**Direct Comparison of 12 Recommendations**

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| **Recommendation Category** | **2016 Guideline** | **2022 Update** | **Major Differences** |
| **Initiating Opioids** | #1: Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.  #2: Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.  #3: Before starting and periodically during opioid therapy clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy. | #1: Nonopioid therapies are effective for many common types of acute pain. Clinicians should only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient.  #2: Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the known risks and realistic benefits of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. | * Application to acute and subacute pain (in addition to chronic pain) * Concepts from the 2016 Guideline’s #3 are also addressed in the 2020 Guideline’s #8 and elsewhere. |
| **Opioid Selection and Dosage** | #4: When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.  #5: When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day. | #3: When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.  #4: When opioids are starting for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest dosage to achieve expected effects. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients.  #5: For patients already receiving higher opioid dosages, clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage. If risks outweigh benefits of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids. Unless there are indications of a life threatening issue, such as warning signs of impending overdose, e.g., confusion, sedation, or slurred speech, opioid therapy should not be discontinued abruptly, and clinicians should not abruptly or rapidly reduce opioid dosages from higher dosages. | * Application to acute and subacute pain (in addition to chronic pain) * Clarification that the recommendation for starting opioids applies to opioid-naïve patients * Clarified that people should be started at the “lowest dosage to achieve expected effects” (previously just said “lowest effective dosage”). * 90 MME upper dosage limit has been removed. * 50 MME dosage cautionary point has been removed from primary recommendation (is still included in supporting text) * Adds a new recommendation for patients already receiving higher dosages * Adds a caution against rapid tapers and abrupt discontinuation |
| **Opioid Duration and Follow-Up** | #6: Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.  #7: Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids. | #6: When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.  #7: Clinicians should evaluate benefits and risks with patients within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain or of dose escalation. Clinicians should evaluate benefits and risks of continued therapy with patients every 3 months or more frequently. | * Three-day duration limit for acute pain has been removed. Recommendation now focuses on “no greater quantity than the expected duration of pain severe enough to require opioids” * Repeated recommendation to taper and discontinue opioids if benefits do not outweigh harms has been removed. |
| **Assessing Risk and Addressing Harms of Opioid Use** | #8: Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.  #9: Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.  #10: When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.  #11: Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.  #12: Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. | #8: Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss with patients*.* Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone when factors that increase risk for opioid overdose are present.  #9: When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose.  #10: When prescribing opioids for subacute or chronic pain, clinicians should consider toxicology testing to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances.  #11: Clinicians should use extreme caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.  #12: Clinicians should offer or arrange treatment with medication for patients with opioid use disorder. | * Application to acute and subacute pain (in addition to chronic pain) * More focus on involving patients in decision-making around risk evaluation and incorporating rick mitigation strategies into the management plan. * Wording around co-prescribing of opioids and benzodiazepines has changed (from “avoid prescribing pain medication and benzodiazepines concurrently whenever possible” to “use extreme when prescribing opioid pain medication and benzodiazepines concurrently”) * Caution has been added around prescribing opioid pain medications and other central nervous system depressants concurrently (this can include, but is not limited to, some medications commonly taken for insomnia, anxiety, panic attacks, and seizures) |