

Do not prescribe ER/LA opioids for **acute pain**



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- Long-term opioid use often begins with treatment of acute pain
- When opioids are used for **acute pain**, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids
- **Three days** or less will often be sufficient; more than seven days will rarely be needed

The Most Effective Pain Medicine

- Many believe opioids are the strongest pain medications, however scientific literature does not support that belief
- The number needed to treat (NNT) is the number of people who must be treated to obtain a 50% relief in pain, which is considered effective treatment
- NNT of 1 means 100% of people receive that benefit
- A NNT of 2 is less effective, or that 2 people need treatment for every 1 person to have benefit
- The smaller the NNT, the better

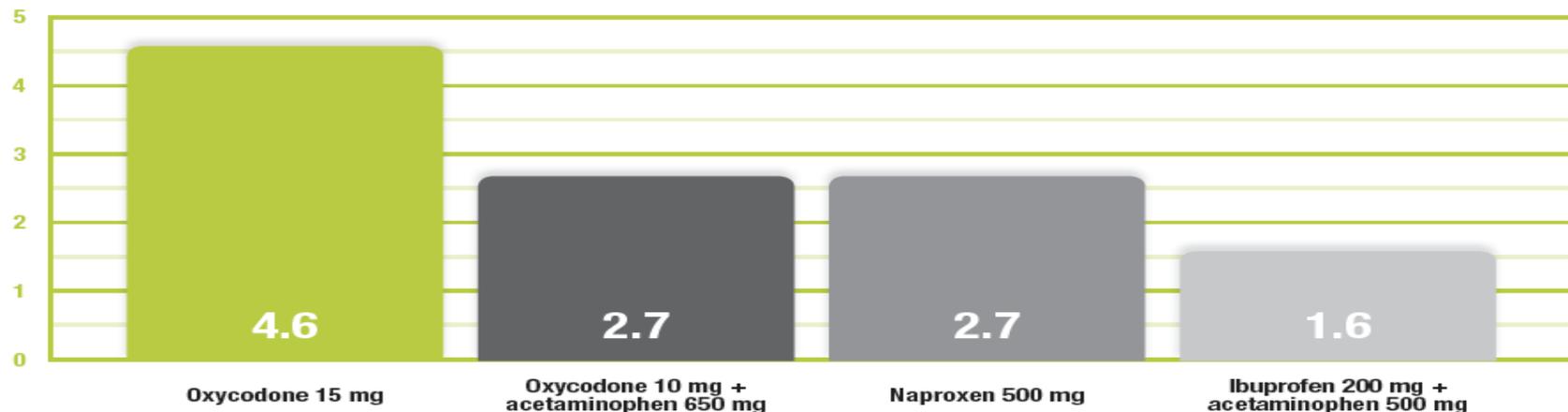


Ibuprofen and Acetaminophen



- The Cochrane Collaboration noted that several organizations reviewed the comparative effectiveness of oral medications in post operative pain
- Post operative pain was studied because it is an example of acute pain with tissue trauma resulting in pain
- It also occurs in a controlled environment (hospital or office) where experimental protocols can be followed
- The results of these reviews showed that **ibuprofen with acetaminophen is more effective** than naproxen or oxycodone

Number of people needed to treat for one person to get 50% pain relief



Comparison of Oral Pain Medication

- Bandolier is an independent organization in Europe that produces reports on evidence-based medicine
- In 2003, Bandolier issued a report on the treatment of **acute pain**

Medication	Type of medication	# of patients studied	NNT
Diclofenac 100 mg	Prescription NSAID	545	1.8
Celecoxib 400 mg	Prescription NSAID	298	2.1
Ibuprofen 400 mg	Prescription NSAID	5456	2.5
Naproxen 400 mg	Prescription NSAID	197	2.7
Ibuprofen 200 mg	OTC NSAID	3248	2.7
Oxycodone 10 mg + acetaminophen 1000 mg	Prescription opioid	83	2.7
Morphine 10 mg intramuscular	Injectable opioid	948	2.9
Oxycodone 5 mg + acetaminophen 325 mg	Prescription opioid	149	5.5
Tramadol 50 mg	Prescription opioid	770	8.3

(Bandolier, 2007)

National Safety Council.
Evidence for the efficacy of pain medication.
Donald Teater, MD

Follow-up and re-evaluate risk and harm;
reduce dose or taper and discontinue



Evaluate

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- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation
- Clinicians should evaluate benefits and harm of continued therapy with patients **every 3 months or more** frequently
- If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to **taper** opioids to lower dosage or to taper and **discontinue** opioids

Consider Naloxone

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- Before starting and periodically during continuation of opioid therapy, clinicians should **evaluate risk** factors for opioid-related harms
- Clinicians should incorporate into the management plan strategies to **mitigate risk**, including considering naloxone when factors increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME), or concurrent benzodiazepine use, are present

Check CURES

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Clinicians should review:

- Patient's medication **history** of controlled substance prescriptions using state prescription drug monitoring program (PDMP, aka CURES) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose
- **PDMP data** when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months