



UNITED STATES SURGEON GENERAL

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Dear Colleague,

I am asking for your help to solve an urgent health crisis facing America: the opioid epidemic. Everywhere I travel, I see communities devastated by opioid overdoses. I meet families too ashamed to seek treatment for addiction. And I will never forget my own patient whose opioid use disorder began with a course of morphine after a routine procedure.

It is important to recognize that we arrived at this place on a path paved with good intentions. Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do so safely. This coincided with heavy marketing of opioids to doctors. Many of us were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain.

The results have been devastating. Since 1999, opioid overdose deaths have quadrupled and opioid prescriptions have increased markedly – almost enough for every adult in America to have a bottle of pills. Yet the amount of pain reported by Americans has not changed. Now, nearly two million people in America have a prescription opioid use disorder, contributing to increased heroin use and the spread of HIV and hepatitis C.

I know solving this problem will not be easy. We often struggle to balance reducing our patients' pain with increasing their risk of opioid addiction. But, as clinicians, we have the unique power to help end this epidemic. As cynical as times may seem, the public still looks to our profession for hope during difficult moments. This is one of those times.

That is why I am asking you to pledge your commitment to turn the tide on the opioid crisis. **Please take the pledge at www.TurnTheTideRx.org.** Together, we will build a national movement of clinicians to do three things.

First, we will educate ourselves to treat pain safely and effectively. A good place to start is the enclosed pocket card with the CDC Opioid Prescribing Guideline. Second, we will screen our patients for opioid use disorder and provide or connect them with evidence-based treatment. Third, we can shape how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing.

Years from now, I want us to look back and know that, in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way. I know we can succeed because health care is more than an occupation to us. It is a calling rooted in empathy, science, and service to humanity. These values unite us. They remain our greatest strength.

Thank you for your leadership.



PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

BEFORE PRESCRIBING

1 ASSESS PAIN & FUNCTION

Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).

- Q1: What number from 0 – 10 best describes your PAIN in the past week? (0 = “no pain”, 10 = “worst you can imagine”)
- Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = “not at all”, 10 = “complete interference”)
- Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = “not at all”, 10 = “complete interference”)

2 CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE

Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

3 TALK TO PATIENTS ABOUT TREATMENT PLAN

- Set realistic goals for pain and function based on diagnosis.
- Discuss benefits, side effects, and risks (e.g., addiction, overdose).
- Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
- Check patient understanding about treatment plan.

4 EVALUATE RISK OF HARM OR MISUSE. CHECK:

- Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
- Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
- Urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
- Medication interactions. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE USE WHENEVER POSSIBLE.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW. IN GENERAL:

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
- Avoid ≥ 90 MME/day; consider specialist to support management of higher doses.
- If prescribing ≥ 50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- For acute pain: prescribe < 3 day supply; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused opioids.

See below for MME comparisons. For MME conversion factors and calculator, go to TurnTheTideRx.org/treatment.

50 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15mg)

90 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:

- 90 mg of hydrocodone (18 tablets of hydrocodone/acetaminophen 5/300)
- 60 mg of oxycodone (4 tablets of oxycodone sustained-release 15mg)

AFTER INITIATION OF OPIOID THERAPY

ASSESS, TAILOR & TAPER

- Reassess benefits/risks within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals (≤ 3 months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- If over-sedation or overdose risk, then taper. Example taper plan: 10% decrease in original dose per week or month. Consider psychosocial support.
- Tailor taper rates individually to patients and monitor for withdrawal symptoms.

TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT). MAT combines behavioral therapy with medications like methadone, buprenorphine, and naltrexone. Refer to findtreatment.samhsa.gov. Additional resources at TurnTheTideRx.org/treatment and www.hhs.gov/opioids.
- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at www.samhsa.gov/medication-assisted-treatment.
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage (≥ 50 MME/day), concurrent benzodiazepine use.

ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:
www.cdc.gov/drugoverdose/prescribing/guideline.html

SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):
store.samhsa.gov/MATguide

NIDAMED: www.drugabuse.gov/nidamed-medical-health-professionals

ENROLL IN MEDICARE: go.cms.gov/pecos

Most prescribers will be required to enroll or validly opt out of Medicare for their prescriptions for Medicare patients to be covered. Delay may prevent patient access to medications.

JOIN THE MOVEMENT

and commit to ending the opioid crisis at TurnTheTideRx.org.



The Office of the
Surgeon General

