Comparative Effectiveness Review Disposition of Comments Report

Research Review Title: *Opioid Treatments for Chronic Pain*

Draft review available for public comment from October 15, 2019 through November 12, 2019.

Research Review Citation: Chou R, Hartung D, Turner J, Blazina I, Chan B, Levander X, McDonagh M, Selph S, Fu R, Pappas M. Opioid Treatments for Chronic Pain. Comparative Effectiveness Review No. 229. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No. 20-EHC011. Rockville, MD: Agency for Healthcare Research and Quality; April 2020. DOI: 10.23970/AHRQEPCCER229. Posted final reports are located on the Effective Health Care Program search page.

Comments to Research Review

The Effective Health Care (EHC) Program encourages the public to participate in the development of its research projects. Each research review is posted to the EHC Program Web site or AHRQ Web site in draft form for public comment for a 3-4-week period. Comments can be submitted via the Web site, mail or E-mail. At the conclusion of the public comment period, authors use the commentators' submissions and comments to revise the draft research review.

Comments on draft reviews and the authors' responses to the comments are posted for public viewing on the Web site approximately 3 months after the final research review is published. Comments are not edited for spelling, grammar, or other content errors. Each comment is listed with the name and affiliation of the commentator, if this information is provided. Commentators are not required to provide their names or affiliations in order to submit suggestions or comments.

The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

Section	Commentator & Affiliation	Comment	Response
FDA Reviewer	Not applicable	In your first key message (on page ii) you say: “Opioids are associated with small improvements versus placebo in pain and function and increased risk of harms at short-term (1 to <6 months) follow-up; evidence on long-term effectiveness is very limited and there is evidence of increased risk of serious harms that appear to be dose-dependent. “ We think it is important to clarify what you mean by " evidence on long-term effectiveness is very limited". Do you mean that there is some evidence that long-term opioid analgesic treatment does not work well in long-term pain control, or do you mean that there is an absence of high-quality evidence to support the long-term effectiveness of opioid analgesics? It’s our understanding that your literature review only supports the latter (an absence of high-quality evidence on long-term opioid analgesic effectiveness). We are concerned that characterizing your findings as “very limited” evidence could easily be misinterpreted by others, and we recommend that you clarify this point, throughout, as the remedy to these two situations is quite different .	We do not feel that the statement as written is subject to confusion; “limited” evidence means that there is not a lot of evidence; however the available (very limited) evidence also suggests no long-term benefit. We did not change the wording here or in the Abstract/Conclusions. We did not receive other peer review or public comments noting confusion over the phrasing.

FDA Reviewer	Not applicable	2. The results of an observational cohort study (Veiga, 2018) was cited as new evidence to support the lack of long-term opioid analgesic effectiveness. The citation was included in the following places of the AHRQ report: • On page ES 12, "One new cohort study found no association between long-term opioid therapy versus no opioids and pain, function or other outcomes." • The study was described on page 63, under the heading "Intermediate (6-<12 month) and Long-term (>=12 months) follow-up" • Appendix Tables H1 and H2: In Table H2, AHRQ rated the quality of the study as "good" FDA epidemiologists identified important limitations of the cited study that we encourage ARHQ to consider when reaching conclusions regarding the new evidence: • Mean doses of prescribed opioid analgesics were not reported. The appropriateness of opioid analgesic dosing cannot be assessed because the study did not provide dose information for patients in the opioid group. So, the finding of no long-term benefit associated with opioid treatment could be due to opioid analgesic users receiving inadequate doses. • The study compared opioid analgesic users versus non-users: Opioid analgesic users were defined as patients taking opioids for six or more months during the 2-year follow-up. It is unclear if the authors excluded patients who used opioid analgesics for less than 6-months from the study analyses, or if they are included as "non-opioid users". If the patients who used opioid analgesics for less than 6-months were included in the non-opioid group, it would not be an appropriate comparator to evaluate long-term effectiveness. • The propensity score model does not fully account for some confounders that would influence pain treatment. Such confounders could include other analgesics (e.g., NSAIDs), alternative medications (e.g., gabapentin), or alternative therapies (e.g., acupuncture, physical therapy, cognitive behavioral therapy). • The analyses were not stratified by the various pain conditions included in the study. It is unclear if opioid analgesic treatment might have been successful in treating one or more pain conditions, while	The median dose was described in the Supplemental Table of the study (60 mg MED/day at baseline and at 6 months and 90 mg MED/day at 12 and 24 months). We do not think that "non-users" would include people on opioids for <6 months. Some information is provided in the Supplemental table on other medications and treatments. The propensity model accounts for a number of demographic and clinical variables; although inclusion of additional variables on other treatments would be ideal, we do not think it is likely to impact the results. Information about the underlying pain condition was also provided in the supplemental tables and was added to the Results. We added a sentence noting that results were not stratified by pain condition. We do not feel that any of these issues represent serious methodological limitations and did not change the quality rating of the study. However, the strength of evidence is still low because it is a single observational study.

Section	Commentator & Affiliation	Comment	Response
		unsuccessful in treating others. • The study population is recruited from a pain clinic. It is unclear if the findings can be generalized to patients that are treated by their primary care physician or general practitioner, which is the case for most patients treated for chronic pain .	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #1, Lewis Hsu, (Pediatric hematologist-oncologist)	Question 1	There should be a stronger statement in the exec summary about limitations of the approach. State that chronic pain is heterogeneous and complex, so Analysis of large groups can miss the impact on individuals and on subgroups. This analysis of chronic pain does not ban the use of opioids in individual cases and individualized multimodal pain management plans based on best practices guidelines and evidence-based guidelines for specific subgroups and rare diseases with pain such as sickle cell disease and cancer.	The report analyzed effects of opioids in subgroups based on the underlying effects; as noted, in some analyses effects were slightly larger in patients with neuropathic pain. Evidence on how effects varied depending on patients demographics was extremely limited. There was very little evidence on how effects of opioids varied based on presence of comorbidities such as past or current opioid use disorder or depression. The report synthesizes the evidence on opioids for chronic pain; it does not make recommendations.
Public Reviewer #1, Lewis Hsu, (Pediatric hematologist-oncologist)	Question 10	This has academic rigor but it has a high likelihood of causing harm to Individual patients. Statements like this from the CDC were used to block or delay care for individual patients, when the global conclusions were applied without nuance to individual cases that had careful risk-benefit judgements in creating pain management plans that are agreement with the patient and longterm physician. The CDC had to add amendments and exceptions and subgroups after public outcry. The authors should be aware that the policy recommendations can be misused in the real world as blunt instruments to set up roadblocks to prescriptions for patients who have short term pain, for complex pain, for acute exacerbation of chronic pain, and for subgroups like cancer and sickle cell disease. Please amplify the Limitations section and Executive Summary sections.	The report synthesizes the evidence available in the published literature and does not make recommendations
Public Reviewer #10, Tom Supinka, National Safety Council	Uploaded Document	AHRQ Opioid Treatments for Chronic Pain NSC Comment.pdf	Thank you for the comment. The attachment (#1) was reviewed.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #101 and 102, Cheryl Brown	Question 1	Transparency in government means disclosure of all information regarding any government committee and the so called [and] quot;evidence from studies [and] quot; you have taken your information from. I insist that any further drafts or final reports include this information. Also, I believe your summary is based on the wrong [and] quot;evidence [and] quot; and your conclusions will, of course, be flawed also. Basically, You have selected certain studies because they reflect this panels views and personal choices. They do NOT consider the CDC [and] #039;s reiteration that their own guidelines were exactly that - guidelines. And that current patients do not need to change their current dosages, much less have their only effective relief from chronic everyday pain taken away from them.	The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input. The report was conducted by investigators at the Pacific NW Evidence-based Practice Center; we do not know what "panel" the reviewer is referring to. The report does not make recommendations.
Public Reviewer #101 and 102, Cheryl Brown	Question 10	I suggest that current medications be left alone until new medications are approved and made affordable for the general public when their doctor or clinician prescribes it. I would suggest that you remember your oath to [and] quot;First, do no harm. [and] quot;	Thank you for the comment
Public Reviewer #101 and 102, Cheryl Brown	Question 2	The majority of opioid deaths in this country are from fentanyl. Whether legally prescribed or obtained from illicit sources. Current patients are not being allowed their due process and allowed to choose for themselves with their doctor what is in their best interest. And if there are doctors on this committee, I would suggest that you remember your oath to [and] quot;First, do no harm. [and] quot;	Thank you for the comment. Fentanyl is discussed in the Introduction.
Public Reviewer #101 and 102, Cheryl Brown	Question 3	No matter the methods used, you need to let physicians take care of their patients and only suggest they have meaningful discussions with patients on the risks of opioid medications. Until politicians and unqualified people stop trying to interfere, there will be dire consequences for the patients.	The report synthesizes the evidence and does not make recommendations.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #101 and 102, Cheryl Brown	Question 4	While many patients with chronic pain do become dependent on their medication, that does NOT mean they are addicts. And that clarification is not shown in your draft. Since 2016 prescriptions for opioid medications have fallen. Yet the deaths due to opioids, no matter the source, have risen. That suggests that patients that are not drug seeking or are addicts are going without and real addicts are still killing themselves. Unfortunately, the focus is on doctors and patients doing the right thing and no one is trying to deal with the real problem. You have drug dealers using the dark web without repercussions and no one is considering them a problem. And real patients are left without medications to deal with the pain that is not affected by non-opioids, therapy or any other methods. They are turning to the unfettered dealers for relief or worse they see no way out and cannot cope with the stigma now unnecessarily put upon them of drug seekers and they look to suicide.	Thank you for the comment. Evidence on the association between use of opioids and risk of addiction is addressed in KQ 3c. The report does not state or imply that all patients who take opioids become addicts.
Public Reviewer #101 and 102, Cheryl Brown	Question 5	Also, you have not made any mention of new medications that have yet to be approved by the FDA that may or may not be effective for chronic pain sufferers. I suggest that current medications be left alone until new medications are approved and made affordable for the general public when their doctor or clinician prescribes it. I would suggest that you remember your oath to [and] quot;First, do no harm. [and] quot;	The report addresses published evidence on the benefits and harms of currently available opioids.
Public Reviewer #103, Sharon Grider, Retired Veterans Administration	Question 1	As a patient that has taken both opioids vs other alternatives such as tylenol or motrin for pain for over 20 years I can assure you that your study is wrong. I along with many other patients who rely on these medications know that opioids work better to relieve pain. I say this from personal experience and 14 painful surgeries.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #103, Sharon Grider, Retired Veterans Administration	Question 10	I disagree with all of the report. Scientific data from the AMA states differently. The 2016. CDC guidelines need to be thrown out. They are hurting patients doctor relationships and people are suffering. Many are dying from being tapered after years of relief. Many are committing suicide. And the worst part is many are now seeking relief in the worst places where medications are not safe. Illegal fentanyl. Please stop the madness of denying patients opioid medications. Pain patients have been shamed and stigmatized for their disease and suffering. This report is so one sided. I am a medically retired patient that lives with chronic and severe unrelenting pain that is not relieved without opioids. It was also my last resort after all other options failed.	Thank you for the comment, the report does not make recommendations or guidelines. It summarizes the published evidence on benefits and harms of medications for chronic pain.
Public Reviewer #103, Sharon Grider, Retired Veterans Administration	Question 2	I disagree with the statements that opioids are not safe or effective after 6 months for the treatment of chronic pain. I also DISAGREE with tapering opioid stable patients. As a patient that functioned on a high dose of these medications I was tapered and put back on a lower dose. Every since my dose was reduced I now have no quality of life. Basically home bound. Not having my pain adequately treated is a slow death. I feel as if these studies have not been done scientifically. Or they are pushing an agenda for a new drug such as Suboxone.	Thank you for the comment, the report summarizes the published evidence on benefits and harms of medications for chronic pain.
Public Reviewer #103, Sharon Grider, Retired Veterans Administration	Question 3	As stated by the American Medical Association. Opioids are an effective in pain management. There is no magic MME number. Every patient is different and should have their pain treated by a medical specialist. Putting limits on pain relief in absurd. Weight age and metabolism should be factors. Not arbitrary limits.	Thank you for the comment, the report does not make recommendations or guidelines. It summarizes the published evidence on benefits and harms of medications for chronic pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #103, Sharon Grider, Retired Veterans Administration	Question 4	Results are inconclusive per your charts. But I and million of other patients that correctly use opioid medications can attest to the benefits of these medications over a placebo or NSAIDS. Also Veterans and Civilians that were tapered from their opioid pain medications are dying. My husband actually had a heart attack and died 3 months after his medications were tapered that he had safely taken for 8 years. Veterans are committing suicide because they can [and] #039;t get relief. America is being infiltrated with illegal fentanyl that is killing our citizens because they are seeking relief. Or they are suffering without help or they are committing suicide. Americans should have access to safe legal medications to relieve their pain. By the way. Alcohol and cigarettes kill too and you can purchase these items at any store. Why not educate adults and let them choose safe relief.	Thank you for your perspective
Public Reviewer #103, Sharon Grider, Retired Veterans Administration	Question 5	I totally disagree with the 2016 CDC guidelines that were implemented by non medical personnel. It was PROP members that initiated these guidelines all in the name of GREED to sell their new drug Suboxone. The 2016 guidelines need to be terminated. They have caused more harm in America and will go down in history as one of the most barbaric events in medical history. Overdose deaths are now from illegal drugs. Patients are in agony. Proper research is available. Not biased as what is being used.	Thank you for the comment, the report does not make recommendations or guidelines. It summarizes the published evidence on benefits and harms of medications for chronic pain.
Public Reviewer #103, Sharon Grider, Retired Veterans Administration	Question 7	As with this publication the research used is biased against opioids and their effectiveness. Please remember there are two sides to this coin. I personally think it is safer to allow legal opioid pain medications to patients that require said medications. The alternatives are very grim for those of us that have safely used these medications successfully for relief for 20 years.	Thank you for the comment, the report does not make recommendations or guidelines. It summarizes the published evidence on benefits and harms of medications for chronic pain.
Public Reviewer #103, Sharon Grider, Retired Veterans Administration	Question 8	Not enough time to check the references due to short notice for comments.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #103, Sharon Grider, Retired Veterans Administration	Question 9	Not enough given time to research due to time limits when comments are due.	Thank you for the comment
Public Reviewer #104	Question 10	I am a chronic pain patient who was stable on my medications Due to the guidelines I no longer get my medications. I have fibromyalgia, spinal stenosis, disc degenerarion, herniated discs and due to a car accident in 2013 severe neck.pain and headaches. I have tried every alternative treatment and.medications but there are now ongoing health problems due to the pain. I no longer have any quality of life and cannot work more than 15 hours a week. When i was on my medicatiins I was working 40-50 hours.a week with a no problem and could do things outside of work with my family. I no longer can do much besides lay in bed crying due to the pain. Please stop hurting chronic pain patients	Thank you sharing your story, we are sorry to hear about your pain. The report does not make recommendations or guidelines. It summarizes the published evidence on benefits and harms of medications for chronic pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #105, Douglas Hardin	Question 1	I am a cancer patient and the new and old limits on pain meds. have put me in agony. Chronic pain patients have a very large crowd of people who have no training in chronic pain treatment that must say yes before they can receive relief from their pain. I really don [and] #039;t understand how pushing the pain patients out on the streets is going to do anything to solve the opioid situation. I feel that somthing sinister is afoot here because the only people being punished are the people that followed the letter of the law and went to a doctor and got their meds. The numbers of overdoses don [and] #039;t seem to have changed much with the new guidelines so this would leave me to believe that going after the cronic pain community has only pushed those people to the streets and made the problem worse. This to me would indicate to me that this is a illicit drug problem and not a opioid problem. The problem must be correctly identified before any real progress can be made. I find it has to believe that all of these collage edjucated doctors and law inforcement and politicians misunderstood the guidelines. This is a horrible miscarriage of justice and must be reversed as people are dieing both addicts and cronic pain patients alike..	Thank you sharing your story, we are sorry to hear about your pain. The report does not make recommendations or guidelines. It summarizes the published evidence on benefits and harms of medications for chronic pain.
Public Reviewer #106, Debra Winterroth	Question 1	I personally know that long term high doses of opioids Do control my husband [and] #039;s pain from graft vs host and neropathy secondary to chemotherapy. The alternative meds had severe adverse reactions, were debilitating, little to no pain control and in2 cases life threatening.	Thank you for sharing your story, we are sorry for your husband's pain.
Public Reviewer #106, Debra Winterroth	Question 4	Again your results are totally opposite of my husband [and] #039;s results. It is essential his pain be controlled or his graft vs host will fail and can easily be a very painful death sentence.	Thank you for sharing your story, we are sorry to hear about your pain. The report is not making recommendations or guidelines. It summarizes the published evidence on benefits and harms of medications for chronic pain
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 1	The Government Overstepping, their authority, without all the answers related to facts, nothing new or unexpected. The citizens of the USA, who follow the laws, go to the doctor trying to get some help for constant pain, or after surgery being held responsible for illegal drugs and junkies.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 10	God Bless your efforts and thank you for your hard work.	Thank you for the comment
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 2	It doesn [and] #039;t take 214 to figure out facts. Politicians don [and] #039;t give a hoot about suffering, they have taxpayers insurance, best doctors, I would bet my bottom dollar, if anyone of them are in even temporary pain, they receive the medication to help stop suffering. Hypocrites in the most expensive form, who sees through dollar signs, if not being paid off for their pocketbooks, they could care less for the people. Actually they should be held accountable for murdering all those who commit suicide because their pain is unbearable.	Thank you for the comment
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 3	More BS, to full the ignorance of no serving the people, these fools will never listen too because there are no dollars for them connected.	Thank you for the comment
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 4	A lot of hard work and words that will go in one ear and out the others, without results. It [and] #039;s truly sad for those who are putting in so much work on behalf of us who suffer constantly to closed ears and minds.	Thank you for the comment
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 5	Thank you for all your efforts.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 6	A lot of hard work, my mind, and thoughts hope the report helps, but my heart still believes these fools don [and] #039;t understand or care without almighty dollar hook.	Thank you for the comment
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 7	Thank you for all your hard work, Bless you for your efforts.	Thank you for the comment
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 8	Rather, your pain is from being chronically ill, have birth defects, disease or temporary pain, the control and reach of government is overstepping The Constitution in every facet of taxpayers rights to push something or someone [and] #039;s agenda, without any compassion, common sense or any kind of educational exposure related to chronic pains horrific consequences.	Thank you for the comment
Public Reviewer #107, Elois Beaty, Not an Organization, just a chronic suffer who is pissed!	Question 9	Something, that [and] #039;s should be so simple, with medical tests for suffering humans, being controlled by junky [and] #039;s behaviors, it [and] #039;s just pathetic.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #108, Holly Skelton	Question 10	We need to widen the field of providers that can prescribe to include chronic illness specialists and primary care doctors. They know us best and understand the painful conditions. Pain clinics pressure us to get injections that are both dangerous and ineffective. One of my first severe pain episodes happened when I woke up from a cervical injection for spinal stenosis. It has been greatly ignored as a possible reason for the rapid degeneration. Things have gotten much worse since then. Most in an effort to curb opioid use. It [and] #039;s wrong morally and ethically to put patients through this. Monitored use of opiates for chronic pain has been successful in the past for me and many other pain patients I have spoken with. The contracts need to be based more on opioid education than rules, so that the rules make sense to the patient. Also, someone in pain is going to find a way to relieve it eventually. I worry that we have a serious issue with lack of pain care to a point that will fuel the black market. And that feels very dangerous to me.	Thank you for sharing your story, we are sorry to hear about your pain. We agree the patient should work with her doctor to find a solution that works for her.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #109, Candi P, https://www.facebook.com/groups/DontPunishPainRally	Question 1	Key messages are NOT correct at all. Long term opioid treatments work for many many people. So does higher strengths. [and] amp; they don [and] #039;t put patients at any higher risk. This report is all wrong. [and] amp; A LOT of misinformation. Prescription opioids are safe [and] amp; effective for the many many pain patients that take them. Its illegal street drugs(heroin, fentanyl, carafentanyl, etc. - opioids) that people are over dosing [and] amp; dying from. NOT prescription pain medicine(opioids). This opioid crisis/epidemic needs to be made known that its the illegal street drugs killing. NOT prescription pain medicine. People are now committing suicide or turning to illegal street drugs because of the massive tapering or being cut off from their long time safe [and] amp; effective prescription pain medicine [and] #039;s. Also with people being in SO much pain now, its causing them to have other detrimental health conditions such as heart attacks. Most people taking safe [and] amp; effective pain medication are older(40 [and] #039;s, 50 [and] #039;s, 60 [and] #039;s or older). Yet people over dosing [and] amp; dying are younger in their teens [and] amp; twenties. Again, showing this epidemic is from illegal street drugs. NOT prescription pain medicines.	Thank you for the comment. The conclusions and findings are based on the available evidence in the published literature.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #109, Candi P, https://www.facebook.com/groups/DontPunishPainRally	Question 10	Again, most or all of what [and] #039;s written in here is wrong/not correct. You cannot get conclusive results from a small group of people from some time ago. Millions [and] amp; millions of pain patients are compliant with their medicines [and] amp; get effective function, relief from pain [and] amp; quality of life with safe, effective prescription pain medicine. Its illegal/illicit street drugs that people are over dosing [and] amp; dying from. NOT prescription pain medicine. Stop punishing people in pain because of illegal street drugs. By doing so you [and] #039;re just pushing them to the cause(illegal street drugs), committing suicide or having other detrimental health conditions(such as heart attacks, strokes, etc.). People just can [and] #039;t live in SO much pain. Prescription pain medicines have been found to be effective [and] amp; safe because they are controlled. Please stop going against prescription pain medicines.The govt [and] amp; media went against rx pain meds because they don [and] #039;t know what to do about the illegal street drug problems. So they figured they [and] #039;d(govt) would go after easy targets like doctors [and] amp; manufacturers to make it look like they [and] #039;re [and] quot;doing something about it(opioid epidemic) Also, they(govt) can or actually is getting a ton of money by blaming prescription opioids by suing the manufacturers. [and] amp; probably get a ton of money off of addiction drugs such as Narcan [and] amp; Suboxone.This is completely unfair [and] amp; totally not right. Its illegal street drugs causing the opioid epidemic/crisis. NOT prescription pain medicines. [and] amp; everyone is just hurting more [and] amp; more people by going against the safe [and] amp; effective rx pain meds. Instead of going after [and] amp; doing something about the real cause, illegal street drugs.Please STOP punishing people in pain more then they [and] #039;re already suffering! PLEASE!!!	The report is based on the available published evidence, including over 130 randomized trials as well as observational studies.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #109, Candi P, https://www.facebook.com/groups/DontPunishPainRally	Question 2	There are A LOT of wrong things with this report. Many, many people have had significant(not small but BIG) improvements in pain([and] amp; quality of life) with opioid medicine compared to non-opioid as well as big improvements with function, mental health status, sleep [and] amp; a lot less depression. [and] amp; great increase in quality of life in long term use [and] amp; effectiveness. I don [and] #039;t know where you got or did your research or got your findings but pretty much this whole thing is wrong.The majority of people in pain taking prescription pain medicine take it as prescribed(even in higher doses) ([and] amp; yes higher doses do help the effectiveness [and] amp; relieve pain better then lower doses) [and] amp; have never had any problems. They also have increased quality of life, function, sleep, etc.Again, the problems are with the illegal/illicit street drugs(opioids) such as heroin, fentanyl, carafentanyl, etc. There needs to be made known a difference between the illegal/illicit street street drugs [and] amp; prescription pain medicine. Since they [and] #039;re both considered opioids. Because its the illegal/illicit street drugs that people are over dosing [and] amp; dying from. NOT prescription pain medicine.Prescription pain medicines are controlled [and] amp; therefore safe [and] amp; effective(when taken as prescribed, even in higher doses). Illegal/illicit street drugs are NOT controlled [and] amp; are getting stronger [and] amp; stronger as well as cheaper [and] amp; cheaper being mixed with other dangerous substances. People take take illegal street drugs [and] amp; then combine them with other substances [and] amp;/or alcohol [and] amp; that [and] #039;s when they over dose [and] amp;/or unfortunately die. They keep chasing to get a good [and] quot;high [and] quot; [and] amp; keep doing more [and] amp; more.Where as people on prescription pain medicine just want pain relief [and] amp; take the same dose day after day [and] amp; are safe. They might need a higher dose of rx pain meds. But when they get to a certain dose(increased slowly) they stay at that dose [and] amp; take the same dose day after day.	Thanks you, noted. The report is based on evidence on the benefits and harms of prescription opioids.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #11, Spencer Dunstan	Question 1	I personally disagree with the belief that there [and] quot;IS [and] quot; [and] #039;no difference [and] #039;. As a long time chronic pain patients, pharmaceutical opioid medications have made a DRASTIC improvement for my over all pain management, and well being. I am shaking my head in disbelief at the supposed [and] #039;findings [and] #039; of this study. I have tried many different medications, pharmaceutical, and over the counter, and by FAR the most effective have been prescribed opioid pain medications, every single time.	Thank you for the comment. The conclusions and findings are based on the available evidence in the published literature.
Public Reviewer #11, Spencer Dunstan	Question 10	I strongly disagree with this report, and feel this report may have been drawn out to support a biased, prejudiced position based on false premises. This WILL harm pain patients who need medications. Scapegoating medications, that DO work, and maligning and adding yet MORE suffering to pain patients, who have little to no alternatives is barbaric and already leading to disastrous results.	Thank you for the comment. The conclusions and findings are based on the available evidence in the published literature.
Public Reviewer #11, Spencer Dunstan	Question 2	I disagree with many of these statements. My personal experiences have been different. My interactions with doctors themselves, chiropractors, and even physical therapists, ALL of which who have managed THOUSANDS of pain patients, ALL have told me the same thing, that they have observed clinical improvements in patient pain management due to prescribed opioid medications.	Thank you for the comment. The conclusions and findings are based on the available evidence in the published literature.
Public Reviewer #11, Spencer Dunstan	Question 3	I do not understand the methods, because as a member of many Chronic Pain support groups, whom I interact with on a daily basis, and have been involved with since about 2010 or so, ALL patients have been saying essentially the same thing. So I have to disagree with the [and] #039;methods [and] #039; they are using to get these off the wall results/findings. They do not speak to the THOUSANDS of pain patients, and HUNDREDS of doctors who actually treat pain patients , who say that Opioids ARE effective short term and long term.	Thank you for the comment. The report is based on the available evidence, including over 130 randomized trials as well as observational studies.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #11, Spencer Dunstan	Question 4	I disagree with the results. I have experienced pain with OTC/nothing and pain WITH prescribed pharmaceutical opioids and I observe NO placebo effect, or an imaginary improvement, or no verifiable, quanitifable results. I DO experience well being, increased range of motion, decrease burning, stabbing pain, and so on. We have had studies and use of these medications for at least 50 years, any studies that are saying to the contrary are suspect. If these medications had [and] #039;no effect [and] #039;, there would be NO use of them, period.	Thank you for sharing your story, we are sorry to hear about your pain. The report is based on the available evidence, including over 130 randomized trials as well as observational studies.
Public Reviewer #11, Spencer Dunstan	Question 7 and 8	I suspect any reference on this draft, as I have personally seen, and read many studies that SUPPORT that prescription opioids used in a clinical manner, for both acute and long term chronic pain DO benefit.	Thank you for the comment

Public Reviewer #110, R Devane	Question 1	This report is so disturbing to read. Pain medications can be literally life-changing and saving for those with chronic conditions that cause pain. This report is flawed and the summary misrepresents the facts, as the most of the populations studied do not have the varied conditions, which are known to be helped by pain medications. Many of the studies were for patients with osteoarthritis or bone-related pain. Where are the studies of patients with Ehlers Danlos Syndrome, RA, cancer, etc? Those populations are significantly helped by pain medications and most patients have tried alternative therapies for years without success. Many of these studies were short-term and we know that long-term pain medication use has been extremely effective in certain populations. Where is the recent study out of Boston Medical showing that only 1.3% of opioid deaths were for patients who were prescribed the medications? Where are the recent studies that show the benefits of pain medication use, including the anti-inflammatory properties of certain medications? Where are the studies showing the harms of the suggested alternatives, as well as the comparative studies of those medications [and] amp; pain medications? Furthermore, most studies were for only a couple of medications. This report seemed to be written with the intended outcome; I suspect the PROP coalition and those who have a financial gain in minimizing pain medication use, informed this report. There has been too much harm to the chronically ill population already. Enough with the assault on pain patients and their physicians! Furthermore, those who actually treat pain patients for their physical pain need to be consulted. The suffering these populations endure is unimaginable. For example, in EDS, patients dislocated shoulders, ribs, and hips even while sleeping. Pain medication is often the only thing that allows these patients to get out of bed and have a higher quality and functioning life. The facts are also that leas than 1% of those taking pain meds for chronic conditions will addict. The facts are addiction rates have not changed for a century; the facts are as prescriptions have declined, deaths have soared. This is a very dangerous and completely inhumane game that is being played with peoples lives. As a caregiver and advocate for those with serious, chronic medical conditions, I am deeply troubled by this report.	Thank you for the comment. The report is based on the published evidence. End of life cancer pain was excluded. The conditions addressed in the trials are described in the Tables. There was little difference in findings when trials were stratified according to musculoskeletal or neuropathic pain (1 trial evaluated fibromyalgia). There are no randomized trials of opioids for Ehles Danlos syndrome.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #110, R Devane	Question 10	See section 1 above.	Thank you for the comment
Public Reviewer #110, R Devane	Question 2	Misleading, please see above. The introduction makes sweeping statements, but the studies are not relevant to all populations.	The Introduction provides national-level data on harms of opioids.
Public Reviewer #110, R Devane	Question 3	See comments in section 1. One certain populations and medications were studied. This report is misleading and dangerous.	Thank you for the comment. The report included evidence on opioids in various types of chronic pain.
Public Reviewer #110, R Devane	Question 4	See section 1 comments. The results are based on flawed information. The populations that benefit the most from Rx pain medications, such as EDS, were not studied.	There were no randomized trials of opioids for Ehles Danlos syndrome.
Public Reviewer #110, R Devane	Question 5	See section 1 above. This report is dangerously flawed and biased.	Thank you for the comment
Public Reviewer #110, R Devane	Question 7	The references seem to have been picked and chosen in order to support a conclusion that appears to have been pre-conceived. References and studies that show the benefits of opioid therapy and lack of harm to those being prescribed by a qualified physician were not included, nor were those that show the harms of the alternative medications.	Studies were identified using systematic searches and studies were selected for inclusion based on pre-specific inclusion criteria.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #111, Amanda Lapworth	Question 1	While getting second opinion after exhausting all brain surgery options for infection that traveled to brain and caused severe Trigeminal neuropathy and hemifacial spasms, 13 CVS pharmacies in CA refused to fill pain medicine. This is probably the result of red flags after getting 2nd opinions in NC, Michigan, and CA (dr shopping) and filling medicine at other pharmacies other than one near my home despite dr approval due to extended travel and stay while getting extensive testing. I was forced cold turkey off medicine in an environment where my pain and spasms were already uncontrollable. My intense desire to get better by getting recommendations from best instead scarred my husband/caretaker for life and resulted in him struggling for yrs with PTSD as I writhed in pain when medicine was taken away. I stayed off medicine for another 1 1/2 mo in my desire to not need medicine to control pain. All the rules and regulations have resulted in missing my grandmothers funeral, holidays, and being close to family out of state because I can only fill medicine at my home pharmacy.After 11yrs of trying all available medicine, the only medicine that stopped the pain was ER morphine. I resisted pain medicine for yrs as I struggled to work as a scientist. My symptoms and pain over the last 16 yrs have progressively gotten worse and often cant see from hemifacial/blepharospasms.I have successfully been on ER morphine for 2 yrs. I have never experienced any high just pain relief that enables me to get out of bed and improve daily function and take care of self. However, no medicine will stop the horrific helpless memories my husband has from the experience these regulations taking away Nucynta ER medicine.	Thank you for sharing your experience.
Public Reviewer #111, Amanda Lapworth	Question 10	The secretive members and funding is a major concern. When affecting public policy and not disclosed there is obvious conflicts of interest. Stop doing social experiments on CPP. We are not the same as the addict. These are 2 completely different populations. CPP want pain medicine to improve quality of life and be present and participate in the lives of their loved ones. Addicts destroy the family fabric at all cost just to serve their own needs.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #111, Amanda Lapworth	Question 2	Your analysis of how to evaluate if pain medicine is deeply flawed. Pain medicine that alleviates pain allows CPP to participate in their life and function better with better quality of life. However, the majority of painful conditions worsen when patients do more or too much. It is very important that pacing oneself is critical. However, when pain medicine increases ability to be a functioning family member at home who can participate in simple tasks, this often results in increased pain.A CPP who lives every moment in pain or knowing that doing too much will increase pain must make decisions about what they wish to be part of and not let their pain separate them from the healthy living. Grandparents often choose play time with grandchildren, parents choose activities with kids, I wish I could have chosen my grandmothers funeral that was 700 miles away . These are moments you never want in life to pass you by and CPP must make a trade off. The pain medicine will allow us to be present however too much activity often worsens pain. However, every single person denied long term pain medicine for conditions that will not get better or exhausted all medical options can not make the choice to participate in life and have a better quality of life with better relationships with the people they love. Denying opioids for these people because there pain has not changed does not capture the real reason pain medicine helps. Long term opioids allows a sick person a chance to get out of bed and have better quality of life by participating in the lives of their loved ones and being able to help in small ways to care and be present for children and grandchildren and their parents.Long term opioids increases quality of life dont take CPP ability to connect and participate in the lives of people they love. This activity may increase their pain however they would not accomplish this without pain medicine and wouldnt change these decisions even if the trade off is more pain. Their loved ones are always worth it.	Thank you for sharing your story. This report does not make clinical recommendations, but reviews the published evidence. Patients should work with their provider to make the best decision for pain relief.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #111, Amanda Lapworth	Question 3	Just because its unethical to take away a pain patients opioid to study the positive effects of medicine or if u are going to study pain medicine you must take into account the CYP polymorphisms that affect drug metabolism and clearance and titrate medicine upwards to their effective dose. As a scientist the inaccurate conclusions that are drawn in this report are not scientific or correct.	Thank you for the comment. The trials did not evaluated effects of CYP polymorphisms on benefits or harms. We revised the Research Needs section to note this as a future research need.

Public Reviewer #112, Lori Ravelli	Question 10	My name is Lori Ravelli I am a 51 year old professional living in Galveston, Tx. I am writing to ask for a change in attitudes toward people in pain who need improved access to treatments. I want my voice to be heard when actions are taken to curb the opioid abuse problem.I need your helpI suffer and have suffered for years from severe chronic lower back and coccyx pain that is unbearable. Some of the issues I have been diagnosed with lumbar spondylosis with narrowing disc space at every level, there are also anterior and posterior osteophytes at all bubbles, hypertrophic set arthropathy at all levels, degenerative disc disease and also scoliosis. I also had a gastric procedure which limits the kinds of medications I am able to take(such as ibuprofen, muscle relaxers, naproxen and nsaids). I have had multiple appointments with neurosurgeons and other doctors to be told I have too much wrong with my lower back to have any surgical procedure. I have stacks of reports, cds and test results justifying my issues. My only option is pain management thru medication. I can not sit down for any length of time, lying down hurts and I can only stand for so long without my legs giving out. In addition to that these days I have been getting shooting pain down my leg when I do sit. Sadly as much as a body needs rest...I can no longer rest comfortably. My quality of life is almost non existent due to the debilitating pain and without relief I really contemplate ending my life. I can no longer deal with the agony and doctors being scared to treat patients that are suffering is not fair to us...the ones in pain. I do not want my friends and family to grieve because I took my life due to pain and lack of treatment. As a concerned, responsible patient I try my best to not even use all the medication prescribed by my doctors to avoid needing to raise the does of medication needed to relieve my pain in the future. The chronic pain patients are the ones that actually visit their doctors more often, are subject to drug tests and are not the reason there is a crisis in this country. The problem seems to be addicts that purchase medication from the streets, not knowing what they are purchasing and not receiving medication thru the proper channels. When people are not able to get their medication from the proper channels they will seek options from the street with hope of finding some relief. Pain relief is a human right and without relief	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		people will take their lives. Living with debilitating pain you have no quality of life and no reason to wake up in the morning. I am tired of being treated like I am a drug addict because I am suffering severely and need medication to be a functioning adult. I know I will never be pain free but any relief is welcomed. Please, please for the love of God stop punishing the patients and the medical professionals trying to help them!	

Public Reviewer #113, Lori Ravelli	Question 10	My name is Lori Ravelli I am a 51 year old professional living in Galveston, Tx. I am writing to ask for a change in attitudes toward people in pain who need improved access to treatments. I want my voice to be heard when actions are taken to curb the opioid abuse problem.I need your helpI suffer and have suffered for years from severe chronic lower back and coccyx pain that is unbearable. Some of the issues I have been diagnosed with lumbar spondylosis with narrowing disc space at every level, there are also anterior and posterior osteophytes at all bubbles, hypertrophic set arthropathy at all levels, degenerative disc disease and also scoliosis. I also had a gastric procedure which limits the kinds of medications I am able to take(such as ibuprofen, muscle relaxers, naproxen and nsaids). I have had multiple appointments with neurosurgeons and other doctors to be told I have too much wrong with my lower back to have any surgical procedure. I have stacks of reports, cds and test results justifying my issues. My only option is pain management thru medication. I can not sit down for any length of time, lying down hurts and I can only stand for so long without my legs giving out. In addition to that these days I have been getting shooting pain down my leg when I do sit. Sadly as much as a body needs rest...I can no longer rest comfortably. My quality of life is almost non existent due to the debilitating pain and without relief I really contemplate ending my life. I can no longer deal with the agony and doctors being scared to treat patients that are suffering is not fair to us...the ones in pain. I do not want my friends and family to grieve because I took my life due to pain and lack of treatment. As a concerned, responsible patient I try my best to not even use all the medication prescribed by my doctors to avoid needing to raise the does of medication needed to relieve my pain in the future. The chronic pain patients are the ones that actually visit their doctors more often, are subject to drug tests and are not the reason there is a crisis in this country. The problem seems to be addicts that purchase medication from the streets, not knowing what they are purchasing and not receiving medication thru the proper channels. When people are not able to get their medication from the proper channels they will seek options from the street with hope of finding some relief. Pain relief is a human right and without relief	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		people will take their lives. Living with debilitating pain you have no quality of life and no reason to wake up in the morning. I am tired of being treated like I am a drug addict because I am suffering severely and need medication to be a functioning adult. I know I will never be pain free but any relief is welcomed. Please, please for the love of God stop punishing the patients and the medical professionals trying to help them!	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #114, Gwen Hanson	Question 10	I have been on opioid pain treatment and Xanax for a couple decades actually I took Xanax on and off since 18 for horrific anxiety and panic attacks, I tried every different kind of medication for panic attacks and the pain meds, antidepressants and seizure meds are widely used for pain and bipolar issues, sadly none of these worked both families of antidepressants make me nuts as in cutting myself and ending up in the hospital, I [and] #039;ve had two specialist one rheumatologist and I think a neurologist hand me antidepressant and say this will help with your pain I know that the one the rheumatologist handed me ended up with me cutting my arms legs and hips before my mother who lived upstairs realized something was terribly wrong, for these doctors to knowingly give me something I told them I could not take is horrible, but now for doctors to refuse to give me opioids and tell me if I don [and] #039;t take Suboxone I won [and] #039;t be treated in their facility, my doctor is retiring after 30 years that [and] #039;s why I [and] #039;m looking for a new doctor. So this facility has an opioid oversight committee and even if I agree to go on Suboxone and it doesn [and] #039;t work for my skin pain or my spine pain they still won [and] #039;t prescribe any opioids and even though they [and] #039;re not the psychiatrist the doctor repeatedly talked down Xanax and talked over the issues I [and] #039;ve had with being hospitalized on Wellbutrin Neurontin Depakote Paxil and well from what I understand both families of antidepressants don [and] #039;t work for me. Believe I wish I could take an antidepressant and not be in pain physical and mental	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #115, Lonnie Torrance	Question 10	Degenerative disc disease need surgery. No pain meds at all. Inpatient VA hospital for suicidal due to pain also no pain meds. Was offered Tylenol and 28 day inpaitent drug rehab program. Spondolytis with MS like diseases. Every day consider suicide and how it will effect anyone I know. Will I end up in Hell things like that. Im called a drug addict and accused of drug dealing labs gathered for search of illicit drugs. No warrant. It feels like I am being punished for joining infantry time of conflict Dec 7 1978 and being paralyzed at military hospital in 80s . Im in hell now. Why when people get pain meds if they are deemed important like a senator or police officer every time they get their meds right in front of me. I have never had drugs in my labs or been arested for anything. I always want cancer so I dont have to kill myself. Drs are cruel to me. How long before I snap? 22 vetrans commit suicide every day while important people get relief. Oh hell no one cares. So angry. I hear personal stories on Facebook of children not getting pain meds for horribly painful conditions. No one cares that untreated pain causes sicknesses.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #116, Ronda Bruse, Mrs.	Question 10	Critical pain deserves recognition! Crying your life away literally unable to move deserves recognition! Please the only treatments that have helped is strong pain medicine. I have personally been through everything trying to help my affliction and Nothing else helps at all compared to my opioids ..without I will be severely disabled unable to shower, move without excruciating pain to the point I [and] #039;m vomiting and literally cry my life away.. Please help restore healthcare back the way it was, that will enables the chronically ill some kind of restoration with there health and well being .If left untreated all that [and] #039;s left is unimaginable torture of excruciating pain , that will only manifest our demise.	Thank you for sharing your story, sorry to hear about your pain.

Public Reviewer #117, Michelle Bannasch	Question 10	I am a CPP that was doing well on my pain medication for many years. Since the [and] quot;opioid crisis, I have been forced by my PCP to a PMP who quickly force tapered me down to practically nothing within 2 months and is sending me for an epidural injection next week. I do not want this, but as I [and] #039;ve heard, if we don [and] #039;t do as the doctor says, we may lose the little bit of pain medication we have left. I have had one of these before and it did nothing. I [and] #039;ve also been told that arachnoiditis can be a result of epidural injections. The last thing in the world I need is another painful condition. Next will be physical therapy, of which I [and] #039;d be all for, except for the fact that he [and] #039;s basically taken away my ability to move without excruciating pain. How am I supposed to do this to any benefit? I used to be able (with the benefit of my opioid pain medication) to have a quality of life and do the things that everyone else does. Grocery shop, cook, clean, take short walks, spend time with friends [and] amp; family, go to church. I [and] #039;m now in bed or on the couch most of the time. I was hoping to go back to work part time before all of this happened. I [and] #039;ve been working on my disability for years, but it seems like it [and] #039;s never going to happen. I [and] #039;d (rather) be able to work. The reason I was working on disability is because even with pain medication, CPPs have bad days, but without them, we have zero good days. I was worried that (on the really bad days) I may have to call in sick [and] amp; end up losing the job. That [and] #039;s been how my life was going for many years once my back got so bad, I was unable to keep a job. Imagine if, everything I [and] #039;ve explained to you here was your life. Believe me, I know very well that there are many many stories of CPPs that are way worse than mine. I [and] #039;ve got to live with my story though and I [and] #039;m facing homelessness soon if I don [and] #039;t get my disability before my friends lease is up in April. This terrifies me. Dear God, why is this happening to people who [and] #039;ve already been dealt a raw deal with chronic 24/7 intractable pain? If you ask me, addicts and CPPs should have been separated in the first place when all of this started. I believe that way, both groups of people would [and] #039;ve been treated fairly and there wouldn [and] #039;t be so many CPP	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		suicides due to force tapering and revoking of pain medication. How can we treat CPPs this way, let alone our Vets? Reprehensible!	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #118, Alexandra	Question 10	Quality of life is so important. Due to the government conflating heroin and fentanyl overdoses with intractable pain patients getting the pain management they need to be productive members of society.Quality of life. That [and] #039;s all I [and] #039;m asking for. Not having to choose between showering or cooking. Not having to choose between getting dressed or attempting to complete a load of laundry. THIS is my life now because of the disastrous CDC guidelines (which are abused and misinterpreted). HOW is that a quality life? I ask you some very serious questions, as patients that have been abandoned and are committing suicide. They are not going to the streets. They aren [and] #039;t turning to alcohol. They are permanently leaving. How on earth does withholding necessary pain medication from a 70 year old, help a heroin addict? How does withholding monitored medications from an spinal patient, help a meth addict? The insanity has to stop. The doctor knows the patient and trust me, in this day and age, if a patient has medication, they have a valid reason. I [and] #039;ve lost too many brothers and sisters to suicide because they couldn [and] #039;t take the pain anymore.Please return medical care back to doctors, and help save us.Sincerely,Disk Degenerative Disease Patient	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #119, Tina ONeal	Question 10	I have lived without any I [and] #039;ll side effects on opioid therapy for 15+ years. I was a paralegal and suddenly fell I [and] #039;ll. I now live with 6 failed back surgeries, 5 hip surgeries (3 total hip replacements) Intractable Chronic pain on a daily basis. One cannot imagine the grief a Chronic pain patient goes through when their [and] quot;normal [and] quot; life is changed completely and they now live with incurable illnesses, constantly in pain. My opioid medication allows me to get out of bed, interact with my family and grandchildren. I no longer have the career I loved, helping people in need. Your life is a total adjustment of what it was. Imagine loosing your career because of an accident or illness that has reformed your [and] quot;normal [and] quot; life as you knew it.Without my opioid medication I would be completely bedridden, unable to physically function, cook, clean, watch my grandchildren grow. My life would be 4 walls dividing me from what my life was. I would rather be gone in the physical sense than put my family through any more than they have had to adjust their lives around and understand my illness, my pain, limitations, cancelled events, interacting with them.On the short term could you imagine going through surgery which any type is invasive within the body without something for pain? You could not! It would shut your body down to endure such torture. It would be very inhumane to allow anyone to suffer in such pain; including cancer, hospice and palliative patients.If it were one of your loved ones you would argue they receive the best medical treatment. Any form of guidelines, regulations, laws etc. Pertaining to Chronic pain, opioids, etc should include true experts on this subject. Without true experts inclued a report/study would be considered bias or onesided.Many true experts are available to participate in such a platform but, have not been included, invited or contacted.I totally reject this report as true fact and a platform established to include true experts in the field of pain treatment, medication, science and patients that live it daily.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #12, thomas stanley	Question 1-10	our government are all useless terrorist bastards that need a monthly drug test and min wage	Thank you for the comment.
Public Reviewer #120, Karine Hatfield	Question 10	Opioids will always need to be available for diseases and injuries with severe intractable pain. The pendulum has swing too far in the other direction and is not backed by research or data. Allowing those with conflicts of interest to drive this agenda is legally and morally wrong. Yes, powerful potentially dangerous medicine. Oversight can be done with out promoting hysteria and a narrative not in line with facts.	Thank you for the comment.

Public Reviewer #121, Mildred Bradway, Nonr	Question 1	I have been on hydrocordone for 10 years. No problems following the direction from the doctor who prescribed 1 kind of pain medication. I value my pain medication that worked for Osteoarthristis, Osteoprosis, Fibromyalgia. Because of the Roux En Y gastric by pass i can not absorb coated extended release medication. I have Malabsorption. Doctors don [and] #039;t know at what percentage our Malabsorption is. AARP United Healthcare Medicare Complete in their drug formulary book states I can have up to 180 ml der day. Thats 12 servings of pain medication every 2 hours.. Rite Aide guide lines states children 7 to 9 years of age weighing 51 to 69 pounds get 5 ml. A 14 year old weighing 101 pounds gets 15 ml. Why am I only getting a child doseage of 5 ml 3x a day for a revision from a failed Total knee surgery when I have had 14 knee surgeries with 15 ml 3x a day for 3 months. I am still here suffering in cronic pain from the surgery. You cant get though Physical therapy without the proper pain medication. I am sure the government wants to pay for doctors to take patients back into surgery because they cant get past 90 degrees angel. Just think how much the government [and] amp; insurance company could of saved if they would of let the Doctors [and] amp; patients decide their treatment. At $118,000.00 for the revision. 2nd was $15,000.00 for an infection in the incision. How much more our you willing to pay for emergency unessecessary proceedures because of illegal illicit street drugs entering out country allowing our citizens to suffer cronic pain. Its an individual accountability of each person being respinsable for their own actions. We are ALL NOT drug seeking. We are only asking for our pain to be treated equally. Drug junkies have a choice to be accountable they choose to do wrong to overdose or commut suicide. People who have Dieases with no cure should be able to discuss with their doctors the treatment that they can afford. Not everyone has a pocketbook as a politician. Seniors have a limited source of money to afford a $40.00 prescription weekly. $120.00 a week for Physical Therapy, $315.00 for each: Cortizone injections, Radio Frequency Abbrasions. Do we choose medical proceedures, medication pay billis, or file bank Ruptcy because your guidlines are all too general to catorized all of us into Drug addicts. We are	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		Not All drug addicts! Pain patients did not ask to have dieases that have NO CURE. One meducation does not fit all. Nsaids can cause bleedibg or place a hole in Roux En Y gastric by pass patients.YOU ARE ALL A SECOND AWAY FROM A ACCIDENT.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #121, Mildred Bradway, Nonr	Question 10	Research show that pain medication tappering can do harm to people who pain medication are discontinued. Especially to our Veterans. War on illegal illict drugs have been around since 1906 it is not going to go away until the government does something about the drugs coming into the USA. Its not the prescribed medication that our doctors give to their patients. The problem lies with the individual who can [and] #039;t follow the rules of being accountable to oneself. Drug addicts ruin family life. They don [and] #039;t care who they hurt. They will rob you when your back is turned. Dont blame the legal pain medication blame the parents for slacking in parenting their child wrong behavior!	Thank you for the comment. The report addressed benefits and harms of tapering vs. no tapering and different tapering strategies, though evidence was limited.

Public Reviewer #122, Marisa Hansen	Question 10	I don [and] #039;t believe that enough long-term opioid patients have been included. Each person will react to chronic pain treatments in differing ways, so there isn [and] #039;t really a place for generalizations. If opioid therapy for chronic pain, which can shorten the lives of those who suffer from it, helps a particular patient more than other therapies attempted, then there is a need for patients to be able to receive opioids without the problems so many patients now experience. I personally am a patient who suffers not only daily chronic pain but also severe anxiety and panic disorder. Although many therapies were attempted to relieve my anxiety, I responded to clonazepam therapy right away, and it has basically given me back a quality of life I had thought to never experience again....along with opioids for my pain. I never abuse my medications, as they are far too important to me and I would never risk overdosing. I am disabled by my health conditions, and as I age, the problems get worse, not better. I also now have chronic pre-cancer which must be monitored, and I have to have surgical procedures to eradicate the pre-cancerous areas. I suffer from Degenerative Disk Disease, Neuropathy, severe chronic headaches, adhesions in my abdomen that cause blockages at times, Fibromyalgia, and IBS. As you can see, my pain doesn [and] #039;t have a single simple source, nor does it have a single location. Anxiety makes the pain worse, and the pain in turn aggravates my anxiety. However, for almost 20 years now, I have been receiving concurrent opioid and benzodiazepine therapies. I do use other modalities such as exercise (mostly walking) and ballet type stretches for flexibility. I also use heat and rest at times. I wouldn [and] #039;t be able to do the walking that I do without the pain medications, and I would not be able to work from home and take care of myself and my two dogs without these medications. This leads to the fact that if I have my therapeutic medications taken away from me or have my doses reduced any more than they already have been, I will become homeless. I have no other way to pay my rent than working from home, because my disability (Soc Sec) check is small. I know other pain sufferers much like myself who take opioids daily for chronic pain and have for many years, and none of us experience significant enough side effects to make it undesirable to continue these	Thank you for sharing your story, sorry to hear about your pain. As noted in the Results, of the 73 placebo-controlled trials of opioids, seven trials were restricted to opioid-experienced patients and 37 trials enrolled mixed pouplations of opioid-naïve and -experienced patients. In stratified analyses, the effects of opioids versus placebo on pain and function were similar in opioid-experienced and opioid-naive populations.

		medications which have quite literally saved our lives. Since most patients are not in any way responsible for any [and] quot;opioid crisis [and] quot;, we should not be subject to dosage restrictions and other attempts to make it hard for us to get the therapy which works for us. I [and] #039;ve taken clonazepam for anxiety longer than I have opioids, for 28 years. I have never experienced any feelings of being over-medicated, or any breathing difficulties, while taking my anxiety medication along with my pain medications. In fact, the two in combination also help my muscle pain, in addition to actually making my most severe headaches rare. I have however been subject to my health providers [and] #039; fears of government retaliation and loss of their licenses. This is ridiculous, since I have been a compliant patient who doesn [and] #039;t abuse my medications. I have never diverted my medications nor tried to use them to get [and] quot;high [and] quot;. I have never been a drug user, and I don [and] #039;t want to be high. I want to remain independent and productive for as long as I can, and my medications help me to do so. The latest dosage reduction was too much, and now my pain and anxiety are not under good control, and I am finding working very difficult, as well as many physical activities. And now I am afraid. I didn [and] #039;t like the fact that I had to start submitting to random [and] quot;pill counts [and] quot; and urine testing, but I agreed to it because I thought that it might just be enough to stop the clueless idiots who are trying to impose some sort of a Prohibition on opioid treatment for pain. Of course opioids work for pain! They may not be as effective for various types of pain, or may be inappropriate for certain individuals, but if they do work, and a patient has improved functioning through their use, there is not any reason that patients should have difficulty obtaining them. What frightens me even more is that now the clonazepam I need in addition to my other medications is considered to be part of a dangerous combination. I will not do well without opioids nor will I thrive without the clonazepam. I only know that life will become unbearable for me if I am reduced any more, or made to [and] quot;choose [and] quot; one or the other. For 20 years I have SUCCESSFULLY taken them together, and I should be allowed to continue to do so. My healthcare	

Section	Commentator & Affiliation	Comment	Response
		providers should also not feel threatened by the fact that I take both. In summary, I feel that until enough patients who have been on opioid therapy for many years have been asked how their lives have been affected, as well as if the medications actually help their pain, any study is incomplete. I feel very much as if we are not being asked to participate in studies deliberately. We seem to be a group of people that this country feels are no longer viable as productive and valuable individuals, which is not only very sad, but is in fact discrimination.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #123/124, Sarah Bekins Tompkins, RDLA Ehlers-Danlos Syndrome Patient Advocate and Admin of WA EDS Facebook Group	Question 10	As a Chronic Intractable Pain Patient, I am very concerned regarding this Report. I have not found any example of Pain Patients being represented or consulted in the making of any of these Pain Policies. I am concerned of the statement that there is no difference between Tylenol and opioids in treating such conditions as knee or hip replacement surgeries, especially as Pain Patient input was not considered, nor collected as evidence. Im discouraged by the policys inability to create policy consistent and safe for Pain Patients who have chronic intractable pain, Patients with Diseases like Ehlers-Danlos Syndrome, a Connective Tissue Disease affecting a patients every system in the body: Nervous System Symptoms, GI Symptoms, Blood Pressure Symptoms, Heartrate, Temperature Regulations, Recurring painful Subluxations and Dislocations from loose tissue requiring stabilization and pain treatment, surgery and/or PT. EDS patients have loose and stretchy skin that tears easily, and I experience multiple recurring joint, muscle tears, and injuries requiring Daily Pain Medication to function on a daily basis. I am concerned with limiting post-op meds to 10 pills-particularly if a patient doesnt have a diagnosis yet, and experiences more pain and more dislocations/subluxations, necessitating multiple repetitive stabilization and surgical repair surgeries, that this patient (undiagnosed with EDS) would suffer tremendously not having adequate pain medication, and suffering more to even find an accurate diagnosis. I would like to see more Pain Patients represented in the report, as well as describing the potential experience of how a patient in pain would establish a diagnosis and find a doctor to treat their pain. I am concerned with the science used, and discouraged that Pain Patients were not consulted or allowed to give evidence.	Thank you for the comment. The protocol for this report was developed with stakeholder and public input. The findings are based on the available evidence. Ehlers Danlos was an included condition but no randomized trial evaluated patients with this condition. The Research Recommendations section was revised to note the need for research on specific pain conditions.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #125, Robert Stelzl	Question 10	I am a chronic pain patient. I suffer from adhesive arachnoiditis and have been classified as a catastrophic case. I have never been asked to take part in any opiod related study. I have been on medication that includes opioids for 5 years. I know that long-term use of opioids are safe and effective given my circumstances. Until I am presented with an safe, effective alternative I will not survive without pain control. Put money into pain - control research first. And stop scarring the hell out of people like me in the mean time.	Thank you for the comment. As noted in the Results, of the 73 placebo-controlled trials of opioids, seven trials were restricted to opioid-experienced patients and 37 trials enrolled mixed pouplations of opioid-naïve and -experienced patients. In stratified analyses, the effects of opioids versus placebo on pain and function were similar in opioid-experienced and opioid-naive populations.
Public Reviewer #126, Jennifer Ellis	Question 1	Evidence was not diverce in sources or results and appears cherry picked to support an anti opioid agenda.	Studies were identified using systematic searches and studies were selected for inclusion based on pre-specific inclusion criteria.
Public Reviewer #126, Jennifer Ellis	Question 2	Those involved in composing the draft and it [and] #039;s contents and that will follow does not include the patients who the law will affect the most those of us with chronic pain. We ask any policy that rise from this draft provide law establishing that pain patients are not restricted in the length or the amount of opioid pain medication available to them in order to treat their pain effectively and provide the ability to function and have a quality of life	The report synthesizes the evidence and does not make recommendations
Public Reviewer #126, Jennifer Ellis	Question 3	Evidence was not diverce in results and cherry picked to support an anti opioid agenda.	Studies were identified using systematic searches and studies were selected for inclusion based on pre-specific inclusion criteria.
Public Reviewer #126, Jennifer Ellis	Question 5	Results are bias and unscientific and should not be allowed to affected by of American citizens.	Thank you for the comment. The protocol for this report was developed with stakeholder and public input. The findings are based on the available evidence.
Public Reviewer #126, Jennifer Ellis	Question 7 and 8	Those who drafted the contents of the draft at hand not include any of those of us would be most affected by the changes in laws for opioids especially those of us with chronic pain who require opiates in order function on a daily basis and live our lives without horrible torture.	Thank you for the comment

Public Reviewer #127, Amy Kirkwood	Question 10	I want everyone to know that the cuts and regulations nonprescription opioid is hurting and killing many elderly and disabled. My personal experience has been forced off opioid into bad withdrawal. Got into another docter weeks later but my dose is now so low (on the maximum) that I am,basically house bound. My blood pressure is now very difficult to control. Most of my serious medicines have had to been increased to compensate for the constant stress on my body from uncontrolled pain. The stress is horrible. My and anxiety and depression have increased and I can no longer take anxiety meds so my blood pressure spikes at times and my emotions go nuts. I have never thought about suicide in my life but now I wonder how much longer I can tolerate this. People are literally dying from uncontrolled pain. Besides the huge increase in suicide of pain patients and veterans, it can also cause heart attack and strokes due to uncontrolled blood pressure and excessive stress. I [and] #039;ve already had one little stroke. I [and] #039;m scared of another. Before my pain killers were cut I had returned to school working on a masters so I could perform a job and get back in the workplace. I had finished all my classes and was starting on my internship. But I am unable to do that now and had to drop out. The prices of my prescriptions has tripled due to the new and additional and increased meds they have had to put me on. I have tried every modality to help the pain that is available and all that is left for me is pain killers and managing my illnesses. It is so frustrating and depressing. Then I see everyone else suffering too.Its not right that law enforcement is controlling how our doctors treat us all based in lies and made up numbers. The truth is the addiction and overdose rates of chronic pain patients are both under 2%, showing that we are responsible law abiding patients that just need pain control. I have never gotten [and] quot;high [and] quot; or abused my pain meds. I just need them to have some semblance of a life. That [and] #039;s all I want, just be able to live and have some enjoyment in life. Now Im basically house bound and mostly bed ridden. I beg you to lift the restrictions on pain meds. I hadbern on them over a decade and they helped me tremendously. I can no longer use NSAIDS as they have damaged my kidneys. Tylenol has damaged my liver so can [and] #039;t use that	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		either. The other drugs for some help with pain I have had serious reactions to. There is nothing else to help me yet due to the threats and pressure law enforcement has put on doctors none will prescribe an adequate dose to ease my pain enough to allow me to have some function. Please fix this situation before anymore lives are lost and games ruined. Chronic pain patients are not adddicts. Thank you.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #128, Corey North	Question 1	I m a chronic pain sufferer and im afraid that i will be forced off or drastically reduced the meds and dosage that helped me live somewhat of a normal life that i did before the CDC guidline.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #129, Lawrence Favero	Question 10	I take exception to your stating statistics regarding 165,000 opioid related deaths without clarifying that the majority of these are not related to legally prescribed medications. Your analysis needs to account for the majority of these deaths being related to illicit fentanyl, heroin, diverted medications, and contraindicated mixing of substances.It is also disturbing that conclusions are being stated based on low to non-existent strength of evidence.	The figures is for the number of deaths related to prescription opioids; it does not specify how the opioids were obtained.
Public Reviewer #129, Lawrence Favero	Uploaded Document	Stop persecuting docs for legitimately prescribing opioids for chronic pain.pdf (280 KB)	Thank you for the comment. The attachment (#2) was reviewed.
Public Reviewer #13, Jessica Layman	Question 10	I [and] #039;ve been a pain management patient for 17 years; I have spondylothesis, facet joint arthritis in numerous places, reduced disk space, annular tears and mild scoliosis. I rely on opioids to live. For this report to imply that opioids are ineffective in treating chronic pain is irresponsible at the highest level. Primarily, the study cannot conclude anything of the kind when the highest dose given to patients in [and] gt;50MME. That is considered a low dose, suitable for someone with mild to moderate pain. True chronic pain patients have no quality of life at the CDC [and] #039;s 90MME. I had a career and a decent life when I was taking 120MME before the publication of the 2016 guideline and the rampant jailing of pain management physicians. As my dose was decreased my pain increased and I was left with zero quality of life and no way to support myself. At best, this study shows that low doses of opioids are ineffective at treating chronic pain. At worst this is just another piece of propaganda intent on demonizing the 25 million pain patients who need medication to live.	Thank you for the comment. The report summarizes the published evidence on benefits and harms of medications for chronic pain.
Public Reviewer #130, Brian Zbikowski	Question 1	I have been taking Opioid Pain Medicine for 8 years for no opperation can be done for my stenosis. Pain medication allows me to have some qaulity of life and be able to care for my self.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #130, Brian Zbikowski	Question 2	Thank you for your concerns.	Thank you for the comment
Public Reviewer #130, Brian Zbikowski	Question 3	Without pain medication that works my life is over.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #130, Brian Zbikowski	Question 4	2016 CDC med changes have caused much harm and has stopped all my bloodwork, teeth removal, shots, caused my to chew my lip apart.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #130, Brian Zbikowski	Question 5	I follow all pain contract rules.My levels are below 40 MME.Death could occur if my pain medication is disturbed.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #130, Brian Zbikowski	Question 6	Opiod Pain Medication = OPM	Thank you for the comment
Public Reviewer #131	Question 10	Obvious bias against opioid medication in that the biochemistry sciences are not considered as factual evidence.	Thank you for the comment, we reviewed evidence on clinical outcomes
Public Reviewer #132, Deborah McKinley	Question 1	I don [and] #039;t know where the [and] quot;research [and] quot; for your paper comes from probably PROP. I don [and] #039;t care it [and] #039;s a lie. I have been using narcotic medications for years and they have allowed me to go from bedridden to getting out of my house, getting to the gym, losing weight and having a lot healthier happier life! I am not addicted but I am now in bedridden again due to the damage that these lies caused when the CDC published these lies! All I can say is good luck killing the disabled and elderly Lebensunwertes Leben	The conclusions are based on the available evidence. The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included stakeholder and public input. Studies were identified using systematic methods and selected based on application of pre-defined inclusion criteria. Thank you for sharing your story, sorry to hear about your pain, but glad you are leading a healthy happy life.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #133	Question 10	If this is not in support of physicians being able to ethically treat chronic pain patients pain at a point where they are able to have quality of life, then I hope karma comes to each and everyone of you in the night to steal all you love and hold dear and sacred in your life, just as these horrendous policies and guidelines have done to mine. Its killed many of my friends, caused severe torture and agony of beautiful people, wreathes havoc on lives of innocent people and has done NOTHING to ease what you erroneously deem an opioid crisis and all for the sake of $, for yourself own pockets. Its genocide. You all better fix this damage now because the truth always comes out and there will be consequences. I never believed my own country would be not only fine with me me tortured every minute of every day while withholding the one thing that would allow me the dignity to have a life and the excruciating pain eased, but knowingly do so and continue to falsely report and cover up your vile actions. Stop this now!	Thank you for sharing your story. This report does not make clinical recommendations, but reviews the published evidence. Patients should work with their provider to make the best decision for pain relief.
Public Reviewer #134, Peggy Oconnor	Question 1 and 4	Pain meds work for chronic pain and those that had/have them are your biggest pool of evidence. Since there is so much graft and greed in research and selective results such as [and] quot;studies [and] quot; can not be trusted. What I trust and I know is they work or use to work for thousands and now with all the propaganda thousands are left suffering and in pain. Note the rising suicide rate.	Thank you for sharing your story. This report does not make clinical recommendations, but reviews the published evidence. Patients should work with their provider to make the best decision for pain relief.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #135, Carrie Barnhart, Ms. **Public Reviewer #136, William Difilippantonio, Pain Advocate Warriors**	Question 1	section (**note this first page is numbered E-1 whereas the next pages begin at ES-2)The months time frame given. Clarify if this is from initial pain, or from 91st day of pain, or from initial opioid prescribed. What time frame are you talking about??Anytime mental health is mentioned, add suicidal ideation. Pain patients [and] #039; biggest battle is with that and it cannot be summarized into mental health.Remove prescription from prescription Opioids. There isn [and] #039;t a distinction between licit and illicit Fentanyl on here. Put one.The number of deaths- if someone died of a heart attack and had opioids in their system, it was called an overdose. Overdosed deaths still are at increasing levels despite the drastic reduction of opioid prescriptions. (Some states cut scripts by 66% and overdose deaths are still at an increase.) Make this note in the intro.Identify that only 1.3% of people that died with opioids in system had an active script for opioids. (Active meaning a month or newer). Make this note.High impact pain needs acknowledgement here too. Chronic pain isn [and] #039;t just a sore back or a knee ache.Chronic pain is [and] gt;90 days. At this point, the patient has ALREADY tried NSAIDs for pain relief (duh). Patients have also been sent to Physical therapy, pain management (because PCPs can only write for a month of Opioids), and probably have triedYoga, meditation, more NSAIDS, removing gluten, stretching every hour at work, to sleep hygiene, and ice and heat therapy. People don [and] #039;t want to be in severe chronic pain. They have tried everything to alleviate the pain.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #135, Carrie Barnhart, Ms. **Public Reviewer #136, William Difilippantonio, Pain Advocate Warriors**	Question 10	Lack of clear communication as to differences in chronic pain v. Intractable pain v. High Impact Pain.Diseases with pain as a symptom most likely have little or no treatment. The only thing that patients can do is manage the pain.There is no distinction that depression remains at the short term follow up is due to disease progression, mismanaged pain, or due to isolation because of immobility and loss of contribution in society. This report needs more high quality studies for depression and pain, anxiety and pain, and intractable pain.As far as tapering, need studies showing Adverse Events such as cardiac events, strokes, Suicidal ideation, spontaneous death, or death by suicide due to pain	Thank you for the comment. The report focused on chronic pain; we are not aware of a standardized definition for "intractable" pain but most would consider these terms to overlap substantially. Effects on depression and anxiety are described in the report, as well as available evidence on cardiovascular events, mortality, and suicide/suicide risk.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #135, Carrie Barnhart, Ms. **Public Reviewer #136, William Difilippantonio, Pain Advocate Warriors**	Question 2	b. 3) the medical cormobiditiesThere are so many agonizingly painful diseases, too many to list, that have no cure or treatment. The ONLY thing that the patient can do is pain management. This little item listed here is HUGE for most patients with intractable, chronic pain. Misuse...well this pharma QA word means something completely different in the non-QA world. Please specify. It is a copout word and should not be in this report anywhere. Key Question 2. Harms and Adverse Eventsb. 3) comorbidities also needs to include statement pertaining to the fact that there are so many agonizingly painful diseases, too many to list, that have no cure or treatment. The ONLY thing that the patient can do is pain management.c and d. 3) other harms, please add connective tissue damage, joint damage, neurological damage, memory loss, behavioral loss, suicidal ideation, and death. (Isn [and] #039;t death an adverse event in the pharma QA world anyways?)Key Question 3. Dosing StrategiesRemove the term misuse. (Either use it as a Pharma QA term or remove it.)Nothing mentioned about needing additional doses due to surgery or other qualifying event in addition to the baseline dosage. Please add.Nothing mentioned about the differences in drug metabolism due to underlying diseases. Please add.Key Question 4. Risk Assessment and Risk Mitigation StrategiesDO NOT INTERFERE WITH MENTAL HEALTH MEDICATIONS INCLUDING BENZOS FOR ANXIETY. No patient should have to pick between mental health and physical anguish.Those strategies only keep addicts from coming to pain management clinics. They [and] #039;ve NEVER stopped overdosing. They won [and] #039;t prevent addicts from buying illicit drugs laced with deadly illicit Fentanyl.These mitigation strategies have only dehumanized legitimate pain patients.	Thank you for the comment. The trials did not evaluate effects of genetic polymorphisms on benefits and harms of opioids. We revised the Research Recommendations section to note this as a future research need.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #135, Carrie Barnhart, Ms. **Public Reviewer #136, William Difilippantonio, Pain Advocate Warriors**	Question 3	Statistically performed well. Overall good section. Good at describing everything for the layman. Grading strength of evidence is good to include.	Thank you for the comment
Public Reviewer #135, Carrie Barnhart, Ms. **Public Reviewer #136, William Difilippantonio, Pain Advocate Warriors**	Question 4	Co-prescription of benzodiazepines or gabapentinoids... in one study, the risk decreased with longer duration of concurrent use (SOE: low).---let those that have been taking both, stay on both!!! ... risks were higher at increased gabapentinoid doses---gabapentinoids don [and] #039;t help pain anyways, never have. Key Question 1a. When referring to [and] quot;pain [and] quot; in this section, does this mean chronic pain ([and] gt;90 days), acute pain, or pain in general??Key Question 3 h) This study found that buccal fentanyl was found more effective than placebo or oral opioids for acute exacerbations of pain? Good. That section needs to be bold!Key Question 3i. In patients with chronic pain, what are the effects of decreasing opioid doses or of tapering off opioids versus continuation of opioids on outcomes related to pain, function, quality of life, and opiate withdrawal symptoms? ** Need high quality studies done!!	Thank you for the comment. Key Question 1a states that it is in patients with "chronic" pain. The Results are for pain as reported by patients (not specified as chronic or acute, but likely primarily chronic).
Public Reviewer #135, Carrie Barnhart, Ms. **Public Reviewer #136, William Difilippantonio, Pain Advocate Warriors**	Question 5	The 2016 Guidelines were not meant for chronic pain patients or cancer patients. Also, there is zero discussion about high impact pain and intractable pain. Not all chronic pain is the same!Page 221, fourth line down. Short-term is misspelled.	We corrected the typo. There is no standardized definition for "intractable" pain though this concept overlaps significantly with "chronic" pain. Trials did not report the proportion of patients with "high impact" pain, a relatively new term developed by an NIH committee that the lead author was a member of. Studies on outcomes associated with tapering were included, but were limited.
Public Reviewer #135, Carrie Barnhart, Ms.	Uploaded Document	Pain, Opioids, CDC - Devil in the Data.PDF (4169 KB)	Thank you for the comment. The attachment (#3) was reviewed.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #136, William Difilippantonio, Pain Advocate Warriors	Uploaded Document	Regulatory-Overreach-Lawhern.pdf (18 KB)	Thank you for the comment. The attachment (#4) was reviewed.
Public Reviewer #137, Susan Williams, None	Question 1	This report is misleading. I have been a chronic pain patient for over half my life...I am 61 years old and this all started when I was 27. I have had 13 back surgeries with number 14 pending. I haven [and] #039;t had ANY pain medication for over 5 years and my quality of life has taken a nose dive.I used to be able to do things for myself...i.e. shopping, cooking, cleaning, personal hygiene, driving, etc. Now, I am unable to do anything. I spend 90% of my time lying in bed on my left side only. I cannot even sit up to eat. I cannot take a shower, sponge baths only...I have to wash my hair in the bathroom sink. I am fused with titanium instrumentation from T-2 down to my sacrum with wires to each pelvic crest. I have 12 loosened screws and a broken rod. The pain is so excruciating that I only get up to use the bathroom. The only time I leave my house is for doctors appointments. I use medical marijuana, but it does not work for me and it is very expensive, especially when on a fixed income. Insurance does not cover it.	Thank you for sharing your story, sorry to hear about your pain. The report is based on the available published evidence.
Public Reviewer #137, Susan Williams, None	Question 10	I noticed that a lot of the conclusions were not available or reached no conclusion at all.	Thank you for the comment
Public Reviewer #137, Susan Williams, None	Question 2	Inconclusive.	Thank you for the comment
Public Reviewer #137, Susan Williams, None	Question 3	Misleading and inconclusive.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #137, Susan Williams, None	Question 4	Chronic pain patients wtih a pain level of 8.5 daily for over 20 years is not mentioned. When I was taking Morphine ER, I was able to tend to activities of daily living, now, I cannot.I am tired of not being able to sleep...I average about 3-4 hours sleep per 24 hours. When I was on pain medication, I was a productive member of society. I used to volunteer helping people to read. I can no longer do this.	Characteristics of the study populations including average baseline pain and duration of pain were provided in the report. In the placebo controlled trials, the duration of pain was >10 years in several trials and average baseline pain was as high as 8.2
Public Reviewer #137, Susan Williams, None	Question 6	Very hard to follow.	Thank you for the comment
Public Reviewer #137, Susan Williams, None	Question 7	Much too long and confusing.	Thank you for the comment
Public Reviewer #137, Susan Williams, None	Question 8	Much too long and confusing	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #138, Charlotte Troyer	Question 10	My story:My name is Charlotte Troyer. I am a 60 year old wife, mother, and grandmother. Many years ago, as a consequence of a problematic pregnancy, I endured 5 abdominal surgeries in approximately 8 years time. The last 2 surgeries were bowel resections and the final resection resulted in a significant removal of my small bowel. This left me forever changed and resulted in disability. I have what the Doctors call short bowel. It took years of treatments to manage the constant diarrhea and ongoing debilitating pain. Early on, I became dehydrated and malnourished often. Ive seen many specialists over the years and came to a satisfactory treatment which consisted of nutritional health shakes, meditation, and pain medication. Specifically, a managed dose of oxycodone 10 mg 4 times per day: 1 at each meal and bedtime. For approximately 5 years Ive been able to be productive and function at a reasonable level.Because of the current climate of opioid crisis, my Doctor has recently reduced my pain medication to 2 per day with the expressed intention of taking the medication away entirely. Im regressing to increased pain and constant diarrhea. I fear returning to the days I was in bed often and unable to function. Ive been looking for a pain clinic or doctor to see without good results so far. Sir, my life has value. Ive done research and have reached out to advocacy groups and organizations that work for patients like myself. I have been compliant as a patient always and never have I failed a drug screen. My original dose was well below the new recommended value of 90MME or less. The CDC which published their guidelines back in 2016 which started much of this hysteria has recently, in April 2019, published a new report stating the over correction was not their intent and that their guidelines were misconstrued.Can you advise about legal action for myself and thousands like me?Charlotte Troyer	Thank you for sharing your story, sorry to hear about your pain. We hope you are able to find a pain clinic that will help you manage pain and function. The report does not make recommendations about legal action. The report is summarizing the published evidence.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #138, Charlotte Troyer	Question 5	My story:My name is Charlotte Troyer. I am a 60 year old wife, mother, and grandmother. Many years ago, as a consequence of a problematic pregnancy, I endured 5 abdominal surgeries in approximately 8 years time. The last 2 surgeries were bowel resections and the final resection resulted in a significant removal of my small bowel. This left me forever changed and resulted in disability. I have what the Doctors call short bowel. It took years of treatments to manage the constant diarrhea and ongoing debilitating pain. Early on, I became dehydrated and malnourished often. Ive seen many specialists over the years and came to a satisfactory treatment which consisted of nutritional health shakes, meditation, and pain medication. Specifically, a managed dose of oxycodone 10 mg 4 times per day: 1 at each meal and bedtime. For approximately 5 years Ive been able to be productive and function at a reasonable level.Because of the current climate of opioid crisis, my Doctor has recently reduced my pain medication to 2 per day with the expressed intention of taking the medication away entirely. Im regressing to increased pain and constant diarrhea. I fear returning to the days I was in bed often and unable to function. Ive been looking for a pain clinic or doctor to see without good results so far. Sir, my life has value. Ive done research and have reached out to advocacy groups and organizations that work for patients like myself. I have been compliant as a patient always and never have I failed a drug screen. My original dose was well below the new recommended value of 90MME or less. The CDC which published their guidelines back in 2016 which started much of this hysteria has recently, in April 2019, published a new report stating the over correction was not their intent and that their guidelines were misconstrued.Can you advise about legal action for myself and thousands like me?Charlotte Troyer	Thank you for sharing your story, sorry to hear about your pain. We hope you are able to find a pain clinic that will help you manage pain and function. The report does not make recommendations about legal action. The report is summarizing the published evidence.
Public Reviewer #139, Melanie Bowzer, National Academies of Practice (NAP)	Question 10	Please find general comments on the draft report from the National Academies of Practice (NAP) attached.	Thank you for the comment. The attachment (#5) was reviewed.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #14, Lisa Kronus, Rn, RN Former CHPN	Question 1	This report needs to be part of HHS and on regulations.gov. It has no merit	Thank you for the comment
Public Reviewer #14, Lisa Kronus, Rn, RN Former CHPN	Question 10	You need to get out of the physician:patient relationship. Pills are no longer the problem. Patients have become collateral damage because of heroin addicts. I demand this gods up on regulation.gov	Thank you for the comment, the report does not make recommendations or guidelines. It summarizes the published evidence on benefits and harms of medications for chronic pain.
Public Reviewer #14, Lisa Kronus, Rn, RN Former CHPN	Question 2	It has NO merit. People are needlessly suffering across the country. How does withholding prescribed medicine from a patient suffering, help a heroin addict?	Thank you for the comment, the report does not make recommendations or guidelines. It summarizes the published evidence on benefits and harms of medications for chronic pain.
Public Reviewer #14, Lisa Kronus, Rn, RN Former CHPN	Question 3	Article is without merit. See above	Thank you for the comment
Public Reviewer #14, Lisa Kronus, Rn, RN Former CHPN	Question 4	Article and report has no merit. See above	Thank you for the comment
Public Reviewer #14, Lisa Kronus, Rn, RN Former CHPN	Question 5	No merit. See above	Thank you for the comment
Public Reviewer #14, Lisa Kronus, Rn, RN Former CHPN	Question 7	Disclose all affiliations	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #14, Lisa Kronus, Rn, RN Former CHPN	Question 8	Poor references. This is without merit and not studied	Thank you for the comment. The report has a complete reference list.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #140, Sheryl Henley	Question 10	I wish I could comment on each section as requested. I am in too much pain to read everything as well as comment on everything. I did read enough to see that once again you begin with the premise that opioids provide little relief and that the risk is greater than the benefit. Why does no one ever ask the people who took short term and long term opioids for years with great success and no problems? Opioids are the best tool in the pain toolbox. They help tremendously in cutting back pain, drastically increasing function and most people have no problems with them. Less than 1% of pain patients that are prescribed them actually get addicted. We become dependent on them but that is no different than someone that takes insulin for type 2 diabetes. You become dependent on the medicine to function well. There are literally hundreds of thousands of us that have successfully taken this medicine. You have a wealth of research material that no one seems to want to touch. I personally took both long acting and short acting opioids (Oxycontin and Oxycodone) for 7 years and they drastically improved my life. Now, I have nothing to take because it has been taken away. My quality of life is very poor, I can barely function. How would you like to try and function and take care of yourself with a 24/7/365 level 8 pain? It [and] #039;s amazing more of us haven [and] #039;t committed suicide-it [and] #039;s a miserable way to live and totally unnecessary as the medication is there-we are just not allowed to take it. It [and] #039;s unconscionable that our own government would torture us like this. You must listen to the facts and not the popular line that [and] quot;opioids are bad [and] quot;. It is NOT based on science and the people making those statements are ignorant. Again, I urge you to study the people who actually took the medication for years to find out the truth of it. The government has stolen the rest of our lives and we want it back.	Thank you for sharing your story, we are sorry to hear about your pain. The report summarizes the published evidence on the benefits and harms.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #141, Jennifer Martin-Romme	Question 1	The studies reviewed here all have methodological problems so severe that this summary of them should be discarded. As you note, none of the studies lasted longer than 6 months and they didn [and] #039;t control for the most basic information, such as the type of pain the patient was experiencing, other medical or psychiatric diagnoses, or whether the patient had any history of substance abuse. You fail to note in the [and] quot;Limitations [and] quot; section that test subjects were mostly on very low doses of opioids, so it [and] #039;s unsurprising that they reported little difference between opioid and non-opioid painkillers. Given that the subjects [and] #039; baseline rating of their pain was only an average of 4---not even moderate pain---these results cannot be generalized to moderate or severe pain. Another unexplored scenario that would produce the same false result is if subjects were in so much pain that low doses of opioids were ineffective. Either way you haven [and] #039;t accounted for this in your conclusions. Cancer patients are being forced off opioids, and yet the test subjects had a pain level more on par with menstrual cramps.	The report is based on the available evidence on opioids. The limitations including the short duration of follow-up in the trials are described. Baseline pain scores varied but in many trials the baseline pain scores averaged 6 to 8 on a 0 to 10 scale.
Public Reviewer #141, Jennifer Martin-Romme	Question 10	Considering the the overall poor quality of the studies cited and the significant studies that were left out, I urge you to expand this report to include other relevant research and to reconsider your conclusions in light of research that contradicts your current conclusions.I am baffled as to why your conclusions did not place primary emphasis on the need for more research. The widespread assumption among medical professionals, lawmakers, law enforcement, and virtually every federal agency is that opioid therapy carries high risks of addiction, and yet we have NO long-term studies to support that, let alone any studies that justify the refusal and discontinuation of opioid therapy that [and] #039;s happening in medical settings across the country. The assumption that pain patients will get addicted has become so entrenched that even cancer patients, post-operative patients, and those in acute pain are being denied opioids or not given sufficient dosages to control their pain. Please remember that whatever you publish will have immediate, real-world consequences for millions of Americans.	The Discussion includes a section on future research needs. Studies were identified using systematic searches on multiple electronic databases and supplemented with review of reference lists, and selected for inclusion using pre-defined inclusion criteria.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #141, Jennifer Martin-Romme	Question 2	Your assertion in this section about the number of deaths from prescription opioids is outdated. Last month, Boston University released a study (Walley, et. al., Public Health Reports) that scanned overdose death certificates for the specific opioid(s) involved. Only 16% involved prescription opioids alone, and of those, only 1.3% of the decedents had an opioid prescription. This makes the numbers you cite for 1999-2016 grossly inflated and lacking the crucial context that most of these were polydrug overdoses, frequently combining alcohol with an opioid obtained illicitly.	We updated the number of deaths due to prescription opioids with the 2017 data, which was similar to the 2016 data cited in the draft (~17,000 deaths). The Walley study evaluated all overdose deaths, including persons with opioid use disorder (with or without treatment). The 1.3% described in the Walley study refers to decedents in whom there was a prescription for each opioid identified in toxicology reports, not the proportion with an opioid prescription. The proportion of deaths with solely prescription opioids was 16.5% and those with prescription opioids + heroin or fentanyl was 23.7%. We revised the Introduction to note that estimating the proportion of deaths due to prescription opioids is a challenge because causes are often multifactorial, prescription opioids may be obtained through diversion, prescription opioid use may lead to illicit use, and patterns of opioid use are changing rapidly, with local variations; we also added a reference to the Walley study. We did not add a sentence describing the Walley study in more detail because many patients were being prescribed opioids for OUD (~27% were prescribed methadone for OUD and ~19% were receiving buprenorphine [indication not reported]).

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #141, Jennifer Martin-Romme	Question 3	The methodology employed here is a standard review of the existing literature. However, that existing research has significant flaws, and you haven [and] #039;t incorporate some of the most recent research, such as Walley et. al. mentioned above. Carrying over the terms [and] quot;abuse [and] quot; and [and] quot;misuse [and] quot; as they were used in the literature is problematic. For one thing, different researchers may have used the terms in different ways. For example, the term [and] quot;misuse [and] quot;---which you indicate you sometimes substituted with [and] quot;opioid use disorder [and] quot; or [and] quot;opioid dependence [and] quot;---is routinely used clinically to refer to the patient taking FEWER opioid doses than prescribed. Obviously not ingesting an opioid would be diametrically opposed to the concept of having a use disorder or a dependence. You [and] #039;ve essentially carried over other researcher [and] #039;s mistakes and then compounded them by sometimes substituting [and] quot;use disorder [and] quot; or [and] quot;misuse. [and] quot; There [and] #039;s already a lack of consistent working definitions in the research pertaining to prescription opioids, and this portion of your methodology actually makes that problem worse.	The Walley study does not address any Key Question for this report and does not meet inclusion criteria, but we added a reference to it in the Introduction. With regard to the term "opioid dependence" the Methods note that opioid dependence refers to the term as used by DSM-IV, not to physical dependence without an opioid use disorder.

Public Reviewer #141, Jennifer Martin-Romme	Question 4	By almost every measure, opioids were associated with at least a small improvement over placebo---a fairly significant result, considering most of these studies were short-term and most involved low doses of opioids, usually no higher than 50 Morphine Milligram Equivalents. And yet subjects still demonstrated small improvements on almost every measure. This would seem to favor opioid therapy far more than your conclusions take into account.I [and] #039;ve already outlined the problems with studies comparing opioid to non-opioid therapy (ranging from no long-term data to no information about the patients [and] #039; pain conditions, their medical history, or their history of substance use). Another glaring problem with this comparison is the dangers of opioids versus the dangers of non-opioids. How many patients on ibuprofen/aspirin/acetaminophen/naproxen overdosed on those drugs? How many experienced gastrointestinal bleeding? How many experienced liver damage? It [and] #039;s intellectually dishonest---and dangerous to patients----to inflate the risks of opioid analgesics while completely ignoring the risks of non-opioid analgesics, especially when used long-term. The serious and well established risks of long-term NSAID use aren [and] #039;t even acknowledged in your discussion. Cannabis, in addition to posing a legal risk due to its Schedule I status, can cause or exacerbate anxiety, and unlike opioids, cannabis users rarely habituate, so cannabis remains intoxicating despite prolonged use. (See Lekens, et. al., 2018, Society for Neuroscience/still under peer review, which found that, contrary to popular belief, most people do not experience euphoria from ingesting opioids.)When opioids were combined with a non-opioid analgesic followed by a decrease in opioid usage, it [and] #039;s not clear whether the patient lowered their dose voluntarily because the non-opioid was reducing their pain, or whether their doctors forced a dosage reduction of the opioid. If the decrease in opioid use was for any reason OTHER than effective pain management with the non-opioid, then the relationship between these variables is spurious and should be discounted.Key Question 2a is ridiculous. How could anyone develop opioid use disorder and/or overdose on the placebo?? Test subjects couldn [and] #039;t possibly get addicted to opioids if they [and] #039;re	The report notes the small benefits of opioids for short-term pain and function. Results were similar in trials that used higher doses of opioids. Adverse events of non-opioids, including serious adverse events and withdrawals due to adverse events, were reported. There was no difference between opioids and nonopioids in the risk of serious adverse events. Patients randomized to placebo could develop opioid use disorder if they are exposed to illicit opioids or diverted prescription opioids. The Brat study focused on acute postoperative pain and is not relevant for this review. The Noble review is an outdated systematic review that was almost entirely based on uncontrolled studies; in addition the studies in the Noble review were not designed to evaluate risk of opioid use disorder. Please see response to other comment from this reviewer regarding the Walley study.

Section	Commentator & Affiliation	Comment	Response
		not exposed to opioids. You have no null hypothesis in that question, because only the experimental variable---the real opioid---is capable of producing the effects tested for. It [and] #039;s not as if these adverse effects haven [and] #039;t been studied, but those studies aren [and] #039;t included in your review. I refer you to Brat, et. al. (BMJ, 2018) and Noble, et. al. (Cochrane, 2010), which found that between 3% and 0.27% (respectively) of patients prescribed an opioid, both long-term/chronic (Noble) and short-term/acute/post-op (Brat), go on to develop opioid use disorder. Please see the aforementioned Waller, et. al. with regards to overdose rates among patients with a legitimate opioid prescription. It [and] #039;s understandable that Waller was not included in your review since it was published very recently, but the absence of Brat and Noble is an oversight that introduces bias into your conclusions.You accept the studies that suggest post-operative opioids lead to opioid use disorder, but did not include Neilesh, et. al. (2016, JAMA), which had a much stronger sampling method and applied proper controls that are lacking in most of the studies you did include. Neilesh found that only 0.4% of post-op patients prescribed an opioid were still taking it one year after surgery---note that the reason why they were still taking it is unknown, so we can [and] #039;t conclude that even as many 0.4% developed an opioid use disorder.It seems any research that definitively contradicts the assertion that prescription opioids will lead to addiction and that non-opioids work just as well were simply omitted from this draft report---and despite that, the studies that you did cite often can be interpreted more favorably towards opioids than your conclusions suggest. For that reason alone, this study needs to go back to the drawing board and include the full spectrum of relevant research.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #141, Jennifer Martin-Romme	Question 5	There [and] #039;s a noticeable lack of studies related to questions around effectiveness of opioids for pain control, as well as the effects of titration, dose maintenance, extended release, etc. What few studies do exist on those topics are all identified as low quality. This biases your results in favor of the more commonly studied questions about opioid use disorder, misuse, and overdose---all of which reflect negatively on opioids, while providing no information with regards to questions that might favor opioids. This bias is not taken into account in your conclusions. I was dismayed to learn that the risk mitigation strategies that have been in use for years----urine drug screens, pills count, the PDMP, etc.----apparently have no research supporting their effectiveness, and thus I was baffled that your conclusions support the continued use of these measures, which are degrading and treat patients like parolees.	The report synthesizes the evidence in each of these areas. The lack of evidence in one area does not change the findings for another area.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #142, Chad Kollas	Question 10	This should serve as an addendum to my previously transmitted comments that expressed concerns that concealing the authors of this report during the comment period reduces process transparency and reduces opportunities to uncover potential, undisclosed conflicts of interest on the part of the authors.In addition to that concern, I have the following concerns. The AHRQ Report states that Opioids are often prescribed for chronic pain. In the United States, prescription of opioid medications for chronic pain more than tripled from 1999 to 2015. [5] This increase was accompanied by marked increases in rates of opioid use disorder and drug overdose mortality [5-7] involving prescription opioids. [and] quot; While both of these assertions are truthful, pairing them implies causation or at least association, but an examination of the driving factors for the opioid crisis suggests that illegal drugs (heroin and illegal fentanyl, often in the form of counterfeit medications) are the main problems in opioid overdose deaths for the last 5-6 years. Opioid prescribing rates have dropped since 2010, but overdose deaths rates have climbed over that same period. I am concerned that the AHRQ would reinforce a popular false narrative that prescription opioids are driving overdose deaths, when illegal fentanyl and heroin have become the main sources of those deaths.Additionally, the AHRQ report found insufficient evidence to show benefits of long-term opioid therapy for chronic pain, due to the absence of trials with follow-up of at least 1 year. This is a case of the absence of evidence does not constitute evidence of absence; more simply put, there are few (if any) studies of opioid analgesia efficacy that last longer than 90 days, since that is the time interval the FDA requires to establish efficacy of any marketed drug. There is no financial incentive for pharmaceutical companies to perform longer-term studies (that is, their medications are already on the market), and there would be profound ethical problems with a control group of patients with chronic, severe pain that were denied opioid analgesia in a long-term study. I find this portion of the report disingenuous on that basis.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process. The primary driver of opioid overdose mortality was initially prescription opioids, as noted in the Introduction, deaths related to heroin and synthetic fentanyl have been an important contributor in the last 5 or 6 years.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #143, Shirley Lane, N/A	Question 1	A lot of these so-called [and] quot;studies [and] quot; are flawed because they are testing opioids for types of pain that do NOT respond to opioid treatment, such as arthritis, some types of back/knee pain that is inflammatory. But for other types of pain such as nerve and bone pain opioids are the ONLY treatment that is effective!If the [and] quot;experts [and] quot; and bureaucrats who have never experienced Chronic Intractable Pain would bother to take the time to go to any Pain blog website and read the comments section, they would understand that opioids are extremely effective for the treatment of Intractable Pain!Dr. Richard Lawhern (former director of The Alliance For Treatment Of Intractable Pain), and Dr. Josh Bloom provide strong counteracting scientific evidence much of it gleaned from the CDC [and] #039;s flawed statistics.	Thank you for the comment. Separate analyses were conducted for neuropathic pain and effects were slightly larger compared with musculoskeletal pain. The trials did not distinguish "intractable" pain from "chronic" pain, nor are we aware of a standardized definition for "intractable" pain.
Public Reviewer #143, Shirley Lane, N/A	Question 10	The draft report shows clear bias and lack of evidence. If I had to make an educated guess, my suspicions lead me to believe that addiction psychiatrists who have no expertise in treating pain patients, only addicts, are behind the writing of this draft which is aggregious in and of itself.Andrew Kolodny, Jane Ballyntine and the other members of PROP have an agenda to take everyone off of opiods, get them into THEIR Addiction Treatment Centers (The Phoenix House), and into taking SUBOXONE! All for personal profit! Their are serious conflicts of interest behind every one of these people and are inherent to not only the CDC work groups , but I suspect also to the identity of the authors of this draft report.The secrecy in refusing to identify the authors of this draft should consign it to junk file 13!	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #143, Shirley Lane, N/A	Question 3	The myth of the flawed Krebs Paper is that opioids are not effective in treating chronic/intractable pain. There are millions of pain patients who will tell you that this is a lie of epic proportions (myself included)!I had a crush injury 20 years ago and have been on opioids 20 years. I would either be dead or at minimum, unable to function and lead a productive life!Pain Patients do NOT get [and] quot;high [and] quot;. The pain signals in our brain neutralize the feel-good chemical Dopamine, which creates the high, craving and addiction.The AMA has publicly denounced many of suppositions and ALL of the methodology of the CDC Guidelines and this applies to this draft report as well.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #143, Shirley Lane, N/A	Question 7	The secrecy in refusing to identify the authors of this draft should consign it to junk file 13.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #144, Jeanne Showalter	Question 10	Chronic painful diseases exist and those of us that are diagnosed with them should not be treated as criminals because of them. The access to pain medication that is necessary to have some quality of life is getting harder by the day. The stigmatization needs to stop and the general public needs to understand our diseases are real as is our pain.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #145, Monica Moceikis	Question 10	As a chronic pain patient, I can easily testify that long term opioids work. I have failed back surgery syndrome. My dose has never changed since 2014 when I had my surgery. Before that I was on opioid therapy at half my dose, along with tylenol, muscle relaxer, and anti-inflammatory and continuous ice packs. Now I am able to work, have a slightly increased social life. Without opioids, I was bedridden and only able to work 3 hours every other day. This constant fear of losing these life saving medications is doing psychological harm to me. The shame of going to the doctor, consenting to urine analysis, and hearing condescending comments from the pharmacist does not help either, but I deal with it every 28 days just to get some of my life back. I used to have a full time and a part time job. I used to work out religiously 3 days a week. I kept my home stocked and cleaned. I raised my two children and attended all their activities. Now I have to lay down on ice and forgo a pill for a few hours if I want to go out to dinner or to a function. The rest of my medication I use when I work 8 to 9 hour shifts 3 days a week. I am a small business owner, a home owner, a parent of two young adults, a wife, a tax payer, and a law abiding citizen who was unfortunate to get in a car accident and then had horrible experiences with the insurance team that held up my surgery for 13 months, forcing me to walk around with a broken spine. I have suffered enough and still have to suffer daily with the nerve damage I have. We need to be compassionate to others and allow the single treatment that helped so many millions of Americans, opioids, to be accessible to patients if they decrease their pain. Anything else would and is medical abuse and cause further patient harm.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #146	Question 1	Why didn [and] #039;t someone ask those of us who have serious issues causing pain to compare opioids with otc poducts? We can tell you with no doubts that opioids work significantly better than drugs such as Tylenol and advil, if the opioids are prescribed at a therapeutic dose for the pain condition that is being treated. Otherwise we would not be willing to do what is needed to obtain the prescription for the opioid or put up with the side effects , such as constipation, that we experience. Why weren [and] #039;t experts in the field of pain management contacted for their expertise?	Thank you for sharing your story, sorry to hear about your pain. The report included the SPACE trial, which used NSAIDs or acetaminophen as step 1 nonopioid therapy. We would have included other trials of opioids versus OTC meds if available. Several trials compared opioids to (prescription) NSAIDs and the findings were similar to opioids vs. other nonopioids.
Public Reviewer #146	Question 10	same as evidence summary	Thank you for the comment
Public Reviewer #147, Charles Bruscino, Research $ Advocacy	Question 1	Defer at this time due to severe physical disabilities caused by iatrogenic intractable incurable poly-osteoarthritis.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #147, Charles Bruscino, Research $ Advocacy	Question 10	How many Americans have responsibly and safely taken prescription opioid for pain, never overdosing or becoming addicted? Millions. We are the empirical experts you have not invited to the table. To the question are opioids effective in treating non-cancer chronic pain the answer is it depends on the patients and his or her circumstances and environment. Each patient has unique DNA so it depends on the particular opioid prescribed as all the opioids are different. Prescription opioids are more safe than not given the millions helped through these drugs. CDC and FDA had to backtrack in April 2019 and publicly state that [and] quot;responsible pain patients [and] quot; are being harmed by misapplication and misinterpretation of the Prescribing Guideline. Severe chronic pain can kill through deprivation and decline in general health. Addiction is indeed rare in pain patients (Lawhern; Nadeau). Withholding adequate pain medicine from a responsible pai patient is abusive. It [and] #039;s illegal in most states to abuse, neglect or exploit children, the elderly and adults with disabilities. It violates civil rights laws re discrimination. The Surgeon General [and] #039;s 2005 Call To Action To Improve the Health and Wellness of Persons with Disabilities is also applicable to the discussion about prescription opioids. We already suffer a general decline in health our health further declined without adequate opioid therapy. My apologies I couldn [and] #039;t be more forthcoming, but my disabilities have gotten worse ever since the CDC Prescribing Guideline came out. I have a 10-point overdose risk reduction methodology that has worked 100% in 21 years of taking prescription opioids even at very high dosages. It [and] #039;s pure empirical science, so talk to the experts on taking prescription opioids-- those of us who have responsibly taken these medications for years or decades. EVERYTHING in life is risky. Prescription opioids are profoundly effective at attenuating pain signals.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #147, Charles Bruscino, Research $ Advocacy	Uploaded Document	PPM letter to editor1215-2018.pdf (532 KB)	Thank you for the comment. The attachment (#6) was reviewed.
Public Reviewer #148	Question 1	The report is missing key information. Withholding the names till the final report is a red flag. The information contained is extensive. We need to allow more time than 30 days to evaluate this document.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #148	Question 10	Studies show increase in all cause mortality for chronic pain patients when taken off opioids. If there are not enough studies to determine long term risk, then it would deem inappropriate to force taper patients who [and] #039;ve been on them long term. With the data bases in place, it would not be difficult to study patients currently on opioids with those who were force tapered to determine risk and QOL. In addition, there are many patients willing to participate in those long term studies who would benefit greatly from opioid therapy at the same time. Co-prescribing opioids with benzo medications can also be studied more in depth with those who are currently taking both along with those who were forced to chose between one or the other and forced off of one. They can also look at the data of those who were on both (legacy patients) and evaluate their QOL and harms lack of harms during those years. Based on the information coming directly from chronic pain patients and QOL, the data does not match what was mentioned in the study. A large question regarding some of the studies provided is the lack of information in regards to switching opioids if side effects were not tolerated. Were they able to titrate to appropriate doses? Did they have time for side effects to subside as their body adjusts to the medication? What was the pain level prior to initiation of opioids compared to their levels on appropriate dosage?	The report addressed benefits and harms of tapering; as described in the report the evidence was limited. The report also addressed published evidence on risks of co-prescribing with benzo's, which was also limited but indicated increased risk when adjusting for confounders available in administrative databases.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #148	Question 4	There is so many [and] #039;inconclusive [and] #039; or [and] #039;not enough evidence [and] #039; in almost every outcome. How can any guidelines be issues without further legitimate studies to provide accurate information to make those determinations? Sudden discontinuation of medications on assumptions and fear is not the answer. Allowing informed consent and personal responsibility IS the answer. As with any drug taken, there are risks. With every person having their own unique situation, metabolism, ect, setting a guideline on dosage limits assumes a one size fits all model and discriminates against those who process meds outside that window. This is not individualized care.	The report synthesizes the evidence and does not make recommendations
Public Reviewer #149, Pennsylvania Nurse	Uploaded Document	Opioid Treatments for Chronic Pain Response 11.11.2019 PA RN.docx (27 KB)	Thank you for the comment. The attachment (#7) was reviewed.
Public Reviewer #15, Melissa QuackenbushQuackenbush , None	Question 1	Offering several modalities for chronic pain should always be considered. Pain medication is one tool that should be offered along with physical therapy, massage therapy, acupuncture, etc. Until there are other alternatives to help alleviate chronic pain we must keep all options open to those who suffer.	Thank you for the comment
Public Reviewer #15, Melissa QuackenbushQuackenbush , None	Question 10	I have tried several different modalities to treat my chronic pain conditions and opioids along with massage and muscle relaxers has allowed me to continue to function in society for over a decade. I was forced tapered down to below 90 MMEs and suffered for months before finding a new doctor to treat me with injections, therapy, and opioids. I have little to no side effects and only use the pain medication as prescribed. Having pain every second of every day is too much for anyone and your body will start to be impacted negatively. There are certain conditions where opioid medication works well for those of us with chronic pain. Pain medication should be an option for the doctor and patient relationship where applied responsibly.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #150, Delorse Croissette, Pain advocate	Question 1	As someone that suffers with an auto-ammune disease that 1/1000000 people have and my husband that has progressed Parkinson this is study shows no proof whatsoever that opioids do not work long term I have been on them for over 39 yrs and without them I have no QOL	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #150, Delorse Croissette, Pain advocate	Question 10	I believe this to be unconstitutional	Thank you for the comment
Public Reviewer #150, Delorse Croissette, Pain advocate	Question 2	There isn [and] #039;t any one author	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #150, Delorse Croissette, Pain advocate	Question 3	You have picked and chooses people that actual didn [and] #039;t need opioids because make a pain patient go without medicine was ruled unconstitutional	The characteristics of the patients in the trials is described in the Tables and Results.
Public Reviewer #150, Delorse Croissette, Pain advocate	Question 4	It [and] #039;s a crock	Thank you for the comment
Public Reviewer #150, Delorse Croissette, Pain advocate	Question 5	I found it to be uninformed	Thank you for the comment
Public Reviewer #150, Delorse Croissette, Pain advocate	Question 6	Hard to read	Thank you for the comment
Public Reviewer #150, Delorse Croissette, Pain advocate	Question 7	Seems. That you have used anti opioid researchers	Conflicts of interest will be disclosed with the final report
Public Reviewer #150, Delorse Croissette, Pain advocate	Question 9	Fine	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #151, Janice Garland, None	Question 10	All of AHRQ work need to stop until more information about authors is released. In addition AHRQ need to freeze program development with Mitre corporation that is building CDC guidelines into the back end of EHR. This surveillance was nit voted on by the public stakeholders. Stop and assess the full extent of damage, especially suicide due to pain from CDC guidelines.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #152, Jeffrey Edney, Alliance for Treatment of Intractable Pain	Uploaded Document	Commentary to Opioid Report.docx (49 KB)	The attachment (#8) was reviewed. Much of the attachment is excerpts from the report. The characteristics of the SPACE trial were described in the report, including the baseline pain scores (which were similar to other opioid trials) and average opioid dose used. There was not a marked dose-response effect, as described in the report. In the study that reported rates of opioid addiction in patients not prescribed long-term opioids, people can become addicted to opioids that are not prescribed. None of the cited studies meet inclusion criteria: they are systematic reviews that are outdated or only published as a conference abstract, evaluate intrathecal morphine, evaluate non-approved drugs, are uncontrolled observational studies or case series, do not provide data, or report an uncontrolled survey not published in a peer reviewed journal.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #153, Kimberly Lang, Chronic Disease Coalition	Question 1	The biases in this report almost jump off the pages. It attempts to fault science for disallowing long term studies (longer than 3 mos.) when it is unethical to conduct studies that remove a patient [and] #039;s pain medication for longer than 12 weeks. There are several respected Cohort studies on opioids for CNCP and a 10 year long term observational study that find opioids to be efficacious with an extremely low risk for adverse events. The body of evidence studying opioids is far from complete, but there was little reason to perform 12 week studies prior to current social attitudes and mores, since opioids, used as a last resort, have been efficacious for millenia. Despite the irony, it is still scientifically unethical to perform RCT studies for longer than 12 weeks duration. The only conclusion that can truly be drawn from the body of evidence is that more study is necessary.	The lack of long-term studies is an important limitation of the evidence because evidence is lacking on effects of opioids as often used in clinical practice (i.e., long-term). As benefit of opioids versus placebo at short-term follow-up are small, we do not see how longer-term trials would be unethical. We included long-term cohort studies that compared opioids versus no opioids; the reviewer does not cite the study she is referring to but it is likely an uncontrolled studies that did not meet inclusion criteria.
Public Reviewer #153, Kimberly Lang, Chronic Disease Coalition	Question 10	It is quite disturbing that AHRQ refuses to identfiy the authors of this report, even if this is typical policy. If we have learned anything from the debacle and subsequent patient harm caused by the CDC Guidelines for Prescribing Opioids, it is the manner in which the Guidelines were formed by an unidentified, unqualified and severely biased [and] quot;core expert group [and] quot; that left an open doorway for such harm to come to patients. The severely biased CDC Guidelines, although now outdated, were legislated into 33 states. Without knowing the identities of the authors of this report, we are unable to know their possible biases, appropriate qualifications, and possible agnedas or conflicts of interest. It essentially rules this document moot for all intents and purposes. This report should also be put into the federal register regulations.gov with a public announcement for the typical 12 weeks time to give researchers, providers, professional organizations, others, and most importantly, patients, a reasonable prospect to dissect and comment on a report that affects them more than anyone. The patient/advocate stakeholder voice has been lost in this process. Please consider doing the right thing before submitting a report that affects so many lives without giving those voices a chance to at the very least comment.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #153, Kimberly Lang, Chronic Disease Coalition	Question 2	Let me note using the profoundly flawed Krebs study (SPACE) to draw any kind of conclusion of opioids and non-opioids is quite telling of the authors agendas and biaes. The Krebs study used a patient population whose pain was not signifigant to receive opioid therapy, which would have not provided maximum benefit, and dosage was low and not titrated to analgesic effect. The optional use of antidepressants in the non-opioid group mitigated the effect of other non-opioid therapy. The Krebs study is a prime example of a researcher with a preconcieved notion with an agenda creating a study to attempt to prove it to the scientific community, who saw it for exactly what it was.	The baseline pain scores in the Krebs trial was ~5.4 on a 0 to 10 scale and similar to other trials of opioids vs. nonopioids (ranged 4.9 to 7.4). Opioids were titrated in the opioid arm to a mean of 21 mg MED/day (range 14 to 112 in the trials of opioids vs. nonopioids). Other analyses in the report found only a small association between higher opioid dose and greater analgesic effects. Antidepressants were part of the nonopioid therapy arm.
Public Reviewer #153, Kimberly Lang, Chronic Disease Coalition	Question 3	As a patient and advocate, I detest that the prioritized outcome of a 30% improvement in function should be a metric for measurement of success. The notion of 30% improvement is traditionally a metric established by insurance payers who don [and] #039;t want to pay for analgesia. With intractable and high impact pain, the improvement of being able to urinate by oneself, while not a 30% improvement, is humanizing and imperative to patient quality of life, and well worth the analgesia. Opioid analgesia may not be the panacea we [and] #039;d all like for it to be, but there is no comparably effective alternative for many patients. We cannot continue to restrict or deny access to LTOT when it is effective and stable on patients who rely on it to have quality of life. For some patients, it prevents them from having to apply for disability, for others it means the difference of having a meaningful life as opposed to being a bedridden burden. There has to be consideration of the substantial anecdotal evidence for the use of opioids. There are other issues here that need to be reexamined by the most important stakeholders in this report that I suspect were left out completely- patients.	The report evaluated mean improvement in outcomes (pain, function, and others) as well as the proportion experiencing an improvement, as defined in the trials. Some trials used a 30% cutoff and others used other thresholds or categories. The 30% threshold has been proposed by several expert groups as a clinically relevant threshold.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #153, Kimberly Lang, Chronic Disease Coalition	Question 4	This report draws a bar for evidence that the body of opioid studies does not and cannot ethically include-time. Long term studies (ie anything longer than 12 weeks) are still unethical to perform on patients suffering with intractable or high impact pain. The only conclusion that can be drawn here is that more studies are necessary within the ethical guidelines. The absence of evidence is not evidence of absence. There are many credible and respected studies that conclude the risks of opioid use disorder are extremely minimal that were excluded from this report. The entirety of the metrics used for determination of positive outcome using opioid therapy need to be reevaluated. This is too important to a population of patients totaling 12 million who use (or used) this therapy to provide adequate analgesia so as to be productive members of society.	The lack of long-term studies is an important limitation of the evidence because evidence is lacking on effects of opioids as often used in clinical practice (i.e., long-term). As benefits of opioids versus placebo at short-term follow-up are small, we do not see how longer-term trials would be unethical. We included long-term cohort studies that compared opioids versus no opioids; the reviewer does not cite the study she is referring to but it is likely an uncontrolled studies that did not meet inclusion criteria.
Public Reviewer #153, Kimberly Lang, Chronic Disease Coalition	Question 5	There are serious concerns as to who the authors are of this report. It is evident the report has an agenda against opioid therapy and a poor understanding of pain and its effects on the patient. The lack of transparancy has truly affected all aspects of this report.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Public Reviewer #154, Anon Anon	Question 10	Im going to comment on the whole thing. Im a physician trained at a world famous academic institution. My spouse is as well. We both have multiple serious illnesses that will worsen until death, which will occur at an uncertain time, probably relatively young for both of us. We can no longer practice, but we retain the ability to reason. This document is going to inflict further damage upon the public that will not be reversible. Opioids have been used to relieve pain for a very long time. They work. They work long term. We have a growing population that has survived trauma, cancer, genetic disease, autoimmune disease, and other degenerative, progressive illnesses that become more painful with time, sometimes requiring more pain medication, which is likely a major reason researchers are able to falsely claim that opioids dont work, or tolerance is common, or opioid induced hyperalgesia is common. In my case, the number of dislocations I experience daily has increased dramatically, as well as rectal prolapses, and other painful events. A low dose of opioid in addition to multimodal treatment is critical for me to maintain independence, quality of life, and functionality. The same is true of my spouse, who has multiple autoimmune diseases, frequent kidney stones, inflammatory neuropathy..the list goes on for us both. I have already watched my father endure an amputation and receive nothing for pain. When he finally went into hospice, stinking up an entire ward with multiple infection sites, he was given 1 small dose of morphine over a week. He screamed until he coughed up blood and finally slowly bled to death. He was terrified; he was given 1 small dose of sedative in hospice. I honestly think cutting off a leg and not giving an opioid is not only unethical and cruel, its criminal. My mother died with terminal cancer and rheumatoid, in pain. Stop this nonsense. People are addicted to lots of things. They always will be. They are dying from heroin and fentanyl, not prescription opioids, which have already dropped massively. Patients like us now routinely get abandoned for no reason and have nowhere to turn. Its happened to us more than onceonce as a result of a healthcare system suddenly terminating care for all patients with continuing pain. Weve never abused or misused medications. You cant depend on even keeping a primary physician if	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		you have a painful diagnosis. You are increasing stigma and discrimination with this document.	
Public Reviewer #155, Anonymous Anonymois	Question 1-10	The CDC and other fed. Agencies have ruined so many lives, caused so much suffering, with your dishonest and misguided anti-opioid crusade.....read this article: Systems Thinking [and] amp; How It Can Solve The Overdose Crisis. A start repairing the damage.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #156, JOANNE O [and] #039;BRIEN	Question 10	Your conclusion ignores thousands of years of empirical evidence. It is not even logical. If opioid medications don [and] #039;t work, why would anyone ever refill a prescription? Why would the medical community and the general public be fighting government restrictions that seek to eliminate access to opioids? Why would surgeons and hospitals be highly concerned about the anticipated shortages because of government supply cut backs. There was simply too much in this [and] quot;study [and] quot; for me to unpack at this time. In reading it, specifics I would want to see about how patients were selected and their causes and levels of pain were missing. The medication and dosages, and verification of assimilation are absent. This [and] quot;study [and] quot; was so poorly designed, it [and] #039;s hard to know where to begin.	Thank you for the comment. The report summarizes published research on the benefits and harms of opioids.
Public Reviewer #156, JOANNE O [and] #039;BRIEN	Question 3	What efforts were made to ensure that participants got the correct opioid medication in the correct dose? Was genetic testing done? Did you test the assimilation of the medication administered. Because if you simply used morphine in a low dose, many people would not find relief (I know because I am someone who cannot properly assimilate morphine.)	In many trials, the dose of opioids was titrated. Only a small dose-response relationship was observed. Most trials did not perform genetic testing related to opioid metabolism; this is not standard practice.
Public Reviewer #156, JOANNE O [and] #039;BRIEN	Question 4	You had reached your conclusion before you designed the study.	The conclusions are based on the available evidence. We did not have a priori conclusions.
Public Reviewer #157, Angie Stengal, ASRA	Uploaded Document	ASRA_AHRQ Draft Reports on Nonopioid and Opioid Chronic Pain Treatments_FINAL_0.docx (161 KB)	Thank you for the comment. The attachment (#9) was reviewed.
Public Reviewer #158, Martha Mioni	Question 1	I don [and] #039;t have time to read, but the Chronic Pain Patient is being needlessly punished.	Thank you for the comment
Public Reviewer #158, Martha Mioni	Question 10	You should be ashamed of yourselves. This report should be thrown in the garbage right along side the CDC guidelines. You all have my two friends [and] #039; bloodstains on your hands.	Thank you for the comment
Public Reviewer #158, Martha Mioni	Question 2	If you want a trial to see if pain meds work, ask me. I [and] #039;ve been taking them successfully for over 15 years.	Thank you for sharing your story, sorry to hear about your friends.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #158, Martha Mioni	Question 3	I [and] #039;ve lost two friends to SUICIDE because of not having access to their pain meds.	Thank you for sharing your story, sorry to hear about your friends.
Public Reviewer #158, Martha Mioni	Question 4	Meds are now being prescribed to those in their 50 [and] #039;s, but the people that are overdosing are in their 20 [and] #039;s and 30 [and] #039;s.	Thank you for sharing your story, sorry to hear about your friends.
Public Reviewer #158, Martha Mioni	Question 5	Are the PROP members the authors to this report? Kolodny sucks!!! So does Jane Ballantyne and Franklin, all PROP members.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #158, Martha Mioni	Question 6	This is the biggest human rights violation depriving the CPP (Chronic Pain Patient) their pain meds.	Thank you for the comment. This report does not make recommendations but summarizes the published research.
Public Reviewer #158, Martha Mioni	Question 7	Genocide	Thank you for the comment
Public Reviewer #158, Martha Mioni	Question 8	Suboxone is a bad drug. Kolodny is probably getting kickbacks from it along with his invested interest in recovery centers. Follow the money.	Thank you for the comment
Public Reviewer #158, Martha Mioni	Question 9	Suicide is not a cure for pain.	Thank you for the comment
Public Reviewer #159, Robert Campbell	Question 4	I find this absurd. Ask any person with true chronic pain knows how ridiculous this report is. Until you [and] #039;re in constant chronic pain you can make these foolish claims. Once you or a family member is suffering with chronic pain then you will curse this blatant dishonest claim.	Thank you for the comment, this report summarizes the published research.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #16, S. Loughlin	Question 1	I became a chronic pain patient due to the FDA allowing a product onto the market that it shouldn [and] #039;t have, and due to the greedy actions of a pharmaceutical company. I was then victimized by the CDC. Post-surgery, the surgeon/ anesthesiologist apparently bought into the anti-opioid hype. They unconscionably, severely under-treated my pain post-surgery. I came very close to committing suicide as I lay in bed in agony, cut top to bottom, and no relief. The few Norco they gave me were used up immediately and I was left with zero pain relief. After suffering for days my spouse couldn [and] #039;t bear it and planned to go to the city to purchase me illegal pain relief. We are and have always been law-abiding, now older citizens. What you have done to patients is SICK.That was just the beginning of my nightmare. What the CDC has done is unconscionable. I [and] #039;ve had Walgreens refuse to fill my script while in another state, I was questioned by the Pharmacist for having tramadol AND an opiate, and been forced to spend money I did not have on urine tests. I have never had an addiction problem and I [and] #039;m old! And I did absolutely nothing wrong either to put myself here; I don [and] #039;t want myself here. I don [and] #039;t want to be damaged and on pain medication. But I [and] #039;m here.My spouse said that some day those pushing for denial of pain relief are themselves going to need pain relief one day and they [and] #039;ll be the victims of their own cruel and harmful policies. Some day we will all stand before our Maker and answer for what we [and] #039;ve done, and I am as certain as I [and] #039;ve ever been that God will DAMN TO HELL those who have inflicted so much pain and suffering on the public.	Thank you for sharing your story, sorry about your pain.
Public Reviewer #16, S. Loughlin	Question 10	Stop what you [and] #039;re doing. You are irreparably harming many lives. I will forever be scarred by what happened to me post-surgery. I do not trust the medical profession anymore.	Thank you for sharing your story, sorry about your pain.
Public Reviewer #16, S. Loughlin	Question 2	Opiates DO WORK for long term pain relief. I AM A LIVING, BREATHING EXAMPLE.	Thank you for sharing your story, sorry about your pain.
Public Reviewer #16, S. Loughlin	Question 7	Illegal drugs have been definitively proven to be driving the opioid epidemic.	Thank you for the comment

Public Reviewer #160, Ashley Walton, American Society of Anesthesiologists	Question 10	ASA appreciates the opportunity to weigh-in on the AHRQ Draft Comparative Effectiveness Review: Opioid Treatments for Chronic Pain. We provide this feedback with the knowledge that the information derived from the review will be used to inform the update and expansion of the existing CDC Guideline for Prescribing Opioids for Chronic Pain. The ASA recognizes that the Guideline was created to improve patient care, comprehensively promoting best practices in patient selection and monitoring, as well as in treatment planning with the end goal of improving the safety of opioid prescribing. However, we also know the Guideline has been misapplied in a number of venues. The Guideline was meant as guidance for primary care providers, not for its recommendations to be applied to all patients in all circumstances. While we acutely recognize and greatly appreciate the concerns with overprescribing of opioids, we worry that the pendulum has swung too far in the direction of not treating chronic pain in accordance with evidence-based methodology. Chronic pain is a disease with systematic effects, impacting a range of organs, including the brain which must be diagnosed, evaluated and properly treated. Therefore, ASA asks that caution be exercised in any recommendations that stem from the systematic review.With the misapplication of the Guideline, patients have suffered the consequences. A patient on a chronic stable regimen of opioids that has a successful level of function and quality of life, can be cut-off based on daily dosing thresholds based upon the CDC Guideline. This is especially problematic because the CDC Guideline is being applied retroactively. For some patients, the rapid decrease in their medications has been unmanageable resulting in depression, illegal substance use and even suicide. Consequently, the FDA announced the harm caused from sudden discontinuation of opioid pain medicines and required label changes to guide prescribers on gradual, individualized tapering. Other unintended consequences have been both a reduction in physicians willing to treat chronic pain patients and an overwhelming flood of patients to physicians still willing to provide care to these patients and prescribe opioids. This can also have negative impacts on physician well being, due to the high volume of transfers in care and	The report synthesizes the evidence and does not make recommendations. There are limitations of the evidence for generalizing to all patients.

Section	Commentator & Affiliation	Comment	Response
		may ultimately lead to burn out in turn, this affects patients. Again, ASA supports federal efforts to reduce opioid overdose deaths, but we are concerned that the existing evidence highlighted in the review, if utilized to create concrete recommendations around opioid prescribing for chronic pain patients, could result in further unintended consequences. For instance, the conclusion that the evidence showed no differences between opioids versus nonopioid medications in improvement in pain, function, mental health status, sleep, or depression could be misleading. ASA would note that physicians can assess functional improvement when considering whether opioids are effective. To illustrate, in treating a patient who is employed and regularly working, a physician can evaluate whether opioids enable the patient to continue to work. ASA would also like to caution against interpreting the evidence from the review to develop strict guidance or thresholds around prescribing certain morphine milligram equivalents (MME). Blanket prohibitions against filling prescriptions beyond certain numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances that would support such prescribing are ill advised and fall outside of quality patient care. Individualized patient care and safety should be the utmost priority when treating chronic pain. The treatment plan and modality should be the decision of the treating physician and the patient after jointly discussing options, weighing benefits and risks, as well as expectations. Last, when the initial CDC Guideline draft was available for comment ASA warned that the Guideline inaccurately portrayed the effectiveness and risks of interventional procedures. This is particularly concerning since interventional pain procedures are a key non-opioid therapy to treat chronic pain. ASA hopes that any final product that is produced as a derivative of this literature review would include acknowledgement of interventional procedures and other non-opioid options for patients.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #161, Britinia Galvin, American Academy of Physical Medicine and Rehabilitation	Question 10	The American Academy of Physical Medicine and Rehabilitation (AAPM [and] amp;R) appreciates the Agency for Healthcare Research and Qualitys (AHRQ) distribution of and opportunity to provide feedback on the Noninvasive Nonpharmacological Treatments for Chronic Pain: A Systematic Review Update, the report on Opioid Treatments for Chronic Pain, and the report on Nonopioid Pharmacologic Treatments for Chronic Pain. AAPM [and] amp;R appreciates AHRQs efforts to assess the effectiveness of common treatments for chronic pain, including opioids, nonopioid pharmacologic treatments, and noninvasive nonpharmacological treatments. Many physiatrists are leaders of health care teams that provide care for patients presenting both acute and long-term chronic pain management needs. Physiatrists treat countless conditions resulting in the manifestation of pain including spinal cord injury, multiple sclerosis, post-stoke pain, fibromyalgia, peripheral neuropathy, and limb amputations. AAPM [and] amp;R strongly advocates that the treatment for acute, subacute, and chronic pain management should be multimodal. While many physiatrists aim to provide interdisciplinary, nonpharmacological regimens; treatment plans may also include the use of non-opioid medications, opioids and interventional medicine. Regarding the Noninvasive Nonpharmacological Treatments for Chronic Pain: A Systematic Review Update, AAPM [and] amp;R notes that a review of interventional treatments (e.g. nerve blocks, neuromodulation, etc.) were excluded from this review. AAPM [and] amp;R believes that an additional report regarding advanced interventional, nonpharmacological treatments would be beneficial and would appreciate such a review by AHRQ. Lastly, regarding the report on Opioid Treatments for Chronic Pain, AAPM [and] amp;R notes that with meta-analysis, effects tend to homogenize. As such, we would like to emphasize that pain is a subjective and personal experience that widely varies by patient and condition. It is important to evaluate and treat each patient individually, using the best available data to inform personalized treatment.	Thank you for the comment. Another report on nonpharmacological noninvasive interventions for chronic pain is being conducted.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #162, Davina George, N/A	Question 10	This is too convoluted for the average person to review. That said, I would like to see a study of chronic pain patients who have taken opioids for years and can prove the benefits such as additional function, enabling them to continue working and affording self care rather than relying on more expensive modalities and social services.Data can be manipulated to fit ANY study. [and] quot;A lie told often enough becomes the truth. [and] quot; - Vladimir LeninStudies such as these are harming populations of chronic pain patients in an effort to stem a heroin and fentanyl problem in this country, not legitimate use buy chronic pain patients. You are demonizing the wrong problem in an effort to look like you are addressing the situation. The government should do better, rather than harm a significant population of people such as the disabled, the elderly and and those suffering terminal illnesses.Please select all of us who object and put us into one of your [and] quot;controlled studies [and] quot; (by whom?) !	Thank you for the comment. Seven of the placebo-controlled trials enrolled patients already prescribed opioids and about half of the trials enrolled mixed (opioid-naïve and opioid-experienced) populations. We performed analyses stratified by opioid status at baseline and there were few differences in effects on pain or function.
Public Reviewer #163, Matt Powell, No Affiliation	Question 1-10	The conclusions are not supported by the findings. The Conclusion states that [and] quot;Findings support the recommendation in the 2016 CDC guidlines.. [and] quot; This is in direct conflict with the stated limitation of the study. The findings clearly do not support CDC findings because as stated in the Limitations [and] quot;...analysis could not be conducted for most questions.. [and] quot;. The conclusions are contradictory, not supported by the findings, and represent bad science.The Limitations are honest. The Conclusions are dishonest, not supported by the findings, and lay in direct conflict to the stated limitations of the study itself. It is also somewhat disingenuous that you have included a section in this form for everything - except - the [and] quot;Limitations [and] quot; and [and] quot;Conclusions [and] quot; sections of the report. So I will be adding this same comment to each of the feedback sections found here.	The Findings of the report support the 2016 CDC guideline because the benefits of opioids were small, there was evidence significant harms (in some cases dose-dependent), and effects of opioids were similar to nonopioid therapies.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #164, Laurie Stout	Question 10	Anyone who has any familiarity with research methods can tell this paper is flawed. Why are the names of responsible parties not disclosed? Who did this paper and who are the peer reviewers? What grade do you think this paper would receive in an accredited learning institution?	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process, we followed standard systematic review methods
Public Reviewer #165, Robert Twillman, Integrative Health Policy Consortium	Uploaded Document	AHRQ Response 11-12-19.pdf (2136 KB)	Thank you for the comment. The attachment (#10) was reviewed.

Public Reviewer #166, Lindsay Baran, NCIL	Question 1	Studies cited support a conclusion that opioids do not appear to be superior to nonopioid therapy for *first-line* treatment of chronic pain. These studies do not, however, support AHRQs stated conclusion that opioids do not appear to be superior to nonopioid therapy for chronic pain in general.In typical 2019 clinical practice, opioid medication (particularly extended-release medication) is reserved for a small category of patients after other available therapies have failed, when remaining nonopioid therapies have an inferior risk profile, and when a palliative protocol can mitigate disability and enable participation in life. Indeed, all professional and government guidelines leave a role for opioids in the treatment of chronic pain where other treatments have failed.Evidence suggests somewhere between 5-25% of patients with long-term pain may belong to this smaller category, and that doses above 180 MME (morphine milligram equivalent) may be beneficial in exceptional cases:https://www.ncbi.nlm.nih.gov/pubmed/25503691 https://www.ncbi.nlm.nih.gov/pubmed/20091598https://uk.cochrane.org/news/traditional-opioids-chronic-non-cancer-pain-untidy-unsatisfactory-and-probably-unsuitableExceptional cases include some people with severe disabilities whose function and quality of life depends on higher dosage. As the HHS Task Force report points out, although risks increase with higher doses, given the variability in underlying conditions and in how patients metabolize opioids, there is no clear cut off point.Conclusions drawn from first-line treatment of osteoarthritis and common low-back pain cannot be extrapolated to last-resort palliation for congenital malformations, catastrophic injuries, autoimmune disorders, sickle-cell disease, or other pain-generating conditions.Unfortunately, studies that specifically select for this smaller group do not exist. This is partly because, as this draft acknowledges, studies have high dropout rates and ethical issues with leaving patients incapacitated on placebo when they could be participating in life activities.AHRQs conclusions about chronic non-cancer pain should be limited to first-line therapy for chronic pain. Conclusions must allow for exceptional cases along with more common clinical scenarios.	The report does not make recommendations. The conclusions regarding effects of opioids vs. nonopioids are based on evidence showing no differences between opioids vs. nonopioids on short-term pain, function, or other outcomes; there were also no differences for specific types of nonopioids. The lack of studies for certain pain conditions is described in the Limitations of the Evidence Base section. The need for research in specific pain condiitons was added to the Research Recommendations section.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #166, Lindsay Baran, NCIL	Question 10	Please see attached letter from NCIL (National Council on Independent Living), a leading national disability rights organization, and the longest-running national cross-disability, grassroots organization run by and for people with disabilities. NCIL represents thousands of individuals with disabilities and organizations including Centers for Independent Living (CILs), Statewide Independent Living Councils (SILCs), and other organizations that advocate for the human and civil rights of people with disabilities throughout the US.We write this letter on behalf of the National Council on Independent Living (NCIL), a leading national disability rights organization, and the longest-As an organization representing people with disabilities across the country, many who live with chronic pain, NCIL works to protect the rights of people with chronic pain. Our work in this area began as efforts to address the opioid crisis ramped up in the US, and we saw people with chronic pain left out of these efforts and harmed as a result.	We reviewed the attachment (#11). The inclusion criteria were determined with input from stakeholders. The report excluded studies of patients with pain at end of life, including cancer pain, and pain due to active malignancy, because clinical and ethical considerations may differ in these patients. The report did not exclude trials of patients with a history of cancer or pain in persons with cancer not related to the malignancy; however, no such studies were identified. The Vermont study and Washington study cited by the reviewer are included in the report. In both of these studies it was not possible to determine whether patients were tapered or opioids were discontinued for other reasons. The studies also had other methodological limitations. The Colorado study cited by the reviewer on variability in opioid doses does not address a Key Question in the report; this study is not relevant to the question of tapering as dose variability includes patients who receive higher doses. Conclusions regarding the benefits of opioids vs. nonopioid therapy are based on analyses of head-to-head trials of opioids vs. nonopioids. The assertion that conclusions only apply to first-line treatment is not supported by the evidence, as most of the trials of opioids enrolled patients who had previously tried other therapies. No study on tapering versus no tapering distinguished voluntary versus involuntary tapering; furthermore we are unaware of any validated method for categorizing the “voluntariness” of tapering. The Limitations of the evidence are discussed in the Discussion.

Public Reviewer #166, Lindsay Baran, NCIL	Question 2	AHRQ informs policy for payers, health systems, state agencies, and other decision-makers. Because policies may be applied across entire populations, statements intended to inform policy should always be carefully worded to allow for complex cases, exceptions, and outliers. Chronic pain is a large, umbrella category that includes conditions that may vary dramatically in severity and underlying etiology. Weve already seen the dangers of taking a one-size-fits-all approach to patients with diagnoses in this broad category. According to Adm. Brett P. Giroir, M.D., Assistant Secretary for Health, the Department of Health and Human Services (HHS) emphasizes personalized care tailored to the specific circumstances and unique needs of each patient.As an agency within HHS, AHRQ should take special care to avoid generalizations regarding any class of medication. Such statements compromise the individualized care espoused by HHS guidelines, including the Pain Management Best Practices Inter-Agency Task Force Report and the Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics.After reviewing the AHRQ Draft Comparative Effectiveness Review Opioid Treatments for Chronic Pain, we are concerned that the Key Messages and Conclusions sections do not align with evidence-based HHS policy, nor do they reflect limitations expressly acknowledged later in the same document.First, we question the value of reviewing evidence for non-cancer pain, when science does not support a categorical division between cancer and non-cancer. Non-cancer conditions can be just as damaging, incapacitating, and lethal: https://www.regulations.gov/document?D=FDA-2012-P-0818-0793This year, Centers for Disease Control (CDC) and other federal agencies warned against widespread misapplication of CDCs 2016 Guideline for Prescribing Opioids for Chronic Pain: https://www.tandfonline.com/doi/full/10.1080/08897077.2019.1613830Such potential harms include incentivizing forced or abrupt cessation of opioid therapy and patient abandonment, a practice the FDA recently came out against: https://www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-	Thank you for the comment. The report excludes patients with active cancer pain and pain at end of life, as treatment considerations and priorities may differ compared to persons with other types of chronic pain; pain related to treated cancer (or cancer treatments) was not excluded, though evidence in these populations was very sparse. The report evaluated how effects varied for different types of pain. There was little evidence on how effects vary by demographic factors, but the available data indicate little impact. There was insufficient evidence to show how effects vary based on other factors such as severity of baseline pain, presence of depression, current or past opioid use disorder, and others. The report did address risk of opioid discontinuation including the Vermont study.

Section	Commentator & Affiliation	Comment	Response
		label-changesSeveral other studies that have emerged this year raise concern regarding abrupt tapering, including a study in Vermont of Medicaid patients at high MME for more than 90 days finding that the average amount of time for opioid discontinuation was one day, with nearly half having an opioid-related hospitalization or emergency room visit: https://www.ncbi.nlm.nih.gov/pubmed/31079950A study in Colorado shows that simply destabilizing dosage resulted in a three-fold increased risk in an opioid overdose: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2730786A study in Washington found that discontinuation of long-term opioid therapy was associated with increased overdose risk, and did not reduce risk of death: https://link.springer.com/article/10.1007/s11606-019-05301-2Other studies suggest concerns about a paucity of physicians being willing to treat chronic pain patients on long-term opioid therapy, patients who did not put themselves on these prescribed medications. A study in JAMA found that more than 40% of primary care physicians will not treat a new patient who uses opioids for pain: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2737896A recent study conducted by Quest Diagnostics and the Center for Addiction found that 81% of physicians were reluctant to treat a chronic pain patient who uses opioids and 70% felt ill-equipped to taper patients: https://questdiagnostics.com/dms/Documents/drug-prescription-misuse/Health_Trends_Report_2019.pdfConsidering these known harms, AHRQ should consider potential misapplication of this Comparative Effectiveness Review, should policymakers incorporate the Key Messages and Conclusions section without noting limitations enumerated in later sections.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #166, Lindsay Baran, NCIL	Question 3	This evidence review does include many relevant studies. Yet a critical question remains: do the studies themselves include every relevant subgroup of patients?Again, it is not clear that studies included in this review include scenarios where opioid medication offers the most benefit: where other therapies are less effective or riskier, and where long-term supportive palliative care can enable independent living.	The review conducted systematic searches and applied predefined criteria to identify studies for inclusion. The characteristics of the patients included in the trials are reported and extensive analyses were conducted on patient subgroups.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #166, Lindsay Baran, NCIL	Question 4	Chronic pain is an umbrella term, encompassing hundreds of conditions with different etiologies, treatments, and research needs. Results cited in this review do not adequately answer the Key Questions, because the cited studies do not apply to all chronic pain in general.Consider, for example, Key Question 1: In patients with chronic pain, what is the effectiveness of opioid therapy versus placebo or no opioid therapy for outcomes related to pain, function, and quality of life?This evidence review actually answers a different question: In patients *undergoing first-line treatment for chronic pain*, what is the effectiveness of opioid therapy versus placebo or no opioid therapy for outcomes related to pain, function, and quality of life?Among those who arrive at opioid therapy as a last resort, the effect of opioid medication on pain, function, and quality of life is often very different. While no studies specifically select patients who have already failed nonopioid therapies, anecdotal evidence from our members lived experience bears this out.Consider also, Key Question 3: In patients with chronic pain, what are the effects of decreasing opioid doses or of tapering off opioids versus continuation of opioids on outcomes related to pain, function, quality of life, and opiate withdrawal symptoms?This question should be separated into two questions, as evidence suggests vastly different results for voluntary versus involuntary taper.Correlation of higher dosage with higher risk is not evidence that lowering dose will reduce risk. Quite the contrary, new research suggests change in dose predicts overdose risk more than high dosage itself, and involuntary taper is associated with harm:https://www.ncbi.nlm.nih.gov/pubmed/31002325https://link.springer.com/article/10.1007/s11606-019-05301-2https://link.springer.com/article/10.1007/s11606-019-05227-9https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6235338/	Most trials of opioids required that patients had previously tried nonopioid therapies. No study meeting inclusion criteria on effects of tapering specified reasons for tapering or distinguished involuntary from voluntary tapering (nor are we aware of a standardized/reproducible definition for "voluntariness").

Public Reviewer #166, Lindsay Baran, NCIL	Question 5	This draft acknowledges the following limitations, among others:Patients typically had moderate pain, which might reduce applicability to patients with mild or severe pain. Selection of patients could also impact applicabilityrisk estimates across studies at specific thresholds vary, complicating decisionmaking in this areaFew studies evaluated how benefits and harms vary in subgroups defined by demographic characteristics, characteristics of the pain condition, medical or psychological comorbidities, and substance use history.evidence was lacking for certain pain conditions, including fibromyalgia, chronic headache, chronic abdominal pain, and chronic pain related to sickle cell diseaseGiven these limitations, the Key Messages and Conclusions sections should be revised, specifically acknowledging limited applicability to:people with severe pain,people excluded from selection criteria,people who cannot participate in studies due to physical disability, people with complex and poorly-researched conditions, and people with a clinical history of benefit outweighing risk at high dosage.Evidence cited does not support the broader conclusion that opioids do not appear to be superior to nonopioid therapy or that there are no differences between opioids and nonopioid medications for these populations.Research recommendations section:It is important for future studies on opioids to evaluate long-term outcomes, including newer or emerging harms potentially associated with long-term use.It is equally important for future studies to evaluate benefits associated with long-term use (e.g. workforce participation, mobility, enhanced participation in life activities, avoidance of harms from involuntary taper including incapacitation and suicide).In 2019, thousands of patients have been forced into involuntary opioid taper. Some of these patients, after tapering medication that was beneficial for them, are no longer able to participate in work and family activities. This cohort needs to be counted and included in research.Similarly, patients (and clinicians) who report ongoing benefit from long-term opioid therapy should be specifically included in the evidence base.We predict, if such studies are undertaken, future evidence will align with the anecdotal experience of our members: Opioids are not especially effective for many cases of chronic pain, but exceedingly effective for a	The characteristics of the study populations are described in the Results section and presented in detail in the Tables and Evidence Tables. As noted by the reviewer, limitations related to applicability are described in the Discussion of the report. However, most patients enrolled patients with moderate to severe pain. The conclusions are based on the available evidence, which include 115 RCTs and 39 observational studies. The studies were mostly funded by industry and generally intended to demonstrate optimal efficacy by enrolling patients with less complex pain conditions and fewer comorbidities and focusing on short-term studies. Some studies intentionally enrolled patients who already demonstrated benefit (i.e., studies using the enriched enrollment randomized withdrawal design). The report does not make any recommendations on tapering. The Discussion includes suggestions for future research.

Section	Commentator & Affiliation	Comment	Response
		minority unresponsive to nonopioid therapies.Failure to account for outliers may be, in effect, discrimination on the basis of disability. To prevent further harms from misapplication of federal guidelines, we hope to see AHRQs conclusions align with HHS guidelines, acknowledging the need for individual care within a diverse population of patients who may or may not be reflected in this evidence review.	
Public Reviewer #166, Lindsay Baran, NCIL	Uploaded Document	AHRQ 11-2019.docx (304 KB)	Thank you for the comment, the attachment (#11) was reviewed.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #167, Anonymous Anonymous , ATIP	Question 1	AHRQThe [and] quot;evidence [and] quot; is severely *lacking*. Cherry picked propaganda studies that have been proven wrong while excluding multiple studies [and] amp; Cochrane reviews showing efficacy is wrong and unethical. Multiple state analysis show OD deaths are the combination of 5-14 illegal drugs *NOT* opioids prescribed to the patient! To continue to ignore this obvious data is malfeasance! Illegal drug deaths have risen 52o% while reports such as this ignore those dying and instead target innocent patients. There is no causation or correlation supporting prescribed medications causing rising ODs. Over 100 million Americans have been prescribed opioids, yet addiction numbers are still at 2million, with no significant increase after more opioids were prescribed for pain management. Now innocent patients and doctors are targeted and harmed! AHRQ should be embarrassed to have their name on this!https://reason.com/2019/10/23/massachusetts-study-confirms-that-people-rarely-die-after-using-opioids-prescribed-for-them/https://www.painnewsnetwork.org/stories/2019/11/6/nbsp-feds-using-cone-of-silence-again-for-rx-opioid-review .Jeffrey A Singer MD, Jacob Z Sullum, Michael E Schatman, Ph.D. Todays nonmedical opioid users are not yesterdays patients; implications of data indicating stable rates of nonmedical use and pain reliever use disorder,J Pain Res. 2019; 12: 617620. Published online 2019 Feb 7. doi:10.2147/JPR.S199750https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6369835/Richard A Lawhern, Ph.D., Over-Prescribing Did Not Cause Americas Opioid Crisis, Lynn Webster, MD BLOGMarch 30, 2019,http://www.lynnwebstermd.com/over-prescribing/	The conclusions are based on the available evidence. The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included stakeholder and public input. Studies were identified using systematic methods and selected based on application of pre-defined inclusion criteria.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #167, Anonymous Anonymous , ATIP	Question 10	Burn, Bury, Run from this disgusting, embarrassing biased travesty of propaganda! This should have never seen the light of day! It deserves nothing but destruction and scorn! Use a true literature search- including ALL reserved on topic- NO exclusions of industry standard, ethical studies! Including those stating the harm and death prevalent to patients denied the prescibed opioids that kept them stable. Use the literature provided to you in these comments. Use authors who do not fear thier name being used. Include those NOT tied to PROP or Pharmed Out as they have clear negative biases and no wish for neutrality. If those things are done, *then* post the article *Properly* for public comment!	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #167, Anonymous Anonymous , ATIP	Question 2	STOP lying to us all about lack of [and] quot;evidence [and] quot;. The lack is only in the proof that prescribed opioids do not work. They would not be used for post surgery or chronic pain if they did not work. As you support the propaganda and unethical cherry picked data forcing a narrative against patients- pain patient suicides have risen dramatically!! AHRQ- YOU are contributing to torturing and killing people! There are many studies showing efficacy of opioids and ways to study long term effects. They were not done because they weren [and] #039;t needed. Patients and doctors saw improvements for patients when on them. Now they will not be funded due to propaganda! The lack of evidence is in tapering stable patients. There is ZERO research to support tapering stable patients off of their medications!! Yet you now support this? Fake cry [and] quot;no evidence [and] quot; for prescribed opioid use and then push tapering which actually has no evidence? Has the AHRQ lost all credibility, ethics, and morality??Baraa O. Tayeb, Ana E. Barreiro, Ylsabyth S Bradshaw, Kenneth K H Chui, Daniel B Carr, Durations of Opioid, Nonopioid Drug, and Behavioral Clinical Trials for Chronic Pain: Adequate or Inadequate? Pain Medicine, Volume 17, Issue 11, 1 November 2016, Pages 20362046https://academic.oup.com/painmedicine/article/17/11/2036/2447887https://www.practicalpainmanagement.com/treatments/pharmacological/opioids/opioid-treatment-10-year-longevity-survey-final-reporthttps://www.mdmag.com/medical-news/why-are-we-still-talking-about-opiophobiahttps://www.mdmag.com/conference-coverage/painweek-2016/study-says-oxycodone-effectively-manages-chronic-pain-in-elderly-patients	The conclusions are based on the available evidence. The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included stakeholder and public input. Studies were identified using systematic methods and selected based on application of pre-defined inclusion criteria. The report does discuss the need for future research on long-term outcomes.

Public Reviewer #167, Anonymous Anonymous , ATIP	Question 3	To say that this [and] quot;study [and] quot; was scientific is an unfront to every statistician and every student who [and] #039;s ever taken a statistics report. A chils can see that you [and] #039;ve cherry picked data to force your narrative and ignored multiple studies that would counter your point. There are mountians of data you ignored for no valid reason. This was 100% biased! A true review looks at ALL the evidence. Refusing to do so screams loudly that claims that prescribed opioids do not work for long term pain cannot actually stand up to a true literature review! Yet their efficacy has been shown by Cochrane reviews, FDA reports and more. The title says this [and] quot;report [and] quot; is about [and] quot;Opioid Treatments For Pain [and] quot;. However the report you wrote is [and] quot;Support for Government Propaganda That Knowingly Harms Patients But Supports Pharmaceutical Legislation Money So We Don [and] #039;t Care If Patients Suffer and Die. We Just Want The Money. [and] quot;Why do supposed scientific entities keep denying that ethical long term studies are 12 weeks long! This is industry standard and known!! To ignore all data found with only 12 week studies would be to repudiate 80% of ALL medical research. Unless AHRQ and the federal government is willing to throw out EVERY study on EVERY topic that is 12 weeks of lesa is it ludicrous to deny them for prescribed opioids! Especially when studies for counter measures are all also 12 week studies!This report ignored multiple studies and post hoc analysis re long term opioid use efficacy! And the only [and] quot;negative [and] quot; side effects you can find are constipation and some mood changes?? With. .002-2% unproven, unsupported by data *chance* of addiction? That is ZERO reason to deny 98-99.98% people treatment!The entirety of this [and] quot;report [and] quot; is a travesty. Failing to reveal the authors and thier biases/conflicts of interest is a complete failure of ethics and proper procedure. If the authors are appropriate than their names should be included. Failing to do so smacks of impropriety and lies. Considering that illegal opioid deaths have risen 520% (and prescibed opioid deaths have NOT risen) while the government had attacked patients instead of drug dealers- shows clear proof that illegal drugs and *failure* of the government to address illegal drugs is	The conclusions are based on the available evidence. The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included stakeholder and public input. Studies were identified using systematic methods and selected based on application of pre-defined inclusion criteria. The methods used to analyze studies, including the meta-analysis methods, are described in the report. The report included all studies at least 4 weeks in duration. Longer term studies are important because opioids are often prescribed long-term.

Section	Commentator & Affiliation	Comment	Response
		the actual problem! The government and now AHRQ have created a new epidemic of patients denied proper pain care. Causing rising suicides, increased health issuss, increased disabilities, increased trauma to chronic pain patients as they are abandoned and forced tapered. 81% of doctors already refused to see chronic pain patients since the 2016 [and] quot;Guidelines [and] quot;. This travesty supports the abadonment and mistreatment of chronic pain patients! This report will be the cause of more suicides and more patients dying of pain! Stephen A. Martin, MD, EdM; Ruth A. Potee, MD, DABAM; and Andrew Lazris, MD, Neat, Plausible, and Generally Wrong: A Response to the CDC Recommendations for Chronic Opioid Usehttps://medium.com/@stmartin/neat-plausible-and-generally-wrong-a-response-to-the-cdc-recommendations-for-chronic-opioid-use-5c9d9d319f71https://www.practicalpainmanagement.com/treatments/pharmacological/opioids/fentanyl-separating-fact-fictionhttps://www.acsh.org/news/2017/10/12/opioid-epidemic-6-charts-designed-deceive-you-11935	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #167, Anonymous Anonymous , ATIP	Question 4	The data that exists but was ignored does support pain patients. It will not go away! Patients will be heard! This [and] quot;report [and] quot; is not a true scientific review until ALL literature on prescribed opioids and ALL reports on efficacy and OD deaths are included. Until this happens, this disgusting propaganda, this offense to all scientific research must be burned and buried. There is not 1 single thing that was not intentionally biased against prescribed opioids. And AHRQ, you know this. Because you [and] quot;forgot [and] quot; to post it for public comment. These [and] quot;mistakes [and] quot; are known for the lies and propaganda they are. Burn and bury this travesty. We will find out the authors! We will fight back! And given that every biased point you attempt to make is already easily countered this travesty will be further exposed!https://medium.com/@heatherzamm/an-open-letter-to-all-who-hold-public-office-in-america-from-painful-disease-patients-e1afebaca945https://www.dailymail.co.uk/health/article-6152779/Chronic-pain-drives-millions-Americans-suicide.html	Thank you for the comment. The report was posted for public comment for 4 weeks.
Public Reviewer #167, Anonymous Anonymous , ATIP	Question 6	Seriously?? People are being abandoned by doctors, forced to taper off of stable medications, dying, and suiciding ?!?! And you wanr to ask about intitals?? For Shame!	Thank you for the comment

Public Reviewer #167, Anonymous Anonymous , ATIP	Question 7	What references? The parody of the flawed CDC [and] quot;Guidelines [and] quot;?? You ignored vast quantities of research. If this report were turned in for a grade for a college professor it would be an F. Failure to properly analyze the subject objectively. Failure to include opposing information. Failure to examine ALL available information to draw a true conclusion. This intentionally biased embarrassment would be used as a teaching example of What NOT to do!References-here are references!Citations for pain****Relieving Pain in America Reporthttps://www.nap.edu/read/13172/chapter/1#xiHere are the citations:http://thecrimereport.org/2018/06/21/the-phony-war-against-opioids-some-inconvenient-truthshttp://www.lynnwebstermd.com/over-prescribing/https://www.politico.com/story/2018/06/22/house-opioid-bills-lobbying-637695https://www.usatoday.com/story/news/politics/2018/07/02/chronic-pain-patients-needs-ignored-opioid-epidemic/727015002/http://www.philly.com/philly/health/addiction/fentanyl-is-killing-more-philadelphians-than-any-other-drug-medical-examiner-finds-20180424.html?mobi=truehttps://www.nejm.org/doi/full/10.1056/NEJMra1507771https://www.lasvegasnow.com/news/local-news/i-team-doctors-to-tell-lawmakers-of-patients-left-suffering-because-of-opioid-crackhttps://www.cato.org/publications/commentary/drug-prohibition-blame-opioid-crisisIllegal drugs causing opiod crisishttps://m.washingtontimes.comhttps://www.practicalpainmanagement.com/treatments/pharmacological/opioids/editorial-have-we-gone-too-far-can-we-get-backhttps://medium.com/@ThomasKlineMD/opioidcrisis-pain-related-suicides-associated-with-forced-tapers-c68c79ecf84dhttp://www.pressrele11asepoint.com/feds-double-down-pills-fentanyl-deaths-doublehttps://www.practicalpainmanagement.com/meeting-summary/time-pain-practitioners-take-back-pain-prescribinghttps://www.painnewsnetwork.org/stories/2017/6/20/the-consequences-of-untreated-pain#.Wzflu3mH9ao.facebook=https://m.youtube.com/watch?feature=youtu.be [and] amp;v=FzY2tIU83IIhttps://www.cato.org/blog/cdc-researchers-state-overdose-death-rates-prescription-opioids-are-inaccurately-	The references were reviewed and do not meet inclusion criteria.

		highhttp://ushealthtimes.com/many-with-chronic-illness-denied-prescriptions-in-fight-against-opioids/http://ushealthtimes.com/how-fear-of-losing-their-doctor-affects-chronic-pain-patients/https://www.cato.org/policy-report/septemberoctober-2017/myth-opioid-prescription-crisishttp://amp.slate.com/technology/2018/03/pill-limits-are-not-a-smart-way-to-fight-the-opioid-crisis.html?__twitter_impression=truehttps://omny.fm/shows/roy-green-show/cutting-chronic-pain-patients-off-opioid-medicatiohttps://www.circa.com/story/2018/04/02/nation/fentanyl-made-illicitly-could-have-inflated-opioid-prescription-deaths-and-wrongly-influenced-cdc-guidelines-on-opioid-prescribing-some-doctors-sayhttps://www.ncbi.nlm.nih.gov/pubmed/28582659jhttps://www.acsh.org/news/2017/10/12/opioid-epidemic-6-charts-designed-deceive-you-11935https://atipusa.org/news/has-the-opioid-pendulum-swung-too-far-finding-the-balance-between-pain-and-addiction/https://atipusa.org/2018/04/02/atip-white-paper-on-prescription-opioids-and-chronic-pain/https://reason.com/blog/2018/04/19/as-opioid-prescriptions-fall-opioid-deatwww.painnewsnetwork.org/stories/2018/5/3/study-finds-opioid-medication-effective-for-chronic-painhttps://www.statnews.com/2018/05/01/fentanyl-opioid-overdose-deaths-prescription-painkillers/https://medium.com/@jonleighton1/why-access-to-morphine-is-a-human-right-80ce2965de1awww.painmedicinenews.com/Web-Only/Article/04-18/CDC-Deaths-From-Synthetic-Opioids-Doubled-in-1-Year/48515?sub=5D69EC3B9D3D4FC2DE842B61731C826FEC96BC1C185E597A5BC274C75F94 [and] amp;enl=truehttps://www.cbsnews.com/amp/news/fentanyl-deaths-now-outpace-prescription-painkiller-overdoses-study-finds/https://www.courier-journal.com/story/news/crime/2018/07/23/louisville-opioid-patients-displaced-federal-raids/787784002/?utm_medium=twitter [and] amp;utm_source=dlvr.ithttps://tonic.vice.com/en_us/article/a3z98b/big-pharma-didnt-cause-the-opioid-crisis-most-pain-patients-dont-get-addictedhttps://edsinfo.wordpress.com/2018/08/02/wh	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		at-makes-buprenorphine-risky-for-pain-patients/http://www.kentreporter.com/opinion/we-need-a-new-approach-to-fight-opioid-crisis-stark/https://www.painnewsnetwork.org/stories/2018/7/25/pain-management-is-not-the-same-as-addictionhttps://www.cjr.org/covering_the_health_care_fight/what-the-media-gets-wrong-about-opioids.phphttps://www.nejm.org/doi/full/10.1056/NEJMp1807117?query=TOChttps://legalnewsline.com/stories/510653285-plaintiffs-firm-consultant-helped-develop-cdc-s-controversial-opioid-guidelines#.W19QnJucDN0.twitterhttp://reason.com/blog/2018/08/15/new-cdc-numbers-show-the-drug-war-continhttps://www.westernjournal.com/opinion-battle-opioids-mean-misery-patients-pain/amp/?utm_source=twitter [and] amp;utm_medium=tpnn_thepointhttp://thehill.com/opinion/healthcare/402083-cdc-opioid-guideline-is-causing-harm-to-people-in-chronic-pain?amphttp://www.pharmaciststeve.com/?p=20995https://www.madinamerica.com/2018/08/new-study-investigates-negative-side-effects-therapy/https://www.cato.org/publications/research-briefs-economic-policy/how-reformulation-oxycontin-ignited-heroin-epidemichttps://www.harmreductionohio.org/not-right-the-problem-with-how-reporters-cover-fentanyl/https://healthier2day.com/2017/12/29/opioid-prohibition-is-destined-to-fail/amp/?__twitter_impression=truehttps://www.painnewsnetwork.org/stories/2018/8/19/message-to-cdc-tear-down-your-walls-of-silencehttps://www.scientificamerican.com/article/people-are-dying-because-of-ignorance-not-because-of-opioids/?amp%3Btext=Peoplehttps://tearsoftruth.com/2018/07/31/about-suboxone-buprenorphine-and-naloxone/https://www.postandcourier.com/opinion/commentary/place-opioid-blame-where-it-belongs/article_0e924542-9ca1-11e8-88e3-6fd45e5a5c25.htmlhttps://www.vox.com/platform/amp/policy-and-politics/2018/8/23/17769392/opioid-epidemic-drug-overdose-death-study?__twitter_impression=truehttps://nationalpost.com/feature/my-year-on-death-rowhttps://reason.com/blog/2017/10/13/the-former-head-of-the-cdc-wants-to-	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		driv/amp?__twitter_impression=truehttps://www.healthaffairs.org/do/10.1377/hblog20180117.832392/full/https://tonic.vice.com/amp/en_us/article/7xqa44/forcing-pain-patients-off-their-meds-will-not-end-the-opioid-crisishttps://www.politico.com/story/2018/08/28/how-the-opioid-crackdown-is-backfiring-752183https://www.courier-journal.com/story/news/crime/2018/08/02/kentucky-doctors-fear-arrest-treating-pain-opioids-amid-clinic-raids/863407002/https://www.kansascity.com/news/business/health-care/article217447815.htmlhttps://www.painnewsnetwork.org/stories/2018/9/4/diversion-of-blame-and-the-opioid-crisishttps://www.painnewsnetwork.org/stories/2016/3/27/pain-patients-tired-of-being-labeled-as-addicts-by-hospital-staff#at_pco=smlrebh-1.0 [and] amp;at_si=5b8f63384d14e738 [and] amp;at_ab=per-2 [and] amp;at_pos=0 [and] amp;at_tot=5https://sciencebasedmedicine.org/bait-and-switch-in-oregon-substituting-quackery-for-opioids-for-medicaid-patients/https://www-m.cnn.com/2018/09/05/opinions/opioid-crisis-and-pain-management-cancer-sara-stewart/index.htmlhttps://www.painnewsnetwork.org/stories/2018/9/2/disabled-by-the-war-on-opioidshttp://itoldyouiwassick.info/2018/07/02/chilling-truth-opioid-crackdown/https://edsinfo.wordpress.com/2018/03/09/krebs-study-shows-opioids-are-safe/#comment-14719https://www.theguardian.com/business/2016/oct/21/reckitt-benckiser-drug-company-sued-suboxone-profiteering-opiod-addiction?CMP=share_btn_fbhttps://www.painmedicinenews.com/Clinical-Pain-Medicine/Article/09-18/Suicide-Accounts-for-Higher-Percentage-Of-Opioid-Deaths-Than-Previously-Believed/52566?sub=5D69EC3B9D3D4FC2DE842B61731C826FEC96BC1C185E597A5BC274C75F94 [and] amp;enl=truehttps://www.medpagetoday.com/meetingcoverage/painweek/75005?xid=nl_mpt_special_reports_2018-09-11 [and] amp;eun=g1260305d0r13187881uhttp://www.ksby.com/story/39064043/doctors-pharmacists-not-always-on-the-same-page-when-it-comes-to-opioid-	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		epidemic?fb_action_ids=10156161887544051 [and] amp;fb_action_types=og.comments [and] amp;fb_source=other_multiline [and] amp;action_object_map=%5B2370797039605046%5D [and] amp;action_type_map=%5B [and] quot;og.comments [and] quot;%5D [and] amp;action_ref_map=%5B%5Dhttps://www.dailymail.co.uk/health/article-6152779/Chronic-pain-drives-millions-Americans-suicide.htmlhttps://www.practicalpainmanagement.com/meeting-summary/under-scrutiny-whats-pain-practitioner-dohttps://www.nytimes.com/2016/05/21/health/opioid-prescriptions-drop-for-first-time-in-two-decades.html?action=click [and] amp;module=RelatedCoverage [and] amp;pgtype=Article [and] amp;region=Footerhttps://www.nytimes.com/2017/07/06/health/opioid-painkillers-prescriptions-united-states.html?module=Promotron [and] amp;region=Body [and] amp;action=click [and] amp;pgtype=articlehttps://youtu.be/j3k0_Wa36k0 https://www.houstonchronicle.com/news/houston-texas/houston/article/Insurers-take-aim-at-opioid-crisis-by-not-13221068.phphttps://www.medscape.com/viewarticle/901649https://spectator.org/never-let-an-opioid-crisis-go-to-waste/https://m.youtube.com/watch?feature=youtu.be [and] amp;v=72Y8YB6OY_Uhttps://functionallivingwithchronicpain.blogspot.com/2015/11/be-aware-of-statistics-of-nih-report.html?m=1https://www.medpagetoday.com/neurology/painmanagement/75078?xid=nl_mpt_DHE_2018-09-14 [and] amp;eun=g1198058d0r [and] amp;pos=1 [and] amp;utm_source=Sailthru [and] amp;utm_medium=email [and] amp;utm_campaign=Daily%20Headlines%202018-09-14 [and] amp;utm_term=Daily%20Headlines%20-%20Active%20User%20-%20180%20dayshttps://www.acsh.org/news/2018/03/19/cdc-quietly-admits-it-screwed-dishonestly-counting-pills-12717https://www.acsh.org/news/2017/08/16/heads-sand--real-cause-todays-opioid-deaths-	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		11681https://www.pewtrusts.org/en/research-and-analysis/speeches-and-testimony/2017/06/pew-analysis-finds-no-relationship-between-drug-imprisonment-and-drug-problemshttps://nypost.com/2016/12/19/how-the-feds-are-fueling-americas-opioid-disaster/https://www.practicalpainmanagement.com/pain/other/co-morbidities/complications-uncontrolled-persistent-pain?page=0,1https://psmag.com/social-justice/the-opioid-crisis-is-also-a-crisis-of-speechhttp://nationalpainreport.com/what-is-happening-to-the-chronic-pain-patient-survey-results-8837189.htmlhttps://www.medpagetoday.com/meetingcoverage/painweek/75005https://www.nejm.org/doi/full/10.1056/NEJMp1807117https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3175299https://www.bostonglobe.com/metro/2018/08/22/rules-control-opioid-prescribing-don-always-work-intended-studies-say/K446Q2iNvngaRRbnfTHANJ/story.htmlhttps://www.acs.org/content/acs/en/pressroom/newsreleases/2018/august/illicit-drug-use-could-be-higher-than-previously-thought-soars-during-special-events.htmlhttps://thehill.com/policy/healthcare/403060-sessions-moves-to-block-two-ohio-doctors-from-prescribing-opioidshttps://www.wvgazettemail.com/opinion/gazette_opinion/op_ed_commentaries/doug-hughes-as-nation-cracks-down-on-pill-abuse-chronic/article_3a6fcd7d-8776-59e9-b8da-d352caa3fba4.htmlhttps://www.washingtonpost.com/graphics/2018/local/impact-of-americas-opioid-crackdown/?utm_term=.0a608c6560c9https://uspainfoundation.org/news/massachusetts-passes-landmark-legislation-that-includes-help-for-pain-patients/https://m.huffpost.com/us/entry/us_5a304403e4b04bd8793e9535?ncid=engmodushpmg00000003https://www.practicalpainmanagement.com/treatments/pharmacological/opioids/united-nations-says-untreated-pain-inhumane-cruelhttps://www.painnewsnetwork.org/stories/2017/9/16/restricting-opioid-doses-wont-help-the-overdose-crisishttps://tonic.vice.com/en_us/article/7xqa44/forcing-pain-patients-off-their-meds-will-not-end-the-opioid-crisis?utm_campaign=broad [and] amp;utm_source=tonicfbusadshttp://www.pharmaciststeve.com/?p=27246	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		https://medium.com/@heatherzamm/an-open-letter-to-all-who-hold-public-office-in-america-from-painful-disease-patients-e1afebaca945https://www.news-line.com/PH_news27263_enewshttp://paindr.com/speaking-truth-to-power-cdc-must-recall-and-rewrite-their-2016-guideline-for-prescribing-opioids/https://fee.org/articles/addiction-and-dependence-are-media-aware-theyre-not-the-same-condition/http://nationalpainreport.com/as-meeting-nears-message-to-hhs-no-forced-tapers-8837288.htmlhttps://www.cincinnati.com/story/opinion/2018/06/08/opinion-fentanyl-floods-streets-dont-blame-doctors-patients/679133002/https://www.usatoday.com/story/opinion/2018/04/02/jeff-sessions-donald-trump-opioids-epidemic-death-penalty-real-pain-column/374829002/http://notdeadyet.org/ndy-public-comment-to-fda-on-patient-focused-drug-development-for-chronic-pain#_edn3https://m.youtube.com/watch?feature=youtu.be [and] amp;v=IrSfdfMcM84https://www.acsh.org/news/2018/09/27/foolish-us-drug-policies-keep-making-things-worse-now-its-meth-again-13450https://www.newsday.com/news/health/stony-brook-medicine-symposium-opioids-1.20278189https://www.practicalpainmanagement.com/treatments/pharmacological/opioids/fentanyl-separating-fact-fictionhttps://www.uab.edu/news/health/item/9620-new-efforts-to-control-opioids-become-funhouse-mirror-image-of-prior-policieshttps://www.dovepress.com/terminology-of-chronic-pain-the-need-to-quotlevel-the-playing-fieldquo-peer-reviewed-fulltext-article-JPRhttps://demwritepress.com/2018/09/25/opioid-pain-medication-scourge-or-miracle-yes-its-complicated/https://www.dovepress.com/getfile.php?fileID=41888https://www.conservativereview.com/news/sanctuary-baltimore-is-ravaged-by-an-illicit-drug-problem-not-prescription-pain-killers/https://www.c-span.org/video/?c4749903/retired-police-captain-opposes-opioid-restrictionshttps://www.hopkinsarthritis.org/patient-corner/disease-management/benefits-and-risks-of-opioids-for-chronic-pain-	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		management/https://www.practicalpainmanagement.com/meeting-summary/time-pain-practitioners-take-back-pain-prescribinghttps://www.theglobeandmail.com/amp/canada/british-columbia/article-study-finds-prescription-opioids-not-a-significant-driver-of-bc/?__twitter_impression=truehttps://www.practicalpainmanagement.com/resources/practice-management/editorial-our-clinical-pain-neighborhoodhttps://www.theglobeandmail.com/amp/canada/british-columbia/article-study-finds-prescription-opioids-not-a-significant-driver-of-bc/?=truehttp://nationalpainreport.com/forced-opioid-tapering-and-patient-safety-8837443.html https://www.kevinmd.com/blog/2018/03/real-cause-opioid-epidemic-government.htmlhttp://nationalpainreport.com/a-former-federal-peer-reviewers-analysis-of-the-draft-cdc-guidelines-8828910.htmlmlmhttp://thefederalist.com/2018/01/29/big-pharma-fox-anti-addiction-hen-house/https://www.surveymonkey.com/stories/SM-X6H9VGD/ http://www.pharmaciststeve.com/?p=20995#jp-carousel-20997http://www.pharmaciststeve.com/?p=27574http://www.governing.com/gov-institute/voices/col-oregon-medicaid-wrong-turn-fight-opioid-abuse.htmlhttps://www.acsh.org/news/2018/10/23/opioid-policies-based-morphine-milligram-equivalents-are-automatically-flawed-13529https://www.practicalpainmanagement.com/resources/practice-management/behind-ahrq-reporthttp://nationalpainreport.com/what-i-would-have-told-oregon-officials-about-its-forced-opioid-taper-idea-8837654.htmlhttp://nationalpainreport.com/national-chronic-pain-advocate-joins-california-effort-to-improve-pain-treatment-8837489.htmlhttps://csupalliativecare.org/opioid-restrictions-2018/?fbclid=IwAR05_64mckA64BzkhzqQ-HTqGUii01RdooL0oA8Exbpqit8gIN4TBXmvhUchttps://www.acsh.org/news/2018/11/05/who-telling-truth-about-prescription-opioid-deaths-dea-cdc-neither-13569https://www.medpagetoday.com/blogs/doing-time/76060?pop=0 [and] amp;ba=1 [and] amp;xid=fb-md-pcp [and]	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		amp;trw=nohttp://nationalpainreport.com/lack-of-pain-psychologists-cited-8837732.htmlhttps://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-8-8 https://www.medpagetoday.com/meetingcoverage/ama/76322https://nam05.safelinks.protection.outlook.com/?url=https%3A%2F%2Fbreggin.com%2Fthe-dr-peter-breggin-hour%2F [and] amp;data=02%7C01%7C%7C5d5d7ab5d83045c790f508d649904ef6%7C84df9e7fe9f640afb435aaaaaaaaaaaa%7C1%7C0%7C636777281476183472 [and] amp;sdata=PnnVy6jb7Jc%2FMMzhXD3mKOCthCTg9EoDxBdMSJLjcz8%3D [and] amp;reserved=0https://mynews4.com/news/local/pharmacy-wont-fill-nevada-doctors-patients-prescriptions.https://medium.com/@heatherzamm/an-open-letter-to-all-who-hold-public-office-in-america-from-painful-disease-patients-e1afebaca945http://www.nashuatelegraph.com/news/local-news/2018/11/17/drug-enforcement-administration-fentanyl-meth-getting-worse-in-area/https://www.jpain.org/article/S1526-5900(08)00831-6/abstract#/article/S1526-5900(08)00831-6/abstracthttp://www.pharmaciststeve.com/?p=27750http://www.nashuatelegraph.com/news/local-news/2018/11/17/drug-enforcement-administration-fentanyl-meth-getting-worse-in-area/?fbclid=IwAR2fSU1muJ1VR92tFGReBk6XqHGuTiXdwKFlo6oYpLZ7lC-DhEAteE4DWgwhttps://medium.com/@ThomasKlineMD/the-opioid-refugee-crisis-causes-and-recommendations-revised-10-31-18-89559573eb86?_referrer=twitterhttps://tonic.vice.com/en_us/article/8x5m7g/opioid-crackdown-chronic-pain-patients-suicide?utm_campaign=sharebuttonhttps://themighty.com/2018/11/opioid-fentanyl-deaths-increase-cdc-data/?utm_source=engagement_bar [and] amp;utm_medium=facebook [and] amp;utm_campaign=facebook_sharehttps://www.painnewsnetwork.org/stories/2018/11/28/i-hope-to-find-a-doctor-that-thinks-my-life-is-worth-living#.W_8kzk6xdi0.facebog5fctokhttps://academic.oup.com/painmedicine/advance-	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		article/doi/10.1093/pm/pny228/5218985?fbclid=IwAR1_vdc7_X6c7ygg-Urwyd81ZcFVTUWtnAs8HV0wXD_nuW3CXIVP0oE1vE8#https://www.documentcloud.org/documents/5331724-Overdose.html#document/p1http://www.pharmaciststeve.com/?p=27907https://www.cato.org/blog/todays-iv-drug-abusers-were-not-yesterdays-patientshttps://www.painnewsnetwork.org/stories/2018/12/4/joint-letter-calls-for-urgent-review-of-opioid-tapering-policieshttps://www.statnews.com/2018/12/06/overzealous-use-cdc-opioid-prescribing-guideline/https://drseanmackey.com/blog/https://www.foxnews.com/health/as-opioids-become-taboo-doctors-taper-down-or-abandon-pain-patients-driving-many-to-suicidehttp://www.pharmaciststeve.com/?p=28023https://www.foxnews.com/health/doctors-abandon-opioid-prescribing-as-state-and-federal-authorities-step-up-enforcement.amp?__twitter_impression=truehttps://apnews.com/aef4ff655da045cba0988587856327d4https://www.nydailynews.com/opinion/ny-oped-opioids-are-a-godsend-for-people-suffering-from-chronic-pain-20181211-story.htmlhttps://edsinfo.wordpress.com/2018/12/12/manipulated-study-on-opioids-after-tooth-extraction/#comment-18859https://www.foxnews.com/health/undoing-the-harm-of-the-response-to-the-opioid-overdose-epidemic-health-experts-suggest-solutionshttps://www.huffingtonpost.com/entry/multiple-drugs-overdose-deaths-report_us_5c0fe121e4b06484c9ff3b2f?ncid=engmodushpmg00000003https://www.acsh.org/news/2018/12/12/dear-propcdc-heres-what-happens-when-you-over-restrict-pills-more-deaths-nice-going-13663http://doctorsofcourage.org/eric-backos-md/http://nationalpainreport.com/mainstream-media-is-beginning-to-tell-the-other-side-of-the-opioid-crisis-help-spread-the-word-8838047.htmlhttps://www.sciencedirect.com/science/article/pii/S0011502918301081?via%3Dihubhttps://m.okgazette.com/oklahoma/painful-consequences/Content?oid=5271761 [and] amp;fbclid=IwAR3MjNd5lBSQNpGyXK1CBdOG0ngQxNkqWMlrUqz3v0y4lSKZr5qKlNYpePchttps://www.cons	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		ervativereview.com/news/the-governments-war-on-pain-patients/https://www.hrw.org/report/2018/12/18/not-allowed-be-compassionate/chronic-pain-overdose-crisis-and-unintended-harms-ushttps://www.foxnews.com/health/readers-respond-to-special-report-about-the-opioid-crisis-unintended-victims-pain-sufferers-losing-access-to-painkillers https://chicago.suntimes.com/columnists/opioid-deaths-overdose-ama-drug-abuse/https://www.google.com/amp/s/amp.cnn.com/cnn/2018/12/22/health/illegal-fentanyl-driving-opioid-epidemic-cdc-bn/index.htmlhttps://www.linkedin.com/pulse/conflating-legitimate-pain-prescribing-opioids-street-william-mangino/?published=t [and] amp;fbclid=IwAR3GnY-_Gz_cTuJD0zh6YLi4O3plCdxcLXOsict-XgR_eLijy557un3fkwlhttps://www.facebook.com/120913035l/posts/10218538884242550/https://www.wfsb.com/cdc-illegally-made-fentanyl-driving-opioid-deaths/article_c2cc6909-ff31-51b3-aa99-c29373abc9a8.htmlhttp://www.pharmacisteve.com/?p=28172https://medium.com/@bdarnall/international-stakeholder-community-of-pain-experts-and-leaders-call-for-an-urgent-action-on-7c153d8c1318https://www.nytimes.com/2013/11/17/health/in-demand-in-clinics-and-on-the-street-bupe-can-be-savior-or-menace.html?fbclid=IwAR1z_FRy802YijckQHlzH5aNTdHEo1RxPj8MZ4IatoWMLnvRqzEjoWfKXjMhttps://www.cato.org/publications/commentary/opioid-crisis-not-helped-panichttps://thehill.com/opinion/healthcare/420500-the-civil-war-over-prescription-opioidshttps://www.pharmacytimes.com/publications/issue/2018/november2018/should-we-believe-patients-with-pain?fbclid=IwAR1P7NE4gfNpkkdXTPMg33OwCWZ4wsR70s8y7XQmkn-Cb-JCdJHOOUI7SFAhttp://www.pharmacisteve.com/?p=28279https://amp.lansingstatejournal.com/amp/2257458002?__twitter_impression=true [and] amp;fbclid=IwAR1n-qzg9O7UdnPU7zKvkfMfKFacHuRlcHaefgHiee_ASgbzNED0X0bBIb8https://www.acsh.org/news/2017/06/22/dear-cdc-why-are-you-torturing-pain-patients-	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		11469https://www.acsh.org/news/2018/11/21/little-state-debunks-big-lie-deas-opioid-scam-13614note tramadol id by CDC as [and] quot;synthetic opiod...like fentanyl- how does that skew #s? https://www.smh.com.au/lifestyle/spinal-steroid-injections-dont-workhttps://medium.com/@ThomasKlineMD/opioidcrisis-pain-related-suicides-associated-with-forced-tapers-c68c79ecf84dhttps://www.painnewsnetwork.org/stories/2017/10/23/how-the-dea-keeps-changing-the-overdose-numbers?fbclid=IwAR0lKFv1B5SGG0l95B1Qll2hJ0oaR2TVSgR45nM-qh_iDc2ruB3hIMbZnQQ#at_pco=smlrebh-1.0 [and] amp;at_si=5aaabbc97b63195f [and] amp;at_ab=per-2 [and] amp;at_pos=3 [and] amp;at_tot=5https://www-m.cnn.com/2019/01/02/health/most-addictive-substances-partner/index.html?utm_medium=social [and] amp;utm_source=fbCNN [and] amp;utm_content=2019-01-05T12%3A30%3A04 [and] amp;utm_term=link [and] amp;r=http%3A%2F%2Fm.facebook.com%2Fhttps://ramblingsoapbox.com/2015/04/06/wackydruglaws/https://ramblingsoapbox.com/2016/06/14/strangulation-on-medicine-my-life-as-a-pain-patient/https://www.wtnh.com/news/connecticut/hartford/judge-dismisses-opioid-crisis-lawsuits-against-drugmakers/1694181747?fbclid=IwAR0PDoZjO2hmcisTcb47Zi9Jh3pieqjyiMqk-A6mMGDrJ6nCycUa2AaFgEghttps://www.statesmanjournal.com/story/opinion/2019/01/11/oregons-illegal-drug-users-rewarded-chronic-pain-patients-suffer/2548946002/https://onedrive.live.com/view.aspx?resid=90499927EC9E0B24%21143 [and] amp;ithint=file%2Cdocx [and] amp;app=Word [and] amp;authkey=%21AN8FW8GGzJTtUlEhttps://medium.com/@stmartin/neat-plausible-and-generally-wrong-a-response-to-the-cdc-recommendations-for-chronic-opioid-use-5c9d9d319f71https://www.forbes.com/sites/brucejapsen/2019/01/03/amid-opioid-crisis-the-joint-commission-revises-pain-standards-for-health-facilities/amp/?__twitter_impression=truehttp://www.pharmaciststeve.com/?p=28406http://paindr.com/%ef%bb%bfresponse-to-oregons-tapering-guidance-and-tools/https://www.painnewsnetwork.org/stories/2019/1/	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		14/how-modern-medicine-pretends-to-treat-painhttps://www.painnewsnetwork.org/stories/2019/1/16/another-misleading-report-on-opioids-by-national-safety-council-nbsp**********https://medium.com/@heatherzamm/its-all-an-illusion-d286f3710003**********https://www.newsobserver.com/opinion/op-ed/article145348794.htmlhttps://www.latimes.com/opinion/op-ed/la-oe-nicholson-opioids-20190118-story.html?outputType=amp [and] amp;__twitter_impression=truehttps://www.wfla.com/8-on-your-side/investigations/former-volunteer-lashes-out-at-nursing-home-over-mother-s-treatment/1706691547https://tonic.vice.com/en_us/article/pay85k/the-opioid-problem-is-our-problemhttps://medium.com/@ThomasKlineMD/the-opioid-refugee-crisis-causes-and-recommendations-revised-10-31-18-89559573eb86http://nationalpainreport.com/opiophobia-the-irrational-fear-of-opioids-8838398.htmlhttps://www.acsh.org/news/2018/10/23/opioid-policies-based-morphine-milligram-equivalents-are-automatically-flawed-13529https://www.acsh.org/news/2019/01/23/opioid-study-so-bad-it-disproves-itself-13753https://www.creators.com/read/betsy-mccaughey/08/18/the-opioid-lawsuit-circushttp://www.pharmaciststeve.com/?p=28561https://americanhealth.jhu.eu/RuralOpioidsCount,https://www.ktuu.com/content/news/Board-reprimands-pharmacists-over-refusals-to-fill-opioid-prescriptions-504881401.htmldeath rates re pyschiatric meds rise http://www.pharmaciststeve.com/?p=28537https://www.ncbi.nlm.nih.gov/pubmed/28582659jhttps://www.acsh.org/news/2017/10/12/opioid-epidemic-6-charts-designed-deceive-you-11935https://atipusa.org/news/has-the-opioid-pendulum-swung-too-far-finding-the-balance-between-pain-and-addiction/https://atipusa.org/2018/04/02/atip-white-paper-on-prescription-opioids-and-chronic-pain/https://www.unionleader.com/news/stigma/chronic-pain-patients-rally-for-change-in-concord/article_2f5ef1bb-b5fd-5a91-b34d-508358b3fc53.htmlHuman rights Watchhttps://www.hrw.org/report/2018/12/18/not-	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		allowed-be-compassionate/chronic-pain-overdose-crisis-and-unintended-harms-us?fbclid=IwAR3Lf4MousMSYLAg5ziAJqnex_PoLORKfGZnAy7UPE5o0cueXFtr4XAnBMUhttps://themighty.com/2018/12/american-society-of-anesthesiologists-criticizes-oregon-opioid-taper/?utm_source=engagement_bar [and] amp;utm_medium=facebook [and] amp;utm_campaign=facebook_sharehttps://www-m.cnn.com/2019/01/31/health/fentanyl-customs-bn/index.html?utm_term=link [and] amp;utm_content=2019-02-01T01%3A00%3A11 [and] amp;utm_source=fbCNN [and] amp;utm_medium=social [and] amp;r=http%3A%2F%2Fm.facebook.com%2FResponse to: Advil/tylenol for painhttps://www.acsh.org/news/2017/11/07/advil-works-well-opioids-acute-pain-not-so-fast-12089https://www.practicalpainmanagement.com/resources/intractable-painHeroin 1st use not Rxhttps://www.ncbi.nlm.nih.gov/pubmed/28582659Rx restrictions NOT lowering ODshttps://jamanetwork.com/journals/jamanetworkopen/fullarticle/2723405more deaths from alcohol [and] amp; tobacco https://www.vox.com/platform/amp/policy-and-politics/2017/10/27/16557550/alcohol-tobacco-opioids-epidemic-emergencyStudy shows policy changes = negative effects on chronic pain patients https://m.facebook.com/story.php?story_fbid=364260607488336 [and] amp;id=313227042137369 [and] amp;_rdrhttps://www.sciencedirect.com/science/article/pii/S0955395919300234https://scholar.google.com/scholar_lookup?title=Exploring%20perceptions%20and%20experiences%20of%20patients%20who%20have%20chronic%20pain%20as%20state%20prescription%20opioid%20policies%20change%3A%20A%20qualitative%20study%20in%20Indiana [and] amp;publication_year=2017 [and] amp;author=M.%20Al%20Achkar [and] amp;author=D.%20Revere [and] amp;author=B.%20Dennis [and] amp;author=P.%20MacKie [and] amp;author=S.%20Gupta [and] amp;author=S.%20GrannisSelling your datahttps://www.politico.com/story/2019/02/03/health-	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		risk-scores-opioid-abuse-1139978Suicides from painhttps://everytown.org/momentsthatsurvive/?source=fbnp_GVSW19_CK-ET-GVSW19-FB-FBLP-FCA-US-ET108-BO-18p-C07.P02 [and] amp;refcode=fbnp_GVSW19 [and] amp;utm_source=fb_n_ [and] amp;utm_medium=_p [and] amp;utm_campaign=GVSW19Policy causing more Policy change= negative effecthttps://m.facebook.com/story.php?story_fbid=364260607488336 [and] amp;id=313227042137369 [and] amp;_rdrhttps://www.sciencedirect.com/science/article/pii/S0955395919300234https://scholar.google.com/scholar_lookup?title=Exploring%20perceptions%20and%20experiences%20of%20patients%20who%20have%20chronic%20pain%20as%20state%20prescription%20opioid%20policies%20change%3A%20A%20qualitative%20study%20in%20Indiana [and] amp;publication_year=2017 [and] amp;author=M.%20Al%20Achkar [and] amp;author=D.%20Revere [and] amp;author=B.%20Dennis [and] amp;author=P.%20MacKie [and] amp;author=S.%20Gupta [and] amp;author=S.%20Grannishttps://www.painnewsnetwork.org/stories/2019/2/3/overdose-crisis-will-worsen-but-not-due-to-rx-opioidshttps://medium.com/@heatherzamm/the-profiling-system-in-every-state-you-never-signed-up-for-d2f6a886865ahttps://www.painnewsnetwork.org/stories/2019/2/6/fda-patients-dependent-on-opioids-are-not-addicted#.XFtMr9MKuxU.facebook=https://www.passionatepachyderms.com/fake-opioid-crisis-created-manufactured-elected-representatives-v-a/doctors suing for abandonment https://bertlinglawgroup.com/veterans-forced-cold-turkey-opioids/ critique of Krebs SPACE trialhttps://academic.oup.com/painmedicine/advance-article/doi/10.1093/pm/pny234/5193809https://www.painnewsnetwork.org/stories/2018/4/23/do-80-of-heroin-users-really-start-with-a-prescription?fbclid=IwAR2HiHrjDbxionwmrN2XwjnSJjcd1Xn32x73kzxHviGUaSOY-v7DKkNmGbQhttps://www.painnewsnetwork.org/stories/2018/2/26/how-the-opioid-crisis-has-changedhttps://www.wpr.org/advocate-says-opioid-	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		crackdown-hurting-people-chronic-painhttps://www.nationalreview.com/corner/sacrificing-pain-patients-to-prevent-opioid-abuse/https://losangeles.cbslocal.com/2019/02/06/chronic-pain-opiod-shortage/#.XF5XYVrmlq4.facebookhttps://www.nytimes.com/2019/02/09/opinion/sunday/pain-opioids.html#click=https://t.co/YEttpfioMRFDA dependence is not addictionhttps://www.painnewsnetwork.org/stories/2019/2/6/fda-patients-dependent-on-opioids-are-not-addicted#.XF2cAB-F7II.facebook=http://nationalpainreport.com/the-media-reporting-about-chronic-pain-and-opioids-is-changing-8838715.htmlfocus on lack of Rx opiods = higher illegal use, excellent useful details re inaccurate data, + benefits of Rxhttps://www.cato.org/publications/policy-analysis/overdosing-regulation-how-government-caused-opioid-epidemicHuman Rights Watchhttps://www.hrw.org/news/2018/12/18/us-fears-prescribing-hurt-chronic-pain-patientsHormones for pain control https://www.painnewsnetwork.org/stories/2019/1/29/hormones-and-pain-care-what-every-patient-should-know https://www.foxnews.com/health/readers-respond-to-special-report-about-the-opioid-crisis-unintended-victims-pain-sufferers-losing-access-to-painkillershttps://www.vox.com/platform/amp/policy-and-politics/2017/10/27/16557550/alcohol-tobacco-opioids-epidemic-emergencyhttps://www.acsh.org/news/2017/03/25/cdc-opioid-guidelines-violate-standards-science-research-11050opiate death #s wrong, refers to ACSH belowhttps://nypost.com/2018/05/24/the-insane-crackdown-on-pain-medication/amp/http://www.pharmacisteve.com/?p=28918https://www.acsh.org/news/2018/12/12/dear-propcdc-heres-what-happens-when-you-over-restrict-pills-more-deaths-nice-going-13663 Case study of iotragenic harm from anti opiod policies https://www.nejm.org/doi/full/10.1056/NEJMp1811473little efficacy for invasive procedures https://www.ncbi.nlm.nih.gov/pubmed/30204920/https://medium.com/@kaatjegotcha/its-a-fentanyl-crisis-stupid-8540c266304increased pain patients =	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

		increased medshttps://www.painnewsnetwork.org/stories/2019/2/22/prevalence-of-chronic-pain-increasinghttps://www.lasvegasnow.com/news/local-news/i-team-doctors-to-tell-lawmakers-of-patients-left-suffering-because-of-opioid-crackhttps://www.cato.org/publications/commentary/drug-prohibition-blame-opioid-crisisIllegal drugs causing opiod crisishttps://m.washingtontimes.comhttps://www.practicalpainmanagement.com/treatments/pharmacological/opioids/editorial-have-we-gone-too-far-can-we-get-backhttps://medium.com/@ThomasKlineMD/opioidcrisis-pain-related-suicides-associated-with-forced-tapers-c68c79ecf84dhttps://edsinfo.wordpress.com/2019/02/27/when-chronic-pain-takes-away-your-life/https://edsinfo.wordpress.com/2018/09/10/pain-awareness-is-suicide-prevention/Brit review- opiods work, US policy harmful https://www.bmj.com/content/364/bmj.l917https://edsinfo.wordpress.com/2018/09/26/many-opioid-deaths-are-suicides/https://www.painnewsnetwork.org/stories/2019/3/7/menopause-linked-to-chronic-painhttps://reason.com/blog/2019/03/07/experts-urge-cdc-to-clarify-opioid-presc/amphttps://reason.com/blog/2019/03/07/experts-urge-cdc-to-clarify-opioid-presc?fbclid=IwAR2y9DanK8xW7IQPfRLEMD_mMr_6J9BPmkdE1uevbAhym8O2ABH-0gh5W0IThe Other Opiate Problemhttps://www.americanthinker.com/articles/2019/03/the_emotherem_opiate_problem.htmlhttps://www.washingtonexaminer.com/opinion/op-eds/feds-battle-opioid-abuse-with-a-circular-firing-squadNo opiod induced hyperaglasiahttps://edsinfo.wordpress.com/2019/03/12/the-truth-about-hyperalgesia/#comment-21915tylenol vs tylenol NOT vs opiodshttps://www.acsh.org/news/2019/03/13/oral-and-iv-tylenol-work-equally-well-hip-replacement-pain-do-they-work-all-13877No research for tyelon [and] amp; pain!https://www.acsh.org/news/2019/02/26/johnson-johnsons-shameless-exploitation-opioid-crisis-13832https://uspainfoundation.org/news/learn-about-the-draft-report-on-pain-managemen	

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #168, Caroline Burgess	Question 1	Pain medication works post surgery and for chronic pain patients. Many have used for years with no issue. Pain meds have been around for decadesMost people speaking about pain meds have no experience.	Thank you for the comment
Public Reviewer #168, Caroline Burgess	Question 2	Keep prescribing to chronic pain patients. Untreated pain can kill. Reducing pain meds will not solve the problem. People are overdosing on illegal Fentynal and fake pills made with it. Have media cover the truth please.	Thank you for the comment
Public Reviewer #169, Jacob Marzalik, American Psychological Association	Uploaded Document	Comment on AHRQ's Opioid treatment for chronic pain.pdf (139 KB)	We reviewed the attachment (#12). We revised the intro to clarify that high impact chronic pain refers to pain resulting in limitations in major life domains. Usual care was only a comparator for KQ 4b on effectiveness of risk assessment instruments. The definition of usual care varies from study to study, but since there were no studies that met inclusion criteria for this question, we did not revise to further define usual care. Information regarding race and ethnicity is in the Tables. As described in the Results, there was insufficient evidence to evaluate how effects of opioids vary according to race/ethnicity. The effects of industry funding was evaluated and reported in stratified analyses--there was little impact on most estimates. We revised the results to define how the study on effects of opioids on risk of depression defined augmentation therapy. Regarding the comments related to p 211, the best practices were related to use of urine drug screening, PDMP, and opioid medication agreements, as described in the sentence. Effects of the DEA policy changes (and other policy measures) were beyond the scope of the review. The cited study on implicit bias addressed bias related to substance use and recovery and we did not add it.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #17, None, I am a patient	Question 10	I cannot speak from a scientific perspective, only from a personal and anecdotal one. Opioids have been nothing but a positive in my life personally and in the life of many others I know who are chronic pain patients. I have never been diagnosed with an opioid use disorder, use my medications responsibly, have never doctor shopped and am a productive member of my community. Opioids make my pain better, they allow me to take care of my family and have a wonderfully productive life. Im only one of many people who benefit greatly from opioids. Kindly take into consideration the opinions of myself and others with any formal documentation. Thank you.	Thank you for sharing your story, glad to hear that you have a good personal experience.
Public Reviewer #170, Anonymous Anonymous	Question 1	Please modify your evidence review to indicate only what evidence can support: 1) opioids are not routine first-line therapy for chronic pain, but 2) there is a population for whom benefits of opioid medication outweigh risks.It is ludicrous to assume that clinical trial results can be extrapolated from osteoarthritis and common low-back pain to every other pain-generating condition that exists: osteogenesis imperfecta, congenital malformation, primary dystonia, interstitial lung disease, hereditary chronic pancreatitis, epidermolysis bullosa, ulcerative colitis, sickle-cell disease, etc.	The report does not make recommendations, it synthesizes the evidence. The conclusions are based on the available evidence. The trials evaluated a variety of pain conditions in addition to low back pain and osteoarthritis, including various types of neuropathic pain and fibromyalgia. Seven placebo-controlled trials enrolled patients previously prescribed opioids and about half enrolled mixed populations of opioid-naive and opioid-experienced patients. We conducted analyses stratified by prior opioid experience (naive, experience, or mixed) and results were very similar.

Public Reviewer #170, Anonymous Anonymous	Question 10	Everyone agrees, opioid medication is not routine first-line therapy. However, as 40th-line therapy, for a small percentage, even high-dose opioid medication can be lifesaving. Your review should state this.Consider, for instance, ulcerative conditions of the colon and bladder. Prior to starting high-dose opioid medication, some of these patients literally spent their entire lives in a bathroom. When nothing else helps, opioid medication can allow carefully-selected patients a completely normal life with a professional career and family. Quality in health care has to include these people too. These are real human lives, directly affected by policies you inform:https://www.washingtonpost.com/outlook/the-other-opioid-crisis-pain-patients-who-cant-access-the-medicine-they-need/2018/03/09/5ad83b24-2301-11e8-badd-7c9f29a55815_story.htmlhttps://www.healthaffairs.org/do/10.1377/hblog20180117.832392/full/https://www.ncbi.nlm.nih.gov/pubmed/29173267https://www.nytimes.com/2019/02/09/opinion/sunday/pain-opioids.htmlhttps://news.yahoo.com/crackdown-opioids-victims-people-need-live-100058361.htmlhttps://tarbell.org/2019/03/gambling-with-lives-oregon-medicaid-cutting-off-opioids-to-chronic-pain-patients/https://www.unionleader.com/news/stigma/chronic-pain-the-other-side-of-the-opioid-epidemic/article_52bf3d80-3b47-54ae-ae4e-9dac192ea6e7.htmlhttps://filtermag.org/abandon-americas-pain-patients/https://www.hrw.org/sites/default/files/report_pdf/hhr1218_web.pdfAHRQ [and] #039;s evidence review should incorporate the ethos encapsulated in this statement, by a physician to Human Rights Watch: [and] quot;I gulped and put him back to 600 [MME], and he immediately went back to his previous stable level of functioning, smiling and comfortable. It was a hard decision because Im putting my license on the line every time I do something unconventional like that. There is no formula to solving [the opioid crisis], were being shepherded into a formulaic solution, which doesnt work well for people with chronic pain. Each person is individual, and they have their own story, their own response to opioids. [and] quot;Finally, I encourage your committee to consider this	The report does not make recommendations on using opioids as 1st line therapy or a subsequent option.

Section	Commentator & Affiliation	Comment	Response
		dissertation, explaining why evidence is invalid without input from patients who successfully use opioid medication to restore normal daily life:Opioid using pain patients should receive greater attention in the pain care literature. Their claims of safe and efficacious use of opioids with and without dosage escalation should be taken seriously by medical researchers and practitioners. There may yet be sound reasons that some patients have claimed COT facilitates continued productivity or improved quality of life through mitigation of pain related suffering. Understanding what these reasons might be can inform decisions. Is it possible that some chronic pain is the result of on-going, or recurrent nociceptive input which ought to be addressed or at least acknowledged? [W]hat of the opioid using patients with neuropathic and/or myelopathic conditions that assert positive response to COT? Are these complainants to be discredited at the fore, and if so on what grounds?https://etd.ohiolink.edu/!etd.send_file?accession=antioch1474030298586346 [and] amp;disposition=inline	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #170, Anonymous Anonymous	Question 2	Policies informed by this AHRQ review will not only affect common clinical scenarios, they will also affect outliers. Until patients thriving on opioid medication for years (or decades) have been adequately studied, AHRQ evidence reviews cannot adequately inform any policies affecting this group.Until outliers are included in the evidence base, evidence reviews are insufficient to inform policy. Evidence reviews must acknowledge these limitations, not in the back pages of the review, but right up front in the [and] quot;Conclusions [and] quot; and [and] quot;Key Messages. [and] quot;	Thank you for the comment
Public Reviewer #171 and 172	Question 1	I have learned this myself as a chronic noncancerous pain patient and through support groups from all over the world. None of it sounds like any of the people in the statistics. I am not being smart just saying what I have observed and heard pain patients that have suffered for more than five years.Some people are allergic to medical marajuana. Some people medical marajuana does not help their pain. Opioids helps suicidal, torturous type pain that nothing else provides the relief it does. I realized through all of this that people confuse side effects from Percocet and MS Contin as being high. Small pupils does not mean you are high. Opioids and morphine help torturous pain like nothing else can. Thriving to survive is on death certificates. We still have who knows how many years to go and we are thriving to survive. We are without doctors. Please see attachment with some websites. Thank You.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #171 and 172	Question 10	This seems so bizarre to me. There are pain support groups all over the internet that tell a whole different story. I have lived with chronic pain for 33 years. The last seven and a half years I have lived with agonizing pain constantly. If it were not for the opioids I would have not had the life that I had mobility wise etc. Our bodies are torturing us and we go unheard. Doctors have abandoned us. Suffers are committing suicide. This has to be handled with a different approach. Doctors do not read the internet. Please see attachment for a few more statements to understand. Thank you.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #171 and 172	Uploaded Document	Government Plea.docx (15 KB)	Thank you for the comment, the attachment (#13) was reviewed.

Source: https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research
Published Online: April 16, 2020

Public Reviewer #173	Question 1	I have been disabled due to intractable chronic pain for just over 11 years. At age 52 I needed a hysterectomy. I thought I [and] #039;d be out of work for just a few weeks. But I developed severe Pelvic Pain Syndrome which did not respond to any of the usual treatments, leaving me in this condition, and permanently unable to work --- or do much of anything except go to medical appointments. Without opioids, I would have killed myself years ago because the never-ending acute pain would otherwise be intolerable. I [and] #039;ve always known this -- long before I ever heard of any gov [and] #039;t attempts to restrict legal opioids.Short term pain is one thing. Never-ending pain is entirely different.Some months after I developed the Pelvic Pain Syndrome, I had an epiphany about my body. That this problem is just another in a lifelong series of acute reactions to medical procedures and injuries; that I react in a way that most people don [and] #039;t. I also dont [and] #039; heal normally.I am telling some of my story to show how unique my body is -- how unique each person is -- so that, as the FDA stated a few months ago, there can be no one size fits all treatment for any patient for any condition.At about age 15, I sprained my right ankle. That caused me a lot of pain until I was in my 30 [and] #039;s, and meant that I had to stop ice skating, which I [and] #039;d loved. My ankle never completely stopped bothering me and still bothers me at times.About 40 years ago I suffered whiplash from a car accident. My neck hurt badly for decades, sometimes so badly that I had to miss work and have friends do my grocery shopping and laundry. I had countless types of treatments, including many that were not covered by insurance, such as acupuncture and chiropractic. I had OT, PT, aquatic-PT, massage, osteopathy, and more PT and more. My neck never healed completely. I developed arthritis from the accident and it [and] #039;s stiff and slightly painful every day. My left arm and shoulder have always had associated pain and a sense of coldness and weakness, which never have been diagnosed.About 35 years ago, I had my wisdom teeth out and suffered a horrible painful reaction which the dentist said was basically 1 in a million, and I missed almost a week of work and used the prescribed Tylenol with codeine during that time. When the pain ended, so did my use	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		of that Rx.About 25 years ago, I suffered a horrific reaction a few days after gum surgery. I was screaming in pain and no medication helped. The periodontist had to remove my stitches on an emergency basis on a Sunday. I still frequently have gum pain in that area, and sometimes the pain is extremely intense. About 20 years ago, I banged my forehead. I still frequently have pain in that area, and sometimes the pain is extremely intense. About 20 years ago, I tripped and fell and hurt my arm and shoulder. The pain was so bad that I thought I [and] #039;d broken a bone. I hadn [and] #039;t. But I could barely lift my arm for months and it took over a year to regain full range of motion.The list goes on.Additionally, I have adverse reactions to more Rx [and] #039;s than I dont [and] #039; have such reactions to, and many of these reactions are extremely rare. This makes me extra hard to treat.I also have unusual adverse reactions to non-drug treatments. For example, after having some success with acupuncture after that car accident, I started feeling pain with every needle and had bruising as well, and the treatment stopped working on my pain. The doctor told me this reaction was incredibly rare. For my pelvic pain, I had to stop pelvic floor PT due to intense pain it caused that was not the [and] quot;good [and] quot; type of pain which signals that the PT is working. PSTIM also caused me pain and didnt [and] #039; help. And probably more that I don [and] #039;t remember.I took a mind-body workshop for my pelvic pain but my attempts at meditation have not born much fruit, although they certainly didn [and] #039;t harm me -- except for my wallet since the workshop was not insured.I also have fibromyalgia and some other medical conditions.The technical aspects of this draft report are mostly too much for me but I will do my best to comment in the correct section.	

Public Reviewer #173	Question 10	Every single human being is one accident or illness away from needing opioids to get thru their day.Terrible, never-ending pain that no non-opioid drug treatment will help and that no non-drug treatment will help.Please remember that you or your loved one could be next. It could be tomorrow.The amount of opioids available before my forced taper allowed me to travel across country 2 years ago to see my late mother on her deathbed. Without my meds, I never could have done that. Imagine that please.Within the last couple of years I tried medical marijuana -- a CBD tincture with no THC. After spending about $1000 out of pocket, I gave up experimenting. If the federal govt persists in attacking legal opioid use, then at least it could legalize medical marijuana so that research could be conducted to enable doctors to know how to prescribe it so that desperate patients aren [and] #039;t left to experiment on their own. And if it were legal at the federal level, then insurance companies could start to pay for it. Although for some reason I dont [and] #039; think that it will help my pain no matter how much I experiment with it. But it helps so many others; that [and] #039;s been proven over and over and over.The fact that so many Americans die from drinking too much legal, easy-to-get-at-the-market alcohol, while it [and] #039;s impossible to OD on marijuana, is just one more part of this whole situation that makes no sense.Attacking opioid use while allowing insurers not to pay for alternative treatments is even more inhumane, adding salt to the wound.Making it even harder for pharmacies to stock opioids will add to the nightmare. It [and] #039;s already so hard for people in pain to have to go monthly to the doctor and pharmacy. Those must-do [and] #039;s mean that laundry doesn [and] #039;t get done, or cooking a simple meal, etc. Getting to the pharmacy, waiting in line, only to be told that they are out of stock is a nightmare because of the extra physical labor required, and because patients most likely wont [and] #039; have enough pills to survive until the pills are back in stock. Ever since 9/11, govt policy urges citizens to keep emergency supplies of water, food, and meds at home -- but for opioids, we are regulated so strictly that having an emergency backstock is pretty impossible and if say, a hurricane is on the way and everyone is trying to fill their Rx [and]	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		#039;s at once due to a govt [and] #039; waiver for such times, then clearly the pharmacies won [and] #039;t have enough pills and people will suffer.There are so many consequences of gov [and] #039;t policy that don [and] #039;t appear to be considered -- like stated in the last paragraph. Also, I read about a woman who can [and] #039;t take care of her child because she has lost access to her opioids. I [and] #039;m single and that horror never occurred to me. The list goes on of how lives are ruined by this govt policy.	

Public Reviewer #173	Question 2	Again, I dont [and] #039; understand the draft report well enough to comment technically about each section.What I do know is that I was given Percocet after my hysterectomy 11 years ago. After I was diagnosed with the Pelvic Pain Syndrome, I was told I needed Internal Pelvic Floor Physical Therapy. At the time I lived in the Boston area --- not exactly a [and] quot;provider-desert [and] quot;. I called around to providers that were close enough for me to feel I could to drive to safely in my condition, and they all had waiting lists that were many months long. I kept calling. I was lucky to call one day when the best place had a cancellation and due to my crying on the phone, they let me begin as a new patient. The therapy was agonizing, and ultimately, we decided to end it because it was doing harm but no good. A situation I had been in before. [I want to tell some of my personal story to emphasize that each patient is unique and therefore, there should be no govt regulation interfering with any doctor-patient relationship. I also want to show how hard it is to have access to some providers, even in a place like Boston, where I often had long wait times for various types of medical providers.]I also had been put on gabapentin which, after months, didn [and] #039;t help my pain at all --- which turned out to be a good thing because when I got off it, my brain started working properly again. During the months of being on gabapentin, I had developed terrible problems with spelling, word retrieval and name retrieval. Between my intense pain and the medication and having to stop working and having my entire life disrupted, it never occurred to me that my brain problems were caused by the gabapentin. So, I [and] #039;m glad that that particular med didnt [and] #039; work.I also tried lyrica which didnt [and] #039; work and/or had bad side effects; and other meds as well.The only thing that helped and that I could tolerate was percocet.Eventually, my Pain Manager added methadone to my daily regimen. At first, it caused extreme nausea which included vomiting. But within a short time, I did adapt to it and it has helped a lot. It never ever caused me to feel the least bit high and I could not understand why anyone would volunteer to take anything so awful.At the very beginning of taking percocet, I felt [and] quot;happy [and] quot; a few times, but only rarely; a very small	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		percentage of the time. After that beginning, it never happened again. I do not get high from opioids. Not at all. They help with the pain; that [and] #039;s all they do. If my pain ended, I wouldn [and] #039;t need, or want, opioids any more.I [and] #039;ve also tried several other meds for my pelvic pain which either didnt [and] #039; help and/or had adverse side effects, including Savella and Keppra.Only one non-opioid med helped -- Cymbalta -- but the side effects were so severe that I had to stop it. It caused me to have constant involuntary muscle spasms/twitches and also to always fear falling as I felt weak and dizzy.Also, not all opioids help. I never tried Vicadin for my Pelvic Pain Syndrome, but have had it in the past (but I [and] #039;m not sure what for) and it never did anything at all for any type of pain that I tried it for. It may as well have been Tic-Tacs.And, Percocet and Methadone do absolutely nothing to help my occasional migraines or even more moderate headaches. For regular headaches, the only thing that helps me is Advil. For migraines, I need Zomig. When I still menstruated, Advil did absolutely nothing for my cramps; only Aleve helped. And Aleve never helped at all for any headache.Different meds are needed for different types of pain, even for the same person. No one med can help all pains even in the same person. And each person is different in what will help them for each of their various pains.Also, non-cancer pain can be just as bad than any cancer pain; and maybe worse. I do not understand why cancer pain is given special treatment in the govt [and] #039;s war on opioid Rx [and] #039;s.	

Public Reviewer #173	Question 3	Who exactly wrote or contributed writing to, this report?Were pain clinicians involved? Any advocates for pain patients? Any pain patients?Authorship matters a great deal here due to past govt [and] #039; bias against pain patients/opioids, as especially demonstrated by the 2016 CDC Guidelines which have been repudiated, but not until they did incredible harm and they still are doing incredible harm.I can understand the pain of those who have lost loved ones to OD [and] #039;s, but, those OD [and] #039;s were NOT caused by legal Rx [and] #039;s taken by Chronic Pain Patients (CPP [and] #039;s).Absent clear evidence of illegal actions: Attacking CPP [and] #039;s is simply wrong. Attacking Pain Managers is simply wrong. Attacking pharmacies which simply seek to dispense legal Rx [and] #039;s is simply wrong.Go after the illegal Chinese fentenyl which is currently the main cause of OD [and] #039;s. And the illegal heroin which I understand to be the second leading cause of OD [and] #039;s.Go after illegal drugs and illegal addicts. NOT the pain community.Remember, [and] quot;There but for the grace of God go I..... [and] quot; You could be the next pain patient desperate for help, not because you want to get high but simply because nothing else helps your never-ending horrific pain which ruins your life.Last year, my Pain Manager showed me the 2016 CDC Guidelines and told me that due to those Guidelines and due to gov [and] #039;t pressure, he had to put me on a forced taper.His knowledge of me as a compliant patient and of my pain was irrelevant. He felt he had no choice.He also expressed concern about me being blacklisted --- and I have now heard/read of other CPP [and] #039;s who have been blacklisted for no good reason.That was the first time I [and] #039;d heard of the Guidelines.The Gov [and] #039;t came between my relationship with my doctor, where it does not belong.Sarah Palin called such interference [and] quot;death panels [and] quot;, and the CDC Guidelines have in fact been death panels, because so many CPP [and] #039;s, cut off from their meds and from their pain doctors, have resorted to suicide. So many doctors have stopped prescribing opioids out of fear of the govt that some places have no doctors at all -- also a death sentence for some.Using the asset-seizure law (that allows confiscation of drug dealers [and] #039; assets even	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process. Thank your for sharing your story, sorry to hear about your pain.

		before trial) against doctors who are simply doing their job is unconscionable in America.As I indicated above by telling some of my bizarre medical history, every patient is unique. There simply is no one-size-fits-all medicine -- also a position that the FDA clearly stated in April 2019.The Govt should not be practicing medicine.The Govt should not be treating doctors and patients as guilty until proven innocent. Not in America.The Govt should not be trying to withhold desperately needed pain meds -- should not be inflicting unconstitutional cruel and unusual punishment against Americans.Due to my forced taper, my already very limited quality of life became even worse. Much worse. With my Pelvic Pain Syndrome, any movement triggers pain. The forced taper forced me to barely move all day, even more than before -- and I wasnt [and] #039; doing much before due to the extra pain triggered by even mild activity.The apter forced me to literally feel attached to my sofa.I [and] #039;d keep snacks on my coffee table to be able to avoid getting up when I was hungry.My ability to make any meal beyond an unhealthy frozen dinner virtually disappeared.I resorted to nutrition drinks which required absolutely no prep or cleanup.I started washing my upper body with a washcloth because I didnt [and] #039; feel up to showering.And on and on.At one point, on Day 4 of a particularly bad pain spike, I spent the day thinking about suicide as my only way of being able to end the pain.The only reason that I am still alive and able to write this is that, after hours that day of wondering what I [and] #039;d do, I finally realized that I still had much of my monthly supply left and that I could take the one or two pills I [and] #039;d need to LITERALLY survive the day; and that I [and] #039;d worry about making up those pills later in the month instead of worrying about that at that moment. So, I took another percocet. And later one more. And then the pain let up enough that I no longer felt the need to weigh my options about living vs dying.Making up later for those extra pills was no fun. But I survived.The other alternative -- buying street drugs -- is not something I [and] #039;d ever seriously consider because I [and] #039;d have no idea how to do that (I never have) and because I [and] #039;m simply not someone who could be a criminal let alone risk jail without any meds. At least if I [and] #039;m home	

		without meds I can kill myself if I get desperate enough.I [and] #039;m still on a forced taper, but not as severe as it was, thanks to the spring FDA and CDC statements, and HHS Pain Management Best Practices Report. I [and] #039;m still having a harder time than I was before the original taper, but I haven [and] #039;t been suicidal again. But, I should not be on a taper at all because the only reason I [and] #039;m on it is my pain manager [and] #039;s continuing fear of the gov [and] #039;t for him and for me. I dont [and] #039; know how much of his concern is the state, which has taken its cue from the federal govt.Another thing about street drugs is that evidence has proven that THEY are the true cause of OD [and] #039;s, often due to them being tainted with who knows what. So, for pain patients cut off from their legal, regulated meds, to be faced with the choice of suicide or street drugs as the only way to deal with their horrific pain, the irony is that those who choose to live and so choose street drugs very well may die from tainted, unregulated, illegal drugs. It is beyond bizarre that the gov [and] #039;t would push people in that direction, but it is doing just that. I never asked to have this pain. I am a victim. A patient, just like any other patient. Denying meds that my trained doctor believes I need is not something the govt [and] #039; should be doing.The gov [and] #039;t should go after the tiny minority of docs who are bad and should go after those people who are dealing and taking illegal drugs.But pain patients and our docs are NOT that population.Pain patients like me who need our legal Rx [and] #039;s to stay alive would NEVER sell our drugs.We are NOT criminals.And, we do NOT need Naloxone Rx [and] #039;s because we take our meds as our docs prescribe and dont [and] #039; abuse them and don [and] #039;t OD.I am in zero danger of an accidental overdose.I write down every single percocet I take. I [and] #039;ve been doing that since shortly after my surgery, when I realized that I couldnt [and] #039; keep track in my mind well enough.And, as to my 3x per day methadone ---- I forget to take it all too often, especially my mid-day dose. If I [and] #039;m not home (at a medical appointment or grocery shopping since I really almost never go out except for those 2 things), then it [and] #039;s especially easy to forget that dose. And sometimes in the morning I find	

Section	Commentator & Affiliation	Comment	Response
		that I forgot to take my bedtime pills, which include methadone.Addicts don [and] #039;t forget to take their drugs. I am not an addict, just like millions of others in my position. Virtually no CPP [and] #039;s are addicts. Dependency is not addiction. Countless Americans on countless meds are dependent. We are no different.The fact that some Emergency Rooms completely deny opioids to patients in case there are drug seekers is mind-blowing. What about innocent until proven guilty?!What about the majority of ER patients who are NOT drug seekers?!Leaving them in pain is cruel and inhumane and seems to violate the hyppocratic oath.I dont [and] #039; want to die. People like me should not be put in such a position.What about the Constitutional ban on cruel and unusual punishment?!	

Public Reviewer #173	Question 4	Pain means that any activity can be extremely difficult -- even something as basic as showering or unloading the dishwasher, or scrambling an egg -- and hand-washing the pan.For CPP [and] #039;s for whom opioids are the only source of any relief, opioids are essential for even these most basic daily activities.Restricting Rx access means more pain -- so it also means being even more sedentary -- meaning that not only does it become near impossible to live in a halfway clean home and eat a somewhat healthy diet -- but also meaning increased likelihood of bone density problems, cardio problems, etc -- which ultimately lead to poorer overall health and likely more cost to Medicare and other insurers.As to benzos --- on days when opioids don [and] #039;t help my pain enough for whatever reason, sometimes the pain gets so bad that I also get extremely anxious. The extreme intense pain and stress are not good for my heart. I have discovered that tiny doses of diazepam relieve my anxiety and take the edge off my pain. In fact, this happened last week. I was in such agony that I was considering going to the emergency room even though I doubted they [and] #039;d do anything for me; but I was that desperate for relief. One mg of diazepam relieved my pain enough that I was able to watch TV calmly, even though still in much pain. For me, the benefit far outweighs any risk. That choice must be made by each patient and his/her doctor and not by the gov [and] #039;t. It MUST be an individual decision.Virtually all medical decisions and all Rx [and] #039;s and even OTC meds involve risk. I have never filled an Rx which doesn [and] #039;t list all sorts of terrible risks, many times including death. But those Rx [and] #039;s are still commonly prescribed and taken due to discussions between doctor and patient. Even Tylenol can kill, as can Advil. As can legal alcohol. There is no reason to treat legal opioids which are needed to address acute chronic pain any differentlyAnd I do mean [and] quot;acute chronic pain [and] quot;, even though that [and] #039;s not the commonly used term. My pain is acute, and it is chronic.In Spring 2019, the FDA issued a statement that pain management must be individualized, and the authors of the 2016 CDC Guidelines issued a similar statement, repudiating the Guidelines.The HHS Pain Management Best Practices Report also supported	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		pain patients as does the AMA. These unwarranted attacks on pain patients and their doctors must stop.	

Public Reviewer #173	Question 5	Overdoses in this country are NOT caused by legal Rx opioids. They are caused by ILLEGAL drugs and alcohol.In the rare cases that legal Rx [and] #039;s are involved, they are combined with illegal drugs and/or alcohol, and they are stolen.I [and] #039;m sure that people who are experts will submit specific statistics which I [and] #039;m not able to do. Numbers dont [and] #039; stick in my mind at all.Punishing pain patients who are patients like any other, makes no sense. We are a totally separate population from criminal addicts.We are not addicts !! Dependency is NOT addiction !! Cure our pain and then we [and] #039;ll gladly give up the Rx [and] #039;s. But until our pain can be cured another way, opioids are as essential for life as food and water.Please imagine the worst pain you can imagine and then having it NEVER end. Please, try. Try imagining your child or other loved one in that much pain forever and being told that there is help that [and] #039;s been invented but she can [and] #039;t have it because some other people have abused it. One woman posted her story in the National Pain Report -- her husband had managed successfully with opioids for decades. Then he lost access. Eventually, he couldn [and] #039;t take the pain any more. They drove together to a parking lot and while she held his hand, he blew his brains out with a gun.No one should be forced to resort to that because of gov [and] #039;t interference in the doctor-patient relationship! Far too many CPP [and] #039;s have had to resort to suicide, and I was almost one of them. In America !!As to constipation -- I have always been constipated. I don [and] #039;t need anything special to manage any increased constipation that may be caused by my opioids. Taking psyllium fiber, colace, and eating veggies is all that [and] #039;s needed for me. Given the severe side effects I suffer from so many other drugs, it [and] #039;s nothing.On the macro-economic level --- some lucky pain patients have been able to continue working thanks to opioids. But when, due to govt pressure, these people lose Rx access, then they stop working and go on disability. So instead of being productive taxpaying citizens, they are not productive and are collecting Social Security Disability. This makes NO sense.One woman wrote her story in the National Pain Report --- that in spite of her terrible pain, thanks to opioids, she managed to	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		own and operate a small yarn shop in NH. When she lost her access to opioids, she had to close her beloved shop and go on disability. She lost out, her town lost out, and the govt [and] #039; lost out. For no valid reason!	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #174	Question 1	There are people on support groups for pain suffers from all over the world and this does not make any sense to me because it is totally contradictory with what your statistics say. People are suffering, have less mobility, committing suicide all do to not enough pain control. Doctor will not take them as patients. They do not want to help them. There are problems not being addressed. Please see my attachment for further details and some websites. Thank You.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #174	Question 10	People are not getting pain relief from Medical Marajuana and some are allergic to it. It does not give people with some nerve conditions such as the central nervous system relief. When they up the dose people are getting high on it and they never got high on opioids. Things I have learned: people confuse side effects as being high. When people [and] #039;s pupils are small does not mean they are high. Please See attachment Thank You	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #175, Mary Wille, Chronic Pancreatitis Group	Question 1	I find very Ironic,,that this report claims , [and] #039; [and] #039;Evidence Summary , [and] #039; [and] #039; ,but no-where does any of the conclusions that opiates have very , [and] #039; [and] #039;little effect, [and] #039; [and] #039; state the dosage ,height or weight of each participant? It would appear there is already a prejudicial bias consensus all you wanted to do was use prop-aganda that opiates don [and] #039;t work.How can there be any honest truthful conclusion on this myth when the dosages used are not states or in the case of the Krebbs study such a low dose was used,, [and] lt;50 or below,,of course opiate MEDICINE at such a low dosage would only work on a mouse,a pig or a monkey,ie animals use in recent studies against the use of opiate medicine...Are u saying the dose for mouse is thee acceptable dose for a human?	The dose of opioids used in the trials was reported. Analyses were performed on a dose-response effect and little evidence of a dose-response relationship was found.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #175, Mary Wille, Chronic Pancreatitis Group	Question 10	This report is prejudicial and bias.It appears a , [and] #039; [and] #039;agenda, [and] #039; [and] #039; is more important then the truth.Thus when 165 other countries are not harming their chronic medically ill patient in physical pain from their medical conditions,I do not agree w/your prejudice or mehods on implementing that prejudice.Using non-effective dosages of opiate medicines so some anti opiate agenda can happen,that will hurt,harm or even kill another human being,,,no,I will not agree w your methods or corrupted researches.As 1 judge in England stated,when America is torturing their medically ill and NOT adhereing to the U.N doctrine against torture in the healthcare setting.,,America [and] #039;s views and actions do not line up that of a civilized world.Using thee archaic hatred that comes from your prop-aganda to promote a prejudice,thus hatred towards a medicine opiates and all those who take this medicine to lessen physical pain..and those doctors still human enough,or not in fear of their own government,,no I don [and] #039;t agree w/u.Mark my words,this is #11 of thee worse atrocities committed onto mankind.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #175, Mary Wille, Chronic Pancreatitis Group	Question 2	Again you all claim , [and] #039; [and] #039;Evidence Base [and] #039; [and] #039; [and] #039; yet the names are being hidden from public view whom came to these prejudicial inhumane conclusions that opiates don [and] #039;t work.Well of course they won [and] #039;t work at miniscule dosages.,It woud appear via hiding the names to infer that a corrupt regime has no use for truth??Again,,unless all participates of these , [and] #039; [and] #039;studies, [and] #039; [and] #039; were allowed effective dosage of medicines to actually lessen their physical pain from medical conditions,,the researches have just wasted a whole lot of tax payers money to spread the prejudicial bias that opiates don [and] #039;t work,,In many studies no surprise those whom shall/have gain financially ,ie addiction warehouse,therapist,psychiatrist,PROP members all have gain billions financially by using a age old archaic prejudice that a medicine designed for lessing physical pain is bad..History isrepeting itself,psyhiatrist pulled the same thong back after the Civil War..Only to now find out these poor men did NOT LIE,,,THEY WERE IN TRUE PHYSICAL PAIN,,FROM LEAD POISENING.Every bullet used was a death sentence ,for they were all made out of lead,,but point being psychiatrist have pulled this before,only to truly harm/kill a segment of population thru their arrogance turn to inhuman stupidity..	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #175, Mary Wille, Chronic Pancreatitis Group	Question 3	The methods used were corrupt.Again,the fact that no actual medical doctor did not raise a red flag when the dosages were not indicated,or dosages that are at a non-effective levels,then to come to a conclusion that will/has harmed millions of human that opiate MEDICINES don [and] #039;t work,truly shows the , [and] #039; [and] #039;prejudicial bias , [and] #039; [and] #039;group think, [and] #039; [and] #039; occurring from your , [and] #039; [and] #039;Evidence Base team/researchers.Furthermore the fact that all involved have willfully used this methodology to ignore the law,the treaties, signed by the United Nations,,;that defines medical torture as denial of access to effective medical care to EFFECTIVELLY lessen physical pain with the use of effective medicine,ie the medicine opiates,,and,not distinguishing between street drug and medicine used for medical purposes,truly shows the extent these researchers will go to get the Agenda,not truth nor effective physical pain relief for the medically ill,but their Agenda,to deny opiate medicine at effective dosage to all who live in America.I find it very telling that America and Eastern Providences of Canada,,not the western,only 2 countries out of the 167 that belong to the U.N treaties are violating the treaties on medical torture.America is one,and Eastern Providence of Canada is the other.All of Europe is following the U.N treaties guideline against torture in the healthcare setting.Western Providences of Canada have chosen to follow the U.N doctrine on torture and are actually confronting doctor who do NOT give their medically ill in physical pain enough opiate medicine to EFFECTIVELLY lessen their physical pain from their medical illness,thus following the U.N doctrine against torture.All of your researchers have chosen to deny the U.N doctrine against torture,thus willfully torturing the medically ill in physical pain.Sooo no,I do not agree with the methods you people have chosen to use.I don [and] #039;t believe in torturing the medically ill., or anyone fellow mortal for that matter.	The doses of opioids were reported and analyzed in stratified analyses and meta-regression. There was little evidence of a dose-response effect.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #175, Mary Wille, Chronic Pancreatitis Group	Question 4	Again when the results are based upon not disclosing all information or not disclosing the dosages, or in this day and age,,where are the videos of all this research.Using video would definitely disengage the prejudicial bias obviously present in these researcher.Furthermore the fact that all of these researchers belong to 1 of only 2 countries out of 167,,meaning 166 other countries are not willfully torturing [and] #039;s their medically ill over a archaic prejudice over the use of opiate medicines to lessen physical pain.165 other countries are adhering the U.N doctrine against torture in the health care setting,but not you?!Your psychiatrist have made it a disorder for a NORMAL natural human behavior for gods sake!The very very basic human right and human nature to want physical pain lessen [and] #039;d is now a disorder according to your psychiatrist involved in this research.Psychiatrist by the way who have and stand to make billions off of that diagnose..They have literally already LIED on patients medical records,deeming substance [and] #039;s use disorder for asking for pain medicine from pancreatits,,that [and] #039;s crazy!When your result go against 165 other countries,against the U.N doctrine of torture in the healthcare setting,,NO,,,I DO NOT agree,recommend your results.I will not be a part of this , [and] #039; [and] #039;group think, [and] #039; [and] #039; of a archaic prejudice against a medicine used and designed to lessen physical pain,for it is WRONG,INHUMANE.	Thank you for the comment. The report synthesizes published literature and provides a reference list of all included and excluded studies.
Public Reviewer #175, Mary Wille, Chronic Pancreatitis Group	Question 8	Very bias references.	The studies were identified using systematic searches and included based on application of pre-specified inclusion criteria.
Public Reviewer #175, Mary Wille, Chronic Pancreatitis Group	Uploaded Document	madinamerica.com-10 of the Worst Political Abuses of the Psychiatric and Psychological Professions in American History.pdf (66 KB)	Thank you for the comment. The attachment (#14) was reviewed.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #176, ann cataldo	Question 5	Please make exceptions for people with rare, painful genetic conditions like Nail-Patella Syndrome and Ehler Danos Syndrome. We can not take NSAIDS because of kidney deformities and need opioids to manage our lives. Individualized care must be the focus for incurable palliative care conditions.	The report synthesizes the evidence and does not make recommendations. No study meeting inclusion criteria evaluated these populations. The Research Recommendations section notes the need for research in specific populations.
Public Reviewer #177, David Becker, - Select -	Question 1	Market and regulatory failure of pain care and addiction care has been established by the myriad efforts of government over the past 6 years. Yet despite such efforts rates of fentanyl deaths have climbed in the past 3 years and government regulations have added to the perfect misery of pain by promoting forced tapering of opioids under the misguided and unsubstantiated belief that controlling supply controls demand.AHRQ confirms John Deweys statement that experts have a false sense of familiarity, independence, and completion by creating an expertcentric report- as if there werent enopugh expertcentric reports created by AHRQ, NIH, NAS and countless government entitites in our Nation. Expertcentric report piled on expertcentric report were all too little to make way to lower the prevalence of chronic pain or addiction in our Nation. It is clear experts lack [and] quot;the right stuff [and] quot; and stand in the way of real moral, social, and political progress in pain care. I have already provided over 600 citations to DHHS on the unreliability of medical research- citations they refused to include in my comments to the FPRS. I would add that AHRQ failed to use clear metaanlytic criteria in analyzing data from the cherry picked studies they used.	Thank you for the comment
Public Reviewer #177, David Becker, - Select -	Question 10	This report is pure politics and reflects vice epistemology and lack of integrity.	Thank you for the comment
Public Reviewer #177, David Becker, - Select -	Question 2	AHRQ was biased from the get go to support the erroneous belief that all must be done to limit access to opioids- regardless of the consequences to people in pain. Neutralization theory was used to support a political agenda of preventing people from using as much opioids as possible.	The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #177, David Becker, - Select -	Question 3	Your methods are inauditable and therefore not credible and not open to public accountability.	The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input.
Public Reviewer #177, David Becker, - Select -	Question 4	The results were foregone conclusion. AHRQ had marching orders to support the poor politics of pain care- and so no surprise on the results.	The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input.
Public Reviewer #177, David Becker, - Select -	Question 5	lol. FOR AHRQ, democracy is 4 wolves and a sheep voting on dinner. You carefully avoided counterpoint or fair and full representation of person in pain or the public. And so I accuse AHRQ of testimonial injustice and quick and dirty politics.	Thank you for the comment
Public Reviewer #177, David Becker, - Select -	Question 8	Poor literature reviews. I guess AHRQ is not aware that the public can sapere aude as well as you and know the difference between good literature reviews and the cherry picking AHRQ indulged in.	The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input.

Public Reviewer #178, Desiree Nelson, National Advocacy Access Clinic (not yet incorporated)	Question 10	See attachment. It is appropriate for AHRQ and other stakeholder agencies to postpone the release of the AHRQ final report until all appropriate expert stakeholders 1. Have had time to read the report in full and vet the information in the appendices 2. Stakeholders have been given time to communicate their concerns 3. Concerns of expert stakeholders are taken seriously (as this did not happen when the CDC Guideline was submitted for publication and is based on the same flawed, weak, or non-existent evidence this report contains) 4. Valid expert stakeholder dissent is implemented within the process of quality improvement (as this has also not taken place historically and this lack of remediation needs to come to an end) 5. Appropriate studies are conducted by neutral parties without conflicts of interest6. Weak, flawed, or non-existent evidence is no longer used as a justification for further initiatives and interventions (this is unacceptable and any stakeholder worth their salt knows it)I would have provided comment on each section of the report had I been given a reasonable amount of time to do so. This should not be merely ceremonial, federal agencies have a duty to include and consider expert stakeholders and the fact that this wasn [and] #039;t posted in the Federal Register where most of us look for such documents is a massive failure on the part of AHRQ and HHS and does not reflect the stated mission of AHRQ or HHS. I will remind both AHRQ and HHS of their mission statements:HHS: The mission of the U.S. Department of Health and Human Services (HHS) is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.AHRQ: The Agency for Healthcare Research and Quality [and] #039;s (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.Recent actions by both agencies are not consistent with stated mission.I will also remind AHRQ and any other stakeholder agency that the CDC, FDA, and HHS have all circulated public acknowledgements of harm to	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process. The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input and stakeholder input. The draft report was posted for public comment in accordance with standard AHRQ procedures, and those on the Effective Health Care listserve were notified of the opportunity to comment on the draft report.

		American citizens health and well-being in the wake of the CDC Guidelines dissemination. This is particularly applicable as the AHRQ draft report is based on the same flawed, weak evidence and goes so far as to admit that the evidence is lacking.Below is a detailed list of reasons why this report should be postponed at the very least, or scrapped altogether:1.The request for comment was not provided via the Federal Register where most stakeholders look for such documents and proposals for initiatives2.Continued bias exists within the draft report3.Key messages from extract clearly demonstrate bias and lack of evidence4.The draft report withheld the names and qualifications of both the Technical Expert Panel at the Evidence-based Practice Center and peer reviewers This failure to identify authorship in the draft essentially disqualifies the document5.The American Medical Association has publicly repudiated many of the assumptions and all of the core methodology incorporated into the guidelines, and by extension, this applies to the AHRQ draft report as well6.The profoundly flawed and biased Krebs report (SPACE clinical trial from the University of Michigan), among others, is among the references quoted in the draft report7.There is strong countervailing scientific evidence according to Dr. Lawhern and many other appropriate stakeholders8.Serious conflicts of interest in regard to CDC workgroups are just now beginning to surface9.Evidence on the effectiveness of tapering opioid doses versus usual care and the effectiveness of different tapering strategies remains very limitedPlease see my article on the topic. I would like to see remedial steps taken in your processes which I explain in my article. I would also like to see systems theorists and thinkers, designers, and disaster planners added to the conversation as I don [and] #039;t feel that agencies have a firm handle on the harms they [and] #039;re causing via the continued force of interventions that have not been working, have little to no evidence of their efficacy or safety, not to mention the fact that no federal agency is tracking patient-reported outcomes in any meaningful way. This also needs to be rectified immediately and before any more reports, guidelines, interventions or the like are proposed or implemented by any federal agency concerned with and responsible for the health of	

Section	Commentator & Affiliation	Comment	Response
		American citizens. Please rectify these mistakes immediately and see Systems Thinking [and] amp; How It Can Solve The Overdose Crisis for more details on how repeated failures can be addressed in a meaningful way.https://medium.com/swlh/systems-thinking-how-it-can-solve-the-overdose-crisis-f9a545ff4148 Regards,Desiree NelsonFormer Environmental Health [and] amp; Safety professionalFounder [and] amp; Executive Director of the National Advocacy Access Clinicnaac.hq@gmail.com	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #178, Desiree Nelson, National Advocacy Access Clinic (not yet incorporated)	Uploaded Document	Expert Comments by NAAC RE AHRQ Draft Report 11122019.pdf (140 KB)	The attachment (#15) was reviewed. AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process. The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input. The draft report was posted for public comment in accordance with standard AHRQ procedures.
Public Reviewer #179, Carol Jagiello	Question 1	I am submitting with a few hours before deadline just being alerted to opportunity to comment. I glanced at but have not read report. I hope you will consider my comments based on 25 years of experience with severe chronic pain and how analgesics have allowed me to have a heal to some extent and have real quality of life.Active and athletic girl had lots of injuries, none serious until age 16 when I needed a knee surgery. I had several minor surgeries and had no problem healing or stopping prescribed percodan when pain was tolerable. I had a bilateral laminectomy in 1991. I did well for a couple of years then the pain returned. I was introduced to depo medrol in the spine. One day after the second shot my foot snapped like a branch and I was in misery. I wore a cast for six weeks. The bone took years to heal.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #179, Carol Jagiello	Question 10	I have read for years that there is very little real research on long term opiate use for chronic pain. Seems you still do not. Start there. Your conclusions seem wishful. I know contributors are secret but this seems more like anti opiate bias at work again. I hope propaganda agents provacatour or not are not involved again here. Or the Pro suboxone crowd. They had incentives as I recall. Dangerous and deadly conclusions to suggest all be tapered off stable doses of live saving medicine.I hope you consider all I have been through and my vast experience. All patients are different. My father, oldest sister and myself metabolize drugs and anesthesia fast. We have all been told we need at least three times standard dose of both. My mom, brother and other sister respond normally. All patients are different.	Thank you for the comment. The report synthesizes published literature and also identified areas for future research.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #179, Carol Jagiello	Question 2	I was referred to University Hospital pain management in 1995. They were cutting edge, used the team approach,including a psychologist, taught mind body techniques and used experimental procedures if appropriate. Dx RSD after six diagnostic blocks. Foot still fractured at 5th metatarsal. In order to cast I was given a phenol block at T2. It worked! No pain. My percoset dropped off. I used crutches. One month later my shoulder to finger tips were in severe pain. Bier and gluathione blocks did not help beyond a couple of hours. I could no longer use a crutch. I was given a walking cast. What the hell my left arm and hand felt severely sprained and burned. The nerve grew back, my foot hurt more than ever. The phenol block was repeated in late September. Even under fluroscope the phenol back tracked into the tissue and I woke up in recovery wanting to die. I now had severe pain from t2 to my knee. I could not tolerate clothing and used cradles to keep bedding from touching me. I wanted to find a tall building. The percoset did not touch this pain. For the next week all I could do was crawl to the bathroom when I needed to and back to the couch. I was then given an IV drug test. They injected short acting drugs to see if I had pain relief before side effects. The first was lidocaine. It went straight to my head and made me very ill. Several hours later a different drug was tried, nothing happened. Third drug started to work but not much. I was doing NY Times crossword and they kept injecting my IV. It was slowly helping, no adverse reactions. Finally I was able to tolerate the pain with no side effects. Doctor asked me to finish the puzzle, I did. It was morphine.They were surprised at how much it took to help. I told them the shots after my knee surgery did not work, I needed several. That I woke up from sedation during oral surgery a few minutes in. Every one is different. I was sent home on 300mg er 3 x day plus 30 mg ir. I was a little groggy at first but that only lasted a couple of days. Other drugs were tried over the years from zero to disaterous effects. The worst Neurontin made me suicidal after one dose. Tegratol homicidal - one dose. Dibenzyline gave me violent terrifying re current nightmare every single night for a year.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #179, Carol Jagiello	Question 3	The following year I had dystonia shoulder to finger tips. Frozen. I had nerve blocks every day to move limb. 9 months every day for some movement. It finally worked. For 5 years I maintained this level of medication. It finally allowed me to do more, get stronger and focus on healing. I was finally able to feel normal acute pain. Before any new pain triggered a pain circuit that lit up every damaged site. I got to the point where I could do virtually anything I wanted for several hours twice a day. I had a life! As I improved the pain receded and the dosage dropped. Over the year I was down to 100mg 2x day plus 30 mg ir as needed. After a couple of years I was getting too sedated. I wanted to switch to oxycodone ir. for break through pain. This worked much better. I had an emergency surgery for obstruction, 9 inches of illeum removed from nsaid webs blocking intestine. Recovery was normal, no increased pain. Dosage temporarily upped post op. Later I was given durogesic patch to by pass gut.. A nightmare - the longest weekend of my life. Anxiety like I never experienced. I just watched movies and breathed until I could reach my doctor. It did not work for pain.A few months later I dropped 1 100mg er. Just did not need it. In 2009 I dropped the er completely. Just stopped. I upped ir 30 oxycodone from 4 to 6 per day. I stayed here for years. I had a functioning happy life. I had pain but tolerable. I used brand name. Generics are terrible and need several more doses a day for equal relief. The prices stared to double each year. $200.00 pr month brand name turned into $2700.00 after a few years. Insurance no longer covered it all. I am on generics again and they really are in adequate. Some are worse than others..I had a hysterectomy that caused severe burning pain at incision site for 8 months until it lifted and disappeared. Post op and this new pain caused my only dosage increase since 2009.Due to doctor fear I was switched back to morphine er, ir. My gut slowed down and I had a year of un specific gut issues. I switched back and it stopped.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #179, Carol Jagiello	Question 4	I write this detailed back round to state interventional medicine ruined my life. Now due to interventional pain management high dose narcotics was the only thing that helped and saved me. It took many years to get to the place where I could begin the work to heal. I learned every alternative method I could to heal myself. Visualization and vibrational therapy - tuning forks help me the most. I have a knowledge of and use homeopathy, herbs and essential oils for my pain and other issues. Over a decade these have helped me improve. Three years ago a hysterectomy and omentumectomy crashed my body. Orthostatic B P, weight loss, malnutrition. All post op. I had a benign softball size tumor on ovary. It torsioned. The ER treated me like a criminal when I explained my situation. The shots did not work. They wanted me to stay in ER with out adequate pain relief. I went home and un torsioned my own ovary It took days, was terrifying but I did it with my self taught tools. The nurse actually said beggars can [and] #039;t be choosers as I cried in agony. The oncology nurses post op also ignored my pain. My sister found my surgeon who was angry. He showed the nurses my chart where he had written instructions I was to get shots as needed. The nurse felt I should not need so much medication. Oncology nurses! Extra shot meant I could sleep and begin to heal. I was much better the next day. Without the initial relief where a patient can relax healing can not happen. Under medication will always translate into not helpful. Proper dosage works for all pain. I read opiates do not help nerve pain - ridiculous. The patients are under medicated. Also the reason patients run out early - they need the initial relief from suffering. My doctor of 17 years retired. He said I was the only rsd arachnoiditis patient he ever had that had gotten 50% better. He was amazed how well I managed my condition and ease of drug reduction. I was and am stable. New PM docs. I am now being tapered. They feel they must. CDC says so.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #179, Carol Jagiello	Question 5	When I was put on opiates I never had another drink of alcohol though I did not have a drink often.. Duh. Common sense. In 1998? I read a Newsweek cover story on Hillbilly heroin. Very long detailed article about oxycontin. How dangerous and addictive it was. When my doctors recommended oxycontin I said it sounded too scary, I wanted no part of it. They assured me they were having good results and it was safe. I refused. I have never taken oxycontin to this day. It was well known 20 years ago. Don [and] #039;t blame real patients for those who will abuse drugs or alcohol or both.The CDC numbers must be eliminated. Patients like me and worse simply will not survive without access to appropriate levels of medicines that help us live. This is between patient and doctor. I have been on analgesics for over twenty five years with virtually no adverse effects. My other health issues have nothing to do with medication according to every doctor I see. One of my new doctors spouted these new guidelines and told me I am way over legal limits. When I mentioned advisory nature of rules he spouted more CDC talking points, no real conversation as one would hope with a doctor.These false maximums have caused extreme suffering in stable patients and suicides in those cut off. Patient education and tools to cope and heal are ideal but it may take years to benefit patients. They must never be in place of medicines that work. You would never take away or lower BP drugs or insulin. Pain patients are not abusing their drugs, they want to live and hopefully recover. If they do not recover or [and] quot;show Progress [and] quot; then the drugs don [and] #039;t work? That makes no sense. Some will never improve that does not mean they should be denied the only medicines that help then get out of bed and care for themselves. Gabapentin caused me suicidal ideation after one dose. It is a dangerous drug and patients need to know the risks.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #18, Sherri Look	Question 1	Lots of low evidence. I [and] #039;m not sure how anyone can make conclusions from these poor studies	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #18, Sherri Look	Question 10	There is such a lack of good research in this area it is stunning. At this point, due to lack of research especially on long term opioid therapy, I do not believe it is scientifically correct to forcibly stop or begin opioid therapy for chronic pain patients. Adverse effects of non-opioids were completely ignored. More research is needed before policy decisions can be made. Human biology is individual so we should expect different people to react differently. Assuming people fall into statistically identified labels is medically unsound. Therefore the government should only provide information to physicians, not develop laws or even guidelines. Doctors are professionals, let them use their professional judgement without government interference -particulary when the research is of such low quality.	Thank you for the comment
Public Reviewer #18, Sherri Look	Question 3	There were no studies included on the adverse effects of non-opioid medications or on surgical implantation of pain pumps or stimulators.	Key Question 2c addresses adverse effects of opioids vs. nonopioids, there were 10 trials included for this question. Surgically implanted devices were not included in this report.
Public Reviewer #18, Sherri Look	Question 4	So many studies of low quality the results are almost meaningless.	Thank you for the comment. The limitations of the evidence are described in the report.
Public Reviewer #18, Sherri Look	Question 5	No long term studies of opioid use for chronic pain is NOT evidence that it does not work. We should not experiment on unwilling chronic pain patients bt refusing them opioids based on LACK of evidence. No one took into account the adverse effects of non-opioid pain medication. Tylenol and liver disease and NSAIDs and kidney and heart function. These drugs are not meant to be taken long term. I find this a serious omission of data.	The report does not state that opioids do not work long-term; it summarizes the existing evidence which as noted by the reviewer is very sparse for long-term outcomes.
Public Reviewer #180, Melanie Brown, Children [and] #039;s Minnesota	Question 10	Thank you for addressing this important topic. My most important observation is that there is no mention of opioid use in youth and teens. There is also minimal discussion of drug diversion and the only mention of diversion is that it is not evaluated as a preference in the systemic reviews. In the risk discussion, there is no mention of the effect on family or the children of those who are prescribed opioids for chronic pain. Neonatal Abstinence Syndrome is an important sequela of opioid use for chronic pain during pregnancy.	The report focused on adults.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #181, Anna Bono, Ms.	Question 1	[and] quot;Opioids are associated with small improvements versus placebo in pain and function and increased risk of harms at short-term (1 to [and] lt;6 months) followup; evidence on LONG TERM effectiveness is very LIMITED and there is evidence of increased risk of serious harms that appear to be dose-dependent. [and] quot;My response:I take serious issue with this misleading statement. As a chronic pain patient for over 25 years, I can attest to the fact that opioid medications are far superior for alleviating moderate to severe pain versus non-opioid treatments such as lyrica, gabapentin, neurontin, SNRI antidepressants, NSAIDs, and acetaminophen.I suffer from endometriosis, fibromyalgia, ulcerative colitis, interstitial cystitis, osteoarthritis, pelvic adhesions, pid, IBS, widespread pain, severe anxiety. Prior to trying opiate medications, I had first tried ALL treatment modalities including: non opioid OTC and prescription medications, 17 surgeries, acupuncture, physical therapy, nerve blocks, steroid injections, and several other methods all to no avail. Drugs like gabapentin, neurontin, and SNRI antidepressants were by far the WORST medications I [and] #039;ve ever taken with severe side effects. It took me 8 months to wean myself off each of them and once I did, the difference was astonishing. I have continued my opioid pain medications which work extremely well without the addition of the aforementioned.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #181, Anna Bono, Ms.	Question 10	The state [and] amp; federal government continues to [and] quot;shrug off [and] quot; our repeated of cries for help, and voluminous stories depicting the negative outcomes happening as a direct result of the barbaric policies THEY [and] #039;VE put in place. Stories of endless suffering, grieving our once productive lives, losing our careers, jobs, families, children, friends, and worst of all, stories of thousands who felt they had no other choice to escape their debilitating pain, so they chose suicide. So where [and] #039;s the nonstop media coverage? Where [and] #039;s the moral outcry from lawmakers, human rights groups, ACLU, or media outlets? Oh, that [and] #039;s right...they can [and] #039;t shed light on our issue because it doesn [and] #039;t fit the anti opioid agenda...opioids for pain = BADmarijuana, alcohol, cigarettes, sugar = A OKSo you see, WE are NOT the problem. Our doctors are NOT the problem. However, we ARE the ones taking the proverbial fall for the transgressions of others. We WANT to live. We WANT to be productive and present for our loved ones. Unfortunately, what WE want doesn [and] #039;t matter, because we [and] #039;re NOT important to the [and] quot;puppet masters. [and] quot;	Thank you for sharing your story, sorry to hear about your pain.

Public Reviewer #181, Anna Bono, Ms.	Question 4	As a pain patient [and] amp; advocate, I communicate with thousands upon thousands of Americans who suffer from daily pain who HAD achieved adequate analgesia in the form of a responsible opioid pain management regime. However, as a result of government overreach and intervention, there are now MILLIONS of patients suffering from acute [and] amp; chronic pain due to cancer, sickle cell, fall or motor vehicle accident, post operative pain, pancreatitis, lupus, fibromyalgia, Crohn [and] #039;s, and countless other diseases that are now UNABLE to ACCESS the aforementioned life saving medications to achieve pain relief. Even stage 4 cancer patients on their death bed are suffering in torturous pain because doctors are afraid they [and] #039;ll become [and] quot;addicted [and] quot;. Come on, that [and] #039;s ridiculous! If you had 2 weeks left to live [and] amp; suffering like a dog would you be concerned about getting addicted? This has gone too far, and we are begging you to put the brakes on before it gets any WORSE. The large majority of patients have been FORCED to reduce their stable, effective pain medications to a non therapeutic level, followed by those who were completely ABANDONED by their health care providers without warning out of fear of law enforcement or regulatory repercussions. The health care providers we communicate with have said they [and] #039;re faced with increased scrutiny, time consuming burdensome paperwork, pop visits from the DEA, and thinly veiled threats advising doctors to curtail their prescribing significantly. Basically, the government has inserted itself into the sacred physician/patient relationship which is eroding trust and public confidence in our nation [and] #039;s health care system. We have been ABANDONED by our health care system. We have been ABANDONED by our government. It seems as if our lives are expendable and our voices do NOT matter because our government (NOT our doctors) know what [and] #039;s best for us. Unfortunately, these stories are NOT folklore. However, certain anti opioid zealots refuse to acknowledge their existence as anything more than [and] quot;anecdotal [and] quot; evidence. In any other situation, this abhorrent behavior would be setting off alarm bells across the entire country [and] amp; our elected officials would be organizing [and]	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
		amp; working across party lines to put an immediate stop to this BARBARIC practice of TORTURE against its own citizens. Where [and] #039;s the ACLU? Where [and] #039;s the mainstream media talking heads? Funny, when it comes down to the health [and] amp; well being of American citizens we hear NOTHING but CRICKETS from the people who are in a position to champion our cause.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #181, Anna Bono, Ms.	Question 5	Several studies in controlled settings have concluded that the risk of addiction is less than 1%. If we use the statistics released by government agencies, i.e. 1 out of 4 will addict, then there would be ~25 million Americans addicted to opioids, and actively seeking illicit drugs to replace their once prescribed pain medication. This is a slippery slope. Our government has inserted itself into our health care decisions which has progressively evolved into a complete nightmare for legitimate pain patients and our compassionate doctors who are terrified to prescribe controlled substances for the treatment of pain. Honestly, I don [and] #039;t blame them. However, the mass hysteria over a non existent [and] quot;prescription drug crisis [and] quot; will eventually come to light and the public will realize that they [and] #039;ve been hoodwinked by manipulated statistics that have no correlation with prescribing rates whatsoever. If opioid prescribing rates were a tool to measure the number of overdose deaths, then the number would be dropping significantly each year as the prescribing rate has dropped (over 33% since 2012). However, it is the complete opposite. Overdose deaths have skyrocketed since 2012, and shows no signs of leveling off anytime soon because prescribing [and] amp; abuse rates are NOT connected. In fact, if the government continues to force doctors to undertreat pain and the DEA continues to decrease opioid production, the overdose rate will continue to RISE [and] amp; millions of Americans will continue to suffer the consequences of the collateral damage we have become.	Thank you for the comment. The risk of addiction <1% is likely based on the Noble et al Cochrane review, which was largely based on uncontrolled studies that were not designed to evaluate risk of addiction; these studies were not eligible for this report. The report includes studies that reported rates of opioid abuse/dependence of 0.72 to 6.1% and 10.9 per 10,000 person-years. The goal is not to undertreat pain but to look at research on what methods are effective for treating pain.

Public Reviewer #182, Lacy Fowelr, International Pain Foundation	Question 1	Being segregated into pain management has lead to years of agonizing inhumane suffering of living with untreated pain, along with many more years of experiencing medical harm due to lack of knowledge around spinal cord injurys and arachnoiditis. Step therapy has been being dished by doctors and insurance companies since. This is not just a personal problem but is a running ram-pate problem among our nations healthcare system and pain patients are paying the piper. As of present, up to 51% of chronic pain patients are now unknowingly living with arachnoiditis. Many of these problems are due to arachnoiditis being classified as a rare orphan disease, miss communication of all the healthcare changes that have trickled down pipeline since the push for PDMP, medical harm, tackling prescription pill problems and OUD (opioid use disorder) became labeled as chronic condition ensuring opioid addicts healthcare. Seperating opioid addicts and pain patients while ensuring implaments of the PDMP that not only services OUD patients but also fairly services opium alkaloid therapy to pain patients who live with daily pain from various diseases and conditions without leaving our community feeling like ravished governed prisoners, is the right thing to do. This separation is imperative for the development of moral and ethical welfare of healthcare. Those of us who live with our physical anguish of pain more than likely did not chose this disposition. However due to this medical experience I chose to create a better tomorrow for patients in pain by taking action. Let me share with you what 8 years of being denied remission and proper pain control has gotten me. A excellent resourced network of highly skilled individuals specialized in healthcare and various other avenues that are dedicated to compassionate care! I have also experienced personal disease progression of CRPS/RSD (reflex sympathetic dystrophy type 2)among many other health issues. I fear if I continue to experience step therapy and am not properly treated, soon, I will develop full blown crps as the symptoms seem to be slowly taking over my body. I am now concerned with finding doctors who are properly educated and specialize in opium alkaloid therapy.Morphine treatment is quality of life, life saving medication for the type of arachoniditis I live with.	Thank you for sharing your story, sorry to hear about your pain. The goal is not to undertreat pain but to look at research on what methods are effective for treating pain.

		Morphine is the antidote by helping to thin the thick blood created from a over worked CNS. Morphine and benzodiazepams serve as a CNS depressant and allows thinning of blood stream which promotes the flushing of the blocked up cerebral spinal fluid to temporarily flow through the over growth of scar tissue (fibrosis) during extreme inflammation. Opium alkaloid therapy counter acts flares preventing disease progression during flares. Morphine has a 3 target direct action sites CNS, myocardium and peripheral blood vessels. Before the treatment over a long period the blood becomes backed up with sticky proteins and gums up or suffocates blood cells and tissue. Leaving your muscles feeling fatigued and constant state of constriction, like a rat encased in the vice grips of a boa constrictor. The scare tissues constricts and prohibits the flow of the thick gummy blood causing miss firing of messages of the efferent and afferent neuropathways in the spinal cord. Miss firing of these pathways over time cause malfunctions throughout host of systems and anatomy causing disease progression of arachnoiditis, crps/rsd, cauda equine pain syndrome and can lead to faster paced disease progression. Signs of disease progression can be monitored through correct blood work testing. Example of a flare symptoms that can be traced through hematology, low potassium for long periods which can lead to hypokalemia which has symptoms of vomiting, muscle weakness, paralysis. Other symptom indications of flare high blood pressure, high pulse rate, increased pain, brain fog, chronic fatigue and more. Long term untreated arachnoiditis can lead to brain disease progression of the medulla oblongata and affects the vasomotor center (vmc). Long term untreated chronic pain is detrimental to the frontal lobe. Your frontal lobe is responsible for processing emotions, feelings, problem solving, memory, language and on. I explain these things in more detail to help others gain a more comprehensive understanding through scientific facts and sharing my personal experience tracking, living an copping with many if not all of these symptoms throughout 19 years worth of disease progression and encountering healthcare. Benefits of i.v. Morphine has been shown to give patients with cardiac disease remarkable circulatory stability. Morphine is recommended to	

Section	Commentator & Affiliation	Comment	Response
		patients with poor myocardial reserve and who are under going surgery. Following the use of i.v. morphine a decrease in peripheral vascular resistance has been well documented. Peripheral resistance is determined by three factors: Autonomic activity: sympathetic activity constricts peripheral arteries. CRPS/RSD is a disease of the peripheral nervous system. Certain types of opium alkaloid therapy are extremely beneficial to stop the progression of arachnoiditis and its lengthy Disease progression in patients.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #182, Lacy Fowelr, International Pain Foundation	Question 2	The intorduction covers the basic foundation of the declared crisis in pain care. I wish there was info on the difference between addiction which a mental illness and physical anguish which is the deteriation of a body part were included and discriptive. Differtiate between addiction and physical anguished pain is imperative to the improvements necessary for the chronic pain communtiy. Helping them to understand analgesics of opioids, opiate alkaloid therapy and which receptors combine to which In the body would help improve doctors understanding on prescriptions used to treat diseases and there pain.	Thank you for the comment. These issues are beyond the scope of the Introduction for this report.
Public Reviewer #182, Lacy Fowelr, International Pain Foundation	Question 3	After implementation of new rules and regulation across healthcare my treatment plan was abandon and remission has been denied multiple times since 2011. My most recent experience was 11/11/19 at the ER department. I was instructed in 1999 to be to retrieve care during there flares. I was administered 6mlg of morphine which only gave a few short hours of relief and then the return of the flare by 5pm. At 3pm it began to wear off and was administered around 11am. Previously I was sedated and released with a taper prescription to recover at home before unknowingly enter the pain management program in 2008 that literally demolished my personal health. I have been targeted, segregated, emotionally violated and treated like an addict because of improperly ego bosting doctors who find their actions of isolation and the removal of my medication ethical. Taking away opiate alkaloid therapy has caused financially hardship, health declines and much more. The methods being used to access this epidemic are discrimination against a group of people and the result are wreak havoc all over the nation. Basiclly I was given a few hours of rest from the pain for it to return like a hurricane. And due to financial situation created from living with disease travel 8 hrs round trip again to hospital is not plausible. So I am once again left to suffer in my agonized pained state. I must try to function as normal as possible	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #182, Lacy Fowelr, International Pain Foundation	Question 4	the results of these poorly rated stats have trickled down the pipe line resulting in patient abandonment, suicide, mistreated and untreated pain. I have personal experienced various forms of mistreatment and improper pain control that provided remission over 40 times after all the changes being made. My abandonment of pain control actually began upon entering a flawed pain management program that unknowingly collected my personal patient data singled me out then red flagged me. I am here because I dont want to die in pain and I wanted to know why this was happening to me. Those who are real empathetic doctors have moral obligations to get this right not just for me but and entire nation of pain patients. Imagine waking up ever day just so you can feel pain to just a breathe.	Thank you for sharing your story, sorry to hear about your pain.

Public Reviewer #182, Lacy Fowelr, International Pain Foundation	Question 5	What we are not talking aboutOpioid Use Disorder-types and classificationOpiate receptors Opioid mediation and which receptors it binds to-Apart from the muscarinic and nicotinic effects seen in cholinergic crisis, patients might also exhibit neurological symptoms like a headache, dizziness, tremor, and paresthesia.-Cholinergic crisis is caused by overstimulation of the postsynaptic membrane by the neurotransmitter acetylcholine(ACh). ACh is a chemical substance that was first proven to be a neurotransmitter by Loewi in 1921. -On activation, there is an increase in intracellular cyclic adenosine monophosphate (AMP). Activation of cyclic AMP triggers the action of protein kinase. The muscarinic receptors form part of the parasympathetic that helps with the regulation of secretions (both in the bronchial tree and the gastrointestinal tract), heart rate, pupillary response,and urination. All which are extremely painful symptoms.*****important******-Opioids are a group of analgesic agents commonly used in clinical practice. There are three classical opioid receptors (DOP, KOP and MOP. The receptors are on there 4th name change.-NOP receptor is considered to be a non-opioid branch of the opioid receptor family (servicing OUD patients, naloxecan, bupnepheran, suboxin)-Opioids can act at these receptors as agonists, antagonists or partial agonists.-Opioid agonists bind to G-protein coupled receptors to cause cellular hyperpolarisation-opioid analgesics bind to MOP receptors in the central and peripheral nervous system-Opioids classified according to their mode of synthesis into alkaloids, semi-synthetic and synthetic compounds.originally named mu (after morphine, its most commonly recognised exogenous ligand), delta (after vas deferens, the tissue within which it was first isolated) and kappa (after the first ligand to act at this receptor, ketocyclazocine). -The classical opioid receptors are distributed widely within the central nervous system and, to a lesser extent, throughout the periphery, occupying sites within the vas deferens, knee joint, gastrointestinal tract, heart and immune system-Soon after the discovery of the opioid receptors, a series of endogenous ligands active at the receptors were discovered in brain extracts. -morphine penetrates the blood brain barrier slowly-morphine lipid soluble morphine), the drug travels quickly to the brain	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
		through the bloodstreamMorphine also binds to areas involved in the pain pathway (including the thalamus, brainstem, and spinal cord). Binding of morphine to areas in the pain pathway leads to analgesia (loss of pain).morphine binds to opiate receptors in certain areas of the brain. Those Parts are of the cerebral cortex, the VTA, nucleus accumbens, thalamus, brainstem, and spinal cord -Glucosamine occurs naturally in the fluid around joints and plays an importantly role in building cartilage-*regular use of glucosamine was associated with a statistically significant reduction in C reactive protein concentrations, which is a marker for systemic inflammation,This study adds to the growing body of evidence suggesting potential differences in inflammatory or anti-inflammatory properties of fatty acids in blood cell membranes	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #182, Lacy Fowelr, International Pain Foundation	Question 6	Various organizations and types of marketing strategies have been used through the nation and media to combat and sway the public without fully informing them of this vocabulary. Addiction and physical anguish is two separate issue and smooshing them into one is unethical and plain wrong. This marketing has created millions of uneducated providers and patients who are not aware of the difference due to miss leading wording. There are two types of opioid use disorder. There should be a break down of analgesics and which belong to which medication so each patient can be provided the correct medication.	Thank you for the comment. The report distinguishes between addiction and physical pain.
Public Reviewer #183, S. DANIELS	Question 1	I am in strong disagreement that opioids only provide small improvement in patients with chronic pain. Opioids NOT only provide significant improvement vs. placebo, they provide quality of life back [and] amp; desire to live in patients because pain is adequately managed [and] amp; treated to regain normal daily function back [and] amp; relieve much suffering. Opioids are extremely safe [and] amp; effective when adequately dosed [and] amp; the pain is therefore appropriately treated [and] amp; suffering ended to regain as normal as possible functioning back [and] amp; quality of life vs. placebo [and] amp; no opioid treatment. We have decades of case reports, evidence, studies [and] amp; real life experience going back to pre-Civil War that opioids are extremely safe, effective, with few side effects when taken exactly as prescribed [and] amp; monitored by primary care physicians with invested interest in the treatment of pain of disease [and] amp; incurable illness of their patients. Effectiveness has long been established [and] amp; the fact millions of Americans are effectively managed on opioids w/out side effects [and] amp; addiction, prove they are not only successful in managing pain appropriately, they also provide an end to unnecessary suffering we have the medicine to relieve [and] amp; should [and] amp; take an oath to treat. Opioids must continue to be used [and] amp; prescribed reasonably for the treatment of chronic pain management because they work exceptionally well in 99.5% of patients.	Thank you for the comment. The findings of the report are based on the published research as it meets the inclusion criteria.

Public Reviewer #183, S. DANIELS	Question 10	I have personal experience, knowledge [and] amp; real life firsthand experience that opioids not only are safe, but exceptionally effective in treating [and] amp; managing pain. As a nurse [and] amp; surgical tech, my career depends on knowing even moreso than physicians how important [and] amp; vital opioids are in providing pain relief [and] amp; giving quality of life back in chronic incurable pain patients. I personally witness patient [and] #039;s pain, demeanor [and] amp; quality of life change when their pain is treated appropriately [and] amp; adequately. When opioid treatment is reduced or not adequate, the patient suffers gravely [and] amp; inhumanely, including causing risk of heart attack, stroke due to rise in blood pressure spike [and] amp; severe depression [and] amp; stress on all body systems. It has become a stigma to treat pain in this country [and] amp; I [and] #039;ve seen patients on the verge of suicide from the depression, grief, agony [and] amp; relentless pro-longed suffering of not having adequate opioid treatment for their chronic pain [and] amp; disease. Doctors prescribe, we as nurses witness firsthand the change [and] amp; relief in patients in the hospital [and] amp; in care units [and] amp; nursing homes. I have worked 20+ years at all aspects of medical care facilities, including surgery centers, nursing homes, hospitals, private in home daily care [and] amp; physician offices [and] amp; cosmetic surgery care. The use of opioids was not only effective [and] amp; safe in the vast majority of all patients [and] amp; settings, it was truly life saving for people in chronic [and] amp; acute pain. Long acting [and] amp; short acting opioids are vital in medicine [and] amp; they should not be reduced, banned or reversed b/c less than 1% of patients have a genetic [and] amp; chemical propencity to addict. We have used opioids since pre-Civil War safely [and] amp; effectively [and] amp; prescription opioids are a necessity we cannot afford as a society to pretend we don [and] #039;t need when pain is a very real [and] amp; serious medical problem. Our bodies are highly fallible [and] amp; malfunction frequently [and] amp; disesae manifest [and] #039;s often in all age groups w/out discrimination. We cannot pretend sickness, disease does not suddenly exist or occur. It does [and] amp; will continue to w/more environmental causes [and]	Thank you for sharing your story, sorry to hear about your pain.

		amp; accidents [and] amp; simply as age dictates. Body [and] amp; organ pain is not imagined, strictly psychosamatic or simply faked. No patient I have ever met nor myself has chosen, picked or wanted severe, acute or chronic pain. No one chooses to be born with a disease that is incurable. I know because I was diagnosed w/a rare bladder disease [and] amp; interstitial cystitis w/Hulner [and] #039;s Ulcers through no fault or cause of my own [and] amp; w/out opioid treatment to manage the pain I would NOT have any quality of life [and] amp; be back to being bed ridden, vomiting non-stop, losing weight, unable to eat, think, function or leave the house, slipping into a deep despair wishing death b/c it would at least be relief. While opioids do not completely end pain in all patients, they make life liveable by regaining some simblance of a life [and] amp; quality of life back [and] amp; make it worth living again b/c pain is reduced [and] amp; minimized to at least function at some basic level. Every action, moment, step of life in a chronic pain patient [and] #039;s day is controlled by relentless, ongoing, non-stop 24/7 pain. There are no breaks, no time outs, no escape from it. The pain is a cage in [and] amp; around your body that you cannot escape. It is the vessel you are charged with carrying daily throughout life [and] amp; that vessel is stricken w/pain [and] amp; nothing can change it. Only proper [and] amp; adequate pain treatment can quell the non-stop raging storm that rages relentlessly in a chronic pain patient [and] #039;s organs [and] amp; body. It is their life [and] amp; opioids are the only way to manage that pain to make any activity [and] amp; daily function bearable. I suffered gravely through multiple surgeries, barbaric treatments w/no FDA approved treatment drug that cures my condition [and] amp; disease. I have to live w/it [and] amp; the excruciating pain it causes daily [and] amp; all the other symptoms [and] amp; hardships a chronic illness w/pain forces on a me. To make me suffer w/the pain is more cruel than death itself [and] amp; I know that firsthand now w/my own disease, but saw it daily in my career. I beg you to not pretend pain is not real or worthy of treating. It is [and] amp; millions of Americans take opioids safely [and] amp; effectively w/out a single side affect. I am one of them [and] amp; thank God daily we are an advanced enough nation to recognize pain as a	

		legitimate medical condition that deserves treatment [and] amp; realize suffering is unacceptable [and] amp; inhumane to do to any human when we have effective treatment for it, as opioids are. Purposeful untreated pain is inhumane, cruel [and] amp; almost sadistic to deny to treat effectively. We treat animals in veterinary care with more respect [and] amp; dignity than we are currently doing now to humans due the opioid epidemic [and] amp; subsequent hysteria. Our advanced nation has stepped back in time [and] amp; reversed course on treatment of pain [and] amp; made it taboo for physicians to continue to treat their patients with opioids when it should not be. We should be embarrassed [and] amp; ashamed that we are treating humans this way as the most advanced nation on earth. Allowing the suffering of the diseased, disabled, elderly, cancer ridden, children, sick [and] amp; injured to be left in agonizing relentless chronic pain b/c we fear they will addict is truly the epitome of ignorance [and] amp; the desire to [and] #039;help [and] #039; without proper course, education [and] amp; emotionless reaction. To leave these groups abandoned w/no relief simply b/c other people have another disease they don [and] #039;t suffer from is unimaginable but it [and] #039;s happening. Addiction in some cannot dictate how we treat others w/unrelated diseases [and] amp; conditions that are non-addicts. We cannot remove entire classes of medications b/c some have adverse affects to them when abused or misued. We do not take away sugar from all Americans b/c some are diabetics [and] amp; die of diabetes complications. That would be absurd. So why are we allowing the complications of some [and] #039;s disease to dictate how others are allowed to be treated with their own disease? Worse, why are we saying it [and] #039;s acceptable to leave others in undeniable relentless pain, as if that [and] #039;s somehow better than having someone suffering from addiction? Are we truly saying we are not only willing but ready to let the cancer ridden, celebral palsy, ALS, amputations, etc. [and] amp; everyone who needs surgery to just be abandoned w/pain care [and] amp; stop the use of opioids on, b/c there [and] #039;s a very small chance .05% of them might addict? Does that truly sound reasonable, rational or logical at all? Some of the things this report claims [and] amp;	

		purports are far from the medical community [and] #039;s experience. My own pain is significantly improved with the treatment of opioids, as well as that of all my patients. My collegues, the physicans I work w/agree [and] amp; have the same sentiment [and] amp; evidence based results in real life [and] amp; clinical setting. Addiction of some should not dictate treatment for completely different diseases in others. That is not how medicine works or should suddenly start to be. We should treat individuals as individuals, individually. Blanket regulations [and] amp; claims on all populations are not only inaccurate, but highly dangerous [and] amp; not scientifically based. Each patient should have individualized care based on their own set of circumstances, history, disease present [and] amp; prognosis. There are millions of painful diseases in this world that are incurable. To ignore that very real fact [and] amp; reality would be simply put, almost going back to the dark ages [and] amp; living in denial w/grave, inhuman consequences to all who is sick. The point of medicine is to TREAT disease, illness [and] amp; manage those that are not curable yet. We cannot do that w/out the use of effective pain opioid medications. Opioids exist, they are [and] amp; always have been an effective tool, treatment management in disease, symptoms, surgeries [and] amp; pain. Nothing will change that fact. History proves them effective. Millions of patients across America prove that, attest to it [and] amp; are living proof of it. You are [and] amp; will kill people removing [and] amp; restricitng these meds. You already have. People have committed suicide from the pain. People cannot be left in agonizing pain [and] amp; misery [and] amp; be expected to function in life [and] amp; live like that. Pain MUST be treated [and] amp; opioids are the best treatment [and] amp; option to control pain [and] amp; manage it. Quality of life must be considered. Living in pain is not living. We cannot ignore that reality [and] amp; stick our heads in the sand [and] amp; deny opioids to non-addicts b/c addicts exist! We must act within reason, conscience, morally [and] amp; ethically upholding our oath to do no harm to patients [and] amp; use our skills, medical degree to end [and] amp; ease suffering. Pain will always exist [and] amp; opioids have long been an effective tool management [and] amp; control for diseased patients. These	

		decisions should not be left up to people who don [and] #039;t know the patient [and] amp; that [and] #039;s sitting behind a desk in Washington or on a PROP board that are biased [and] amp; with known highly conflicted interests. Personal PCP [and] #039;s should be allowed [and] amp; given the legal leway they [and] #039;ve always had to prescribe [and] amp; treat as they see fit for each [and] amp; every individual patient they examine [and] amp; treat. A patient [and] #039;s own doctors are the best persons to decide who [and] amp; what [and] amp; how much of a medicine a patient needs. To remove opioids from their tool bag would be dangerous, a knee jerk [and] #039;feel good [and] #039; reaction to a completely unrelated problem [and] amp; be ineffective at helping addicts, as we [and] #039;ve already seen. Addicts need treatment [and] amp; have nothing to do w/non-addict [and] #039;s diseases [and] amp; pain that the disease causes. To lump the two together is highly inaccurate [and] amp; problematic claim [and] amp; history has proven the last 10 years, reducing, restricting prescription opioids in non-addicts has done NOTHING at all to curb addiction [and] amp; instead has caused completely innocent non-addicts to suffer gravely in a cruel, inhumane manner. I beg you as a medical provider [and] amp; health care worker [and] amp; as a patient w/an incurable painful disease that has been proven [and] amp; studied to have worse pain than end stage renal failure, do not further restrict opioids hastingly. It won [and] #039;t work to help addicts or curb addiction, as the last several years proves; it will only hurt, harm [and] amp; send already suffering [and] amp; severely hardshipped individual [and] #039;s further into despair, depression, suicide [and] amp; no reason or will to live if they have to try to exist in a world w/excruciating [and] amp; severe, ongoing, incurable pain is not treated adequately [and] amp; swiftly as in anyone else [and] #039;s disease is [and] amp; should be. I BEG you. I plead w/you. I pray to God you have to realize PAIN is no joke, REAL [and] amp; worse than death itself if let untreated or ignored. None of us escape disease, pain, illness [and] amp; it will be you one day, your child, your parents, your siblings that need pain relief [and] amp; will be denied b/c someone else is an addict. Trust me [and] amp; millions of Americans that has had this	

Section	Commentator & Affiliation	Comment	Response
		happened to us since the opioid hysteria, it is CRUEL, INHUMANE, SADISTIC [and] amp; 100% UNNECESSARY forced suffering to people who did nothing wrong but be born w/a disease they didn [and] #039;t ask for or want. It could [and] amp; will be you one day. You will expect your doctor to treat you w/dignity, respect [and] amp; compassion using every tool in his modern day medical bag to relieve your suffering. To do anything else would be going back 100 yrs in medicine [and] amp; the dark ages. PLEASE understand we cannot escape the very real reality of painful disease [and] amp; must treat it or we mine as well set up euthanisia clinics, b/c that would be less cruel than denying pain managing opioid treatment. Thank you kindly for you time [and] amp; consideration on the very real [and] amp; personal topic of opioid efficacy use. I 100% stand by my statement as 100% accurate, true [and] amp; honest w/real life [and] amp; firsthand experience [and] amp; would testify under oath to every single patient I have seen lives helped, managed [and] amp; treated [and] amp; given life back to from pain [and] amp; misery of agonzing painful symptoms of incurable disease, including my own by opioid treatment. God Bless [and] amp; please may God compel you to act on behalf of pain, disease, cancer vs. fear [and] amp; the need to [and] #039;do more [and] #039; without evidence, facts, NIH stats or real life patient feedback [and] amp; those that treat pain every single day for several hours a day the last 40-60+ yrs. Amen	

Public Reviewer #183, S. DANIELS	Question 3	The methods used are highly concerning [and] amp; fall short in several areas to address the wideness of opioid use in differing conditions that cause [and] amp; manifest as chronic pain. Age, history, disease type, pain type, pain presentation, pain duration, how long pain has been present, intiation of pain, pain origin, gender, weight, blood pressure, heart rhythem, body type, outstanding illnesses, previous treatments, surgeries, etc., injury or genetic or disease type, [and] amp; a multitude of other factors in each individual patient that needs consideration that this method leaves out [and] amp; fails to show consideration for; [and] amp; fails to mention the fatal flaw as such in counting on these methods to be anything more than anecodately based on the subjects studied only. Without study [and] amp; evidence from every chronic pain patient with consideration for each [and] amp; every factor mentioned above, it is impossible [and] amp; would be highly presumptive [and] amp; flawed to use this sample as a widespread base or determining factor result for all chronic pain that exists, or surmise conclusions on chronic pain treatment for all with opioids. Each [and] amp; every single human is different [and] amp; should be considered [and] amp; treated as individual patients. What works effectively in one, may not in all; but we long well have known [and] amp; established that opioids are effective [and] amp; do safely treat chronic pain in a vast majority of patients w/evidence far over reaching this report [and] #039;s small sample base. Even the sample based used, surmised opioids were in fact effective, however small. They were proven effective nonetheless in this report vs. placebo. One disease pain does not react to treatment as it may in another. We know this as physicians [and] amp; scientists [and] amp; nothing will change that fact. It would be a grave mistake [and] amp; fatal error [and] amp; misjudgement to take only a small sample source w/out consideration of the disease or illness the opioid is treating. Not too mention, it doesn [and] #039;t consider how many patients have several disorders, pain [and] amp; diseases combined [and] amp; therefore have a complex pain [and] amp; symptom presentation [and] amp; manifestation [and] amp; can [and] #039;t be quantified or broken down by the methods presented in the report. As such, I stand by	The Tables summarize information regarding the pain condition, duration of pain, prior opioid use status, baseline pain, age, female, and race/ethnicity. Information wasn't provided on the other variables mentioned by the reviewer. Stratified analyses were conducted on pain condition, showing little impact on most estimates. The report also summarizes information on the effects of patient demographics, clinical characteristics, and patient comorbidities, which was very limited.

Section	Commentator & Affiliation	Comment	Response
		my declaration that this report [and] #039;s methods are highly concerning to use as any real life comparison outside the sample base [and] amp; at best, prove that opioids do in fact work effectively on chronic pain in this sample of patients, [and] amp; therefore likely provide effective pain relief in most chronic pain patient populations.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #184, Mr.	Question 10	It [and] #039;s mentioned that the AHRQ was a basis for the 2016 CDC Guidelines for Opioid Prescribing. From the little I [and] #039;ve seen, as a layman with nothing but empirical observation of 40 years to rely on, it seems the HHS critiques on the methods and weak evidence contained in the 2016 Guidelines were well founded. My better half has been relying on some form of opioid pain medication since the late 1970s which enabled her to participate in many, many activities of normal life, including hiking in the Sierras, going on a trip to Europe, attending concerts, gatherings of family and friends, etc. Now, after a severe tapering of pain meds commencing October of 2018, she is 90% bedridden, just trying to find the least painful position as possible. And not only increased pain but fatigue is now so easily brought on. A few minutes in the kitchen makes her so tired she has to go back to bed. She also has to take additional meds not taken before (including acetaminophen, nearly useless, gabapentin,etc.) as a way to make up for the lack of proper pain treatment.Sometimes it seems to me that scientific methods cannot tell the whole story. It [and] #039;s like looking at stark black notes on a page of music to determine if Mozart was better than Salieri and not bothering to ask concert going audiences who they prefer.	Thank you for sharing your story, sorry to hear about your pain. Context must always be considered when implementing scientific findings.
Public Reviewer #185, Tamera Stewart, C50	Question 1	Our organization found this entire evaluation of the evidence used for and since the CDC Guidelines a sham. The evidence that was reviewed was once again older or biased data that was likely pre selected due to it neatly fiting the desired outcome. I have broken down the quality level of the reviewed studies into 2 charts and attached them with comments regarding each.	The attachment (#16) was reviewed. It was not possible to determine the methods that the reviewer used to evaluate evidence, classify results, or synthesize the information. Our report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included stakeholder and public input. Studies were identified using systematic methods and selected based on application of pre-defined inclusion criteria.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #185, Tamera Stewart, C50	Question 10	This entire draft report seems to be focused on reinforcing the 2016 CDC Guidelines by using the same or even lesser quality data than were used by the biased and not qualified [and] #039;core expert group [and] #039; that was used to create the 2016 CDC Guidelines. The CDC, HHS, FDA, and other federal agencies as well hundreds of state, national, and even international organizations have spoken out about the very harms that this document minimizes and attempts to ensure these dangerous policies are continued and even taken further. This cannot be allowed to stand, this review should be rewritten to reflect the need for individualized treatment above profit and population health. That could be accomplished by using the evidence cited by HHS Pain Management Task Force and aligning these recommendations with their final report which has been submitted to Congress. This document represents an abysmal failure and embarrassment for the AHRQ and the CDC who has continued to allow this and other organizations to push further than their self admitted failure of the CDC Guidelines. I suspect when the final report is released and the [and] #039;experts [and] #039; are revealed they will be just as biased as the CDC Guideline creators which have already been exposed.	Thank you for the comment. The report synthesizes the available published literature.
Public Reviewer #185, Tamera Stewart, C50	Question 2	Due to this draft report being over 200 pages long by itself, without reviewing each individual paper or study cited as evidence our organization feels that it is impossible to give an accurate comment that would reflect the pain patients position in such a short time. Even with an increased timeline, such as the length required to comply with federal laws for similar reviews that will affect such a large and vulnerable population, it would be extremely difficult to provide the feedback AHRQ is likely hoping to receive due to the cited evidence seems to greatly contradict our daily experiences.	Thank you for the comment. AHRQ followed standard posting processes for draft evidence reviews.
Public Reviewer #185, Tamera Stewart, C50	Question 3	The method for this entire review revolves around secrecy and out of date information that focuses on population health (with incorrect conclusions) instead of the all important individual health and health outcomes.	The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #185, Tamera Stewart, C50	Question 4	Again I repeat that our organization, which represents tens of thousands of the very patients that this review is claiming to want to protect and provide better evidence based care for, disagrees with the majority of the results as they often directly focus on population health and the conclusions were reached by evaluating cherry picked data that likely met a predetermined outcome. Our cases should each be reviewed individually and based on individual clinical factors instead of biased guidelines that have already proven to do more harm than good.	Thank you for the comment. The report synthesizes published research on the benefits and harms of opioids.
Public Reviewer #185, Tamera Stewart, C50	Question 6	This entire document was worded in such a way that precluded most patients from being able to provide a comment that would be of value, which is likely the reasoning behind the secrecy, wording, and short time frame to comment.	The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input. The standard process for posting of the draft report was followed.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #19, Lisa Egan	Question 10	Opioid pain medications are extremely helpful for many people. Without opiate pain medication I was bed bound for over 2 years! When I was finally put on a pain medication (after years of trying everything else from physical therapy to biofeedback and none of it worked!) I got a part of my life back. I was finally able to take care of myself for the most part. With Legal prescription opiate pain medication, I was finally able to get out of bed and do things! There are millions of people suffering right now because of lying [and] quot;doctors/scientists [and] quot; and false reports like this that are to blame for them being taken off their medication. After the CDC guidelines came out I was abruptly dropped by my doctor and thrown into withdrawals, on top of my pain. I didn [and] #039;t think I was going to make. Fortunately, I was able to find another doctor quickly and be put back on my meds. Unfortunately, now I have to deal with ignorant pharmacists who refuse to fill my medication and my insurance company who is unlawfully practicing medicine without a license by refusing to cover my medication because they think it is too much. Question, was anyone who had anything to do with making these false accusations about pain medication an actual chronic pain patient? I [and] #039;m guessing not because there are millions of chronic pain patients who disagree with everything in your Fake report! Please Stop Killing Us!!!	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 1	The CDC and the FDA have put out warnings to never force a patient off a medicine they have taken for as long as I have been made to take this medicine. The irreparable harm being done to my health, I am scared, I will end up totally bed ridden. I ask you to please help me to live the decent life I WAS LIVING without the pain of this disease. I have MRI [and] #039;s and X-Rays and any other medical records you are welcome to view, I thank you for your time and help in this matter. I have been given NO alternative medicine to deal with the pain I have been treated INHUMANELY since this all began. fior doing NOTHING MORE than being born with a RARE GENETIC DISEASE THAT HAS NO CURE	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 10	Its important to adequately treat a patient in pain, as studies show that inadequately treated pain can lead to the stress response being triggered, Almgren said. A triggered stress response can impact the patients overall recovery, including tissue healing, ventilation and gut motility. But inadequately treated pain and addiction are not necessarily a cause and effect relationship. Someone who is biologically wired for addiction may have poor pain control and go on to develop addiction problems, while another patient with no predisposition for addiction, given equally poor pain control, will have no issues.Despite the backlash the guidelines have received from professional organizations and patients, little has been done to change them, Jay concluded. [and] quot;Months after the FDA and CDC statements, pain physicians and pain patients are still not sure if anything changed, [and] quot; he said. [and] quot;While they stated the guidelines were used inappropriately, nobody has made them appropriate. [and] quot;	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 2	I AM no longer able get the exercise I need that kept this disease from building up in my joints, it is now eating away all the cartilage-turning my bones black, causing my urine to turn black. I do not wish to become dependent and more sickly, when I was so independent for so many years. I have no where or one to turn to. PLEASE I NEED HELP! I bought my own home in my early thirties, I was the first female camera operator doing ENG field work in Los Angeles, I have a FCC 1st Class Radiotelephone License that entitled me to run and operate any television or Radio station in America. Yet, after I bought my land and home, I found out- after four botched surgeries, that I had a rare genetic bone disease that was non operative and has no cure. I still was able to stay independent, Until, the misapplied CDC Guidelines forced me off a medicine I had been taking responsibly and safely for over twenty-six years- This has caused this disease to now, start attacking my heart, liver, kidneys and rest of my cervical spine. I pray that revision of CDC Guidelines and allowing doctors to do their jobs without being persecuted will give me back my life and I can grow old with dignity. Please watch this video if you have any questions about my disease : https://www.youtube.com/watch?v=7PpQU3wrdIM [and] amp;t=30s	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 3	I am having great harm done to my health. Being forced off a medicine dosage, I had been prescribed safely for over twenty-six years. I need to be tapered off this drug SAFELY so as to cause NO HARM to the genetic bone disease, Alkaptonuria/Ochronosis, rare genetic disease which causes bones to go black and brittle hence why its also called black bone disease. AKU is caused by a missing enzyme which means patients cannot fully breakdown a toxic acid called homogentisic acid (HGA). HGA attacks bones and cartilage, causing severe pain and disability as life progresses. The way I have been forced off a medicine I had taken for so long is hurting my heart along with causing the HGA levels to attack my bones even more than they already have. The stress of not getting my pain medicine is causing my body to over-produce the HGA that attacks and eats away at my bones - my urine has turned black- I need help- I don [and] #039;t not enjoy needing this pain medicine! I hate I trusted my doctor and took a medicine that is NOW causing so much harm to my health - by being denied this medicine my disease is spreading and spreading there is NO CURE for this and I can not bear this pain if it is allowed to get much worse. How can a government be allowed to intervene in such a harmful way! Causing this disease to spread even more through my body. OCHRONOSIS causes bones to grind against each other cutting into my nerves, causing my right or left side of my body to be paralyzed it [and] #039;s a severely painful disease, every joint in my body is hurting me now! The only treatment that is listed, for this disease is pain medicine- there is no cure for this disease. Ochronosis is perhaps the oldest known metabolic diseases on the planet- found in Female Egyptian Mummies. I wish to go back to my life- without the pain of this debilitating disease, as, I was living- before all this [and] quot;opioid crisis [and] quot; began. I have been abandoned by my doctor, he retired after pressure from the state, I have been treated like a criminal at my pharmacy, that I had gone to for over thirty years, one day, I am their loyal customer, and the next, they were treating me like a some kind of criminal. I was forced off my medicine dosage and Because of these mis-applied rules by the CDC, the rare incurable bone disease OCHRONOSIS/Alkaptonuria, is getting worse and	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
		worse by the day! I do not want to become totally bed ridden suffering a life with the debilitating pain of this disease that turns your bones black after it eats away all the cartilage between the bones causing them to grind and scrape against each other , it has attacked the valves to my heart, my kidneys and liver. And, now my entire cervical spine has been totally damaged. The doctor I had for 32 years was able- having me change my diet, do chiropractic adjustments, and cortisone shots, and water exercises, was able to keep this disease from spreading, it had stayed in my neck and hip for over twenty-six years, but, now it is spreading down my spine. By being denied my pain medicine dosage -without being able to ween off of it SAFELY at required 10% at a time , and being made to live in total pain day and night, causing much HARM TO MY HEALTH	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 4	I am having great harm done to my health. Being forced off a medicine dosage, I had been prescribed safely for over twenty-six years. I need to be tapered off this drug SAFELY so as to cause NO HARM to the genetic bone disease, Alkaptonuria/Ochronosis, rare genetic disease which causes bones to go black and brittle hence why its also called black bone disease. AKU is caused by a missing enzyme which means patients cannot fully breakdown a toxic acid called homogentisic acid (HGA). HGA attacks bones and cartilage, causing severe pain and disability as life progresses. The way I have been forced off a medicine I had taken for so long is hurting my heart along with causing the HGA levels to attack my bones even more than they already have. The stress of not getting my pain medicine is causing my body to over-produce the HGA that attacks and eats away at my bones - my urine has turned black- I need help- I don [and] #039;t not enjoy needing this pain medicine! I hate I trusted my doctor and took a medicine that is NOW causing so much harm to my health - by being denied this medicine my disease is spreading and spreading there is NO CURE for this and I can not bear this pain if it is allowed to get much worse. How can a government be allowed to intervene in such a harmful way! Causing this disease to spread even more through my body. OCHRONOSIS causes bones to grind against each other cutting into my nerves, causing my right or left side of my body to be paralyzed it [and] #039;s a severely painful disease, every joint in my body is hurting me now! The only treatment that is listed, for this disease is pain medicine- there is no cure for this disease.	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 5	Ochronosis is perhaps the oldest known metabolic diseases on the planet- found in Female Egyptian Mummies. I wish to go back to my life- without the pain of this debilitating disease, as, I was living- before all this [and] quot;opioid crisis [and] quot; began. I have been abandoned by my doctor, he retired after pressure from the state, I have been treated like a criminal at my pharmacy, that I had gone to for over thirty years, one day, I am their loyal customer, and the next, they were treating me like a some kind of criminal. I was forced off my medicine dosage and Because of these mis-applied rules by the CDC, the rare incurable bone disease OCHRONOSIS/Alkaptonuria, is getting worse and worse by the day! I do not want to become totally bed ridden suffering a life with the debilitating pain of this disease that turns your bones black after it eats away all the cartilage between the bones causing them to grind and scrape against each other , it has attacked the valves to my heart, my kidneys and liver. And, now my entire cervical spine has been totally damaged. The doctor I had for 32 years was able- having me change my diet, do chiropractic adjustments, and cortisone shots, and water exercises, was able to keep this disease from spreading, it had stayed in my neck and hip for over twenty-six years, but, now it is spreading down my spine. By being denied my pain medicine dosage -without being able to ween off of it SAFELY at required 10% at a time , and being made to live in total pain day and night, HAS CAUSED GREAT HARM TO MY HEALTH, I AM A LAW ABIDING RESPONSIBLE CITIZEN - I DO NOT DESERVE TO BE ABANDONED MY MY COUNTRY IN SUCH INHUMANE WAYS!!	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 6	It is now apparent that the whole of US regulatory and law enforcement policy on prescription opioids is founded on a mythology. Prescribing didn [and] #039;t create our [and] quot;opioid crisis [and] quot; in the first place and most certainly isn [and] #039;t sustaining it now. Both the overdose trends and the demographics strongly contradict this assertion. I find it simply appalling that senior managers at HHS, CDC, FDA and DEA are willing to continue killing patients by misdirected suppression of medical opioids, when the [and] quot;real [and] quot; problem is street drugs and economic despair. This is madness.	Thank you for the comment
Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 7	Patients who have been on high doses of opioids, who have had little negative effects from those drugs and are doing well with good quality of life, are being forced by their doctors to reduce doses often with no discussion against their will. Some are turning to the black market and others are deciding upon suicide.These policies defy and run counter to all that modern society has deemed to be ethical in medical research.If this experiment was being conducted by universities, it surely would be disallowed as all research on humans must first be approved by independent research ethics boards. Any research that resulted in an increase in suffering, disability, and/or deaths of human subjects would never be approved.	Thank you for the comment
Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 8	If federal agencies and the media told the truth, they would make it clear that prescriptions are at an all-time low while overdoses are at an all-time high (and expected to climb) and yet they still claim that most overdoses are the result of prescription opioids, and they continue to tout the success of their guideline and dare to call it evidence-based. After being exposed to some of the more moderate experts who have loudly dissented to the implementation of the unscientific guideline, do you believe its evidence-based or is it possible there is another agenda at play here?	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #2, Virginia Brandford, SSDI legitimate patient who has been treated inhumanely	Question 9	Unscientific Guidelines: Why did the CDC seek out the advice of mostly radically biased addiction psychiatrists, who are not trained in pain medicine, instead of actual pain medicine experts; especially considering that some may have had some glaring conflicts of interest? As Dr. Lawhern pointed out, there could be criminal intent at play here and that possibility needs to be deeply explored.	Investigators working on AHRQ reports and stakeholders who provide input complete disclosures of interest and are not permitted to participate if they have significant financial or other conflicts. The final report will include conflict of interest disclosures for investigators.

Public Reviewer #20, Martha Stanley	Question 5	As a Retired Hospice Nurse, and Chronic Pain patient, I am expressing my concerns with this report as there have not been long term studies of Chronic Pain and opioid benefits vs negative outcomes. I tried every convention of pain relief before turning to medical professionals. Over the counter NSAIDS for years leading to chronic gastritis and being told by Gastroenterologist to NEVER take another NSAID (yet current political involvement in medical care PUSHES NSAIDS. When I did seek medical help for pain it was undertreated for several years while pain levels increased. Finally referred to Pain Specialist. I have had numerous injections in my spine and sacrum with little relief yet setting me up for the disease from hell, Arachnoiditis. The ONLY relief I have had is the mix of Lyrica for nerve damage, Opioids, and Ativan for sleep. I have been kep at minimal dose therapy for two years and the undertreated pain (lack of increasing Opioid in the reign of terror on physicians/patients) has created Chronic Pain Syndrome. While my bones deteriorate, as well as joints due to multiple chronic diseases, my pain remains undertreated. I want a quality of life and that cannot be achieved while I suffer on a daily basis. The political goal, I realize, is to reduce opioid usage based on government need to show parents of overdosed children that something is being done. The initial focus should have been on the illicit market. But it was not done. CDC was commissioned to do a study (very faulty, biased study). And the avalanche of studies supporting CDCs. I find your study lacking in evidence based information. Coroners should be held accountable for distinguishing overdose deaths as those from heroin, fentanyl, meth, alcohol, street opioids vs medically prescribed opioids. Patients of Pain Clinics need to be included in studies. The people left suffering from pain who have used every resource being pushed by government yet with little benefit. I have used Accupuncture, Accupressure, Massage, Chiropractic, PT and exercise (I do yoga every day and push thru the pain most days. Unbearable to do 2 out of 7 days. Ive blown my gastric system with NSAIDs (being pushed by government). Ive done it all. And in tpresent, the ONLY relief I have is from my too low dose opioid therapy. Why cant my last few years be in comfort so I can interact more with my grandchildren vs spending my days trying to cope with the pain? I	Thank you for sharing your story, sorry to hear about your pain. The report notes the need for future research in long-term outcomes

Section	Commentator & Affiliation	Comment	Response
		dont know why I am writing. I guess I have a tiny sliver of hope that someone with compassion will hear me. Hear US. Chronic pain patients around the US are suffering because of the unavailability for physicians to treat each of our unique medical circumstances like they use to before CDCs faulty guidelines and the governments quick policies to alter our lives forever. Little regard for quality of life. History will show that a genocide was created in the aged community of chronic pain sufferers. Pain does kill. And it is a torturous way to live. My country has failed me and millions of others. We are NOT drug addicts, but some may turn to illicit market for relief. Or to suicide for relief. Because access to opioids that work has been limited.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #21, Sonia Bodie, State and Nationally Registered Paramedic	Question 1	WHERE and WHO did you receive your [and] quot;evidence, [and] quot; from? It [and] #039;s also quite evident that the [and] quot;experts, [and] quot; names have been conveniently withheld!? This is pathetically and emphatically FLAWED and ERRONEOUS!! There is absolutely no supporting validity of this extremely cherry picked report! This is most harmful and results will be SEVERE and WIDESPREAD!!	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Public Reviewer #21, Sonia Bodie, State and Nationally Registered Paramedic	Question 10	This is a daunting and formidable task to be heard! Why must the innocent continue to suffer in untold measures because of untruths AND WRONGFUL NJMBERS in epic proportions? What follows is my story: A Captain at a very busy fire department, an instructor with SC Fire Academy and employed with Homeland Security. This was my spouse [and] #039;s life for seventeen years. He and I both had busy careers in public safety. I [and] #039;m a firefighter/medic. One morning, after getting off of a particularly grueling twenty four hour shift, decided to drive up to some property we own to put out a trail camera to observe the wildlife. We had ridden our four wheeler many times before but this day a grave mistake was made! Whether it was being tired, careless or just a sense of invincibility, I [and] #039;ll never know, but up an extremely steep hill we went. We [and] #039;d made it almost to the top when suddenly the four wheeler lurched, rolled and threw us both off violently! I sustained an open tibia, fibula (lower leg) fracture that required surgery to repair. My husband fractured C 5, 6, and 7. His neck was broken. Life as we knew it came to a screeching halt! It was like a nightmare that just wouldn [and] #039;t end. Our world now encompassed extensive surgery, including cadaver bones, pins, screws and of course a halo. WAIT! This happens to the people we care for, not us! But yes this time it was the protector that needed protection. His career was put on hold. He thought if he did exactly what the physicians said, to the letter, It would be just a matter of time before he [and] #039;d be back to work and [and] quot;normal [and] quot; life! The pain in his neck was mind boggling in addition to the numbness in his right arm and hand. He began physical therapy four to five days per week. The pain continued! Prescription anti-inflammatories, TENS (transcutaneous electrical nerve stimulation) ice and heat therapy. He tried them all. Relief was not to be. All the while thinking his career was just a short step away. I was recoverd and back to work. My strong,NEVER sick, NEVER took medication husband was slowly becoming a man I barely knew! The severity of the pain had completely changed him. After one year his neurosurgeon gently told him his part in his healing was over and he wouldn [and] #039;t sign any medical clearance for him to return to full fire	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
		fighting duty. My husband looked at him somewhere between shock, horror and bewilderment. With tears streaming down his face, a voice so soft and cracking. He asked, [and] quot;what do I do now, I [and] #039;ve been a fireman since I was eighteen years old and when will this non-stop agony end? [and] quot; I couldn [and] #039;t believe things would get worse but they certainly did. Talk of suicide started swirling. He shut down! I cannot count how many times I came home, from my twenty four hour shift, to find him in a ball on the floor in horrific pain. The straw breaker occurred one cold, windy, gray morning. I [and] #039;d arrived home from work to find him sitting at the kitchen table with a pistol lying beside him. I felt a bone chilling coldness course through me! I couldn [and] #039;t find my voice! He whispered, in a tone I [and] #039;d never heard, [and] quot;I will NOT continue to live another day, not one single more, in this much agony! [and] quot; The little hairs on the back of my neck stood on end! I IMMEDIATELY contacted the doctor, who got him in that day, to see a neuro pain specialist. This was the beginning of a new day, a new life. I [and] #039;m SO grateful for this physician! I cannot say his torment ended on the spot because it wouldn [and] #039;t be true. There were medications started and stopped but after three months they had a medication regiment that worked for him. There are monthly urine drug tests, visits with the psychologist and then he sees the physician. This is a new season, one that includes opiates. They are taken exactly as prescribed and kept securely locked in a fireproof safe. I [and] #039;m one of many, who daily give their ALL to save those who have chosen to smoke, snort or ingest, mostly illegal, opiates for a life ending high! I come home to my best friend, one who opiates have literally saved his ! I [and] #039;m SO fearful of what will happen if his medication is lowered or stopped because of new, yet severely antiquated laws. The persecution of the innocent, who require these life giving medications must cease! My husband, who saved so many, his VERY life depends upon it and HE [and] #039;S IMPORTANT TOO!	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #21, Sonia Bodie, State and Nationally Registered Paramedic	Question 2	It is MOST FRIGHTENING to ascertain the preamble or any other portion of this report as factual information! It has been proven again and again that opiates are extremely helpful for chronic pain patients. The fallacies that are being presented, in a radically and biased [and] quot;research, [and] quot; is as horrendously damaging as they come! The innocent will CONTINUE to pay for these absolute untruths!	Thank you for the comment
Public Reviewer #21, Sonia Bodie, State and Nationally Registered Paramedic	Question 3	The methods segment is sheer barbarism at it [and] #039;s finest! [and] quot;Broad expertise and perspectives, [and] quot; by WHOSE And WHAT STANDARDS? Independent peer reviewers? WHO are they? It [and] #039;s MOST EVIDENT the tragic harm thats been inncited on so many innocents as a result of the 2016 report! As an 18+ year health care provider, I [and] #039;d like to know how can those who are supposed to be expert authorities [and] quot;and first do harm, [and] quot; lie down and sleep at night knowing the horror they are privy to along with the agony and DEATHS THEY ARE COMPLETELY RESPONSIBLE FOR because of [and] quot;their methods!! [and] quot;	The list of stakeholders and peer reviewers will be published when the final report is published.
Public Reviewer #21, Sonia Bodie, State and Nationally Registered Paramedic	Question 4	Just when I thought I [and] #039;d read and studied the utterly ridiculous innaccuracies and deceptions above, then I read the result portion!? Instead of documentation from ignorant [and] quot;no named experts, [and] quot; with pickings here and there from unsound [and] quot;studies,! [and] quot; why aren [and] #039;t these very same questions put forth to genuine chronic pain patients, speciality trained pain management physicians, and other health care workers?	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #21, Sonia Bodie, State and Nationally Registered Paramedic	Question 5	Two studies, three trials etc. an expert does not make! If non-opiate therapy was or had been effective, then this [and] quot;report [and] quot; nor any other in similarity would exist! PERIOD! How can those who are so [and] quot;educated, [and] quot; not PLAINLY see that opioid prescriptions for the elderly and chronic pain patients have dropped to their very lowest in years yet the overdose rates in younger people continue to SOAR SECONDARY TO ILLEGAL FENTANYL AND HEROIN FLOWING FREELY into the United States FROM CHINA AND MEXICO. Control those dire issues and your [and] quot;research and reports [and] quot; will look quite different!!!	Thank you for the comment
Public Reviewer #21, Sonia Bodie, State and Nationally Registered Paramedic	Question 7 and 8	PATHETIC!! I have no idea how else to respond. Along with the no named experts the references are at best shady, minimal and extremely vague! They have been hand picked here and there from anywhere that fits the desire that must be metted.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process. Similarly, the list of stakeholders and peer reviewers will be published when the final report is published
Public Reviewer #21, Sonia Bodie, State and Nationally Registered Paramedic	Question 9	Again very vague, no one wants to own up to ANYTHING because they know this report and [and] quot;research [and] quot; is flawed and erroneous. The HARM BEING ACCOMPLISHED is beyond words!	Thank you for the comment
Public Reviewer #22, Ronda Bruse, Mrs.	Question 1	Evidence for me someone who [and] #039;s lived severe excruciating crying pain is IT works best, excuse me but this is life or Death to me I want to shower, smile etc all the thing most take for granted! Lived 17 years of a CP nightmare had all treatments to no avail the only thing that has helped is opioid therapies.	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.
Public Reviewer #22, Ronda Bruse, Mrs.	Question 10	Reverse narratives so severe CP can be treated properly thank you!	Thank you for the comment
Public Reviewer #22, Ronda Bruse, Mrs.	Question 2	Need my meds or I will be bed bound crying unable to move until my heart gives out from under treated pain.	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #22, Ronda Bruse, Mrs.	Question 3	Severe unrelenting unimaginable torturous pain conditions deserves recognition. Nobody should be left this way crying their life away literally	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.
Public Reviewer #22, Ronda Bruse, Mrs.	Question 4	Opioid work better than Any other treatments	Thank you for the comment
Public Reviewer #22, Ronda Bruse, Mrs.	Question 5	Severe pain deserves recognition and proper treatment	Thank you for the comment
Public Reviewer #22, Ronda Bruse, Mrs.	Question 6	Praying for the narratives to be reversed unimaginable pain deserves recognition most of all it deserves proper treatment..	Thank you for the comment
Public Reviewer #22, Ronda Bruse, Mrs.	Question 7	Let [and] #039;s let doctors manage patients pain as god intended	Thank you for the comment
Public Reviewer #22, Ronda Bruse, Mrs.	Question 8	Opioids are most definitely needed in this country.. Painful diseases deserve the treatment that best helps manage them	Thank you for the comment
Public Reviewer #22, Ronda Bruse, Mrs.	Question 9	Please help I deserve to live!	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #23, Robert Rust, MD ABAM FASAM, NA	Question 10	Opioids work for chronic pain. Physicians or adminstrators who tell you differently have not practiced medicine for many years. I fully agree with what Richard Lawhern and Dr. Andrea Trescot have submitted to your site. The CDC guidelines were not scientific or evidence based, as their own letter of May, [and] #039;19 reports, they misguided readers into reducing medications or weaned completely. They need to be discarded as scientifically inappropriate, focused incorrectly on an opioid OD epidemic that was due to non-medical illicit use, not physician prescribing, as proved on the Lawhern website and presentation to yourselves by Richard Lawhern, PhD and Dr. Andrea Trescot, with which I fully concur.1) Consult the UK publication EVIDENCE BASED CHRONIC PAIN MANAGEMENT for references on the benefits of opioids.2) Belbuca, an opioid, was FDA approved for chronic pain on the basis of evidence based studies of its effectiveness. Buprenorphine is schedule lll, and approved for pain in many forms. Even with IV abuse, there has only been a single death (Invidior) in an elderly patient when not combined with other sedative meds like alcohol or benzodiazepines.3) The effects of opiates are clear to anyone, including practicing medical providers. First they sedate, then cause sleep, then respiratory depression, followed by respiratory arrest and death. At a point early in the process, they reduce pain. Titrated to appropriate doses, they help decrease functional limitation of patients and reduce pain, especially when prescribed as part of a program of multidisciplinary treatment for pain. Maintained effectively the sedation they initially cause subsides, and the DOT allows driving a commercial vehicle while chronic pain is managed. Patients who have had doses reduced or discontinued will be happy to explain how well their pain effects were working. We doctors and other providers never needed or need now someone to tell us they are effective. It is self evident.	Thank you for the comment. Trials of buccal buprenorphine (Belbuca) were included and results were similar to other opioids with regard to efficacy. Evidence on the comparative overdose risk of buprenorphine versus other opioids is lacking.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #24, Joseph Rietdorf	Question 1	The real experts are the ones who [and] quot;experience [and] quot; the effects of opiate pain medications. If I was looking for a honest assessment of what effect the drug has on the patients, I would obviously ask the patient. This entire argument is missing a foundation of proof. As is the entire War on Opiates is in our government.	Thank you for the comment
Public Reviewer #25, Pamela Aylor	Question 4	I would like to report that I have taken prescription opioids on and off for 12 years and they were very beneficial to me. I was able to do everything I wanted for most of that time. I traveled, enjoyed a busy social calendar, did volunteer work, and took care of myself without a problem. At no time did I enjoy a high, nor did I crave more or divert medication. Ive never failed a urine test or doctor shopped. Before being placed on opioids I tried Voltaren, gabapentin, other nsaids and muscle relaxers without relief. I have cervical fusions; posterior c3-7, and anterior c5-7 which were done in 2008. By 2010 I was diagnosed with Failed neck surgery syndrome. I have taken everything from Tramadol to Fentynal patches for my pain without a problem other than constipation! Please understand there are millions of other pain patients just like me. Stop the interference between my doctor who knows me personally and me! We havent had any problems at all.	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.
Public Reviewer #26, jane Doe, We will hunt all of you anti opiod zealots down. org.	Question 1	American patients in pain do NOT agree with any of your anti opiod stances with NO author identification, while pushing the now debunked and discredited KREBS junk science paper.	Thank you for the comment
Public Reviewer #26, jane Doe, We will hunt all of you anti opiod zealots down. org.	Question 10	EVERY. SINGLE. ONE. OF. YOU. that are at the executive and committee levels where you committed crimes against humanity pushing anti opiod policies that have killed and harmed us all WILL be called to account in and out of a court of law. Make no mistake: You are Nazis. I mean that literally as someone who lost half my family in the Holocaust. YOU KNOW WHAT YOU ARE DOING. You are committing crimes against humanity by definition.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #26, jane Doe, We will hunt all of you anti opiod zealots down. org.	Question 2	Again, we do not support any anti opiod stances in regards to patients who need and demand opioids for pain relief. We do not support any interference with our own care as WE DETERMINE it to be. Anything other than that is a violation of the Nuremberg code and THOSE responsible for supporting ANY anti opiod policies in place over the past 2 decades WILL be searched out , found and PROSECUTED later as human rights violations as outlined in the international pain treatment dictates that stated refusing opioids to human beings in pain is torture: We will NOT forget. We keep all your names.	Thank you for the comment
Public Reviewer #26, jane Doe, We will hunt all of you anti opiod zealots down. org.	Question 3	Anyone connected with these anti opiod reports will be held accountable in or out of a court of law	Thank you for the comment
Public Reviewer #26, jane Doe, We will hunt all of you anti opiod zealots down. org.	Question 4	those in PROP and HHS and other institutions like Stanford, Mayo, Cleveland clinic and any other leading medical institution will be excoriated when enough people die from refusal of pain treatment with opioids or from UNETHICAL uses of NON opioids that have harmed and killed hundreds of thousands at this point. We will not forget.	Thank you for the comment
Public Reviewer #27, 28, and 29, Robin Stitt, DDPR	Question 1	If I were tested in a study, it would be conclusive that Opiate Pain Meds are completely more effective than Non Opioid Meds, as I have recieved Tylenol #3, Percocet and Percodan following childbirth and surgery, and now take an occasional Tramadol for weather changes and following instances of increased activity, which causes Nerve Pain from Osteoarthritis of the spine and hip joints. I use nonOpioid OTC meds and Homeopathic products daily but these do not cover when pain exacerbates. Making effective Pain Medication unavailable will result in much suffering which will affect each of us one day, and everyone is different, treatment should be left in the hands of trained Medical Professionals to evaluate and prescribe.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #3, Wendy Hart, Self advocate	Question 3	I had been dealing with my chronic pain issues since 1998, and have been effectively and responsibly pain control, through pain management specialist, with opiates. I have NEVER had any issues with [and] quot;near misses [and] quot; regarding overdose . I am urine screened to assure that I am using my meds responsibly. However, now my meds have been severley decreased to the point that I suffer daily with pain. I feel that I should be allowed to have my MD be the one who decides my abilities to be pain controlled ,as well as, whether I am at risk for abusing my meds. Now, doctor [and] #039;s are running scared and afraid of licensure loss. Pharmacists are refusing to fill my LEGALLY prescribed prescriptions, due to THEIR fear of legal penalties and loss of licenses. Additionally, I do not feel that my legal and proper acquisition of opioids should be included in the reports of people who are dying from an overdose, when they have gotten meds from unknown sources and distributors. I do not understand how, my being denied my basic right to humane treatment and meds, will, in any way, prevent the addict from continuing to procure and introduce to their bodies at unsafe levels, ill gotten, and questionable sources of their drug. All of this money being put into denying legitimate pain patients their meds, should be put into better rehab programs for the addicts. An addict may have a [and] quot;drug of choice [and] quot;, but will settle for ANY drug, when desperate for their next high. The pain patient, generally speaking, will not seek out street drugs, but rather, suffer in silence, when denied their pain relief meds. And, those who ARE, as a desperate and last ditch solution, are being put at risk for being given drugs of unknown origin and quality. So, these denial of meds that are being forced upon patients, because pain professionals are protecting themselves, livelihoods and licenses, is creating more of a problem than they are solving.	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #30, Nancy Stoehlker, Dont Punish Pain Advocate	Question 1	The study you are basing your evidence on did not include participant representation of the population of patients with moderate to severe chronic pain. Also the opioid dose was not titrated to therapeutic doses for those patients. The study was also 6 months. You must do a study of at least a year for it to be valid since most chronic pain patients with moderate to severe chronic pain have had measurable improvement in function when maintained on a therapeutic dose for years, most for decades. These patients, of which I am one of them, benefited greatly in function and quality of life on a stable dose of therapeutic opioids. What is a therapeutic level is based on the individual.	We included trials with durations of ≥1 month, this includes studies of ≥1 year. The SPACE trial followed patients for 1 year.
Public Reviewer #30, Nancy Stoehlker, Dont Punish Pain Advocate	Question 10	The Evidence you are basing your draft from is weak and does not represent the majority of chronic pain patients with moderate to severe chronic pain who benefit from therapeutic doses of opioids that improve their function and quality of life. You are hurting millions of chronic pain patients by continuing to use your flawed study and by not including countervailing scientific evidence that opioids are not effective for moderate to severe chronic pain. Also by not including the names of your panel experts you appear to be hiding information that is critical to ensure there is no bias.	Thank you for the comment. The limitations of the evidence are described in the Discussion. The final report will include the names of the technical experts.
Public Reviewer #30, Nancy Stoehlker, Dont Punish Pain Advocate	Question 3	Methods flawed for above reasons.	Thank you for the comment. The limitations of the evidence are described in the Discussion.
Public Reviewer #30, Nancy Stoehlker, Dont Punish Pain Advocate	Question 7	References are flawed because you do not identify the panel of experts. How do we know these experts are not biased or have a predisposition.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #31, Sean Savarese	Question 1	The war on pain patients is criminal. Thats all that needs to be said.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #32, Tracey Callahan Burnett	Question 10	Garbage in = Garbage outThere are millions of chronic pain patients suffering inhumane medical treatment right at this very moment. Stop collating garbage data from shady sources in search of grant funding and listen to the people that are in pain. We are dying while everyone is parsing data to populate excel spreadsheets. Dead Veterans sitting on their medical records in the VA parking lot should be all of the proof that you need. Just one should have been enough. FFS.	Thank you for the comment
Public Reviewer #33, Amanda Handy	Question 10	This study should have included a significant number of chronic patients. Opiods are not perfect but for a chronic pain patient they make the difference between being able to be even just a little productive or being stuck in bed all day. We chronic pain patients are ignored in all of these studies. Most of us are on dosages that only barely help us because our providers are so afraid of prescribing opiods to us. If anything, we need more pain meds than we are prescribed to be able to live a decent life. I have been on pain meds for over a decade and I have no signs of addiction even when going without my meds for a few days. But I AM dependent on them which is completely different. The stress of not knowing from month to month what is going to happen with the meds that we absolutely need only makes our pain worse.	The report is based on published scientific studies that met the pre-specified inclusion criteria.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #34 and 35, Anne Pogue, I am a citizen with chronic pain from traumatic injuries.	Question 10	Wow! Just wow! There is nothing in this study that advised how much each person was given. Was it 5 mg of oxycodone? Was it Tylenol 3? Because neither of those amounts would help much for anyone. And speaking of anyone, what was the height, weight, race, and gender of the participants. Were they genetically tested? Were they opioid naive? Were they opioid dependent currently or previously? Were they evaluated for the mental health diagnosis of addiction or any other mental health diagnosis? Does less than 200 people exemplify billions? What pain conditions were they being treated for? Were they fast metabolizers or slow? Do they methylate efficiently? How many actually overdosed for you to reach the conclusion that they were at higher risks of overdose? What are you so obsessed with legitimate pain medication when the opioid overdoses are majority illicit Fentanyl and heroin? Why arent you educating the masses about them instead of stigmatizing the disabled? Studies have shown repeatedly that chem panels on cadavers do not give a verifiable view of how when or what was involved in their death. Why are you ignoring the bill of rights and interfering with the doctor patient relationship? Why are you trying to eliminate a substance that has been used for thousands of years to effectively treat pain and how is it that this one study contradicts every study on opioids since studies on opioids began? It is incredulous frankly. Almost as though it is designed to draw a preconceived conclusion. When your turn comes to experience pain, what do you want that future to look like? Do you want a blanket protocol or one that is based on you as a patient and you particular biology and situation?	The Tables summarize information regarding the pain condition, duration of pain, prior opioid use status, baseline pain, age, female, and race/ethnicity. Information wasn't provided on the other variables mentioned by the reviewer. Stratified analyses were conducted on pain condition, showing little impact on most estimates. The report also summarizes information on the effects of patient demographics, clinical characteristics, and patient comorbidities, which was very limited. The trials did not provide information about genetic tests and there was very little information on persons with opioid use disorder/dependence (many trials excluded these patients).

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #36, T R	Question 10	I [and] #039;ve been taking the same opioid-based medication for over 14 years. It is what has allowed me to work and can absolutely be effective for many people. I know many who [and] #039;ve been taking opioid-based medication responsibly and for years, even decades. The continuing restrictions and demonization of opioid-based medication, which is very safe when used as directed and for legitimate medical need, is pushing more people to commit suicide or seek illicit substances with strong pain relieving properties from the streets. Suicide has increased greatly and is now at an all-time high. Unfortunately, there [and] #039;ve been many suicides in the chronic pain community due to force-tapering (or cut off cold turkey) from medication that gave these people some quality to their lives. Don [and] #039;t forget you, the reader, are just one diagnosis away from cancer and just a heartbeat away from a vehicle accident which renders you, the reader, with constant, never-ending pain that can only be relieved with strong opioid-based medication. One of these days, you, the reader, or your loved ones will most likely need this medication and instead, be forced to suffer needlessly.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #37, Jenifer Markoe	Question 1	They appear to be one sided and out dated. For example one study was done where chronic pain patients were taper off and the other group was not. After 2 years 10% of those who left on their opiate medication died. However those who were tapered off 30% died. A 20% difference. As far as you studies that say opiates medication dont work you might want to ask chronic pain patient about that because that certainly has not been a current study.	Thank you for the comment. We included studies comparing effects of opioid vs. no tapering, but cannot identify the study that this reviewer is referring to.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #37, Jenifer Markoe	Question 10	Basically this whole thing is full of falsehoods and question many of the results of these studies. Those chronic pain patients who have been dropped or greatly taper 87% are doing worse. Medication like NSAIDS can not be use in large amount dose and for life and not have some major effects on a person stomach with bleed ulcers, heart damage and none loss. Also very few studied have been done on long term opiate use for those who have intractable pain. Basically most studies are limited to 90 days because most people who are not being treated for pain are not going to stick around past that time. Basically ethic reasons. Also you have to ask the issue where they say NSAIDS work as well as opiate for chronic pain. Well if you are giving a very small dose of a opiate I would imagine that might be true especially if you give 800 mg Motrin for inflammatory pain. Since their is no information on dose of what dose or even what opiate was use their is not enough information to make a clear conclusion one way or the other. This is horrible.and should be embarrassed by this.	Thank you for the comment. The report focused on chronic pain; we are not aware of a standardized definition for "intractable" pain but most would consider these terms to overlap substantially.

Public Reviewer #38, Suzanne Weinstein, Select	Question 10	This report would not pass a peer review of KNOWLEDGEABLE , unbiased working medical practitioners that have been in the field of pain care with direct patient contact.The entire [and] quot;report [and] quot; seems to say that opiates do not work [and] amp; only cause harm? That is simply false. The sample size of the studied group is too small. The amount of opioid used to control pain was insufficient to have any efficacy! The conclusions are therefore tainted [and] amp; biased from start to finish.. No one that is in severe chronic pain would benefit at all from doses as small as 10-50 mme. So of course this study would conclude they do not work because no one was adequately medicated. This report will not age well if adopted . It could lead to mistrust of the Department of HHS. Opioid pain treatment has been used for thousands of years. It [and] #039;s efficacy is well established. To try to create a study to support removing unaddicted patients from their OPT and put them on Suboxone(a mild analgesic @ best,that has proven effective for ADDICTS that choose MAT but was never intended to be used for pain)-which appears to be this studies conclusion- reads as insincere [and] amp; false. Pain patients have suffered suicide and death from the withdrawal of their OPT. Many have suffered heart attacks , stroke [and] amp; HBP.Few people will want to grow old in a society without the comfort care that opioids provide for our elderly. Addiction is a different animal altogether [and] amp; we need to treat it as such.. Withdrawing legally prescribed opiates from verifiable pain patients has NOT resulted in a decrease in deaths from overdoses. The few lives that have been saved are from Narcan being made available to addicts.(Harm reduction)In point of FACT the original study tapering patients to 90 mme (this group was given 10 to 50 mme to control their severe chronic pain -an insufficient amount) was done a decade ago. Dr Joseph Merrill did that study . His study was carried out on 572 people. He was alarmed w/ the results.20% of the patients that were tapered died of all causes within 5 years.There were NO lives saved! He recorded his study done at the University of Washington in the early 2000 [and] #039;s.IF opioids don [and] #039;t work why are we having an opioid epidemic in this country?If anything they appear to work too well. Of course they work	The study cited by the reviewer (James et al; last author is Merrill) was published in August 2019 (too late to be identified in the update search) but was added to KQ 3i. The study found an increased risk of overdose mortality in persons discontinued from opioids vs. those continued. However, there was no difference in overall mortality. About 3/4 of patients had a safety reason for discontinuation. In addition, the study was rated poor-quality because it did not attempt to adjust for confounders other than age and race; also 75% of discontinued opioids subsequently received opioids from another provider and there was no information about rate of discontinuation. Therefore, it is not possible to determine a causal association between discontinuation and increased overdose mortality risk; rather, the findings may reflect that patients who have an indication for discontinuation are at higher risk for opioid-related overdoses.

Section	Commentator & Affiliation	Comment	Response
		[and] amp; trying to convince medical practioners that they don [and] #039;t seems frankly inauthentic. Acute [and] amp; severe chronic pain is worse than death.To sentence a person in severe pain to a life w/o opioids is cruel beyond all imagination. [and] quot;It is easier to find men who will volunteer to die, than to find those who are willing to endure pain [and] quot;. Julius Caesar. Rome 743 BC. People have endured suffering [and] amp; pain only because opiates made that possible. Our own SCOTUS found in 1996 that Physician Assisted Suicide was not legal [and] amp; should remain illegal because our society enjoys access to legally prescribed opiate pain medication. This report, if adopted, could take that access away from everyone. The illegal drug trade would explode even further. Causing more deaths.Present [and] amp; future health care would suffer a devastating blow. I don [and] #039;t know who the [and] quot;researchers [and] quot; were that designed this study. It reads as if few of them truly cared about the pain of these patients. I find it cruel in the extreme. Something is badly wrong when a study this biased, this inadequate, this lacking in good controls [and] amp; good sense is ever considered [and] quot;evidence [and] quot; If you want to study addiction then study addicts. Stop asking Dr [and] #039;s [and] amp; their patients to suffer because the streets are filled with heroin, illicit fentanyl [and] amp; meth.Please consider instituting further Harm Reduction measures into the addicted community to witness a reduction in ODs. Medicine is individualistic and good health becomes illusive for people in severe pain. Dictating from the department of HHS that their suffering will increase [and] amp; their health will be even further impacted w/o access to pain care is a direct abuse of HHS [and] #039;s powers. This is an abysmal study. Do not publish . You will undermine our own credibility if this study is published. Trying to prove opioids do not work is similar to trying to prove the sky is not blue.	

Public Reviewer #39, Virginia Brandford	Question 1	Aloha [and] #039;oe, I am writing this letter because I am having great harm done to my health. Being forced off a medicine dosage, I had been prescribed safely for over twenty-six years. I need to be tapered off this drug SAFELY so as to cause NO HARM to the genetic bone disease, Alkaptonuria/Ochronosis, rare genetic disease which causes bones to go black and brittle hence why its also called black bone disease. AKU is caused by a missing enzyme which means patients cannot fully breakdown a toxic acid called homogentisic acid (HGA). HGA attacks bones and cartilage, causing severe pain and disability as life progresses. The way I have been forced off a medicine I had taken for so long is hurting my heart along with causing the HGA levels to attack my bones even more than they already have. The stress of not getting my pain medicine is causing my body to over-produce the HGA that attacks and eats away at my bones - my urine has turned black- I need help- I don [and] #039;t not enjoy needing this pain medicine! I hate I trusted my doctor and took a medicine that is NOW causing so much harm to my health - by being denied this medicine my disease is spreading and spreading there is NO CURE for this and I can not bear this pain if it is allowed to get much worse. How can a government be allowed to intervene in such a harmful way! Causing this disease to spread even more through my body. OCHRONOSIS causes bones to grind against each other cutting into my nerves, causing my right or left side of my body to be paralyzed it [and] #039;s a severely painful disease, every joint in my body is hurting me now! The only treatment that is listed, for this disease is pain medicine- there is no cure for this disease. Ochronosis is perhaps the oldest known metabolic diseases on the planet- found in Female Egyptian Mummies. I wish to go back to my life- without the pain of this debilitating disease, as, I was living- before all this [and] quot;opioid crisis [and] quot; began. I have been abandoned by my doctor, he retired after pressure from the state, I have been treated like a criminal at my pharmacy, that I had gone to for over thirty years, one day, I am their loyal customer, and the next, they were treating me like a some kind of criminal. I was forced off my medicine dosage and Because of these mis-applied rules by the CDC, the rare incurable bone disease	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

		OCHRONOSIS/Alkaptonuria, is getting worse and worse by the day! I do not want to become totally bed ridden suffering a life with the debilitating pain of this disease that turns your bones black after it eats away all the cartilage between the bones causing them to grind and scrape against each other , it has attacked the valves to my heart, my kidneys and liver. And, now my entire cervical spine has been totally damaged. The doctor I had for 32 years was able- having me change my diet, do chiropractic adjustments, and cortisone shots, and water exercises, was able to keep this disease from spreading, it had stayed in my neck and hip for over twenty-six years, but, now it is spreading down my spine. By being denied my pain medicine dosage -without being able to ween off of it SAFELY at required 10% at a time , and being made to live in total pain day and night, I AM no longer able get the exercise I need that kept this disease from building up in my joints, it is now eating away all the cartilage- turning my bones black, causing my urine to turn black. I do not wish to become dependent and more sickly, when I was so independent for so many years. I have no where or one to turn to. PLEASE I NEED HELP! I bought my own home in my early thirties, I was the first female camera operator doing ENG field work in Los Angeles, I have a FCC 1st Class Radiotelephone License that entitled me to run and operate any television or Radio station in America. Yet, after I bought my land and home, I found out- after four botched surgeries, that I had a rare genetic bone disease that was non operative and has no cure. I still was able to stay independent, Until, the misapplied CDC Guidelines forced me off a medicine I had been taking responsibly and safely for over twenty-six years- This has caused this disease to now, start attacking my heart, liver, kidneys and rest of my cervical spine. I pray that revision of CDC Guidelines and allowing doctors to do their jobs without being persecuted will give me back my life and I can grow old with dignity. Please watch this video if you have any questions about my disease : https://www.youtube.com/watch?v=7PpQU3wrdlM [and] amp;t=30sThe CDC and the FDA have put out warnings to never force a patient off a medicine they have taken for as long as I have been made to take this medicine. The irreparable harm being done to my	

Section	Commentator & Affiliation	Comment	Response
		health, I am scared, I will end up totally bed ridden. I ask you to please help me to live the decent life I WAS LIVING without the pain of this disease. I have MRI [and] #039;s and X-Rays and any other medical records you are welcome to view, I thank you for your time and help in this matter. Mahalo Nui Loa,Virginia L. Brandford92-8688 King Kamehameha Blvd.P.O.Box 6455Ocean View, Hawaii 96737 gigibrandford@gmail.com 808 929-9516	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #39, Virginia Brandford	Question 10	Not treating a person in pain is negligence. Abandoning people with painful disease, to the streets with no doctor, is negligence. Believing you can addict the general population is ignorance. Believing serious pain can relieved with Tylenol, meditation, expensive injection therapy, anticonvulsants, and physical therapy is ignorant. The longer you wait to treat pain the more serious it becomes. Opiates remain the treatment of choice for serious pain, no matter what a few extremists purport. the CDC/PROP misguided guideline manifesto must be revised using the guidance of real pain management doctors, not politicians! Opioids are safe for ALL PATIENTS who need them for painall types of pain from acute to lifelong. The only people who should not take opioids are drug addicts. [and] quot; To deny legitimate pain patients and Veterans vital pain medicines because of street drugs and addicts is the result of a corrupt government, and they must be held accountable!	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #39, Virginia Brandford	Question 2	ALOHA [and] #039;OE, Please I need a caring doctor, the rare bone disease OCHRONOSIS, has been getting worse and worse everyday! There is no cure for this disease, having a good diet, help with strengthening muscles etc, but that can [and] #039;t be done without pain medicine- my bones lost all cartilage between them and they grind against each other, I do not want to become totally bed ridden suffering a life with the pain of this disease that turns your bones black after it eats away all the cartilage between the bones causing them to grind and scrape against each other , it has attacked the valves to my heart, my kidneys and liver. And, now my entire cervical spine has beentotally damaged, when it had stayed in my neck for over twenty years, stable without spreading like it is now, it is spreading down my spine, by being denied my pain medicine and made to live in total pain day and night. I can no longer get the exercise I need that kept this disease (HGA) from building up in my joints eating away all thecartilage-taking away the only thing that helped keep this disease at bay.I have no where or one to turn to. PLEASE I NEED HELP! I bought my own home in my early thirties, I was the first female camera operator doing ENGfield work in Los Angeles, I have a FCC 1st Class License that entitled meto run and operate any television or Radio station in America. Yet after Ibought my land and home, I found out after five botched surgeries that Ihad a rare genetic bone disease that was non operative and has no cure. Istill was able to stay independent,thru taking pain medicine, but now I am treated like a criminal for needing it- I need a doctor who will help me grow old with this disease with dignity- thank you for your help.	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Public Reviewer #39, Virginia Brandford	Question 3	NOT SURE HOW MUCH LONGER I CAN GO ON LIKE THIS! thirty-two years I only saw one doctor along with the surgeons he sent me to, in all that time ,I have tried and tried seeking a specialist for the genetic bone disease they diagnosed me with - a Rheumatologist who could also help me live with this disease. But, every doctor that my old doctor referred me to- rejected seeing me - saying they could not help, especially now, when they see my medical records and see there is no cure for this disease, that only treatment that is listed for my disease- is pain medication - they have expressed they do not want to risk their livelihoods by taking me on as a patient. THIS DISEASE IS INTRACTABLE PAIN, its turns my bones black, brittle and eats way all the cartilage and the disc between my bones -my body over-produces a acid that literally nukes my vertebra and makes them inoperable black bones that look like a Mummies [and] #039; bones , it causes the nerves down my arms to become paralyzed and eats away at the valves to my heart , attacks the kidneys etc etc etc, BUT beyond all that I was doing as well as a person could. I have to have a chore service person because I can not lift anything more than 10 pounds, and if I sleep wrong I wake up not being able to use my arms - But I changed my diet I kept my body as strong as I can And most people would never know the pain I live with every day NOW since this disease has spread even further down my back and they only let me have half the medicine I was on, the pain of going without it did irreparable damage me me!! I NEED TO SUE THEM FOR PUTTING ME THROUGH THIS - How can legitimate patients be treated so inhumanely. PLEASE IF ANYONE KNOWS A GOOD LAWYER WHO WON [and] quot;T LET THE PHARMACEUTICAL BUY HIM OR HER OUT -but stick with me to the end I NEED A LAWYER WHO has the balls to go up against these Politicians and the CDC and DEA and anyone else who is behind taking away the rights of our American disabled people in our country! My old doctor had also stopped being able to help and has retired because of the pressure put on him for prescribing his patients pain medicine, I asked DEA if my doctor was guilty of wrong doing, they said they had no charges against him. But, that didn [and] #039;t stop pharmacies from denying to fill any of my doctors prescriptions. Its like they treat me like a	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain. We do not provide legal advice

Section	Commentator & Affiliation	Comment	Response
		criminal for needing medication I was put on and took safely without any problems, for 32 years. To wake up one morning and have pharmacies treat you like a drug addict for picking up the same medicine you have picked up every month for years and years I FEEL MY HUMAN RIGHTS ARE BEING VIOLATED ESPECIALLY SINCE EVERY DAY THAT I AM MADE TO GO WITHOUT MY MEDICINE, IT CAUSES MY DISEASE TO GET WORSE AND WORSE. I feel so alone and abandoned.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #39, Virginia Brandford	Question 4	Opioids are safe for ALL PATIENTS who need them for painall types of pain from acute to lifelong. The only people who should not take opioids are drug addicts. [and] quot; To deny legitimate pain patients and Veterans vital pain medicines because of street drugs and addicts is SADISTIC AND INSANE!!	Thank you for the comment
Public Reviewer #39, Virginia Brandford	Question 5	Physicians, scientists, and other important stakeholders have repeatedly cautioned, written, and admonished the CDC, they have advocated tirelessly in an attempt to mitigate adverse outcomes due to the CDC guideline and those warnings fell on deaf ears every time. CDC barreled forward despite an avalanche of dissent from professionals and patients and now, were beginning to see the fruits of that disregard. Ive already begun to dismantle the claim that the guideline fosters increased safety for patients, but please keep an eye out for my next article where I will detail harms in-depth.	Thank you for the comment
Public Reviewer #39, Virginia Brandford	Question 6	his trend in federal initiatives that seek to apply these types of one size fits all approaches may be due to the shift from individualized care to population health, which is a focus of current public health practice. Unfortunately, this type of approach has simply been catastrophic. Its not yet clear exactly how damaging these initiatives have been to human health on a mass scale because appropriate tracking and control systems were never put in place before (or after) the execution of these initiatives, however, we will discuss some small scale studies that are beginning to shed light on just how dangerous these policies have been for patients in the future.	The report synthesizes the evidence and does not make recommendations
Public Reviewer #39, Virginia Brandford	Question 7	Unscientific GuidelinesIf federal agencies and the media told the truth, they would make it clear that prescriptions are at an all-time low while overdoses are at an all-time high (and expected to climb) and yet they still claim that most overdoses are the result of prescription opioids, and they continue to tout the success of their guideline and dare to call it evidence-based. After being exposed to some of the more moderate experts who have loudly dissented to the implementation of the unscientific guideline, do you believe its evidence-based or is it possible there is another agenda at play here?Conclusion	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #39, Virginia Brandford	Question 8	Despite the backlash the guidelines have received from professional organizations and patients, little has been done to change them, Jay concluded. [and] quot;Months after the FDA and CDC statements, pain physicians and pain patients are still not sure if anything changed, [and] quot; he said. [and] quot;While they stated the guidelines were used inappropriately, nobody has made them appropriate. [and] quot;	Thank you for the comment
Public Reviewer #39, Virginia Brandford	Question 9	Patients who have been on high doses of opioids, who have had little negative effects from those drugs and are doing well with good quality of life, are being forced by their doctors to reduce doses often with no discussion against their will. Some are turning to the black market and others are deciding upon suicide.These policies defy and run counter to all that modern society has deemed to be ethical in medical research.If this experiment was being conducted by universities, it surely would be disallowed as all research on humans must first be approved by independent research ethics boards. Any research that resulted in an increase in suffering, disability, and/or deaths of human subjects would never be approved.	Thank you for the comment
Public Reviewer #4	Question 1	The chronic pain community has been dehumanized and made to feel like criminals instead of being treated like people who need medical care which we do. I have never given a dirty urine I dont even drink alcohol. However I lost 60 pounds in two months and I thought I was going to die because I was rapidly being taken off my medication. After the CDCs retraction and theyre realization that chronic pain patients do not fit the huge gamut of opiate abusers. I still see people committing suicide and turning to street drugs because they cannot function or dress them selves or shower because they are in agony I was hit by a tow truck at 96 it is a miracle that I am walking if I can use my pain medication responsibly which I have shown why must I be collateral damage for people who want to abuse all substances. The only thing you have given us is a choice whether to get an attorney for a class action suit or lay down and die I will not lay down and die..	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #40, Mirielle Faraj	Question 10	The narrative that [and] quot;opioids don [and] #039;t work for chronic pain [and] quot; is patently false. There are upwards of 40 million chronic pain patients in this country who, up until recently, were obtaining relief from Severe Intractable Pain that NEVER ENDS with opiate medication prescribed by their pain specialists. In my case, I suffer from a horrendous case of Interstitial Cystitis. My pain, without medication, is at a 10. WITH medication, I can reduce my pain to as low as a 5 or 6. There is no cure for my condition. I have tried everything and anything under the sun, INCLUDING Mindfulness, Yoga, Chanting, and lots and lots of Prayer. NOTHING helps reduce my pain better than my prescription opiate medication. The folks that say otherwise are, sad to say, either misinformed or LYING to the government and the public.Put more simply, for patients like myself, if this medication is taken from me, I will die sooner. That is how bad my pain is. That is how disabling this condition is without pain medicine. And if you, and/or other entities formulating policy, continue to reduce and/or make medication like this harder for legitimate patients to obtain, you will be directly contributing to the early demise of millions of people. People who will become so disabled that they will not be able to continue to work and take care of their families.This draconian policies being enacted also will not now, nor ever, reduce the number of overdoses from people taking illicit narcotics.Please stop this madness. I beseech you.P.S. As I stated, there are 40+ million chronic pain patients like myself. And we vote.	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 1	What I have seen draft report appendices is preposterous, sadistic, and medically incorrect.. I have been adequately treated for 30 years for chronic pain for several forms of arthritis, Pott [and] #039;s Disease, and massive spine damage and am at the lowest narcotic dose in many years now -- what exactly are you people saving me from? Is it even morally any of your business, or do you ignore court cases like the old FBN did in the 1920s? From what I hear about the fake opioid cri$is you people are only going to make things worse. 50 mg Morphine Base Equivalent Per 24 hours sounds like for what you are aiming for, no? How many of your staff have no medical background? The traditional upper end of the Low category for chronic pain is 200 mg.	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 10	I do not expect you people to improve the situation without a dramatic, mass volte face. I think your agency should be abolished and its components devolved to the states and medical profession.It is not heresy, and I will not recant.	Thank you for the comment
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 2	You know, you are going to accelerate the exodus of doctors, patients, pharmacists and researchers to Canada, Europe, and elsewhere. Is that the intent? Turning the US into a medical and technological backwater and a source of fear and loathing for scientists? Soliciting hostility from other countries and NGOs, maybe even ridicule by the United Nations? Poor people cannot escape, and I know you know that. People are already checking out by their own hand and I think that is a full-scale atrocity.	Thank you for the comment
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 3	Abysmal and not completely scientific.	Thank you for the comment
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 4	Horrific	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 5	[and] quot;Alle Menschen haben das Recht auf Schmerzfreiheit [and] quot; All people have the right to freedom from pain. 1995 World Health Organisation report.	Thank you for the comment
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 6	INCB = International Narcotics Control Board	Thank you for the comment
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 7	Same thing	Thank you for the comment
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 8	You can sure say that again.	Thank you for the comment
Public Reviewer #41, Philip Schumacher, Self-Employed	Question 9	Reading it made me physically ill.	Thank you for the comment
Public Reviewer #42, Philip Schumacher, Self-Employed	Question 1	Cherry picking	The studies were identified using systematic searches and included based on application of pre-specified inclusion criteria.

Public Reviewer #43, Mel Evans	Question 10	Please stop attacking and removing a treatment that works for LONG TERM CHRONIC PAIN PATIENTS. OPOID PAIN Meds work. As a long-term chronic pain patient myself, I take of every load dose regimen of pain medication that gives me a quality of life that everybody else has. What I mean is I [and] #039;m able to get out of bed prepare meals, take care of my personal needs, work/volunteer, socialize, be involved in life. Before receiving medications The pain was so bad it affected so much my life in my body. It affected my diabetes and affected my blood pressure. It affected my social and emotional areas of my life too. Once I began opiate pain therapy I was able to begin to get my life back. It may not be 100% the way it was prior to being in pain but an improvement of 50% and gave me back the will to live. The pain being untreated cause severe depression. When a person [and] #039;s severe pain every day, They can [and] #039;t function normally. More research needs to be done on CHRONIC long term pain and how it affects people [and] #039;s everyday life. Only checking with short-term pain people is not the answer.. Until you personally have experience long-term chronic pain or have witness a family member or close someone go through it you [and] #039;ll never understand. The only correct ethical thing to do is to only have physicians that have direct experience working with chronic long-term pain patients help bright these research papers and guidelines. There are too many people that does not have the experience or knowledge to be able to accurately state facts in regards to pain medications. Where are all the pain patients on this panel?. More than likely none. I will along with a lot of other pancations Will be accepting of these guidelines when you can read the streets of illegal fentanyl heroin Does being brought over from other countries. The black market [and] amp; federal government is directly contributing to the illegal fentanyl distribution into the communities. How was that? By limiting pain medications being prescribed. people in pain will find away to relieve some of that pain if not all of it. If that means they buy pills off the black market they have more than willing to accept the risk. They [and] #039;re in a position without medication of pain they rather die. They go Get the illegal pills off the street and take the gamble. The	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
		gamble is will I get relief or will I die either way I [and] #039;ll have relief. It [and] #039;s pretty sad when it [and] #039;s come down to this. It seems that America is going backwards in treatments. This amounts to torture. Torture for taking away medication that is proven to work all because of people that are not in chronic long-term pain makes decisions. Stop the torture give us back the medicine that WORKS..	
Public Reviewer #44	Question 1	There is no evidence showing long term therapies	As noted in the report, evidence on the long-term effects of opioids was very limited.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #44	Question 10	I am a chronic pain patient and was stable on opoids for pain. Since being taken off due the [and] quot;guidelines [and] quot; i have had major medical issues and uncontrollable blood pressure even with medication. I have no quality of life and may have to quit working due to not being able to work 2 hours a day where as before i could work 8-10 hours and also could do things with my family which i physically cannot do anymore. Please take into account the pain patients that are not addicts but people who are compliant and not doing anything wrong!	Thank you for sharing your story, sorry to hear about your pain.

Public Reviewer #45, J. Bartel, PassionatePachydermsDigitalMedia Group	Question 10	The draft report has withheld the names and qualifications of both the Technical Expert Panel at the Evidence-based Practice Center (EPC) and of peer reviewers, promising to provide this information in the [and] quot;final [and] quot; report. This failure to identify authorship in the draft essentially disqualifies the document. Without knowing who wrote and reviewed this document, we cannot identify their biases or predispositions.If anyone among these groups was also among the writers group that supported US CDC in 2015-2016, then we have reason for concern that the AHRQ comparative review will be equally biased and unsupported by real research. It should be noted that no less an authority than the American Medical Association has publicly repudiated many of the assumptions and all of the core methodology incorporated into the Guidelines (see AMA House of Delegates Resolution 235, November 2018 and AMA Board of Governors Study 22, June 2019).I also note that the profoundly flawed and biased [and] quot;Krebs report [and] quot; (SPACE clinical trial from the University of Michigan) is among the references quoted in the draft report. This inclusion by itself would be grounds for deep alarm. As Dr Stephen E Nadeau and R. Lawhern have written in the journal Practical Pain Management, [and] quot;The paper by Krebs, et al., in the authors opinion was flawed by a failure to include participants representative of the population of patients with moderate to severe chronic pain and a failure to adequately titrate opioid dosage. However, its repeated reference in the draft recommendations [of the HHS Task Force on Pain Management report] perpetuates the myth that opioids are not effective in treating chronic pain. There is strong countervailing scientific evidence. [and] quot;https://www.practicalpainmanagement.com//draft-report-painAlso noted in a second paper published by the same journal, [Lawhern, Nadeau and Dr Andrea Trescot] [and] quot;This trial involved 240 patients treated for chronic pain in US Department of Veteran Affairs (VA) hospitals. It has been widely represented as proof that opioids are no more effective than non-opioid treatments for chronic pain. However, a review of the supplementary material from this study reveals that the mean dose of opioid was 21 MMED, and only	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process. An analysis on effects of dose and effects of opioids was performed; as described in the report, there was little evidence of a dose response above 50 mg MED/day. Baseline pain in the SPACE trial was similar to other opioid trials.

Section	Commentator & Affiliation	Comment	Response
		12.6% of patients randomized to the opioid group were taking [and] gt; 50 MMED, itself a low dose. Furthermore, antidepressants were among the treatment options in the non-opioid group. Thus, results of this trial may best be construed to one of three points:1) patients whose pain is not sufficiently severe to warrant opioid treatment do not particularly benefit from opioids2) opioids are not of benefit to patients with moderate to severe chronic pain when opioid dosage is not sufficiently titrated3) optional use of antidepressants in the non-opioid group substantially mitigated the inadequacy of other non-opioid therapy.=====end quotation==This draft report should be withdrawn immediately and re-published on the regulations.gov website after announcement in the Federal Register. When re-published, the names and qualifications of all [and] quot;key experts [and] quot; and peer reviewers should be disclosed.	

Public Reviewer #45, J. Bartel, PassionatePachydermsDigitalMediaGroup	Question 4	There is far too much information missing in this report for it to be used as any sort of conclusive proof of opiate effectiveness in the treatment of short or long term pain.As a patient who has suffered moderate to severe chronic pain for over two decades I am uniquely qualified to speak on this subject, what is missing, what should have been considered but wasn [and] #039;t, what information should have been provided but isn [and] #039;t, as well as what looks remarkably like a study/report which was deliberately skewed and performed to achieve a specific outcome, specifically an outcome which in essence [and] quot;retroactively [and] quot; attempts to lend validity to the bias, illegitimate 2016 CDC Guidelines for Prescribing Opiate Pain medications. Guidelines which have resulted in predicted catastrophic consequences for millions of patients suffering moderate to severe chronic pain, hospice patients, post surgical patients, accident victims, Cancer patients, and even children suffering moderate to severe pain in the United States. These consequences include days, months, years or torture and misery caused by patients inability to obtain opiate pain meds they had in many cases been stable on and experiencing effective pain control, a return of function, productivity, and perhaps most importantly quality of life prior to publication of those [and] quot;guidelines [and] quot;. Patients were forcibly rapid tapered off of these safe effective medications designed specifically for the treatment of pain, many of which have been in use for more than 100 years as a direct result of these irresponsible guidelines. Still others were simply cut off of their medications without warning resulting in horrific periods of withdrawal combined with destabilization of their medical conditions and soul crushing return of unbearable pain. Thousands unable to find pain doctors willing to prescribe them medically needed medications for legitimate conditions, in sufficient doses to control their pain, (thousands unable to find any physician to treat them at all, simply because they suffer chronic pain) turned to the streets in desperation and attempts to find relief enough to return to their jobs, care for/support their families, then ended up dead due to fentanyl laced illegal drugs, or mixing what ever they managed to find on the street with other drugs and alcohol. Others, unwilling to turn to illegal, illicit street	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

		drugs, unable to obtain the safe effective pain medications that once controlled their unrelenting pain which continued to worsen, in utter desperation, after having lost their jobs, families, marriages, homes, life savings, dignity, self respect, hope and faith, unable to stop their pain, have committed suicide. These include Veterans who have been completely cut off all pain and anxiety medications suffering from unimaginable, unrelenting pain, are committing suicide at a rate of more than 22 per day!The destruction those [and] quot;guidelines [and] quot; and their subsequent effects have wrought on those least able to fight back in our country is incalculable, and those involved in creating and writing them in secrecy without contribution or consultation from professionals actively treating patients in the fields of pain management, pharmacology, anesthesiology, physical medicine, physical rehabilitative medicine and/or the treatment of life long unrelenting pain caused by rare, incurable, progressive, degenerative disease processes and/or conditions are wholly responsible for this destruction. They are now realizing they are legally and morally responsible for each and every patient affected by the dissemination of those [and] quot;guidelines [and] quot; and are engaged in doing everything possible to try and validate their bogus claims, junk science, manipulated, twisted interpretations of illegitimate studies just like this one and the others associated with it. I will leave it to others to point out the many ways this study and report were improperly done, and give you those specifics. As a Chronic Pain Patient, and advocate for other Chronic Pain Patients, I felt it my duty to comment on this and call it out for exactly what it is, TRASH! Trash meant to attempt to cover the posteriors of those who thought they were untouchable regardless of the lives ruined and lost due to the irresponsibility, ineptitude, and pompous arrogance of PROP, it [and] #039;s members and affiliated associates including the EX CDC director Tom Frieden whose very [and] quot;close [and] quot; affiliation with [and] quot;PROP [and] quot; founder and self described [and] quot;expert [and] quot; on drug addiction Andrew Kolodny. Neither exactly known for stellar reputations, factual information gathering, or ability to control inappropriate behaviors and/or statements. Perhaps those reading these remarks will	

Section	Commentator & Affiliation	Comment	Response
		have more integrity, I certainly hope so.Before dismissing what I [and] #039;ve said here as the rantings of some [and] quot;Drug addicted [and] quot; chronic pain patient, (that is the most recent narrative being fed the American public, that those suffering Painful debilitating diseases and conditions are [and] quot;Drug addicts who just don [and] #039;t know it yet [and] quot;) Perhaps you [and] #039;ll take the time to follow this link and read about the laws that were broken, and the warnings the CDC got a full year prior to release of those [and] quot;Guidelines [and] quot; from the Washington Legal Foundation, here is the link https://s3.us-east-2.amazonaws.com/washlegal-uploads/upload/litigation/misc/CDCComments-Opioids.pdf	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #46	Question 1	I have DDD Degenerative Disc Disease. At some point you will get it as well. The non-opiate treatments do not work for DDD, not a single one. I have over a 7 year period, they have done close to 30 of those injections aimed at treating swelling and inflammation, not a single one helped. Physical Therapy, only strengthens back muscles, again this will not treat DDD. The disc get weak, get pushed around, can get pushed into the spinal nerves, slowly degenerate, and disappear. The only thing medical has to treat DDD is fusion surgery, as well in the meantime, the pain medications can help ease the pain. DDD is like cancer, there is none known cure. Now because of the new rules, in order to keep getting the pain meds, I am forced, compromised into doing treatments that will do nothing, and those injections can damage tissue and bone. Sure spine surgeries are risky, no guarantee. But I would rather take a chance on surgery, if it meant lessening the pain, getting off the pills, than to get stuck in a situation that does nothing but steal my time and my money. But then again that [and] #039;s what is all about, profit over patient. There is an addiction that outweighs all other addictions, it [and] #039;s the addiction to power and money, look how THEY lie, cheat, steal, manulipulate, kill to get it.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #47, Sharon Rose, Pain foundation volunteer	Question 10	I have benefited from prescription opioids, this is true for myself and millions of others. I have been on opioids for 30 years without any complications! I only take the medication exactly as prescribed. I never drink or smoke. My dosage has been cut in half involuntary and I dont have adequate pain relief. The 2016 CDC Guidelines have been an absolute failure as many Chronic pain patients are suffering needlessly. I demand that this report be recalled until they are willing to identify who wrote it and what their qualifications were! Intractable pain patient and advocate.	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #48, Kristie Walters	Question 10	I have intractable, centralized pain due to a spinal cord injury and have been taking opioids for 7 years without evidence of harms or addiction. Without opiates I would not be able to walk or attend to activities of daily living. They work for me and millions of others. Why was the Krebs report used? It was extremely flawed. This gives me an idea of what you are trying to disprove (opiate efficacy) in a most un-scientific manner. Why are the authors of this draft report not disclosed? This is highly irregular, with the exception of the flawed CDC guidelines.	Thank you for the comment. The SPACE trial (Krebs et al) met inclusion criteria because it compared stepped therapy initiated with opioids vs. stepped therapy initiated with nonopioid therapy. It was assessed as a good-quality trial using standardized risk assessment criteria. The patient characteristics, use of opioids in the control arm, and the doses of opioids in the intervention arm in the SPACE trial are presented in the Results.
Public Reviewer #49, Tanja Johnson, RH Integrative Healthcare	Question 2	I am a chronic pain provider and an addiction provider. I see 400 patients monthly, all treated with opioids. In my 20+ years of specialty practice, I have not witnessed even one of the Risks listed below. Continue to see consistent functional benefits With opioid Therapy. I agree with the report in that we need new studies. All chronic pain practices should be included in the research. WE in clinical practice are NOT seeing what your seeing! Think about it, if chronic pain patients had no benefit why would they be taking opioids. Day after day I see remarkable transformation with improved function. The research is not matching what we are seeing in clinical practice! Reference:in your intro, Its cited that there is increased risk of discontinuation due to adverse events, gastrointestinal adverse events, somnolence, dizziness, and pruritus versus placebo. In observational studies, opioids were associated with increased risk of an opioid abuse or dependence diagnosis, overdose, all-cause mortality, fractures, falls, and myocardial infarction versus no opioid use; there was evidence of a dose-dependent risk for all outcomes except fracture and falls.	Thank you for the comment. The report is based on published peer-reviewed studies; studies were identified using systematic searches and selected for inclusion based on pre-specific inclusion criteria.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #5, Kathi Cordingley	Question 10	I don [and] #039;t believe this study. I see no evidence of the actual ages, diagnoses, concomitant disorders that would make an impact upon pain; nor, do I see objective data of pain ratings, lengths of time between oral administration of pain to the findings represented. This study could have provided more information, worked with Chronic Pain nationally recognized organizations - but alas, produced what I consider a bogus study. As a true chronic pain patient who has benefited from opioid therapy with no harm, no addiction, and no adverse side effects - this study purports to diminish the benefit that chronic pain patients experience with opioid therapies and how it increases our quality of life.	Thank you for the comment. The report presents analyses based on the pain condition treated. Limited evidence showed no effect of age on outcomes. Evidence on concomitant conditions was insufficient.
Public Reviewer #50, Tanja Johnson, RH Integrative Healthcare	Question 2	I am a chronic pain provider and an addiction provider. I see 400 patients monthly, all treated with opioids. In my 20+ years of specialty practice, I have not witnessed even one of the Risks listed below. Continue to see consistent functional benefits With opioid Therapy. I agree with the report in that we need new studies. All chronic pain practices should be included in the research. WE in clinical practice are NOT seeing what your seeing! Think about it, if chronic pain patients had no benefit why would they be taking opioids. Day after day I see remarkable transformation with improved function. The research is not matching what we are seeing in clinical practice! Reference:in your intro, Its cited that there is increased risk of discontinuation due to adverse events, gastrointestinal adverse events, somnolence, dizziness, and pruritus versus placebo. In observational studies, opioids were associated with increased risk of an opioid abuse or dependence diagnosis, overdose, all-cause mortality, fractures, falls, and myocardial infarction versus no opioid use; there was evidence of a dose-dependent risk for all outcomes except fracture and falls.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #51, David Acevedo	Question 1	There is no correlation between Opiate prescribing by ethical Doctors of Medicine, and other health care professionals, to chronic or intractable, incurable severe pain sufferers and overdose death or opioid (opiate) use disorder. So... [and] quot;accompanied by marked increases in rates of opioid use disorder and drug overdose mortality involving prescription opioids. [and] quot; is grossly and lethally and cruelly incorrect.Mere anecdotal evidence and vast amounts of patient experiences more than proves there is sufficient [and] quot;evidence to show benefits of long-term opioid therapy for chronic pain, due to the absence of trials with followup of at least 1 year. [and] quot; You just can [and] #039;t ask around because it does not fit the money making ploy that tries to blame pharmaceutical manufacturing for [and] quot;opioid crisis [and] quot;. So [and] quot;The Review [and] quot; could not have [and] quot;found that long-term opioid therapy was associated with increased risk of overdose, opioid abuse, and other harms... [and] quot;Holding up and reviewing and updating the Centers for Disease Control and Prevention guideline on opioids for chronic pain is simply a case for those who love the [and] #039;Emperor [and] #039;s New Clothes [and] #039;. Where this was not severely flawed and numbers not clumsily and criminally misrepresented it still should not effect chronic severe pain sufferers, but it has, ...revealing the ulterior motive. The rape of pharmaceutical manufacturing for money by the DOJ/AG.Scientifically, even grammatically [and] quot;crisis [and] quot;, [and] quot;epidemic [and] quot; and [and] quot;emergency [and] quot; can not even be distantly applied to prescribed severe pain medicine, revealing yet another bad motive. It IS a [and] #039;street [and] #039; Fentanyl/Heroin, poly-pharma over-dose, pseudo-addiction issue.	Thank you for the comment

Public Reviewer #51, David Acevedo	Question 10	TRANSCRIPTION...Dr. Richard Lawhern speaks to the Health and Human Services - Pain Management Best Practices Inter-Agency Task Force Meeting, Sept. 26, 2018 Washington, DC - David Acevedo [and] quot;I am Dr. Richard Lawhern, PHd, co-founder and Director of Research for The Alliance for the Treatment of Intractable Pain. As I noted before this group in May, published CDC data show us that there is very little relationship between rates of opioid prescribing by doctors versus rates of opioid related overdose mortality from all sources. The numbers are there. Today I offer further insight on demographics of chronic pain which amplify on that message. If MEDICAL prescribing contributes substantially to opioid mortality then we SHOULD expect to see expect to see HIGHER mortality in groups that are prescribed opioids more often. But we DO NOT. People over 50 are prescribed opioids %250 more often than youth and young adults. But over the past seven-teen years mortality has SKYROCKETED in youth while remaining STABLE AMONG SENIORS AT THE LOWEST LEVEL OF ANY AGE GROUP. Patients who benefited the most from liberalized prescribing policy before 2010 have shown NO INCREASED RISK OF MORTALITY. Where is the cause and effect HERE? The typical initiating drug abuser and the typical chronic pain patient are very different people. Beginning drug abusers are most often young males from economically stressed areas of the country, sometimes with a history of mental health issues. But while both men and women become pain patients by a ratio of 60:40 - chronic pain patients are most often women of middle age or older. If the patients life is stable enough to see a doctor they are almost NEVER found to be abusers. Large scale studies also show us that the risk of abuse or chronic opioid prescribing among post-surgical patients prescribed opioids is %0.6 OR LESS. Yet prevailing public policy, at this moment, seeks to SAVE the small minority by RESTRICTING OR DENYING PAIN TREATMENT to %99.4 OF PATIENTS. WHERE IS THE JUSTICE IN THAT??? You need to be guided by a quote from Dr. Nora Volkow who addressed this Task Force in May. This is from New England Journal of Medicine; [and] quot;Unlike tolerance and physical dependence, addiction is NOT A PREDICTABLE RESULT OF	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
		OPIOID PRESCRIBING. Addiction occurs in only a small percentage of persons who are exposed to opioids, even among those with pre-existing vulnerabilities. [and] quot; The article is worth reading. From this background on behalf of hundreds of thousands of patients, I urge this Task Force NOT TO FURTHER RESTRICT THE AVAILABILITY OF OPIOID ANALGESIC THERAPY TO PEOPLE IN AGONY, THE MEDICAL EVIDENCE DOES NOT SUPPORT THAT STEP. [and] quot;	
Public Reviewer #51, David Acevedo	Uploaded Document	Dr. Richard Lawhern speaks to the Health and Human Services.pdf (31 KB)	Thank you for the comment. The attachment (#17) was reviewed.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #52, Daniel Elliott	Question 10	I suffered a Traumatic Brain Injury in 1991 due to being electrocuted in a household accident. I use the term [and] quot;electrocuted [and] quot; because I was connected to the electricity for approximately 15 minutes and had to be revived by EMTs using CPR. Seeking treatment for the severe head pain I was experiencing, I spent 10 years being trying every non-opioid treatment available, including acupuncture, hypnosis, biofeedback, relaxation techniques, chiropractic adjustment, as well as meditations including blood-pressure, anticonvulsants, antidepressants, NSAIDs, muscle relaxers, just to name a few. However, in 2002, I began treatment with a certified Pain Management Specialist. This doctor immediately prescribed high-dose, high-strength opioids and, for the first time in a decade, I experienced relief from the pain that was driving me to consider ending my life. Once I was treated with pain medications, I was able to get some of my life back. I was able to attend church, meet with friends, and generally live in semi-normal life. This lasted until the idiotic DEA began arresting doctors for treating chronic pain. For over a year, I was without the meds that had saved my life. Again, I almost couldn [and] #039;t survive. That is, until I found another doctor willing to treat me under palliative care. I am now back on the same exact medications that I had used for over 16 years and I [and] #039;m doing well again.This may not be a [and] quot;scientific [and] quot; study, but it is proof that opioids are useful and successful in the treatment of chronic pain.For this organization to not release the names of those responsible for its ill-conceived and moronic conclusions is simply proof that, once again, a government agency is trying to pull the wool over the eyes of the American public. If you are successful in eliminating pain medications for the treatment of chronic pain, you will most certainly have blood on your hands due to the inhumane policies that will certainly result in suicides and the deaths from street drugs overdoses of those searching for some type of relief. Please reconsider this matter	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #53, Mark Adams	Question 4	How you can even draft [and] quot;results when the majority of the data is either fair or poor is beyond me. I, as a long term chronic pain patient who lost access to [and] quot;high dose [and] quot; medication, can assure you that not only has my pain increased, but my level of function has severely decreased. The fact is for many the safest medical treatment for our pain is long term in some cases [and] quot;high dose [and] quot; opiates. I hurt too much to concentrate on debunking this report but can assure you what is happening to many CPP [and] #039;s is nothing short of torture.	Thank you for the comment. The conclusions and findings are based on the available evidence.
Public Reviewer #54, Cindy Caron, N/A	Question 10	Oh my, we seem to have alot of problems here. First, no transparency, second, inaccurate information and an obvious bias.I am, and have been a chronic pain patient for over 20 years. Through these years, i have found that opiate medication works for me. I have tried other modalities, massage, physical and mental therapy, chiropractic, steroid shots, acupuncture, and many other modalities. I suffer from an inoperable condition and ,yes, I [and] #039;m dependent- not addicted to my pain medication. I am also a disabled senior citizen who is appalled at the lack of accuracy in statistics that are being used.I worked all my life until I was no longer able. I have always been an upstanding citizen and now, in my later years, I am experiencing a dreadful amount of intractable pain. How my government can be a part of pushing inhumane practices on the injured, the disabled, and veterans is beyond my grasp.The 2016 CDC guidelines have been retracted. The AMA, over 500 learned physicians, and so many advocates have spoken up to the truth. The opioid epidemic is not related to prescription drugs- it [and] #039;s on the streets and daily coming across our borders. Why and how is it that the government, the DEA, and politicians feel it [and] #039;s acceptable to storm our doctors offices, and monitor citizens, such as myself? I am not a criminal, I am a chronic pain patient, who, in the last years of my life would like to be treated with compassion and adequate pain relief! Please, get the government out of my doctors office and attend to issues that are truly a problem!!!	The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input.

Public Reviewer #55, Thomas Dikel, Thomas N. Dikel, Ph.D.	General comment	Although 287 pages is a daunting amount of reading, it is not enough to protect the essential flaws in the document and apparently the committee that developed said document. From the first, when points listed included fallacies that have been clearly, empirically, and repeatedly refuted, for example regarding long-term efficacy of opioid managed pain treatment or that NSAIDS are as effective as opioids for treating pain, this report is a document serving more as a polemic or perhaps a defense of the initial flawed report, put together by the flawed committee for the CDC in the 2016 recommendations that have become law in over 30 states and treated as such all over the country. You must know that that the terribly flawed recommendations have caused thousands of deaths and millions of patients to suffer debilitating pain - many of whom were successfully treated for years with the same long-term opioid therapy you claim does not work. Because of the CDC report, hundreds of thousands of patients have been forced to tapir to levels that are clinically deficient or have been forced off opioid pain medication altogether. The standard has always been functionality, and when these patients who were completely and successfully functional with opioid pain management and when forced down or off their medication were no longer able to function, in the workplace or at home, how on earth can you consider this an improvement? And it is not a matter of a few patients here and there. The numbers are staggering. It is therefore more than a puzzle as to how people as esteemed as yourselves can possibly continue this policy that is 180 degrees away from the oath you took as physicians. You are actively participating in the harm and death of patients, for no good reason that I can find. You do not have demonstrable numbers to indicate that following the [and] quot;recommendations [and] quot; has improved the lives of patients - anywhere. And there are more than enough data demonstrating the contrary. The evidence for everything I have said is readily available, and an objective group would have more than enough time to find those data - the CDC [and] #039;s own database contains much of it. Therefore, it is nearly unbelievable that a second powerful governmental group would continue these policies that, when observed in retrospect - historically - will be considered	Thank you for the comment. Conclusions regarding opioids versus NSAIDs are based on head-to-head trials that directly compared these medications.

Section	Commentator & Affiliation	Comment	Response
		damning evidence against the careers and reputations of those who participated in this terrible attack on patients and their doctors. If that means nothing to you, and the suffering of patients means nothing to you, then there is nothing I can say to make a difference.	

Public Reviewer #56, Lori Cain	Question 10	The study, admittedly in places acknowledges little evidence. Please wait until ample evidence is available. As a chronic pain patient, not taking fulltime or long term opiate right now, I can tell you taking an opiate when I needed was the difference between being able to work, function at home and get my daily chores done. What we see now with the decrease in dosage and prescriptions is people going to the black market for opiates. Clearly opiates work over placebo and non opiate medications because if there was another easier to get medication that is certainly what they would seek. They would not be seeking black market opiates that are likely laced and therefore will end their life. We Pain patients would love it if there was a non opioid answer that worked as well. We would all be running to use it. Anything that works and is easy to access of course would be our golden ticket. We do not like to have to fight for the only thing that we have found to work, sometimes after many thousands of dollars of varying therapies only to go back to what worked prior to all the medical procedures, tests and medication trials. Some of those procedures causing more medical problems with long lasting effects and increasing intractable pain. All that when a prior prescription for opiates worked with little side effect. The majority of CPP use it as directed as it is in their best interest. Taking more then prescribed leaves one short medication when it is needed. We do not like to have to take it, we would rather not have pain. Doctors prescribing medicine that was never intended for chronic pain or approved for such is a huge disservice to all. For one, they do not work on chronic pain and secondly they come with many side effects that are far worse than an opiate pain medicine taken as prescribed. Opiates and benzodiazapines have been used in conjunction for many many years and were approved to do so. We did not have a problem with CPP and overdosing. CPP are not drug or prescription abusers in general. There will always be people who abuse anything, alcohol for one, yet we cannot restrict everyone due to the few that over indulge in everything. The majority of CPP are over 50 years old and when looking at the rates of overdoses there are few in that age range. I have seen vibrant members of society become non working, disabled shut ins due to pain and lack of opiate medication to control it. Clearly	The findings of the report represent the current state of the science and are based on the available evidence in the peer reviewed literature, which includes over 130 randomized trials.

Section	Commentator & Affiliation	Comment	Response
		opiates worked for them and their doctors have found nothing else that will thus they are now depressed, in pain and no longer enjoying life or working.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #57, John Schoellman, Mr.	Question 1	As a Chronic pain patient being cut off opioid pain medication after 25 years as prescribed is wrong. The medication were effective. Because of the CDC guidelines I was reduced to a lessor pain med that was not effective. Then forced to have injection that are NOT FDA approved and caused more damage to my spine. This whole opioid crisis has harmed so many people that suffered in pain. They have become a causality of the 2016 CDC Guidelines written by a group of doctors that had NO knowledge treating real pain. They treated addiction. They did not include any real pain management doctors or chronic pain patients when forcing these biased guidelines. So biased that it made it appear everyone taking pain medication were druggies. Then what makes it worse is they got a campaign with the media saying all opioids are bad, They even lied when saying no long term studies show opioid pain meds work. What a deceiving message. The truth is the CDC never did a long term study and the wording sounded like they did. So many studies have been done on effectiveness of long term opioid treatment and it is very effective. As the 50 million people that has been treated for many years. Therefore the 2016 CDC guidelines needs to be completely abolished and rewritten by a group of pain management doctors and even have several chronic pain patients on board for reference. Why? Because these pain patients have been harmed and they know what wording should be used in the new guidelines from past experience from being forced tapered or denied. We can [and] #039;t allow people to suffer in pain, that is inhumane, it [and] #039;s discriminating against the disabled and it [and] #039;s wrong.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #57, John Schoellman, Mr.	Question 10	Sorry, this is written by someone who suffers in chronic pain. I [and] #039;m not good at writing or emailing. My fingers are locking up and my hands have no feelings in them. All I ask you to do is put yourself in my shoes. Would you sit back and watch your spouse suffer in pain and do nothing? I [and] #039;m so tired the stigma that comes with pain. Everyone treats you like dirt if you say I hurt. Every doctor looks at your records and the fiirst word out of their mouth is: are you taking pain meds (Tylenol 3 a day) and they are giving you a dirty look are start lecturing you about addiction. Same with the pharmacy. I went to the ER and a lady about 80 years old was in the next certain room beside me screaming in pain. I ask the nurse that elderly lady sounds like she is in horrible pain, cant you give her any pain medicine. They said NO, we are in an opioid crisis. I said how can you listen to her scream and do nothing. Nurse said we get use to it and tune it out. This is so wrong, cold hearted. We are teaching the whole medical community to discriminate. If any of you read this what I [and] #039;m writing please put yourself in my shoes and try to imagine hurting in so much pain every day, knowing it will never go away and then to make it worse everyone looks at you like you are the worse scum on earth and you should be ashamed of yourself just for saying you are in pain. My congressman Bill Flores looked at me and said there is no reason you should have to suffer in pain like this. He said the 50 million chronic pain sufferers should have never been associated with the opioid crisis crisis. It will go down as one of the most tragedies in history. Please fix this problem today and not next year.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #57, John Schoellman, Mr.	Question 2	We need to treat with opioids till a better pain technology comes. The government spends so much money on treatment (CDC PROP plan) but very little if any on research on new technology of a new drug for pain treatment.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #57, John Schoellman, Mr.	Question 3	Chronic pain patients are now being force to have expensive surgeries and many are failed surgeries just because they are suffering. They also are filing for social security disability in record numbers now because of pain. Then they go on medicare/medicaid. This is a large expense that could have been easy prevented by treating pain.	Thank you for the comment
Public Reviewer #57, John Schoellman, Mr.	Question 4	Many chronic pain patients that have been cut off their pain meds by their pain doctor have chose to go to the streets and buying illegal drugs to treat their pain. This is driving up the demand for drugs coming across the border. I would call this counter productive. Some chronic pain patients can [and] #039;t bear the amount of pain taking their lives. This is driving up suicides .Some chronic pain patients are experiencing many health problems from untreated pain. Heart problems are the worse. We have seen many have heart attacks and strokes and dying. How cruel for this to happen.	Thank you for the comment
Public Reviewer #57, John Schoellman, Mr.	Question 5	Please write the new guidelines where it is clear to treat chronic pain. People that suffer in chronic pain are not the problem and should NOT be associated with addiction. I pray that you stop torturing people and start treating people. This is something that should not be dragged out because people are suffering and dying because of past poor guidelines and an overreaching DEA	The report synthesizes the evidence and does not make recommendations
Public Reviewer #57, John Schoellman, Mr.	Question 6	Myself I have rods/screws 3 level fusion in lower back, 2 level fusion in neck, Many bulging disc. I live with DDD. My knee, I wore off over 1/2 inch of bone before they did a total knee replacement. I was forced to have failed back and neck surgeries to try to get the pain down. I was forced to get a pain pump because of untreated pain. My troponin levels are 3 times higher. This has been going on for a while. I have a perfect heart, no heart family history, no blockage, perfect cholesterol and after 3 months of test and heart caths all they can say is my heart is stressing 3 times the normal, If I don [and] #039;t get my pain fixed then I know I will die. I said all this because after 25 years of taken opioid pain meds the 2016 CDC guidelines came out and I was reduced to 3 Tylenol a day. What is wrong with our government? FIX THE PROBLEM NOW!!!	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #57, John Schoellman, Mr.	Question 7	In past DEA raids at (PMD [and] #039;s) Pain Management Doctors, many CPP [and] #039;s were left untreated with other doctors willing to treat them. In fact no other PMD [and] #039;s would accept them and treated them like criminals. In the past, we have also seen that CPP [and] #039;s blood-pressure will rise to uncontrollable levels causing heart attacks, strokes and even death due to untreated pain. We also have seen that some patients will choose to go to the streets to self medicate because they have exhausted all avenues of pain treatment, adding to the problem of addiction and the opioid crisis. Lastly, we have seen that others choose to end their lives.	Thank you for the comment
Public Reviewer #57, John Schoellman, Mr.	Question 8	As we see the past few years now the DEA has cut opioid prescription production over 50% but yet we still have overdoses. Quit blaming legal prescriptions and concentrate the DEA resources on the border where these illegal drugs are coming in. Why is the DEA spending so much time with legal prescriptions. Most resources should be spent on the border. If the DEA wont concentrate resources to the border then congress needs to cut funding. The DEA does NOT have a license to practice medicine so why are they setting limits on doctors prescribing pain meds with legitimate pain? The DEA has not seen the patient or have a medical background to diagnose them. Next the DEA is putting limits on pharmacies, stop the practicing medicine without a license without a license,. The PDMP system can show if someone is doctor shopping and that is something that a doctor or pharmacy can see and stop themselves. The DEA has to get out of the doctors office.	Thank you for the comment

Public Reviewer #57, John Schoellman, Mr.	Question 9	We need a national pain card that will fix the problem.How does The National Opioid Pain Card WorkIt allows a person who sufferers in pain to get the opioid pain medication he/she needs.Patient has a proven need (MRI [and] #039;s and/or proper medical diagnoses).Patient has been prescribed opioids in the past with no history of abuse and they are at low risk. How does the Pain Card work with the present system we have?The Pain Management Doctor files for a Pain Card with the diagnosis and the stable amount of pain medicine needed for the patient to have quality of life.The Doctor and the Pain Patient explores risk vs benefits and also the patient goes through a training class about opioid risks and educated about prescription opioid diversion control. Then the patient assumes all risk at this point.Once the patient gets approved (just like the state approves Social Security benefits) he gets a number that will allow him to be treated without delay and be able to pick up their pain prescriptions.It allows the Pain Management Doctor to be exempt by points or red flagged by the DEA when prescribing opioid pain medicine to patients who have the Pain Card.(PDMP) Prescription Drug Monitoring ProgramsIt is a system that is used by all Pharmacies, Doctors, Healthcare and even the DEA.It shows all prescriptions that a patient is taking and the doctors name who is prescribing it.Doctors monitor it to make sure patients are not doctor shopping.Pharmacies monitor it to make sure patients are not doctor shopping and they can see the doctors diagnosis and pain treatment plan.DEA can monitor all (the patient, the doctor, the pharmacy) and look for any wrongdoing.All agencies will see the Pain Card Exemption Number using the PDMP system.The HHS has already approved their report on: Pain Management Best Practices The HHS has written new guidelines in response to the (2016 misguided CDC Guidelines) after seeing the lack of treatment which resulted from those ineffective guidelines. The HHS approved report will allow pain patients to be treated again with proper medication without being discriminated against. The only problem we have are that doctors are still in fear of the DEA raiding or shutting down their practices for several months, only to find no wrongdoing.This has happened many times!The Pain Management Doctor is left with	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
		negative publicity and no funds or desire to begin their pain practice again. Most go to work as an MD and quit prescribing opioid pain medicine all together. This is leaving most people who suffer pain (cancer or chronic pain patients) with no place to go for treatment. Unfortunately, many have taken their own lives because they just cannot bear the pain they have to live with. The is truly inhumane!They fear the DEA is not going to adhere to the New HHS report which was passed on May 9th and supported by the AMA and the CDC.The Pain Card will allow Pain Management Doctors to be exempt in prescribing proper opioid pain medication and will not have to fear the DEA will raid their practice just for treating chronic pain patients.This is an easy and inexpensive fix combined with the system we already use daily. Please help approve the Pain Card which will allow Chronic Pain Patients who suffer to be treated once again, thereby receiving quality of life without the stigma attached to treatment!	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #58, Kira Sieni	Question 10	You are using doses that are far below normal prescription strengths. 20 mme is 3 oxycodone pills a day. Of course someone with severe pain wont have benefits. If you never break the pain cycle you are always playing catch up. Also what other pain control methods are you using? NSAIDS which kill as many people as prescription opioids? I used to take pain medication and had a life. Now I am virtually bedbound except for three days a week when I drag myself to work, where I swear my boss thinks I might drop dead at any moment. This entire study proves nothing as you used miniscule amounts of medication.	We report the dosages used in the trials, which varied. Evidence indicated little dose effect above 50-60 mg MED/day (the majority of trials evaluated doses of 50-90 mg MED/day).
Public Reviewer #59 Kline	Question 1	I would like to know who is on this committee and what professional affiliations they have and/or conflicts of interest. The CDCs guidelines being co-authored by PROP zealots was quite harmful, to patients and the integrity of the report itself.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #59 Kline	Question 4	Illogical. There is a tremendous difference between non-narcotic pain relievers and narcotic pain relievers in treating both acute and chronic pain.	Thank you for the comment
Public Reviewer #6, Katharine Ingalls	Question 4	What I am having a hard time understanding is that not everyone is the same, what works for one may not work for another. For example, I have Fibromyalgia along with several other chronic conditions. I am also a gastric bypass patient of 16 years and I cannot take NSAIDs at all so I am very limited as to what I can take for my pain. I have spent the last two months cooped up in my house because of the pain. I was not on any narcotics. My doctor asked me to try a medication called Topamax which I agreed to do however, it upset my stomach terribly and I was unable to take it. I have now gone back on the long release morphine of 30 mg and I can [and] #039;t even begin to explain to you what I am able to do. I lost my quality of life and two little pills one in the morning and one at night gives me back my life and if that [and] #039;s what it takes then that [and] #039;s what I [and] #039;m going to do. I am a 55-year-old mother and grandmother. I understand the risks of opiates but if that [and] #039;s the only thing that allows me to have a quality life then I am certainly not going to abuse it and risk the chance of losing that option. I don [and] #039;t want to be looked at as a drug addict anymore!	Thank you for sharing your story, sorry to hear about your pain. The goal of the report is to synthesize the published literature on what is effective for treating pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #60, Maria Higginbotham , Voice	Question 1	Long term studies on opioid use for chronic intractable pain are not feasible and unavailable due to patients in agonizing pain cannot endure long periods of no treatment for their pain. Start listening to public outcry. Get public comment from patients, caregivers and especially pain specialists!	Given the relatively small benefits of opioids observed in short-term trials, longer-term trials would appear to be both feasible and ethical to understand outcomes with more extended use.
Public Reviewer #60, Maria Higginbotham , Voice	Question 10	Stop creating policies that hurt the most vulnerable citizens in this country. Weve been destroyed already, physicians are critiqued for providing treatment for those with cancer, are suffering from rare incurable diseases and left to suffer agonizing pain or choose suicide rather than live with no quality of life. Accept and include public comments. Especially those of pain specialists who live this everyday. Stop the anti opioid bias. Start going after illicit drugs use ie heroin and illegal fentanyl. Patients are already suffering and policy after policy is only creating more hardship	The report synthesizes the evidence and does not make recommendations.

Public Reviewer #60, Maria Higginbotham , Voice	Question 3	8.4 million patients including hospice patients, terminal cancer patients, victims of severe automobile accidents that sever limbs and damage internal organs, brave combat veterans who came back from combat with legs blown off by IEDs or similar injury, helpless nursing home residents, and victims of genetic autoimmune disorders, sickle cell anemia, and many other serious chronic health problems rely upon opioids to provide the last line of defense and only tool that can give these 8.4 million US citizens some degree of quality of life, and they and their physicians should not be living in perpetual fear and agony because misguided addiction experts drew a line on a chalkboard at 90 MME without any basis in medical science or rational reasoning, empowered by making false exaggerated claims of overdose fatalities, and operated in secret in violation of the CDC [and] #039;s own standards of scientific decision making. False information and one-sided arguments based on the tragic loss of young lives to illicit street drugs that dominate true overdose statistics have been used to manipulate decision-makers into enacting policies that only inflict harm on the innocent chronic pain community and do nothing useful to solve the real problem of illicit street drugs used by depressed, anxious, or just bored younger Americans, must be stopped and a major course correction enacted before more chronic pain patients are driven to suicide, forced to become bedridden, removed from taxpaying jobs onto an already overburdened social security system, and forced to spend all waking hours in literal torture that the United Nations outlawed for enemy combatants but somehow that is OK for chronic pain patients who did nothing wrong, followed doctors orders, and were merely victims of genetic disease or accidents they could not help? Where is the justice, humanity, and compassion in that? What have we become, a ruthless government-controlled society where individual freedom and the right to life, liberty, and pursuit of happiness are tossed out the window in a misguided attempt to rein in bad decisions and illegal street drug use? Help the addicts through compassionate medical care but don [and] #039;t confuse addicts and chronic pain patients and pass rules that hurt pain patients and don [and] #039;t even help the addiction problem which is why we see	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
		overdoses continuing to soar despite a 35-45% reduction in opioid prescriptions!!! Its time to stop and think about solutions rather than write guidelines without public input and that of world renown pain specialists. Start listening to patients whose lives have been made live able through the use of long term opioids.Stop passing bills, let the dust lie and start putting focus on illicit drugs such as heroin, illegal fentanyl etc.Youve already decimated the chronic pain community by forcing patients to live in agonizing uncontrollable pain with no quality of life Stop passing 60 bills with 3 hours of discussion, debate, and voting on the floor of the US Congress as was done with HR.6 last year and ultimately became the SUPPORT of communities act. 3 minutes per law is all that went into the HR.6 bill. How can over 400 US Representatives have time to analyze and decide such far-reaching legislation in 180 seconds per bill? That is insane!!!!	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #60, Maria Higginbotham , Voice	Question 4	Again another guideline created without public comment, this should be made available via the regulations website for public input and the authors and investigators should be made known, are you only utilizing anti opioid fanatics? Try listening to those who lives are made live able through the use of pain meds	The report synthesizes the evidence. It is not a guideline and does not make recommendations
Public Reviewer #61, Rose	Question 1	You can [and] #039;t tell many chronic pain patients that opioids dont help long term! Most chronic pain patients have tried every other medication available to treat their chronic pain and its symptoms and they don [and] #039;t help and opioids are usually the last medication tried.	Thank you for the comment
Public Reviewer #61, Rose	Question 10	This report will be just as pathetic and irresponsible as the CDC [and] #039;s 2016 prescribing guidelines. Stop harming the most vulnerable people that already have a hard time living on a day to day basis in excruciating and debilitating pain that rely on opioids to have some form of quality of life.	Thank you for the comment
Public Reviewer #61, Rose	Question 2	You are harming chronic pain patients!	Thank you for the comment
Public Reviewer #61, Rose	Question 4	Many patients, far more than the small amount of people in this study would and will disagree with your results on long term use!	Thank you for the comment
Public Reviewer #61, Rose	Question 5	This study needs massive input by many doctors and chronic pain patients. A small number of people and doctors in this study can [and] #039;t speak for thousands of us out here living with chronic pain.	The systematic review was conducted using a protocol developed with stakeholder and public input.
Public Reviewer #62, Gary Stein	Question 1	It is troubling that this report has no input from medical practitioners, or members of the chronic pain community. Its is also troubling that there is no actual discloser as to the authors identities and no discloser as to the authors qualifications.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #63	Question 1	It doesnt appear that any disclosure of which opioids were used	Types of opioids and nonopioids are described in the text and the tables; the opioid evaluated in each randomized trial is presented in the table.
Public Reviewer #63	Question 10	People involved should be listed NOW!	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #63	Question 6	Confusing	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #63	Question 7	Incomplete and picked on a bias	The protocol used to conduct this review was developed with stakeholder and public input and followed standard systematic review procedures. Studies were identified using systematic searches and selected for inclusion based on application of pre-specified criteria.
Public Reviewer #64, Colleen Parker, n/a	Question 1-10	11/7/19Dear AHRQ Reps and others: I have benefited from long term Opioid therapy. My long term intractable pain from incurable conditions are proven best treated with this. I am a caregiver to my spouse who also receives long term Opioid therapy. His physical conditions that cause intractable pain benefit most from this method also.However, unless theres a recall; and until/unless those who wrote it are identified as well as their qualifications, the end results may not best suit all concerned, perhaps even the powers that be.Thank you.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #65, Mickey Mouse	Question 1	Im sure reality is buried under tons of numbers and psychobabble so I did not even bother to look at the [and] quot;evidence [and] quot; as I take pain medication and I KNOW it works. Just like codeine cough syrup WORKED before it was yanked from the market and replaced with what? Oh ya, a whole lot of unrelieved coughing and a small boom for honey producers from those who were led to believe that it may help	Thank you for the comment
Public Reviewer #65, Mickey Mouse	Question 10	I hope everyone involved in putting together this report ages horribly. I hope you all get terrible incurable, painful diseases and are left in a world without any way out of it besides assisted suicide. Its what you deserve because you have not listened to any of us who are living this nightmare. You are like the Nazis exterminating the Jews. I think they did [and] quot;studies [and] quot; too, to prove the Jews were the cause of all their problems. Not unlike us being blamed for the addiction problems of others.	Thank you for the comment
Public Reviewer #65, Mickey Mouse	Question 2	The introduction need only say the word [and] quot;opiod [and] quot; and I know it is in the line of all the so called [and] quot;scientific studies [and] quot; designed to rid the entire world of the demon poppy products that relieve pain. Im not even going to dignify the question of whether or not pain medication works with a response to it.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #65, Mickey Mouse	Question 3	Again, Im sure the methods were all designed to [and] quot;prove [and] quot; the predetermined hypothesis that pain relievers are no good for relieving pain. I can do some basic math and that is 2 million addicts and 50 million pain patients. So 1 addict is basically worth the lives of 25 pain patients. Oh wait, this ridding the medical field of any effective way to relieve pain (therefore GUTTTING MEDICINE AS WE KNOW IT) is NOT EVEN CHANGING THE ADDICTION RATE. Not ONE addict has been saved! IN fact, they are dying even more, because they have moved on to street fentanyl, cocaine, and meth, all of which contain street fentanyl now and are very very deadly. So perhaps the purpose was to kill us all? Addicts AND the chronically ill, cull the whole lot of us?	The protocol used to conduct this review was developed with stakeholder and public input and followed standard systematic review procedures.
Public Reviewer #65, Mickey Mouse	Question 4	Im sure if some billionaire funded a study to prove the sun did not set in the west that there would be tons of [and] quot;research [and] quot; coming up with that conclusion.	Thank you for the comment
Public Reviewer #65, Mickey Mouse	Question 5	Lets discuss instead why millions of disabled people worldwide are being tortured to death. Lets discuss how horrible unrelenting pain is and the toll it takes on the body. Lets also discuss why this group is so hated that this mass extermination of them continues in earnest with barely a whimper from anyone outside of the pain community. What exactly are YOU going to do when your body starts to age and your life becomes a living hell? When YOU have to have surgery or get in a horrible accident? Im guessing you are going to want more than Tylenol or scented candles.	Thank you for the comment
Public Reviewer #65, Mickey Mouse	Question 6	I dont care what terminology you use to exterminate people. Wrong is wrong no matter how you word it	Thank you for the comment
Public Reviewer #65, Mickey Mouse	Question 7	Why are the people behind this being kept secret? Is this another PROP action, another Stanford psyop? Who IS behind this gun?	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #66, Donna Gerber	Question 10	This report is illegitimate in that none of the studies were over two years in length. How can you Determine opioid effectiveness for chronic pain patients if there are no long-term studies that have been done. I have been a chronic pain patient using opioids successfully for well over 15 years. My dosage has not changed and I am able to live a high quality of life taking under the CDC guidelines. I am not without pain, but my pain is managed without any side effects. I have never fallen or experienced A desire to take more of my medication and able to function lucidly. Prior to the opioids I was forced to take anti-seizure meds which caused severe side effects one leading to hospitalization. I was unable to think clearly while on these medications. I was also forced to try antidepressants which caused me to have serotonin syndrome. Muscle relaxers which put me in a zombie like state and I was unable to get off of my couch. Then there were the NSAIDs which almost put a hole in my stomach. Tylenol elevated my liver enzymes to a dangerous place and I developed several cyst in my liver. So opioids have been the only thing that have help me to maintain a quality of life with no negative impact. There need to be made accommodations for patients like myself who have failed at all alternative therapies including chiropractic acupuncture spinal injectionsAnd cryo-ablation. Do not take these life-saving medications away from us.	Thank you for the comment. Only 1 RCT was 1 year in duration and none evaluated outcomes at longer than 1 year; this is noted as a limitation of the evidence. Due to the propensity of opioids to induce tolerance, it is unlikely that the benefits of opioids would be greater at long-term than at short-term.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #67, Dana Runge, Patients Not Addicts, US Pain Foundation	Question 10	This draft is more worthless than the toilet paper in my bathroom. Without acknowledging who the experts are that contributed to this draft, its meaningless. You could have the homeless guy who lives under the bridge at the corner of Lake and Parkview as an expert contributor for all we know. Chronic pain patients are suffering more than ever because of guidelines and studies that prove nothing, yet are said to prove opioids work no better than OTC medications for pain. How about studying some actual chronic pain patients? We are the only experts qualified to tell you whether or not opioids work long term for chronic non cancer pain and can tell you whether or not weve become addicted to our medications, if any of us are still getting them by the time you decide to interview people who can actually tell you what difference there is between opioids or OTC meds we take for pain. By the time you decide to listen to any of us, there probably wont be many CPPs left because well all have committed suicide due to our untreated intractable pain. Why not just round us all up and put us out of our misery? Its clear you think of us as a worthless population. My cat gets better pain management than I do after surgery and its now a federal felony to mistreat animals, yet millions of actual humans, who can voice their pain, are being tortured daily because some politicians lost children who overdosed on opioids they didnt have a prescription for. How is that fair to the millions of chronic pain patients who do everything theyre asked, even give urine samples like were criminals, just to prove were taking the medication were prescribed and nothing else? Just stop. Let doctors do what they went to many years of schooling for. Let them treat their patients as the individuals they are and prescribe the medications they feel they need to allow them to have some quality of life. Treatment of pain is a basic human right. Yet so many are suffering because of bullshit guidelines that have basically been repealed because the authors have admitted they were wrong. Were tired. Were tired of fighting every day, when we already dont have much fight in us, for something that should be a basic human right. Just stop.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #68, Personal	Question 10	I am a chronic pain management patient and have been for five years. If any of the alternatives I used prior to Pain management MD I would not have gone. I have unfortunately have had several surgeries over the years including a CABG and I think I would have popped the staples if they had tried to give me Tylenol. Opioids are not the same as acetaminophen or ibuprofen thats like saying Crown Royal is equivalent to water. I have bone spurs on my cervical vertebrae one impeding upon my spine. Blown disc C and L-spine degenerative arthritis etc... also my liver and spleen are enlarged so I cant take Tylenol I am on blood thinner so I cant take ibuprofen I have terrible reflux so naproxen is just painful so....I have been to the same clinic for five years and follow every guideline I am given. I want to be held accountable and I would say that any pain management patient legit patient wants that too. But you all want to take away what makes it possible to get out of bed, take care of our families, to feel like just living. I dont expect my pain to be taken away just the edge gone so I can deal with it. I dont want to share, sell any of my prescribed meds. I take them as ordered. I lock them in a safe at all times except when going to the doctor. All these new studies and guidelines are having a negative effect on those of us who already jump through hoops to find a doctor, go through testing, get a diagnosis, find specialist, go through therapies, injections, nerve blocks ect...before you are FINALLY given pain med. I think instead of punishing those of us that followed the rules you should be teaching surgeons about tapering meds after a major surgery nd have required them for weeks instead of just taking them away and causing withdrawals which will lead to drug seeking. Thank you for your time please consider what I have written	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #69, thomas kline md, JATH educational consortium llc	Question 1	same biased language nothing newwithholding names of authors? breaking new ground in scientific obfuscation congress needs to investigate	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #7	Question 4	I believe the source of the pain for each person should be included. A recovery from minor surgery or injury is a completely different situation that someone suffering from a long term injury or illness. Also as the CDC continues to suggest (they actually control) guidelines they need to separate illegal drug us from those who take prescribed pain medication coreectly.	The report focuses on chronic pain. The type of pain is described in the Tables and analyses were done to evaluate effects of type of pain on outcomes.
Public Reviewer #70, Amanda Letanosky	Question 1	It is absurd to claim that my IBS-D, my digestion and appetitive, my emotional stability and depression, AND MY PAIN AND MOBILITY arent MIRACULOUSLY improved Only By Opioid Pain management Medications! They are! Tylenol, Other anti-inflammatories, arthritis medications, nerve medications, psychiatric medications, other therapies and treatments and medications, do NOTHING to help me compared to convincing my brain its not in pain and therefore making my body react terribly to that pain which is what Opioid Pain Management Medications do for me.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #70, Amanda Letanosky	Question 10	Opioid Pain Management Medications are my personal Miracle medication/treatment for my personal diseases/ailments/injuries/chronic illness/intractable chronic pain. I am mobile and a contributing member of society on what these non-medical/pain doctors like to call high doses (not for me) of Opioid Pain Management medications, but off them, I am totally bed-bound and suicidal over my pain.	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #70, Amanda Letanosky	Question 7	This failure to identify authorship in the draft essentially disqualifies the document. Without knowing who wrote and reviewed this document, we cannot identify their biases or predispositions, said Richard Red Lawhern, PhD, a patient advocate with the Alliance for the Treatment of Intractable Pain (ATIP). I cant say it better than Dr. Lawhern.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #71, Robert Adams	Question 1	Ridiculous!! Ive been a chronic pain patient for 11 years receiving opioid therapy. I have cervical stenosis (only one disc not fused) thoracic, and lumbar stenosis. Spondylitis, spondylethesis, etc. Despite the progression of all 3 my opioid pain medication has been reduced to 1/3 of my previous dosage. I find the evidence seriously lacking and poorly collected.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #71, Robert Adams	Question 10	When will you come to your senses? Chronic pain patients on stable long term opioids are dying from under treated pain EVERY day. Please stop this insanity. Chronic pain patients are committing suicide, turning to illicit street drugs, and suffering horribly all because of an erroneously named War on Opioids. Illegal Fentanyl and Heroin are the problem . Despite the facts we are punished. 99% suffer for 1%. Where is the logic in this cruel insanity?	Thank you for the comment
Public Reviewer #71, Robert Adams	Question 3	How were these methods developed and constructed and on what basis? Despite millions of chronic pain patients suffering , erroneous and biased methods are still used. You make them sound solid but usually biased.	The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included public input.
Public Reviewer #71, Robert Adams	Question 4	Completely erroneous and biased.	Thank you for the comment
Public Reviewer #71, Robert Adams	Question 5	Nonsense	Thank you for the comment
Public Reviewer #71, Robert Adams	Question 6	As usual trying to develop a new language no one understands but the writers.	Thank you for the comment
Public Reviewer #72, Tricia Lupole, HCVets.com Educational Website [and] amp; Support Forums	Question 10	Small beneficial effects versus placebo thus equal [and] quot;Quality of Life. [and] quot; That [and] #039;s the bottom line and should always be a patients [and] #039; choice. As a caretaker I saw first hand how opioids changed a life to functional when non opioids were exhausted. As an Advocate, I encourage accurate data without political or financial influence, to access opioid use. Too many suicides and needless suffering when we have the ability to help.	Thank you for the comment. The Conclusions describe the small, short-term benefits of opioids.
Public Reviewer #73, Duane Pool, Pain Advocacy Coalition	Question 1	Seems one hand establishes policy framework ie; HHS The Chronic Pain Task Force and the other hand ie; AHRQ seeks to immediately dismantle with no other agenda other than to stall moving forward and creating further confusion for providers and adding to significant harm of patients!	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #73, Duane Pool, Pain Advocacy Coalition	Question 10	Stop, cease and desist! Few of the studies were long-term, an evidence gap that exists not only for opioids but for all medications used to treat pain. Long-term studies are lacking because it would be unethical for researchers to knowingly treat someones severe pain with a placebo which would essentially amount to torture. The old saying that absence of evidence is not evidence of absence would seem to apply to the effectiveness of opioid medication.	Thank you for the comment
Public Reviewer #73, Duane Pool, Pain Advocacy Coalition	Question 2	Who is the author of the AHRQ report? What experts were involved in drafting it? Who are the peer reviewers? We dont know because the AHRQ wont identify any of the participants until the final report is released.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #73, Duane Pool, Pain Advocacy Coalition	Question 3	Federal health officials at AHRQ are releasing a draft report on the risks and benefits of opioid pain medication without seeking substantive input from the public or medical community.	The protocol used to conduct this review was developed with stakeholder and public input and followed standard systematic review procedures.
Public Reviewer #73, Duane Pool, Pain Advocacy Coalition	Question 4	Limited EvidenceIn drafting the report, the AHRQs experts reviewed over 150 clinical studies and reviews of pain patients prescribed opioids. Few of the studies were long-term, an evidence gap that exists not only for opioids but for all medications used to treat pain. Long-term studies are lacking because it would be unethical for researchers to knowingly treat someones severe pain with a placebo which would essentially amount to torture.The old saying that absence of evidence is not evidence of absence would seem to apply to the effectiveness of opioid medication, but not in the AHRQs draft report. Limited evidence is repeatedly cited as a reason not to use opioids, while similar low-quality evidence is cited as proof that opioids are risky.	The report does not state that opioids do not work long-term; it summarizes the existing evidence which as noted by the reviewer is very sparse for long-term outcomes.
Public Reviewer #73, Duane Pool, Pain Advocacy Coalition	Question 5	Discuss the lack of transparency to create another conflated document to serve an agenda and not the truth.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process. The report was conducted using a protocol that was developed with stakeholder and public input and posted on the AHRQ website.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #73, Duane Pool, Pain Advocacy Coalition	Question 7	The draft top level summary reveals a deliberate and scientifically unsupported bias against opioid analgesic therapy that continues and expands on the cherry picked research quoted in the 2016 CDC guidelines on prescription of opioids.	The conclusions are based on the available evidence. The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included stakeholder and public input.
Public Reviewer #73, Duane Pool, Pain Advocacy Coalition	Question 8	Particularly concerned about references in the draft to the Krebs report, a controversial study that found opioids no more effective than acetaminophen in treating back or knee pain. Critics say the Krebs study was small, poorly designed and failed to prove anything.profoundly flawed and biased Krebs report is among the references quoted in the draft report. This inclusion by itself would be grounds for deep alarm.	The details of the Krebs trial are presented in the report. Opioids were actually compared against stepped care nonopioid therapy which included NSAIDs or acetaminophen as step 1 with the addition of antidepressants, antiseizure medications, topicals, or tramadol at step 3. It was well designed in terms of RCT methodology. As previously noted, the population had moderate pain at baseline (similar to many other trials of opioids). The trial was not small relative to other opioid trials--e.g. of the trials of opioids vs. nonopioids, the sample size was <130 in 10 of 16 trials (the sample size for SPACE was 240).
Public Reviewer #74, brian bine, N?A	Question 10	This madness must stop!! How is it that we have literally abandoned people in pain. Focus should be on the cartels and high level dealers of illegal drugs, not chronic pain patients. The true measure of a man, institution, and/or government is how they treat the most vulnerable in their population. It is obvious that our politicians and government have lost all humanity in regards to the chronically ill, in pain, and facing more agony as misapplied legislation continues. It is imperative that physicians be allowed to perform their art without harassment from the government. The thousands of people in chronic pain should not be left to their own devices (suicide?) as their need for adequate pain medication is ignored or denied. I view with disgust how we approach a prohibition on necessary pain relief for our injured, victims of botched surgeries, veterans, and elders. DON [and] quot;T PUNISH PAIN!!!!	Thank you for the comment
Public Reviewer #75, Randall Carter, Retired	Question 1	If [and] quot;evidence on long-term effectiveness is very limited [and] quot; it would be ill advised to recommend changes in treatment and dosing or to assume harms in long term use.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #75, Randall Carter, Retired	Question 10	This effort requires more research on a larger patient population, over a wider geographic area and needs to be supplemented with data from the PDMP systems from multiple states before adoption of any recommendations. I see nothing to indicate as of late 2019, that any further steps are need at reducing patient exposure to opioids. Enough damage has already been done to this community of patients. The problem with opioid addiction and deaths is now in our streets, not in the clinical setting.	Thank you for the comment
Public Reviewer #75, Randall Carter, Retired	Question 2	Claims made in the introduction require evidence through large scale studies by multiple investigators which currently do not exist. A rehash of existing and outdated studies is insufficient evidence for any further actions.	We updated the Introduction with the most recent data on prescription opioid-related deaths (from 2017).
Public Reviewer #75, Randall Carter, Retired	Question 3	As a former anesthesia provider of 27 years and chronic pain patient of 17, I can testify that opioids are significantly better than placebo for most moderate to severe painful conditions, and they are patient dependent due to body mass, genetic predisposition, underlying condition and tolerance. With proper supervision and regular testing, they are safe for use as prescribed and have been for hundreds of years.	Thank you for the comment
Public Reviewer #75, Randall Carter, Retired	Question 4	Until data collected through state PDMP [and] #039;s is used to quantify the number of overdose deaths caused by prescribed opioids only, the data currently in use is inadequate for assuming risks and harms.Your conclusions appear to be based on outdated research which is now biased, because of more accurate data is now collected and available through state PDMP [and] #039;s.	Thank you for the comment
Public Reviewer #75, Randall Carter, Retired	Question 5	Again your discussion is based on old data and is a rehash of what was already known, therefore it neither adds useful information or effective guidance for taking steps beyond those which have been taken. The studies cites have small patient populations, or are limited geographically raising concerns about local factors which may have unduly affect your methods.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #75, Randall Carter, Retired	Question 7	For the most part, old data.The opioid crisis has changed, your data and methods do not reflect this. Most states have seen a greater than 45% reduction in prescribed opioids and yet overdose deaths have increased dramatically since 2014. Attacking prescribing efforts is not going to make a dent in the current problem. While the healthcare system essentially operated on an honor system prior to 2014, leading to a some bad actors, those loop holes have been effectively shut down. Fear within the prescribing community has resulted in a greater than 70% reduction in dosage amounts for the few who remain on opioids, further restriction and reductions would do more harm than good. If you want to fight addiction, fight it where the battle now is, on the street not in doctors offices.	Based on provisional data from CDC and the National Center for Health Statistics, the drug overdose rate decreased about 5% from December 2017 to December 2018; this was the first decline sine 1980. As noted in the Introduction, overdoses due to illicit fentanyl have increased dramatically. None of these issues impact the findings or conclusions of the report regarding the benefits and harms of opioids for chronic pain.
Public Reviewer #75, Randall Carter, Retired	Question 8	Mostly outdated data.	The findings of the report are based on searches conducted through August 2019.
Public Reviewer #76, Cyndi Lowerison	Question 10	Please dont take our quality of life away from us! I have a much better, more meaningful life when my pain is treated. I hate that so many people have overdosed due to the street drugs available now! I dont take street drugs at this point..... please dont take my prescribed medication away.	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #77, Barbara Roberts, Chronic pain patient	Question 1	I dont see true evidence. I have had severe chronic pain since 1994. Thanks to prescription pain medications I was able to continue working a fairly active job. I stayed on the same dosage of methadone for pain for 18 years. No increase, yet it was beneficial to me. It kept me from vegetating in bed. These studies that say there is no evidence that opiatemedications help are construed wrong. How can they possibly show this? Ive tried probably every possible alternative to medications [and] amp; they are extremely expensive, insurance doesnt always cover, they can do more damage, (surgeries, various nerve blocks, injections, more) I had severe allergic reactions to Gabapentin [and] amp; Lyrica that put me in the hospital. How are these modalities superior to opiate pain medications in moderation prescribed to people who dont become addicted to them? You all [and] amp; we all know the issues are illegal drugs, Heroin [and] amp; illegal Fentanyl coming in over our borders from other countries I wont name. Alcohol [and] amp; cigarettes kill way more people each year than illegal drugs. Youve lost the war on drugs [and] amp; just want to justify your use of billions of dollars of money. Now Ive been force tapered very rapidly, making me absolutely miserable, my life is no longer productive, Im on SSDI. How is that so superior? People with severe chronic pain consider suicide a lot. Does this cause you satisfaction?	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #78, Debra Aellig, DPP	Question 10	Chronic pain patients are suffering unnecessarily. Due to government overreach, the hysteria about legitimate Opioids is out of control! We need to return proper pain management back to the MD/patient relationship! The DEA needs to stand down and away from threatening MDs who treat people with chronic pain. I [and] #039;m a responsible 59 year old woman suffering with undertreated chronic pain! This hysteria about Opioids must stop! Opioids are another tool an MD can use to help chronic pain sufferers. I [and] #039;m in pain so it [and] #039;s difficult to read and answer every question. Sincerely, Debra Aellig 262-364-6041	Thank you for sharing your story, sorry to hear about your pain.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #79, Kel G	Question 10	Every patient has pain for different reasons, every patient responds differently to various treatments [and] amp; various medications, various doses, etc. Opioids do not respond to everyone the same way. Metabolism plays a huge part, pain tolerances, etc. The morphine equivalent table is incorrect!! These meds are not equal in many ways. One doesn [and] #039;t override the other. Upping one [and] amp; tapering another just doesn [and] #039;t cut it. We [and] #039;ve all tried when on multiple meds. It doesn [and] #039;t work- if it did, why would anyone be on multiple meds in the first place??? No one is immune from pain. Not you. Not your loved ones. Everyone is one car accident away from a life of pain!! Everyone is one diagnosis away from a painful incurable disease!!! Do you want your future family members to be left with nothing??I go thru dental pain that my chronic neck/back pain meds don [and] #039;t even acknowledge!!! Multiple pains will not be subsided because you just happen to be on a lain med already. You may need to I crease for a week or two. Not just [and] quot;no [and] quot; cuz I [and] #039;m already on pain meds. It just doesn [and] #039;t work this way!!!Let Drs be Drs and politicians be politicians!!!!Drunk drivers [and] amp; alcohol kill and costs so much every year but you don [and] #039;t even try to do anything about this!!! You will sell it any where one can get a license!! At most times of day/night! No one sits at a liquor store waiting for the alarm to stop so i can buy a 6 pk!!!!!Look at your priorities and what you are doing to the future medical care of your loved ones. Life was supposed to get easier not go back to 3rd world stages of living.Would t you want to keep people off disability if you could?? If someone needed 90 pills a month to stay off disability every day, would nt it be worth looking into???	It is necessary to calculate morphine equivalents to be able to evaluated effects of different opioids. We used published dose conversion ratios from a systematic review to calculate morphine equivalents (Nielsen S et al. Pharmacoepidemiol Drug Saf 2016;25:733-7).
Public Reviewer #8, Judith Miller, Soaring Hope / Cordinated Alternative Therapies	Question 1	We have developed a successful science-based model of care for chronic pain that requires no medication. We treat the cause of pain rather than the symptoms. Please contact me for further information - it may save a lot of medicine dependence as it works. Judith Miller, Ph.D. 719-541-4912.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #8, Judith Miller, Soaring Hope / Cordinated Alternative Therapies	Question 7	I have 50 years research to back our non medicative model for pain relief. Judith Miller, Ph.D. 719-541-4912	Thank you for the comment
Public Reviewer #80, Julie Killingworth	Question 1-10	I am a Sarciodosis Sufferer with several rarer manifestations. I am disgusted by this hostile takeover of junk science Suboxone pushing New Age zealots who have no clue what it is like to live in a confused deteriorating body. I believe 80% of the authors are Scientologists or paid Reckitt Shills and the others are overruled. Ive been reading their Evidence-based Peer-Reviewed regurgitated studies for nearly 2 years since Ive been targeted for extermination for the crime of inheriting this horrific disease from my father and Im disgusted. They dont know what its like to be in the medical gauntlet, they are removed from hums it and have no business entering the world of incurable disabled pharmaceutical and medical choices. It was difficult enough surviving before these vultures invaded my very private world. My father was tortured to death over the hysteria they drummed up. We will not tolerate this much longer. This is a shameful targeting of the least fortunate and a violation of every international and national medical ethic code, civil rights and disabled abuse. Its unspeakable I have rare fatal lung disease and refused a small bottle of cough syrup to relieve my scared congested lungs because these lunatics claim it will not work. It did work and now the quality of my life is diminished. Suboxone will not break up the phlegm in my lungs! Those medically illiterate hacks who wrote that draft think we all have ingrown toenails. Im 50 years old and with the lungs of a 75 year old shipyard worker!!!	Thank you for sharing your story, sorry to hear about your pain.

Public Reviewer #81, John Pezzani, Patient	Question 10	This report should be shredded and not looked at by anyone in charge of policy. This report claims its goal is to research the treatment of chronic pain with opioids, but no actual research was done. Pulling up extremely flawed studies that in the reports own admission are of poor quality is not research. Research would involve contacting prescribers and patients to determine the effects of the CDC guidelines. Simply reviewing the same materials the CDC did for a second time is insane when it will obviously produce the same result and knowingly effect the lives of patients. A simple google search would show the tens if not hundreds of thousands of patients that are needlessly suffering as a direct result of the CDC guideline. Many patients that no longer have their pain controlled turn to the streets for heroin. Many times this is laced with illicit fentanyl in amounts too high for even these opioid tolerant patients. An inexcusable number of them have died from overdose that never would have happened had their medications not been dramatically decreased or discontinued. Everyday there are new stories about chronic pain patients that have committed suicide due to uncontrolled pain after reduction or discontinuation. In the 2017 CDC survey nearly 50 percent of patients force tapered have contemplated suicide. These overdose and suicide deaths are the direct responsibility of the CDC and they should be held accountable. If this report is published as is you will bear just as much responsibility as the CDC. While there is contradicting information about opioid prescriptions and overdose, there is nothing that can contradict the cause of these deaths. Earlier this year the FDA and even the CDC issued statements that the guideline was being grossly misapplied and it was never intended to force taper legacy patients or to set a firm limit on the MMED doctors could provide to new patients when clinically justified. The guideline explicitly states that it is only intended for primary care physicians treating chronic pain. It even suggest that is pain is not adequately controlled at the suggested 90MMED doctors should consider sending their patients to a pain specialist. The irony is that those most effected by the guideline are those already being treated by pain specialists. Pain specialists have rigorous specialized training in pain management and	The study was conducting using standard systematic review methods, based on a protocol developed with stakeholder and public input. The findings are based on the available evidence.

Section	Commentator & Affiliation	Comment	Response
		have already been using multiple approaches to treat pain. I have tried physical therapy with no success and it actually resulted in increased pain. I also receive cortisone injections in my joints, at trigger points and in epidural spaces on a regular basis that prior to the guideline had kept me comfortable at a steady dose of opioids at 10x the suggested CDC dose for 5 years. Since MO started mandating doctors taper doses to the CDC recommendation my pain has increased every month to an intolerable level that has rendered me nearly completely bedridden. I only get up for the restroom, to microwave meals, my now twice monthly shower and for doctors appointments and pharmacy trips. I am not an outlier and represent the vast majority of patients that have been force tapered. The ramifications of this report need to be strongly reviewed before its release. By simply submitting it to the AMA you will find that this information is rejected by slightly less than a consensus of applicable practitioners. I am well aware that this has only been opened for comments as a matter of procedure and no amount of contradictory information will change the minds of the authors who are blatantly biased against the use of opioids, however I want my objection as well as the reasons to be documented. Even if you receive only negative comments, which would not surprise me, this will not change. No amount of clinical evidence is enough for you people. It is the same as there is no amount of evidence that shows the successes of the Trump administration that is enough to change the minds of democrats, never Trumpers and the main stream media. Even the loss of all credibility does not bother those who are not effected by the ramifications of this report. If any of you retain any sense of morality you will scrap this report and conduct new research on the real world evidence of treating chronic pain with opioids. I used to say I would not wish chronic severe pain on my worst enemy but this has officially changed my mind. A pray that all those responsible for this will have to live in severe chronic pain and suffer from the consequences of this report.	

Public Reviewer #81, John Pezzani, Patient	Question 7	The references to studies in the report shows the bias of the drafters of this report. None of the chronic pain studies even meet the CDCs definition of chronic pain which is pain lasting 6 months with most lasting about 12 weeks. It is even shown that the quality of most of these studies was poor. They are also treating the pain with far too low of a dose to have a measurable impact on chronic pain. Several of these studies also suggest that opioid use for chronic pain has a high risk of addiction and abuse. This cannot be further from the truth. If a person is truly in chronic pain they do not abuse their medication as it would lead to a massive increase in pain when they run out early. Actual studies show there is a very small, about 0.15 percent, chance of addiction in long term opioid treatment for chronic pain. The same studies show that the death rate from medication in chronic pain patients is exactly the same as for patients with atrial fibrillation being treated with blood thinners to reduce the risk of stroke at 0.25 percent. There is ample clinical evidence that supports the use of opioids in high doses for chronic pain. There have been and will never be any studies that assess results for long term use since that would be paramount to torture for the chronic pain patients on placebo. If a study was done replacing opioids with placebo for those with long term use it would only last 1-2 days before those on placebo were in excruciating pain and opioid withdrawal. Withdrawal cannot be avoided with prolonged use of opioids and dependence begins in on only a few days for some patients. When legitimate high quality studies cannot be done the only solution is to use clinical evidence. On my own I have easily found dozens of studies with thousands of pages supporting the use of opioids to treat chronic pain and contradicting evidence for addiction. This was just done when I was bored and not in severe enough pain to keep me from getting online. Unfortunately being in too much pain to get online has become the norm. The craziest thing about all of this is that in this report I found a link to a 2017 CDC survey on chronic pain that shows how detrimental the guidelines have been to chronic pain sufferers by both patients and practitioners. You had to have gone out of your way to ignore all the evidence that shows the harms caused by the guideline. You have cited the same flawed studies the CDC used	We only included studies of patients with chronic pain, defined as >=3 months. Effects of dose were evaluated; there was little evidence of a dose-response relationship, particularly above 50 mg MED/day.

Section	Commentator & Affiliation	Comment	Response
		when issuing the guidelines guaranteeing the same result. Again there is no way this was not done purposefully. Your draft result fails not only to mention the authors and peer reviewers but also fails to list any and all of the professional organizations they are affiliated with. This is extremely relevant considering that many of the authors of the CDC guideline represented organizations against prescribing opioids. An unbiased conclusion cannot be made by these people. Pain management specialists should be responsible for reports like this since they can back their decisions with clinical evidence. This whole report is a joke and is being used to further punish chronic pain sufferers simply for being in pain.	
Public Reviewer #81, John Pezzani, Patient	Uploaded Document	Lawhern FDA Advisory Committees.PDF (37 KB)	Thank you for the comment. The attachment (#18) was reviewed.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #82, John Pezzani, Patient	Uploaded Document	cdcsurvey2017.pdf (558 KB)	The attachment (#19) was reviewed. The survey is about the CDC guideline, not this report.
Public Reviewer #83, John Pezzani, Patient	Uploaded Document	Response to HHS Pain Management Task Force - Lawhern.PDF (276 KB)	Thank you for the comment. The attachment (#17) was reviewed.
Public Reviewer #84, John Pezzani, Patient	Uploaded Document	Lawhern Comments to HHS Meeting.PDF (7 KB)	Thank you for the comment. The attachment (#17) was reviewed.
Public Reviewer #85, John Pezzani, Patient	Uploaded Document	Opioid-Crisis-Pain-Related-Suicides_0.PDF (744 KB)	Thank you for the comment. The attachment (#20) was reviewed, and presents descriptions of patient suicides and does not meet inclusion criteria because it is not possible to estimate risk of suicide.
Public Reviewer #86, John Pezzani, Patient	Uploaded Document	Physicians Call for End to Political Interference in Medicine.PDF (183 KB)	Thank you for the comment. The attachment (#21) was reviewed.
Public Reviewer #87, John Pezzani, Patient	Uploaded Document	Regulatory Overreach - Lawhern.PDF (18 KB)	Thank you for the comment. The attachment (#22) was reviewed.

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #88, G Miller	Question 4	I did not read the report.I was an RN for about 30 years, and an CNA for 10 ears before that. And a regular person for 20 years before that.I have personal knowledge,hands on knowledge, general knowledge, and some simple common sence.I as also worked directly for years as a MDS coordinator accessing pain. I know what we found. Pain was vastly undertreated. Pain negatively impacted quality of life and patient outcomes.Pain is the 5th vital sign. It has a larger negative impact than most other things.We have opiates that have been used very safely for years. With negligent negative side effects and very low addiction rates.... addicts have pain sometimes too.Pain is a basic thing that needs to be treated, and is a basic human right. Addiction a separate issue. Get pain under controll worry about addiction later.It is inhumane to do otherwise. To with hold pain medication that is effective,those are opiates, is an act of torture.People have a God givin right to treat their ills, including pain how they see fit.Until research is done azad nd a non addictive effective substitute is found, we should continue with medications we have .The inchurance companys may not want to pay for it, but their profits are not paramount here.And actual addicts of any kind are separate issues. People have a right to do what they wish to their own body [and] #039;s. We dont have to like it. We can focus on offering treatment but can not forse it on anyone.Pain needs to be treated as the 5th vital sign. It needs to be treated. It is noones right to take that away.	Thank you for sharing your experience.
Public Reviewer #89, Chad Kollas	Question 10	The failure to disclose the authors of this document severely hampers its credibility. Given recent failure of prominent authors to disclose clear conflicts of interest (see https://annals.org/aim/fullarticle/2754188/correction-rethinking-opioid-dose-tapering-prescription-opioid-dependence-indications-buprenorphine), transparency in creating balanced opioid policy is critical. Misapplication of the CDC Guidelines resulted in unacceptable harms to many patients; dont repeat an egregious policy error.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #9, James Rotchford, M.D., M.P.H., Olympas Medical Services LLC	Question 1	The studies and evidence are based on population studies that have no evidence of screening and or patient selection based on a host of comorbid conditions including moderate-severe opioid use disorder. Demonstrating benefits from opioids may well be a function of an ability to properly select appropriate patients. This is the case for most pharmaceuticals. Selection based soley on diagnosis is problematic. It may not be the opioids but the selection and criteria for selection that reflect the outcomes observed and measured. In addition varied dosing and pharmacology of varied opioids are important to recognize in any attempt to validate outcomes associated with opioids. We wouldn [and] #039;t judge the benefit of antibiotics in general without attention to dose, duration, patient history, patient selection, antibiotic selection, comorbid conditions, etc. Yet look at how we study opioids and their outcomes.	The characteristics of the patients in the trials is described in the Tables and Results. Most trials excluded patients with moderate-severe opioid use disorder; this would generally be expected to improve outcomes. Analyses were conducted on duration and dose, as presented in the report.
Public Reviewer #9, James Rotchford, M.D., M.P.H., Olympas Medical Services LLC	Question 10	Please acknowledge implicit biases quite prevalent in this arena of study and recommendations.	The limitations of the report are discussed in the Discussion.

Public Reviewer #9, James Rotchford, M.D., M.P.H., Olympas Medical Services LLC	Question 2	Individualized care is essential for the best of outcomes in all areas of medicine. No mention is made of the significant cultural biases and prejudices regarding the use of psycho-active and addictive substances, let alone opioids. How about the old reality handed down to us by the Greeks?: One man [and] #039;s poison is another [and] #039;s food. No mention to the risks particularly high in patients with immature brains, PTSD, family hx. of SUDs, OUDs..short acting, prn medicating, etc.It [and] #039;s as if the government wants everyone to be the same. Opioids good or bad. Not so...It depends.. The level of opioid prescribed can be either life saving or risky. It depends, similar to insulin in a diabetic. No one is talking about the unintended consequences of limiting opioid use without other accessible options for effective pain management. Why not emphasize the CDC [and] #039;s finding that 25% of patients on COAT have an OUD! The implications are enormous and no one talks about it or the importance of agonist therapy for those with OUDs. No one speaks to the relative lack of payment for effective non-pharmacological and behavioral care for pain. No one acknowledges that chronic pain is largely a disorder of the CNS and is subjective in nature and our medical culture and larger culture has a distinct bias toward the objective. How about discussing the morbidity and mortality associated with unmanaged pain, SUDs, mental illnesses, lack of access, etc..What are the consequences of undermining physician authority. Third parties are being given increasing authority to define what constitutes proper care for an individual. I thought it was the dominion of States to assure the standards of medical care. What are the consequences and serious side effects of undermining trust in a physician [and] #039;s discretion and judgement in the context of a therapeutic relationship. What about acknowledging that recommendations given our litiginous and highly regulated health care industry are readily translated into [and] quot;laws [and] quot; in which one shoe fits all, and medical care becomes black and white. What about exploring the nature of blame and shame in our culture, particularly as it relates to substance use and abuse, let alone mental illness that plays a significant role in chronic pain. It is not a coincidence we have	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
		more people incarcerated in prisons for untreated mental illness and SUDs than perhaps any other country now or historically. How about a formal review and study of the impact of our regulatory system and how it impacts substance misuse and abuse. We assume it is all for the better? This assumption is highly predicated on our culture [and] #039;s predilection for ever burgeoning laws and regulations.	

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #9, James Rotchford, M.D., M.P.H., Olympas Medical Services LLC	Question 5	While association clearly does not imply causation and some of the findings suggest same, how about the association between the amount of regulatory efforts in our culture, even over highly selected and trained professionals, and the amount of substance misuse and abuse? I suggest more humility regarding the findings and recommendations are for anyone with an ability to think critically and who appreciates subconscious cultural factors play a significant and often unspoken role.	Effects of regulatory efforts was out of scope for this report
Public Reviewer #90	Question 1	Without the authors being disclosed this study can not be deemed unbiased nor accurate	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process
Public Reviewer #90	Question 10	Patient whom experience moderate to severe chronic pain that have been treated long term on such a low dosage threshold most being treated with a dosage under 50 mg MME, the outcome of ineffectiveness would not be surprising for many of these patients would be under treated for moderate to severe chronic pain [and] amp; henceforth would not receive the full [and] amp; adequate benefits that prescription opaites can provide to patients long term whom suffer from debilitating levels of chronic pain. Without a disclosure on the authors biase can not be ruled out. I feel this study is basically at this point irrelevant to determine the true effectiveness of the treatment of moderate to severe levels of chronic pain. To give this study any weight upon making decessions upon patient health care [and] amp; the effectiveness of opaites used long term would be outlandish.	Thank you for the comment
Public Reviewer #90	Question 2	It appears as if they have [and] quot;cherry picked [and] quot; data that soley benefits the agenda [and] amp; supports the V.A. Adminstration implementation of the illegally written [and] amp; [and] quot;accidentally [and] quot; fabricated numbers contained within the 2016 CDC opaite prescribing guidelines as a standard of care.The patients were most all on a extremely low dosage of opaites which could also effect the outcomes when chronic pain is under treated the opaites of course shall not be effective if the dosage is to low.	We followed standard systematic review methods

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #90	Question 3	The study does not effectively evaluate the effectiveness of opaite treatments used at a proper dosage to be effective to treat moderate to severe chronic pain long-term being most all participants were treated with a dosage level of under 50 mg MME	Thank you for the comment, we included available published evidence and reported the dosages as reported by the studies.
Public Reviewer #90	Question 4	The study should not warrant any weight be given to it. It should be removed [and] amp; republished on regulations.gov soley after the authors have been disclosed.	Thank you for the comment
Public Reviewer #90	Question 7	Again as I stated I feel the supporting data was cherry picked per say to support the undisclosed authors ideology that opaites used long term are not effective in the treatment of chronic pain. Therefore I can give little if any weight to this study [and] amp; feel it should not be considered in any manor in determining the effectiveness of opaite medications used long term to treat chronic pain.	The conclusions are based on the available evidence. The report was conducted using methods described in a protocol published prior to conducting the report. The protocol was developed though a process that included stakeholder and public input.
Public Reviewer #91, Laine Tipton	Question 1	The number of people studied and study methods are not nearly large enough to gain ac Co irate results from this pseudo-report.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #91, Laine Tipton	Question 10	With the author(s) unwilling to give their name and affiliation at the outset of this report, everything in it comes up for questioning as personal bias and affiliation will surely have a negative bent. I am a retired RN who is also a veteran who uses VA facilities for healthcare (which is extremely marginal at best), and a chronic pain patient. I have been forcefully tapered from opioids, and that taper has had negative and deleterious effects on my personal and professional life. Being forced to further cut the dose of medications I take will further remove me from living a single life to one continually dependent on others from personal ability to perform the activities of daily life such as dressing, cooking, and light housekeeping in my own abode to further requiring the assistance of others in those functions. I find it extremely distressing to have this report valued on any level for a multitude of reasons. The aforementioned lack of knowledge regarding the author(s) and their affiliations, the minimal size of included patients from a relatively restricted portion of real people that make up the population of chronic pain patients, and a very clear bias against opioid use within that population give strong reason why this entire document and its contents permanently scrapped and not revisited. There have been long term, appropriate studies done showing that opioids ARE effective for chronic pain, that chronic pain suffers do not have an increased risk of abusing their opioid medication, and the overall benefit taking opioid medication has had on their long term ability to hold a job, do their own shopping and cooking, interact in group settings with others, and continue to care for themselves on the most basic levels. It is my very strong request that this entire study and document be discarded before yet more chronic pain sufferers are placed in a more difficult situation than they already are.	AHRQ followed standard procedures and does not publish the names of authors until the report is finalized, in order to maintain the integrity of the review process

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #92, Kimberly Barry	Question 5 and 10	My Story:I was stable on my opioid prescriptions for 5 and a half years. My quality of life was good. Good enough to do a load of laundry and do physical therapy in the warm water therapy pool at a nearby hospital for life long physical therapy and exercise. I was able to do many things in moderation per day and I was happy - the pain was under control. L3/L4 Fusion Surgery allowed me to walk; however, it also gave me a spinal staph infection. I was lucky because the neurosurgeon and the plastic surgeon doing the emergency surgery were able to leave the hardware on L3/L4. The staph infection denied any further, L4/L5, surgery to help further reduction with the mind-blowing pain. I have DDD, Degenerative Disc Disease, as well as a severe herniation injury caused from unpacking dish packs (boxes) from the 10th military move. I am a military veterans spouse of 27 years. My husband retired and became a civil servant after 23 years of duty due to my inability to keep moving.Just had forced defibrillator/pacemaker [and] quot;procedure [and] quot; so heart doctor will authorize the pain pump [and] quot;procedure [and] quot; by my pain management doctor due to FORCED opioid reduction by my pain manager. Shouldn [and] #039;t it be illegal to [and] quot;force [and] quot; 2 surgeries by forced reduction? No one has any answers because the state of TX passed protection for chronic pain along with cancer pain, palliative, and end of life care; pain manager says it is the federal DEA. Is this true? The feds march on Texas and we have zero protections? Who is allowing this? The governor of Texas, the White House? Thanks for all your help and support everyone!Sincerely,Kimberly A Barrykimbarry@live.com	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #93, Jess Walker	Question 4	Taking away opioids from chronic pain patients is nothing more than cruel and unusual punishment. Further, the patient doctor relationship is ruined once an MD causes harm by stopping, reducing, or refusing adequate pain control of any patient.Quality of life is a basic human right.	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #94, 95, 96, and 97, Joy Maxwell, Dont Punish Pain Rally	Question 1	This needs to be put out to the public you are so very wrong to say opiate opioid or narcotic pain medication works no better than placebo	Thank you for the comment
Public Reviewer #94, 95, 96, and 97, Joy Maxwell, Dont Punish Pain Rally	Question 10	Please help me I just want my life back I just want to go to work go to my grandkids activities go for a walk. I was on the same medication same dose for over 22 years. Now I cannot get out of bed I thought I was alone. Millions and millions of of others are telling MY story please please help WHO Are WE hurting??? No one but ourselves by having our narcotic opiate opioid Pain medication forced taken from us	Thank you for sharing your story, sorry to hear about your pain.
Public Reviewer #94, 95, 96, and 97, Joy Maxwell, Dont Punish Pain Rally	Question 2	I would like to have you take anyone of the over 50 Million Veterans and non veterans and do a study, we in the pain community have done all other treatments why can you tell us that our narcotic opiate opioid Pain medication does not work we know for a fact YES it works	Thank you for the comment
Public Reviewer #94, 95, 96, and 97, Joy Maxwell, Dont Punish Pain Rally	Question 3	Millions and millions of people with painful diseases have been on same medication same dose for over 15,20 years	Thank you for the comment
Public Reviewer #94, 95, 96, and 97, Joy Maxwell, Dont Punish Pain Rally	Question 4	How do you just force Millions and Millions of Veterans and non veterans off our medication we are dying due to untreated pain	Thank you for the comment
Public Reviewer #94, 95, 96, and 97, Joy Maxwell, Dont Punish Pain Rally	Question 5	This report needs REAL people with painful chronic illness and disease we need your help	Thank you for the comment
Public Reviewer #94, 95, 96, and 97, Joy Maxwell, Dont Punish Pain Rally	Question 7	You need to exam real people with painful diseases painful illness that have been harmed forced taken off their prescription pain medication	Thank you for the comment

Section	Commentator & Affiliation	Comment	Response
Public Reviewer #94, 95, 96, and 97, Joy Maxwell, Dont Punish Pain Rally	Question 1	This needs to be put out to the public you are so very wrong to say opiate opioid or narcotic pain medication works no better than placebo	The conclusions are based on the available evidence. The report does not state that there is no benefit--it found that benefits were small.
Public Reviewer #98, Sara Burdett	Question 1-10	You need to publicly make your guidelines available for input.	The report synthesizes the evidence and does not make recommendations

Public Reviewer #99 and 100, DEBORAH MILLER , Me, as a suffering human being and an RN with a Master degree for 40 years. And have pain so bad Im bed-ridden and wear diapers	Question 1	As an RN of 40 years?? You stated exactly what I wanted to do and then some. We went from pill mills to shot mills!! Which were incredibly LUCRATIVE to these anesthesiologists, who suddenly, thought they would actually be able to handle awake bodies!! I and they have found that they dont like awake bodies. These bodies, which were, in the past, in chemically induced comas? Now have voices, feelings, including pain! And these docs do NOT! Know how to deal with these feelings and all of these people that they corral down their halls, to load up with all kinds of steroids and various other meds to be injected in to spinal spaces between vertebrae and into SI joints, only to find out that none of these magical powers do not help and left their patients begging for more. This lead us back to full circle where PILLS, narcotics, non-narcotics, NSAIDS, neuroleptics being used off brand or off market were now having to be used. This appeased the true pain patients, while bringing us back full circle. And the real catch? The MD? The anesthesiologist? Would have you coming in every 3 months to risk your spine to another epidural; your kidneys, uterus, and thyroid, to more radiation during the injections! And like me? Developed Cushings Syndrome from all the damn steroids putting me my bedroom and apt. for 13 months straight. No one could figure out what was wrong with me. I was sent all over Daytona Beach to all sorts of specialists! To the hospital for tens of thousands of $$$ of tests. I was exhausted, could barely move, could rarely take care of my service dog, and no family, no friends, and no support system. All while my non-Americanized MD, with a God complex, and short man syndrome held the fact over me that without taking the epidurals? No VICODIN...which I have been taking since 2003. Each shot made me sicker and I sank deeper. I found an endocrinologist and be confirmed my diagnosis. Iatrogenic Cushings Syndrome. He was forced by my pain md to write a letter stating that I was to get NO MORE STEROIDS! He did. Well? This CASH COW? Was not so valuable to my PMD anymore. It was just going in every month to get my VICODIN refilled. That went on for many months. He decided to review my chart and had me go in to his actual office one day and told me that he reviewed my chart and all he was doing was giving me VICODIN and I was not improving. He	Thank you for sharing your experience.

Section	Commentator & Affiliation	Comment	Response
		threatened to discharge me to the street without anymore VICODIN. My anxiety turned in to straight thinking and anger. I told him if he throws me to the street like a bag of garbage? And I had a bad withdrawal and died of a massive heart attack that I would make sure that my 90 year old Mother in Illinois would own his practice and his BMWs. He straightened out. I left with a script. I made a consultation with a FEMALE orthopedic surgeon. He was shocked and flabbergasted!! As I handed him the consult that stated I was a perfect candidate for a pain pump and I needed to find another MD! It was even written in the notes! What doctor to go to!! So? I will stop my story right there. For now! But? I wanted to add on to this story. How we went from pill mills to shot mills and what happened to just one patient, ME!! And how my life was almost totally destroyed by one nasty, non-empathetic, uncaring man who thinks that waves are splashing against his feet when he walks in to a surgical suite!!	