VA/DoD CPG

Use of Opioids in the Management of Chronic Pain

RECOMMENDATIONS (20)

The following evidence-based clinical practice recommendations were made using a systematic approach considering four domains as per the GRADE approach (see Summary of Guideline Development Methodology). These domains include: confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient values and preferences, and other implications (e.g., resource use, equity, acceptability)

Initiation and Continuation of Opioids

#	Recommendation	Strength[a]	Category[b]
1.	We recommend against the initiation of opioid therapy for the management of chronic non-cancer pain (for non-opioid treatments for chronic pain, see the VA/DoD CPGs for Low Back Pain, Headache, and Hip and Knee Osteoarthritis).[c]	Strong against	Reviewed, New-replaced
2.	We recommend against long-term opioid therapy, particularly for younger age groups, as age is inversely associated with the risk of opioid use disorder and overdose.	Strong against	Reviewed, New-replaced

Initiation and Continuation of Opioids

#	Recommendation	Strength[a]	Category[b]
3.	We recommend against long-term opioid therapy, particularly for patients with chronic pain who have a substance use disorder (refer to the VA/DoD CPG for the Management of Substance Use Disorders).[d]	Strong against	Reviewed, New-replaced
4.	For patients receiving medication for opioid use disorder, there is insufficient evidence to recommend for or against the selection of any one of the following medications over the other for the management of their co-occurring chronic pain: methadone, buprenorphine, or extended-release naltrexone injection. Treat the opioid use disorder according to the VA/DoD CPG for the Management of Substance Use Disorders.[d]	Neither for nor against	Reviewed, New-replaced

Initiation and Continuation of Opioids

#	Recommendation	Strength[a]	Category[b]
5.	For patients receiving daily opioids for the treatment of chronic pain, we suggest the use of buprenorphine instead of full agonist opioids due to lower risk of overdose and misuse.	Weak for	Reviewed, New-added
6.	We recommend against the concurrent use of benzodiazepines and opioids for chronic pain (refer to Recommendation 10 in the VA/DoD CPG for the Management of Substance Use Disorders[d] for further guidance related to tapering one or both agents).	Strong against	Reviewed, Amended

Dose, Duration, and Taper of Opioids

#	Recommendation	Strength[a]	Category[b]
7.	If prescribing opioids, we recommend using the lowest dose of opioids as indicated by patient-specific risks and benefits.	Strong for	Reviewed, Amended
8.	If considering an increase in opioid dosage, we recommend reevaluation of patient-specific risks and benefits and monitoring for adverse events including opioid use disorder and risk of overdose with increasing dosage.	Strong for	Reviewed, New-replaced

Dose, Duration, and Taper of Opioids

#	Recommendation	Strength[a]	Category[b]
9.	When prescribing opioids, we recommend the shortest duration as indicated.	Strong for	Reviewed, New-replaced
10.	After initiating opioid therapy, we recommend reevaluation at 30 days or fewer and frequent follow-up visits, if opioids are to be continued.	Strong for	Reviewed, New-replaced

Dose, Duration, and Taper of Opioids

#	Recommendation	Strength[a]	Category[b]
11.	We recommend against prescribing long-acting opioids: • For acute pain • As an as-needed medication • When initiating long-term opioid therapy	Strong against	Reviewed, Amended
12.	We suggest a collaborative, patient-centered approach to opioid tapering.	Weak for	Reviewed, New-replaced
13.	There is insufficient evidence to recommend for or against any specific tapering strategies.	Neither for nor against	Reviewed, New-replaced

Screening, Assessment, and Evaluation

#	Recommendation	Strength[a]	Category[b]
14.	We recommend assessing risk of suicide and self-directed violence when initiating, continuing, changing, or discontinuing long-term opioid therapy (refer to the VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide[e] for guidance on intervention timing and strategies).	Strong for	Reviewed, New-replaced
15.	For patients with chronic pain, we recommend assessing for behavioral health conditions, history of traumatic brain injury, and psychological factors (e.g., negative affect, pain catastrophizing) when considering long-term opioid therapy, as these conditions are associated with a higher risk of harm.	Strong for	Reviewed, New-added

Screening, Assessment, and Evaluation

#	Recommendation	Strength[a]	Category[b]
16.	For patients with acute pain when opioids are being considered, we suggest screening for pain catastrophizing and co-occurring behavioral health conditions to identify those at higher risk for negative outcomes.	Weak for	Reviewed, New-added
17.	For patients on opioids, we suggest ongoing reevaluation of the benefits and harms of continued opioid prescribing based on individual patient risk characteristics.	Weak for	Reviewed, New-replaced

Risk Mitigation

#	Recommendation	Strength[a]	Category[b]
18.	We suggest urine drug testing for patients on long-term opioids.	Weak for	Reviewed, New-replaced
19.	We suggest interdisciplinary care that addresses pain and/or behavioral health problems, including substance use disorders, for patients presenting with high risk and/or aberrant behavior.	Weak for	Not reviewed, Amended
20.	We suggest providing patients with pre-operative opioid and pain management education to decrease the risk of prolonged opioid use for post-surgical pain.	Weak for	Reviewed, New-added