

## EDUCATIONAL OBJECTIVES

At the end of this continuing education activity, pharmacists will be able to

- Identify risk factors and common causes of chronic pain
- Compare patient scoring systems used in opioid risk management
- Differentiate pharmacological regimens based on pain type
- Evaluate the pharmacist's role in chronic pain management in the emergency department

At the end of this continuing education activity, pharmacy technicians will be able to

- Describe risk factors and common causes of chronic pain
- Compare patient scoring systems used in opioid risk management
- Identify pharmacological regimens based on pain type
- Review the pharmacy technician's responsibilities in medication reconciliation for chronic pain patients



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## Education on Chronic Pain Management in the ED

**ABSTRACT:** The emergency department (ED) is most often patients' first encounter when presenting to the hospital. Many patients present with a chief complaint of pain. Patients with acute and chronic pain often present with uncontrolled pain that is difficult to treat. Many providers resort to prescribing opioids for these patients, which has in part fueled the current opioid epidemic. Providers can use patient scoring systems, such as the opioid risk tool and the Diagnosis, Intractability, Risk and Efficacy score, to assist with opioid risk management. Pharmacists can help colleagues select an optimal treatment regimen based on the severity and type of pain while also considering other patient-specific factors like comorbidities and other medications. The sooner acute pain is appropriately managed, the better chance that the patient will not develop chronic pain.

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## INTRODUCTION

Pain is one of the most common reasons patients seek medical attention and accounts for up to 80% of ED visits.<sup>1</sup> Among patients who seek emergency care for pain, almost 20% present with chronic pain.<sup>2</sup> The ED's purpose is to address acute issues and triage patients to appropriate levels of care. The ED is not intended to treat chronic pain, yet emergency medicine providers will often find themselves caring for patients who suffer from chronic pain.<sup>1</sup> Therefore, it is important for emergency medicine providers to understand how to treat these patients appropriately. **Table 1** provides some common reasons that patients with chronic pain present to the ED instead of their pain management specialist.

**Table 1. Example Concerns for Chronic Pain Patients Presenting to the ED<sup>1,2</sup>**

Reason for presentation to the ED	<ul style="list-style-type: none"><li>● Acute headache</li><li>● Acute incident/injury (motor vehicle collision/fall)</li><li>● Back pain</li><li>● Change of pain severity or symptoms from baseline</li><li>● Chest pain</li><li>● Chronic pancreatitis</li><li>● Lower abdominal pain</li><li>● Sickle cell disease</li></ul>
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Pharmacists are being consulted more than ever for pain management recommendations, especially for difficult-to-treat chronic pain. Emergency medicine pharmacists report many patients who present with chronic pain do not have a pain management specialist or their pain management specialist is unavailable, a common occurrence on weekends and holidays. Many of these patients present with pain secondary to back pain or other work-related injuries. Other common causes of chronic pain include sickle cell disease and headaches.<sup>1,2</sup>

Unsurprisingly, chronic pain is associated with a significant financial burden. The annual cost of untreated pain in the United States (U.S.) is estimated to be between \$560 and \$635 billion.<sup>3</sup> This includes tangible costs like healthcare costs and workers compensation in addition to intangible costs such as absenteeism, presenteeism (presence at work but, because of medical conditions, inability to function fully),<sup>4,5</sup> and income loss. These costs strain the U.S. healthcare system and healthcare systems around the world.

### Acute Pain Evolution into Chronic Pain

The International Association for the Study of Pain defines chronic pain as “pain that persists past the normal time of healing.”<sup>2</sup> Some experts define chronic pain as pain lasting one to three months, and other providers define it as pain lasting six months or more.<sup>2</sup> Chronic pain is difficult to treat and has led to the overprescribing of opioid medications, fueling the current opioid epidemic.

All chronic pain starts with acute pain, so it may be possible to prevent chronic pain by treating acute pain appropriately as soon as possible.<sup>6</sup> A recent prospective study looked at patients who presented to the ED with acute pain and were discharged with opioid prescriptions. Investigators observed these patients for six months after discharge to identify predictors and incidence of transition to chronic pain. Of 408 patients, 110 patients reported new-onset chronic pain at six months (27%; 95% confidence interval 23 - 31%).<sup>6</sup> The majority of patients reported persistent pain, with 348 of 453 patients reporting pain after one week (77%; 95% confidence interval 73 - 80%).<sup>6</sup>

This study suggests that persistence of pain at one week after an ED visit for acute pain is associated with chronic pain (odds ratio 3.6; 95% confidence interval 1.6-8.5).<sup>6</sup> Thus, healthcare

**PAUSE AND PONDER:** Among your patients who have chronic pain, what kind of acute pain have they experienced? How could you have helped?

providers might identify persistent pain at one week as a risk factor for chronic pain development. Pharmacists should consider this as an opportunity to become more involved in appropriate acute pain management.

Patients most at risk for chronic pain were those with extremity, neck, or back pain.<sup>6</sup> Additional patient-specific risk factors include psychiatric disorders, such as depression, and psychological traits, such as catastrophizing. Specifically, patients who anticipated pain duration would last more than one week had a modest risk for chronic pain.<sup>6</sup> The difference in onset of chronic pain based on age or sex was insignificant.<sup>6</sup>

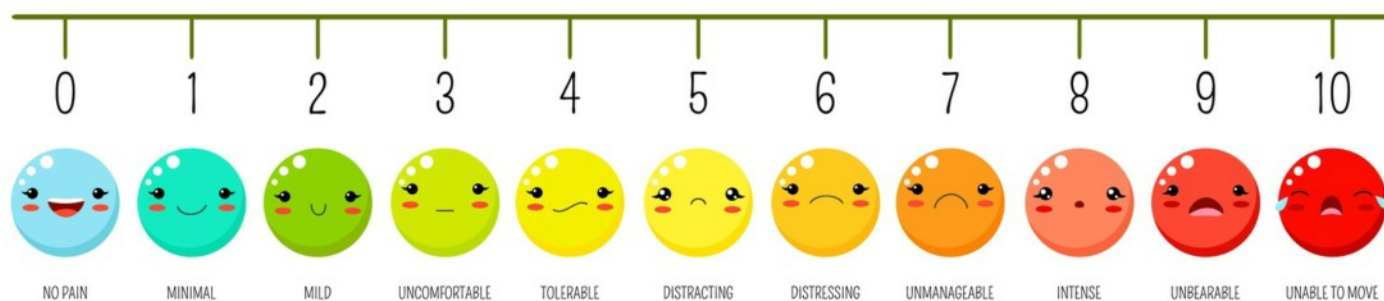
### Assessing Chronic Pain

Determining the pain’s source and type is essential for effective pain management. Chronic pain can be caused by many diseases, including arthritis, cancer, HIV/AIDS, several neuromuscular disorders, and sickle cell disease. Untreated pain can lead to negative health outcomes including anxiety, depression, impaired immunity, and sleep disorders.

Pain is highly subjective. Thus, healthcare providers usually use rating scales to help assess a patient’s pain. These tools are quick and easy to use and are useful for short patient interactions. The most commonly used tool is the numeric rating scale. Healthcare providers ask patients to rate their pain on a scale of 0 to 10. In general, 0 corresponds to no pain, 1 to 3 corresponds to mild pain, 4 to 6 corresponds to moderate pain, and 7 to 10 corresponds to severe pain.<sup>7</sup>

Providers can use several other pain rating scales to measure a patient’s pain. These include the visual analogue scale, verbal rating scale, and faces pain scale.<sup>7</sup> When using the visual analogue scale, clinicians show patients a scale and ask them to point to the part of the scale that corresponds to their pain. Patients using the verbal rating scale are asked to verbally state their pain as mild, moderate, or severe. The faces pain

# PAIN MEASUREMENT SCALE



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scale shows different facial expressions for different pain intensities.

With the many tools available to measure a patient's reported pain, healthcare providers should know which tool to use and when. Most ED providers have a standard "go-to" scale, but it is important to know when other scales should be used. For the majority of patients, the numeric rating scale is the easiest and most reliable tool. This tool, along with the verbal rating scale, may have a higher utility in those who are visually impaired. The visual analogue scale or the faces pain scale are particularly useful for pediatric patients, non-English speaking patients, or patients with low health literacy. Pharmacists can be involved in assessing a patient's reported pain by recommending appropriate pain assessment tools based on patient-specific factors.

Pain rating scales are meant to improve the consistency of pain assessment and thus pain management. However, these tools are still prone to scoring variability due to inconsistencies in how healthcare providers record the scores. For example, some EDs use pain scores to measure the patient experience. Unfortunately, some healthcare providers are tempted to report the patient's pain score based on their own judgment instead of what the patient stated.<sup>8</sup>

EDs should have policies in place to avoid this from occurring. If a healthcare provider's perception of a patient's pain differs from that which the patient states, the healthcare provider should document what the patient reports. Some healthcare practitioners alter the patient-reported rating because they assume certain patients have exaggerated their pain. However, if patients overestimate their pain on a pain scale, the pre- and post-medication assessment will reveal if the pain relief was effective.

Some variability in pain assessment is also related to the patient's ability to use the scoring tool. For example, some patients have difficulty imagining what maximum pain would feel like and, thus, are unable to accurately rate their pain on a scale.<sup>8</sup>

Patients with language barriers may also have difficulties accurately reporting their pain using these scales. Despite these barriers to accurate pain assessment, pain rating scales still remain the most reliable measure of pain. These scales help guide patient therapy within the ED as an indicator of analgesia effectiveness. Typically, ED staff consider a patient's pain score before and after administering an analgesic medication. Providers are then able to adjust the patient's medications to optimize pain management.

## Managing Chronic Pain and Implicit Bias

A long-term patient-provider relationship offers the best chance of achieving appropriate chronic pain management.<sup>9</sup> This is another one of the many reasons why chronic pain is difficult to manage in the ED. ED providers are limited in the time they have to interact with their patients and have limited access to medical records. Many patients will come to the ED specifically requesting a prescription for opioids, and some providers feel pressured to honor such requests because of limited time and patient history. Most often, providers do not have time to contact the patient's primary caregiver in these situations. Instead, ED providers should prescribe nonopioid analgesic medications if possible. If prescribing an opioid, providers should write for a small quantity that will carry patients over until they are able to meet with their primary caregivers.

Long-term, effective chronic pain treatment is difficult to achieve since pain is a highly subjective condition. An experience that is deemed painful to one patient might not be to another. Healthcare professionals can fall into the trap of placing patients into categories based on their past experience.<sup>9</sup> For example, emergency room staff may label a patient with uncontrolled pain who has visited the ED multiple times during the month as a "frequent flier." This association of repeat visits to the ED can lead to the assumption that the patient is present only for pain medication.<sup>10</sup> Pharmacists in the ED can assist in identifying drug-seeking patients using several resources, including contacting the patient's community pharmacy and referencing the state-specific prescription drug monitoring program (PDMP). However, it is important to remember that "drug-seeking" is not

always the case; the patient may just be suffering from inadequate treatment.

The healthcare system and its staff often fear or stigmatize patients who have or seem to have addictions. In 2003, the manufacturer of OxyContin, extended release oxycodone, exploited stigma in their advertisements to physicians by underplaying the drug's addictive risks.<sup>10</sup> The company stated that the medication would be "unattractive" to addicts because of time-released coating that prolonged time to effect.<sup>10</sup> The U.S. Food and Drug Administration (FDA) cited the manufacturer for these misleading advertisements as they underplayed the addictive risk of the drug.<sup>10</sup> Despite the FDA's actions, providers' perceptions of OxyContin were that it was less addictive than other opioids. As providers gained more experience with this drug and advertisements have changed, many have now come to realize its addictive potential.

### Prescription Drug Monitoring Programs

A PDMP is a statewide electronic database that tracks and documents all controlled substance prescriptions. Authorized users can access data to help guide controlled substance prescribing for individual patients. Information provided on the PDMP includes the controlled medication's name, dose, morphine milligram equivalents (MME), quantity, date the prescription was filled, dispensing pharmacy, and the authorizing provider.<sup>11</sup> State requirements for providers who prescribe controlled substances vary, but the Centers for Disease Control and Prevention (CDC) recommends checking the PDMP, at minimum, once every three months and before every opioid prescription for primary care providers.<sup>11</sup> Within the ED, this recommendation is more stringent; prescribers should check the PDMP before writing any opioid prescription.<sup>11</sup>

An issue with checking the PDMP within the ED is the time that is required to gain access to the site, log in, and request the information. Researchers conducted a mixed-methods study in Massachusetts that showed that ordering a computerized tomography (CT) scan for a pulmonary embolism took half the clicks (~25 clicks) in comparison to checking a patient's PDMP (~50 clicks).<sup>12</sup> The time required for this process makes it difficult—but does not make it any less necessary—for ED providers to complete this step for every patient reporting pain. To improve this process, electronic medical records, such as Epic, have begun to incorporate easy access to the PDMP in fewer clicks. Pharmacists and technicians who are authorized to access the PDMP can assist by checking the PDMP for providers and relaying the information found.

Prescribers should take several steps before prescribing opioids. First, the entire healthcare team should counsel patients on the increased risk of respiratory depression/overdose with high dose opioid prescriptions. This risk can be mitigated by also prescribing naloxone, a rescue medication that works as an opioid antagonist to reverse the effects of opioids. The CDC recommends a

concurrent naloxone prescription for patients who take an equivalent dose of 50 MME/day or more.<sup>11</sup> Second, someone on the ED team should coordinate care for patients with chronic pain; such coordination should involve their primary care provider, pain management specialist, and ED provider to create a sole prescriber who manages their pain and opioid prescriptions. All providers should discuss the risks of medication interactions while discussing the patient's quality of life goals. For example, concurrent prescribing of opioids and benzodiazepines should be avoided due to the increased risk of overdose and respiratory depression.<sup>11</sup> Appropriate use of the PDMP can improve patient safety and reduce the number of patients who are able to misuse, abuse, and overdose from opioid use.

### Risk Reduction, Pain Management Expectations

Pain is often referred to as the fifth vital sign. Providing pain relief is vital to the patient's overall quality of life. Acute pain may mimic anxiety with increased blood pressure, heart rate, and restlessness while chronic pain may mimic depression with flat affect, withdrawal, and no vital sign changes. Having the patient score a 0 on a numerical scale indicating no pain can be an unrealistic pain management goal in the ED when managing acute pain. Rather, the goal should be reaching an acceptable and/or tolerable level of pain that allows patients to return to their daily activities—these are called functional goals.<sup>10</sup> This level is different for each individual.

The World Health Organization (WHO) 2011 guidelines can help guide pain management. These recommendations are commonly referred to as the "Pain Ladder" based on the analogy WHO employed in the guidelines.<sup>13</sup> The WHO originally created these recommendations for the management of chronic cancer pain, but their use has expanded to encompass other kinds of pain seen throughout clinical practice.<sup>13</sup> The WHO recommends the following three steps to help relieve chronic pain to a level that allows for an acceptable quality of life for the patient.<sup>13</sup>

- Step 1: mild pain (reported score of 1 to 3 of 10)
  - Schedule non-narcotic medications
  - Example regimen: acetaminophen 975 mg every 6 hours
- Step 2: moderate pain (reported score of 4 to 6 of 10)
  - Scheduled non-narcotic and opioids for moderate pain
  - Example regimen: acetaminophen 325 mg and oxycodone 5 mg every 6 hours
- Step 3: severe pain (reported score of 7 to 10 of 10)
  - Scheduled non-narcotic adjuvants (acetaminophen, NSAIDs, gabapentinoids, or muscle relaxers) with around the clock opioid
  - Example regimen: hydromorphone 1-4 mg every 4 hours, titrating to pain with acetaminophen 975 mg every 6 hours and gabapentin 200 mg every 8 hours

One of the Pain Ladder's components is vital: if pain persists or increases, the medical team should re-evaluate the source of the pain and attempt to control the pain source before moving on to the next step of the recommendation.

The CDC also provides a guideline for prescribing opioids for chronic pain. This guideline does not address patients who receive active cancer treatment, palliative care, or end of life care. The CDC provides 12 clinical recommendations when prescribing opioids for chronic pain.<sup>11</sup> These recommendations fall into three categories: determining when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and last, assessing risk and addressing harms of opioid use.<sup>11</sup> Below are some of the key clinical reminders within each category.

*Determining when to initiate or continue opioids for chronic pain<sup>11</sup>:*

- Identify that opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits, risk, and availability of non-opioid treatment therapies

*Opioid selection, dosage, duration, follow-up, and discontinuation<sup>11</sup>:*

- Start low and go slow, using immediate-release opioids when starting
- When used for acute pain, prescribe no more opioids than required
- Do not use extended release or long-acting opioids for acute pain

*Assessing risk and addressing harms of opioid use<sup>11</sup>:*

- Check the state PDMP for high doses of opioids and prescriptions from other providers
- Avoid concurrent benzodiazepine and opioid prescribing
- Offer naloxone
- Offer medication-assisted treatment (i.e., treatment with buprenorphine or methadone)

To help mitigate risk for narcotic abuse, the CDC recommends use of an opioid risk tool (ORT), which is available online, to identify patients at increased risk for opioid abuse. The medical provider uses the ORT before prescribing an opioid for pain management. It is a self-report screening tool that accounts for family and personal history of substance abuse. This risk assessment is not validated in the non-pain population.<sup>14</sup> Questions address the use of alcohol and illegal or prescription medications, the patient's age, mental health disorders, and history of preadolescent sexual abuse.<sup>14</sup> All of these factors increase the predicted risk of opioid abuse; for example, a 47-year-old female with a



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history of prescription drug abuse scores a 5 on the ORT. Scores are evaluated as low risk (score 0 to 3), moderate risk (score 4 to 7), and high risk (score 8 and above) for aberrant behaviors.<sup>14</sup> Aberrant behaviors include using additional opioids than those prescribed, requesting refills instead of attending a clinic visit, skipping clinic visits, receiving opioids from other providers, and unauthorized ED visits for pain.

An additional screening tool used to predict the patient's adherence to long-term opioid therapy is the Diagnosis, Intractability, Risk and Efficacy Score, also known as the DIRE Score.<sup>14</sup> A clinician administers the assessment and evaluates seven items. The scoring system can range from 7 to 21. A score of 13 or below suggests that the patient is not a suitable candidate for long-term opioid therapy. A retrospective study analyzing 61 patients reports the sensitivity and specificity of the DIRE score for predicting patient adherence to the opioid regimen prescribed by their physician was 94% and 87%, respectively.<sup>14</sup> A patient with a low compliance score indicates this individual can be at elevated risk of taking medication other than the way it was prescribed. Both the DIRE and ORT scoring calculators are available online for clinicians through easy-to-use websites such as MDCalc or GlobalRPh.

## Selecting an Analgesic Regimen

Choosing the correct analgesic regimen for the individual patient is important. The choice of medication depends on the patient's self-reported pain severity. Mild pain (pain score 1 to 3) should be treated with nonopioid analgesics. Moderate pain (pain score 4 to 6) and severe pain (pain score 7 to 10) may be treated with an opioid if pain is not adequately controlled with a nonopioid.

**Table 2. Overview of Common Analgesics for Chronic Pain**

Drug or drug class	Mechanism of action	Onset of action	Duration	Clinical considerations
Acetaminophen	Poorly defined, but thought to inhibit prostaglandin synthesis * No anti-inflammatory effect	Oral: < 1 hour	Oral: 4 - 6 hours	▪ Caution in severe hepatic insufficiency.
Nonsteroidal anti-inflammatory drugs (NSAIDs) * Ibuprofen	Inhibits prostaglandin synthesis through inhibition of cyclooxygenase enzymes (COX1 and COX2)	Oral: < 1 hour*	Oral: 6 - 8 hours*	▪ Caution in patients with renal insufficiency or congestive heart failure. ▪ Potential increased bleeding risk, particularly GI bleeding.
Opioids	Mu opioid receptor agonists in the central nervous system	* See Table 3	* See Table 3	* See Table 3
Gabapentinoids (gabapentin, pregabalin)	Binds to voltage-gated calcium channels in the central nervous system and inhibits excitatory neurotransmitter release	2 - 4 hours	8 - 12 hours	▪ Caution in patients with renal insufficiency. ▪ Potential for tremor, fatigue, or increased sedation.
Antispasmodics with analgesic effect (baclofen, cyclobenzaprine, tizanidine)	Decrease muscle spasticity and transmission of reflexes through multiple mechanisms	< 1 hour	6 - 8 hours	▪ Caution in patients with renal insufficiency. ▪ Potential for dizziness and CNS depression.
Antidepressants (SNRIs/TCAs)	Inhibit the reuptake of serotonin and norepinephrine by presynaptic neurons in the central nervous system	1 - 2 weeks	24 hours	▪ Caution in elderly patients. ▪ Potential for increased average blood pressure with chronic use. ▪ Potential benefits can take 2-3 weeks to completely materialize.
Lidocaine patch	Blocks conduction of nerve impulses by decreasing permeability of neuronal membrane to sodium ions	4 hours	12 - 24 hours	▪ Avoid in areas of open skin. ▪ Most effective in post-herpetic neuralgia. Patches can be cut for administration.

To measure analgesic effectiveness, the best practice is to have the patient rate their pain on a numeric scale before and after medication administration. **Table 2** lists common analgesic medication options, mechanism, onset of action, and duration, and **Table 3** (page 7) lists the same for common opioids.<sup>15</sup>

Additionally, the choice of drug depends on the type of pain. Some medications fail to ease a patient's pain because of the drug's mechanism of action. A common example is the use of opioids for neuropathic pain; opioids will not address neuropathic pain. **Table 4** (next page) organizes common types of pain, characteristics, and treatment options.

Clinicians should treat patients' pain using a stepwise approach. When initiating an analgesic medication, the best recommendation is to start low and stop at the lowest dose that reduces the pain. ED providers can do this by limiting the quantity to be dispensed when discharging a patient with an analgesic prescrip-

tion, especially if it is an opioid. For consistent pain control throughout the day, medications should be scheduled around the clock with as-needed (PRN) doses available. When patients need multiple medications, it is important to choose medications with different mechanisms of action to produce additive or synergistic effects (called multimodal therapy).

### Medication Reconciliation for Chronic Pain

Pharmacy technicians, interns, and pharmacists play a large part in the medication reconciliation process, which is especially im-

**PAUSE AND PONDER:** What strategies have you tried in the past to work with your team when you have patients who have chronic pain and experience acute episodes? Have those strategies worked?

How can you do better?

**Table 3. Overview of Common Opioids for Chronic Pain**

Opioid	Onset of action	Duration	Clinical considerations
Buprenorphine	Sublingual: 30 – 60 minutes Transdermal: 18 – 24 hours	Sublingual: 12 – 24 hours Transdermal: 7 days	▪ Consider avoiding in patients taking chronic opioids as it may cause withdrawal.
Fentanyl	Transdermal: 6 hours	Transdermal: 72 - 96 hours	▪ Safe in renal insufficiency.
Hydrocodone	Oral (IR): 10 - 30 minutes Oral (ER): 5 hours	Oral (IR): 4 - 6 hours Oral (ER): 12 hours	▪ Avoid in patients with renal insufficiency.
Hydromorphone	Oral (IR): 15 - 30 minutes Oral (ER): 6 hours	Oral (IR): 3 - 4 hours Oral (ER): 12 hours	▪ Safe in renal insufficiency.
Methadone	Oral: 30 - 60 minutes	Oral: 4 - 8 hours	▪ Safe in renal insufficiency. Caution due to long half-life. Do not change dose earlier than every 5 days.
Morphine	Oral (IR): 30 minutes Oral (ER): 90 minutes	Oral (IR): 3 - 5 hours Oral (ER): 8 - 24 hours	▪ Avoid in patients with renal insufficiency, elderly, or on concomitant MAOIs.
Oxycodone	Oral (IR): 10 - 15 minutes Oral (ER): 1 hour	Oral (IR): 3 - 6 hours Oral (ER): 12 hours	▪ Avoid in patients with renal dysfunction.
Oxymorphone	Oral (IR): 10 - 15 minutes Oral (ER): 1 hour	Oral (IR): 4 - 6 hours Oral (ER): 12 hours	▪ Avoid in patients with renal dysfunction.
Tapentadol	Oral (IR): 30 minutes Oral (ER): 1 hour	Oral (IR): 4 - 6 hours Oral (ER): 12 hours	▪ Avoid in patients taking MAOIs.
Tramadol	Oral (IR): 60 minutes Oral (ER): 60 minutes	Oral (IR): 6 hours Oral (ER): 24 hours	▪ Avoid total daily doses over 200 mg in patients with severe renal insufficiency.

Abbreviations: ER = extended release, IR = immediate release

portant in chronic pain patients. Medication reconciliation technicians should follow standard procedures each time they enter a patient’s room.

Helpful tips for conducting an efficient medication reconciliation are listed below.

- Review the patient’s diagnosis before entering the room.
- Introduce yourself and explain what you are doing.
- Ask patients if they have a list of their medications or if they have the bottles with them.
- Use open-ended specific questions. For example, “What do you take for breakthrough pain?”
- Ask about routes of administration other than oral. For example, “Do you put any medications on your skin?”
- Ask about over-the-counter (OTC) products, herbals, vitamins, and other supplements.
- Listen to the patient’s answers and concerns. Chronic pain patients will likely have concerns about their pain management, so be prepared to defer to the provider or pharmacist.
- Ask about recent medication changes and ask why the medication was changed.
- Ask how long the patient has been on the medication and when he or she last saw the prescriber.
- Finish the job: call the patient’s pharmacy and/or prescriber to resolve questions or discrepancies.
- Document medications and adherence in the electronic health record.

**Table 4. Common Types of Pain**

Type of pain	Characteristics/Description	Treatment
Somatic pain	<ul style="list-style-type: none"> <li>▪ From deep tissues, such as joints and tendons</li> <li>▪ Throbbing, aching, less localized</li> <li>▪ Common in cancer patients</li> </ul>	<ul style="list-style-type: none"> <li>▪ Acetaminophen</li> <li>▪ NSAIDs</li> <li>▪ Opioids</li> <li>▪ Steroids</li> </ul>
Visceral pain	<ul style="list-style-type: none"> <li>▪ From damage to internal organs</li> <li>▪ Dull, deep, diffuse</li> </ul>	<ul style="list-style-type: none"> <li>▪ Acetaminophen</li> <li>▪ NSAIDs</li> <li>▪ Opioids</li> </ul>
Neuropathic pain	<ul style="list-style-type: none"> <li>▪ From damage to nerve fibers</li> <li>▪ Burning, shooting, stabbing, tingling, pins and needles</li> </ul>	<ul style="list-style-type: none"> <li>▪ Gabapentinoids</li> <li>▪ Baclofen</li> <li>▪ Tizanidine</li> <li>▪ SNRIs</li> <li>▪ TCAs</li> <li>▪ Lidocaine patch</li> <li>▪ Steroids</li> </ul>

Abbreviations: NSAIDs = nonsteroidal antiinflammatory drugs, SNRIs = serotonin-norepinephrine reuptake inhibitors, TCAs = tricyclic antidepressants

## Conclusion

Chronic pain is difficult to manage and becomes even more difficult the longer it is left untreated. Chronic pain can develop from inappropriately managed acute pain, so it is important for healthcare providers, especially in the ED, to treat the source and type of pain accordingly. Within the ED, it requires a team-based approach to coordinate present treatment with the goals of patients and their pain management clinician. The current opioid epidemic highlights the need to reassess pain management strategies, especially in our patients with chronic pain on long-term opioids. Pharmacists can identify patients at risk for chronic pain and optimize medication therapy within the ED.

Figure 1 summarizes key points from this continuing education activity.



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## Figure 1. The Pharmacy Team's Role When Patients with Chronic Pain Go to the Emergency Department

### Best

- 1 **BE COMMUNITY CHAMPIONS.** Talk to local prescribers, especially those who see many patients who have pain. Create a network of involved, caring professionals.
- 2 **Discourage use of derogatory terms,** and encourage careful assessment of every patient.
- 3 **Recommend a concurrent prescription for naloxone** for patients on higher doses of opioids!

### Better

- 1 **Develop a process** so you don't miss steps when conducting medication reconciliation.
- 2 **Ensure that prescribers limit the number of doses** to the minimum number needed until the patient can see his or her primary care provider
- 3 **Counsel, counsel, counsel** about potential respiratory depression and addiction.

### Good

- 1 **Recognize that patients who are treated for chronic pain** can and do experience acute breakthrough pain.
- 2 **Act quickly** to determine the most appropriate pain assessment tool.
- 3 **Follow the CDC's recommendations** and always check your state's PDMP.

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