Oregon Opioid Prescribing Guideline for Acute Pain

DRAFT 8/17/18

Background

Despite a greater than 20% reduction in opioid prescribing in Oregon since 2012, prescribing rates in Oregon continue to far exceed the 1999 baseline rate; as of 2017, more than 20% of residents received an opioid prescription annually. Recent analysis by the CDC[1] illustrates a linear association between the duration of an initial prescription and the risk of on-going opioid use demands prompt safety measures around acute prescribing.

This statewide Oregon guideline is intended to improve patient safety while emphasizing effective and compassionate treatment of acute pain across several domains of practice:

- Primary care/urgent care/ emergency departments
- Dental care
- Post-procedure/post-surgical care

These guidelines address acute pain in these settings, but exclude: chronic pain, cancer pain, palliative and end-of-life care.

Rationale for an Oregon Guideline

Several lines of evidence have recently emerged that makes addressing acute opioid prescribing an urgent matter. Most compelling is the 2017 analysis released by the CDC which demonstrated 'the likelihood of chronic opioid use increased with each additional day of medication supplied starting with the third day'. Among those receiving an initial 30-day prescription, more than 30% remained on opioids a year later. Another analysis among post-operative patients found that the majority did not use the quantities of opioids prescribed.[2] Finally, to avoid confusion, Oregon providers, healthcare systems, and payers would benefit from a single document that clarifies expectations around opioid prescribing for acute pain.

Oregon's Efforts to Promote Safe Prescribing

Opioids are a powerful class of medications to treat pain; however, their use has inherent risks and prescribers are encouraged to remain up-to-date in current understanding of the pathophysiology of pain and its treatment. (See the Oregon Pain Management Commission's updated Pain Management Module: https://www.oregon.gov/oha/HPA/CSI-PMC/Pages/module.aspx)

In 2016, Oregon's Opioid Prescribing Guidelines Task Force approved adoption of Oregon-specific opioid prescribing guidelines[3] based on the *CDC Guideline for Prescribing Opioids for Chronic Pain*.[4] The guideline includes recommendations to improve patient safety and care for those with chronic pain, and address the ongoing prescription opioid overdose epidemic. This guideline 'provides recommendations for the prescribing of opioid pain medication for patients 18 years and older in primary care settings' but does not address prescribing for acute conditions in detail. In the absence of a national standard of care for acute opioid prescribing, a variety of specialty-specific guidelines have

emerged from the dental, emergency medicine, and surgical communities. All emphasize that, for acute pain, clinicians should first use non-opioid medication and then, if needed, judiciously prescribe of opioids in small quantities with duration typically limited to less than a week.

Guideline Summary

This Oregon opioid prescribing guideline for acute pain provides general recommendations across all practice settings. It also makes recommendations for maximum opioid prescription amounts by severity and anticipated duration of acute pain, in the tables that follow. Guidelines for specific conditions and procedures by practice setting (e.g. dental, Emergency Departments, post-operative) are being developed as companion recommendations to this guideline. [Note: the selection and use of specific medications listed in these guidelines should be considered after reviewing indications and contraindications of each medication, with schedule and dose adjustment as necessary for the individual patient.] While these acute pain guidelines are not intended for pediatric patients, they may be applicable to adolescents (e.g. those who have wisdom teeth extractions, or suffer a sports-related injury).

In general, opioids should NOT be considered first line therapy for mild to moderate pain.

If an opioid is prescribed for acute pain, then follow these recommendations:

Amount and type

- Prescribe the lowest effective dose of immediate-release, short-acting opioids usually for less than 3 days, in cases of more severe acute pain limit initial prescription to less than 7 days.
- Do not prescribe opioids and benzodiazepines simultaneously unless both have clear indications documented
- Avoid prescribing opioids over the phone
- Eliminate pre-packaged opioids in Emergency Departments unless systems are in place to share information via Prescription Drug Monitoring Program (PDMP)
- For Computerized Provider Order Entry in an electronic health record (EHR): consider eliminating 'default' amounts of opioids and make each opioid prescription an individualized, patient-centered decision, OR have clinic, hospital or health system update the 'default' to reflect recommended maximum dose outlined in this document (e.g., <8 pills)

Prescription Drug Monitoring Program

- Check the Prescription Drug Monitoring Program (PDMP) to understand the patient's prescription history before prescribing opioids; take note of chronic opioid use, and any concurrent prescription for a benzodiazepine.

Assess patient history of opioid use and SUD

- Assess patient for history of opioid use disorder (OUD). Opioids should be prescribed with great caution in patients with OUD. Document indication for prescribing opioids in these patients.
- Assess patient for a history of long-term opioid treatment. Be aware that another provider may be helping the patient taper off opioids, which a new opioid prescription could jeopardize.

Patient Education

- Counsel patient about pain and expected duration before procedures or after injuries
- Review with patient the risks and side effects of opioids
- Provide opioid safety handout and review with patient before prescribing
- Provide information on safe storage and disposal of unused opioid medications.

Patient Follow up

- One primary clinician should write a patient's prescriptions for opioids. After visits to urgent care and/or the Emergency Department necessitate follow up with a primary care provider rather than providing additional opioid refills.
- Before providing a refill, re-assess the patient's pain, and response to treatment. Ideally this should be done in a face-to-face provider-patient visit. Explore other non-opioid treatment options.

Recommended treatments and maximum opioid prescription amounts by severity and anticipated duration of pain. (Adapted from the Bree Collaborative guidelines on prescribing opioids for post-operative pain: http://www.breecollaborative.org/wp-content/uploads/Supplemental-Bree-AMDG-Postop-pain-18-0718.pdf)

Type I – Expected rapid recovery	
Emergency/ urgent care: migraine, sore throat, uncomplicated neck pain, uncomplicated back pain, sprains, contusion, **Surgical:** Procedures such as hernia repair, laparoscopic appendectomy, inguinal hernia repair, carpal tunnel release, thyroidectomy, laparoscopic cholecystectomy, breast biopsy/lumpectomy, meniscectomy, lymph node biopsy, vaginal hysterectomy.	Prescribe non-opioid analgesics (e.g., NSAIDs, acetaminophen, lidocaine patches) and non-pharmacologic therapies (e.g. heat, ice, physical therapy) as first-line therapy. If opioids are necessary, prescribe ≤3 days (e.g., 8 to 12 pills) of short-acting opioids in combination with an NSAID or acetaminophen for severe pain.
Type II – Expected medium term recovery	
Emergency/ urgent care: fractured bones **Surgical:** Procedures such as anterior cruciate ligament (ACL) repair, rotator cuff repair, discectomy, laminectomy, open or laparoscopic colectomy, open incisional hernia repair, open small bowel resection or enterolysis, wide local excision, laparoscopic hysterectomy, simple mastectomy, cesarean section.	Prescribe non-opioid analgesics (e.g., NSAIDs, acetaminophen) and non-pharmacologic therapies as first-line therapy. Prescribe ≤7 days (e.g., up to 42 pills) of short-acting opioids for severe pain. For those exceptional cases that warrant more than 7 days of opioid treatment, the surgeon should re-evaluate the patient before a second refill and taper off opioids within 6 weeks after surgery.

Type III – Expected longer term recovery	
Emergency/ urgent care: prescribe for Type II, refer for definitive care **Surgical:** Procedures such as lumbar fusion, knee replacement, hip replacement, abdominal hysterectomy, axillary lymph node resection, modified radical mastectomy, ileostomy/colostomy creation or closure, thoracotomy.	Prescribe non-opioid analgesics (e.g., NSAIDs, acetaminophen) and non-pharmacologic therapies as first-line therapy. Prescribe ≤14 days of short-acting opioids for severe pain. For those exceptional cases that warrant more than 14 days of opioid treatment, the surgeon should re-evaluate the patient before refilling opioids and taper off opioids within 6 weeks after surgery.
Patients on Chronic Opioid Analgesic Therapy	
Elective surgery in patients on chronic opioid therapy	Prescribe non-opioid analgesics (e.g., NSAIDs, acetaminophen) and non-pharmacologic therapies as first-line therapy. Resume chronic opioid regimen if patients are expected to continue postoperatively. Follow the recommendation above for prescribing the duration of short acting opioids following a particular surgery (e.g., 3, 7, or 14 days). An increased number of pills per day may be expected compared to an opioid naïve patient. Patients on chronic opioid therapy should have a similar tapering period as opioid naïve patients postoperatively. For those exceptional cases that warrant more than 14 days of opioid treatment after hospital discharge, the surgeon should re-evaluate the patient before refilling opioids and taper off opioids within 6 weeks after surgery to no higher total daily dose than was present pre-operatively.

Dental Opioid Prescribing Recommendations and Initial Limits

Severity/ Procedure	Recommended Pain Treatment
Type A Routine restorative treatment (fillings), cleaning, prosthodontic care, exams/ xrays, orthodontics,	None needed before or after
Type B Simple Extraction Deep cleaning (SRP) with heavy subgingival calculus, Endodontics	● During Procedure: Use long-acting local anesthesia such as bupivacaine/epinephrine for anticipated pain unless contraindicated ● Post-procedure: NSAID or NSAID in combination with acetaminophen
Type C Complex (surgical) Extraction E.g. 3rd molar, impacted teeth, Endodontics presenting with acutely infected tooth, exceptionally 'hot' tooth, (i.e., acute apical abscess), dry socket from difficult extractions, multiple extractions in one visit	● Pre-procedure: consider Non-steroidal anti-inflammatory (NSAID) one hour before procedure ● During Procedure: Use long-acting local anesthesia such as bupivacaine w epinephrine for anticipated pain unless contraindicated ● Post-procedure: ○ 1st Line NSAID or NSAID in combination with acetaminophen ○ 2nd line: 1st line plus maximum of 6 tablets of short-acting opioid such as hydrocodone or oxycodone
Type D Oral Surgical procedures other than surgical extractions, Periodontal surgery (i.e. grafting)	● Pre-procedure: consider Non-steroidal anti-inflammatory (NSAID) one hour before procedure ● During Procedure: Use long-acting local anesthesia such as bupivacaine w epinephrine for anticipated pain unless contraindicated ● Post-procedure: ○ 1st Line NSAID or NSAID in combination with acetaminophen ○ 2nd line: 1st line plus maximum of 12 tablets

[1] Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use – United States, 2006-2015. MMWR 2017; 66: 265-9.
https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm

[2] Hill MV, McMahon ML, Stucke RS, Barth RJ Jr. Wide variation and excessive dosage of opioid prescriptions for common general surgical procedures. *Ann Surg*. 2017;265(4):709-714.

[3] Oregon Health Authority. Oregon Opioid Prescribing Guidelines: Recommendations for the Safe Use of Opioid Medications.
https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf

[4] 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.
https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf