tipSC | Timely Information for Providers in South Carolina

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ACUTE NON-CANCER PAIN TREATMENT

An outreach service for Medicaid providers to help identify and prevent potential gaps in evidence-based care, as well as detect fraud, abuse, overuse or inappropriate use.

https://msp.scdhhs.gov/tipsc/

PICK UP QUICK TIPS ON…balancing comfort and patient safety to more effectively manage acute pain

If acute pain requires medication for relief in addition to non-pharmacologic management, treat with non-opioid options (e.g., ibuprofen and acetaminophen) unless the benefits of opioids outweigh the risks.

QUICK tipSC

Always consider scheduled dosing around-the-clock for acute and chronic pain treatment

QUICK FACTS TO CONSIDER

- Some recent evidence suggests that **opioids may not be more effective than non-opioids** for moderate to severe pain.
- As many as **1 in 7** patients will still be **taking opioids a year later if** they **fill it more than once**.
- **Uncontrolled pain** in patients with a substance use disorder **may decrease retention in treatment maintenance** programs.
- **Undertreated acute pain may increase the risk** for development **of chronic pain**.
- Despite the high incidence of pain in **older adults**, they **are less likely to receive adequate management of acute pain** compared to younger counterparts.

CLINICAL PEARLS

Patient feedback, along with diagnosis, is essential to evaluate pain and its impact on daily function when designing a **multi-modal acute pain care plan** that **uses non-drug and drug treatments.** Acute pain is immediate and typically self-limiting (often resolving within 4 weeks but may last up to 3 months). **Clinical pain evaluations should not differ from other workups**; when possible, treat the underlying cause while addressing the pain itself. If pain lingers or is not improving, **re-evaluate** the patient **and adjust the plan accordingly to meet treatment goals (pain relief and return to daily activities)** and reduce risk of complications; e.g., possible progression to chronic pain.

Three common psychosocial factors[1] that may influence acute pain progressing to chronic pain and disability are:

- Catastrophizing *(exaggerated thoughts that pain is serious threat)*
- Fear avoidance *(avoids activity – fears will worsen injury or pain)*[2]
- Depressed mood – pre-existing or new onset

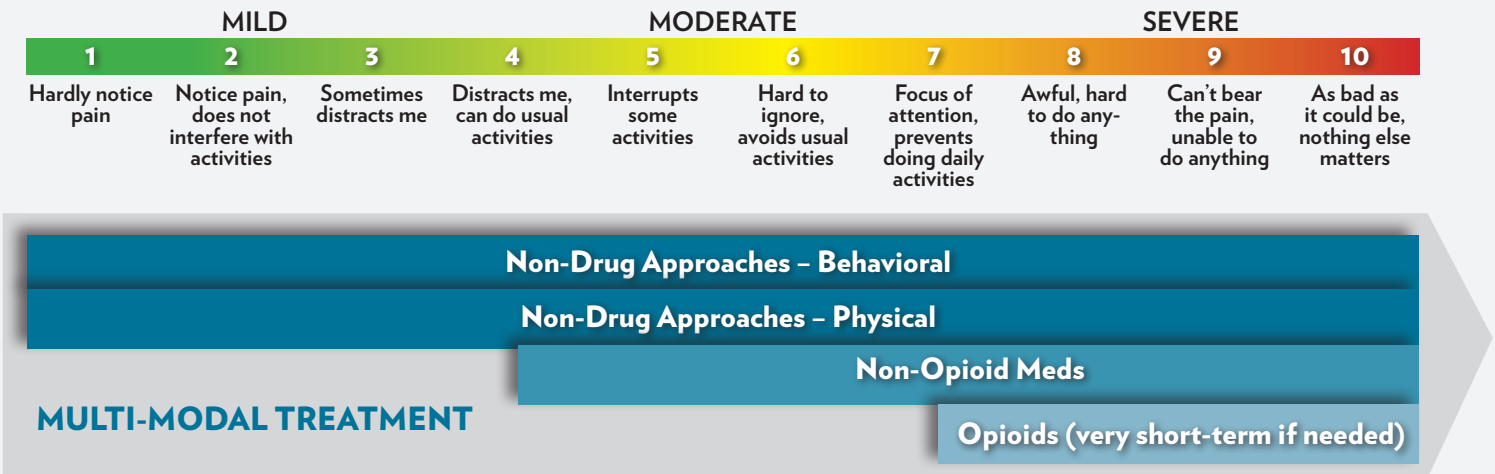
1. Patients may benefit from: Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), Mindfulness-based stress reduction (MBSR).

2. It is unnecessary avoidance that is problematic.

Just simple conversations to educate the patient **about acute pain and set realistic expectations** for recovery go a long way to **reassure the patient** and meet treatment goals with less interventions. It is important to recognize and **address emotional/mental factors that heighten pain perception;** e.g., anxiety, depression, fatigue, anger.

…"your pain will get better"…"this pain is short-lived"…"your pain is not life-threatening"…"keep moving"…"too much worry and fear can make your pain feel worse…"

MULTI-MODAL ACUTE PAIN CARE BASED ON PATIENT FUNCTION AND PAIN SEVERITY



NON-OPIOIDS FOR ACUTE LOW BACK PAIN, SPRAINS, AND STRAINS

Non-drug approaches – self-care (e.g., ice or heat, rest), complementary and integrative therapies (e.g., massage), physical rehabilitation, and exercise – are foundational and considered first line for acute pain

WHEN A NON-OPIOID MEDICATION IS NEEDED IN ADDITION TO NON-DRUG TREATMENTS

Acetaminophen (APAP) and NSAIDs are both options for initial treatment. Source of pain, patient risk factors, and patient response determine the more appropriate medication and dosage form selection (see table below).

In acute low back pain:

- Evidence is mixed on the effectiveness of APAP
- Note: *Opioids have not been shown to offer benefit beyond NSAIDs*
- Addition of a skeletal muscle relaxant is a consideration if associated with muscle spasms (mixed evidence on effectiveness)

For acute sprains and strains:

- Topical NSAIDS may provide good pain relief. Number needed to treat (NNT) is 1.8 – 4.7.
- Note: *Opioids may be no more effective than NSAIDs or a combination of APAP and NSAIDs*

All NSAIDs can increase the risk of GI and CV events.

- Ibuprofen and naproxen are first line non-selective NSAID options based on effectiveness, adverse effect profile, and OTC availability.
- Among non-selective NSAIDs, naproxen is associated with fewer CV events.
- A selective COX-2 NSAID (i.e., celecoxib) has a lower risk of GI toxicity and a dose-dependent increase in CV events.
- The addition of a PPI or H2 blocker to an oral NSAID may help prevent GI complications.
- If an anti-inflammatory is needed, a topical NSAID may offer a safer alternative due to minimal systemic absorption.

There is no known role for gabapentin or pregabalin in the management of acute back pain, sprains, and strains

SELECTED NON-OPIOID MEDICATIONS FOR ACUTE PAIN TREATMENT

Includes Indications for Use and Risk Factors for Drug-Related Adverse Effects

	MEDICATION CLASS Medication (Rx max daily dose)	Rx or OTC	PAIN CONDITION		PATIENT RISK FACTORS WARRANTING CAUTION					COMMENTS
			Acute Low Back Pain	Sprains, Strains, & Overuse Injuries	Older Adults	CV Risk Factors	GI Risk Factors	Hepatic Dysfunction	Renal Dysfunction	
ORAL	**NON-SELECTIVE NSAIDS** Ibuprofen (3200 mg)[1,2] Naproxen Sodium (1100 mg)[1-4]	Rx/OTC	✓	✓	✓	✓	✓✓		✓	Avoid in patients with both high CV and GI risk factors, history of heart failure, or recent MI; Add PPI or H2 blocker for patients with higher GI risk; Try another NSAID if first one is inadequate; May be opioid sparing
ORAL	**COX-2 SELECTIVE NSAIDS** Celecoxib (400 mg)[1,3,5]	Rx	✓	✓	✓	✓	✓		✓	
ORAL	**ANALGESIC** Acetaminophen (4000 mg)[6,7,8]	Rx/OTC	✓	✓	✓			✓		May have NSAID dose-sparing effect; Minimal drug interactions
ORAL	**NON-BZD SKELETAL MUSCLE RELAXANTS** Cyclobenzaprine (30 mg)	Rx	✓		✓					Dose at bedtime if sedation occurs; For short-term use (≤ 7 days)
TOPICAL	**NSAID** Diclofenac	Rx		✓						Consider in patients with CV or GI Risk factors
TOPICAL	**ANALGESIC**[9] Capsaicin Lidocaine Methyl Salicylate	OTC		✓						Use on intact, non-vesicular skin; Effectiveness not well supported by the evidence

1. Risk of CV and GI adverse effects is increased with higher doses and longer duration. **2.** OTC maximum daily dose is lower. **3.** Day 1 maximum daily dose can be higher. **4.** Naproxen Sodium 1100 mg equivalent to 1000 mg naproxen. **5.** Less CV risk associated with 200 mg/day. **6. Consider 3000 mg maximum, especially if elevated liver function tests, known liver impairment, or older adult; Use 2000 mg maximum in patients with alcohol use disorder or taking warfarin. 7.** Consider lower maximum daily dose and/or prolonged dosing interval in patients with severe renal impairment. **8.** Caution patients to look for hidden acetaminophen in OTC or prescription products. **9.** May be considered for back per package labeling.

Key: ✓ Indication for use; ✓ Risk for drug-related adverse effects; ✓✓ Higher risk for drug-related adverse effects; **APRN** Advanced Practice Registered Nurse; **BZD** Benzodiazepine; **CDC** Centers for Disease Control and Prevention; **CV** Cardiovascular; **DHEC** Department of Health and Environmental Control; **GI** Gastrointestinal; **H2 blocker** Histamine type-2 receptor antagonist; **MI** Myocardial Infarction; **MME** Morphine Milligram Equivalents; **NSAID(s)** Nonsteroidal anti-inflammatory drug(s); **OTC** Over-the-counter; **PDMP** Prescription Drug Monitoring Program; **PPI** Proton Pump Inhibitor; **Rx** Prescription; **SCRIPTS** South Carolina Reporting & Identification Prescription Tracking System (SC PDMP)

MINIMIZING OPIOIDS FOR ACUTE PAIN TREATMENT

Encourage the patient to adhere to the non-drug treatment plan regardless of medications prescribed – just popping a pill is not enough

IF AN OPIOID IS REQUIRED

All guidelines agree to provide patient education about risks of opioid therapy prior to prescribing the lowest effective dose for the shortest duration.

Tramadol is NOT necessarily the "safer" opioid. Studies suggest it is less effective and may increase risk of long-term opioid use.

Screen for opioid misuse or abuse risk factors using a validated screening tool (e.g., Opioid Risk Tool [ORT]) prior to prescribing	Check SCRIPTS (PDMP or DHEC Report) to support safer opioid prescribing and to avoid dangerous combinations (e.g., opioids and benzodiazepines)	Prescribe only short-acting/ immediate-release opioid medications for acute pain	Share proper disposal methods for unused or unwanted medication (e.g., year round take back bins)

SELECT OPIOID PRESCRIBING LIMITS FOR ACUTE AND POSTOPERATIVE PAIN[1,2]

	Source	Law/Recommendation
State Laws	SC Controlled Substance Act – 2018 (SC Code of Laws 44-53-360)	**Initial opioid prescriptions** for acute pain management or postoperative pain management must not exceed a **seven-day supply**[3]
	SC Physician Assistants Practice Act – 2019 (SC Code of Laws 40-47-965)	May write an initial opioid prescription for **up to five days**; subsequent prescriptions may be greater than five days with physician consult and approval documentation in chart
	SC Nurse Practice Act – 2018 (SC Code of Laws 40-33-34)	Schedule II opioid prescriptions must not exceed a **five-day supply**; another prescription can be written with the written agreement of the physician (with whom the APRN has entered into a practice agreement)
	North Carolina Strengthen Opioid Misuse Prevention (STOP) Act – 2017	Limits initial opioid prescription for acute pain to a **five-day supply** unless postoperative immediately following procedure
Select Payer Policies	SC Medicaid Opioid Prescribing Limits – 2018	Initial opioid prescription for treatment of acute or postoperative pain must not exceed more than a **five-day supply** and **90 MME/day**[4,5]
	Medicare Part D Opioid Policies – 2019	Opioid-naïve patients (i.e., no opioid prescription within the past 60 days) limited to a **seven-day supply** unless postoperative immediately following procedure
	SC Blue Cross Blue Shield Opioid Management Program – 2018	Initial immediate-release opioid prescriptions are limited to a **seven-day supply** and **90 MME/day** in 30 days[4]
Select Guidelines	SC Boards of Medical Examiners, Dentistry, Nursing, and Pharmacy Pain Guidelines – 2017	Prescribe lowest effective dose of immediate-release opioids. **Three days or less** will often be sufficient; more than seven days will rarely be necessary.
	CDC Guideline for Prescribing Opioids for Chronic Pain – 2016	

1. Pharmacies and other payers may have additional limitations/restrictions. **2. Post-surgical pain management beyond the scope of this issue. 3.** Excludes opioid prescriptions for cancer pain, chronic pain, hospice care, palliative care, major trauma, major surgery, treatment of sickle cell disease, treatment of neonatal abstinence syndrome, or medication-assisted treatment for substance use disorder. **4.** Prior authorization is required for opioid prescriptions greater than 90 MME/day. **5.** Except in the cases of chronic pain, cancer pain, pain related to sickle cell disease, hospice care, palliative care or medication-assisted treatment for substance use disorder. If, in a prescriber's clinical judgement, an initial supply of more than five days or 90 MMEs is medically necessary, the prescriber must document that need in the patient's medical record.

ACUTE PAIN TREATMENT FOR CHRONIC PAIN PATIENTS ON OPIOIDS

Patients on chronic opioids for pain **often have** new onset **acute pain that is undertreated**. It is important to conduct a careful history and assessment to determine pain etiology AND if the pain is an exacerbation of the chronic pain condition or new onset acute pain (e.g., sprained ankle).

Reevaluate the chronic pain **management plan if it is an exacerbation** of the existing condition.

Patients on chronic opioids may have increased pain sensitivity

For new onset acute pain:

- Continue current chronic pain therapy
- Optimize non-drug options and scheduled dosing of oral or topical non-opioids to stay ahead of pain
- If can't avoid additional opioids, add a short-acting opioid very short term
  - Co-prescribe naloxone for rescue if patient has none

Only use non-drug & non-opioid options if no objectively identifiable cause

ACUTE PAIN TREATMENT IN PATIENTS WITH OPIOID USE DISORDER (OUD)

Just like any other patient, patients with OUD need acute pain management. **Treatment should be coordinated with a pain specialist and/or MAT provider.**

Keep MAT[1] On Board

- OUD treatment should continue while treating the acute pain

Use Non-Drug & Non-Opioid Options First

- Non-drug and oral or topical non-opioid (schedule optimal doses around-the-clock to maximize response/stay ahead of pain episode) options are first line
- IM ketorolac may be an option to avoid an add-on opioid

If Opioids Cannot Be Avoided[1,2], Use Short-Acting Formulation Very Short Term

- Patients on opioid agonists (methadone or buprenorphine) may require higher doses of opioids
- Combination of opioid with NSAID or APAP (i.e., multimodal analgesia) may have opioid-sparing effect
- There is little evidence that opioid treatment for acute pain management in patients on MAT increases their risk for relapse

Co-prescribe naloxone for any patient that does not have rescue on hand

1. **Avoid opioids in patients taking naltrexone** (for information on pain management in patients on naltrexone go to https://pcssnow.org/wp-content/uploads/2015/06/PCSS-MAT-Naltrexone-Module-AOAAM1.pdf)
2. **Total OUD buprenorphine daily dose can be divided and given every 6 – 8 hours for pain as a first step.**

KEY: APAP Acetaminophen; **MAT** Medication-assisted treatment; **NSAID** Nonsteroidal anti-inflammatory drugs

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The information contained in this summary is intended to assist primary care providers in the management of acute non-cancer pain in adults in the primary care setting. This information is advisory only and is not intended to replace sound clinical judgement, nor should it be regarded as a substitute for individualized diagnosis and treatment. Special considerations are needed when treating some populations with certain conditions (such as respiratory/sleep disorders; cardiac, gastrointestinal, liver, and renal impairment; debility; dementia; addiction; and pregnancy/breastfeeding). Management of post-surgical pain is beyond the scope of this issue.