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*

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**Non-pharmacologic approaches for acute pain**

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

- **Encourage self-care**
  - Ice, heat, rest, elevation

- **Recommend activity**
  - Swimming, walking, yoga, chair exercises, Tai Chi, stretching

- **Refer to complementary integrative health**
  - Acupuncture, massage, chiropractic therapy

- **Refer to rehabilitative therapies**
  - Physical therapy, occupational therapy

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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](https://vaww.portal2.va.gov/sites/ad)
### Non-opioid pharmacotherapy

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

<table>
<thead>
<tr>
<th>Topical</th>
<th>Type of pain control</th>
<th>Additional information</th>
</tr>
</thead>
</table>
| 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 musculoskeletal 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](http://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.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Role in treatment</th>
<th>Additional information</th>
</tr>
</thead>
</table>
| 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**

<table>
<thead>
<tr>
<th>High-risk patient populations</th>
<th>Treatment options</th>
</tr>
</thead>
</table>
| • 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.
Short-term use of fast-acting opioids (≤ 5 days)

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

![Graph showing probability of continuing use over different durations of opioid use.]

Opioid pharmacotherapy for acute pain2,3

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

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

*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

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 substance use disorder (SUD)*
- Misusing prescription opioids
- Using non-prescribed substances¥
- Using opioids after a period of abstinence
- Concomitant benzodiazepines
- High-dose opioid prescriptions§
- Mental health comorbidities
- History of 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