ELABORATED GUIDELINES FOR THE TREATMENT OF ACUTE AND CHRONIC PAIN

ACUTE PAIN

1. Use non-opioid medications and therapies as first-line treatment for mild and moderate acute pain.

Patients should receive treatment for pain that provides the greatest benefits relative to risks. There is evidence that acute pain can be ameliorated by non-pharmacologic and non-opioid therapies, including psychological therapies, exercise treatments (aerobic exercise, physical therapy), and NSAIDs.\(^1\)\(^2\)\(^3\)\(^4\)\(^5\)\(^6\) Due to their low harm, these therapies should be offered to all patients with mild or moderate pain. Opioids should only be initiated after weighing the benefits against the risks of use. Long-term opioid use can result from opioids initially intended for short-term use\(^7\)\(^8\)\(^9\), and both acute and long-term opioid use run the risk of opioid overdose.\(^9\)\(^10\) Realistic expectations regarding duration and severity of expected pain should be provided to patients.

2. If opioids are indicated for acute pain, initiate therapy at the lowest effective dose for no longer than a 3-5 day duration; reassess if pain persists beyond the anticipated duration.

Because there is no absolute safe dose of opioids, opioid therapy should be initiated at the lowest effective dose and for the shortest possible duration. Evidence shows that the longer duration of early opioid exposure is associated with greater risks for long-term use.\(^11\) There is also a risk of opioid-related adverse events even during acute, short-term therapy.\(^12\)

The recommendation for a short duration of opioid therapy for acute pain is supported by recent evidence, which suggests that each additional day of opioid use beyond 3 days increases the likelihood of an adverse event or long-term use.\(^13\) Each day of unnecessary opioid use increases the likelihood of physical dependence without adding benefit.\(^14\) Prescriptions with fewer days’ supply will also minimize the number of pills available for nonmedical use or diversion.

Clinicians should reevaluate patients with severe acute pain that continues longer than expected before continuing opioid therapy. Patients who do not experience clinically meaningful pain relief early in treatment are unlikely to experience pain relief with long-term use,\(^14\) and revisions to the initial diagnosis and management plan may be necessary. In addition, the risk of acute opioid therapy extending into long-term opioid therapy is increased in patients who refill the initial prescription.\(^11\)

A note about a particular opioid, tramadol: tramadol has two known mechanisms of analgesia – it is a weak \(\mu\)-opioid receptor agonist and it inhibits the reuptake of norepinephrine and serotonin. Use of tramadol is a risk factor for continued opioid use: over 64% of patients started on tramadol for acute pain remain on tramadol after one year.\(^15\) Emergency department visits associated with tramadol-related adverse effects have also increased by 145% from 2005-2011.\(^15\) There are increased adverse effects when tramadol is combined with benzodiazepines, opioid pain medications and/or alcohol. Co-administration of tramadol with agents that increase serotonergic activity can precipitate serotonin syndrome and caution should be used with this combination.

A note about post-surgical indications: this guideline may apply to the treatment of postoperative pain from low-risk surgical procedures. A 2017 systematic review found that postoperative prescription opioids often go unused, unlocked and undisposed.\(^16\) More than two-thirds of patients reported unused prescription opioids following surgery, consists across several studies of general, orthopedic, thoracic, and obstetric inpatient and outpatient surgeries.\(^16\)

**DO IT** Change the default duration for electronic opioid prescriptions to 3- or 5- days.

- See Appendix F, How to manage pain and opioids in special populations for further details on post-surgical opioid use.
- See Appendix G, How to connect with local and national resources for Arizona Data from Enhanced Surveillance, showing that 60% of persons with a suspected opioid overdose had a prescription written for six or more days.


Multiple national agencies, including the Veterans Administration and Centers for Disease Control and Prevention, recommend against using long-acting opioids for the treatment of acute pain. There is a higher risk for overdose among patients who initiate treatment with extended-release/long-acting opioids than among those who initiate with immediate-release opioids.\(^17\) Further, long-acting opioids are associated with an increased risk of all-cause mortality.\(^18\)

CHRONIC PAIN

4. Prescribe self-management strategies, non-pharmacologic treatments and non-opioid medications as the preferred treatment for chronic pain.

Self-management approaches should be recommended to all patients with chronic pain. Self-management refers to management of the pain, its symptoms, and of one’s relationship with the symptoms. (Evidence shows self-management approaches improve self-efficacy in multiple chronic
conditions\textsuperscript{19-21} and that opioid treatment of chronic pain may undermine self-care.\textsuperscript{22}

Many non-pharmacological therapies, including physical therapy, weight loss, psychological therapies (e.g. cognitive behavioral therapy) and multidisciplinary rehabilitation can ameliorate pain and function.\textsuperscript{12-23} Spinal manipulation, massage and acupuncture may be helpful in some chronic pain conditions.\textsuperscript{24-26} Non-opioid pharmaceuticals (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) may also be helpful for a variety of chronic pain conditions.\textsuperscript{27-30} 31-33

Due to the favorable benefit-to-risk profile, these noninvasive, non-opioid therapies are preferred and should be offered to all patients with chronic pain. There is a lack of evidence showing any sustained functional benefit of long-term opioid therapy for chronic pain, but there is evidence of dose- and duration-dependent harms (see Guideline #5).

**DO IT** Create acute and chronic pain order sets that include non-pharmacologic treatment, non-opioid treatment and common referral sources (such as physical therapy, psychotherapy, substance use treatment, addiction specialists, pain medicine specialists, etc.).

### 5. Do not initiate long-term opioid therapy for most patients with chronic pain.

While benefits for pain relief, function and quality of life with long-term opioid use for chronic pain are uncertain, risks associated with long-term opioid use are significant and increase with increasing dose and duration of opioid use.\textsuperscript{12,42-43} Risks to patients include overdose, overdose death, addiction, depression, opioid induced hypogonadism, opioid-induced hyperalgesia, and worsening function.\textsuperscript{18,44-45} A 2017 Cochrane Review found good-quality evidence that use of opioids for greater than 2 weeks is associated with a significantly increased risk of experiencing an adverse event when compared to use of a placebo and non-opioid pharmacotherapy, and identified a very high absolute rate (78\%) for adverse events.\textsuperscript{54} Due to this unfavorable balance of risks compared to benefits, initiating opioid therapy for common causes of chronic pain including low back pain, osteoarthritis pain, fibromyalgia, neuropathy and headache is not recommended. The decision to initiate opioid therapy must be made on a case-by-case basis after carefully weighing the known risks against possible benefits.

**DO IT** Develop a system for opioid stewardship, i.e. monitoring opioid prescribing practices, outcomes and provider alignment with guidelines and best evidence.

- See References, Veterans' Administration 2017 Clinical Practice Guideline for Opioid Therapy, “Recommendation 1) We recommend against initiation of long-term opioid therapy for chronic pain.”

### 6. Coordinate interdisciplinary care for patients with higher complexity chronic pain to address pain, substance use disorders and behavioral health conditions.

There is an increased risk of poor outcomes including opioid overdose, opioid use disorder and death, for patients taking opioids that have substance use disorders or behavioral health conditions.\textsuperscript{7,8,55-57} These clinical situations can be challenging to manage, and are further complicated by the possibility of providers inadvertently exposing the patient to dangerous drug-drug interactions. Interdisciplinary care for patients is advised, even as more research is needed on efficacy and feasibility of arranging such care.

The key disciplines that benefit patients with higher complexity chronic pain include primary care, substance use specialties, pain medicine, mental health, dieticians, health coaching and movement specialties (e.g. physical therapy). If interdisciplinary care is not available in a single care setting, it should be coordinated virtually between distinct care sites.

**DO IT** Use available case management resources, which may be offered by facilities, insurance companies, accountable care organizations or other local resources.

### RISK MITIGATION

### 7. Evaluate patient risk factors and obtain informed consent, which includes education about the risks of opioid use, alternative therapies and therapeutic boundaries, if long-term opioid therapy is prescribed.

The degree of risk associated with long-term opioid therapy (see Guideline #5) warrants completion of informed consent, to ensure and document patient and provider understanding of the risks and benefits of opioid therapy. Informed consent should be obtained prior to initiation and with any changes to the treatment plan.

A risk stratification should be performed as part of a risk/benefit assessment prior to initiating or continuing opioid therapy in patients with chronic pain. Risk assessment can be accomplished either by using existing opioid risk assessment tools such as the Opioid Risk Tool or the Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP-R). There are known limitations of risk tools, including low-sensitivity for the ORT and