CDC Recommendations for Nonopioid Treatments in the Management of Chronic Pain

Clinician Outreach and Communication Activity (COCA) Call
July 27, 2016
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Planners have reviewed content to ensure there is no bias.

This presentation will include discussion of non-FDA approved nortriptyline for the treatment of fibromyalgia.
Objectives
At the conclusion of this session, the participant will be able to:

- State the evidence related to effectiveness and potential risks associated with nonopioid treatments for chronic pain.

- Outline nonpharmacologic and nonopioid pharmacologic treatment options for various chronic pain conditions.

- Review patient evaluation methods that can be used to identify the most appropriate treatment options for chronic pain.

- Describe the role of patient beliefs and expectations, and value of exercise, education, and nonopioid drug treatments in the management of musculoskeletal pain complaints.
Save-the-Dates

Mark your calendar for the upcoming opioid prescribing calls

<table>
<thead>
<tr>
<th>Call No.</th>
<th>Date</th>
<th>Topic</th>
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<tr>
<td>1</td>
<td>June 22</td>
<td>Guideline for Prescribing Opioids for Chronic Pain</td>
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<td>July 27</td>
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<td>3</td>
<td>August 3</td>
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<td>4</td>
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Senior Medical Advisor
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Disclaimer

The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the views of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry.
CDC Guideline for Prescribing Opioids for Chronic Pain:

Nonopioid Treatments for Chronic Pain

Deborah Dowell, MD, MPH

July 27, 2016
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Special Communication

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Deborah Dowell, Tamara Haegerich, and Roger Chou

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Published online March 15, 2016
# Effectiveness and harms of nonopioid treatments for chronic pain

<table>
<thead>
<tr>
<th>Source</th>
<th>Topic or Intervention</th>
<th>Participants or Population</th>
<th>Primary Outcomes</th>
<th>Key Findings</th>
<th>Study Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beach et al. (2005)</td>
<td>Exercise training, unsupervised control or nonexercise intervention</td>
<td>Exercise efficacy plus clinical intervention with fibromyalgia</td>
<td>Pain, physical function</td>
<td>Reduced pain, low back pain</td>
<td>Grade B evidence</td>
</tr>
<tr>
<td>Changaro et al. (2014)</td>
<td>Nonsteroidal anti-inflammatory drugs vs. placebo or other treatments</td>
<td>Systematic review of 15 RCTs with patients with chronic low back pain</td>
<td>Pain, physical function</td>
<td>Low to moderate evidence</td>
<td>Grade B evidence</td>
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<tr>
<td>Collins et al. (2010)</td>
<td>Antidepressants vs. placebo; anticonvulsants vs placebo</td>
<td>Systematic review of 19 RCTs for anticonvulsants or antidepressants</td>
<td>Pain, physical function</td>
<td>Low to moderate evidence</td>
<td>Grade A evidence</td>
</tr>
<tr>
<td>Fransen et al. (2015)</td>
<td>Exercise vs. nonexercise group (active or no treatment)</td>
<td>Systematic review of 66 RCTs for exercise interventions</td>
<td>Pain, quality of life</td>
<td>High-quality evidence for reduced pain, improved quality of life</td>
<td>Grade A evidence</td>
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<tr>
<td>Fransen et al. (2014)</td>
<td>Exercise vs. nonexercise group (active or no treatment)</td>
<td>Systematic review of 10 RCTs for fibromyalgia patients</td>
<td>Pain, quality of life</td>
<td>High-quality evidence</td>
<td>Grade A evidence</td>
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<tr>
<td>Haskard et al. (2013)</td>
<td>Cognitive behavior therapy vs. placebo or other treatments</td>
<td>Systematic review of 61 RCTs for low back pain</td>
<td>Pain, function</td>
<td>Low to moderate evidence</td>
<td>Grade A evidence</td>
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<tr>
<td>Lee et al. (2015)</td>
<td>CM therapy vs. single self-care CM, nonself-care CM, small group treatment, other nonmedication, or other control</td>
<td>Systematic review of 26 RCTs for chronic pain</td>
<td>Pain, symptom outcomes</td>
<td>High-quality evidence</td>
<td>Grade A evidence</td>
</tr>
<tr>
<td>Low et al. (2013)</td>
<td>Corticosteroids vs. placebo or other controls</td>
<td>Systematic review of 18 RCTs for corticosteroids</td>
<td>Pain, quality of life</td>
<td>Grade A evidence</td>
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<tr>
<td>Mooney et al. (2014)</td>
<td>Probiotics vs. placebo or any active control</td>
<td>Systematic review of 25 RCTs for probiotics</td>
<td>Pain, quality of life</td>
<td>High-quality evidence</td>
<td>Grade A evidence</td>
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<tr>
<td>Moore et al. (2014)</td>
<td>Gabapentin vs. placebo</td>
<td>Systematic review of 32 RCTs for gabapentin and placebo</td>
<td>Pain, quality of life</td>
<td>Low to moderate evidence</td>
<td>Grade A evidence</td>
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</tbody>
</table>

### Table 3. Effectiveness and Harms of Nonpharmacologic and Nonopioid Pharmacologic Treatments

<table>
<thead>
<tr>
<th>Source</th>
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<th>Key Findings</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Headsley et al. (2010)</td>
<td>NSAIDs vs. COX-2 inhibitors vs control</td>
<td>Systematic review of 63 RCTs for nonselective low back pain</td>
<td>Acute low back pain</td>
<td>NSAIDs are more effective than placebo for acute and chronic low back pain</td>
<td>Mixed-quality studies</td>
</tr>
<tr>
<td>Saatci et al. (2010)</td>
<td>Antidepressants vs placebo or other controls</td>
<td>Systematic review of 61 RCTs for neuropathic pain</td>
<td>Pain, function</td>
<td>Low to moderate evidence</td>
<td>Grade A evidence</td>
</tr>
<tr>
<td>Salmens et al. (2002)</td>
<td>Systematic review of 9 RCTs for chronic back pain</td>
<td>Pain, function</td>
<td>Low to moderate evidence</td>
<td>Grade A evidence</td>
<td></td>
</tr>
<tr>
<td>Stigler et al. (2013)</td>
<td>Antidepressants vs placebo</td>
<td>Systematic review of 7 RCTs in patients with chronic low back pain</td>
<td>Pain, function</td>
<td>Low to moderate evidence</td>
<td>Grade A evidence</td>
</tr>
<tr>
<td>Truog et al. (2011)</td>
<td>Gabapentin vs placebo or other controls</td>
<td>Systematic review of 31 RCTs comparing any NSAID with other NSAID or placebo for any medical condition</td>
<td>Pain, function</td>
<td>Low to moderate evidence</td>
<td>Grade A evidence</td>
</tr>
<tr>
<td>Wilt et al. (2015)</td>
<td>Opioids (either long- or short-acting) vs. placebo or other controls</td>
<td>Systematic review of 10 RCTs in patients with neuropathic pain, low back pain, or osteoarthritis pain</td>
<td>Pain, function</td>
<td>Low to moderate evidence</td>
<td>Grade A evidence</td>
</tr>
</tbody>
</table>

Overview of findings from the evidence reviews

• Insufficient evidence to determine whether pain relief, function, or quality of life improves with long-term opioid therapy (most RCTs <6 weeks)
• Long-term opioid use for chronic pain is associated with serious risks, including abuse, dependence and overdose
• Many non-opioid therapies can improve chronic pain with less risk for harm
• When opioids are used, they are more likely to be effective if combined with other approaches
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.

(Recommendation category A: Evidence type: 3)
Effective treatments for chronic pain

• Nonpharmacologic therapies
  – Exercise therapy
  – Cognitive-behavioral therapy
• Nonopioid pharmacologic treatments
  – Acetaminophen
  – NSAIDs, and COX-2 inhibitors
  – Selected anticonvulsants (e.g., pregabalin, gabapentin)
  – Selected antidepressants (tricyclics, SNRIs)
• Interventional approaches
• Multimodal and multidisciplinary therapies
Nonpharmacologic therapies can

• Result in sustained improvements in pain and function without apparent risks
• Encourage active patient participation in the care plan
• Address the effects of pain in the patient’s life
Exercise therapy

• High-quality evidence for reduced pain and improved function for hip or knee osteoarthritis
  – Immediately after treatment
  – Improvements sustained for at least 2–6 months
• Previous guidelines strongly recommended aerobic, aquatic, and/or resistance exercises for patients with hip or knee osteoarthritis
• Can reduce pain and improve function in low back pain
• Can improve global well-being, fibromyalgia symptoms, and physical function in fibromyalgia
Cognitive behavioral therapy (CBT)

• Addresses psychosocial contributors to pain and improves function
• Trains patients in behavioral techniques
• Helps patients modify situational factors and cognitive processes that exacerbate pain
• Has small positive effects on disability and catastrophic thinking
Access to nonpharmacologic treatments

- Access and cost can be barriers
- Aspects of these approaches can be used even when there is limited access to specialty care
  - RCT: no difference in reduced chronic low back pain intensity, frequency or disability between
    - Patients assigned to relatively low-cost group aerobics
    - Individual physiotherapy sessions
  - Low-cost options to integrate exercise:
    - Brisk walking in public spaces
    - Use of public recreation facilities for group exercise
Using CBT principles in primary care

- Encourage patients to take an active role
- Teach relaxation techniques
- Support engaging in beneficial but potentially anxiety-provoking activities, such as exercise
- Support patient coping strategies
- Refer patients to support, self-help, and educational community-based programs
- Refer patients with more entrenched anxiety or fear related to pain, or other significant psychological distress, for formal therapy with a mental health specialist
Acetaminophen

- Multiple guidelines: acetaminophen first-line for
  - Osteoarthritis
  - Low back pain

- Can be hepatotoxic at > 3-4 grams/day and at lower dosages in patients with chronic alcohol use or liver disease
  - Avoid in liver failure
  - Reduce dosage in patients with
    - Hepatic insufficiency
    - History of alcohol abuse
NSAIDs and cyclooxygenase 2 (COX-2) inhibitors

• NSAIDs first-line treatment for
  – Osteoarthritis
  – Low back pain

• NSAIDs and COX-2 inhibitor risks:
  – Gastritis, gastrointestinal bleeding or perforation
  – Fluid retention, renal and cardiovascular risks
  – Interference with platelet aggregation
  – Topical NSAIDs have less systemic risk than oral NSAIDs
Selected antidepressants

- Tricyclics (TCAs, e.g., amitriptyline) and SNRIs (e.g., duloxetine) are effective and recommended in multiple guidelines for
  - Neuropathic pain (e.g., diabetic neuropathy, post-herpetic neuralgia)
  - Fibromyalgia symptoms

- TCAs relatively contraindicated in severe cardiac disease, particularly conduction disturbances
- Start TCAs at low dosages, titrate up as needed and tolerated
  - Often effective at lower dosages than for depression
  - Anticholinergic effects include sedation--use at bedtime
Selected anticonvulsants

- Selected anticonvulsants (e.g., pregabalin, gabapentin) are effective and recommended in multiple guidelines for
  - Neuropathic pain (e.g., diabetic neuropathy, post-herpetic neuralgia)
  - Fibromyalgia symptoms

- Start pregabalin or gabapentin at low dose and increase gradually given dose-dependent dizziness and sedation

- Check baseline and periodic CBC and LFTs with carbamazepine
Interventional approaches

• Injections can improve short-term pain and function
  – Arthrocentesis and intraarticular glucocorticoid injection in rheumatoid arthritis or osteoarthritis
  – Subacromial corticosteroid injection in rotator cuff disease
  – Epidural injection for lumbar radiculopathy

• Potential risks
  – Articular cartilage changes (in osteoarthritis)
  – Sepsis
  – Rare but serious adverse events associated with epidural injection: loss of vision, stroke, paralysis, death
Multimodal and multidisciplinary therapies

• Can reduce long-term pain and disability more effectively than single modalities
• Involve coordination of medical, psychological, and social aspects of care
• Are not always available or reimbursed by insurance
• Can be time-consuming and costly for patients
• Should be considered for patients not responding to single-modality therapy, or who have severe functional deficits
• Combinations should be tailored depending on patient needs, cost, and convenience
Selection of therapy: evaluation

• Evaluate patients, establish or confirm diagnosis
  – Focused history, including
    • History and characteristics of pain
    • Contributing factors (psychosocial stressors, sleep)
  – Physical exam
  – Imaging only if indicated, e.g., if
    • Severe or progressive neurologic deficits are present or
    • Serious underlying conditions are suspected
• For complex pain syndromes, consider pain specialty consultation to assist with diagnosis as well as management
Selection of therapy: role of pain mechanism and diagnosis

- NSAIDs for nociceptive pain (e.g., osteoarthritis, muscular back pain)
- Selected antidepressants or anticonvulsants for neuropathic pain (e.g., diabetic neuropathy, postherpetic neuralgia) or fibromyalgia); topical lidocaine for localized neuropathic pain
- Physical or occupational therapy can address posture, weakness, or repetitive motions contributing to musculoskeletal pain
- Surgical intervention can relieve mechanical/compressive pain
- Glucose control can prevent progression of diabetic neuropathy
- Immune-modulating agents useful in rheumatoid arthritis
Selection of therapy: role of risk factors for harm

- Use medications only after determining expected benefits outweigh risks given patient-specific factors
- Consider falls risk when selecting and dosing potentially sedating medications (e.g., tricyclics, anticonvulsants, opioids)
- Weigh risks and benefits of use, dose, and duration of NSAIDs when treating older adults, patients with hypertension, renal insufficiency, or heart failure, or those at risk for peptic ulcer disease or cardiovascular disease
- Consider topical NSAIDs over oral NSAIDs for localized osteoarthritis (e.g., knee osteoarthritis) in patients aged ≥ 75
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- www.cdc.gov/drugoverdose/prescribing/guideline

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- Follow @DebHouryCDC and @CDCInjury for useful information and important Guideline updates.

Find out more about Injury Center social media:

- www.cdc.gov/injury/socialmedia
CDC Guideline for Prescribing Opioids for Chronic Pain

NON-OPIOID MEDICATIONS & NONPHARMACOLOGIC TREATMENT

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CASE LEARNING OBJECTIVES

1. Outline the differential diagnoses for this patient’s symptoms, and the methods to choose among them.

2. Identify patient belief systems that might interfere with treatment, and strategies to address these.

3. Review the role of patient education in setting expectations when managing musculoskeletal pain.

4. Describe the rationale for exercise therapy, and how to overcome patient barriers to physical therapy.

5. Defend the rationale for use of a tricyclic antidepressant drug as the initial medication for this patient.
• Gender: Male
• Age: 38
• Symptoms
  o Non-radicular, aching, stabbing neck pain x 3 weeks
  o Intermittent neck pain/headaches starting in 2008. Also: headaches, diffuse bilateral upper extremity pain + thoracic & lumbar spine
• Electromyography (EMG) 6 years ago: normal
• Magnetic resonance image (MRI) 3 weeks ago:
  o Degenerative disc disease (DDD) + foraminal narrowing C5-6; C6-7
• Rx: oxycodone 5/325 twice daily; cyclobenzaprine 10 mg at bedtime
• Mood: “grumpy because of pain”
• Past medical history: Irritable Bowel Syndrome
• Smokes ½ packs per day; no illicit drugs
• Lives with girlfriend + 10 y/o daughter
• Job: builds cranes; can’t make it to work one day per week
• Activity: 3 hours in recliner after work
PATIENT REPORTED OUTCOME MEASURES

• Pain, interference with Enjoyment, General function (PEG) tool
  ± Brief Pain Inventory (BPI)
  ± Promise 10
  ± Oswestry Disability Index (ODI)
  ± Roland Morris Disability Questionnaire (RMDQ)

• Personal Health Questionnaire PHQ-9 + General Anxiety Disorder GAD-7
  o Or short version PHQ-4
  o When elevated ↑: full PHQ-9, GAD-7 plus Primary Care-Post Traumatic Stress Disorder PC-PTSD

• Alcohol Use Disorders Identification Test AUDIT-C

• ORT, SOAPP, COMM, or DIRE
  o All of these misuse/addiction tools are widely used, though poor predictive validity

• Prescription Drug Monitoring Program (PDMP)
  o Important to check, he may request an opioid refill!
CDC RECOMMENDED ASSESSMENTS

Pain average, interference with Enjoyment of life, and interference with General activity (PEG) Assessment Scale

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

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<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
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<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tr>
<td>No pain</td>
<td>Pain as bad as you can imagine</td>
<td></td>
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2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

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

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Krebs 2009, Kroenke 2009

Patient Health Questionnaire PHQ-4
- Combines Generalized Anxiety Disorder GAD-7 + PHQ-9
- Score ≥ 6 needs attention
PATIENT REPORTED OUTCOMES (PROs)

• Pain intensity: 6/10
• Pain interference with:
  o General function: 7/10
  o Quality of life: 7/10
  o Sleep:
    - Initiation: 6
    - Maintenance: 6

• Mood: PHQ-4: 6/12
  o …so added, GAD-7: 6/21
  o …and, PHQ-9: 8/27

Patient self-selected important activity (“work”): 8
Oswestry Disability Index: 50
Opioid Risk Tool: 4
Satisfaction with pain treatment: 2/10
• Height: 5’7” and Weight: 119 lbs
  o Normal = 130 lbs; Body mass index (BMI) 18.6
• Vital Signs normal
• 14/18 “tender points”
• Limited range of motion – neck, lumbar
• Neuro –
  o Normal deep tendon reflexes (DTRs)
  o No long tract signs
  o Pain inhibited weakness both upper extremities (UEs)
  o Sensation normal
Diagnoses

1. Axial neck pain ("cervicalgia")
2. Fibromyalgia vs. inflammatory arthritis
3. Weight loss, unexplained
4. Long-term opioid therapy, low dose
5. Irritable bowel syndrome
6. Mild depression and anxiety
7. Moderate sleep disturbance
“Fibromyalgia-ness”

Symptom Intensity Scale

Clauw 2014, Wolfe 2009
Plan

1. Discuss likely diagnoses and treatment plan
2. Set up appropriate expectations
   • Records from current health care provider(s)
   • Intentions and plans regarding long-term opioids
3. Labs
   • C-reactive protein (CRP)
   • Anti-cyclic citrullinated peptide antibody (anti-CCP)
   • Anti-nuclear antibody (ANA)
4. Visit summary with links to info on Fibromyalgia
   (e.g. fibroguide.com)
• Resists diagnosis of Fibromyalgia
  …“it is a ‘psychological’ condition”
• Continue discussion of Fibromyalgia pathophysiology
  o Offer brief education re pain mechanisms and treatment to help understand pain
  o Suggest educational materials
• Referral to physical therapy (PT) for neck range of motion (ROM)/strength + general conditioning
1. **Exercise is good; PT is a means**
   
   “Closest thing to a wonder drug? Try exercise”

2. **Optimal exercise? No definite evidence**

3. **PT/exercise often “fails”**
   
   “…made my pain worse!”

4. **Clinician interventions**
   
   - Find PT who will work with complex pts
   - Ask about progress – have pt demonstrate
   - Basic concepts – baseline; “exchange list”; tolerance for flares

Carroll 2016, Hayden 2005
• Discontinue cyclobenzaprine, in favor of **nortriptyline** 10 mg
  - Slow managed titration to 50 mg qhs
• Off opioids because previous prescriber no longer in local practice
  - Consider periodic checking PDMP regardless
Norepinephrine is a principal neurotransmitter facilitating the “descending inhibitory systems”

Millan 2002, Ossipov 2014
CLINICAL TRIALS FOR TCA EFFECTIVENESS:

Post Herpetic Neuralgia
  NNT* 2.1-2.7
Diabetic Peripheral Neuropathy
  NNT* 1.2-1.5
Atypical Facial Pain
  NNT* 2.8-3.4
Fibromyalgia/Central Pain
  NNT* 1.7

*NNT = Number needed to treat

Saarto 2007
FOLLOW UP, OVER MONTHS

8/27/14
1. Nortriptyline + PT – reduction in widespread pain
2. Neck pain/headaches still present, but less
   • Pain reduced 10%
   • Rest of PEG improved 40%
   • PHQ-4 = 4
3. Sleep better
4. Exam – reduced sensitivity of tender points

9/25/14
1. Nortriptyline – AM fatigue, some dry mouth
2. Pain still 6/10
3. Rest of PEG improved 60% from baseline
4. PHQ-4 = 2
NON-DRUG MULTIMODAL ANALGESIA

• Cognitive:
  o Identify distressing negative cognitions and beliefs

• Behavioral approaches:
  o Mindfulness, relaxation, biofeedback

• Physical:
  o Activity coaching, graded exercise land & aquatic with PT, class, trainer, and/or solo

• Spiritual:
  o Identify and seek meaningfulness and purpose of one’s life

• Education (patient and family):
  o Promote patient efforts aimed at increased functional capabilities
**“COMPARING” EFFECTIVENESS**

<table>
<thead>
<tr>
<th>PAIN TREATMENTS</th>
<th>EXTRAPOLATED BENEFITS FOR VARIED PAIN OUTCOMES</th>
</tr>
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<tbody>
<tr>
<td>Opioids</td>
<td>≤ 30%</td>
</tr>
<tr>
<td>Tricyclics/SNRIs</td>
<td>30%</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>30%</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>10-30%</td>
</tr>
<tr>
<td>CBT/Mindfulness</td>
<td>15-50%</td>
</tr>
<tr>
<td>Graded Exercise Therapy</td>
<td>variable</td>
</tr>
<tr>
<td>Sleep Restoration</td>
<td>≥ 40%</td>
</tr>
<tr>
<td>Hypnosis, Manipulation, Yoga</td>
<td>“+ effect”</td>
</tr>
</tbody>
</table>

**NOTE**
- Many studies low GRADE quality of evidence
- Most studies <3 months
- Rarely do studies compare one treatment with another

11/5/14
1. Recent flare up of neck pain
2. Reviewed PT exercises – mainly stretching
3. Discuss neck/shoulder girdle strengthening
4. Sleep/fatigue – trazodone vs. more nortriptyline

2/10/15
1. Weight = 140 (BMI 22)
2. Sleep improved – nortriptyline, amitriptyline, trazodone
3. Worse UE sx’s; possible C6 radic – work up?
SUMMARY

- Anticipate multiple symptoms
- Prepare for adversity
- Setting expectations is key
- Continuing re-evaluation
- *Always* consider psychosocial factors

*Pain management takes time – many dimensions that evolve over time*
Selected References (1)


To Ask a Question

- **Using the Webinar System**
  - “Click” the Q&A tab at the top left of the webinar tool bar
  - “Click” in the white space
  - “Type” your question
  - “Click” ask

- **On the Phone**
  - Press Star (*) 1 to enter the queue
  - State your name
  - Listen for the operator to call your name
  - State your organization and then ask your question
Thank you for joining!

Centers for Disease Control and Prevention
Atlanta, Georgia
http://emergency.cdc.gov/coca
Today’s webinar will be archived

**When:** A few days after the live call

**What:** All call recordings (audio, webinar, and transcript)

**Where:** On the COCA Call webpage

http://emergency.cdc.gov/coca/calls/2016/callinfo_072716.asp
All continuing education (CME, CNE, CEU, CECH, ACPE, CPH, and AAVSB/RACE) for COCA Calls are issued online through the CDC Training & Continuing Education Online system (http://www.cdc.gov/TCEOnline/).

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http://emergency.cdc.gov/coca
# Save-the-Dates

Mark your calendar for the upcoming opioid prescribing calls

<table>
<thead>
<tr>
<th>Call No.</th>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>June 22</td>
<td>Guideline for Prescribing Opioids for Chronic Pain</td>
</tr>
<tr>
<td>2</td>
<td>July 27</td>
<td>Non-Opioid Treatments</td>
</tr>
<tr>
<td>3</td>
<td>August 3</td>
<td>Assessing Benefits and Harms of Opioid Therapy</td>
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<tr>
<td>4</td>
<td>August 17</td>
<td>Dosing and Titration of Opioids</td>
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