April 11, 2022

Re: CDC Clinical Practice Guideline for Prescribing Opioids – United States, 2022

Docket No. CDC-2022-0024
Document Number: 2022-02802

Dear Dr. Dowell and Colleagues,

As physicians and leaders of the American Medical Women's Association (AMWA) Opioid Addiction in Women Task Force, we thank you for drafting the updated CDC guideline for prescribing opioids and for the opportunity to provide comments. The AMWA Task Force focuses on the impact of sex and gender on pain and response to opioids and risks of addiction, especially in women.

This current guideline makes significant changes and clarifications to prior guidelines. In particular, we are pleased to see that the guideline addresses the following points:

a) Improvement of function, as well as alleviation of pain, as an important outcome

b) The influence of social determinants of health on outcomes

c) The higher risk of inadequate pain management in women, despite higher opioid prescription fill rates compared to men

d) ACOG recommendations for pain management after vaginal and caesarean delivery, and American Academy of Pediatrics recommendations on breastfeeding in mothers with opioid use disorder (OUD)

However, there are several specific issues facing women and pain/pain management that were not addressed by the guideline. We respectfully ask the writing group to consider these issues, especially in light of the disproportionate number of women, compared to men, who suffer from disorders associated with chronic pain:

a) Prescribing and use of opioids in women of childbearing age: there is no safe dose of opioids for a developing fetus, and many women do not know they are pregnant at the time they start an opioid prescription. We would recommend that the guideline advise healthcare professionals to consider obtaining a pregnancy test prior to prescribing opioids for any duration to women in this age group, with referral of the woman for appropriate prenatal care and discussion of other options for pain control if the pregnancy test is positive. We suggest that healthcare professionals also consider the benefits of discussing and recommending low-acting reversible contraception (LARCs) or other contraceptive methods in women of reproductive age on chronic opioid treatment for any diagnosis.

b) Stigma among women associated with OUD treatment: this is especially of concern for women who are pregnant and/or have children and can keep them from seeking and continuing the care that they need for their opioid disorder.

c) Greater risk of opioid addiction in women compared to men using the same doses of opioids over shorter periods of time (telescoping). This risk needs to be considered when prescribing opioids to women, and supports the use of other options to reduce pain and improve function. As noted in the recommendations, opioids should be prescribed at the lowest dose for the shortest period of time; this is especially relevant when prescribing opioids to women.

d) Assessment and management of co-morbidities such as depression and PTSD: these conditions are more common among women than men and can impact the pain experience. These conditions are not part of a routine assessment, nor consistently addressed prior to initiating treatment for pain, especially chronic pain, resulting in poorer function and increased risks of continued use of opioids. Evaluation of a patient prior to initiating treatment for pain should include assessment (and treatment) for mental health disorders.

e) Social determinants of health: sex and gender have significant impacts on pain, the pain experience, and response to opioids and should be included in the list of other social determinants of health.

f) Prescribing of opioids to older women: use of opioids in this age group can increase the risk of falls. Older women, in particular, are at risk of low impact fractures especially if they have pre-existing low bone mass. Such fractures are associated with decreased function and increased morbidity and mortality. Caution should be used in prescribing opioids to this patient population, and other means of addressing pain should be explored.

g) In addition to the future research aims noted in the updated guidelines, we would recommend a call for more research into sex and gender influences on pain and opioid response and addiction. Current evidence indicates sex-based physiologic impact on nociception and gendered impact on pain expression. However, more information is needed in this area to better understand women and pain, and to identify better options for pain control and prevention of OUD.

We hope that the above suggestions will be of use to the committee. We think that adding this information to the Guideline will improve health outcomes for all.

Thank you for the opportunity to comment. Please contact us should you have questions.

Sincerely,

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