



## Acute pain phase prescribing recommendations

The acute phase of pain is **one to four days** after a severe injury or a severe medical condition and up to seven days following a major surgical procedure or trauma.

Use caution when prescribing opioids even in this timeframe, given the potential for patients to experience harm related to any new opioid prescription. Avoid using opioids to treat pain in the acute phase unless the severity of the pain warrants the use of opioid analgesia and non-opioid alternatives are ineffective or contraindicated.

### Clinical recommendations

1. **Use multimodal analgesia** (e.g., NSAIDs and acetaminophen) as the first line of drug therapy for acute pain management. The evidence base demonstrates optimal doses of NSAIDs are superior in efficacy to single entity opioids, and are at least as efficacious as optimal doses of opioid combination drugs.
2. **Provide documentation** of the patient's presentation of pain and diminished physical function. Documentation should include use of the pain scale as a relative tool and concordance of the patient's assessment of his or her own pain with the prescriber's objective observations.
3. Know the status of your patient's risk factors for opioid-related harm. Consider any relevant risk factors not already documented in the patient's record.
4. Query the Prescription Monitoring Program (PMP) ([/dhs/opip/opioid-guidelines/factors-in-treatment/patient-safety.jsp](https://dhs.opip/opioid-guidelines/factors-in-treatment/patient-safety.jsp)) whenever prescribing an opioid for acute pain.
5. Avoid prescribing more than 100 MME of low-dose, short-acting opioids. Limit the entire prescription to 100 morphine milligram equivalents (MME) (not 100 MME per day).
6. Prescribe no more opioids than will be needed for initial tissue recovery following more extensive surgical procedures and traumatic injury. Limit the initial acute prescription to no more than 200 MME, unless circumstances clearly warrant additional opioid therapy. Certain surgical procedures may require additional pain management (e.g., total joint replacement, major spine surgery).

In the event that greater than 200 MME is prescribed for the discharge prescription for major surgical procedures, complete the recommended mental health, chemical health and chronicity risk assessments recommended in Appendix B ([https://mn.gov/dhs/assets/mn-opioid-prescribing-guidelines\\_tcm1053-337012.pdf#page=57](https://mn.gov/dhs/assets/mn-opioid-prescribing-guidelines_tcm1053-337012.pdf#page=57)). Complete the assessments recommended for the appropriate dosage.

7. Use appropriate non-opioid medication to manage acute oral or facial pain in patients presenting to a medical facility with no dentist available. Do not prescribe opioids to patients without an examination and diagnosis by a dental provider. Refer to a dental provider and assist with access to follow-up when possible.

8. Postsurgical prescribing recommendation apply to patients undergoing **dental extractions** or other invasive procedures (See Recommendation 6). Avoid prescribing more than 100 MME total supply of low-dose, short-acting opioids following a dental procedure.
9. Avoid prescribing opioids to patients with a **history of substance use disorder** and to those with an active substance use disorder. Maximize appropriate non-opioid therapies. If opioids are necessary, use extreme caution, frankly discuss the risks with the patient and plan for a close follow-up. Obtain a specific patient release to consult with a substance use disorder provider.
10. Consult with a prescriber or pharmacist specifically trained in the pharmacology of buprenorphine or naltrexone when prescribing opioid analgesia to a patient **already receiving buprenorphine or naltrexone** for opioid use disorder (OUD).  
Limit opioid analgesia to 100 MME total when prescribing opioids to a patient on methadone to treat OUD.
11. For an identifiable, new injury in a patient receiving chronic opioids, dosage for the new injury will be the same as for any patient not already on opioids.
12. Manage acute pain in **patients on chronic opioids** undergoing invasive procedures with additional pain resources, such as the prescriber of chronic opioid therapy, pain specialists, anesthesiology and psychologists.
13. For patients already receiving chronic opioids and in the absence of a verifiable new injury, **do not increase opioid dosage** for acute pain at a new site or the acute exacerbation of a chronic pain. Offer the patient non-opioid treatments.
14. If opioids are prescribed to a [pregnant woman \(/dhs/opip/opioid-guidelines/factors-in-treatment/childbearing-age-women.jsp\)](#) for acute pain, prescribe the lowest dose and duration appropriate.
15. Prescribe no more opioids than will be needed for initial tissue recovery following a cesarean section or complicated vaginal birth. Consider prescribing 100 MME when opioid therapy is prescribed.
16. Provide proper pain control to lactating women experiencing acute pain following birth and surgical procedures. If opioids are prescribed to lactating women for acute pain, check an evidence-based resource (e.g. [LactMED \(https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm\)](https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm)) for preferred opioid types and prescribe the lowest dose and duration adequate to manage the pain.
17. **Acute dosing for children** should be proportional by weight to the dosing guidance in Recommendation 5. Screen all children over the age of 10 per the recommendations for adults (See Recommendation 3). Prescribers should check the PMP for all children prescribed an opioid for acute pain, in order to confirm that the child is not at risk for parental diversion of the opioid. Avoid prescribing children codeine in any setting given the high risk posed to ultra-fast metabolizers.

## Discussion

The acute phase of pain is one to four days after a severe injury or a severe medical condition and up to seven days following a major surgical procedure or trauma. The first-line pharmacologic therapy for mild to moderate acute nociceptive pain is acetaminophen or a non-steroidal anti-inflammatory drug (NSAID) such as ibuprofen. Multiple guidelines recommend these two drugs as first-line pharmacologic therapy for pain, however acute pain characteristics and patient risk factors must be considered when prescribing either medication.

Acetaminophen should be avoided in patients with liver failure, and dosage should be reduced in patients with hepatic insufficiency or a history of alcohol abuse (*FDA, 2015; Guggenheim, 2011*). Monitor patients receiving NSAIDs carefully due to the risk of cardiovascular, gastrointestinal, and renal adverse effects (*CDC, 2016*).

Use caution when prescribing opioids for acute pain, given the potential for patients to experience harm related to any new opioid prescription. A growing body of evidence supports the association between opioid therapy for acute pain and long-term opioid use. A retrospective, observational study examined the probability of long-term use based on a number of characteristics of the initial opioid prescription. The study found that the largest increments in probability of continued opioid use were observed after the fifth and 31st days on therapy; the second prescription; 700 morphine milligram equivalents (MME) cumulative dose; and first prescriptions with 10- and 30-day supplies (*Shah, 2017*). Acute pain can often be managed without opioid therapy. Clinicians should avoid using opioids to treat pain in the acute phase unless the severity of the pain warrants the use of opioid analgesia and non-opioid alternatives are ineffective or contraindicated.

Clinicians must employ effective risk management in order to prevent overdose, misuse and diversion when considering prescribing opioids during the acute phase. Opioids have a wide range of adverse effects that can predispose a patient to serious morbidity and mortality. This includes respiratory depression (*Koo, 2011*), negative impact on endocrine function (*Vuong, 2010*), immunosuppression (*Vallejo, 2004*), opioid-induced hyperalgesia (*Ballantyne, 2007*) and possibly heightened fracture risk related to falls (*Saunders, 2010*).

## Risk assessment

It is the opinion of the OPWG that all prescribers of opioid analgesia for acute pain should be aware of the patient's risk factors for opioid-related harm. It is not recommended that formal risk assessments occur in every instance of acute pain in every setting. Yet, prescribers should be aware of the patient's major risk factors. The Institute for Clinical Systems Improvement Acute Pain Assessment and Opioid Prescribing Protocol work group developed a helpful mnemonic for screening for potential contraindications to opioid use. The

**ABCDPQRS mnemonic** is one useful tool that addresses potential contraindications/risks to opioid use.

- A – Alcohol** use
- B – Benzodiazepines** and other drug use
- C – Clearance** and metabolism of drug
- D – Delirium**, dementia and falls risk
- P – Psychiatric** comorbidities
- Q – Query** the Prescription Monitoring Program
- R – Respiratory** insufficiency and sleep apnea
- S – Safe driving**, work, storage and disposal

Please see **Appendix A** of the Institute for Clinical Systems Improvement [Pain Health Care Guideline](https://www.icsi.org/guideline/pain/) (<https://www.icsi.org/guideline/pain/>). (2017) for more detailed information.

## Dose and duration

A number of opioid prescribing guidelines have included dosage and duration recommendations for acute pain (*CDC, 2016a, ICSI, 2017*). In addition, several states have passed opioid prescribing limits for acute pain. A majority of the recommendations and the state limits acknowledge that 3 to 7 days of opioid therapy for severe, acute pain is sufficient. The work group concurred with these recommendations, noting that the lowest effective dose and duration is necessary given the risks related to opioid exposure at any amount.

In most cases, pain from surgical procedures—especially outpatient procedures—can be managed effectively without opioids or with up to 100 MME total supply of low-dose, short-acting opioids. However some surgical procedures (</dhs/opip/opioid-guidelines/resources/index.jsp>) and traumatic injuries require greater pain management, because of an expectation of increased tissue damage and subsequent inflammatory response. This may include, but is not limited to, procedures and injuries that require more than a 48-hour hospital stay. Experts agreed that up to 200 MME total is an appropriate opioid dose for prescribing in the 7 days post-surgery for most surgical procedures.

The MN Health Collaborative is a partnership between major Minnesota health care organizations and the Institute for Clinical Systems Improvement. The collaborative developed procedure-specific, patient-centric postoperative opioid prescribing recommendations to help prevent under- or over-prescribing of opioids. The MN Collaborative Call to Action: Adult Opioid Postoperative Prescribing report ([https://www.icsi.org/wp-content/uploads/2019/09/Opioid-PostOp-CTA\\_Final-090519.pdf](https://www.icsi.org/wp-content/uploads/2019/09/Opioid-PostOp-CTA_Final-090519.pdf)) was released in October 2018 and will be updated periodically.

## **Acute oral pain**

Patients presenting with acute oral or facial pain require adequate pain management.

If a patient presents in pain in a medical facility or hospital with no dentist available, the treating provider should use an appropriate non-opioid medication for pain management prior to diagnosis and treatment for the underlying source of pain.

Non-dental providers should not prescribe an opioid without examination and diagnosis of the underlying reasons for the oral or facial pain.

Opioids can mask pain and allow the patient to ignore an underlying serious dental problem, such as an abscess. Diagnosis should include appropriate tests and x-rays. Refer the patient to a dental provider and assist with access to follow-up when possible.

## **Acute pain in patients receiving chronic opioid analgesic therapy (COAT)**

Prescribing opioid analgesia for acute pain requires additional consideration when the patient is on chronic opioid analgesic therapy (COAT), has a history of substance use disorder or an active substance use disorder. Providers should treat patients with extreme caution, appropriately balancing the need to relieve severe acute pain caused by an injury or surgical procedure and the need to prevent opioid-related harm. It is the expert opinion of the work group that individuals with acute pain generated by an objectively identifiable injury should be treated under the same dosage and duration guidelines. Greater caution should be employed when the patient does not have an objectively, identifiable new injury and providers should treat pain with non-opioid and non-pharmacologic therapies.

Effective management of acute, postoperative pain in opioid-tolerant patients may require additional education and resources. It is important to effectively manage acute, postoperative pain and opioid-tolerant patients should receive no less treatment than opioid-naïve patients. For opioid-tolerant patients taking up to 90 MME/day, the standard postoperative dose and duration recommendations apply. Postoperative pain management for patients taking over 90 MME/day should involve the prescriber of chronic opioid therapy, pain specialists, anesthesiology and psychologists.

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