



Opioid Prescribing Work Group: Acute Pain Recommendations

Prescribing Opioids in the Acute Phase

The acute phase of pain is one to four days after a severe injury or a severe medical condition, and up to seven days following a major surgical procedure or trauma. Use caution when prescribing opioids even in this timeframe, given the potential for patients to experience harm related to any new opioid prescription. Avoid using opioids to treat pain in the acute phase unless the severity of the pain warrants the use of opioid analgesia and non-opioid alternatives are ineffective or contraindicated.

Clinicians must employ effective risk management and minimize the potential for harm, misuse and diversion when considering prescribing opioids during the acute phase. Opioids have a wide range of adverse effects that can predispose a patient to serious morbidity and mortality. This includes respiratory depression (*Koo, 2011*), negative impact on endocrine function (*Vuong, 2010*), immunosuppression (*Vallejo, 2004*), opioid-induced hyperalgesia (*Ballantyne, 2007*), and possibly heightened fracture risk related to falls (*Saunders, 2010*). Evidence does not support the use of opioids for non-specific or self-limited pain, headaches, fibromyalgia and uncomplicated back, neck and musculoskeletal pain (*ICSI, 2014*).

Prescribers of opioids should continuously educate themselves about the risks and benefits of opioids commonly used in their practice. If opioids are prescribed, it should be at the lowest necessary dose and duration, and limited only to the period in which the individual suffers acute pain (acute inflammatory process). Assess patients, including those with mental illness and substance abuse, cardiopulmonary disease, and endocrine disorders, before and during treatment for risks of all adverse outcomes. Provide patient and caregiver education on safe use, safe storage and safe disposal with every opioid prescription.

Clinical Recommendations

1. Provide documentation of the patient's presentation of pain and diminished physical function. Documentation should include use of the pain scale as a relative tool, and concordance of the patient's assessment of his or her own pain with the prescriber's objective observations.
2. Complete the ICSI Alcohol use, Benzodiazepine and other drug use, Clearance and metabolism of the drug, Delirium, dementia and falls risk, Psychiatric comorbidities, Query the Prescription Monitoring Program (PMP), Respiratory insufficiency and sleep apnea, and Safe driving, work, storage and disposal (ABCDPQRS) Opioid Risk Assessment for every opioid prescription. Assess pregnancy risk in women of childbearing age for every initial opioid prescription. Review medications and provide brief screening for substance use disorder. Assess suicidality in every setting for every initial opioid prescription.

Prescribers should check the Prescription Monitoring Program (PMP) whenever prescribing an opioid for acute pain.

3. Avoid prescribing more than a three day supply or 20 pills of low-dose, short-acting opioids, unless circumstances clearly warrant additional opioid therapy, e.g. major surgical procedures or severe trauma. Limit the entire dose to 100 morphine milligram equivalents (MME) (not 100 MME per day).
4. For an identifiable, new injury/procedure in a patient receiving chronic opioids, dosage for the new injury/procedure will be the same as for any patient not already on opioids (See Recommendation 3). Manage acute pain in patients on chronic opioids over 100 MME/day undergoing invasive procedures with additional resources, the prescriber of chronic opioids and anesthesiology.

For patients already receiving chronic opioids and in the absence of a verifiable new injury, do not increase opioid dosage for acute pain at a new site or the acute exacerbation of a chronic pain. Offer the patient non-opioid treatments.

5. Avoid prescribing opioids to patients in recovery from substance use disorder, and to those with an active addiction. Maximize appropriate non-opioid therapies. If opioids are necessary, use extreme caution, frankly discuss the risks with the patient, and plan for close follow-up. Obtain a specific patient release to consult with a substance use disorder provider.

Consult with a prescriber or pharmacist specifically trained in the pharmacology of buprenorphine or naltrexone when prescribing opioid analgesia to a patient already receiving buprenorphine or naltrexone for opioid use disorder.

Limit opioid analgesia dosage to 3 days/20 pills and 100 MME total when prescribing opioids to a patient on methadone to treat opioid use disorder.

6. Avoid providing concurrent, new prescriptions of opioids and benzodiazepines or other sedative-hypnotic medications.
7. Use caution when prescribing opioids to patients using benzodiazepines or other sedative-hypnotic medications on an on-going basis. Advise patients intermittently using benzodiazepines to stop use while taking opioids. Frankly discuss the risks of concomitant use with the patient, and conduct close follow-up during the period in which opioids are used.
8. Avoid prescribing opioids for 1) fibromyalgia; 2) headache, including migraine; 3) self-limited illness, e.g., sore throat; 4) uncomplicated back and neck pain; and 5) uncomplicated musculoskeletal pain. Explore appropriate non-opioid alternatives. Clinicians prescribing opioids for acute back, neck or musculoskeletal pain must be able to provide objectively verifiable evidence of complications, such as severe or rapidly progressive neurological deficit, evidence of infection, new cancer diagnosis or metastasis, or fracture.
9. Avoid prescribing opioids to pregnant women. The safety of opioid use during pregnancy cannot be known. Prescribers must stay current on the known risks of opioids to both the mother and the fetus.

Assess pregnancy risk in all women of childbearing age prior to prescribing an opioid. If the benefit of using an opioid outweighs the risk to the woman, then prescribe the lowest dose and duration appropriate and educate women about the risks and unknown effect of opioids when pregnant for both the mother and the fetus. Avoid prescribing NSAIDs or codeine to pregnant women.

Follow post-surgical recommendations when prescribing opioids for women following a cesarean section.

10. Provide proper pain control to lactating women experiencing acute pain following birth and surgical procedures. Non-pharmacologic therapies, including cold, heat and Sitz baths, are often sufficient relief for mild pain. If pain medication is indicated, use non-opioid pain relievers and avoid prescribing opioids when possible.

If opioids are prescribed to lactating women for acute pain, prescribe the lowest dose and duration adequate to manage the pain. The American Academy of Pediatrics cautions against the use of codeine and oxycodone for lactating women, and recommends other opioids based on lower rates of excretion into breast milk, including hydromorphone, oral morphine and butorphanol. Consult [LactMed](#) for current and comprehensive information about the secretion of specific opioids into breastmilk.

Encourage breastfeeding for women using opioids to manage acute pain following delivery and surgical procedures, but provide education about how to minimize opioid exposure in the baby. Educate mother and other caregivers to monitor the baby for excess sedation, constipation and failure to achieve weight milestones.

11. For patients presenting with acute oral or facial pain in a medical facility or hospital with no dentist available, use an appropriate non-opioid medication for pain management prior to diagnosis and treatment plan for underlying source of pain. Do not prescribe opioids without an examination and diagnosis of the underlying reason for the tooth pain by a dental provider as soon as possible. Opioids can mask pain and allow the patient to ignore a potential underlying serious dental problem, such as an abscess. Diagnosis should include appropriate tests and x-rays. Refer to a dental provider and assist with access to follow-up when possible.

Surgical recommendation apply to patients undergoing dental extractions or other invasive procedures (See Recommendation 12). Avoid prescribing more than a 3-day/20 pill/100 MME total supply of low-dose, short-acting opioids following a dental procedure.

12. In most cases, pain from most surgical procedures (especially outpatient procedures) can be managed effectively without opioids or up to a three-day/20 pill/ 100 MME total supply of low-dose, short-acting opioids. (See Recommendation 3).

Some surgical procedures and traumatic injury (especially procedures and injuries that are more extensive often requiring more than a 48-hour hospital stay) require greater pain management, because of an expectation of increased tissue damage and subsequent inflammatory response. Prescribe no more opioids than will be needed for initial tissue recovery, usually no more than seven days or up to 200 MME, unless circumstances clearly warrant additional opioid therapy. Limit the entire dose to 200 MME.

Effective management of acute, postoperative pain in opioid tolerant patients may require additional education and resources. It is important to effectively manage acute post-operative pain, and opioid tolerant patients should receive no less treatment than opioid naïve patients. For opioid tolerant patients taking up to 100 MME/day, the standard postoperative dose and duration recommendations apply. Postoperative pain management for patients taking over 100 MME/day should involve the prescriber of chronic opioid therapy, pain specialists, anesthesiology, and psychologists.

13. Naloxone is sometimes indicated for patients receiving a prescription for opioids to treat acute pain. Consider prescribing naloxone especially for the following populations who are at high-risk for overdose: 1) individuals with substance use disorder; 2) individuals concomitantly using benzodiazepines; 3) individuals on chronic opioids with an acute injury; 4) individuals with a past overdose; 5) individuals with respiratory insufficiency, especially sleep apnea; and 6) individuals who were recently incarcerated with a history of substance abuse. Provide education to family members and caregivers about the safe storage and use of naloxone.
14. Provide safety information—including safe use, storage and disposal—with every acute opioid prescription. Provide information, both oral and written, to patients, family members and caregivers. Advise patients, family members and caregivers to dispose of any opioids not used for a period of two weeks after discontinuation of therapy.
15. Acute dosing for children should be proportional by weight to the dosing guidance in Recommendation 3. Screen all children over the age of 10 per the recommendations for adults (See Recommendation 2). Prescribers should check the PMP for all children prescribed an opioid for acute pain, in order to confirm that the child is not at risk for parental diversion of the opioid. Avoid prescribing children codeine in any setting given the high risk posed to ultra-fast metabolizers.

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