Pain, Compassion, Addiction, Malingering: How To Use Opioids and how to not use opioids

reuben j. strayer @emupdates slideset and references emupdates.com/help
no disclosures / conflicts
responsibilities of the emergency physician

resuscitation

identification of dangerous conditions

symptom relief

determination of disposition / level of care

managing ED flow

customer service

resource stewardship

public health
The unprecedented increase in opioid pain reliever consumption has led to the worst drug overdose epidemic in US history.
opioids are responsible for **1 in 8 deaths** in americans aged 25-34
Prescriptions for opioid analgesics in the United States increased by 700% between 1997 and 2007.
### Top medicines by prescriptions

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<td><strong>Total U.S. market</strong></td>
<td>3,953</td>
<td>3,995</td>
<td>4,022</td>
<td>4,139</td>
<td>4,208</td>
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<td>1 acetaminophen/hydrocodone</td>
<td>129.4</td>
<td>132.1</td>
<td>136.7</td>
<td>136.4</td>
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<td>2 levothyroxine</td>
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<td>103.2</td>
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<td>3 lisinopril</td>
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<td>99.1</td>
<td>101.5</td>
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<td>4 metoprolol</td>
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<td>76.6</td>
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<tr>
<td>5 simvastatin</td>
<td>84.1</td>
<td>94.4</td>
<td>96.8</td>
<td>89.3</td>
<td>79.1</td>
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<tr>
<td>6 amlodipine</td>
<td>52.1</td>
<td>57.8</td>
<td>62.5</td>
<td>69.1</td>
<td>74.0</td>
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<td>7 metformin</td>
<td>53.8</td>
<td>57.0</td>
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<td>72.8</td>
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<td>8 omeprazole</td>
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<td>53.5</td>
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<td>20.2</td>
<td>23.9</td>
<td>33.3</td>
<td>34.7</td>
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</table>

Source: IMS Health, National Prescription Audit, Dec 2013

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**900% increase in prescription opioid addiction treatment between 1997 and 2011**
43,982 drug overdose deaths in 2013
Drug overdose death rates by intent by age group, US, 2008

- Unintentional
- Suicide
- Undetermined

Age (years):
- <1
- 5-9
- 15-19
- 25-34
- 45-54
- 65-74
- 85+
Figure 1: Annual incidence of neonatal abstinence syndrome in Ontario, 1992–2011. NAS = neonatal abstinence syndrome.

Figure 1. Annualized NICU Admission Rates for the Neonatal Abstinence Syndrome and Median Length of Stay, According to Year.
For every 1 opioid overdose death in 2010 there were...

- 15 abuse treatment admissions
- 26 emergency room visits
- 115 who abuse/are dependent
- 733 nonmedical users

$4,350,000 in healthcare-related costs
morphine equivalence milligrams per person, 2010

japan 26.38

united states 663.45
Figure 13. Morphine: distribution of consumption, 2011

- United States (5.3%) 54.8%
- Europe (11.9%) 26.8%
- Canada (0.6%) 7.1%
- Australia and New Zealand (0.4%) 2.8%
- Japan (2.2%) 0.7%
- Other countries (79.7%) 7.8%

Note: Percentages in parentheses refer to share of the world population (i.e. total population of all reporting countries).
ONE NIGHT
TRADE MARK
COUGH SYRUP

EACH OUNCE CONTAINS
ALCOHOL, (less than 1%) 4 1/4 m.
CANNABIS INDICA, F.E. 4 1/2 m.
CHLOROFORM 2 1/2 m.
MORPHIA, SULPH 7/8 gr.

SKILLFULLY COMBINED WITH A NUMBER OF OTHER INGREDIENTS

DIRECTIONS
POUR ONE TEASPOONFUL THREE TIMES A DAY

BAYER Pharmaceutical Products
HEROIN—HYDROCHLORIDE

is pre-eminently adapted for the manufacture of cough elixirs, cough balsams, cough drops, cough lozenges, and cough medicines of any kind. Price in 1 oz. packages, $4.85 per ounce; less in larger quantities. The efficient dose being very small (1/48 to 1/24 gr.), it is

The Cheapest Specific for the Relief of Coughs
(In bronchitis, phthisis, whooping cough, etc., etc.)

WRITE FOR LITERATURE TO
FARBENFABRIKEN OF ELBERFELD COMPANY
SELLING AGENTS
P. O. Box 200
40 Stone Street, NEW YORK

Am. J. Ph.

[December, 1801] 7

COUGH

THE PROBLEM

HAS BEEN SOLVED BY

the pharmaceutical compound known as

GLYCO-HEROIN (Smith)

Samples and Literature Supplied on Request.
Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases

Russell K. Portenoy and Kathleen M. Foley

Pain Service, Department of Neurology, Memorial Sloan-Kettering Cancer Center, and Department of Neurology, Cornell University Medical College, New York, NY 10021 (U.S.A.)

(Received 10 June 1985, accepted 28 October 1985)

Summary

Thirty-eight patients maintained on opioid analgesics were retrospectively evaluated to determine the efficacy of this therapy. Oxycodone was used by 16; levorphanol by 5; others were treated with pentazocine, or some combination of these drugs. Four or more years at the time of evaluation, with a range of 4 to 7 years. Two-thirds required less than 20 mg/ day, and/or hospitalization for exacerbation of pain, or adequate relief of pain, while 14 patients who had received oncological pain management while gains in employment or social function could be attributed to opioid therapy. No toxicity was reported and only 2 patients, both with a history of prior drug treatment. Characteristics of the 16 patients, the Minnesota Multiphasic Personality Assessment, psychiatric evaluation in 6, failed to disclose psychiatric indicators capable of explaining the success of long-term opioid maintenance therapy. The data for the options of surgery or no treatment in these patients were not discussed.

Correspondence

ADDITION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and Hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

Jane Porter
Hershel Jick, M.D.
Boston Collaborative Drug Surveillance Program
Waltham, MA 02154

Boston University Medical Center

The Epidemic of Untreated Pain
A consensus statement from the American Academy of Pain Medicine and the American Pain Society

I. The management of pain is becoming a higher priority in the United States.
   In the last several years, health-policy makers, health professionals, regulators, and the public have become increasingly interested in the provision of better pain therapies. This is evidenced, in part, by the U.S. Department of Health and Human Services’ dissemination of Clinical Practice Guidelines for the management of acute pain and cancer pain. These publications, which have been endorsed by AAPM and APS, state that opioids, sometimes called “narcotic analgesics,” are an essential part of a pain management plan. There is currently no nationally accepted consensus for the treatment of chronic pain not due to cancer, yet the economic and social costs of chronic pain are substantial, with estimates ranging in the tens of billions of dollars annually.

II. Current conditions dictate the need for a joint consensus statement of two major national pain organizations.
   AAPM and APS believe that the United States is in a critical phase of state-level policy development with respect to the use of opioids in pain treatment. In this regard, there has been recent...
American Pain Foundation Shuts Down as Senators Launch Investigation of Prescription Narcotics

A version of this story [1] was published in The Washington Post.

As the U.S. Senate Finance Committee launched an investigation Tuesday into makers of narcotic painkillers and groups that champion them, a leading pain advocacy organization said it was dissolving "due to irreparable economic circumstances."

The American Pain Foundation, which described itself as the nation’s largest organization for pain patients, was the focus of a December investigation [2] by ProPublica in The Washington Post that detailed its close ties to drugmakers.

The group received 90 percent of its $5 million [3] in funding in 2010 from the drug and medical-device industry, ProPublica found, and its guides for patients, journalists and policymakers had played down the risks associated with opioid painkillers while exaggerating the benefits.
The United States Senate Committee on Finance

For Immediate Release
May 08, 2012
Contact:
Communications Office (Baucus), 202-224-4515
Jill Gerber (Grassley), 202-224-6522

Baucus, Grassley Seek Answers about Opioid Manufacturers' Ties to Medical Groups
Finance Leaders Investigate Whether Pharmaceutical Companies Encouraged Non-Profit Beneficiaries to Promote Misleading Information about Narcotic Painkillers

Washington, DC – Senate Finance Committee Chairman Max Baucus (D-Mont.) and senior Committee member Chuck Grassley (R-Iowa) initiated an investigation today into the connections of drug manufacturers Purdue Pharma, Endo Pharmaceuticals, and Johnson & Johnson with medical groups and physicians who have advocated the increased use of narcotic painkillers, or opioids. The Senators also asked seven other medical groups to produce information about their financial ties and collaborations with opioid manufacturers. In letters sent to each yesterday,
SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF ORANGE

THE PEOPLE OF THE STATE OF CALIFORNIA, acting by and through Santa Clara County Counsel Orry P. Korb and Orange County District Attorney Tony Rackauckas,

Plaintiff,

v.

PURDUE PHARMA L.P.; PURDUE, INC.; THE PURDUE FREDERICK COMPANY, INC; TEVA PHARMACEUTICAL INDUSTRIES, LTD.; CEPHALON, INC.; JOHNSON & JOHNSON; JANSSEN PHARMACEUTICALS, INC.; ENDO HEALTH SOLUTIONS INC.; ACTAVIS, PLC; AND DOES 1 THROUGH 100, INCLUSIVE,

Defendants.

No.

COMPLAINT FOR VIOLATIONS OF CALIFORNIA FALSE ADVERTISING LAW, CALIFORNIA UNFAIR COMPETITION LAW, AND PUBLIC NUISANCE, SEEKING RESTITUTION, CIVIL PENALTIES, ABATEMENT, AND INJUNCTIVE RELIEF
"I gave innumerable lectures in the late 1980s and '90s about addiction that weren't true."

"Clearly, if I had an inkling of what I know now then, I wouldn't have spoken in the way that I spoke. It was clearly the wrong thing to do."
In Guilty Plea, OxyContin Maker to Pay $600 Million

ABINGDON, Va., May 10 — The company that makes the narcotic painkiller OxyContin and three current and former executives pleaded guilty today in federal court here to criminal charges that they misled regulators, doctors and patients about the drug’s risk of addiction and its potential to be abused.

By BARRY MEIER
Published: May 10, 2007
the epidemic of untreated pain
opiophobia
pain is a vital sign
pseudoaddiction
pain score zero
opioids are effective in chronic non-cancer pain
addiction cannot come from treating pain
it is better to over treat than to under treat pain
safety of high dose opioids
always assume a patient claiming pain is in pain
oral opioids don’t cause respiratory depression
When I was in medical school, I was told, if you give opiates to a patient who's in pain, they will not get addicted. Completely wrong. Completely wrong. But a generation of doctors, a generation of us grew up being trained that these drugs aren't risky. In fact, they are risky.

Thomas Frieden
Director of the U.S. Centers for Disease Control and Prevention
prevent addiction

control supply

protect addicts and promote recovery
Opioid use trajectories

- Recreation: self-limited, careful ongoing use, no escalation, few addiction features
- Opioid prescription: escalation, misuse, addiction, morbidity, mortality

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**Opioid Use Trajectories**

1. **Recreation**
   - Self-limited
   - Careful ongoing use
   - No escalation
   - Few addiction features

2. **Opioid Prescription**
   - Escalation
   - Misuse
   - Addiction
   - Morbidity, mortality
opioid use trajectories

- recreation
- opioid prescription
  - careful ongoing use
  - no escalation
  - few addiction features
- self limited
- escalation
  - misuse
  - addiction
  - morbidity, mortality
opioid use trajectories

recreation

opioid prescription

careful ongoing use
no escalation
few addiction features

self limited

escalation
misuse
addiction
morbidity, mortality
opioid use trajectories

recreation

self limited

careful ongoing use
no escalation
few addiction features

opioid prescription

green arrow:

escalation
misuse
addiction
morbidity, mortality

red arrow:
prescribe to fewer patients

- recreation
- self limited
- opioid prescription
  - careful ongoing use
  - no escalation
  - few addiction features
- escalation
  - misuse
  - addiction
  - morbidity, mortality
prescribe to fewer patients

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<th></th>
<th>American</th>
<th>Dutch</th>
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<td><strong>Hip fractures</strong></td>
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<tr>
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<td>85</td>
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<td>77</td>
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<tr>
<td>Outpatient</td>
<td>82</td>
<td>6</td>
<td>&lt;0.001</td>
</tr>
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</table>
acetaminophen 1 g q6
+
ibuprofen 400 mg q6
chasing zero pain

function

chance of harm

10

pain

0
My job is to manage your pain at the same time that I manage the potential for some pain medications to harm you.
Prescribe fewer pills

Recreation

Self limited

Opioid prescription

Careful ongoing use
No escalation
Few addiction features

Escalation
Misuse
Addiction
Morbidity, mortality
Table 2. Sources of diverted prescription pain medication among Ontario students in grades 7 to 12 who used opioids nonmedically in the past year: N = 624.

<table>
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<tr>
<th>SOURCE</th>
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<td>From home</td>
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<td>From a friend</td>
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<td>From someone I know</td>
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<tr>
<td>From the “street”</td>
<td>&lt;0.5</td>
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<td>Other sources not listed</td>
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<tr>
<td>Do not remember</td>
<td>9.7</td>
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</table>
3 days and flush
Opioid use trajectories

1. **Recreation**
   - Self-limited
   - Careful ongoing use
   - No escalation
   - Few addiction features

2. **Opioid prescription**
   - Escalation
   - Misuse
   - Addiction
   - Morbidity, mortality
Acute pain → Opioids → Chronic pain
in chronic pain and addiction opioids provide temporary relief of symptoms but make the problem worse

misplaced focus on deception

benefit:harm
opioid misuse spectrum

opioid naive  chronic pain addiction  recreation  diversion
opioid misuse spectrum

opioid naive  chronic pain addiction  recreation diversion

terminal illness
pain at the end of life

aggressive multimodal analgesia including escalating doses of IV opioids as necessary
PO opioids as necessary
verify outpatient care
everyone else benefit:harm

risk factors judgment
red flags for opioid misuse

poly-provider, poly-hospital
patient, relation, or provider reports addiction or diversion
injects oral opioid preparations
obtains drugs through dubious means (e.g. on the street)
uses others’ meds, steals Rx pads/syringes, forges Rx, false ID

yellow flags for opioid misuse

many visits, refill requests, dose escalation
requesting specific meds, requesting med IV, declines non-opioids from out of town, primary provider unavailable, pt passed by closer institutions
allergies to analgesics and other relevant non-opioids
opioid/Rx is lost, stolen
uninterested in diagnosis or alternative treatments, refuses tests
repeatedly misses followup appointments, has been terminated by providers
history of substance abuse or incarceration
absence of objective findings of acute pain
symptom magnification, inconsistency, distractibility rehearsed, textbook presentations
deterioration of work/social function, disability
low risk
acute pain
no chronic pain
no flags for opioid misuse

in the ED: aggressive multimodal analgesia including escalating doses of IV opioids prn

discharge: optimal outpatient analgesia, +/- breakthrough opioids and guidance
optimal outpatient analgesia

acetaminophen 1g + ibuprofen 400 mg q6

ice, heat, elevation, immobilization, mobilization

set expectations: zero pain is not the goal

breakthrough opioids if necessary, considering harm

prescribe smartly

small number - 3 days and flush

avoid euphorics

avoid combinations
ditch percocet and vicodin

take them off your formulary - if you can

IR Morphine 15 mg tabs
1 tab q3-4h prn pain
disp #12

Wightman 2012
Cicero 2013
Zacny 2008
optimal outpatient analgesia

acetaminophen 1g + ibuprofen 400 mg q6
ice, heat, elevation, immobilization, mobilization
set expectations: zero pain is not the goal

breakthrough opioids if necessary

prescribe smartly

small number - 3 days and flush
avoid euphorics - oxycodone is the most abuse prone
avoid combinations - to maximize scheduled APAP
never ER/LA preparations

be especially cautious in 10-30, sedative use
and social/psych/substance history

Bon 2012
Galinkin 2014
Miller 2015
Meier 2012
high risk
+ chronic pain
+ flags for misuse

avoid opioids in the ED and by prescription

use alternate modalities to manage pain

express concern that opioids are causing harm and refer
I know you are in pain and I want to improve your pain, but I believe that opioids are not only the wrong treatment for your pain, but that opioids are the cause of your pain. I think pain medications are harming you, and if you could stop taking them, your pain and your life would improve. Can I offer you resources that will help you stop taking pain medications?
Pain Medications Are Harming You
Take control of your life.
Get treated.
Call 1-800-662-HELP

SAMHSA’s National Helpline is a free, confidential treatment referral and information service for individuals and families facing mental health and/or substance use disorders, including pain medications and heroin.

1-800-662-HELP
(24/7, 365 days a year)
(in English and Spanish)
www.samhsa.gov/find-help
alternatives to opioids in the ED

discharge
alternatives to opioids in the ED

regional and local anesthesia

“trigger point injection”
alternatives to opioids in the ED

droperidol

or, sadly, haloperidol
alternatives to opioids in the ED

- low back pain
- chronic pancreatitis
- fibromyalgia
- myofascial pain syndrome
- complex regional pain syndrome
- sickle cell
- opioid withdrawal
- neuropathic pain
- cyclic vomiting
- gastroparesis
- abdominal migraine
- chronic ischemic pain
- atypical odontalgia
- phantom pain
- postherpetic neuralgia
- post-stroke pain
- spinal injury pain
- TMJ joint arthralgia
- intractable headache

ketamine

Richards 2011
Hocking 2003
Patil 2012
Bell 2009
Visser 2006
alternatives to opioids in the ED

intravenous lidocaine
dexmedetomidine
propofol
alternatives to opioids for discharge

acetaminophen 1 g q 6
+ ibuprofen 400 mg q 6
alternatives to opioids for discharge

topicals
- lidocaine
- capsaicin
- diclofenac

nonanalgesics
- anticonvulsants
- TCAs
- gabapentinoids

nonpharmacologics
- thermotherapy (heat)
- cryotherapy (ice)
- exercise
- weight loss
- yoga
- tai chi
- meditation
alternatives to opioids for discharge

weed
maybe risk
no history of chronic pain
+yellow flags
I’m not sure

prescription drug monitoring program
no opioids challenge
no opioids challenge

My most important job as an emergency doctor is to make sure there’s no emergency, so I would like to do some tests to make sure there’s nothing dangerous happening to you, and also I want to relieve your pain. But you will not receive any opioids while you are here, because I think opioids could be harmful to you.
opioid naive
chronic pain addiction
recreation diversion
less interested in opioid alternatives
there are options for chronic pain patients
electroanalgesia (TENS), counter-irritative therapy, spinal cord and deep brain stimulators, neuroablation, biofeedback, hypnosis, rehab medicine, OT, chiropractor, meditation, acupuncture, shaman
house of health

psychiatric

substance

medical

social
house of health

- resuscitation
- identification of dangerous conditions
- symptom relief
- determination of disposition / level of care
- managing ED flow
- customer service
- resource stewardship
- public health
want to know more?

emupdates.com/help

@LNelsonMD
@JMPerroneMD
@DavidJuurlink
@andrewkolodny
**moderate or severe pain**

Patient may benefit from opioids

---

**Risk stratify using red/yellow flags**

How likely is the patient to be harmed by opioids?*

---

**Low risk**

Acute pain

No chronic pain

No red/yellow flags

- In ED: Aggressive multimodal analgesia
  - Rx: 1 g acetaminophen + 400 mg ibuprofen q6h
  - +/- breakthrough opioid tabs
  - Avoid euphorics (e.g. oxycodone)
  - Avoid ER/LA preparations
  - Avoid combination pills
  - 3 days supply, flush unused pills
  - Goal is not zero pain

---

**High risk**

Chronic pain

+red/yellow flags

- Avoid opioids in ED and by prescription
- Use alternate modalities to manage pain
- Express concern that patient is being harmed by opioids and nudge toward recovery

---

**Maybe risk**

Acute pain

+yellow flags

- Prescription drug monitoring program
- No opioids challenge: I’m going to try to manage your pain without opioids because I’m concerned that pain medications might harm you

---

* Pain at the end of life: Opioid harms less important, escalate opioids as needed