Acute Pain Prescribing Guidelines

A companion to Ohio's Guidelines for the Management of Acute Pain Outside of Emergency Departments

These guidelines are to be used as a clinical tool, but they do not replace clinician judgment.

Patient Presents with Acute Pain

❶ Pain Assessment:

- Medical history and physical examination, including pregnancy status
- Location, intensity, severity; and associated symptoms
- Quality of pain (somatic, visceral or neuropathic)
- Psychological factors, personal/family history of addiction

❷ Develop a Plan:

- Educate patient and family and negotiate goals of treatment
- Discuss risks/benefits of non-pharmacologic & pharmacologic therapies
- Set patient expectations for the degree and the duration of the pain

GOAL: Improvement of function to baseline as opposed to complete resolution of pain

Options

Non-Pharmacologic Treatment

- Ice, heat, positioning, bracing, wrapping, splints, stretching
- Massage therapy, tactile stimulation, acupuncture/acupressure, chiropractic adjustment, osteopathic neuromusculoskeletal medicine
- Biofeedback
- Directed exercise such as physical therapy

Non-Opioid Pharmacologic Treatment

Role in Therapy	Somatic (Sharp or Stabbing)	Visceral (Ache or Pressure)	Neuropathic (Burning or Tingling)
First Line	Acetaminophen, NSAIDs, Corticosteroids		Gabapentin/pregabalin/TCAs/ SNRIs
Alternatives	Gabapentin/pregabalin, skeletal muscle relaxants, SSRIs/SNRIs/TCAs	SNRIs/TCAs, dicyclomine	Anti-epileptics, baclofen, bupropion, low-concentration capsaicin, SSRIs, topical lidocaine

Opioid Pharmacologic Treatment

For All Opioids:

- **Complete risk screening** (e.g. age, pregnancy, high-risk psychosocial environment, personal/family history of substance use disorder).
- **Provide the patient with the least potent opioid** to effectively manage pain (e.g. APAP/codeine instead of oxycodone). **Refer to Morphine Equivalence Table.**
- **Prescribe the minimum quantity needed with no refills.**
- **Consider checking OARRS** for all patients who will receive an opioid prescription. (OARRS report is required for most prescriptions of 7 days or more.)
- **Avoid prescribing long-acting opioids** for acute pain (e.g. methadone, oxycodone).
- **Use caution when prescribing opioids** with patients on benzodiazepines and sedative-hypnotics or patients known to use alcohol.
- **Discuss how to safely and effectively wean** patient off opioid medication.
- **Remind that it is a unsafe and unlawful** to give away or sell their opioids.
- **Discuss proper storage and disposal of opioid medications.**
- **Coordinate care and communication** of complex patients with other clinicians.

Morphine Equivalence Table

Opioid Naive: Morphine Equivalence*	Notable NSAIDS
Most Potent	
Buprenorphine sublinguam 42:1	
Hydromorphone PO 4:1	
Oxymorphone 3:1	
Hydrocodone 1:1	
Morphine 1:1	
	Meloxicam 0.67:1
	Diclofenac 0.2:1
Codeine 0.15:1	
Tramadol 0.1:1	Celecoxib 0.1:1
Least Potent	

*Source: CDC, 5/2014

14 Days (Key Checkpoint)

Reassess patient within an appropriate time NOT exceeding 14 days

If pain is unresolved, reassess:

- Pain, consider standardized tool (e.g. Oswestry Disability Index for back pain)
- Treatment method
- Context and reason for continued pain
- Additional treatment options, including consultation

Six Weeks (Key Checkpoint)

- If pain is unresolved:
- Repeat the prior step
- Refer to Chronic Pain Guideline

July 2015