SESSION 1: MEDICAL INDICATIONS AND OPIOID PRESCRIBING GUIDELINES FOR ACUTE MANAGEMENT

National Academies of Sciences

Applying Clinical Practice Guidelines to Prescribing Opioids for Acute Pain: A Workshop

February 4, 2019

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UB|MD ORTHOPAEDICS & SPORTS MEDICINE

Meeting of Physicians Treating Acute Pain in Athletes (and non-athletes)

- Emergency Medicine/Primary Care Sports Medicine
- Emergency Medicine
- Orthopedic Surgery Sports Medicine (2)
- Internal Medicine/Pediatrics
- Internal Medicine
- Primary Care Sports Medicine

- *all with experience at Professional, NCAA Division 1,2,3, and/or High School sideline care

What are the medical conditions for which you believe clinical practice guidelines for prescribing opioids for acute pain should be a priority and why?

- Severe pain due to:
- Fracture (different fractures have different amounts of pain) – rib, prox hum
- Dislocation (higher level of pain with lower extremity dislocations)
- Ligament sprains
- Acute Spinal Pain
- Severe muscle tears
- Severe contusion
- Acute radicular pain
- Acute exacerbation of chronic arthritis

- They are common conditions that in certain individuals can cause significant pain

- Treating acute pain aims to restore function, while avoiding chronic pain or drug dependence or misuse.

How are opioids used to treat pain prior to, during or following these conditions?

- Opioids are ideally reserved as a later-level treatment for the above conditions, being employed when other pharmacologic treatments such as oral or injectable NSAIDs, gabapentin, topical anesthetics, oral or injectable steroids, and benzodiazapines or other muscle relaxants; and methods such as education, ice, compression, immobilization, aspiration, and elevation fail to provide adequate pain relief. When these modalities have failed, a short (3-5 day) course of opioids should be available as a treatment option.
- In reality, a 3-5 course of opioids is often given in conjunction with the above when indicated by the severity of the injury

- Opioids should be a consideration and available for treating the above conditions but should be used only when other non-opioid treatments have failed, or in special circumstances where the pain is severe AND the degree of pain would be explained by the diagnosis. If the pain cannot be explained by the diagnosis further information should be obtained to arrive at the correct diagnosis.

What evidence would be needed to develop a practice guideline for each of the above?

- Comparative effectiveness studies are needed on the use and effectiveness of opioids compared to other treatments for acute musculoskeletal pain in the non-operative setting (how many days, how many pills, what is the minimal effective dose, compare them to other treatments)
- Another suggestion: follow-up study on patients from ER given opioid – how many are on them one year later? Focus on patients with no history of prior use, being treated for non-operative problems

Should the guidelines be for specific conditions or general conditions and why?

- All of the above conditions can be grouped under the heading of “acute musculoskeletal pain” or similar descriptive term and one set of guidelines could apply
- If the guidelines are kept general they will be less confusing and also allow for treatment individualization.
- They should refer to the opioid-naïve patient

Should we treat all procedures/situations as equal?

- There should be flexibility in the guidelines to account for high-risk groups (elderly, those with unique social circumstances, pediatric population, prior opioid addiction, medical conditions precluding the use of first-line recommendations, etc) where treatment should be individualized.
- Evidence-based guidelines won't be implemented if health insurance doesn't cover some of the other modalities we know will work.
- Challenge with guidelines will be getting them to be broadly used.

Thank You