

Clinical Practice Statement

Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain (11/12/2013)

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Executive summary

Pain is one of the most common chief complaints among emergency department patients with a reported rate of over 50%.¹ There is great variability among emergency clinicians in the management of pain, especially with respect to the use of opioid medications.² Importantly, morbidity and mortality have increased as the frequency of opioid use for the treatment of pain has increased.³ This includes a significant increase in non-medical opioid use, addiction, drug-related emergency department visits, and death.^{4,5} The dangers of prescribing opioid medications extend beyond the individual patient and may adversely impact public health.⁶ Approximately 13% of high school seniors have reported non-medical use of prescription opioids. Despite emergency departments prescribing only a fraction of those prescriptions written nationally, ED prescriptions for opioids are reported to account for approximately 45% of those opioids diverted for non-medical use.⁷

These guidelines were developed to provide the emergency clinician with recommendations regarding the safe, effective, and ethical practice of pain management in the emergency department setting. These recommendations may be adopted in whole or in part and should be adapted to address individual hospital policies along with state and local regulations. This document is not meant to replace the judgment of the treating clinician who is in the best position to determine the needs of the individual patient.

Recommendations

In the management of the emergency department patient presenting with acute or chronic pain, the emergency clinician should consider the following when prescribing an opioid medication:

- 1. Administer a short-acting opioid analgesic for the treatment of acute pain as a second-line treatment to other analgesics unless there is a clear**

indication for the use of opioid medication (Example-patient with acute abdomen, long bone fracture, etc).

- 2. Start with the lowest effective dose of an opioid analgesic.**
- 3. Prescribe a short course (up to 3 days) of opioid medication for most acute pain conditions.**
- 4. Address exacerbations of chronic pain conditions with non-opioid analgesics, non-pharmacological therapies, or referral to pain specialists for follow-up.**
- 5. Consider assessing for opioid misuse or addiction using a validated screening tool.**
- 6. Consider accessing a centralized prescription network or state-based prescription drug monitoring program, when available, for patient information on recent controlled substance prescriptions.**
- 7. Refrain from initiating treatment with long-acting, or extended-release, opioid analgesics such as methadone.**
- 8. Avoid prescribing opioid analgesics to patients currently taking sedative-hypnotic medications or concurrent opioid analgesics.**
- 9. Refrain from replacing prescriptions for lost, stolen, or destroyed opioid prescriptions.**
- 10. Refrain from refilling chronic opioid prescriptions. Refer the patient to the treating clinician who provided the original prescription.**
- 11. Encourage prescribers to provide safety information about opioid analgesics to patients. This could include information on the risks of overdose, dependence, addiction, safe storage, and proper disposal of unused medications.**
- 12. Following treatment with opioids (in particular the parenteral form) consider an appropriate period of observation and monitoring before a patient is discharged.**
- 13. Understand EMTALA and its requirements for the treatment of pain. The emergency clinician is required under EMTALA to evaluate an emergency department patient reporting pain. The law allows the emergency clinician to use clinical judgment when treating pain and does not require the use of opioids.**

Opioid prescribing is associated with potential misuse and future dependence.^{8,9}
¹⁰ Though attempts can be made to mitigate this, there are no set of predictors that can determine all patients at risk for opioid abuse.¹¹ This should be reserved for only the most painful conditions using good clinical judgment.

Higher doses of opioids are associated with an increased risk of opioid overdose deaths.^{12,13} In addition, increased doses are also associated with an increased risk of abuse.⁹

Few acutely painful conditions treated in the emergency department require more than a short 3-day course of opioid therapy.¹⁴ Longer courses of opioid treatment are associated with increased risk of abuse⁸ and disability.¹⁵ In addition, opioid use beyond 3 days results in diminished efficacy and potential increased pain sensitivity.¹⁶ In special circumstances, when longer courses of opioid treatment may be required, an effort should be made to ensure close follow up as an outpatient. In addition, a patient may return to the ED for reassessment if 3 days of opioid treatment was inadequate and/or they were unable to arrange outpatient follow up within that time.

The benefits and safety of opioids for the management of chronic pain remain uncertain.¹⁷⁻¹⁹ Treatment of chronic pain is complicated and requires a thorough assessment and determination of appropriate long-term therapy. Patients with chronic pain are optimally managed by a single long-term provider who can frequently monitor treatment efficacy and safety. Monitoring practices such as patient-prescriber agreements and urine drug testing are not practical in the emergency department setting.²⁰ Importantly, predictors for opioid abuse in chronic pain patients are difficult to assess during an emergency department evaluation.^{11,21}

Patients with a history of substance abuse are at an increased risk of opioid misuse when prescribed opioid analgesics for acute pain. The single question, "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?" was found to be 100% sensitive and 73.5% specific for the detection of a drug when the patient answered one or more times.²² Consider alternative therapy in these patients.

Centralized prescription networks provide valuable information on a patient's prescription history. Multiple studies have shown that use of these systems leads to decreases in inappropriate prescribing practices.^{23,24}

Long acting opioids are high risk for respiratory depression and do not have a role in the treatment of acute pain syndromes.^{25,26} The pharmacokinetics of these medications result in an unpredictable peak effect and increase the risk of respiratory depression. Prescriptions for long acting and extended release opiates are more susceptible to diversion and non-medical opioid use.²⁶

Consider other risk factors for respiratory depression such as obstructive sleep apnea. Prescribing new, or refilling old opioid prescriptions for patients already on opioids or sedative hypnotics have potential life threatening consequences due to respiratory depression and/or trauma secondary to mental status obtundation.

The EMTALA definition of a medical emergency makes reference to severe pain as a symptom that should be investigated; pain may be the result of an emergency medical condition. EMTALA does not state that severe pain is an emergency medical condition. EMTALA does not obstruct the emergency medical provider from applying their professional judgment to withhold opioid treatment of pain for ED patients without an emergency medical condition.²⁷

Opioid dispensing and administration is fraught with it's own intrinsic problems and related morbidity and mortality. A thoughtful approach using this guideline provided will hopefully assist emergency physicians in treating pain ethically without the subsequent consequences associated with their administration.