing (e.g., a recent surgical procedure). It has a generally short duration (usually less than four weeks), improves over time, and in proportion to healing.[7]

Although pain is expected after injury or surgery, the patient's pain experience can vary markedly. Intensity of pain can be influenced by psychological distress (depression/anxiety), heightened concern or anxiety about an illness, and ineffective strategies to control pain and function despite it.[8] It may also be shaped by personality, culture, attitudes, and beliefs. For example, injured soldiers who had positive expectations of pain (e.g., evacuation and safe recuperation) requested less analgesic medication than civilians with comparable injuries who had more negative associations with pain (e.g., loss of wages and social hardship).[7]

For some patients, pain may last beyond four weeks. The period from 4 to 12 weeks represents a transition period between acute pain and chronic pain, in which pain is called "subacute." In this period, improvement in pain and function may be slower than in the acute phase. The goals of treatment are to reduce symptoms if possible, to identify those at higher risk for developing chronic pain, and to intervene as early as possible.

Chronic pain is typically defined as lasting more than three months or past the time of normal tissue healing.[9] It can be the result of an underlying medical disease or condition, inflammation, injury, medical treatment, or an unknown cause. Similar to acute pain, the perception and experience of chronic pain is influenced by patient's psychological state, personality, culture, attitudes, beliefs, and support systems.

Pain mechanisms

Pain can also be classified based on its pathophysiology.

Nociceptive pain is caused by the activation of nociceptors (pain receptors), and is generally, though not always, short-lived, and is associated with the presence of an underlying medical condition.[10] This is a normal physiological response to an injurious stimulus.

Neuropathic pain is an abnormal response to a stimulus caused by neuronal firing in the absence of active tissue damage resulting from nervous system injury or dysfunction. It may be continuous or

episodic, and it varies widely in how it is perceived and how it affects daily life and functioning. Neuropathic pain is complex and can be difficult to diagnose and manage because available treatment options are limited.

Nociplastic pain arises from altered function of pain-related sensory pathways both in the peripheral and central nervous systems (e.g., in fibromyalgia). It replaces previously ill-defined terms like 'dysfunctional pain' and 'medically unexplained somatic syndromes.' Nociplastic pain may occur in combination with other pain conditions.[11]

Related to all forms of pain is the phenomenon of sensitization, which is a state of hyperexcitability in either peripheral nociceptors or neurons in the central nervous system. Sensitization may lead to either hyperalgesia (heightened pain from a stimulus that normally provokes pain) or allodynia (pain from a stimulus that is not normally painful).[10] Sensitization may arise from intense, repeated, or prolonged stimulation of nociceptors, from the influence of compounds released by the body in response to tissue damage or inflammation, or—importantly—as an adaptation to prolonged exposure to opioid analgesics.[12]

Many patients—particularly those with chronic pain—experience pain that has nociceptive, neuropathic and nociplastic components, which complicates assessment and treatment. **Differentiating between pain types is critical because different types of pain respond differently to different treatments.** Neuropathic pain, for example, responds poorly to both non-steroidal anti-inflammatory (NSAID) agents and most opioid analgesics.[13] Other classes of medications, such as anti-epileptics, antidepressants (e.g., serotonin norepinephrine re-uptake inhibitors), or local anesthetics, may provide more effective relief for neuropathic or nociplastic pain.[11,14]

Assessing pain

Take a comprehensive pain history

Assessing pain is critical to effective pain management interventions. Both patient and caregiver reports of pain should be the starting points. Asking the patient *"how is pain affecting your everyday life?"* can provide a foundation for understanding the patient's concerns regarding pain and may help in creating functional goals for treatment. A comprehensive pain assessment should also include evaluation of the pain quality, duration, location, aggravating or alleviating factors, any previous treatments (both non-pharmacologic and pharmacologic) and their efficacy. Assessing the impact of pain on sleep and screening for mental health conditions potentially related to pain or treatment adherence (e.g., depression, anxiety, or memory issues) will provide useful information for pain management.[15]

Depression, for example, sometimes presents with somatic complaints of pain (particularly in older adults). Pain complaints may resolve when the underlying depression is treated. Screening for co-occurring depression and anxiety can be facilitated with the Patient Health Questionnaire (PHQ), either the two-item screen (PHQ-2) or 9-item form (PHQ-9), and the Generalized Anxiety Disorder (GAD) scale, either the two (GAD-2) or seven item (GAD-7) form.

Assessment tools

Multidimensional tools include questions relating to quality of life and participation in daily activities. Such tools can provide a more comprehensive approach to assessing pain and response to treatment. The

selection of a pain assessment tool must balance the comprehensiveness of the assessment obtained with the time and energy required to use the tool in a real-world practice setting.

PEG scale

The PEG scale (Pain, Enjoyment, and General Activity) is a three-item tool based on the Brief Pain Inventory (BPI) and is commonly used in the initial assessment and follow up of chronic pain in primary care and other ambulatory care clinics. Three 0-to-10 scales are used to assess pain intensity, interference with enjoyment of life, and interference of function. The PEG score is obtained averaging the three questions together. PEG can be self-administered or done by the clinician and is relatively brief.[16]

Figure 2: PEG scale[16]

1. What number best describes your pain on average in the past week?

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

PSEQ scale

The 10-item Pain Self-Efficacy Questionnaire (PSEQ) is preferred by IHS for assessing chronic pain. The PSEQ is applicable to all pain-related conditions and asks patients to rate their level of confidence in functioning and self-efficacy related to household chores, socializing, and work.[17] Raw scores range from 0-60 with higher scores indicating greater confidence in dealing with pain and, thus, more positive outcomes.

Brief pain inventory

The BPI is used frequently in randomized controlled trials to assess pain. The BPI more fully captures the impact of pain on patient function and quality of life than simple 0-10 scales.[18] The BPI includes a diagram allowing patients to map the location of their pain and track it through the course of management. Although developed specifically for chronic pain, it can also be useful for assessing acute pain.[19] While the BPI can be conveniently self-administered, it can be time consuming, taking between 5 to 10 minutes to complete, which may limit its role in clinical practice.

V**isual analog scales (VAS)** rate pain from 0 (no pain) to 10 (worst pain you can imagine). Some scales use a 0 to 100 scale. Such scales are often used in clinical trials of pain therapies, and the minimal clinically important difference using these scales is generally considered a 20%-30% change from

baseline (i.e., 2-3 points on a 0-10 scale or 20-30 points on a 0-100 scale).[20] Unidimensional assessments of pain do not, however, provide information about how pain is affecting a patient's life and it is difficult to interpret from one patient to another.

Assessing pain in patients with cognitive impairment

Although patients with mild-to-moderate dementia can report their pain and its location, those with severe dementia are often unable to communicate their pain experience or request medication. In these patients, clinicians need to observe and document pain-related behaviors, including facial expressions, verbal cues, body movements, changes in interpersonal interactions, activity patterns, and mental status. Caregiver observations and reports are critical for appropriate assessment and management of chronic pain in these patients.[21]

Overview of options for managing pain

Many pharmacologic and non-pharmacologic approaches to treating pain are available to primary care clinicians. These options should be employed using the following general principles:

- **Identify and treat the source of the pain,** if possible, although pain treatment can begin before the source of the pain is determined.
- **Select the simplest approach to pain management first**. This generally means using non-pharmacologic approaches as much as possible and/or trying medications with the least severe potential side effects, and at the lowest effective doses.
- **Consider the advantages of using a multi-modal approach to treating pain**, i.e., using medications from two or more classes, or a medication plus a non-pharmacologic treatment.(See section below for more details.)
- **Establish a function-based management plan** if treatment is expected to be long-term.

Decisions regarding treatment goals and the options selected should be a collaboration between clinicians and patients based on identified needs, wishes, and goals.

(The following summaries are descriptive only—details about the evidence of effectiveness for the various forms of therapy will be provided in the condition-specific sections later in this document.)

Non-pharmacologic approaches

Movement-based options

Movement therapies that may be helpful in patients with chronic pain include muscle-strengthening, stretching, and aerobic exercise (e.g., walking, aquatics). Recommended exercise programs typically occur one to three times a week for a total of 60-180 minutes per week, but any regimen must be carefully tailored to a patient's existing level of physical conditioning, comorbidities, and cognitive status.[22-24]

Additional movement-based options include:

- **Physical therapy** supervised by a licensed physical therapist, which can include resistance, aerobic, balance, and flexibility exercises as well as elements of massage, manipulation, or transcutaneous electrical nerve stimulation.
- **Tai chi,** a mind-body practice that combines controlled movements, meditation, and deep breathing. “Chair tai chi” can be an option for patients with limited mobility.
- **Yoga,** exercises or a series of postures designed to align muscle and bones and increase strength and flexibility. It can also relax mind and body through breathing exercises and meditation. Gentler forms of yoga that may be more appropriate for older patients include Iyengar, Hatha, or Viniyoga.

Although these interventions may cause muscle soreness and entail the small intuitive risks of increased pain or falls, movement-based options are generally considered safe.[24]

Weight loss

Some pain syndromes, such as knee osteoarthritis, are worsened by obesity. For some patients, pain due to this condition is improved by reducing body weight because of reduced loads and physical stresses on the affected joints. The goal of body weight reduction is a baseline weight loss of 7%-10%.[25] Weight loss may occur with exercise, dietary changes, and/or pharmacologic options. Referral to a comprehensive clinical weight center may be appropriate for some patients, particularly those with a body mass index (BMI) > 35 kg/m^2.[26]

Passive physical options

Acupuncture involves the stimulation of specific points on the body, most often involving skin penetration with fine metal needles manipulated by hand. It may also include electrical stimulation or low intensity laser therapy. Potential adverse events include minor bruising and bleeding at needle insertion sites.[27]

Massage may promote relaxation, reduce stress, and improve well-being. Handheld devices may also provide relief for some patients. Some patients may report muscle soreness after massage.[28]

Transcutaneous electrical nerve stimulation (TENS) is the application of mild electrical pulses to the skin. The electrical stimulation may block or disrupt pain signals to the brain, reducing pain perception. TENS machines can be used at home or in conjunction with other interventions such as physical therapy.

Psychological approaches

Cognitive behavioral therapy (CBT) is a structured, time-limited (typically 3-10 weeks) intervention focused on how thoughts, beliefs, attitudes, and emotions influence pain. It teaches patients to use their minds to control and adapt to pain. This therapy includes setting concrete goals, often with recommendations to increase activity to reduce feelings of helplessness.[29]

Mindfulness-based stress reduction (also called simply mindfulness meditation) elicits the relaxation response and can promote pain relief. Programs typically include a time-limited (8 weeks; range 3-12 weeks) training with group classes and home meditation. The objective is to inculcate a long-term practice that helps patients refocus their awareness on the present moment, increase awareness of self and surroundings, and reframe experiences.[30,31]

The self-management education program, originally developed for patients with chronic arthritis, has been expanded for application to other chronic diseases, and is generally referred to as the Stanford model.[32] The elements of Stanford model programs include group meetings, trained leaders (health professionals or lay people), disease management education, goal setting and action plans, and feedback.[33]

Traditional AI/AN culture can play a role in healing and pain management. AI/AN peoples approached health and wellness from a holistic perspective long before this became more common in Western medicine. AI/AN communities are more likely to view health as being a balance of physical, emotional, mental, and spiritual components and, thus, they might consider family and community relationships, spiritual practices, and connections with the land and ancestors as integral parts of wellness and recovery. The use of medicinal plants, sweat lodges, smudging (burning of specific herbs for purification), and healing rituals may be part of an approach to managing pain in AI/AN communities. Such practices may not only relieve physical discomfort but may also help to restore balance and harmony within the individual and the community. Healthcare providers can play a key role in helping patients integrate traditional practices into their care plans in a way that promotes safety while minimizing uncomfortable symptoms.

Pharmacologic approaches

Medications used to treat chronic pain include:

- acetaminophen
- non-steroidal anti-inflammatory drugs (NSAIDs)
  - oral
  - topical
- antidepressants
  - serotonin and norepinephrine reuptake inhibitors (SNRIs)
  - tricyclic antidepressants (TCAs)
- anticonvulsants/membrane stabilizers
- topical lidocaine or capsaicin
- cannabis/cannabinoids
- opioids

Acetaminophen

While its exact mechanism of action is unknown, acetaminophen provides analgesia by acting upon the central nervous system. It is available over the counter (OTC) in 325 mg, 500 mg, and 650 mg tablets. Patients should not exceed 1,000 mg in a single dose. The maximum recommended dose for healthy adults is 4,000 mg/day and 3,000 mg/day for elderly patients.[34] OTC product guidance for healthy adults suggests a dose of 3,000 mg/day and 2,000 mg/day elderly patients.[35]

The most severe potential side effect of acetaminophen is liver toxicity. Acetaminophen is the most common cause of acute liver failure, accounting for 46% of all cases.[36] Patients should stay within recommended doses to help prevent side effects and should only take one acetaminophen-containing product at a time. Advise patients to read labels of all medications to determine if the product contains acetaminophen. Patients taking warfarin should be monitored when acetaminophen is started or stopped and with dose changes.

NSAIDs

NSAIDs reduce inflammation by inhibiting cyclooxygenase (COX), either selectively (COX-2 predominantly) or non-selectively (COX-1 and COX-2 effects).

Oral NSAIDs: Chronic use of NSAIDs may be limited by gastrointestinal (GI) toxicity, including GI bleeding, upper GI symptoms, ulcers, and related complications. For high-risk patients, including the elderly, patients on warfarin or aspirin, and those with coagulopathies, adding a proton pump inhibitor (PPI) may help reduce the risk.[37,38] NSAIDs should be avoided in patients with heart failure (due to fluid retention) or with a history of gastric bypass (due to increased ulcer risk). In addition to GI side effects, NSAIDs have been associated with an increased risk of renal and cardiac complications.

Evidence regarding the comparative safety of celecoxib:

Some early trials suggested that COX-2 inhibitors, as a class, were associated with higher risks for myocardial infarction and stroke compared to other NSAIDs, and the COX-2 inhibitor rofecoxib (Vioxx) was removed from the market in 2004 because of such concerns.[39] More recent trials and meta-analyses, however, provide strong evidence that the risks of CV events with celecoxib are no greater than those of other NSAIDs, and in 2018 two Food and Drug Administration (FDA) advisory panels recommended that the FDA change its advice to clinicians regarding celecoxib's safety.[40]

The advisory panel's decision was based largely on the Prospective Randomized Evaluation of Celecoxib Integrated Safety vs. Ibuprofen Or Naproxen (**PRECISION**) study, a prospective non-inferiority trial of 24,081 patients comparing celecoxib (100-200 mg twice daily, n=8,072) vs. ibuprofen (600-800 mg three times daily, n=8,040) or naproxen (375-500 mg twice daily, n=7969) in patients with osteoarthritis or rheumatoid arthritis, with established cardiovascular disease or risk factors for cardiovascular disease.[41]

After a mean follow-up of 20 months, a primary outcome event (composite of CV death, nonfatal myocardial infarction, or nonfatal stroke) occurred in 188 patients in the celecoxib group (2.3%), 201 patients in the naproxen group (2.5%), and 218 patients in the ibuprofen group (2.7%) ($P<0.001$ for noninferiority for both comparisons). The risk of renal events was significantly lower with celecoxib than with ibuprofen ($P=0.004$) but was not significantly lower with celecoxib compared with naproxen ($P=0.19$). The risk of GI events was significantly lower with celecoxib than with naproxen ($P=0.01$) or ibuprofen ($P=0.002$). Notably, all patients in PRECISION received a proton pump inhibitor (PPI); a PPI is recommended regardless of the NSAID selected, especially for patients at increased risk for GI side effects.[41]

Topical NSAIDs: Side effects with NSAIDs are typically lower with topical formulations. The effects on coagulation and renal function are unknown, but likely not clinically significant given limited systemic absorption.[42]

Serotonin norepinephrine reuptake inhibitors (SNRIs)

SNRIs such as duloxetine, venlafaxine, and milnacipran are characterized by a mixed action on norepinephrine and serotonin, though their exact mechanism of action for pain reduction is unknown. Side effects (e.g., nausea, dizziness, and somnolence) are usually self-limiting, typically resolving in around two weeks. Monitoring is required for blood pressure (duloxetine and venlafaxine), heart rate (venlafaxine), and drug interactions (duloxetine and venlafaxine).

Tricyclic antidepressants (TCAs)

TCAs inhibit reuptake of norepinephrine and serotonin, but their mechanism of action for pain relief is unknown. Examples of TCAs studied for the management of chronic pain include amitriptyline, desipramine, and nortriptyline. In older adults, side effects, such as anticholinergic effects (e.g., dry mouth, constipation, dizziness) and QTc prolongation, limit the use of TCAs. Secondary amines (i.e., nortriptyline) tend to be better tolerated than tertiary amines (i.e., amitriptyline). The majority of side effects are dose dependent. Doses used for pain are much lower than those used for depression.

Membrane stabilizers

Membrane stabilizers or anticonvulsants, such as gabapentin, pregabalin, topiramate, oxcarbazepine, and carbamazepine, are thought to exert their analgesic effect by inhibiting neuronal sodium or calcium channels. Potential side effects include sedation, dizziness, and peripheral edema. While many membrane stabilizers are used off-label for the treatment of pain, pregabalin is FDA approved for fibromyalgia, diabetic peripheral neuropathy, postherpetic neuralgia, and neuropathy associated with spinal cord injury. Gabapentin is FDA approved for postherpetic neuralgia. Oxcarbazepine and carbamazepine are rarely used for chronic pain management due to their side effect profile and drug interactions. Topiramate may be considered in patients who desire weight loss. It requires slow titration and close monitoring.

Gabapentinoid safety: In December 2019, the FDA issued a warning for gabapentinoids (i.e., gabapentin [Neurontin, Gralise, Horizant] and pregabalin [Lyrica, Lyrica CR]); they were reported to cause respiratory depression, particularly when co-administered with other central nervous system (CNS) depressants, such as opioids, in the setting of underlying respiratory impairment, or in the elderly.[43] A cohort study of patients who received perioperative gabapentinoids with opioids compared to those receiving opioids alone found an increased risk of overdose with the combination of a gabapentinoid and opioid vs. an opioid alone, though the rates were low (1.4 per 10,000 patients and 0.7 per 10,000 patients respectively).[44] Two case-control studies, nested with a cohort of patients receiving prescription opioids, identified an increased risk of opioid overdose death when pregabalin or gabapentin were co-prescribed with opioids.[45,46] In patients receiving any dose of pregabalin and also opioids, the risk of overdose death was significantly higher than in patients on opioid prescription alone (adjusted OR 1.68; 95% CI: 1.19-2.36).[45] A similar increase in overdose mortality was found in patients on opioids and gabapentin (adjusted OR 1.49; 95% CI: 1.18-1.88) vs. opioid prescription alone.[46] In both studies, the prescription of combination therapy to patients at higher risk of opioid misuse or abuse, cannot be excluded. Case reports in the literature as well as 49 cases reported to the FDA Adverse Event Reporting System, of which 12 resulted in death, identify an increased risk of respiratory depression in patients who have underlying respiratory impairment or who are co-prescribed other CNS depressants, such as opioids or benzodiazepines.[43]

Recent changes in opioid prescribing patterns were associated with an increase in gabapentin prescribing from 1.5 million episodes in 2006 to 8.1 million episodes in 2018.[47] The rate of opioid and gabapentin co-prescribing rose from 1.9% to 7.6% during the same period. The majority of these prescriptions were written by pain management specialists, to women, non-Hispanic white patients, for patients over age 65, in rural counties, and patients living in counties with the highest quartile of poverty.[47]

While concern for respiratory depression has been noted for gabapentinoids, increasing doses of opioids in order to stop use of gabapentinoids is not recommended. Evidence supporting the risk of serious breathing difficulties with gabapentinoids alone in otherwise healthy individuals is lacking.[43] For most

patients, careful management can reduce the risk of respiratory depression, especially in those who are co-prescribed other CNS depressants, the elderly, those with renal dysfunction, and with underlying respiratory insufficiency. These management steps include:

- Start at the lowest dose and slowly titrate doses
- Monitor patients for symptoms of respiratory depression or sedation
- Adjust gabapentin and pregabalin doses for renal impairment
- Counsel patients about the risks of gabapentinoid respiratory suppression, especially when combined with opioids
- Prescribe naloxone in patients co-prescribed opioids

Pregabalin and gabapentin may have abuse potential in the general population, although the actual prevalence is poorly understood. According to one survey, nearly 20% of the U.S. population reported use of a gabapentinoid - with responses from 6.6% of the population suggesting misuse, abuse or non-prescription use.[48] Misuse and abuse were reported in as many as 1 in 3 gabapentinoid users. Those reporting misuse were younger, male, employed, and had a higher income (>$100,000), but also reported higher levels of prior incarceration, substance use disorder, and prior addiction treatment.[48] Because of the low risk of misuse or addiction, pregabalin is currently classified as Schedule V by the DEA, and prescriptions for gabapentin are tracked by some state Prescription Drug Monitoring Programs (PDMPs).

Topical lidocaine and capsaicin

Topical lidocaine inhibits ionic fluxes required for initiation and conduction of nerve impulses. Irritation at the application site is the most common side effect. The most common products for chronic pain management are lidocaine 5% patches (available by prescription) and lidocaine 4% patches (available over the counter (OTC)).

Capsaicin is an active component of chili peppers and has moderate analgesic properties at 8% concentrations for musculoskeletal and neuropathic pain.[49] The most common side effect is a mild-to-severe burning sensation at the application site.

Cannabinoid preparations

As of June, 2023, 38 states and Washington DC permit the use of medical marijuana.[50] Cannabis contains more than 60 cannabinoids, with Δ^9-tetrahydrocannabinol (THC) and cannabidiol (CBD) being the two of primary interest to patients and clinicians. Exogenous cannabinoids act on cannabinoid receptors located throughout the body, primarily in the brain and spinal cord, to inhibit release of multiple neurotransmitters (e.g., acetylcholine, dopamine, and glutamate) with indirect effects on opioid, serotonin, and other receptors. Activation of cannabinoid receptors can reduce pain. Some exogenous cannabinoids also function as an antiemetic and have anti-spasticity and sleep-promoting effects.[51] Cannabinoids may also cause side effects of euphoria, psychosis, cognitive impairment, reduced locomotor function, and increased appetite.

A variety of doses and routes of administration are available, with the most common presented in Table 1.

Table 1: Common cannabinoid-based preparations[52]

Preparation	Route	Potency
whole-plant cannabis *bud, leaf, weed*	• smoked or vaporized • orally if cooked into food or butters	>20% THC from dispensaries
cannabinoids (primarily THC and CBD)	• vaporized, sublingual tinctures, pills/capsules, and topical creams • oral FDA approved options: dronabinol, nabilone, Epidiolex,	often expressed as a ratio of THC:CBD
concentrates *wax, shatter, dab, butane honey oil*	• smoked	extremely high potency, THC often >90%
edibles (brownies, candies, mints, muffins, beverages)	• oral ingestion	usually ≤10 mg of THC per 'serving'

Edibles require extra caution as they look like common food products and may be ingested by children and other adults. Patients need to understand that the time to onset of effect is longer with edibles than other products. Ingesting another serving too soon may result in unintentional overdose..

A systematic review of both randomized trials (47) and observational studies (57) in patients with chronic non-cancer pain (across multiple pain conditions) published through July 2017 found moderate evidence that cannabinoids can relieve pain.[53] Across RCTs, the overall number needed to treat to obtain a 30% reduction in pain was relatively high (NNT 24; 95% CI: 15-61), while the number needed to harm (NNH) for all-cause adverse events was 6 (95% CI: 5-8). Another review found small but not statistically different pain relief across a variety of chronic pain conditions vs. placebo (37% vs. 31%; OR 1.41; 95% CI: 0.99-2.00). Side effects were three times more common in the cannabis group vs. placebo (OR 3.03; 95% CI: 2.42-3.80).[54] The substances studied were smoked cannabis and nabiximols (a nasal spray formulation not available in the U.S.). The role of cannabinoids in treatment may be best summarized by the National Academy of Medicine report:[55]

> *"While the use of cannabis for the treatment of pain is supported by well-controlled clinical trials, very little is known about the efficacy, dose, routes of administration, or side effects of commonly used and commercially available cannabis products in the United States. Given the ubiquitous availability of cannabis products… more research is needed on the various forms, routes of administration, and combination of cannabinoids"*

Cannabis preparations may pose both short-term and long-term risks. Short-term effects include impaired memory, motor coordination, and judgment. Paranoid ideation and psychotic symptoms, while rare, may occur with high doses of THC. Possible long-term effects include impaired brain development in young adults, potential for habituation, and increased risk of anxiety or depression. Abrupt cessation of cannabis in long-term users may cause withdrawal symptoms such as anxiety, irritability, craving, dysphoria, and insomnia. There is an increased risk of chronic bronchitis, respiratory infections, and pneumonia with inhaled products.[51,55]

No FDA approved cannabinoid products are indicated for the treatment of acute or chronic pain.

These research findings do not apply to hemp-derived cannabis products, such as CBD oil, found at gas stations, convenience stores, and smoke or vape shops. These products may be available regardless of whether or not a state has legalized medical or recreational cannabis products. Few safeguards exist to

ensure product quality, safety (e.g., prevention of the use of toxins or heavy metals in the synthesis process), or appropriate marketing. In many cases products are designed to attract youth, with no minimum age to buy these products, and they are sold alongside tobacco and alcohol.[56]

Opioids for pain

Mechanism of action

Opioids exert their analgesic effects by acting on the mu, kappa, and delta opioid receptors. Individual agents may be classified as agonists, partial agonists, or antagonists of those receptors:[57]

- Agonists (e.g., morphine, codeine, hydromorphone, hydrocodone) stimulate at least one of the opioid receptors and provide continued analgesia with increasing doses.
- Partial agonists (e.g., buprenorphine) have high affinity but lower activity at mu-receptors, are less likely to cause respiratory depression due to a ceiling effect, and do not have a defined ceiling on analgesic effect.
- Antagonists (e.g., naloxone and naltrexone) block opioid receptors and do not have an analgesic effect. Use of an opioid antagonist in patients taking chronic opioids will precipitate an acute withdrawal syndrome.

Opioids are classified by the Drug Enforcement Agency (DEA) according to their presumed abuse and addiction potential, although the evidence base for making these differentiations continues to evolve. Tramadol, for example, is now known to have a higher abuse potential than previously thought.[58]

Table 2: Opioids by schedule[57]

Schedule*	Description	Opioid (examples
Schedule I	No medical use, lack of accepted safety, and a high potential for abuse	Heroin
Schedule II	High potential for abuse, which may lead to physical or psychological dependence	Hydrocodone Oxycodone Morphine Hydromorphone Tapentadol Methadone Fentanyl
Schedule III	Less potential for abuse than schedules I and II, low to moderate physical dependence and high psychological dependence	Buprenorphine Codeine + acetaminophen
Schedule IV	Lower potential for abuse than schedule III medications	Tramadol
*Note: DEA schedules may not accurately reflect the actual abuse or dependence potential for these medications.		

Relative effectiveness

The analgesic efficacy of opioids for treating acute pain has been known for centuries, and opioids continue to be reliable—if potentially risky—agents for moderate-to-severe acute pain. The efficacy appears to wane by three months.[59] *The evidence for opioid efficacy for acute pain cannot be extended to chronic pain*. Neuronal and physiologic adaptations to long-term opioid use can result in reduced analgesic effectiveness, or even, paradoxically, increased pain or sensitivity to pain.[12] Opioid-induced hyperalgesia is different pharmacologically from the phenomenon of opioid tolerance, although both can lead to an increased need for opioids; disentangling the two, clinically, can be difficult.[60]

For chronic pain, the evidence that opioids reduce pain and improve function more than placebo is surprisingly weak. A 2018 systematic review and meta-analysis of 96 trials comparing various opioids vs. placebo or non-opioid analgesics in 26,169 patients with chronic non-cancer pain found that opioids may slightly reduce pain and increase physical functioning compared to placebo, but not compared to non-opioids.[4] In 76 trials comparing opioids vs. placebo with median follow-up of 60 days (range 30-84 days), the reduction in pain scores with opioids (on a 10-point scale) was only 0.69 points, which is below the generally-accepted minimum clinically important difference for pain. Physical function scores (on a 100-point scale) improved with opioids by 2.04 points, which, again, may not be clinically important. The risk of vomiting with opioids, however, was more than four times higher than with placebo (RR 4.12; 95% CI: 3.34-5.07).[4] In these studies, there were no significant differences in emotional functioning or role functioning.

The same meta-analysis compared opioids to non-opioid analgesics including NSAIDs, TCAs, membrane stabilizers, and synthetic cannabinoids. No significant differences were found in physical functioning scores for any of the comparisons, and no significant differences were found in pain scores for comparisons with NSAIDs (9 trials), TCAs (3 trials), or cannabinoids (1 trial). As compared to membrane stabilizers, opioids were associated with slightly lower pain scores, although the confidence interval includes differences that may not be clinically significant (weighted mean difference -0.9 points; 95% CI: -1.65 points to -0.14 points).[4]

The Strategies for Prescribing Analgesics Comparative Effectiveness **(SPACE) trial** randomized 240 patients with moderate to severe chronic low back pain or knee or hip osteoarthritis to regimens of morphine, oxycodone, or hydrocodone or non-opioid analgesics (e.g., acetaminophen, NSAIDs, antidepressants, membrane stabilizers) and followed them for one year.[5] The primary outcome was score for pain-related functioning using the 0-10 BPI scale (lower score indicates better function). At 3, 6, 9, and 12 months there were no significant differences in BPI scores (overall P=0.58). At one year, pain intensity was significantly better in the non-opioid group (P=0.03). No differences in treatment response were seen in analyses by pain condition. The authors concluded that their results “do not support initiation of opioid therapy for moderate-to-severe chronic back pain or hip or knee osteoarthritis pain.”[5]

Opioid formulations

Prescription opioids are available in immediate-release and extended-release/long-acting (ER/LA) formulations. Immediate-release agents are recommended in opioid-naïve patients and for all acute pain conditions, with ER/LA agents reserved for patients or conditions in which the longer duration of action (and, hence, less frequent dosing) are preferred.[61] A trial comparing immediate release to an ER/LA opioid did not find evidence that the continuous, time-scheduled use of ER/LA opioids was more effective or safer than intermittent use of the immediate-release opioid.[62] According to the FDA, ER/LA opioids should only be used for patients who tolerate 60 morphine milligram equivalents (MME) per day for at least one week.[59,63]

Efforts to create formulations with lower risks of abuse have met with limited success. For example, Opana ER (oxymorphone) was removed from the market after reports of intravenous abuse of the oral formulation.[64] Abuse-deterrent or tamper-resistant formulations do not prevent users from becoming addicted or taking too much of an opioid by mouth (the most common route for abuse).[65,66] No prospective randomized clinical trials or rigorous observational studies have measured the impact of abuse-deterrent opioids on the risk of abuse or misuse. As of November, 2022, four opioids FDA approved as abuse-deterrent formations are available: OxyContin (oxycodone), Hysingla ER (hydrocodone), Xtampza ER (oxycodone), and RoxyBond (oxycodone).[67]

Another attempt to improve opioid safety used benzhydrocodone, a pro-drug of hydrocodone that requires metabolism in the gut. Pharmaceutical company-funded studies suggested the need for gut metabolism would reduce the abuse potential via intravenous or inhaled routes.[68,69] The FDA rejected benzhydrocodone/acetaminophen (Apadaz) as an abuse deterrent formulation. It is currently approved for acute pain lasting less than 14 days.[70] Benzhydrocodone is Schedule II, with risks similar to other opioids.[71]

Opioid risks and side effects

To ensure clear communication regarding medical issues and avoid misunderstandings about the nature and risk of addiction, the CDC provides the following definitions:[72]

- **Tolerance** – The need for an increased dose of an opioid to achieve the same effect, which can occur even when taking a medication as prescribed
- **Physiologic dependence** - A state of physical adaptation that is manifested by a substance class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the substance, and/or administration of an antagonist.
- **Misuse** - Use of a medication other than as directed or as indicated, such as taking in greater amounts, more often, or for a longer duration, or using someone else's prescription.
- **Opioid use disorder** - Problematic opioid use leading to clinically significant impairment or distress, with at least two additional criteria, such as taking more opioids or for longer than prescribed, persistent desire or unsuccessful efforts to cut down or control opioid use and craving or a strong desire or urge to use opioids, occurring within a 12-month period.[73]

Problematic opioid use

Although evidence for the long-term effectiveness of opioids for chronic pain is weak, evidence for opioid-related harms is abundant and strong.

In a 2007 study assessing behaviors indicative of opioid misuse, many patients in primary care practices reported having engaged in aberrant behaviors one or more times.[74]

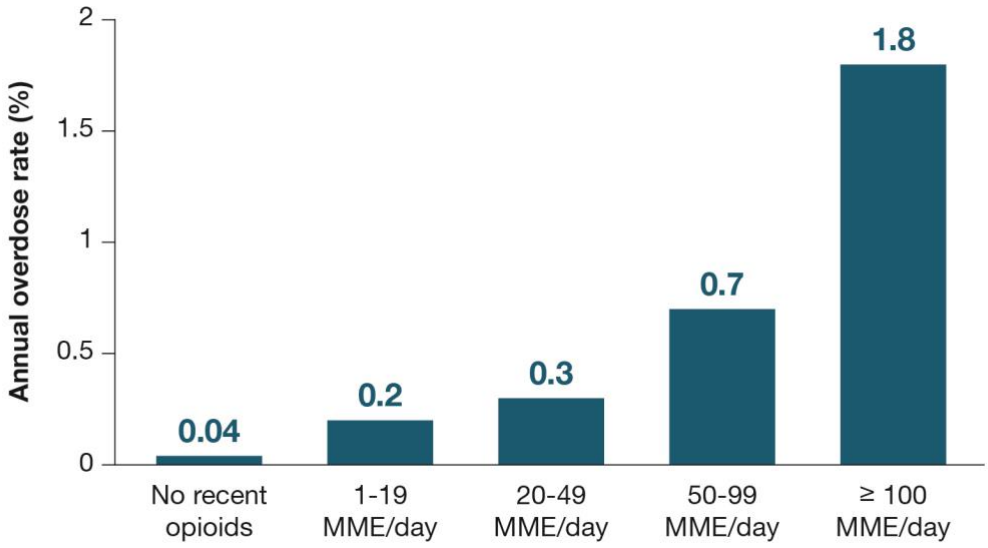
Table 3: Behaviors indicative of opioid misuse[74]

Behavior	Frequency in patients with opioid misuse
requested early refills	47%
increased dose on own	39%
felt intoxicated from pain medication	35%
purposely over sedated oneself	26%
used opioids for purpose other than pain	18%

A 2015 meta-analysis showed that the prevalence of opioid misuse among patients with chronic pain in primary care settings ranged from 0.6%-8%, and the prevalence of physiologic dependence ranged from 3%-26%.[75] In pain clinics, the prevalence of opioid misuse ranged from 8%-16%, and OUD ranged from 2%-14%.[75]

For prescription opioids, long-term therapy is associated with an increased risk in accidental overdose and death. A retrospective study including 9,940 patients who received three or more opioid prescriptions within 90 days for chronic pain between 1997 and 2005 found that annual overdose rates rose significantly as doses exceeded 50 MME per day.[76]

Figure 3: Risk of overdose rises with MME dose per day[76]



Combining opioids with sedating substances such as benzodiazepines or alcohol increases the risk of respiratory depression and overdose death.[61] Benzodiazepines have been linked with overdose fatalities in 50-80% of heroin overdoses, and 40-80% of methadone-related deaths.[61,77] Patients on benzodiazepines who are being initiated on opioids should have their benzodiazepine tapered and discontinued whenever possible. For patients being co-managed by mental health professionals, a plan

should be coordinated regarding continuing or tapering benzodiazepines in the setting of opioid co-prescribing. (Note: in its 2016 warning about the hazards of combining CNS depressants with opioids, the FDA included the benzodiazepine-like insomnia medications: eszopiclone, zaleplon, and zolpidem [so-called "z-drugs"], muscle relaxants and antipsychotics such as aripiprazole, olanzapine, and quetiapine.)[78]

Other adverse events

In addition to risks of misuse, addiction, respiratory depression, and overdose death, there are many well-known side effects associated with chronic opioid use that can significantly compromise quality of life, including constipation, nausea or vomiting, hearing impairment, sedation, pruritus, erectile dysfunction, fracture, immunosuppression, and hallucinations.[79]

Gastrointestinal side effects

Constipation is one of the most common opioid-related adverse events, affecting most patients to at least some degree, and which usually does not resolve with continued use.[9] To mitigate this side effect, patients should use a mild stimulant laxative such as senna or bisacodyl and increase the dosage in 48 hours if no bowel movement occurs. Clinicians should perform a rectal examination if no bowel movement occurs in 72 hours. If there is no impaction, consider other therapies such as an enema, suppository, polyethylene glycol (Miralax, generics), lactulose, or magnesium citrate.[80]

Medications for refractory, opioid-induced constipation include naloxone derivatives:

- naloxegol (Movantik) orally
- methylnaltrexone (Relistor) subcutaneous injection or oral tablet used daily
- naldemedine (Symproic) orally

Another option is a chloride channel activator, lubiprostone (Amitiza). An oral capsule (24 mcg) given twice daily, it increases secretion of fluid in the intestine to help mobilize chyme and stool.[81]

For **nausea or vomiting**, clinicians should consider a prophylactic antiemetic, add or increase non-opioid pain control agents (e.g., acetaminophen), and decrease opioid dose by 25% if analgesia is satisfactory.

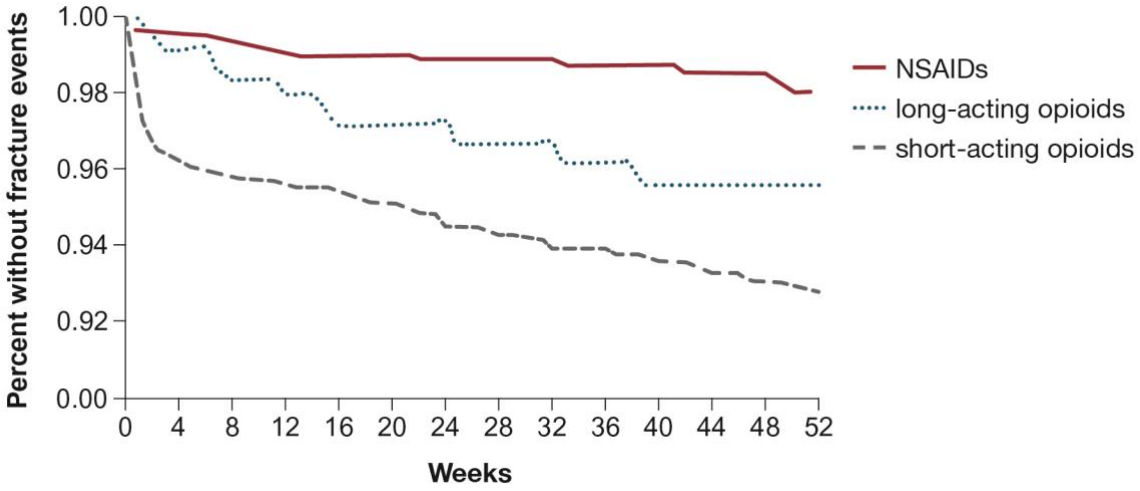
Sedation

If a patient or caregiver complains of sedation, determine whether sedation is related to the opioid, eliminate nonessential depressants (such as benzodiazepines or alcohol), reduce dose by 10%-15% if analgesia is satisfactory, add or increase non-opioid or non-sedating adjuvant, or add a stimulant in the morning. There is insufficient evidence to recommend opioid rotation as a possible means of reducing sedation.[61]

Fracture

A retrospective cohort study over seven years compared the risk of fracture associated with starting opioids vs. NSAIDs (2,436 patients initiated on opioids and 4,874 initiated on NSAIDs: mean age 81, 85% female). Opioids significantly increased the risk of fracture (hazard ratio [HR] 4.9; 95% CI: 3.5-6.9) in a dose-dependent fashion. The opioid formulation mattered (Figure 4), with much of the risk in the first month after initiation for short-acting opioids, though fracture increased for both long- and short-acting opioids over time.[82]

Figure 4: Fracture risk over time for NSAIDs, short-acting and long-acting opioids[82]



A systematic review and meta-analysis of 30 studies analyzed the risk of fall, fall injury and fracture with opioid use older adults and found a small but statistically significant increase in falls (standardized mean difference [SMD] 0.15; 95% CI: 0.02-0.27). Adults ages 65 and over were significantly more likely to have a fall related injury (SMD 0.40; 95% CI: 0.24-0.56) and fracture (SMD 0.71; 95% CI: 0.45-0.97).[83]

Infection

Opioids may increase risk of infection in older adults. A case-control study of 3,061 older community dwelling adults ages 64-95 years evaluated the association between pneumonia and opioid use. Current prescription opioid users had a 38% greater risk of pneumonia (OR 1.38; 95% CI: 1.08-1.76) compared with nonusers. The risk was highest for opioid users categorized as being immunosuppressed, such as those with cancer, recent cancer treatment, or chronic kidney disease, or those receiving immunosuppressive medications or medications for HIV.[84]

Among a national cohort of 5,623 people with Alzheimer's disease (AD), use of opioid medications was associated with a 34% increase in the risk of hospital-treated pneumonia compared to not receiving opioids (adjusted hazard ratio [aHR] 1.34; 95% CI: 1.14-1.57). Risk was greatest in the first two months of use (aHR 2.58; 95% CI: 1.87-3.55) and with more potent opioids (aHR 1.84; 95% CI: 1.15-2.97). Higher doses, such as ≥50 MME per day doubled the risk of hospitalization compared to opioid use <50 MME per day (aHR 2.03; 95% CI: 1.24-3.31).[85] Although not clearly understood, reasons for the increase in pneumonia have been attributed to direct immunosuppressive effects of specific opioids (e.g., fentanyl, morphine) and suppression of cough and respirations.[86]

Myocardial infarction (MI)

A case-control study assessed the risk of MI among adults on opioids for chronic pain in the UK General Practice Research Database (11,693 cases with up to four matched controls). Current opioid use was associated with a 28% increased risk of MI compared to non-use (HR 1.28; 95% CI: 1.19-1.37).[87]

Erectile dysfunction (ED)

In a cross-sectional analysis of 11,327 men with back pain, 909 (8%) received ED medications or testosterone. Long-term opioid use was associated with greater use of medications for ED or testosterone

replacement compared to patients with no opioid use (OR 1.45; 95% CI: 1.12-1.87). Men prescribed daily doses of 120 mg morphine or more had a 1.58-fold increase in medication for ED or testosterone compared to patients without opioid use, suggesting that dose and duration of opioid use were associated with ED.[88]

Differentiating between opioids

Tramadol

Despite the categorization of tramadol as a non-opioid pain management strategy in the SPACE trial, tramadol is a mu-opioid receptor agonist and a reuptake inhibitor of the noradrenergic and serotonergic system. Its analgesic effects are similar to morphine, although it is only one-fifth to one-tenth as potent as morphine.[89] Patients taking tramadol should be monitored for nausea, vomiting, constipation, and drowsiness, all of which are similar to side effects with opioids.[90] There is potential risk of serotonin syndrome when combined with serotonergic drugs such as SSRIs and tricyclic antidepressants.[91] Tramadol may also lower the seizure threshold.

Tramadol is classified as Schedule IV (which is lower than most opioids), but it still can be misused. The 2020 National Survey on Drug Use and Health found that 1.5 million people in the U.S. aged >12 years reported misusing tramadol products (e.g., Ultram, Ultram ER, Ultracet) in the previous year.[92] In addition, a 2019 cohort study of 88,902 patients with osteoarthritis (mean age 70 years) showed increased risks of death with tramadol use at one year compared to the NSAIDs naproxen (HR 1.7; 95% CI: 1.4-2.1), diclofenac (HR 1.9; 95% CI: 1.5-2.6), and celecoxib (HR 1.7; 95% CI: 1.3-2.2), although it is possible that patients receiving tramadol were at higher risk of death due to underlying comorbidities.[93] In that study, the hazard ratio for death at one year was not significantly different between tramadol and codeine (HR 0.94; 95% CI: 0.83-1.10). Compared to other opioids, the risk of overdose is lower at FDA approved doses. Maximum daily dose is 400 mg per day,[94] while a median dose of 2,500 mg was ingested when respiratory depression occurred due to tramadol alone.[95] Of note, the CDC, in its 2022 clinical practice guideline for prescribing opioids for pain, doubled the oral morphine milligram equivalent (MME) conversion factor for tramadol from 0.1 to 0.2.[59]

Abrupt cessation of tramadol is associated with withdrawal symptoms similar to those associated with other opioids (e.g., flu-like symptoms, restlessness, and substance cravings) as well as symptoms which are less typical of other opioids that are likely related to its noradrenergic and serotonergic activity (e.g., hallucinations, paranoia, extreme anxiety, panic attacks, confusion, and numbness/tingling in extremities).[96]

Tapentadol

Tapentadol (Nucynta) is an opioid with a mechanism of action similar to tramadol (that is it has SNRI activity as well as activity at opioid receptors). Unlike tramadol, the opioid potency and side effect profile of tapentadol is similar to other common opioids such as oxycodone. It is FDA approved for treating neuropathic pain (likely due to its SNRI activity) and should be limited to situations when a potent mu opioid is required.

Buprenorphine

An atypical opioid with unique pharmacology, buprenorphine has advantages over full agonist opioids, such as oxycodone. It is a partial agonist with high binding affinity at the mu receptor, which provides analgesia while having a ceiling effect on respiratory depression.[97,98] Buprenorphine also has higher potency and exhibits a slow dissociation rate compared to full agonist opioids, allowing for effective and long-lasting analgesia.[98] An antagonist at the kappa opioid receptors, buprenorphine may also improve mood and reduce tolerance.[99]

Buprenorphine formulations and recommended doses differ by indication. FDA approved formulations for pain severe enough to require daily, around-the-clock, long-term opioid treatment include buccal film (Belbuca) and a transdermal system (Butrans). Transdermal and buccal delivery provide analgesia for patients who may not have optimal absorption orally, such as in patients with gastric bypass. Both the buccal and transdermal products are dosed in micrograms, which differs from buprenorphine's higher strength sublingual formulations (which are dosed in milligrams). See Table 4 (next page). Buprenorphine's sublingual formulations (e.g. Subutex, Suboxone, Zubsolv, generics) are FDA approved for treatment of OUD, but may be used off-label for treatment of chronic pain.[100] Sublingual buprenorphine is available both as the monoproduct (Subutex, generics) and in a co-formulation with naloxone (Suboxone, Zubsolv, generics). To learn more about the treatment of OUD, visit IHS.gov/opioids/recovery/

Table 4: Initial dosing and titration of buprenorphine for pain[101,102]

	Transdermal buprenorphine (Butrans)	Buccal film (Belbuca)
initial dosing	5 mcg/hour patch	75 mcg film once daily or every 12 hours, as tolerated
titration frequency	no sooner than every 72 hours	no sooner than every 4 days
titration dose	based on analgesic response and side effects	from 75 mcg every 12 hours, increase to 150 mcg every 12 hours from 150 mcg every 12 hours, increase by 150 mcg increments every 12 hours
maximum dose	20 mcg/hour	900 mcg every 12 hours

Safety concerns for buprenorphine at initiation are similar to other opioids, with the additional caution that all buprenorphine products carry a warning to monitor for QTc prolongation, and to avoid buprenorphine in patients with known QTc prolongation. In patients with underlying risk factors (e.g., taking other QTc-prolonging medications, cardiac rhythm abnormalities), consider an EKG.

Common complaints related to buprenorphine are nausea, vomiting, constipation, dizziness, and headache. One review suggests that buccal buprenorphine is less likely to have these adverse effects than full agonist opioids.[103] Buprenorphine may also be used in opioid-experienced patients, although in these patients, the transition from full agonist opioid to buprenorphine can cause precipitated withdrawal and, therefore, must be done carefully. Precipitated withdrawal occurs due to buprenorphine's high affinity for mu receptors that displaces full agonist opioids. (Switching from a full agonist opioid to buprenorphine is discussed on page 35.) The two formulations FDA approved for pain, buprenorphine transdermal patch and buccal film, are less likely to cause precipitated withdrawal than the formulations used for OUD.

Buprenorphine may be more favorable for the management of chronic pain as compared to a full agonist opioid in selected patients for the following reasons:[100]

- ease of ordering by clinicians
  - option for refills
  - clinician's ability to call in prescriptions
- favorable therapeutic index and safety profile when used as directed
- ceiling effect on respiratory depression
- can be used to treat chronic pain in patients both with and without OUD

Who may benefit from buprenorphine?[100]

- patients with characteristics that increase the risk of life-threatening opioid-related adverse events:
  - high BMI
  - obstructive sleep apnea
  - co-occurring psychiatric diagnosis
  - pulmonary disease
  - concomitant use of substances known to increase risk (e.g., benzodiazepines, gabapentin, pregabalin, muscle relaxants, alcohol)
  - taking high MME per day
- patients who are CYP2D6 poor or rapid metabolizers and are unable to take medications such as tramadol or codeine due to increased risk of toxicity or lack of effectiveness
- patients with chronic pain and history of substance/opioid use disorder or who are at increased risk of overdose

Note: when used for the treatment of OUD, or in patients with overlapping OUD and chronic pain, high dose buprenorphine (i.e., sublingual OUD treatment formulations that combine buprenorphine and naloxone) should be used in divided doses.

As of printing, buprenorphine products for pain were not on IHS formulary. Please visit ihs.gov/nptc/formularysearch/ for a list of currently available options.

Developing a pain management strategy

A central tenet of pain management, whether acute or chronic, is that the goal of treatment is not necessarily to eliminate pain, but rather make it tolerable and to permit maximum physical and emotional functioning with the lowest risk of side effects, progression to chronic pain, or misuse or addiction.[104] This requires an adroit balancing of patient-related factors (e.g., comorbidities, medical history, risk of addiction) and medication-related factors (e.g., potency, mechanism of action, expected side effects). A commonly-recommended way to achieve this balance is with **multimodal analgesia**, in which several therapeutic approaches are used, each acting at different sites of the pain pathway, which can reduce dependence on a single medication and may reduce or eliminate the need for opioids and associated risks/side effects.[105]

Setting functional goals

Tracking treatment progress requires the establishment of a goal, or goals. For patients with pain, these should be daily activities that they value, which will vary for each patient based on their current limitations and what can be expected after treatment for their given pain condition. Example goals could be walking from bed to the living room, gardening, or going out to dinner with friends. Such goals can help guide assessments of treatment efficacy and decisions to modify a pain management strategy.

Managing patient expectations

Patients in pain are understandably worried that the pain will persist or get worse with time. Clinicians can reduce such fears and set realistic expectations for treatment effectiveness and healing with clear, compassionate communication couched in terms that patients can easily understand. It can be helpful, for example, to tell patients that most forms of acute nociceptive pain (e.g., nonspecific low back pain) are self-limited, subside within weeks, and do not require invasive interventions. (In a systematic review of 15 prospective cohort studies, 82% of people who stopped work due to acute low back pain returned to work within one month.[106]). An example of appropriate expectation-setting language is: “Some pain is normal. You should be able to walk and do light activity but may be sore for a few days. This will gradually get better.”[107]

A systematic review of 14 controlled trials of patient education interventions for acute low back pain showed that compared with usual care/control education, structured messaging by providers can reassure patients with acute pain.[108] Messaging was significantly more reassuring to patients when delivered by physicians than other primary care practitioners, and such communication reduced the frequency of primary care visits.

Examples of effective messaging specific to patients with low back pain include:

- “Based on the history and exam, you have a good prognosis.”
- “The acute pain you are experiencing is not the result of serious injury and is likely to resolve without need for x-rays or invasive treatments.”
- “Avoid bed-rest…daily exercise is helpful.”

For patients who have chronic pain, education about the condition increases understanding of what various treatment strategies can or cannot accomplish.

Addressing mental health

Comorbid conditions such as depression and anxiety can impact pain management. Clinicians and teams should ensure that patients have been screened for depression and anxiety when initiating treatment. In a study of 250 patients with chronic pain and moderate depression, using antidepressant therapy reduced pain levels before analgesic interventions were added.[109] Selecting a medication with antidepressant and analgesic effects can help address both conditions and may become part of the multimodal strategy. Additionally, training on post-traumatic stress disorder and intergenerational trauma are available at ihs.gov/opioids/trainingopportunities/essentialtraining/

Selecting a multimodal management strategy

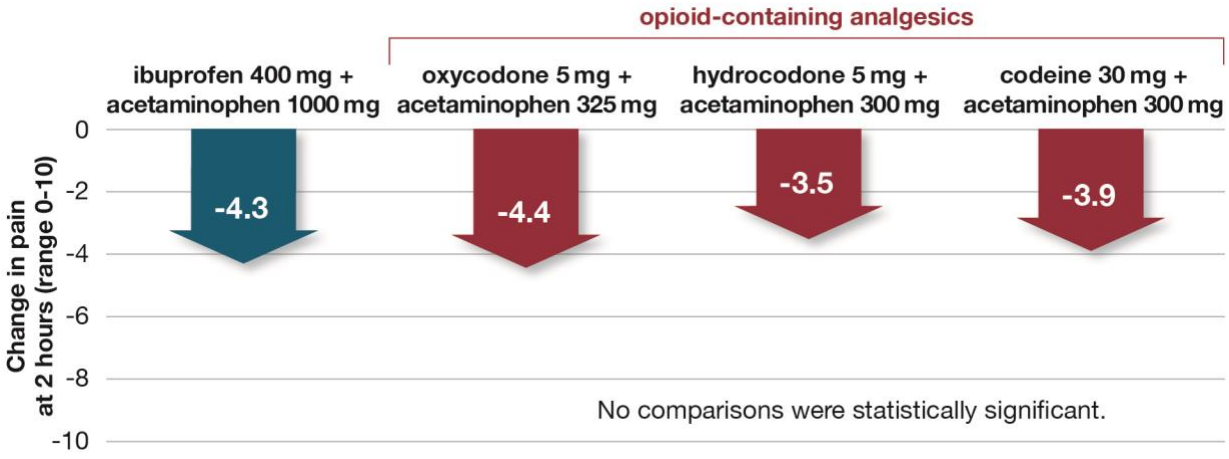
Multimodal analgesia, using medications from two or more classes, or a medication plus a non-pharmacologic treatment, can produce synergistic effects, reduce side effects, or both. One example of multimodal analgesia is the use of acetaminophen, plus physical approaches (e.g., compression or elevation) to manage acute musculoskeletal pain. The acronym PEACE can help with setting the stage for expectations regarding acute pain:[110]

- Protection: engage in movements that do not cause pain or worsen injury
- Elevation: typically the injury is elevated above heart level when possible
- Avoid ice
- Compression: use of elastic bandages or similar options
- Education: teaching about the body's processes for healing with time

Demonstrated benefits of multimodal analgesia include earlier ambulation, earlier oral intake, and earlier hospital discharge for postoperative patients, as well as higher levels of participation in activities necessary for recovery (e.g., physical therapy).[105]

Combining ibuprofen plus acetaminophen is as effective as opioids for severe musculoskeletal pain. In a randomized controlled trial, 416 patients with acute extremity pain were randomized to receive either ibuprofen+acetaminophen, oxycodone+acetaminophen, hydrocodone+acetaminophen, or codeine+acetaminophen.[111] The mean pain scores at two hours after ingestion decreased by 4.3 points (95% CI: 3.6-4.9) with ibuprofen and acetaminophen; by 4.4 points (95% CI: 3.7 to 5.0) with oxycodone and acetaminophen; by 3.5 points (95% CI: 2.9-4.2) with hydrocodone and acetaminophen; and by 3.9 points (95% CI: 3.2-4.5) with codeine and acetaminophen (Figure 5). None of the differences between analgesics were statistically significant.[111]

Figure 5: Effectiveness of ibuprofen and acetaminophen compared with three opioid-containing regimens in patients with severe musculoskeletal pain[111]



These conclusions about the relative ineffectiveness of opioids for musculoskeletal pain were reinforced by results from the 2023 **OPAL trial,** which randomized 347 patients with acute low back and/or neck pain to either standard care and oxycodone (up to 20 mg/day) or standard care and placebo.[112] Mean

pain scores after 6 weeks on the 10-point Brief Pain Inventory were *higher* in the opioid group compared to the placebo group (2.78 (SE 0.2) vs. 2.25 (SE 0.19) P=0.051.

Given these data, it makes sense to treat patients in pain with a multi-modal approach combining movement-based, psychological, and other interventional options, and medication options and interventions that de-emphasize opioids.

Figure 6: Management approaches for chronic pain[113]

Assessing treatment

Determining the success of treatment relies on the unique functional goals identified for each patient. The use of a consistent tool to monitor change (e.g., PEG, PSEQ) can clarify assessments of progress. Discussions about tolerability of each intervention (e.g., side effects of medications or challenges with completing selected movement-based options) determine what adjustments to the pain management plan are needed. Some medications require titration to reach optimal doses and need an adequate duration to produce optimum benefits. See Appendix II for initial dosing, titration, and dose information. A sufficient trial should be attempted before labeling the option as unsuccessful.

Strategies for patients requiring opioids

Although the evidence for long-term effectiveness of opioids is weak, an opioid may be indicated for patients with intractable, moderate-to-severe non-cancer nociceptive pain unresponsive to non-opioid treatment options. However, patients are not required to fail multiple treatment strategies before trying an opioid. Patients with contraindications to other medications, fragility, or hepatic or renal dysfunction may not be able to use other analgesics. In cases where opioids are needed, steps to reduce risk to patients and household members are required.[59]

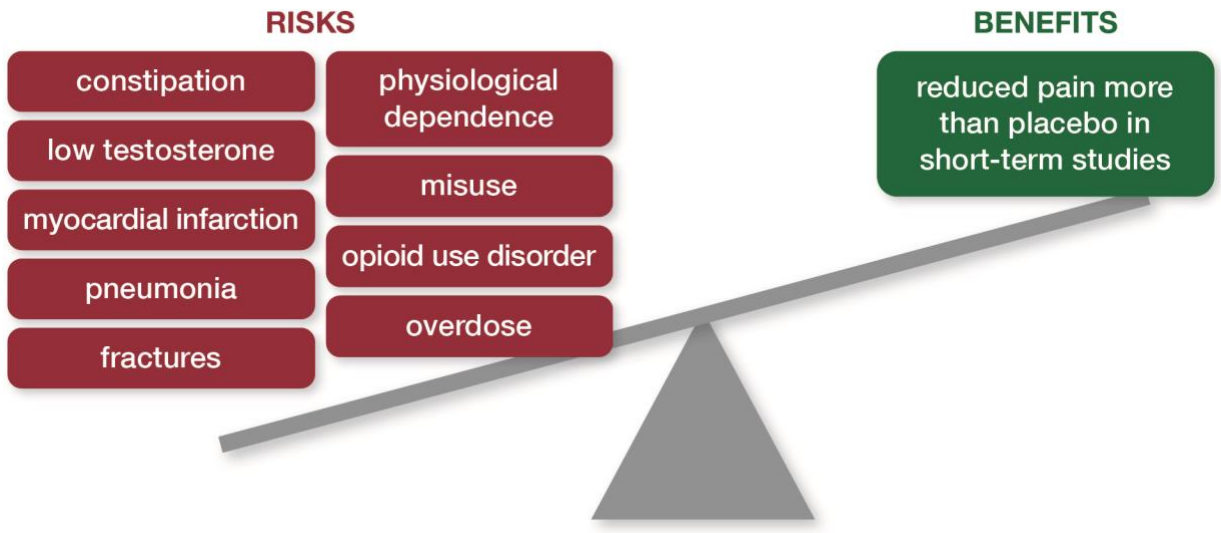
Opioid prescription should be guided by the following principles (each detailed below):

- Discuss risks and benefits of opioid use.
- Establish a written treatment agreement.
- Check or monitor opioid use.
- Use caution with dose escalation.
- Prescribe naloxone.
- Screen for opioid misuse.
- Taper or discontinue opioids when risk outweighs the benefit.

Discuss opioid risks and benefits

Educate patients about the risks and benefits of opioid use prior to initiating opioids and discuss them at each subsequent visit. For most patients, the risks of opioid therapy, as shown in Figure 7, outweigh the benefits. However, for some patients with nociceptive chronic pain, the use of low-dose opioids may be a reasonable approach for short-term use. For these patients, also discuss the duration for which opioid use is anticipated and set a clear end date as part of the decision for opioid use.

Figure 7: Balancing the risks and benefits of opioid therapy



Establish a written treatment agreement

Prepare a written agreement/treatment plan when opioids are initiated to clarify how opioids will be prescribed, goals of therapy, possible risks and side effects, monitoring and documentation requirements, and a discontinuation or tapering plan.[61] A signed informed consent document detailing the potential risks and benefits may be either incorporated into the larger agreement or added as a separate form. Agreements may specify that prescriptions be obtained from a single pharmacy or a single provider. Patients should be informed that opioid prescriptions are tracked and will be monitored. Additional monitoring may include pill counts or toxicology screens. While the use of a written agreement/treatment plan has been recommended by experts, no trials have assessed the benefit of such agreements.[59] Visit ihs.gov/opioids/painmanagement/informedconsent/ for a link to a sample treatment agreement from the National Institute of Drug Abuse (NIDA) and for other useful resources.

Initiating therapy

When initiating opioids, start with immediate-release formulations because their shorter half-life reduces the risk of inadvertent overdose. Prescribe low doses on an intermittent, as-needed basis and emphasize to patients that they should avoid scheduled, around-the-clock use, which will typically lead to tolerance/physical dependence within 5-7 days.[114] For elderly patients who have comorbidities, consider starting at an even lower dose and intensify monitoring for adverse effects.[61]

Long-term opioid use often begins with treatment for acute pain, and research shows that opioids are often over-prescribed for such pain. For example, a study of 1,416 patients in a 6-month period found that surgeons prescribed a mean of 24 pills (standardized to 5 mg oxycodone) but patients reported using a mean of only 8.1 pills (utilization rate 34%).[115] For acute pain, only enough opioids should be prescribed to address the expected duration and severity of pain from an injury or procedure (or to cover pain relief until a follow-up appointment). Several guidelines about opioid prescribing for acute pain from emergency departments[116,117] and other settings[118,119] have recommended prescribing ≤3 days of opioids in most cases, whereas others have recommended ≤7 days,[120] or ≤14 days.[121]

Check or monitor opioid use

Follow-up appointments should occur one to four weeks after opioid initiation or with dose changes, and maintenance therapy visits should occur at least every three months. Each visit should include an assessment using a pain and function tool such as the PEG or PSEQ, inquiry about side effects, evaluation of overdose risk, and discussions about how the medication is being used.[61] At every visit, there should be an active clinical decision as to whether or not to continue the opioid based on whether the benefits are deemed to exceed the risks as well as documentation about decisions made and what progress the patient has made toward his or her functional goals.

Many strategies to assess opioid use and ensure patient safety have been recommended. However, simply asking patients how they are using the medication, how often they take it, how many pills they take at one time, and what triggers them to take the medication, can identify patients who may be misusing opioids or need changes to their pain management plan. Other ways to objectively monitor opioid use are checking prescription drug monitoring programs, completing toxicology screens, or pill counts.

Use prescription drug monitoring programs (PDMPs)

All 50 U.S. states and the District of Columbia have operational PDMPs. Information available through PDMPs varies based on reporting requirements and restrictions. Differences between PDMPs may include DEA schedules reported, timeliness of pharmacy dispensing information, access, and required reviews. The IHS is not required by law to report to state-based PDMPs, however, the IHS has chosen to participate in these programs as outlined in the Indian Health Manual.[122] As emphasized in the Manual, it is critical for providers to check PDMPs because patients may be receiving care outside of the IHS system or in another state.

Some states have specific requirements for PDMP use, such as requiring review prior to initial prescription or any time a specific prescription is written (for example hydrocodone ER [Zohydro]). Clinicians should remain updated about the specific requirements of their state PDMPs. The 2022 CDC updated pain management guidelines recommend that a PDMP be checked upon initial opioid prescribing and then periodically during opioid therapy.[59]

Minimum recommendations for PDMP use include:

- Check the PDMP before starting any patient on opioid therapy.
- Review the PDMP periodically throughout opioid therapy (at least every three months).
- Look for, and document, prescriptions for other controlled substances, like benzodiazepines, that can increase risk of overdose death.
- Review the total MME per day.

Toxicology testing

All patients on long-term opioid therapy should be periodically (at least annually) tested for substance use.[59] Universal testing (testing all patients in an identical manner) may help de-stigmatize testing and remove any perceived bias related to who is tested. Effort should be made to ensure toxicology testing is not financially burdensome or treatment limiting to patients. Toxicology testing should be framed as a therapeutic, rather than a punitive, component of treatment.[123] Rather than setting up an “us vs. them” mentality, toxicology testing can actually improve the therapeutic alliance by transferring the role of detector from the clinician to the test.[123] The 2022 CDC guidelines echo these suggestions. [59]

Although urine remains the most common matrix for toxicology testing, technology using saliva, sweat, exhaled breath, and hair has become increasingly sophisticated, albeit with a currently-limited evidence base.[123] Advantages of non-urine testing include their relative simplicity, ease of administration, and reduction in the possibilities of sample tampering.

The two main types of urine toxicology testing are immunoassay (“presumptive” testing) and chromatography/mass spectrometry (“definitive” testing) (see Table 5 for details). Providers using urine toxicology tests should be familiar with the metabolites and expected positive results based on the opioid prescribed. For example, a patient taking oxycodone may test positive for both oxycodone and oxymorphone (a metabolite).[61] Obtain definitive testing and discuss results with patients prior to making clinical decisions.

Table 5: Comparison of two major types of urine toxicology testing

Immunoassay	Gas chromatography/mass spectrometry
less expensive, fast, easy to use	more expensive, labor intensive
most frequently used test in all settings	requires advanced laboratory
commonly used for screening	used mostly to confirm positive immunoassay result
engineered antibodies bind to metabolites	directly measures substance and its metabolites
qualitative testing: positive or negative results only	quantitative test with precise results
does not differentiate between various natural opioids	differentiates all opioids
typically misses semi-synthetic and synthetic opioids (e.g., fentanyl, oxycodone, buprenorphine)	more accurate for semi-synthetic and synthetic opioids
often has high cut-off levels giving false negative results	very sensitive to low levels of a substance, minimizing false negatives
may show false positives from poppy seeds, quinolone antibiotics, or over the counter medications	very specific, less cross-reactivity, low rates of false positives

Prior to any type of toxicology testing, discuss the following points with the patient:[124]

- purposes/goals of testing
- framing of testing as a normal part of standard safety measures that does not imply a lack of trust on the part of the provider
- what substances the test covers
- timing and dose of opioids and other substances consumed recently
- potential costs if testing is not covered by insurance
- possibility of random testing, depending on treatment agreement and monitoring approach
- what might happen based on test results

When results of a toxicology test come back, clinicians should:[124]

- inform the patient of the results
- discuss any unexpected results or findings of substance use (note: it can be helpful to ask patients beforehand what they expect the toxicology test will show)
- review the treatment agreement and reiterate concerns about the patient's safety
- determine if frequency and intensity of monitoring should be increased

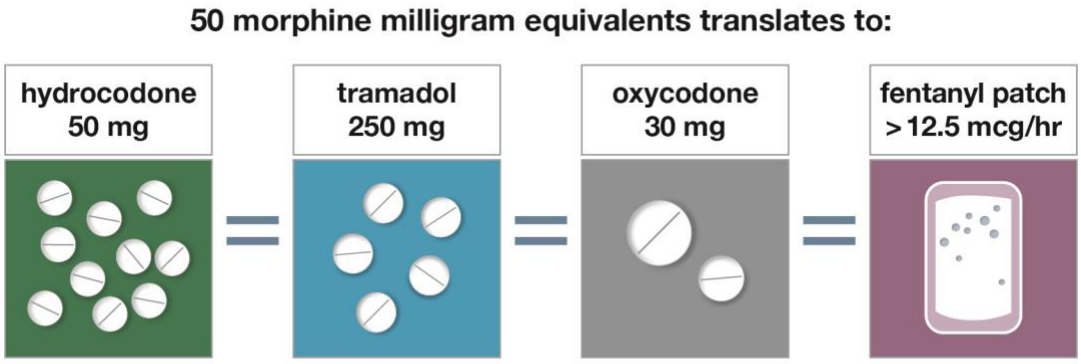
Decision tools and help with interpreting urine toxicology results are available at mytopcare.org.

Caution with dose escalation

When escalating opioid doses, be aware of the 50 MME/day dosing threshold.[61] According to the CDC, doses >50 MME/day are associated with more than double the risk of overdose compared to patients on <50 MME/day.[61] The effect on pain is minimal, and doses higher than 50 MME/day are not associated with functional improvement.[59] The total MME/day for all

prescribed opioids should be noted and monitored. MME/day is automatically calculated on many state PDMP reports but should be confirmed by asking patients how prescribed opioids are being taken.

Figure 8: Morphine equivalents of commonly prescribed opioids for 50 MME/day[59]



Role of ER/LA opioids and methadone

ER/LA opioids include methadone, transdermal fentanyl, and extended-release versions of opioids such as oxycodone, oxymorphone, hydrocodone, and morphine. A 2015 study found a higher risk for overdose among patients initiating treatment with ER/LA opioids than among those initiating treatment with immediate-release opioids.[125] Continuous, time-scheduled use of ER/LA opioids is not more effective or safer than intermittent use of immediate-release opioids. It will quickly lead to tolerance/physical dependence, and may increase risks for opioid misuse or addiction.[61] When starting opioids, begin with immediate release options for both acute and chronic pain.[59]

ER/LA opioids should be reserved for severe, continuous pain and should be considered only for patients who have received immediate-release opioids daily for at least one week.[61] Additional caution is required when prescribing ER/LA opioids in older adults or patients with renal or hepatic dysfunction because decreased clearance of medications among these patients can lead to accumulation of medications to toxic levels and persistence in the body for longer durations.

When an ER/LA opioid is prescribed, using one with predictable pharmacokinetics and pharmacodynamics is preferred to minimize unintentional overdose risk. The unusual characteristics of methadone and transdermal fentanyl make safe prescribing of these medications for pain especially challenging.[61]

The use of methadone for chronic pain in primary care should generally be avoided because of higher methadone-related risks for QTc prolongation and fatal arrhythmias.[61] Equianalgesic dose ratios are highly variable with methadone, making conversion from other opioids difficult, with attendant increased risk of overdose. Death rates related to methadone for analgesia are much lower than rates associated with other opioids and have remained relatively stable. The methadone death rate was 0.5 per 100,000 in 2001, it increased to 1.8 in 2006, then declined gradually to 1.1 in 2021.[126] If methadone is considered, refer patients to pain management specialists with expertise in using this medication. Also, clinicians should not use methadone as a treatment for OUD outside of an Opioid Treatment Program setting.

Prescribe naloxone

Naloxone (e.g., Narcan, Kloxxado, Zimhi, generics) is an opioid antagonist that quickly reverses the effects of opioid overdose. Naloxone is the formulary option within IHS. Given the long distances from emergency health services that exist on many tribal lands, prescription of opioid reversal agents is particularly important in this patient population. Primary care providers should prescribe naloxone to all patients at risk of overdose, and facilities should implement policies to increase community access to naloxone following guidance on this issue in the Indian Health Manual.[127] Indications include

- opioid dose >50 MMED
- renal or hepatic dysfunction
- co-prescription of benzodiazepines or other sedating medications
- patients who smoke, have COPD, asthma, or sleep apnea
- history of overdose or diagnosis of OUD or other substance use disorder

All 50 states have in place a standing order or protocol that allows patients, family members, caregivers, and/or friends to request naloxone from their local pharmacist.[128] Twenty states have some form of co-prescribing requirement with 12 requiring naloxone co-prescribing in certain cases such as high MME/day dose, concurrent benzodiazepine use, or prior history of overdose. Rates of naloxone co-prescription have been rising nationwide in recent years but remain very low in absolute terms. Naloxone dispensing increased from 0.55 per 100,000 population in 2012 to 292.3 per 100,000 population in 2019.[129] The highest rate of naloxone dispensing occurred in states with a co-prescribing requirement. By the end of 2020, naloxone prescribing in the Medicare population dropped significantly,[130,131] although this is likely due to a decline in opioid prescriptions for chronic pain more generally.[131]

In May 2023, the FDA approved nalmefene, an opioid antagonist, as a 2.7 mg nasal spray (Opvee) to reverse the effects of opioids. It has a longer duration of action than naloxone and slower onset.[132]

Anyone receiving an overdose-reversing agent should be taught how to use the particular device and about the common signs of overdose (slow or shallow breathing, gasping for air, unusual snoring, pale or bluish skin, not waking up or responding, pinpoint pupils, slow heart rate). A variety of agents are available (Table 6, next page). The intramuscular (IM) vials require the most manipulation in order to administer. Intranasal naloxone and the IM/SQ injector are easier to use but vary greatly in terms of price and insurance coverage.

Table 6: Dosage forms available for naloxone

	Intranasal		IM/subcutaneous (SQ)	Intramuscular (IM)
				
Brand name	Narcan	Kloxxado	Zimhi	—
Strength	4 mg/0.1 mL	8 mg/0.1 mL	5 mg/0.5 mL	0.4 mg/1 mL
Sig for suspected overdose	Spray full dose into one nostril.	Spray full dose into one nostril.	Follow steps on device.	Inject 1 mL into shoulder or thigh.
Second dose	Repeat into other nostril after 2-3 min if no or minimal response.	Repeat into other nostril after 2-3 min if no or minimal response.	Repeat after 2-3 min if no or minimal response	Repeat after 2-3 min if no or minimal response.
How supplied	2 sprays	2 sprays	1 injector	2 syringes
Cost	$136 (Narcan) $73 (generic)	$150	$156	$35

Depending on the opioid involved in the overdose, more than one dose may be required. All patients who receive an opioid-reversing agent should be taken to an emergency room in case additional doses or other medical support is needed.

Screen for opioid use disorder

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) algorithm can help primary care providers identify patients with problematic opioid use or potential OUD. SBIRT assesses the severity of opioid use, is brief (typically 5-10 minutes), and targets behaviors specific to substance use.

Patients reporting significant impairment or distress as a result of their opioid use may have OUD. More than 2.7 million Americans have OUD, and the number is growing.[133] OUD can be effectively managed with medications, but only an estimated 1 in 10 of adults with OUD currently receive such treatment.[134]

OUD is defined as problematic opioid use leading to significant impairment or distress. It is marked by at least two of the following in the past 12 months:[73]

- use of opioids at higher doses or longer than prescribed
- unsuccessful attempts to control or reduce use
- significant time lost obtaining, consuming, or recovering from opioids
- craving for opioids
- failure to fulfill obligations (i.e., work, home, or school) because of opioid use
- persistent social or interpersonal problems due to opioids
- opioid use displaces social, work, or recreational activities
- recurrent opioid use creates a hazardous situation (e.g., while driving)
- continued use despite a physical or psychological problem caused or worsened by opioid use
- tolerance or withdrawal in patients taking opioids other than as prescribed

Medication options include:

- methadone
- buprenorphine (as buprenorphine/naloxone tablets, buccal film, or sublingual film (e.g., Suboxone, Zubsolv, generics) or subcutaneous injection (e.g., Sublocade, Brixadi)
  - all buprenorphine products for OUD have an associated Risk Evaluation and Mitigation Strategy (REMS)
- naltrexone extended-release injection (Vivitrol)

Buprenorphine and methadone are both effective for helping patients avoid relapse and regain function, and they both have proven mortality benefit in treatment of OUD.[135] However, they are different chemically and also in how they can be prescribed/used (Table 7). (Note that buprenorphine can also be prescribed for pain, and formulations include a patch [Butrans], sublingual film [Belbuca], and injection [Buprenex].)

Table 7: Comparison of buprenorphine and methadone

	Buprenorphine	Methadone
Who can provide treatment	any prescriber with a DEA license with Schedule III authority	certified opioid treatment program
Treatment delivery	no daily clinic visits are required	supervised daily administration or limited take-home treatment
Patient characteristics	preferred as first line treatment for most patients	helpful for patients who have had multiple unsuccessful treatment attempts, and/or need daily support
OUD severity	moderate to severe	moderate to severe
Initiating treatment	home or in office	certified opioid treatment program locations
When to start	patient must have mild to moderate withdrawal symptoms	any time

Naltrexone, as an injectable (Vivitrol), may be an option for patients who have successfully completed a detoxification protocol (7-10 days of abstinence from opioid use).[136]

For more information about identifying and managing patients with OUD, see IHS.gov/opioids/recovery/

Naloxone vs. Naltrexone

Naloxone (Narcan) is an opioid antagonist given by injection or nasal spray to reverse overdoses. It acts within minutes and lasts for only about an hour due to rapid metabolism.

Naltrexone is also an opioid antagonist but has very different effects. It can be given orally or by injection, and can precipitate acute withdrawal in a patient who is still taking opioids. Once successfully initiated, it can block opioid cravings for about a month with the injectable formulation.

Taper opioids

While the goal is to provide flexible, individualized, patient centered care, for some patients the best decision may be to reduce or stop opioids for pain management when the risks outweigh the benefits.[137] Forced or rapid tapers for patients who are physiologically dependent on opioids are not recommended.[59] These recommendations do not apply to pregnant patients, who should be managed by someone experienced in identifying and managing opioid withdrawal in a pregnant patient and the fetus.[59]

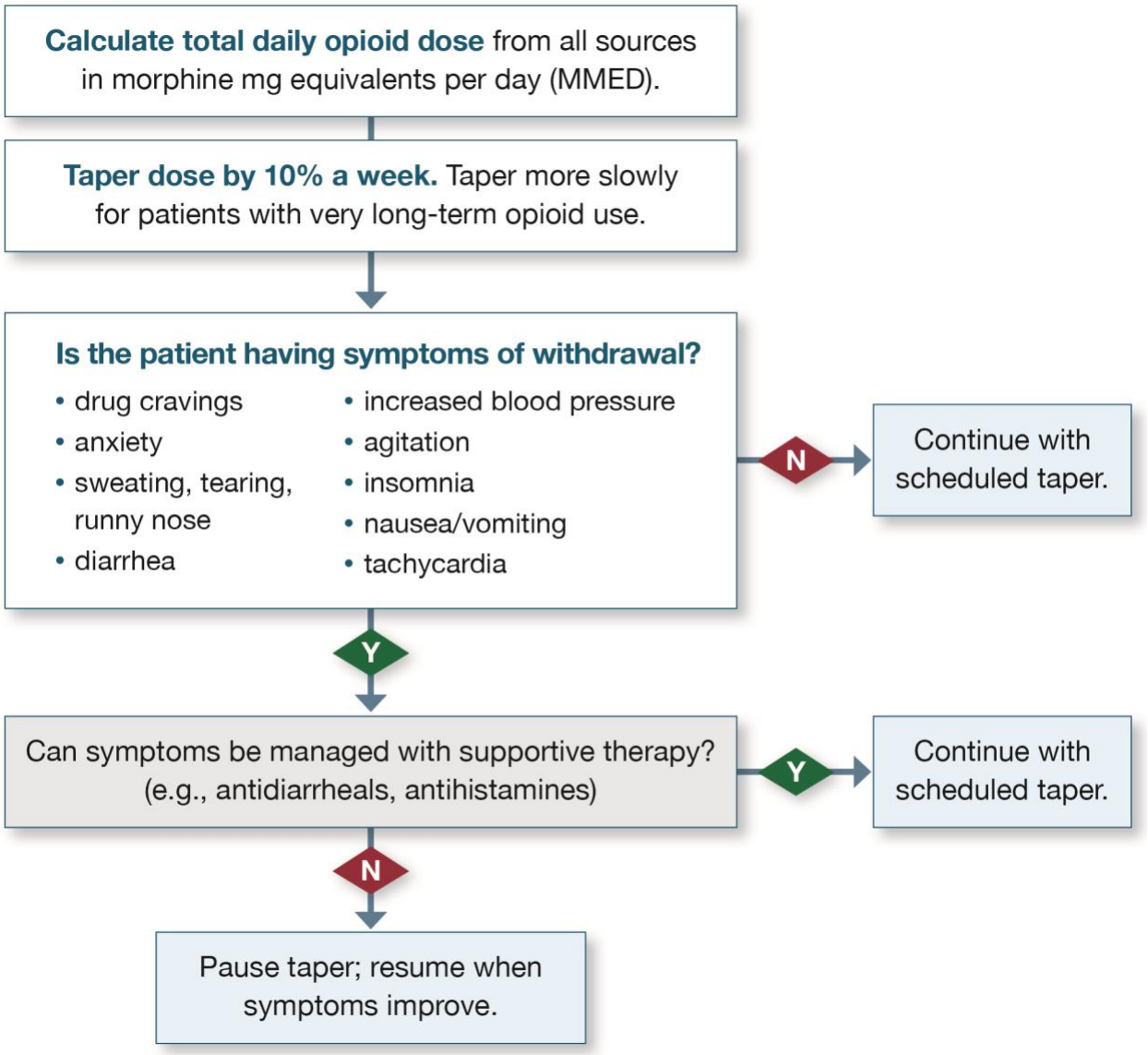
Patients who do not achieve functional goals on stable or increasing opioid doses, have diminished quality of life, have unacceptable side effects (such as an overdose, hospitalization, or injury), or have had healing of the injury (for acute pain) should be engaged in a plan to taper or discontinue opioids.[138] Patients sometimes resist tapering or discontinuation, fearing increased pain. However, a 2020 systematic review found that dose reduction or discontinuation resulted in a decrease in pain severity (9 studies), improvement in pain-related function (7 studies), increase in quality of life (4 studies), and improvement in anxiety and depression symptoms (4 studies).[139] A 2018 retrospective study of 551 veterans with chronic pain (mostly musculoskeletal) assessed pain one year before and one year after discontinuation of long-term opioids (MME/day 75.8 mg).[140] Pain was assessed on a 0-10 scale with higher score indicating worse pain. The mean overall pain score at the time of discontinuation was 4.9, and pain scores dropped during discontinuation by a mean of 0.2 points/month. Patients with moderate pain experienced the greatest reduction in pain after discontinuation.

Recommendations for tapering schedules vary and should always be individualized. The rate of opioid taper should be adjusted based on patient-specific factors such as the severity of withdrawal symptoms One way to recommend a taper is based on duration of opioid use:[59]

- ≤ 3 days of scheduled use or as needed: no taper required
- > 3 days but < 7 days of scheduled use: 50% reduction over two days
- ≥ 7days but ≤ 1 month: 20% reduction every 2 days
- ≥ 1 month but ≤ 1 year: 10% reduction every week
- ≥ 1 year: 10% reduction each month

Another approach to managing an opioid taper is presented in Figure 9. Note, that this is an example opioid taper plan; each taper should be individualized based on patient specific factors including length of time on opioid therapy and patient response to taper.

Figure 9: Tapering algorithm



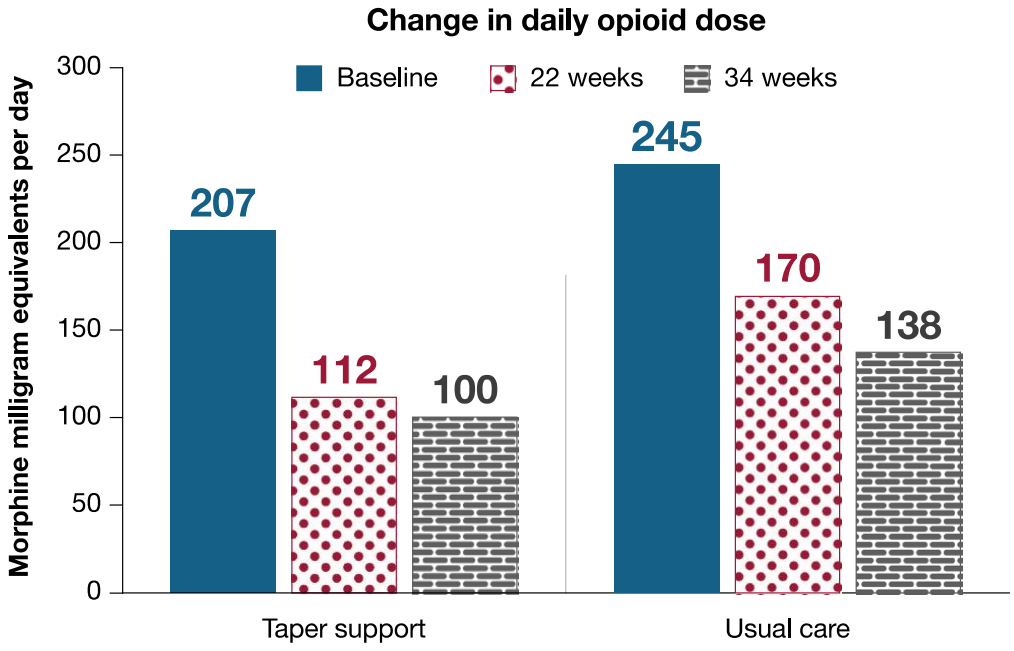
When symptoms of opioid withdrawal appear during a taper, the first approach should be to pause or slow the rate of the taper. Short term use of medications to help address symptoms of opioid withdrawal may be needed to help with specific symptoms. Examples include:

- central-acting alpha agonists (such as clonidine or lofexidine [Lucemyra]) for autonomic symptoms such as sweating or tachycardia
- loperamide for diarrhea
- ondansetron for nausea
- trazodone for insomnia

- dicyclomine for stomach cramping
- hydroxyzine for anxiety, dysphoria, lacrimation, rhinorrhea
- acetaminophen or NSAIDs for myalgias

A structured support program for opioid tapering may improve outcomes. A small trial of 35 patients with long-term opioid use compared a structured intervention including weekly individual counseling sessions vs. standard care and found reduced opioid doses in the intervention group at 34 weeks (mean 100 MME/day vs. 138 MME/day) although the difference was not statistically significant (Figure 10).[141] Pain scores decreased in both groups by about one point on a 10-point scale (not significant).

Figure 10: Change in daily opioid dose[141]



In 2019, the FDA, recognizing the risks associated with abrupt discontinuation of opioid analgesics, required new labeling for opioid analgesics to guide prescribers about safe tapering practices.[142] The key elements include:[142]

- Do not abruptly discontinue opioid analgesics in patients physically dependent on opioids.
- Counsel patients not to discontinue their opioids without first discussing the need for a gradual tapering regimen.
- Abrupt or inappropriately rapid discontinuation of opioids is associated with serious withdrawal symptoms, uncontrolled pain, and suicide.
- Ensure ongoing care of the patient and mutually agree on an appropriate tapering schedule and follow-up plan.
- In general, taper by an increment of no more than 10-20% every 2-4 weeks.
- Pause taper if the patient experiences significantly increased pain or serious withdrawal symptoms.
- Use a multimodal approach to pain management, including mental health support (if needed).

- Reassess the patient regularly to manage pain and withdrawal symptoms that emerge and assess for suicidality or mood changes.
- Refer patients with complex comorbidities or substance use disorders to a specialist when needed.

While the intent of opioid dose reduction and discontinuation is to decrease harms associated with opioid use, recent observational studies have identified some risks of increased harms such as withdrawal symptoms, increased risk of the development of other substance use disorders, opioid overdose, and suicide. A 2020 systematic review found very low to low quality evidence in observational studies that abrupt discontinuation and/or tapering of opioids led to OUD/overdose (4 studies) and suicidal ideation or suicidal self-directed violence (2 studies).[139] An additional observational review found that among patients who have their long-term opioid therapy discontinued or tapered, there is an increased risk of illicit opioid use, increase in opioid-related hospital and ED visits, increased incidence in mental health crises or overdose events, and increased risk of death from suicide.[143] While these risks have not been seen in patient level data, when factors affecting opioid prescribing are available (such as in randomized controlled trials) these flags are nonetheless concerning. Ensuring access to overdose-reversing agents, assessing for mental health concerns or inadequate treatment of conditions like anxiety and depression, and engaging additional support for patients with mental health concerns can help with pain management and can reduce risks of unintended adverse effects from tapering.

Converting to buprenorphine

A question often arises: can buprenorphine provide adequate pain control for those already on full agonist opioids? How can a patient successfully transition from a full agonist opioid to a partial agonist such as buprenorphine? A 2021 systematic review analyzed 22 studies that included patients transitioning from various full agonist opioids for reasons including inadequate analgesia, intolerable adverse effects, risky opioid regimens, and aberrant opioid use. Very low-quality evidence suggested that rotation to transdermal or buccal buprenorphine was associated with maintained or improved analgesia with a low risk of precipitating opioid withdrawal when transitioned appropriately.[144]

Prior to transitioning from a full agonist opioid to a partial agonist such as buprenorphine, a period of mild-to-moderate opioid withdrawal is required. Novel approaches, including using small doses of buprenorphine in conjunction with full agonist opioids (micro-dosing) have been studied in patients with OUD to avoid this period of mild-moderate opioid withdrawal and decrease the risk of precipitated withdrawal on starting buprenorphine. A 2022 systematic review reviewed these novel induction approaches in patients with OUD, with chronic pain, or both. Overall, there was no significant difference in successful rotation to sublingual buprenorphine between patients in the traditional initiation group (95.6%) and patients in the micro-dosing group (96%).[145]

Why convert from a full opioid receptor agonist to buprenorphine?[100]

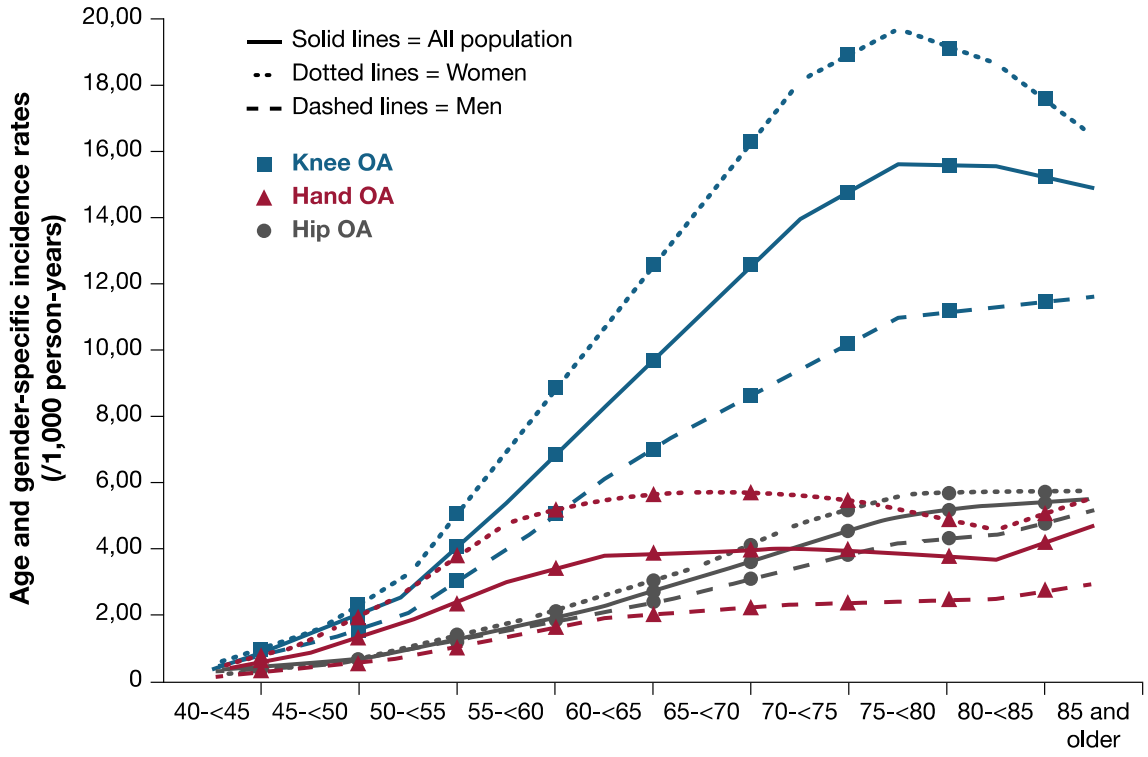
- lack of efficacy (including tolerance or hyperalgesia)
- risk of adverse effects from using a full mu-agonist opioid
- risk of addiction, misuse, and/or overdose
- limited ability to utilize oral formulations in patients with altered gastrointestinal motility/function

Some organizations provide suggestions for how to transition from one full agonist opioid to buprenorphine (qrco.de/VA_bup_chronicpain).

Osteoarthritis

Osteoarthritis (OA) is a common source of pain and disability that affects nearly 70% of those over 65 years of age.[146] The joints involved tend to be the hand, hip, and knee, with knee being most common. As shown in Figure 11, more women than men suffer with OA.[147]

Figure 11: Incidence rates of OA by involved joints[148]



Non-pharmacologic options

Exercise and physical activity

Evidence demonstrates that exercise and physical activity can modestly reduce pain and improve function in patients with OA.

Table 8: Effects of exercise on pain and function for knee and hip OA[22,149]

		Effect on pain		Effect on function	
Condition	**# of RCTs**	**SMD**	**Relative Change**	**SMD**	**Relative change**
OA of knee	44	-0.49	27% (21-32%)	-0.52	26% (20-32%)
OA of hip	9	-0.38	28% (14-38%)	-0.38	24% (3-42%)
SMD = standardized mean difference					

A 2018 Cochrane review of 21 randomized trials including 2,372 patients with hip, knee, or hip and knee OA found that exercise-based interventions reduced pain scores (on a 0-20 scale) by a mean of 1.2 points after about 45 weeks (6% absolute reduction compared to non-exercise treatments; 95% CI: -9% to -4%).[150] Physical functioning improved by 5.6 points on a 0-100 scale but the result was not significant (absolute difference -5.6%; 95% CI: -7.6% to 2%). Exercise interventions were diverse and included tai chi, physical therapy, strength training, and aerobic exercise (e.g., walking, cycling).

The importance of clear patient education about the potential benefits of exercise for patients with OA was suggested by results from a review of 12 qualitative studies, conducted as part of the same Cochrane review. The authors noted that patients are often worried that they might hurt themselves by exercising, or that the exercise might worsen their symptoms. Patients wanted providers to give better information about the safety and value of exercise as well as exercise recommendations tailored to individual patient needs and abilities.[150]

Exercise programs delivered via internet or smart phone can also be effective. At 6 weeks, an app-based exercise program reduced pain scores vs. usual care by 1.5 points (95% CI: 0.8-2.2) on a scale from 0-10 and improved function 3.4 points (95% CI: 0.7-6.2) using the 68 point Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC).[151] A web-based intervention with text message support found longer term benefit vs. a control website with a reduction in knee pain (mean difference 1.6; 95% CI: 0.9-2.2) on a scale from 0-10 and improvement in function (mean difference 5.2; 95% CI: 1.9-8.5) on the WOMAC index at 24 weeks.[152] The program is available for free at mykneeexercise.org.au/my-knee-strength/.

Tai chi

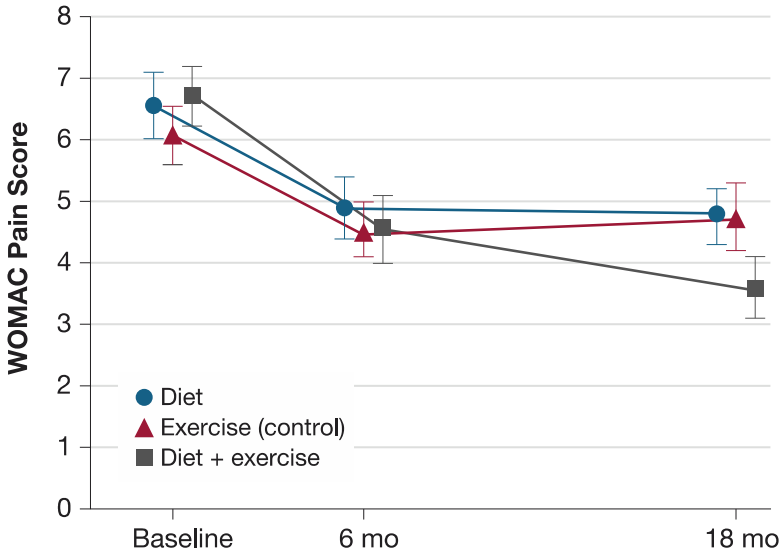
A meta-analysis of 15 randomized trials in patients with musculoskeletal pain (due to OA in 80%) found tai chi to be moderately effective compared to no intervention in improving both pain (SMD -0.66; 95% CI: -0.85 to -0.48) and disability (SMD -0.66; 95% CI: -0.85 to -0.46) at up to 3 months.[153] No statistically significant differences were observed at 3 months to 1 year, or >1 year.

A randomized trial with 204 adults with symptomatic knee OA compared 12 weeks of twice-weekly tai chi vs. standard physical therapy and followed patients for 52 weeks. Both study arms showed significant improvements from baseline pain scores at 52 weeks, but there was no statistically significant difference between groups in terms of pain or function.[154]

Weight loss

Weight loss interventions studied for OA typically focus on joint stress or injury rather than pain. However, in the **Intensive Diet and Exercise for Arthritis (IDEA)** randomized trial, the investigators assessed pain as a secondary outcome.[25] The study included 545 older adults with knee OA and overweight who were randomized to one of three approaches: diet plus exercise, diet alone, or exercise alone. Diet focused on calorie restriction to achieve at least a 10% reduction in body weight. The recommended exercise program called for one hour of aerobic and strength training activities three times a week. Pain was measured with the WOMAC pain subscale at baseline, 6 months (end of intervention), and 18 months (Figure 12). At 18 months the diet plus exercise intervention was associated with greater pain reduction than the diet or exercise alone groups. In the diet plus exercise group 38% of patients reported little or no pain compared with 20% and 22% of patients with diet or exercise alone, respectively (P=0.002 for both comparisons).[25]

Figure 12: WOMAC pain scores across 18 months[25]



WOMAC function scores improved significantly in the diet plus exercise group compared to the diet group (mean difference 4.29 points; P<0.001) and the exercise alone group (mean difference 3.3 points; P=0.003).[25] Secondary analyses of the IDEA trial also showed that there were significant dose responses to weight loss for pain (P=0.01), function (P<0.01), physical (P<0.01) and mental (P=0.03) health-related quality of life in adults with overweight or obesity and knee OA. 18-month weight loss of 10-20% of baseline body weight had substantial clinical benefits, including less pain, compared with less weight loss.[155] Five year follow up of 94 patients from IDEA suggests that improvement in pain compared to baseline was maintained and weight remained lower, though it rose from the end of the original trial period.[156] Given the significant drop-out, the long term impact on weight reduction is unclear.

Obesity impacts recovery after total knee replacement. A trial of 82 obese patients who were waiting to receive a total knee replacement were randomized to either undergo bariatric surgery prior to joint surgery or treatment as usual prior to knee replacement.[157] Patients who had bariatric surgery had significantly fewer post-operative complications compared to those with treatment as usual (difference 22%; 95% CI: 3.7-40.3%; p=0.02). Secondary outcomes suggested no difference in pain or function. Incidentally, after bariatric surgery, 12 patients (29.3%) declined knee surgery while 2 patients (4.9%) declined knee replacement in the treatment as usual group.

Yoga

A review of 12 studies (including four RCTs) involving 589 patients with OA symptoms comparing a variety of yoga regimens to usual care found some evidence that pain, stiffness, and swelling were reduced, although no meta-analyses were conducted due to clinical heterogeneity. No effect on physical function was observed.[158]

A randomized trial of 131 patients (mean age 75) with lower extremity OA compared twice-weekly sessions of chair yoga vs. a health education program.[159] At 3-month follow-up, participants in the yoga group showed greater reductions in pain interferences (P=0.01) compared to control. During the intervention, patients in the yoga group had reduced pain on the WOMAC scale (P=0.048), and improved

gait speed (P=0.024) compared to the control group, but the differences were not sustained at 3-month follow-up.[159]

Acupuncture

A Cochrane review of six randomized trials evaluating acupuncture in 413 patients with hip OA (mean age range 61 to 67 years) found conflicting evidence on its effects on pain and function.[160] In analysis of two trials with 105 patients comparing acupuncture to sham acupuncture there were no significant differences after 5-9 weeks in pain (absolute mean difference in pain score 2.1%; 95% CI: -7.9% to 3.6%) or function (absolute reduction 2.1%; 95% CI: -7.3% to 3%). One trial, however, that compared 13 weeks of acupuncture plus routine primary care vs. routine primary care alone in 137 patients found reduced pain (mean score at follow-up on 0-100 scale 26.3 points vs. 49.2 points; P<0.0001) and improved function (mean score 30.2 points vs. 49.2 points; P<0.001). Two trials reported minor side effects with acupuncture, mostly bruising, bleeding, or pain at needle insertion site.

An unblinded trial randomized 221 adults with hip or knee OA to acupuncture, sham acupuncture, or mock electrical stimulation.[161] After five weeks of treatment no significant differences in mean improvements on a 0-100 pain scale were found for any comparisons.

Massage

An RCT of Swedish massage vs. light touch in 222 adults with osteoarthritis found significant improvement in pain and function compared to light touch and usual care at eight weeks. The short-term improvement in pain and function attenuated over time with no difference in either outcome between light touch and Swedish massage at 52 weeks.[162]

A review of seven randomized trials with 352 participants suggests that massage may be better than no treatment for reducing OA pain.[163] The trials were diverse with respect to outcomes, massage techniques, and patient populations. Clinical effect sizes for pain were moderate with about a 20-point reduction in WOMAC scores from a baseline of 50-60 points. The functional benefits were less clear; some trials showed no benefit while others showed improvements in the 50-foot walk test.[28,163]

Cognitive behavioral therapy (CBT)

Current evidence does not support a benefit for CBT as a treatment for OA. A randomized trial of 111 patients randomized to group CBT or control found no difference in pain or function at three and 12 months.[164] Similarly, an RCT of 180 non-Hispanic white and 180 non-Hispanic African American patients with OA comparing a positive psychological skills program with a neutral program (control) found no benefit in pain or function between the two treatment groups at 1, 3, or 6 months.[165]

Self-management education programs

Small effects were noted in three meta-analyses of studies evaluating self-management education programs, though the benefits were not considered clinically important (Table 9, next page).[166-168] Arthritis-specific programs included techniques to deal with problems associated with arthritis, appropriate exercises and medications, nutrition, and effective communication with healthcare providers and family.

Table 9: Self-management education programs[166-168]

Meta-analysis	Number of RCTs	Setting	Effect sizes vs. controls (lower scores indicate improvements)
Chodosh, et al. 2005	14 (pain) 12 (function)	OA	-0.05 (pain) -0.06 (function)
Warsi, et al. 2003	17	OA and RA	-0.12 (pain) -0.07 (function
Foster, et al. 2008	11 (pain) 8 (function)	OA and low back pain	-0.10 (pain) -0.15 (function)

Other non-pharmacologic interventions

Transcutaneous nerve electrostimulation (TENS) has been used for pain relief for decades, but studies evaluating effectiveness have shown mixed results. Data from four trials, including two RCTs, showed no statistical improvement in pain over placebo.[169]

Mindfulness meditation for chronic pain was evaluated in a meta-analysis of 30 randomized trials (5 trials of questionable quality in patients with OA or rheumatoid arthritis [RA]) and suggest a moderate improvement in pain (standardized mean difference 0.32, result limited by significant heterogeneity) compared to standard care, passive controls, or education/support groups.[31]

Non-pharmacologic summary for OA

Exercise should be encouraged based on patient ability. Evidence supporting the effectiveness of non-pharmacologic interventions for OA is limited, but these interventions are generally safe and therefore may be considered as first-line or adjunctive treatments. For a complete summary of the non-pharmacologic interventions presented, see Appendix I.

Pharmacologic options

Acetaminophen

A 2019 Cochrane review of 10 randomized trials comparing acetaminophen vs. placebo in 3,541 patients with knee or hip OA found small, but not clinically important, reductions in pain and improvements in function with acetaminophen (mean daily doses ranged from 1950 mg to 4000 mg) when used from between 3 weeks and 3 months.[170] Mean change in pain scores (scale 0-100) were 26 points for acetaminophen vs. 23 points for placebo (absolute reduction 3%; 95% CI: 1%-5%, minimum clinically important difference 9%). Mean change in physical functioning scores (scale 0-100) were 2.9 points better for acetaminophen compared to placebo (absolute improvement 3%; 95% CI: 0.95%-4.89%; minimum clinically important difference 10%). These results should be interpreted cautiously, however, because daily acetaminophen doses of ~2,000 mg may not be effective over longer time frames (i.e., 3 months). The incidence of adverse events was similar between groups (risk ratio 1.01; 95% CI: 0.92-1.11).[170]

Generally, scheduled dosing of acetaminophen is better than as-needed dosing for relief of chronic pain. The recommended starting dose of acetaminophen for elderly patients is 325 mg every 4 hours, with a maximum daily dose of 3,000 mg.[42,171]

NSAIDs

Given the inflammatory mechanism of OA, NSAIDs are the first-line pharmacologic option for managing OA-related chronic pain. In a network meta-analysis of 76 randomized trials evaluating oral celecoxib, ibuprofen, or naproxen vs. placebo in 58,451 patients with knee or hip OA, NSAIDs were associated with small-to-moderate effect sizes for improvements in pain (standard mean difference [SMD] range: 0.32-0.57) and function (SMD range: 0.31-0.51), although results were not significant for naproxen at daily dose of 750 mg, or ibuprofen at daily dose of 1,200 mg.[172]

A 2017 Cochrane review of trials comparing topical NSAIDs vs. placebo in patients with hand or knee OA found moderate evidence for analgesia, with greater pain relief seen in trials of shorter durations (Table 10).[173]

Table 10: NNTs to obtain 50% reduction in pain with topical NSAIDs[173]

NSAID	Trial duration	# of studies	# of patients	Number needed to treat (NNT)
diclofenac	<6 weeks	5	732	5
diclofenac	6-12 weeks	4	2343	10
ketoprofen	6-12 weeks	4	2573	7

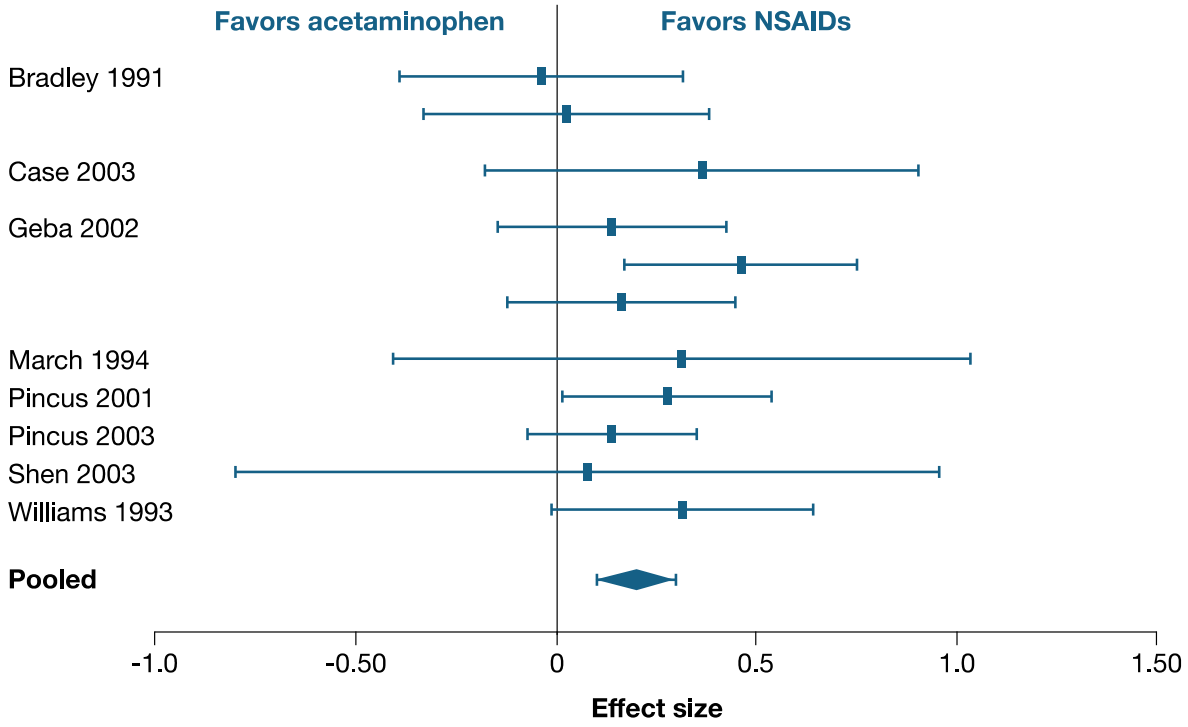
Topical vs. oral NSAIDs

Topical NSAIDs may be as effective as oral NSAIDs for OA pain. A randomized trial of 282 older patients with chronic knee pain comparing oral vs. topical ibuprofen found equivalent changes in the WOMAC OA index (mean difference on 0-100 point scale was 2 points; 95% CI: -2 to 6 points).[174] While side effects in the study did not vary between oral and topical NSAIDs, a small, statistically significant increase in serum creatinine was observed for oral NSAIDs. Generally, topical NSAIDs are considered safer due minimal systemic absorption. Topical NSAIDs may be recommended over oral NSAIDs for localized, single joint pain (e.g., knee OA).[42]

Acetaminophen vs. NSAIDs

A meta-analysis of six trials comparing acetaminophen and NSAIDs in patients with OA found a small, but statistically significant, treatment effect favoring NSAIDs (effect size 0.2; 95% CI: 0.1-0.3; P<0.05), as shown in Figure 13 (next page). NSAIDs, therefore, are preferred over acetaminophen unless patients have high risk for gastrointestinal, renal, or cardiovascular adverse effects.[171]

Figure 13: Effect size of pain reduction from baseline[171]



Serotonin-norepinephrine reuptake inhibitors (SNRIs)

A meta-analysis of three trials of duloxetine for patients with knee OA showed patients on duloxetine (60 or 120 mg daily) were 49% more likely to have a moderate pain response (≥30% reduction in pain intensity).[175] Overall the mean difference in pain score with duloxetine compared to placebo on a 0-10 scale was -0.88 points (95% CI: -1.11 to -0.65 points). Physical function (assessed by the WOMAC subscale, range 0-68) improved by a mean difference of -4.25 points (P<0.001). A small pilot study suggests a possible role for venlafaxine sustained-release, but further study is needed.[176] No SNRIs are FDA approved to treat OA.

Membrane stabilizers

A small RCT of 89 patients with knee OA suggests pregabalin may reduce pain and improve function compared to the NSAID meloxicam, but the combination of meloxicam with pregabalin was better than either alone.[177] The study lasted four weeks, and longer-term RCT data are still needed. Pregabalin is not FDA approved for OA.

Topical lidocaine

A 12-week RCT of 143 patients with knee OA found that a lidocaine 5% patch had similar effects on OA pain and function as celecoxib 200 mg daily using WOMAC pain and function subscales.[178] However, lidocaine patches are not FDA approved for the treatment of OA, and more data are needed to support their use.

Tramadol

A Cochrane review of eight RCTs of 3,972 patients using tramadol for 1 week to 3 months for OA found small improvements in pain (SMD -0.25; 95% CI: -0.32 to -0.18) with 50% more patients reporting a 20% improvement in pain with tramadol compared to placebo. Small improvements in function were found (SMD -0.2; 95% CI: -0.29 to -0.12). For both pain and function the number of patients needed to treat for one patient to benefit (NNT) is 13.[179]

Opioids

A Cochrane review of 22 trials of 8,275 patients using opioids, including buprenorphine, for knee or hip OA found small reductions in pain (SMD -0.28; 95% CI: -0.35 to -0.20) and improvements in function (SMD -0.26; 95% CI: -0.35 to -0.17) compared to placebo at follow-up periods <16 weeks.[180] Intermittent, as-needed use is preferred because time-scheduled use can be associated with greater total average daily opioid dosage. As noted earlier, however the **SPACE trial**, which included 240 patients with moderate to severe chronic low back pain or knee or hip osteoarthritis, found no significant differences in pain-related functioning comparing regimens of morphine, oxycodone, or hydrocodone to non-opioid analgesics (e.g., acetaminophen, NSAIDs, antidepressants, membrane stabilizers) at any time points up to one year.[5]

Other treatment options

Glucosamine and chondroitin, either alone or in combination, do not provide long-term benefit in OA. A small number of clinical trials demonstrated that maximum effects were achieved at 3-6 months.[181]

Topical capsaicin gel reduced pain 53% from baseline compared to a 27% reduction with placebo in one 12-week study. In a review of 2 studies, redness and a burning sensation was reported by 44% and 46% of patients, respectively, who were randomized to capsaicin.[182] A 2018 network meta-analysis of 28 trials, however, found that topical capsaicin 0.025% four times daily and topical NSAIDs were equally effective for relieving pain in patients with knee or hand OA (the effect size of topical NSAID vs. placebo was 0.32 [95% CI: 0.24-0.39] in direct comparison of 13 trials, and the effect size of capsaicin vs. placebo was 0.41 [95% CI: 0.17-0.64] in direct comparison of 4 trials).[183]

Intra-articular injections

A number of injectable intra-articular agents are available to manage knee OA pain, with the two most-recently-approved being the synthetic corticosteroid triamcinolone acetonide extended-release injection (Zilretta) and single-injection hyaluronic acid gel (Durolane). The evidence base for these treatments, however, is very weak, with effects frequently time-limited and study outcomes focused on surrogate (non-clinical) outcomes (such as cartilage and joint structure) rather than clinical ones (such as pain and function).[181] A meta-analysis of 14 double-blind, sham-controlled trials with at least 60 patients in each trial found no clinically relevant differences between hyaluronic acid and sham injections.[184] Two randomized trials comparing single injection hyaluronic acid gel (Durolane) vs. placebo in a total of 564 patients with knee OA found no significant differences in pain, function, or joint stiffness at 6 weeks or 26 weeks.[185,186]

Surgery

OA is a common reason for joint replacement surgery. For older patients with functionally disabling chronic pain unresponsive to other therapies for about six months or who have significant reduction in quality of life due to end-stage OA, surgery may provide relief.[187]

Pharmacologic summary for OA

NSAIDs remain the most effective pharmacologic therapy for managing OA, with duloxetine, acetaminophen, and pregabalin as second-line options. Opioids should be reserved for patients with moderate-to-severe pain for whom all other options have been ineffective or intolerable. No evidence supports intra-articular hyaluronic acid injections for knee OA. Intra-articular injections of steroids may provide short term relief. For a complete summary of the pharmacologic interventions presented, see Appendix I.

Low back pain

Low back pain (LBP) is one of the most common reasons for primary care visits in the U.S., and about 25% of U.S. adults reported having LBP lasting at least a day in the past three months.[188] Imaging is of limited utility in diagnosing the cause of LBP because most patients have nonspecific findings, and asymptomatic patients often have abnormal findings. Magnetic resonance imaging (MRI) is recommended for red flag symptoms (for example, incontinence or saddle anesthesia), radicular symptoms, or risks for pathologic fracture.[189]

Guidelines recommend trying nonpharmacological options such as exercise, multidisciplinary rehabilitation, acupuncture, or yoga as first-line treatments for chronic low back pain, followed by pharmacologic treatment with an NSAID.[188] If the patient has an inadequate response, second-line options are duloxetine or tramadol. Other opioids should be reserved for patients with pain unresponsive to all other treatments, with all of the caveats and cautions described previously[190], although some experts in pain medicine assert that opioids should never be used to treat nonstructural low back pain.[191]

Non-pharmacologic options

Exercise

In a review of 19 RCTs, exercise provided small reductions in pain with a weighted mean difference (WMD) of 10 points on a 0-100 scale (95% CI: 1.3-19.1 points) compared to no exercise. Small, but not statistically significant, improvements in function were also observed (WMD 3 points; 95% CI: -0.53 to 6.48 points).[192] Types and duration of exercise from RCTs included in the meta-analysis were not specified.

Early physical therapy for low back pain, particularly with sciatica, can have lasting effects. A trial of acute low back pain randomized 220 patients to usual care or early physical therapy which entailed 6 to 8 sessions over a 4-week timeframe. Oswestry Disability index scores (range 0-100) improved 8.2 points (95% CI: 4.3-12.1) at 4 weeks, a clinically important difference. Sustained, if attenuated, improvements continued at 6 months (5.4; 95% CI: 1.3-9.4) and 1 year (4.8; 95% CI: 0.7-8.9). Small improvements in

back pain (score range 0-10) were noted as well with reductions of 1.4 points at 4 weeks, 0.7 points at 6 months, and 1 point at 1 year.[193]

Tai chi

Two trials (n=160 and n=320) found that compared to wait list or no tai chi, tai chi reduced pain on a 0- to 10-point scale (mean difference [MD] 1.3 points; P<0.001 and MD 0.9 points; P<0.05 respectively) although these differences may not be clinically important.[194,195] The first trial randomized 160 adults with persistent non-specific low back pain to tai chi (18 sessions, 40 minutes each, over a 10-week period) vs. usual care. In addition to reducing pain, tai chi reduced "bothersome" back symptoms by 1.7 points, and improved self-report disability by 2.6 points on the 0-24 Roland-Morris Disability Questionnaire scale (RMDQ).[194]

Weight loss

Only small, uncontrolled pilot studies suggest possible benefit from weight loss for patients with chronic low back pain.[196,197] After bariatric surgery, there was a 44% reduction in pain and a 26% improvement in function from a BMI reduction of 3 kg/m^2 (n=58).[196] Calorie restriction among obese patients suggests a reduction in pain and a significant improvement in function (n=46).[197] A meta-analysis of weight-loss interventions identified two low to moderate quality RCTs for low back pain with no benefit to pain, improvement in disability, weight loss, or changes in mental health status.[198]

Yoga

Several relatively high-quality RCTs suggest that yoga can modestly reduce chronic low back pain. A 2017 study, for example, found that people with chronic LBP who took weekly yoga classes for 12 weeks had less pain and greater physical function compared to those who just got information about how to deal with back pain.[199] The yoga in the study emphasized strengthening back and core muscles. In addition to reducing pain, those in the yoga group were more likely to have stopped taking pain relievers at one-year follow-up. A 2012 systematic review comparing yoga to standard care found moderate effect sizes for reductions in pain-related disability, with evidence that even short-term interventions might be effective.[200]

A 2017 Cochrane review of 9 RCTs involving 810 participants with chronic low back pain found small to moderate improvements in pain and function associated with yoga compared to no-exercise controls (see Table 11). For pain, a clinically meaningful reduction in pain score based on the RMDQ of 15 points was not achieved.[201]

Table 11: Yoga: improvement in pain and function[201]

	3-4 months effect size (95% CI)	6 months effect size (95% CI)	12 months effect size (95% CI)
pain (weighted difference)	-4.55 (-7.04 to -2.06)	-7.81 (-13.37 to -2.25)	-5.40 (-14.5 to -3.7)
function (standard mean difference)	-0.40 (-0.66 to -0.14)	-0.44 (-0.66 to -0.22)	-0.26 (-0.46 to -0.05)

A 2020 meta-analysis of 18 studies found similar benefits for pain and function over time. However at one year the benefit for pain attenuated, becoming no different from placebo at 12 months, while functional improvements were maintained at 12 months (SMD -0.33; 95% CI: -0.54 to -0.12).[202]

Acupuncture

A 2017 systematic review of four trials evaluating acupuncture vs. sham acupuncture in patients with chronic LBP found non-significant reductions in pain (WMD -16.7 points on a 0-100 scale; 95% CI: -33.3 to -0.19 points), but no improvements in function.[192] Comparing acupuncture to no acupuncture resulted in larger effect sizes, but the quality of the evidence is lower due to the large placebo effects known to manifest in acupuncture studies without a sham comparison.[192] A 2020 Cochrane review of 33 RCTs for non-specific LBP found acupuncture reduced pain (mean difference -12.30; 95% CI: -15.28 to -9.32) and improved function (SMD -0.44; 95% CI: -0.55 to -0.33) based on intermediate term follow-up vs. usual care. No long-term trials (i.e., 12 months or longer) were identified.[203]

Massage

A 2015 Cochrane review of 25 RCTs compared massage vs. inactive (e.g., sham treatment or waitlist) or active (e.g., TENS, acupuncture, traction, physical therapy) controls in 3,096 adults with LBP.[204] Massage compared to sham massage or no treatment was associated with moderate reductions in pain (SMD -0.75; 95% CI: -0.9 to -0.6) and disability (SMD -0.72; 95% CI: -1.05 to -0.39) in the short term (<6 months), but not in the long-term. In studies comparing massage to active therapies, massage resulted in greater pain reduction both in the short term (SMD -0.37; 95% CI: -0.62 to -0.13), and in the long term (SMD -0.40; 95% CI: -0.80 to -0.01), but no difference in disability reduction was observed.[204]

TENS

Several clinical studies indicate that compared to sham or placebo, TENS has no beneficial effect on pain or function.[188,204-206]

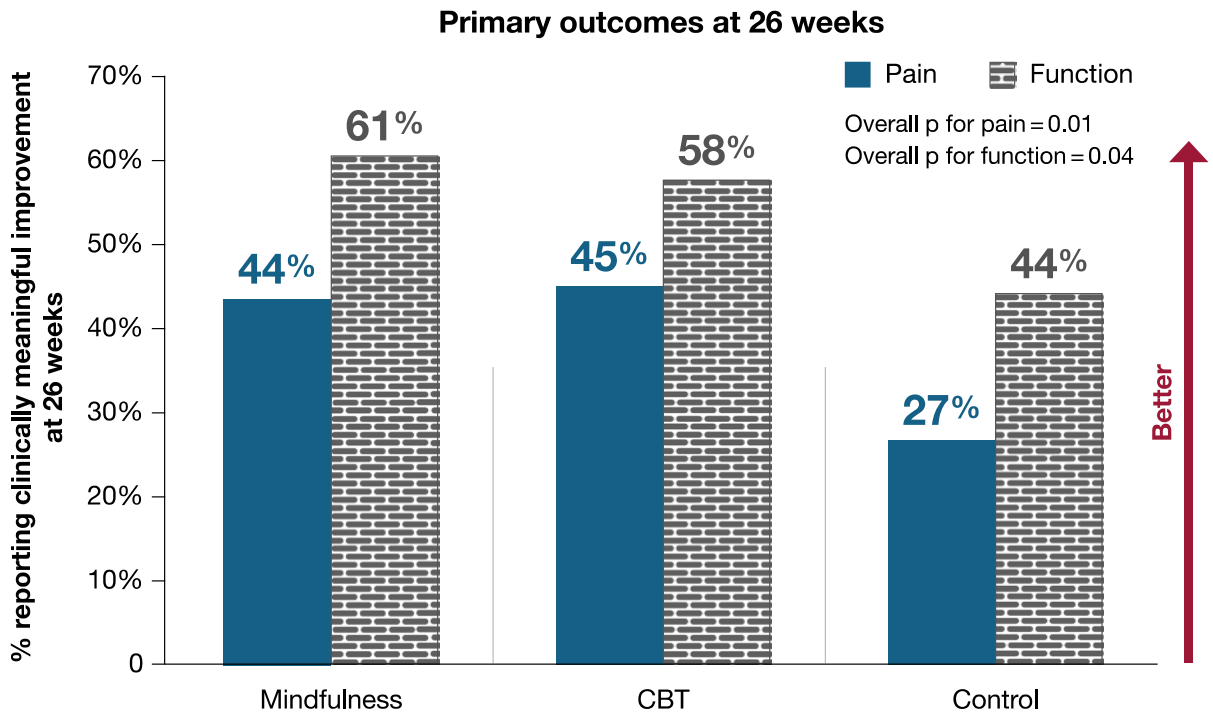
Cognitive and behavioral/mindfulness therapies

A systematic review evaluating CBT found large improvements in disability scores (SMD -0.88; 95% CI: -1.50 to -0.26) but a moderate reduction in pain intensity compared to controls (SMD -0.73; 95% CI: -1.20 to -0.26).[207] One randomized trial of CBT of 701 adults with subacute and chronic LBP found moderate improvement in RMDQ at 3 months (the end of the intervention), with sustained benefit in function and improvement in pain at 12 months compared with usual care.[208] Mindfulness training was associated with small improvements in pain (SMD -0.30; 95% CI: -0.47 to -0.13) but no improvement in disability.[207]

An RCT of 521 patients with chronic LBP randomized patients to CBT, mindfulness training, behavioral therapy or usual care. By the end of the 8-week intervention, pain improved significantly in the intervention groups compared to usual care. This benefit persisted at 6-month follow-up. Functional benefits were not seen during the intervention but appeared during 6 month follow-up, suggesting persistence of benefit beyond the intervention timeframe.[209]

Another trial randomized 342 patients with chronic LBP to CBT, mindfulness-based stress reduction, or usual care. Both the CBT and the mindfulness intervention consisted of eight weekly two-hour classes. Both mindfulness and CBT were associated with greater improvements in pain and function compared to usual care at 26 weeks (with benefit persisting at 52 week follow-up vs. usual care) with no statistically significant differences between CBT and mindfulness groups (Figure 14).[210]

Figure 14: Primary outcomes at 26 weeks[210]



A randomized trial of 342 adults with LBP found that participating in 8 weekly training sessions in mindfulness meditation was associated with significantly higher levels of function and reduced pain compared to usual care (61% vs. 44%, p=0.04).[210] The neural correlates of the analgesic effects of mindfulness meditation were explored in a trial at Wake Forest University in which 76 healthy volunteers were taught mindfulness meditation and then monitored with MRI while a pain-inducing heat device was applied to their leg for six minutes.[211] Meditation reduced pain unpleasantness by more than half (57%) and pain intensity by 40%.

Self-management

Self-management programs showed small effects on pain and function. Based on a meta-analysis of 11 studies, a small reduction in pain was observed (SMD -0.10; 95% CI: -0.17 to -0.04) while eight RCTs demonstrated a small improvement in disability (SMD -0.15; 95% CI: -0.25 to -0.05).[212]

Spinal manipulation

Chiropractic care typically involves manual therapy, including spinal manipulation, which may be augmented with exercises, massage, electrical or laser stimulation, nutritional counseling, or other approaches. Manual treatment techniques used by chiropractors may involve stretching, pressure, or joint manipulations (typically on the spine, but sometimes on other joints).

Evidence from a 2019 meta-analysis of 47 randomized trials involving 9,211 patients with chronic back pain found that spinal manipulation had similar effects to other recommended therapies for short term

pain relief (e.g., exercise or pharmacologic treatments), and was slightly better than no treatment or non-recommended treatments.[213] A review of professional guidelines for the use of spinal manipulation for low back pain suggests that it be considered a second-line or adjuvant treatment option after exercise or CBT.[214] A 2020 updated evidence review by the Agency for Healthcare Research and Quality found that spinal manipulation improved function and/or pain for lower back injury and tension headaches, but not for fibromyalgia, hip or knee osteoarthritis, or neck pain.[215]

Non-pharmacologic summary for chronic low back pain

Tai chi, yoga, acupuncture, cognitive behavioral therapy and mindfulness-based stress reduction can modestly reduce pain and improve function in patients with chronic, nonspecific LBP. Other interventions such as exercise and self-management have smaller or mixed effects, but all of these interventions are generally considered safe. Guidelines recommend initiating non-pharmacologic therapies for managing chronic LBP as the first step in treatment.[188] For a complete summary of the non-pharmacologic interventions presented, see Appendix I.

Pharmacologic options

Acetaminophen

Two small trials have evaluated acetaminophen in patients with chronic LBP. A trial conducted in the early 1980s randomized 30 patients to 1000 mg acetaminophen four times daily vs. the NSAID diflunisal 500 mg twice daily for 4 weeks.[216] Another trial randomized 45 patients with either acute or chronic LBP to 500 mg acetaminophen vs. amitriptyline 37.5 mg four times daily.[217] No significant differences were found between acetaminophen and diflunisal in pain relief or reduced disability, and acetaminophen was less effective than amitriptyline for reducing pain.[218]

No trials have compared acetaminophen vs. placebo for chronic pain. However a 2016 Cochrane review of three trials with 1,825 patients with acute LBP found high-quality evidence that acetaminophen was no more effective than placebo for pain, disability, function, and quality of life.[219]

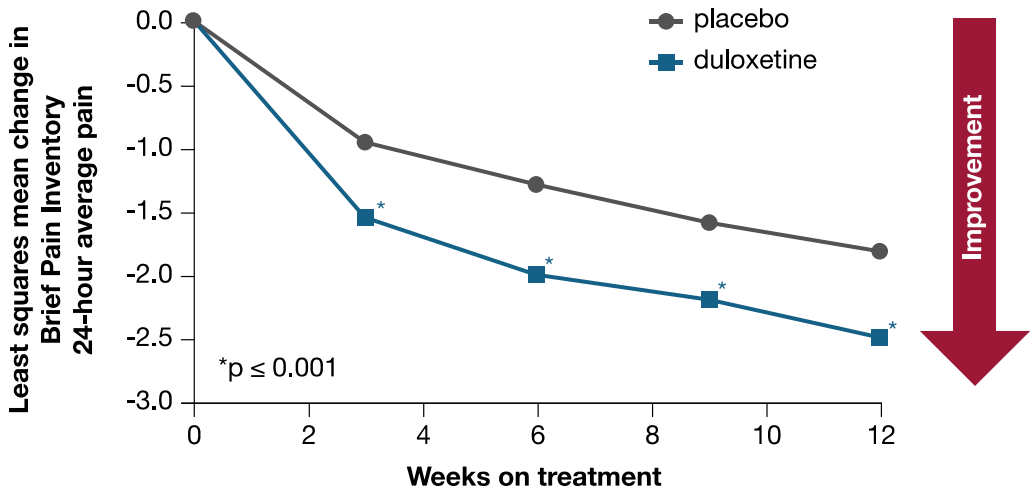
NSAIDs

A review of six RCTs for the American College of Physicians showed that oral NSAIDs are more effective than placebo regarding pain intensity, with a small reduction in pain at 12 weeks (WMD -12.4 points on a 0-100 scale; 95% CI: -15.53 to -9.26).[220] No differences in efficacy between different NSAIDs, including non-selective NSAIDs vs. selective COX-2 inhibitors, were identified. An additional PEER systemic review of randomized controlled trials for the management of chronic low back pain in primary care identified four RCTs with 1,637 patients on oral NSAIDs who were followed for 4 to 16 weeks.[221] 55% of patients receiving oral NSAIDs and 37% receiving placebo attained meaningful pain relief (RR 1.44; 95% CI: 1.17-1.78; NNT=6). Individual adverse events reported and trial withdrawals were simliar between groups. One RCT compared topical NSAID flurbiprofen vs. placebo in 127 individuals with chronic LBP.[222] No statistical difference in cumulative pain intensity was found (p=0.30).

Antidepressants

An analysis of three moderate-quality RCTs found small improvements in pain and function with duloxetine vs. placebo at 12 to 13 weeks.[223] One of the studies involved 401 patients randomized to duloxetine 60 mg daily or placebo. Compared with placebo, duloxetine-treated patients reported a significantly greater reduction (P≤0.001) in pain on the BPI (Figure 15).[224] The other two trials found similar results, although one did not maintain significance at 13 weeks.[225,226]

Figure 15: Change in BPI score duloxetine vs. placebo[224]



A 2021 meta-analysis supports this finding, adding one additional study from the prior analysis.[227] Disability improved between 3 to 13 weeks on duloxetine vs. placebo (mean difference -3.55; 95% CI: -5.22 to -1.88). While statistically significant, the pain benefit is unlikely to be clinically important and those in duloxetine arms had greater adverse effects.

The same 2021 review did not identify any reduction in pain or improvement in function with TCAs, SSRIs trazodone, or bupropion.[227]

Membrane stabilizers

A systematic review identified nine trials comparing topiramate, gabapentin, or pregabalin to placebo in 859 individuals. Fourteen of 15 comparisons found membrane stabilizers ineffective in reducing pain or disability in chronic LBP. Gabapentin was accompanied by an increased risk for adverse events.[228]

Topical lidocaine

Evidence supporting the use of lidocaine in chronic LBP is mixed. Five open-label studies reported statistically significant reductions on pain severity and improvements in quality of life, however, two RCTs failed to find a difference vs. placebo.[229]

Tramadol

In the short term, tramadol reduced pain moderately more than placebo (SMD -0.55; 95% CI: -0.66 to -0.44) with small improvements in function (SMD -0.18; 95% CI: -0.29 to -0.07).[223]

Buprenorphine

Transdermal and buccal buprenorphine have reduced pain in patients with chronic LBP compared to placebo, but functional improvements are less clear.[223] A systematic review and network meta-analysis suggests buprenorphine is more than two times more likely to achieve a 30% reduction in pain than placebo (OR 2.29; 95% CI: 1.05-5.07). Pain reduction was similar between buprenorphine and full-agonist opioids.[230]

Other opioids

The risks associated with using opioids for chronic LBP are likely to outweigh potential benefits. A systematic review of RCTs published through November 2016 found that compared to placebo, opioids provided small short-term pain relief for chronic LBP and small improvement in function, but had a higher risk of nausea, vomiting, dizziness, somnolence, constipation, and dry mouth.[223] No difference in pain response was observed between immediate release or ER/LA opioid products. None of the reviewed trials evaluated the long-term effect (>1 year) of opioids on either pain or function.[223]

In addition, as noted earlier, the **SPACE trial**, which included patients with moderate to severe chronic LBP, found no significant differences in pain-related functioning comparing regimens of morphine, oxycodone, or hydrocodone to non-opioid analgesics (e.g., acetaminophen, NSAIDs, antidepressants, membrane stabilizers) at any time points up to one year.[5]

Muscle relaxants

While widely prescribed, use of skeletal muscle relaxants for chronic LBP is not supported by evidence.[223] A 2021 systematic review analyzed 31 trials of 6,505 patients comparing muscle relaxants vs. placebo in non-specific LBP.[231] Most trials evaluated muscle relaxants in acute low back pain. Those that looked at chronic LBP did not find evidence of improvement for pain or disability.

Additional interventions

Epidural steroid injections

Lumbar epidural steroid injections under fluoroscopic guidance are commonly used to treat low back and lower extremity radicular pain,[232] although evidence for their efficacy is weak. A 2008 Cochrane review of 18 trials (1,179 patients) with subacute or chronic LBP (without meta-analyses due to clinical heterogeneity) found insufficient evidence to support the use of injection therapies.[233]

Spinal fusion

An RCT of 349 patients with chronic low back pain comparing spinal fusion surgery to intensive rehabilitation showed small functional benefits in favor of surgery (mean difference in Oswestry disability index [0-100 scale] -4.1; 95% CI: -8.1 to -0.1; P=0.045). The minimum clinically important difference on

the Oswestry scale is estimated to be between 4 and 17. Those assigned to surgery had more complications (dural tears, excessive bleeding, repeat surgery).[234]

Pharmacologic summary for chronic low back pain

NSAIDs are the first-line pharmacologic option if non-pharmacologic options are inadequate. Duloxetine can be considered a second-line treatment. Acetaminophen may be tried for chronic LBP. For a complete summary of the pharmacologic interventions presented, see Appendix I.

Diabetic neuropathy

Neuropathy has a lifetime prevalence of 30%-50% in patients with diabetes and most commonly affects the distal extremities in a symmetric fashion causing numbness, tingling, pain, loss of vibratory sensation, and altered proprioception. Improved glucose control may reduce the risk of acquiring diabetic neuropathy and slow its progression,[235] and in those who have neuropathy, pain management may improve quality of life.[236]

Current American Diabetes Association guidelines suggest initial management with pregabalin, duloxetine, or gabapentin.[237] Second-line options include TCAs (use cautiously in older adults), venlafaxine, carbamazepine, or topical capsaicin. Opioids, and particularly tapentadol, are not recommended to treat neuropathy due to their high risk for addiction and limited efficacy.[237] Tapentadol is FDA approved for treatment of diabetic neuropathy, but the approval was based on two trials that used a design enriched for patients who responded to tapentadol and the results are therefore not generalizable. Because tapentadol incurs similar risks of addiction and safety compared to typical opioids, its use is generally not recommended as first- or second-line therapy for neuropathic pain.

Non-pharmacologic options

Movement-based options

A small RCT of 39 Korean patients with type 2 diabetes and neuropathy found tai chi improved quality of life on five domains, including pain, physical functioning, social functioning, vitality and a mental component score, compared with usual care, but there was no significant difference in neuropathy scores.[238]

Acupuncture and massage

The evidence for the effectiveness of acupuncture and massage on symptoms of diabetic neuropathy is limited to several small studies. A pilot study of 46 patients found overall symptom improvement from baseline with acupuncture in 77% of patients with 67% discontinuing medication. However, the study did not have a control group nor did it specifically identify pain as an endpoint.[239] A 4-week trial with 46 patients showed that, compared to usual care, aromatherapy and massage reduced pain and improved quality of life.[240] A 2014 trial randomized 45 patients to acupuncture vs. sham acupuncture for 10 weeks and found no significant differences in pain outcomes (SMD -0.43; 95% CI: -1.02 to 0.16).[241] Further studies are required before acupuncture or massage can be recommended for managing pain in diabetic neuropathy.

TENS

A Cochrane review of 15 trials of TENS for peripheral neuropathic pain identified five trials comparing TENS to sham TENS in 204 patients. Using a visual analog scale, TENS significantly reduced pain (mean difference -1.58; 95% CI: -2.09 to -1.09) although the evidence was found to be very low quality. Heterogeneity in the 10 trials of TENS vs. usual care precluded meta-analysis.[242] Another meta-analysis of three small trials comparing TENS vs. placebo in 78 patients with diabetic neuropathy found reduced pain severity at four weeks (SMD -5.37 points; 95% CI: -6.97 to -3.77 points) and six weeks (SMD -1.01 points; 95% CI: -2.01 to -0.01 points) but not at 12 weeks.[243]

An analysis by the Agency for Healthcare Research and Quality, however, did not find significant or compelling evidence to suggest TENS was more effective than placebo for diabetic neuropathy.[244]

Cognitive and behavioral interventions

Little data support cognitive and behavioral interventions for patients with diabetic neuropathy. A small trial of 20 patients receiving CBT showed a greater decrease in pain scores at 4-month follow-up, compared with usual care.[245] A small study of 20 patients found no difference with mindfulness-based stress reduction vs. placebo on pain or quality of life.[246]

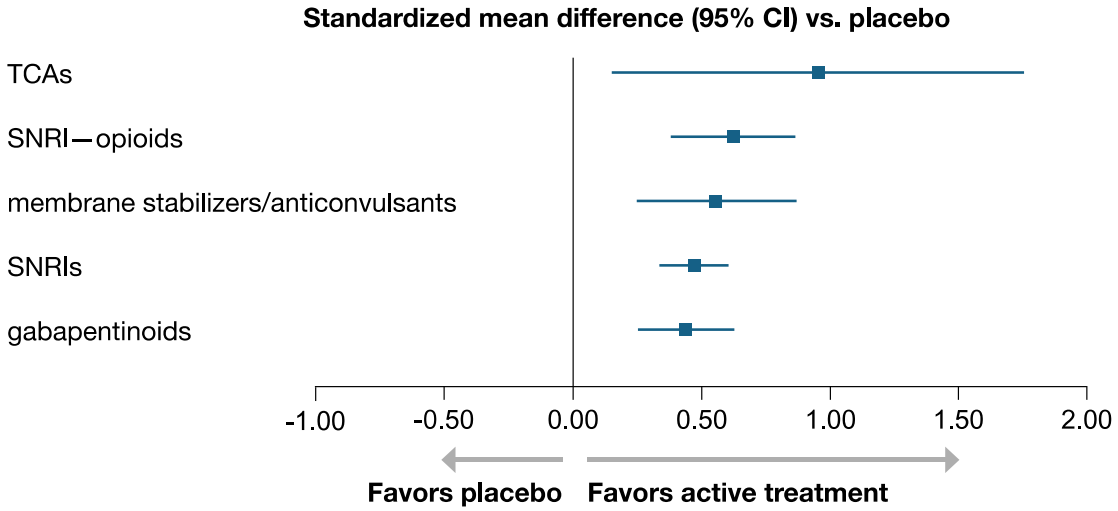
Non-pharmacologic summary for diabetic neuropathy

Few non-pharmacologic options have been studied or shown to be effective for diabetic neuropathy. For a complete summary of the non-pharmacologic interventions presented, see Appendix I.

Pharmacologic options

Pregabalin, duloxetine, and tapentadol are FDA approved for the treatment of neuropathic pain in diabetes. Other medications, such as gabapentin, oxcarbazepine, TCAs, topical lidocaine or capsaicin have been used off-label with varying degrees of success. A meta-analysis of evidence, conducted by an American Academy of Neurology (AAN) guidelines subcommittee, showed that gabapentinoids, SNRIs (e.g., duloxetine), sodium channel blockers (e.g., lidocaine, carbamazepine), and SNRI/opioid dual mechanism agents (e.g., tramadol) all have comparable effects on pain (Figure 16).[247] Decisions about which medication may be best depend on patient factors such as comorbidities. Unless significant side effects manifest, trials of 12 weeks at optimal doses determine treatment efficacy.[247]

Figure 16: Similar efficacy among common medications to treat pain from diabetic neuropathy[247]



Acetaminophen and NSAIDs

No published trials have evaluated the use of acetaminophen alone or NSAIDs, either oral or topical, for diabetic neuropathy.

SNRIs

Both duloxetine and venlafaxine have been shown to reduce pain related to diabetic neuropathy compared to placebo. A network meta-analysis found relatively large effect sizes for pain reduction for duloxetine vs. placebo (SMD -1.33; 95% CI: -1.82 to -0.86 in four trials), and venlafaxine vs. placebo (SMD -1.53; 95% CI: -2.41 to -0.65 in three trials).[248] 457 patients with painful diabetic neuropathy were randomized to one of three duloxetine dosage groups (20 mg/day, 60 mg/day, and 120 mg/day) or placebo for 12 weeks.[249] At follow-up, the mean daily pain severity score in the placebo group had dropped 1.91 points (on a 0-10 scale), with greater reductions in the three duloxetine groups: 2.36 points in the 20 mg group (not significant vs. placebo), 2.89 points in the 60 mg group (P<0.001 vs. placebo), and 3.24 points in the 120 mg group (P<0.001 vs. placebo).[249]

TCAs

TCAs studied for diabetic neuropathy include amitriptyline, imipramine, and desipramine. A meta-analysis of five RCTs found a modest effect size for pain reduction for amitriptyline (SMD -0.72; 95% CI: -1.35 to -0.08).[248] The AAN 2022 analysis of evidence has also shown that amitriptyline is more likely than placebo to improve pain; however, there was low confidence in the significance of the effect size, and additional analyses revealed that amitriptyline was no more likely to improve pain than gabapentin.[247] Adverse effects with TCAs included somnolence and dizziness, which may be particularly important in older patients.

Membrane stabilizers

Gabapentinoids

In a meta-analysis of 16 RCTs with 4,017 patients, pregabalin was effective at reducing pain compared with placebo (SMD -0.34; 95% CI: -0.50 to -0.18).[250] Similarly, oxcarbazepine modestly reduced pain compared to placebo (SMD -0.45; 95% CI: -0.68 to -0.21) in an analysis of 3 trials with 634 patients.[250]

Gabapentin is commonly prescribed off-label to treat diabetic neuropathy. Based on a review of five RCTs with 766 patients, gabapentin had a large overall effect on pain severity, however, the result was not statistically significant (SMD -0.73; 95% CI: -1.54 to 0.09).[250] The AAN analysis showed that gabapentin was more likely than placebo to improve pain (SMD 0.53; 95% CI: 0.22 to 0.84; values > 0 indicating intervention is clinically better than placebo); the conclusion was based on one study that was deemed of acceptable quality to be included in the analysis.[247]

A 2019 Cochrane review of 20 randomized trials compared pregabalin 75-600 mg/day for 4-15 weeks vs. placebo in 5,943 patients with painful diabetic neuropathy.[251] Pregabalin 300 mg/day modestly increased the likelihood that patients would have:

- >30% reduction in pain intensity (RR 1.1; 95% CI: 1.01-1.2)
- >50% reduction in pain intensity (RR 1.3; 95% CI: 1.2-1.5)
- “much” or “very much” improvement on Patient Global Impression of Change score (RR 1.8; 95% CI: 1.5-2)

Doubling the pregabalin dose to 600 mg/day did not result in substantially different levels of pain reduction. Rates of somnolence and dizziness were significantly higher with pregabalin vs. placebo.

The American Diabetes Association recommends using pregabalin, duloxetine, or gabapentin as the initial treatment.[237]

Other membrane stabilizers

Carbamazepine, topiramate, valproic acid, lacosamide, oxcarbazepine, and lamotrigine can be as effective as gabapentinoids and SNRIs for neuropathic pain, though their use is off-label and associated with side effects.[247]

Topical lidocaine

Although lidocaine patches are FDA approved for post-herpetic neuralgia, no RCTs of patches have been conducted in patients with diabetic neuropathy. One open-label, 4-week trial of 300 patients with painful diabetic polyneuropathy or post-herpetic neuralgia evaluated 5% lidocaine medicated plaster vs. pregabalin. In post-herpetic neuralgia, more patients responded to 5% lidocaine medicated plaster treatment than to pregabalin (62.2% vs. 46.5% [no P value reported]), while response was comparable for patients with painful diabetic polyneuropathy (in the per-protocol set): 66.7% vs. 69.1% (no P value reported).[252]

Cannabinoids

Weak evidence suggests that medical cannabinoids may reduce pain related to diabetic neuropathy.

A Cochrane review of 16 randomized trials published through November 2017 comparing cannabis-based treatments to placebo in 1,750 adults with chronic neuropathic pain found slight reductions in pain intensity (SMD 0.35; 95% CI: 0.09-0.60) and increased numbers of patients achieving 50% or greater reductions in pain (21% vs. 17%; risk difference 0.05; 95% CI: 0-0.09).[253] The results, however, are limited by poor trial quality (only 2 trials were judged high-quality) and heterogeneity in treatments (10 trials evaluated an oromucosal spray containing THC or CBD, 2 trials evaluated a synthetic THC, 2 trials evaluated plant-derived THC, and 2 trials evaluated inhaled herbal cannabis). Similarly, a 2018 systematic review found a small signal that cannabinoids likely improved pain by 30% or greater. This benefit was limited to short term use, less than five weeks.[254] There were no significant differences in the rates of serious adverse events, but more people reported sleepiness, dizziness, or confusion in the cannabis groups.

None of the reviewed studies evaluated long-term efficacy and safety of cannabinoid exposure.

Tramadol

Due to their effect on serotonin and norepinephrine receptors, tramadol and tapentadol are thought to be slightly more effective than other opioids at reducing pain in diabetic neuropathy. An analysis of five placebo-controlled RCTs (three of tapentadol and two of tramadol) showed that these opioids were more effective at reducing pain at up to 12-weeks (SMD -0.68; 95% CI: -0.80 to -0.56 vs. placebo).[250] Both medications, as noted earlier, are associated with all of the risks and adverse events common to typical opioids, though tramadol is theoretically preferred over tapentadol in regard to serious opioid-related adverse events, given its weaker opioid agonist effect. No studies have evaluated long-term efficacy or safety of these agents in patients with diabetic neuropathy.

Buprenorphine

A 12-week trial of transdermal buprenorphine for diabetic neuropathy found patients were no more or less likely to have a 30% pain reduction compared to placebo.[255] Nearly 2 in 5 patients dropped out of the study in the buprenorphine arm due to side effects, primarily nausea and vomiting.

Other opioids

Opioid analgesics are ineffective for treating pain in diabetic neuropathy based on an analysis of pooled data from four RCTs (SMD -0.58; 95% CI: -1.53 to 0.36) comparing opioids to control. This analysis excluded tramadol and tapentadol.[250]

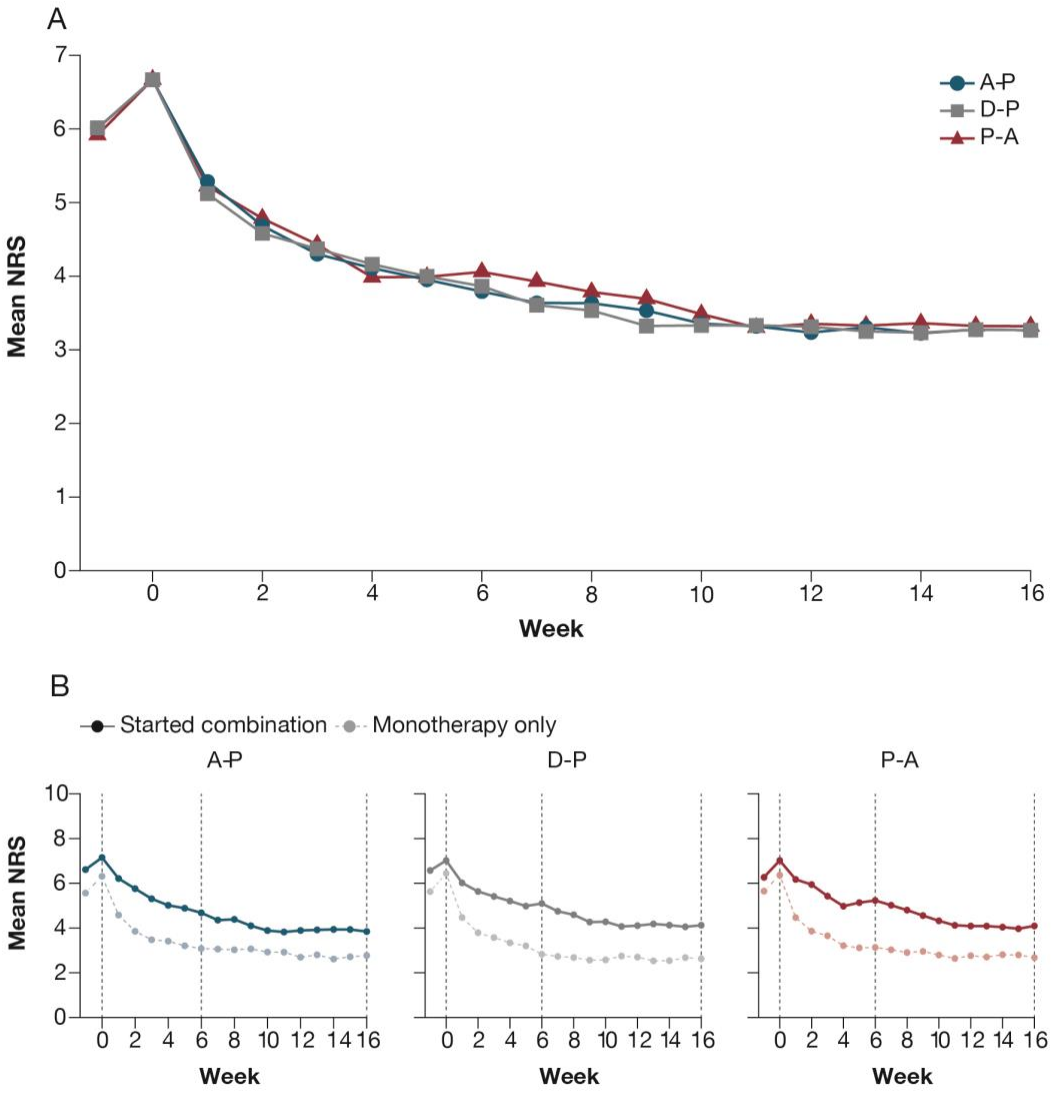
Other pharmacologic options

Evidence for the SSRIs paroxetine and citalopram is inconsistent and insufficient to recommend their use in managing pain in diabetic neuropathy. However, these medications may be effective if patients have coexisting pain and depression.[256] Earlier studies showed that treatment with topical capsaicin was beneficial for relieving pain in patients with diabetic neuropathy.[257,258] However, a 2017 meta-analysis of 5 randomized trials found that 0.075% capsaicin cream was no more effective than placebo (SMD -0.46; 95% CI: -0.95 to 0.03).[250]

Combination therapy

While a 2022 AAN meta-analysis suggests similar pain relief between SNRIs, anticonvulsants, gabapentinoids, TCAs and tramadol,[247] little is known about combination therapy. The **OPTION-DM trial** randomized 130 patients to either amitriptyline, pregabalin, or duloxetine for 6 weeks.[259] If the pain numerical rating score (NRS) was <3, patients remained on monotherapy for 10 more weeks; if the pain was ≥3, patients went on to combination therapy. Those advancing to combination therapy received one of the two options remaining, for example a patient on amitriptyline would be randomized to either pregabalin or duloxetine. The study found that monotherapy resulted in significant pain relief in only 35% of participants (40% achieved 50% reduction from baseline pain); thus, most patients required combination therapy. The combination therapies were well tolerated and similarly effective at reducing pain (Figure 17, next page).

Figure 17: Mean daily pain scores for combination treatment groups (A) or combination therapy vs. monotherapy (B)[259]



A=amitriptyline; P=pregabalin; D=duloxetine

Side effects with combination therapy were not significantly different than monotherapy, and were predictable: increase in dizziness in patients on pregabalin, nausea in patients on duloxetine, and dry mouth in patient on amitriptyline.

Pharmacologic summary for diabetic neuropathy

The American Diabetes Association recommends either pregabalin, duloxetine, or gabapentin as first-line pharmacologic treatments for diabetic neuropathic pain.[260] AAN suggests gabapentinoids, SNRIs (e.g., duloxetine), sodium channel blockers, and SNRI/opioid dual mechanism agents (such as tramadol) as treatment options. Given similar efficacy, clinicians should balance potential adverse events, patient comorbidities, cost, and patient preferences when choosing the treatment.[247] Although tramadol or tapentadol may be considered as third-line treatment options in some patients based on efficacy, they share the risks associated with other opioid analgesics. Other opioid analgesics are not recommended for treating diabetic neuropathy. For a complete summary of the pharmacologic interventions presented, see Appendix I.

Additional interventions

Spinal cord stimulation has been studied for pain relief in diabetic neuropathy but has insufficient evidence for any recommendation; most studies were single-arm with fewer than 10 patients.[261,262]

Fibromyalgia

Fibromyalgia should be suspected in patients having multifocal pain not fully explained by injury or inflammation. Chronic headaches, sore throats, visceral pain, and sensory hyper-responsiveness are very common in patients with fibromyalgia. Checking 18 tender points (9 pairs) on the body may aid in diagnosing fibromyalgia. These tender points are sometimes confused with trigger points, which are associated with chronic myofascial pain. The primary difference between tender points and trigger points is that trigger points can produce referred pain. American College of Rheumatology guidelines suggest a diagnosis of fibromyalgia in patients who have pain in at least 11 of these tender points when a doctor applies pressure.[263]

Non-pharmacologic options

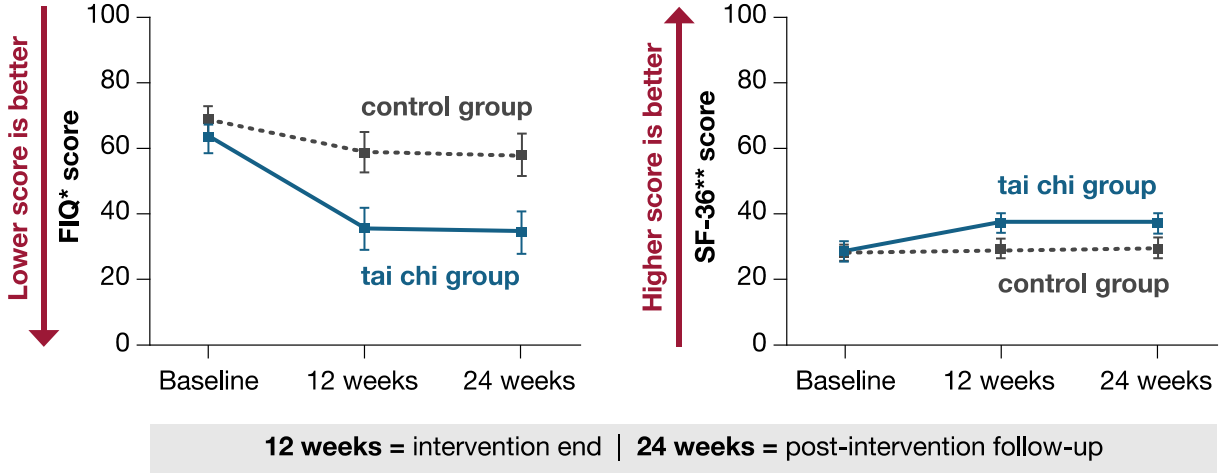
Movement-based options

Exercise training is often recommended for patients with fibromyalgia,[264] not only for potential pain reductions, but for the other known physiologic benefits associated with exercise. The effects of exercise in fibromyalgia have been assessed in more than 30 trials, with the overall quality rated as moderate.[265] Some reviews have concluded that the strongest evidence was in support of aerobic exercise,[266] which is the current recommendation by the American College of Rheumatology. However, resistance training can be of benefit as well.[267] A 2017 Cochrane review of eight RCTs (n=456) comparing aerobic exercise training vs. no exercise or another type of intervention found small improvements (relative to comparators) in pain intensity (relative improvement 18%), stiffness (11.4%) and physical function (22%).[268] A separate Cochrane review of five low-quality studies with 219 women with fibromyalgia found that moderate-to-high intensity resistance training improved function and reduced pain and tenderness

vs. control, and that eight weeks of aerobic exercise was superior to moderate-intensity resistance exercise for reducing pain.[269]

Tai chi may help reduce pain and other symptoms related to fibromyalgia. One trial randomized 66 patients with fibromyalgia to tai chi twice weekly for 12 weeks vs. wellness education and stretching exercises. Tai chi improved scores on the Fibromyalgia Impact Questionnaire (FIQ) that assessed pain, physical functioning, fatigue, morning stiffness, and on the Medical Outcomes Study 36 Item Short Form Health Survey (SF-36) both at the end of the intervention (12 weeks) and at 24-week follow-up (Figure 18). At 12 weeks, mean between group difference was -18.4 FIQ points (P<0.001).[270]

Figure 18: Mean changes in FIQ and SF-36 scores at 12 and 24 weeks[270]



12 weeks = intervention end | **24 weeks** = post-intervention follow-up

*Fibromyalgia Impact Questionnaire **Medical Outcomes Study 36-Item Short-Form Health Survey

As many as 35% of patients with fibromyalgia also have obesity.[271] **Weight loss** in patients with overweight or obesity improved pain and fibromyalgia symptoms in five studies, regardless of the means of achieving weight loss (i.e., low calorie diet alone, low calorie diet in combination with physical activity, gastric bypass surgery). Improvements in pain were found as early as 12 weeks and seen as long as 24 months.[271] Although amount of weight lost was not consistently reported among the studies, in one behavioral intervention pain improved with weight loss as little as 9 pounds or 4.4% body weight at six months.[272]

Yoga, acupuncture, massage, and TENS

Two RCTs suggest **yoga** may relieve pain or improve function in fibromyalgia.[273] One RCT of 53 female patients with fibromyalgia randomized subjects to receive an 8-week yoga program or wait-listed standard care. After eight weeks global FIQ scores were significantly better in patients randomized to yoga vs. control patients (post-intervention mean 35.49 vs. 48.69; P=0.003). Pain was significantly improved (p=0.0186) while function between the two groups was similar (P=0.0727).[274] The other RCT (n=40) compared yoga breathing, but not postures, to a control group that participated in recreational activities. Significant improvements in pain and function occurred at four weeks.[275]

One in five patients with fibromyalgia try **acupuncture** within two years of diagnosis.[276] Low-quality evidence suggests that acupuncture may be associated with reduced fibromyalgia-related pain. A 2013 Cochrane review of nine RCTs with 395 adults with fibromyalgia found reduced pain and stiffness at 1 month with electro-acupuncture compared to either placebo or sham acupuncture, but there were no significant differences in pain, fatigue, or sleep comparing manual acupuncture to placebo or sham acupuncture (4 trials, 182 adults).[276]

Two systematic reviews of four trials suggest improvement for global fibromyalgia symptoms, but unclear benefit on pain and function. The first systematic review identified two small trials of myofascial **massage** that may improve pain over placebo.[277] A 2022 systematic review found two connective tissue massage RCTs that reported improved global FIQ score but had mixed impact on pain.[278]

Six RCTs failed to show that **TENS** reduced pain in patients with fibromyalgia.[279] A 2022 meta-analysis of RCTs that compared TENS to sham TENS (placebo) found a small, but statistically significant effect (SMD -1.09; 95% CI -2.11 to -0.07) in participants with fibromyalgia; the results were based on 3 RCTs with 307 participants and substantial heterogeneity across the three trials.[280]

Cognitive and behavioral interventions

A Cochrane review of 18 low-quality RCTs showed a small benefit from traditional CBT programs on pain (SMD -0.30; 95% CI: -0.44 to -0.15) and function (SMD -0.31; 95% CI: -0.45 to -0.18).[281] Controls included waitlist controls, active controls, or treatment as usual

In seven RCTs of mindfulness-based stress reduction meditation, no reduction in pain was observed. Methods were varied and incorporated different components of meditation, CBT, and yoga.[31] In two RCTs, self-management education did not improve pain or disability, as compared to controls.[31]

Non-pharmacologic summary for fibromyalgia

Exercise has the most favorable benefit/risk profile for fibromyalgia with tai chi, massage, and CBT as possibly helpful adjunctive options. For a complete summary of the non-pharmacologic interventions presented, see Appendix I.

Pharmacologic options

The FDA has approved three medications for the treatment of fibromyalgia: duloxetine, milnacipran and pregabalin. Other options used off-label include gabapentin, amitriptyline, and SSRIs.

Acetaminophen and NSAIDs

No data support the efficacy of acetaminophen or NSAIDs for treating pain in patients with fibromyalgia,[282] although they may be useful to treat pain triggers.[264]

SNRIs

Duloxetine

A 2014 Cochrane review included six RCTs randomizing 2249 adults with fibromyalgia to duloxetine vs. placebo with 12-week to 6-month follow-up.[283] At 12 weeks, duloxetine was superior to placebo for pain

reduction (RR for ≥50% reduction 1.57; 95% CI: 1.2-2.06), with superiority also shown at 28 weeks (RR 1.58; 95% CI: 1.1-2.27).

Milnacipran

In a Cochrane meta-analysis of three RCTs evaluating milnacipran (Savella) 100 mg daily vs. placebo in 1,925 patients with fibromyalgia, milnacipran was more effective for inducing at least 30% reduction in pain (RR 1.38; 95% CI: 1.22-1.57).[284] A similar effect on pain relief was noted with milnacipran 200 mg daily.

An updated (data through August 2017) Cochrane review identified an additional seven trials of duloxetine and nine of milnacipran.[285] The updated analysis did not change the findings from previous reviews: both medications were better than placebo in reducing pain by at least 30%. Both medications were also found to improve health-related quality of life, although more SNRI patients dropped out of trials due to adverse events as compared to placebo.

Antidepressants

A meta-analysis of nine trials of the TCA, amitriptyline, found a small improvement in pain (SMD -0.43; 95% CI: -0.75 to -0.11).[286]

A Cochrane review of seven RCTs comparing SSRIs to placebo found a small difference (risk difference 0.1; 95% CI: 0.01-0.20) in patients who reported a 30% pain reduction. SSRIs included in the review included citalopram, fluoxetine, and paroxetine.[287] These data are insufficient to recommend SSRIs for the treatment of pain alone in patients with fibromyalgia.

Membrane stabilizers

Pregabalin

A meta-analysis of five RCTs found pregabalin, overall, had a small effect on pain (SMD -0.28; 95% CI: -0.35 to -0.20). Low doses (150 mg per day) were no different than placebo, but doses of 300 mg daily or greater were more likely to result in a 50% reduction in pain than placebo (RR 1.45; 95% CI: 1.03-2.05).[288]

A small crossover randomized trial with 41 patients with fibromyalgia found that combining pregabalin with duloxetine more effectively reduced pain (68% reporting at least moderate global pain relief) vs. either pregabalin (39%) or duloxetine (42%) alone ($P<0.05$ for both comparisons with combination).[289]

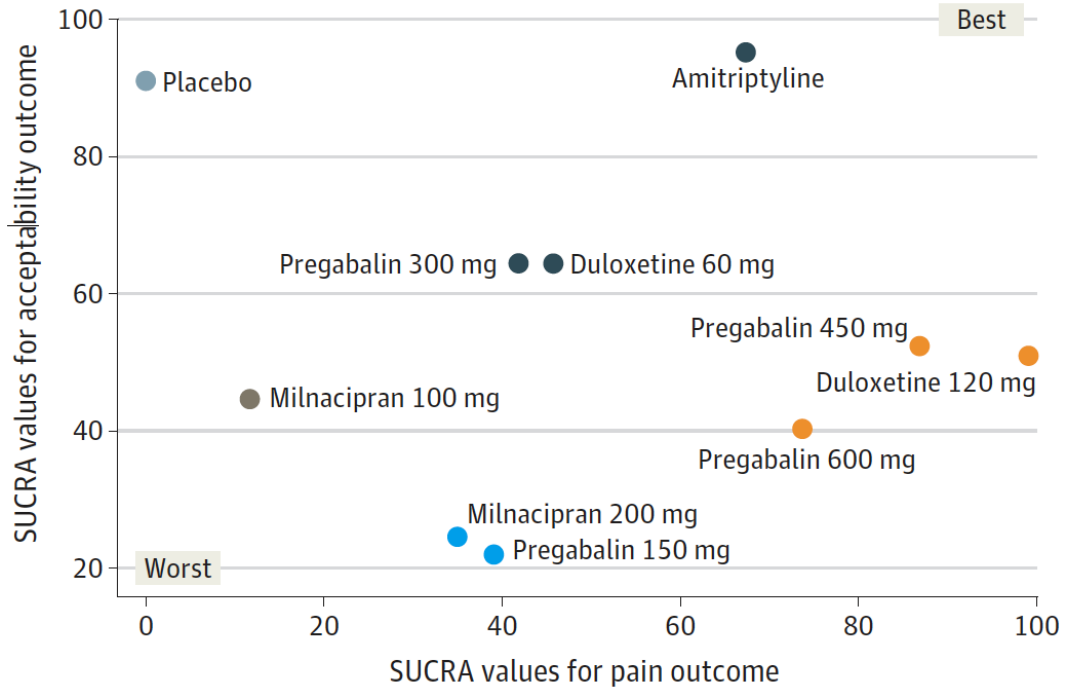
Gabapentin

Evidence supporting the use of gabapentin for fibromyalgia is very limited. In a Cochrane review of RCTs lasting eight weeks or longer (searched through May 2016) two trials were identified. One was only a conference abstract. The other trial randomized 150 patients with fibromyalgia to gabapentin 1200-2400 mg/day vs. placebo for 12 weeks.[290] Gabapentin was associated with a small reduction in pain (mean difference between groups at 12 weeks: -0.92 points on 0-10 point BPI scale; 95% CI: -1.75 to -0.71 points) but this difference may not be clinically important.

Comparing medication options

A network meta-analysis of 35 RCTs in 11,423 adults with fibromyalgia evaluated pain relief with duloxetine, pregabalin, milnacipran, or amitriptyline.[291] Compared to placebo, all of these options provide small, but significant pain relief (SMD range: 0.17-33). A surface area under the cumulative ranking curve (SUCRA) score was calculated to determine the ranking of treatment options on pain relief and side effects, or patient acceptability, by dose given the available data. Plotting SUCRA scores for pain relief and acceptability highlighted the importance of optimizing doses for effect (Figure 19). Pregabalin 450 mg and duloxetine 120 mg were associated with the highest pain reduction. Milnacipran is least likely to be effective compared to other options. While amitriptyline appears very well tolerated and effective, anticholinergic and other side effects limit utility in older adults.[291] All treatments, except amitriptyline, had higher rates of discontinuation due to adverse events than placebo. Also (not in the figure), amitriptyline and duloxetine 120 mg were associated with the highest improvement in quality of life.

Figure 19: Probability of pain relief and patient acceptability by medication and dose[291]



Cannabinoids

Two small trials have evaluated the oral cannabinoid nabilone (a synthetic form of THC) in patients with fibromyalgia. One trial randomized 46 patients to nabilone 0.5 mg to 1 mg twice daily for 4 weeks vs. placebo and found significant reductions in pain and improvements in anxiety on the Fibromyalgia Impact Questionnaire ($P<0.05$ for both outcomes).[292] Another trial randomized 31 patients with fibromyalgia and chronic insomnia to nabilone 0.5 mg to 1 mg at bedtime vs. amitriptyline 10-20 mg at bedtime for 4 weeks.[293] Although nabilone was associated with improved sleep quality, no significant effects were reported for pain, mood, or quality of life.

Another trial looked at whether different ratios of THC:CBD impacted pain response. Patients received a high THC option, a product with approximately a 1:1 ratio of THC:CBD, a product with higher CBD to THC ratio, or placebo. All patients received a single dose of each of the products at least two weeks apart and

in random order. A significant 30% response to pain was noted with the 1:1 THC:CBD product vs. placebo, but no product provided a 50% or greater pain response that differed from placebo.[294]

Opioid options

Tramadol: One RCT suggests that tramadol plus acetaminophen may reduce pain compared to placebo, but the trial duration was limited to 91 days, and long-term evidence is not available.[295] A review of pharmacologic treatment options suggests short-term improvements in pain and quality of life with tramadol. Patients who do not respond to other treatment options may benefit from a trial of tramadol, with understanding of the limitations of evidence and risks of side effects.

Buprenorphine does not have any data to support its use in fibromyalgia.

Other opioids: A Cochrane review found no RCTs of opioid therapy in patients with fibromyalgia lasting more than eight weeks.[296] An observational study followed a cohort of fibromyalgia patients initiating either opioids or non-opioid treatments for 12 months and found no difference in pain severity between the groups, with less reduction in BPI interference scores in the opioids group.[297] The American Academy of Neurology does not currently recommend opioids for treating fibromyalgia due to the lack of evidence for efficacy and the known risks of harms.[298]

Pharmacologic summary for fibromyalgia

The European League Against Rheumatism (EULAR) guidelines for managing fibromyalgia-related pain recommend beginning with non-pharmacologic approaches (exercise, CBT, acupuncture, yoga, tai chi, and mindfulness) and then advancing to pharmacologic options (low dose amitriptyline, duloxetine or milnacipran, pregabalin). Most recommendations were considered weak, with the exception of exercise.[265] A recent meta-analysis of evidence showed that amitriptyline, duloxetine, pregabalin, and milnacipran had similar effects in patients with fibromyalgia, with some medications (i.e., pregabalin, duloxetine) showing higher pain reduction with higher doses. In the elderly, duloxetine and pregabalin may be the more favorable pharmacologic options. For a complete summary of the pharmacologic interventions presented, see Appendix I.

Migraine

The throbbing, often unilateral headaches of migraine are both common and debilitating. The one-year prevalence in women has been estimated at 18%, while the prevalence in men is only 6%.[299] A complete review of options for the prevention and treatment of migraine is beyond the scope of this evidence document, particularly because the acute pain treatment options are unique to migraine and unlike the other pain conditions in this document, prevention is a cornerstone of treatment.[300,301]

No migraine-specific diagnostic tests exist for migraine: diagnosis is clinical and based on a compatible history, physical examination, and alignment with the criteria of the International Classification of Headache Disorders, 3rd Edition.[302] The differential diagnosis of migraine headache includes tension-type headaches, cluster headaches, and headaches caused by other disorders such as head or neck injury. The features most predictive of migraine include nausea, sensitivity to light and sound, and exacerbation by physical activity.[302]

Strong evidence for efficacy in the treatment of acute migraine exists for: acetaminophen, the NSAIDs (ibuprofen, naproxen sodium, aspirin, and diclofenac potassium), and seven triptans (almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan, and zolmitriptan).[303] NSAID–triptan combinations, dihydroergotamine, non-opioid combination analgesics (e.g., acetaminophen and caffeine), and several anti-emetics are also supported by relatively strong evidence.[303] Newer agents such as gepants (rimegepant, ubrogepant) and ditan (lasmiditan) are also effective but side effects limit their use to patients who have not responded to or are unable to take NSAIDs or triptans.[304] Clinical decision making about which specific agent, or agents, to deploy depends on patient-related factors such as the severity and nature of symptoms, the presence or intensity of nausea and vomiting, comorbid conditions, prior response to treatment, and the presence of contraindications to specific agents. These variables mean that treating migraine can be complex and approaches must be tailored to each individual patient.

Treatments to abort an acute attack of migraine are typically more effective if they are given early in the episode and in a large single dose rather than repetitive small doses. If significant nausea or vomiting is present, intravenous, intramuscular, or subcutaneous agents may be more effective than oral formulations.[300] Overuse of acute headache therapies (i.e., analgesics, triptans, and ergots) should be avoided and may worsen headache. If overuse occurs, rotate therapies and add or modify preventive treatment.

A wide range of pharmacological and biobehavioral therapies exist and can be deployed as preventive treatment in patients with severe, disabling, or frequent attacks. Initial treatment may include any of the following agents: amitriptyline, venlafaxine, the beta blockers metoprolol or propranolol, or topiramate.[305] Long-term adherence to oral preventive treatments, however, is generally low (17%-20% at 12 months), which is usually due to poor tolerability and/or inadequate efficacy.[306] Lifestyle changes such as aerobic exercise, mindfulness meditation, routine meal schedules, and good sleep hygiene may be beneficial.[307]

Opioid analgesics are generally not recommended for routine use in current clinical guidelines. Barbiturates should be avoided in the treatment of migraine except as a last resort.[308] Opioids are generally not as effective as migraine-specific medications and no high-quality evidence supports the efficacy of barbiturates in acute migraine treatment.[309] Both of these agents are associated with a host of potential harms, including tolerance, dependence, addiction, and overdose.

Putting it all together

Managing chronic pain is always challenging, and more so in those with comorbidities, polypharmacy, or physical or cognitive impairments. Clinicians and caregivers should work together to develop individualized pain treatment plans identifying realistic functional goals and the type of pain management needed to reach those goals using a shared decision-making approach. As detailed in this evidence document, pain syndromes respond differently to available pharmacologic and non-pharmacologic treatments, but, in general, non-pharmacologic options (which can be as effective as pharmacologic options) should be tried first. When pharmacologic options are considered, it is important to maximize non-opioid options before prescribing opioids. Opioids should rarely be used to treat chronic pain conditions. When prescribed, the risk of long-term opioid treatment should be minimized through patient education, screening of high-risk patients for OUD, close monitoring, and careful tapering.

Appendix I: Evidence for non-pharmacologic and pharmacologic approaches to managing pain

	INTERVENTION	Osteoarthritis	Low back pain	Diabetic neuropathy	Fibromyalgia
Non-drug options	exercise	●	◐	—	●
	physical therapy	●	◐	—	—
	tai chi	●	●	—	●
	weight loss	○	○	—	◐
	yoga	◐	●	—	○
	acupuncture	◐	●	—	○
	massage	◐	◐	—	◐
	TENS*	○	○	◐	○
	cognitive behavioral therapy	○	●	◐	◐
	mindfulness meditation	○	●	○	○
	self-management	◐	◐	—	○
Non-opioid drug options	acetaminophen	◐	○	—	—
	NSAIDs—oral	●	●	—	—
	NSAIDs—topical	●	○	—	—
	duloxetine (Cymbalta, generics)	◐	◐	●	●
	tricyclic antidepressants (TCAs)	—	✖	◐	◐
	pregabalin (Lyrica, Lyrica CR)	◐	—	●	●
	gabapentin (Neurontin, generics)	—	○	●	◐
	topical lidocaine (Lidoderm, generics)	○	—	◐	—
	cannabis/cannabinoids	—	—	◐	○
Opioids	tramadol (Ultram)	○	◐	◐	○
	buprenorphine (Belbuca, Butrans)	○	◐	○	—
	other opioids	✖	✖	✖	✖

Risk/benefit: ● = favorable; ◐ = potentially favorable; ✖ = unfavorable; ○ = no clear benefit; — = insufficient data
***TENS:** transcutaneous electrical nerve stimulation

Appendix II: Dosing suggestions for selected analgesics

Class	Medication	Starting dose	Frequency	Requires slow titration*	Therapeutic daily dose	Maximum daily dose
Acetaminophen	acetaminophen	325 – 650 mg	every 4-6 hours	No	3000 – 4000 mg	4000 mg (adults – acute) 3250 mg (acute - elderly) 3000 mg (chronic)**
NSAID - oral	celecoxib (Celebrex, generics)	100 mg	twice daily	No	200 - 400 mg	400 mg
	ibuprofen (Advil, generics)	200-400 mg	every 8 hours	No	2400 mg	3200 mg (acute) 2400 mg (chronic) 1200 mg (OTC)
	naproxen (Aleve, generics)	220 -500 mg	every 12 hours	No	1000 mg	1500 mg
NSAID - topical	diclofenac gel 1% # (Voltaren, generics - OTC)	2-4 grams	every 6 hours	No	16 grams	32 grams (chronic)
	diclofenac patch (Flector)	1 patch	twice daily	No		2 patches (acute)
SNRI	duloxetine (Cymbalta, generics)	20-30 mg	daily	Every 2 weeks	60-120 mg	120 mg
	milnacipran (Savella)	12.5 mg	daily or twice daily	Every 2 days	100 – 200 mg	200 mg
TCAs	amitriptyline	10 - 25 mg	nightly	Every 2 weeks	25 – 150 mg	150 mg
	nortriptyline	10 - 25 mg	nightly	Every 2 weeks	25 - 100 mg	200 mg
Anticonvulsants	pregabalin (Lyrica, generics)	50-75 mg	Twice or thrice daily	Every 1-2 weeks	300-600 mg	600 mg
	gabapentin (Neurontin, generics)	100-300 mg	nightly to every 8 hours	Daily or longer interval as tolerated	900 - 3600 mg	3600 mg
Topicals	lidocaine 5% patch	1 patch	daily	No	1 – 3 patches	3 patches
	lidocaine 4% patch (OTC)	1 patch	daily	No	1 patch	1 patch
	capsaicin (OTC)	1 application	three to four times daily	No	3-4 applications	3-4 applications
	capsaicin patch (OTC)	1 patch for up to 8 hours	daily	No	1 – 4 patches	4 patches per day

References[42,172,224,310-313]

* If No, the dose may be changed with each administration based on patient symptoms ** lower doses may be required in older adults and patients taking certain medications (e.g., anticoagulants) # Diclofenac 3% gel has an indication for actinic keratosis, not pain.

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These are general recommendations only; specific clinical decisions should be made by the treating clinician based on an individual patient's clinical condition.

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Medical Editor: Alan Drabkin, M.D., F.A.A.F.P.

These materials were created by Alosa Health, a nonprofit educational organization which accepts no funding from any pharmaceutical company. They were printed and distributed through a program with the Indian Health Service.

Oct 2023