evidence based guidelines

PAIN MANAGEMENT

Acute Pain

- Educate patients on the reasons for pain, prognosis for improvement, and set expectations for recovery or chronicity
- Treat reversible causes of pain
- In addition to acetaminophen, determine the best treatment based on the source of pain: musculoskeletal, inflammatory, neuropathic, centralized, or a combination of factors.

Musculoskeletal	Inflammatory	Neuropathic	Centralized
Heat/Ice	Ice/cool compress	Topical cream (e.g. lidocaine, capsaicin)	
NSAIDs*	NSAIDs* / Corticosteroids/DMDs	Neuroleptics (gabapentin, carbamazepine, etc.)	Neuroleptics (gabapentin, pregabalin)
TCA/SNRI		TCA/SNRI	TCA/SNRI
Refer to Orthopedics, Pain Clinic, or Physiatry	Refer to Rheumatology	Refer to Pain Clinic or Physiatry	Refer for psychotherapy

- *If the first NSAID prescribed is not effective, consider switching classes:
  Acetic Acids: diclofenac, indomethacin, ketorolac, nabumetone, etodolac, sulindac
  Cox-2 inhibitor: celecoxib
  Oxicam derivatives: meloxicam, piroxicam
  Propionic Acids: ibuprofen, ketoprofen, naproxen, oxaprozin
- If opiates are appropriate:
  - Check MAPS to become familiar with all controlled prescriptions patient has taken or is taking
  - Document a discussion of potential for addiction, sedation, or overdose
  - Use low-dose, immediate release formulation
  - Seek to limit doses to less than 50 MME/day
  - First prescription should be for no more than 3-5 day supply

Chronic Pain

- Encourage a healthy lifestyle:
  - Adequate sleep
  - Healthy diet
  - Weight loss if BMI>30
  - Regular aerobic activity
- Address psychiatric distress (depression, anxiety, stress, fear of pain, negative thinking)
- Consider centralized treatments as above
- Limit risks of over-sedation or overdose:
  - Allow dose increases only to improve activity level, not reduce pain (e.g. PEG questions)
  - Limit opiate use to < 100mg MME/day, refer to physiatry/pain specialist if requiring higher doses
  - Avoid or limit concurrent use of benzodiazepines, muscle relaxers, neuroleptics
- Determine risk for abuse or diversion (e.g. Opioid Risk Tool), change intensity based on behavior
  Low risk: Office visit at least annually, allow 6-months of refills for schedule III meds
  Mod. risk: Office visit quarterly, UDS twice per year, only one month of refills on controlled meds
  High risk: Office visit monthly, random UDS and/or pill counts, one month refills, max MME/day <50

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