U.S. Department of Veterans Affairs
Veterans Health Administration
PBM Academic Detailing Service

Emergency Department (ED): Treating Acute Pain and Providing Naloxone

Treating most types of pain in the ED

1 Non-pharmacologic approaches

If needed, use:

2 Non-opioid pharmacotherapy

If not effective, or for severe pain, add:

3 ≤ 5 days of short-acting opioids

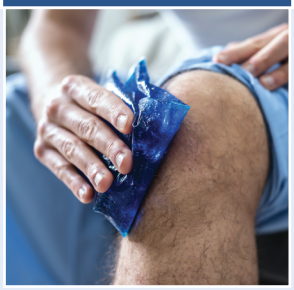
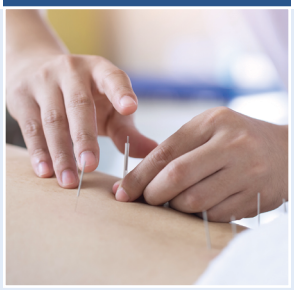
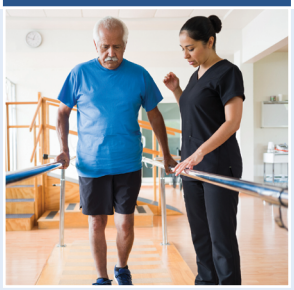
Opioids are not recommended for:*

- Chronic back pain
- Routine dental pain
- Acute exacerbations of chronic pain
- Neuropathic pain
- Chronic abdominal pain
- Migraine headaches

**Potential for harm or little evidence of effectiveness*

1 Non-pharmacologic approaches for acute pain

Consider the following, based on source of acute pain and/or type of injury:

Encourage self-care	Recommend activity	Refer to complementary integrative health	Refer to rehabilitative therapies
			
Ice, heat, rest, elevation	Swimming, walking, yoga, chair exercises, Tai Chi, stretching	Acupuncture, massage, chiropractic therapy	Physical therapy, occupational therapy

This factsheet was created to be used as a tool for VA providers and is available to use from the VA PBM Academic Detailing Service SharePoint Site: **https://vaww.portal2.va.gov/sites/ad**

2 Non-opioid pharmacotherapy

TOPICAL THERAPY: Consider for patients with localized regional pain and intact skin.

Topical	Type of pain control	Additional information
Diclofenac gel, solution, or patch	Best for joint pain (e.g., ankle, wrist, knee, shoulder)	• Provides local anti-inflammatory effects • Similar pain reduction to oral NSAIDs with less side effects due to minimal systemic absorption • For best effect, use on a scheduled basis
Methyl salicylate cream, ointment, or patch	Local/regional effect for musculoskeletal pain	• Counterirritant causing mild inflammation which results in a deeper pain relief
Lidocaine patch	Neuropathic pain	• Systemic absorption is low when applied to intact skin
Capsaicin cream, ointment	Peripheral neuropathic pain and musculo-skeletal pain	• Depletes substance P with daily use, desensitizing the sensory nerve fibers and reducing pain • Must use multiple times daily to maintain effect

NSAIDs = Nonsteroidal anti-inflammatory drugs. Products are listed based on evidence-based recommendations; not all products may be available on VA National Formulary and may require non-formulary request or PA. **pbm.va.gov/PBM/NationalFormulary.asp**

ORAL OR INJECTABLE THERAPY: Consider for patients with systemic/widespread pain or for patients who cannot use or did not respond to topical therapy.

Medication	Role in treatment	Additional information
Acetaminophen	Osteoarthritis and musculoskeletal pain	• Not associated with gastrointestinal (GI) ulcer; no significant platelet or anti-inflammatory effect ≤ 2,000mg/day • Maximum dose: 2,000 mg daily in patients with liver disease; 4,000 mg daily in patients without liver disease
NSAIDs Oral and injectable	Musculoskeletal pain and chronic low back pain	• Associated with more side effects (e.g., GI ulceration, cardiovascular (CV) effects including heart attack and stroke, and renal toxicity) • Adding an NSAID to a pain regimen containing an opioid may have an opioid-sparing effect of approximately 20-35% • Intramuscular or intravenous ketorolac administered in ED can be helpful to quickly address acute pain
Non-benzodiazepine skeletal muscle relaxants	Acute exacerbation of chronic low back or neck pain with muscle spasms (use < 7 days)	• Drowsiness is common—avoid driving, operating heavy machinery, and alcohol • Recommend against carisoprodol or benzodiazepines due to higher risks, potential for abuse/misuse, and lack of benefit

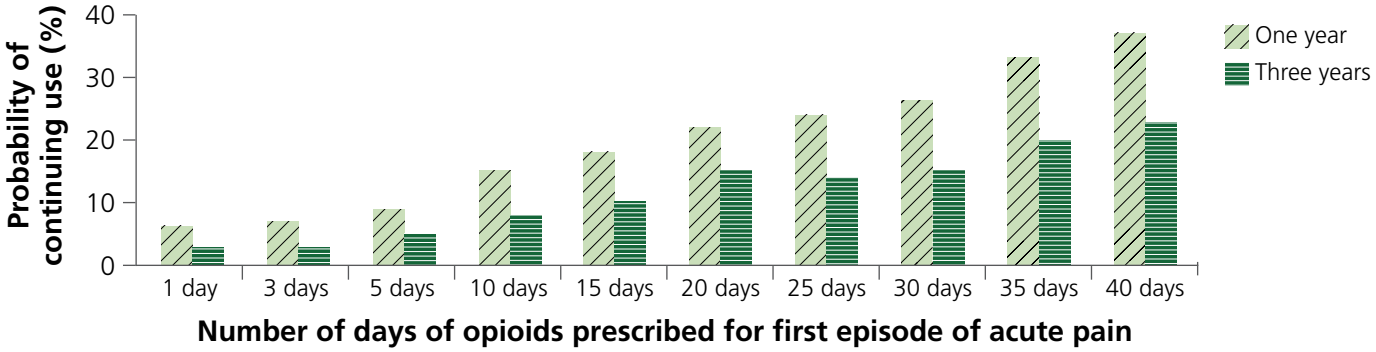
Recommendations in high-risk patient populations

High-risk patient populations	Treatment options	
• Heart failure and cardiovascular disease (CVD) • Chronic kidney disease • Taking anticoagulants • History of recent GI bleed	• Topicals — Diclofenac — Lidocaine — Methyl salicylate — Capsaicin	• Oral acetaminophen • Oral non-benzodiazepine skeletal muscle relaxants — Methocarbamol or tizanidine — Cyclobenzaprine in patients without CVD

AVOID oral NSAIDs in higher risk populations due to potential GI toxicity, increased bleeding, cardiovascular risk, and nephrotoxicity.

3 Short-term use of fast-acting opioids (≤ 5 days)

Any use of opioids for acute pain increases the probability of chronic use.[1]



Opioid pharmacotherapy for acute pain[2,3]

Initial dose, opioid naive: limit to a 3-5 day supply then reassess.*

Opioid	Milligrams	Dose/day	mg MEDD	Drug prescribed	3-day supply
Codeine	15–30	2-3	6.75–13.5	Codeine 30 mg/APAP 300 mg	9 tablets
Hydrocodone	5–10	3	15 to 30	Hydrocodone/APAP 10/325 or 5/325	9–18 tablets
Hydromorphone IR	2	2-3	24	Hydromorphone IR 2 mg	9 tablets
Morphine IR	7.5–15	2-3	22.5–45	Morphine IR 2 mg	9 tablets
Oxycodone IR	5–10	2-3	22.5–5	Oxycodone IR 5 mg or Oxycodone IR 5 mg/APAP 325 mg	9–18 tablets
Oxymorphone IR	5	2-3	45	Oxymorphone IR 5 mg	9 tablets
Tapentadol IR	50	2-3	60	Tapentadol IR 50 mg	9 tablets
Tramadol	25–50	2-3	N/A	Tramadol IR 50 mg	9 tablets

*In cases of severe pain, treatment may need to be longer than 3-5 days. MEDD = morphine equivalent daily dose
Products are listed based on evidence-based recommendations; not all products may be available on VA National Formulary and may require non-formulary request or PA. **pbm.va.gov/PBM/NationalFormulary.asp**

If opioids are prescribed, follow these basic principles to increase safety.

PRIOR TO PRESCRIBING:

STORM Risk Review: Point of care-based review to evaluate risk of opioid-related overdose, adverse events and suicide, clinical factors that increase risk, and pain treatment options to consider. https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx

Urine drug testing: Screen for prescribed and non-prescribed substances.

Prescription Drug Monitoring Program (PDMP):
- Check before prescribing any opioids.
- Required by VA if prescribing > 5 days of opioids; follow state laws and local VA policies if more stringent.

WHEN PRESCRIBING:

Days supply: Up to 3-5 days, depending on state regulations. Reassess if longer treatment needed.

Prescribe only immediate release (IR) forms: Higher risk of long-term use with sustained release forms.

Prescribe naloxone for any patient at risk for an opioid overdose.

Discuss: Provide education (Acute Pain Information Guide, Opioid Risk Discussion Tool). Offer alternatives to opioids.

Disposal: Encourage safe disposal of unused opioids. Offer a medication disposal bag.

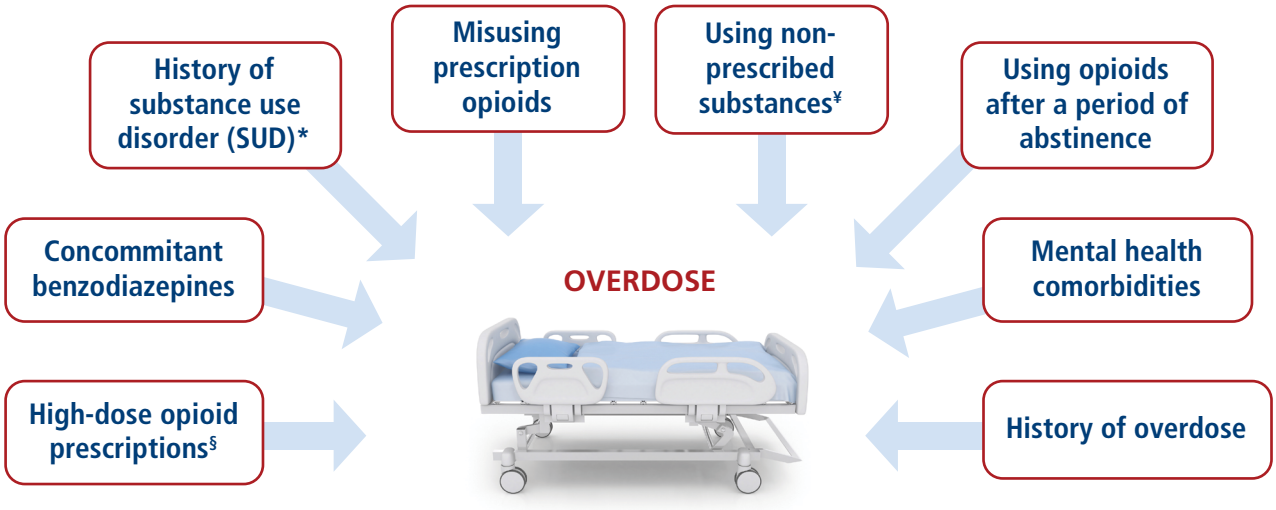
Preventing overdose with naloxone

EMERGENCY DEPARTMENT

Why prescribe naloxone from the Emergency Department?

- ✓ ED providers are the most likely provider type to treat an overdose.
- ✓ Prescribing naloxone is recommended for all patients at risk for opioid overdose.
- ✓ One study found that among people who had opioid related deaths, 1 in 6 had a nonfatal opioid overdose in the year prior to their death.[4]

Risk factors for overdose:



*History of SUD can increase risk of overdose when opioids are used alone or with alcohol, sedatives, stimulants, and cannabis. ¥Risk of overdose may be higher due to contamination with opioids. §Prescribed ≥ 50 mg morphine equivalent daily dose (MEDD). Patients on < 50 MEDD can still be at risk if taking more than prescribed or combining with other substances.

What can you do?

Offer patient education

- Know the name of medications you are taking
- If prescribed opioids, take exactly as directed
- If using non-prescribed opioids, do not use them by yourself
- **DON'T mix** your opioids with:
  - Medicines that make you sleepy
  - Alcohol
  - Benzodiazepines

Help recognize signs and symptoms of overdose

- Appears sleepy
- Slow, shallow or lack of breathing
- Bluish or gray lips or skin
- Clammy, sweaty skin
- Non-responsive

Call 911 if an overdose is suspected.

Prescribe naloxone

- Nasal spray is preferred
- Easy to use
- Free for Veterans!
- Do not prime device
- Spray in one nostril one time
- Repeat dosage in 2-3 minutes, in alternate nostril, if person does not start breathing
- Auto-injector available for patients unable to use nasal spray

REFERENCES: 1. Shah A, et al. Characteristics of initial prescription episodes and likelihood of long-term opioid use–United States, 2006–2015. *MMWR Morb Mortal Wkly Rep* 2017;66: 265–269. **2.** US Department of Veterans Affairs, Department of Defense. VA/DoD Clinical Practice Guidelines for Opioids Therapy for Chronic Pain. February 2017. **3.** Dowell D et al. CDC guidelines for prescribing opioids for chronic pain–United States, 2016. *JAMA.* April 19, 2016; 315(15):1624-1645. **4.** Larochelle MR et.al. Touchpoints–Opportunities to predict and prevent opioid overdose: A cohort study. *Drug and alcohol Dependence,* 2019; 204:107537.

June 2020 IB 10-1409 P96992 www.va.gov