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**

1. **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

2. **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**

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

**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 sublingual 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

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