# Indiana Guidelines *for the* Management *of* Acute Pain

*Unintentional opioid overdose has become one of the leading causes of injury-related deaths in Indiana over the past decade. To respond to this challenge, public health and health care leaders have committed to helping healthcare providers better serve their patients who suffer from pain, while reducing the potential for overdose and death.*

The Indiana Hospital Association, Indiana State Medical Association, and Indiana State Department of Health have developed guidelines for the safe, appropriate, and effective prescribing of self-administered medications for pain. These guidelines provide a general approach to the outpatient management of acute pain. They are not intended to take the place of clinician judgment, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient.

These guidelines are an additional resource to supplement previous work in other settings:

- Indiana Guidelines for Opioid Prescribing in the Emergency Department
- Indiana Chronic Pain Management Prescribing Rule

This set of guidelines is focused on the management of acute pain and the prescribing of self-administered medications for acute pain, and delineates a standardized process that includes key checkpoints for the clinician to pause and consider additional factors. These guidelines are appropriate for patients of all ages presenting with acute pain; however, they may not apply to acute pain resulting from exacerbations of underlying chronic conditions.

## *Definition of Acute Pain*

For the purpose of these guidelines, acute pain is defined as pain that normally fades with healing, is related to tissue damage, and significantly alters a patient's typical function. Acute pain is expected to resolve within days to weeks; pain present at 12 weeks is considered chronic and should be treated accordingly.

## *Assessment and Diagnosis of Patient Presenting with Pain*

In addition to a proper medical history and physical exam, initial considerations when assessing patients presenting with acute pain should include:

- Location, intensity, and severity of the pain and associated symptoms
- Quality of pain [e.g. somatic (sharp or stabbing), visceral (ache or pressure) and neuropathic pain (burning, tingling or radiating)][1]
- Psychological factors, including personal and/or family history of substance use disorder

A specific diagnosis should be made, when appropriate, to facilitate the use of an evidence-based approach to treatment.

1 Institute for Clinical Systems Improvement. Assessment and management of acute pain. Bloomington (MN): Institute for Clinical Systems Improvement; 2008 Mar. 58p.

## *Develop a Plan*

Upon determining that the symptoms of the patient fit the definition of acute pain, both the provider and patient should discuss the risks/benefits of both pharmacologic and non-pharmacologic therapy. The provider should provide education and work with the patient to develop a treatment plan that includes:[2]

- Measurable goals for the increase or improvement in function and the reduction of pain
- Use of both non-pharmacologic and pharmacologic therapies, with a clear path for progression of treatment and plans for discontinuation
- Mutually understood expectations for the degree and the duration of the pain during therapy
- Goal: Improvement of function to baseline or pre-injury status as opposed to complete resolution of pain

## *Treatment of Acute Pain*

While these guidelines provide a pathway for the management of acute pain, care should be individualized as not every patient will need each option.

Non-Pharmacologic Treatment

Non-pharmacologic therapies should be considered as first-line therapy for acute pain, unless the history of the cause of pain or clinical judgment warrants a different approach. These therapies often reduce pain with fewer side effects and can be used in combination with non-opioid medications to increase the likelihood of success. Examples may include, but are not limited to:

- Ice, heat, positioning, bracing, wrapping, splints, stretching, and directed exercise often available through physical therapy
- Massage therapy, tactile stimulation, acupuncture/acupressure, chiropractic adjustment, manipulation, and osteopathic neuromuscular care
- Biofeedback and hypnotherapy

2 Massachusetts Medical Society Opioid Therapy and Physician Communication Guidelines. May 21, 2015.

## Non-Opioid Pharmacologic Treatment

Non-opioid medications can be used with non-pharmacologic therapies discussed above. When initiating non-opioid pharmacologic therapy, patients should be informed on proper use of medication, importance of maintaining other therapies and expectation for duration and degree of symptom improvement. Examples of treatment options, dependent on the quality of pain, are listed below.

### Somatic Pain

- Acetaminophen
- Non-steroidal anti-inflammatory drugs (NSAIDS)
- Corticosteroids

Alternatives include the following: gabapentin/pregabalin, serotonin-norepinephrine reuptake inhibitors, selective serotonin reuptake inhibitors, and tricyclic antidepressants.

### Visceral Pain

- Acetaminophen
- Non-steroidal anti-inflammatory drugs (NSAIDS)
- Corticosteroids

Alternatives include the following: dicyclomine, serotonin-norepinephrine reuptake inhibitors, topical anesthetics (patches, creams, etc.), and tricyclic antidepressants.

### Neuropathic Pain

- Gabapentin/pregabalin
- Serotonin-norepinephrine reuptake inhibitors (SNRIs)
- Tricyclic antidepressants

Alternatives include the following: other antiepileptics, baclofen, bupropion, low-concentration capsaicin, selective serotonin reuptake inhibitors, and topical lidocaine.

## Opioid Pharmacologic Treatment

In general, providers should reserve prescribing opioids for acute pain resulting from severe injuries or medical conditions, surgical procedures, or when alternatives (non-opioid options) are ineffective or contraindicated. Short-term opioid therapy may be preferred as a first-line therapy in specific circumstances, such as the immediate post-operative period. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, the lowest effective dose should be prescribed with no greater quantity than needed for the expected duration of pain severe enough to require opioids.[3] In most cases, opioids should be used as adjuncts to additional therapies, rather than alone.[4] If a patient may be receiving opioid prescriptions from more than one provider, it is critical that healthcare providers communicate with one another about a patient's care to ensure optimum and appropriate pain management.

3 Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1-49. DOI: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

4 Washington State Agency Medical Directors Group. Interagency Guideline on Prescribing Opiates for Pain Washington State Guidance. June 2015.


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Effective July 1, 2017, a new Indiana law places limits on the opioid quantities that may be prescribed to patients. Indiana prescribers may not issue an opioid prescription exceeding a seven-day supply to patients under 18 or to adult patients receiving a prescribed opioid for the first time from that prescriber. The law does provide an exception if the prescriber is providing palliative care, treating cancer, providing medication-assisted treatment for a substance use disorder, or if in the professional judgment of the prescriber, the patient's condition requires more than a seven-day supply of opioids. The new law also allows for partial fills of an opioid prescription, giving patients discretion over the amount of an opioid they bring home. A copy of the Senate Enrolled Act 226 can be found here.

The following are recommendations for the general use of opioids to manage acute pain:

- Appropriate risk screening should be completed (e.g. age, pregnancy, high-risk psychosocial environment, personal or family history of substance use disorder) and the risk/benefit of using opioids should be discussed with the patient. Perform a drug screening if deemed necessary.
- Provide the patient with the least potent opioid to effectively manage pain. A morphine equivalence chart should be used if needed.
- Prescribe the minimum quantity needed with no refills based on each individual patient, rather than a default number of pills.
- Consider checking Indiana's Prescription Drug Monitoring Program (INSPECT) for all patients who will receive an opioid prescription.
- Avoid long-acting opioids (e.g. methadone, oxycodone ER, fentanyl transdermal patch).
- Use caution when prescribing opioids to patients on medications causing central nervous system depression (e.g. benzodiazepines and sedative hypnotics) or patients known to use alcohol or illicit substances, as combinations can increase the risk of respiratory depression and death.
- Discuss with the patient a plan to wean off opioid therapy, concomitant with reduction or resolution of pain.
- Discuss proper, secure storage and disposal of unused medication to reduce risks to the patient and others. Encourage the patient to bring any unused medication to a Drug Take Back location and/or to purchase a drug lock-box.
- Remind the patient that it is both unsafe and unlawful to give away or sell opioid medication, including unused or leftover medication. Consider providing the patient with a handout containing relevant opioid safety information.

*Pain Reevaluation*

Key Checkpoint: Reevaluation of patients who receive opioid therapy for acute pain should be considered if opioid therapy will continue beyond the initial duration. This reevaluation may be through an office visit or phone call based on the discretion of the provider. For patients with persistent acute pain, providers should reevaluate the initial diagnosis and consider the following:

- Pain characteristics [consider using a standardized tool (e.g. Oswestry Disability Index)]
- Treatment methods used
- Reason(s) for continued pain
- Additional management options, including consultation with a specialist

Additional Checkpoint: For patients with unresolved acute pain after 6 weeks, providers should repeat an assessment and determine whether treatment should be adjusted. Referral to the Indiana Chronic Pain Management Prescribing Rule may be helpful at this point.