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January 13, 2016

Thomas Frieden, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329-4027
Attn: Docket CDC-2015-0112

Submitted via: http://www.regulations.gov

Subject: CDC Guideline for Prescribing Opioids for Chronic Pain

Dear Dr. Frieden,

On behalf of the American Association of Neurological Surgeons (AANS), Congress of Neurological Surgeons (CNS), the AANS/CNS Section on Pain and the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves, we are pleased to offer you the following comments on the CDC's Guideline for Prescribing Opioids for Chronic Pain.

Clinical question 1 of the guidelines

The effectiveness of long-term opioid therapy versus placebo, no opioid therapy, or nonopioid therapy for long term (>1 year) outcomes related to pain, function, and quality of life, and how effectiveness varies according to the type/cause of pain, patient demographics, and patient comorbidities (Key Question 1; KQ1).

While page 12 of the guidelines does briefly mention the use of non-opioid medications such as gabapentin or other antiepileptic and/or antidepressant medications for the treatment of neuropathic pain, we believe that this discussion could also be applied to Clinical Questions 2 and/or 3 — particularly with respect to initiating opioid therapy — as the initiation of such therapy may only be indicated for neuropathic pain refractory to other medications.

Clinical question 4 of the guidelines

The accuracy of instruments for predicting risk for opioid overdose, addiction, abuse, or misuse; the effectiveness of risk mitigation strategies (use of risk prediction instruments); effectiveness of risk mitigation strategies including opioid management plans, patient education, urine drug testing, prescription drug monitoring program (PDMP) data, monitoring instruments, monitoring intervals, pill counts, and abuse-deterrent formulations for reducing risk for opioid overdose, addiction, abuse, or misuse; and the comparative effectiveness of treatment strategies for managing patients with addiction (KQ4).

With respect to measures aimed at predicting risk factors for opioid misuse and effective mitigation strategies, organized neurosurgery believes that a reference should be made to surgical options for the treatment of chronic pain — such as intrathecal pain pumps — as this is an effective means of treating chronic pain in the right patient population. Patients with intrathecal pain pumps are less likely to experience the systemic side effects of opioids and tend to be weaned entirely off of oral opioids long-

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term. As such, we believe that more primary care and pain management providers should be aware of this potential therapeutic intervention.

Clinical question 5 of the guidelines

The effects of prescribing opioid therapy versus not prescribing opioid therapy for acute pain on long-term use (KQ5).

We are concerned that recommendations for patients with chronic pain who undergo large surgeries, such as spinal surgery, are not fully addressed. On page 11 of the guidelines, there is a brief mention of data demonstrating that patients who undergo minor surgery, such as cataract surgery, are at greater risk for developing long-term opioid use when more than seven days of postoperative opioids is prescribed. However, for patients who undergo large spine surgeries — particularly for those in whom an underlying chronic pain condition is present — a postoperative course of opioids longer than seven days is often necessary. This distinction of the type of surgery is not clear in the current guidelines. Moreover, prescribing a short course of postoperative opioids for all surgical patients may result in severely under-treated postoperative pain.

Thank you for considering our comments. If you have any questions or need further information, please contact us.

Sincerely,

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