



OPIOID RECOMMENDATIONS for ACUTE PAIN

In October of 2000, the Veterans Health Administration implemented the VHA National Pain Management Strategy in which pain was designated as the “5th vital sign”. As this concept was adopted by hospitals and physicians throughout the country and emphasized by the Centers for Medicare and Medicaid Services (CMS), along with the introduction of long-acting opioid pain medications such as Oxycontin, the United States experienced a dramatic rise in the use and abuse of opioid medications. Opioid overdose is now the leading cause of accidental deaths in young adults, surpassing motor vehicle accidents.⁽¹⁾ The U.S. is the primary consumer (approximately 80%) of all opioids throughout the world while only comprising 5% of the world’s population.⁽²⁾ Statistics also show that orthopaedic surgeons are the fourth leading prescriber, behind primary care physicians (PCPs), internists and dentists.⁽³⁾

The Center for Disease Control recently published the [CDC Guideline for Prescribing Opioids for Chronic Pain](#). However, the vast majority of opioid prescriptions written by orthopaedic surgeons occur in the **acute** setting, such as fractures or following surgery. We recognize, however, that orthopaedic surgeons need to be aware of the opioid epidemic affecting the U.S. and take an active role in combatting it. In a recent study looking at four outpatient procedures, including carpal tunnel release and knee arthroscopy, there was an increase in the number of patients receiving opioid prescriptions post-operatively as well an increase in the daily prescribed dosage over the past decade.⁽⁴⁾ This indicates either a greater reliance on opioid medications for pain control or a more liberal prescribing pattern by surgeons, or both. In an attempt to address the rising non-medical use of prescription opioids and combat this growing epidemic, the Pennsylvania Orthopaedic Society (POS) has created the following recommendations for opioid prescriptions for acute pain.

Recommendation #1: Non-opioid therapy should be considered the initial pharmacological treatment modality of choice for mild or moderate acute musculoskeletal pain. Additional efforts of non-pharmacologic treatment strategies should also be considered. Such strategies include but are not limited to: weight loss programs, exercise, therapy, acupuncture, massage and cognitive behavioral therapy.

Recommendation #2: When considering opioid therapy, clinicians should identify risks factors for opioid abuse and addiction. Risk factors for opioid abuse and addiction include a history of substance abuse, psychiatric conditions, and level of education. While prescribing opioids, physicians should also monitor patients for atypical use patterns and at-risk use or abuse behaviors. Examples of such behaviors include early/frequent refill requests, noncompliance with prescription schedules, obtaining narcotics from multiple providers and reports of lost or stolen medications. The following link is to [MDCalc](http://www.mdcalc.com/opioid-risk-tool-ort-for-narcotic-abuse/), a tool helping physicians identify patients at risk for misuse. <http://www.mdcalc.com/opioid-risk-tool-ort-for-narcotic-abuse/>

Recommendation #3: Prior to the initiation of opioid therapy, physicians should clearly define the duration of therapy and treatment goals of opioid use. Established protocols or policies can limit the amount, type and expected duration of opioid use. These protocols should be discussed with patients and disseminated. In those patients being treated for acute post-operative pain management, it is suggested that opioid prescriptions be limited to 3 months for the indication of acute pain control. Physicians should consider a multi-model approach to pain control in the post-operative period with a combination of non-opioid medications and regional anesthesia when appropriate to lower the opioid requirement. Appendix 1 is an example of a physician-patient opioid agreement.

Recommendation #4: Physicians should know the patient's prescription drug history prior to prescribing opioid medication. It is recommended that opioid prescribers utilize Pennsylvania's Prescription Drug Monitoring Program (PDMP). Legislation authorizing the creation of the ABC-MAP database passed in 2014, and it is expected to be operational in August 2016. It is recommended that physicians periodically review the patient's prescription activity throughout the course of therapy beyond the acute period (e.g. 90 days).

Recommendation #5: When physicians choose to prescribe opioid medications, the least efficacious amount should be written. It is recommended that small quantities of medication be dispensed with patients requesting refills as necessary, as opposed to dispensing large quantities in a single prescription. Although more time-consuming for both the patient and the physician's office, this strategy limits opioid medication excess.

Recommendation #6: Orthopaedic surgeons prescribing opioids should engage not only patients but also involve other providers of the patient's healthcare delivery team (the PCP or pain management specialist) in setting expectations, decisions and treatment plans regarding the prescribed opioids. Good communication among patients and healthcare team members avoids disparities in prescribing assumptions and/or discordant prescription and use expectations (either between patient and provider, or between providers).

In conclusions, the POS recognizes that a change in the cultural expectations in the management of acute and chronic musculoskeletal pain is needed. While moving towards this goal, the POS has partnered with other healthcare organization members within the Commonwealth in creating a workable solution to this complex problem in the acute setting. All physicians should engage in conversations with their patients regarding realistic expectations of pain control and the risks associated with opioid medications. It is encouraged that orthopaedists collaborate with other healthcare members on appropriate management of musculoskeletal pain and take steps to educate the patients in their community of the dangers of opioid prescription and its potential long-term consequences. We are hopeful that through an integrated, team-based approach this complex epidemic can be controlled.

References:

1. Manchikanti et al, *Pain physician* 2008; 11 (2 Suppl): s56-s88
2. Manchikanti et al, *Pain Physician* 2012; 15 (3 suppl): ES9-ES38
3. Volkow et al, *JAMA* 2011; 305(13): 1299-1301
4. Wunsch et al, Opioids Prescribed After Low-Risk Surgical Procedures in the United States 2004-1012; *JAMA* 2016; published online March 15, 2016. Doi: 10.1001/jama. 2016.0130