UCONN HEALTH

CLINICAL GUIDELINE
Management of Acute Perioperative Pain

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<tr><td>A. EFFECTIVE DATE</td><td>6/7/2022</td></tr>
<tr><td>B. PURPOSE</td><td>To establish uniform standards for the management of acute postoperative pain.</td></tr>
<tr><td>C. SCOPE</td><td>Applies to all UConn School of Medicine providers.</td></tr>
<tr><td>D. GUIDELINE</td><td>

Acute pain, often defined as pain lasting 4 weeks or less, may be experienced by patients of all ages due to a variety of different conditions, including post-surgical recovery. Subacute pain lasts 4 - 12 weeks, and chronic pain is defined as pain lasting more than 12 weeks.
Education regarding post-operative pain control and opioid use should be provided to all patients undergoing surgery prior to surgery date.
Intraoperative techniques, specific to the surgical procedure, should be optimized to minimize pain and post-operative opioid use should be considered in all cases.
Consider the use of long-acting local anesthetics, such as bupivacaine, to reduce the severity of post-operative pain.
Multimodal pain therapy optimized for the specific procedure being performed should be considered for all surgical interventions. Examples would be physical therapy, therapeutic massage, acupuncture, cognitive behavioral therapy, e-stim, assessment for concurrent depression/anxiety, etc.
In the absence of a contraindication, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and/or acetaminophen (APAP) should be considered pre-emptively and first-line analgesic therapy to help reduce the severity of postoperative pain. The sequencing of NSAIDs and APAP administration is evidence-based to be synergistic and should be considered. (see attached external guidelines)
If opioids are indicated:
<ol type="a">
It is recommended that the provider screen patients for the risk of developing substance use disorders (SUD) using a validated screening tool, namely, the Opioid Risk Tool (see below).
Per state statute, the provider, or their delegate, must check the CT Prescription Monitoring and Reporting System (CPMRS) for any concerns related to SUDs and potential opioid misuse for opioid prescriptions of greater than 72 hours in length.
Per state statute, if the patient is opioid naïve an opioid prescription is limited to a 7-day supply.
Long-acting or extended-release opioids are not evidence-based for managing acute and post-operative pain.
For situations where a patient is already on chronic opioid therapy for pain or agonist maintenance therapy for OUD (methadone/suboxone):
<ol type="i">
For <u>chronic opioid therapy</u> that is the surgical indication, surgery is anticipated to alleviate problem therefore follow the same protocol for post-surgical pain as any patient including taper of long-acting medications such as methadone and buprenorphine.

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	ii. For patients with OUD, the surgery is unrelated to current medication use. There are several approaches that can be utilized • Temporary hold: a. buprenorphine/methadone would be stopped day of surgery b. Methadone would restart after the surgery once the dose is verified by the patient's methadone maintenance program. The patient can get additional short acting opioids for pain management if necessary per institutional protocol. c. Buprenorphine would restart at previous dose with additional short acting opioids for pain management if needed. • Continuation of therapy: a. Methadone: take the day of surgery and treat with opioid agonist as needed for the shortest time possible tapering dosing and frequency fairly rapidly b. Buprenorphine: See guidance of attached Table 3, referencing total daily dose of buprenorphine. Consider this practical approach to balance concerns of relapse for patients with opioid use disorder (OUD) and humanistic pain control. The reason for tapering buprenorphine to a lower dose if possible is for enhanced pain management. • If post-surgical pain can be managed without opioids it is the preferred choice allowing the patient to restart their OUD treatment. • If opioid therapy is necessary for pain management, it should be limited with a set end date and follow up with their OUD prescriber. iii. For patients on naltrexone for OUD or alcohol use disorder: • Oral naltrexone: should be discontinued at least 24-72 hours prior to anesthesia • Long- acting IM naltrexone: a. Time the surgery for 3 weeks+ after last injection in order to use non-opioid and opioid therapies as needed for pain management b. If unable to delay surgery (i.e emergent surgery), optimize non-opioid therapies including procedures such as nerve blocks and IV acetaminophen as opioid therapies are unlikely to have effect on pain.

	f. Tapering example - The first two days post-op, schedule the dosing as q6hours PRN, then begin the de-escalation and go to q8h PRN for 1-2 days, then q12h PRN for 1-2 days, and then once daily PRN or done. 8. Patient identified as **"lower risk"** of developing SUDs or opioid misuse, and in the absence of 1. an opioid contraindication, 2. a past and family history of SUDs, 3. benzodiazepine and centrally-acting sedative therapy, and 4. drug interactions, a short-acting opioid with the lowest potency may be prescribed **for no longer than 3 days.** 9. Patients identified as **"at greater risk"** of developing SUDs or opioid misuse: a. must be informed of their risk screening result b. must be re-evaluated for the need for opioids. The provider must start with a trial of non-opioid alternatives (NSAID + APAP) prior to prescribing an opioid c. if opioid alternatives are not effective, they may be prescribed a short-acting opioid with the lowest potency for **no longer than 3 days with a clear end date.** 10. A discussion on the risks and benefits of opioid therapy must take place by informing the patient of possible risks associated with opioids. The discussion should be documented in the EHR. Discussion should include but not be limited to: a. Risk of respiratory depression and addiction b. Risk of hyperalgesia (opioids can exacerbate pain sensitization) c. Constipation d. Opioids are short-term therapy for pain with documented end date of prescription e. Tend to reduce pain by no more than 30% f. With each refill, risk of addiction and misuse increases by 44% 11. All patient instructions for analgesia and analgesic prescriptions must be documented in the patient's record. NSAID and APAP Prescribing Precautions can be found in References. The Anesthesia Department has a peri-operative document inclusive of additional medications to be cognizant of from both pain management and sedation concerns.
E. OTHER RELATED DOCUMENTS	Chronic Opioid Therapy Pain Management Agreement: https://health.uconn.edu/policies/wp-content/uploads/sites/28/2019/01/Chronic-Opioid-Therapy-Pain-Management-Agreement-Attachment-to-Chronic-Opioid-Therapy.pdf Opioid Risk Tool (ORT): https://health.uconn.edu/policies/wp-content/uploads/sites/28/2019/01/OpioidRiskTool-Attachment-to-Chronic-Opioid-Therapy.pdf
F. REFERENCES	Acetaminophen: Preventing Harm through Safe Use (Canada): https://www.ismp-canada.org/download/safetyBulletins/2017/ISMPCSB2017-04-Acetaminophen.pdf

	American Society of Anesthesiologists Task Force on Acute Pain Management. Practice Guidelines for Acute Pain Management in the Perioperative Setting: An Updated Report by the American Society of Anesthesiologists Task Force on Acute Pain Management Anesthesiology 2 2012, Vol.116, 248-273, February 2012: http://anesthesiology.pubs.asahq.org/article.aspx?articleid=1933589 Anne, S., Mims, J. W., Tunkel, D. E., Rosenfeld, R. M., Boisoneau, D. S., Brenner, M. J., ... & Monjur, T. M. (2021). Clinical practice guideline: opioid prescribing for analgesia after common otolaryngology operations. *Otolaryngology–Head and Neck Surgery*, *164*(2_suppl), S1-S42. https://journals.sagepub.com/doi/full/10.1177/0194599821996297 Connecticut Voluntary Non-Opioid Directive: https://portal.ct.gov/-/media/Departments%20and%20Agencies/DPH/dph/Injury%202018/CT%20VNOD%20Form_FINAL Dental Guideline on Prescribing Opioids for Acute Pain Management- Center for Opioid Research and Education https://www.solvethecrisis.org/dental-guidelines Interagency Guideline on Prescribing Opioids for Pain – Agency Medical Directors' Group. http://www.agencymeddirectors.wa.gov/files/2015amdgopioidguideline.pdf NSAID Prescribing Precautions: https://www.aafp.org/afp/2009/1215/p1371.pdf Qaseem, A., McLean, R. M., O'Gurek, D., Batur, P., Lin, K., & Kansagara, D. L. (2020). Nonpharmacologic and Pharmacologic Management of Acute Pain From Non–Low Back, Musculoskeletal Injuries in Adults: A Clinical Guideline From the American College of Physicians and American Academy of Family Physicians. *Annals of Internal Medicine*, *173*(9), 739-748. https://www.acpjournals.org/doi/full/10.7326/M19-3602 Safe Paracetamol Use Guideline - Queensland Health (Australia): https://www.health.qld.gov.au/__data/assets/pdf_file/0030/147666/qh-gdl-415.pdf Summary of 2015 Interagency Guideline on Prescribing Opioids for Pain – Center for Opioid Research and Education http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf Summary of Dental Guidelines on Prescribing Opioids for Acute Pain Management – Center for Opioid Research and Education http://www.agencymeddirectors.wa.gov/Files/FY18-305_Summary_of_Dental_Guideline_Print.pdf Summary of Opioid Prescribing Practices for Perioperative Pain – Center for Opioid Research and Education http://www.agencymeddirectors.wa.gov/Files/FY19217SummaryOpioidPrescPerioperativePain.pdf

Surgical Opioid Guidelines - Center for Opioid Research and Education
https://www.solvethecrisis.org/best-practices

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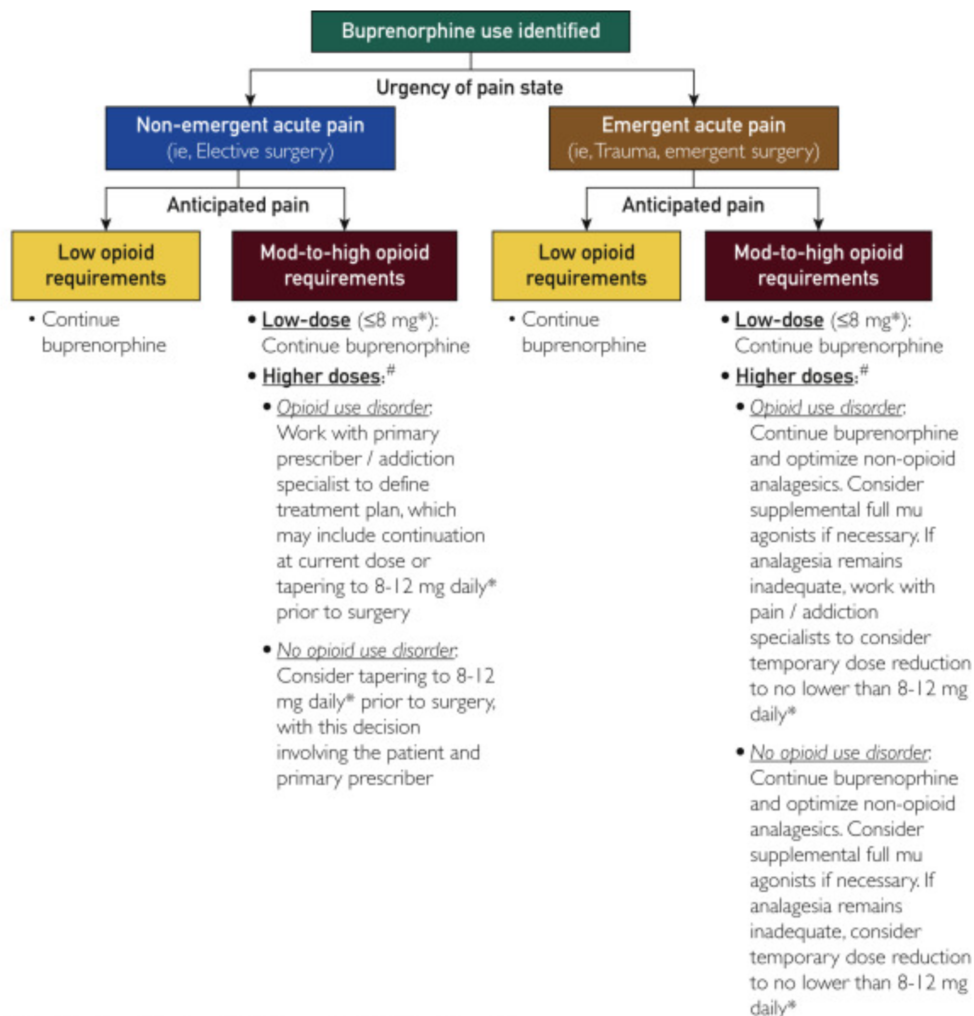

G. RELATED GUIDELINES and POLICIES	UCONN Health CLINICAL POLICY: Chronic Opioid Therapy Pain Management Agreement for Patients with Chronic Pain. https://health.uconn.edu/policies/wp-content/uploads/sites/28/2019/01/Chronic-Opioid-Pain-Management-Agreement-for-Patients-with-Chronic-Pain.pdf
H. SEARCH WORDS	Postoperative Pain, Prescriptions, Opioids, Acute Pain
I. APPROVED BY	1. XXXX XXXX (Signed) xx/xx/xx XXXXXXXXXXXXXX Date 2. XXXX XXXX (Signed) xx/xx/xx XXXXXXXXXXxxxx Date
J. REVISION HISTORY	