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April 4, 2022

Angela K. Oliver, Executive Secretary
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
4770 Buford Highway NE
Atlanta, GA 30341

Attn: Docket No. CDC-2022-0024

Subject: Feedback on the CDC Clinical Practice Guideline for Prescribing Opioids

Dear Ms. Oliver,

The American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) appreciate the opportunity to provide feedback on the Center for Disease Control and Prevention's (CDC) Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids. We congratulate the authors on creating an updated document that avoids many of the unintended consequences and misinterpretations of the 2016 version. However, we believe that this guideline remains incomplete due to several notable omissions.

We agree with the authors' statements regarding the limited benefits of opioids while also acknowledging that some patients benefit significantly from these medications and that they can be used responsibly with appropriate plans in place by a treatment team. Moreover, we are pleased to see the multiple bolded admonitions against forced opioid tapering and that patients currently on chronic opioid therapy should not be abandoned by their prescribing practitioner. Some clinicians frequently used the 2016 guideline to either forcibly and rapidly taper opioid doses or to outright suddenly cease prescribing for patients, both of which can potentially cause significant harm.

We also agree that post-surgical pain may require the use of opioids in the postprocedural period and that surgical teams should pre-emptively develop an exit strategy in the event opioid therapy is inadequate postoperatively. We would also encourage surgical teams to conduct this discussion and share this plan with the patient during preoperative discussions.

Unfortunately, the AANS and the CNS continue to be disappointed that, like the 2016 version, the proposed 2022 version of the guideline is incomplete. While the document devotes significant discussion regarding nonpharmacologic treatments for pain as alternatives to opioid therapy, the guideline fails to adequately explore surgical treatment options to reduce or eliminate opioid use.

Surgical treatment is often an option for a wide range of painful conditions and can significantly reduce the need for oral opioid use. Patients with conditions such as spinal radiculopathy and claudication, peripheral nerve compression syndromes such as carpal tunnel syndrome, neuropathic pain such as trigeminal neuralgia, and other diagnoses can often be relieved of their

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pain and need for opioid therapy via appropriate surgical treatments. **The guideline neglects to mention this and should include statements encouraging referral to determine eligibility for surgical therapies for individuals in pain.**

Surgical treatments run the gamut of decompressive (spinal, peripheral nerve, cranial nerve), reconstructive, ablative and neuromodulatory options. Evidence demonstrates that delays in the surgical treatment of appropriate individuals lead to a lower probability of success, thus further emphasizing the need for a timely surgical workup to maximize the chances of eliminating a patient's need for chronic opioid therapy.

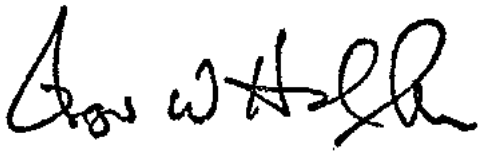
In addition, although the authors mention neurostimulation on line 2109 as a treatment option for selected patients, no further statements are made in the guideline about the role of this minimally invasive opioid-sparing therapy in helping curb an individual's opioid consumption. **Numerous high-quality peer-reviewed publications attest to the ability of implanted neurostimulation devices to significantly reduce patients' overall pain level and opioid use. This is a concerning omission in the guideline that should be corrected.**

Surgical therapies such as neural decompression (spinal, peripheral, cranial), neuromodulation (i.e., spinal cord stimulation, dorsal root ganglion stimulation, peripheral nerve stimulation, brain stimulation), and nervous system ablation (destructive surgical treatments), in conjunction with comprehensive pain rehabilitation clinics, and pain psychology, have been shown to decrease pain-related disability and reduce opioid use. These non-pharmacologic therapies for chronic pain have sufficient clinical evidence (including such resources as clinical trials, prospective data registries, and/or peer-reviewed clinical practice guidelines listing the therapy as a treatment option) to support their efficacy.[1-14] Indeed, advanced spinal cord stimulation (SCS) technologies allow chronic pain specialists to increase patient satisfaction and may decrease overall health care costs through fewer provider visits and less opioid medication.[15-17] Futhermore, data suggest that the sooner SCS is offered, the better the outcomes.[18-19]

Once again, we commend the guideline writing group for producing a much-improved document compared to 2016. Neurosurgeons are committed to working in parallel with opioid prescribers to adopt pain management strategies that incorporate surgical interventions as well as pre- and post-opioid tapering protocols. Great strides are being made and we hope the CDC will incorporate our recommendations to establish a modern guideline that will be embraced by the neurosurgical community.

We look forward to working together for the benefit of our patients. In the meantime, if you have any questions or need additional information, do not hesitate to contact us.

Sincerely,



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Endnotes:

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