Medical Society
County of Erie

Erie County Department of Health
Public Health
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Erie County Opiate Epidemic Task Force

Erie County Community Wide Guidelines

ACUTE PAIN MANAGEMENT

Introduction[1,2]

These guidelines are intended to provide a general approach to acute pain management for adults in ambulatory health care settings. They are not intended to address care in emergency departments, post-operative settings or among pediatric patients. Additionally, they are not intended to apply to patients with chronic pain, pain associated with active cancer treatment, palliative care, hospice and end-of-life care. As with all complex medical decisions, pain management must be individualized to each patient. Therefore these guidelines cannot replace sound clinical judgement. These evidence-based and expert opinion-guided recommendations are not intended to impose any legal mandate or regulations.

Policies and practices developed over the past 20 years to improve the management of inadequately recognized and treated pain has led to an unintentional consequence of increased misuse and addiction to opioids and sedatives. A large proportion of opioid prescriptions are written for acute medical problems.[1] When sedatives are taken concurrently, the risk of overdose significantly increases. The acute pain management principles presented in this document are intended to:

(a) aid in assuring effective and humane treatment of acute pain;

(b) minimize risk of exposures to opioids which may increase the risk of long term dependence, even when prescribed for acute pain;[2] and

(c) reduce diversion to non-medical use by reducing supply of unused medications.[3]

These guidelines are focused on acute pain management and prescribing medications for acute pain, delineating a standardized process that includes key checkpoints for the clinician to pause and take additional factors into consideration.

Definition of Acute Pain

For these guidelines, acute pain is defined as pain that typically diminishes with healing; is related to tissue damage; and significantly alters a patient's typical function. Acute pain is expected to resolve within days to weeks. Pain present at 12 weeks is considered chronic and should be treated accordingly. These guidelines may not apply to acute pain resulting from exacerbation of underlying chronic conditions. For guidance on the management of chronic pain in adults, refer to the Center for Disease Control (CDC) guidelines (www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm).[4]

Assessment and Diagnosis of Patient Presenting with Pain

[1] These Guidelines are the result of the Erie County Opiate Epidemic Task force.
[2] These guidelines are modifications of Ohio Guidelines for the Management of Acute Pain Outside of Emergency Departments. January, 2016 available at http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Acute-Pain-20160119.pdf.

For assessing patients presenting with acute pain, in addition to a proper medical history and physical exam, initial considerations should include:

- Location, intensity and severity of the pain and associated symptoms

- Quality of pain e.g. somatic (sharp or stabbing), visceral (ache or pressure) and neuropathic pain (burning, tingling or radiating)
- Psychological factors, including personal and/or family history of substance use disorder.

A specific diagnosis should be made, when appropriate, to facilitate the use of an evidence-based approach to treatment.

- Develop a Plan: Upon determining the symptoms fit the definition of acute pain, both the provider and patient should discuss the risks/benefits of both pharmacologic and non-pharmacologic therapy. The provider should educate and develop a treatment plan together with the patient that includes:
    - Measurable goals for the reduction of pain
    - Use of both pharmacologic and non-pharmacologic therapies, with a clear path for progression of treatment
    - Mutually understood expectations for the degree and the duration of the pain during therapy
    - Goal: Improvement of function to baseline or pre-injury status as opposed to complete resolution of pain
- Reassure the patient that:
    - acute pain usually improves within a few days or weeks with return to normal activity,
    - in most cases acute pain is not due to serious disease or damage, and
    - remaining as active as possible and limiting bedrest will help maximize recovery.

Treatment of Acute Pain

While these guidelines provide a pathway for the management of acute pain, not every patient will need each option and care should be individualized.

- Non-Pharmacologic Treatment should be considered as first-line therapy for acute pain unless the natural history of the cause of pain or clinical judgement warrants a different approach. These therapies often reduce pain with fewer side effects and can be used in combination with non-opioid medications to increase likelihood of success. Examples may include, but are not limited to:
    1) Ice, heat, positioning, bracing, wrapping, splints, stretching and directed exercise often available through physical therapy
    2) Massage therapy, tactile stimulation, acupuncture/acupressure, chiropractic adjustment, manipulation, and osteopathic neuromuscular care

- Non-Opioid Pharmacologic Treatment should be used with non-pharmacologic therapy. When initiating pharmacologic therapy, patients should be informed on proper use of medication, importance of maintaining other therapies and expectation for duration and degree of symptom improvement. Treatment options, by the quality of pain, are listed below.

    1) Somatic Pain
        - Acetaminophen
        - Non-steroidal anti-inflammatory drugs (NSAIDS)
        - Corticosteroids
        - Alternatives include: Gabapentin/Pregabalin, skeletal muscle relaxants, serotonin-norepinephrine reuptake inhibitors, selective serotonin reuptake inhibitors and tricyclic antidepressants.

    2) Visceral Pain
        - Acetaminophen
        - NSAIDS
        - Corticosteroids

- Alternatives include the following: Dicyclomine, serotonin-norepinephrine reuptake inhibitors, topical anesthetics and tricyclic antidepressants.

3) Neuropathic Pain
   - Gabapentin/Pregabalin
   - Serotonin and norepinephrine reuptake inhibitors
   - Tricyclic antidepressants
   - Alternatives include: other antiepileptics, Baclofen, Bupropion, low-concentration Capsaicin, selective serotonin reuptake inhibitors and topical Lidocaine

4) Opiates should generally not be used to manage conditions such as fibromyalgia, headache, or uncomplicated lower back pain.[5] These are not opiate responsive conditions and the risks generally outweigh any anticipated benefits.

- Opioid Pharmacologic Treatment: In general reserve opioid for acute pain resulting from severe injuries or medical conditions, surgical procedures, or when alternatives (non-opioid options) are ineffective or contraindicated.
  1) If indicated, opioids should be prescribed at the lowest effective dose for the shortest effective duration needed to adequately manage a pain.[6] Patients who have not recently or ever used opioids may have a low tolerance to this class of medications sedating effects.
  2) Short-term opioid therapy may be preferred as a first line therapy in specific circumstances such as the immediate post-operative period. In most cases, opioid should be used as adjuncts to additional therapies, rather than alone.
  3) It is critical that the healthcare providers communicate with one another about a patient's care if the patient may be receiving opiate prescriptions from more than one provider to ensure optimum and appropriate pain management.
  4) The following are recommendations for the general use of opioids to manage **acute** pain:
     - Appropriate risk screening should be completed (e.g. age, pregnancy, high-risk psychosocial environment, personal or family history of substance use disorder. Patients with a history of significant mental illness or substance abuse should be considered at higher risk of subsequent abuse of opioids and should be more closely monitored if opioids are required. All patients should be considered at some risk for opioid abuse.[7]
     - Provide the patient with the least potent opioid to effectively manage pain. A morphine-equivalence chart (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-March-2015.pdf) should be used if needed.
     - Prescribe the minimum quantity needed with no refills based on each individual patient, rather than a default number of pills. In general, prescribe no more than 7 days of opioid medication (https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-07.htm#opioid). This will help reduce the retention of unused medication and provide a check point to reassess the progress in pain.[8]
     - Check the NYSDOH prescription monitoring database for all patients who may be receiving opioid prescription, regardless of the number of days that medication is prescribed.
     - Avoid long-acting opioids (e.g. methadone, oxycodone ER, fentanyl.[9]
     - Use caution with prescribing opioids for patients on medications causing central nervous system depression (e.g. benzodiazepines and sedative hypnotics) or patients known to use alcohol. Advise patients to avoid use of alcohol or other sedatives while taking opioids, as combinations can increase the risk of respiratory depression and death.
     - Discuss with the patient a planned schedule to wean opioid therapy, concomitant with reduction or resolution of pain.
     - Discuss proper secure storage and disposal[3] of unused medication to reduce the risks to the patient and others.
     - Remind the patient that it is both unsafe and unlawful to give away or sell opioid medication, including unused or leftover medication.

[3] For FREE Needle & Medication Disposal Locations see http://www2.erie.gov/health/index.php?q=needle-disposal-amp-access

- The decisions about which pain management strategy to employ should involve full discussion and mutual exchange of information between prescriber and patient.

Pain Re-evaluation

Key checkpoint: Reevaluation of patients who receive opioid therapy for acute pain should be considered if opioid therapy will continue beyond 14 days. This reevaluation may be made through an office visit or phone call per provider's discretion.

For patients with persisting pain, providers should reevaluate the initial diagnosis and consider the following:

1) Pain characteristics
2) Treatment methods used
3) Reasons for continued pain
4) Additional management options, including consultation with a specialist.

Additional Checkpoint

For patients with pain unresolved after 6 weeks, providers should repeat an assessment and determine whether treatment should be adjusted. Referral to chronic pain management guidelines, such as CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 (http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm), may be helpful at this point, although chronic pain is defined as pain persisting for longer than 12 weeks.

References

1. Volkow ND, McLellan TA, Cotto JH, Karithanom M, Weiss SR. Characteristics of opioid prescriptions in 2009. JAMA 2011;305:1299-301.

2. Alam A, Gomes T, Zheng H, Mamdani MM, Juurlink DN, Bell CM. Long-term analgesic use after low-risk surgery: a retrospective cohort study. Arch Intern Med 2012;172:425-30.

3. McCabe SE, West BT, Boyd CJ. Leftover prescription opioids and nonmedical use among high school seniors: a multi-cohort national study. J Adolesc Health 2013;52:480-5.

4. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016. JAMA 2016;315:1624-45.

5. Abdel Shaheed C, Maher CG, Williams KA, Day R, McLachlan AJ. Efficacy, Tolerability, and Dose-Dependent Effects of Opioid Analgesics for Low Back Pain: A Systematic Review and Meta-analysis. JAMA Intern Med. 2016;176:958-968.

6. Volkow ND, McLellan AT. Opioid Abuse in Chronic Pain - Misconceptions and Mitigation Strategies. N Engl J Med 2016;374:1253-63.

7. Dowell D, Kunins HV, Farley TA. Opioid analgesics--risky drugs, not risky patients. JAMA. 2013;309:2219-20.

8. Bateman BT, Choudhry NK. Limiting the duration of opioid prescriptions: Balancing excessive prescribing and the effective treatment of pain. JAMA Intern Med 2016;176:583-4.

9. Miller M, Barber CW, Leatherman S, et al. Prescription opioid duration of action and the risk of unintentional overdose among patients receiving opioid therapy. JAMA Intern Med 2015;175:608-15.