OPTIMIZING PERIOPERATIVE PAIN AND OPIOID VIGILANCE

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GOALS

• Review neurophysiology of pain signaling pathways

• Understand agents/interventions that effect these pathways

• Develop opioid sparing techniques to treat pain

• Review current opioid guidelines and recommendations
WHAT IS PAIN?

- An unpleasant sensory and emotional experience associated with actual or potential tissue damage.
- The sequence of events by which a stimulus is perceived as pain involves four major processes.
PAIN PROCESSING

- Four main processes:
  (1) Transduction
  (2) Transmission
  (3) Modulation
  (4) Perception
TRANSDUCTION

• Transduction occurs in the peripheral terminals of primary afferent neurons

Afferent – Sensory Neurons
Four Types

• A-beta and A-alpha fibers – large diameter, fast transmitting, myelinated sensory fibers for proprioception and touch

• A-delta fibers – smaller, fast transmitting, myelinated fibers that transmit sharp pain
  • Mechanoreceptors – Triggered by strong mechanical pressure and intense temperature

• C-fibers – smallest, slow transmitting unmyelinated nerve fibers that transmit dull or aching pain.
  • Mechanoreceptors – Mechanical & Thermal
  • Chemoreceptors – Triggered by chemicals released during inflammation
INFLAMMATORY SOUP

Figure 2.1 Schematic diagram of the neurochemistry of somatosensory processing as peripheral sensory nerve endings.
TRANSMISSIO N

• Process by which electrical activity is conducted through the nervous system
  • Three major components
    1. Peripheral sensory neurons (A-delta and C-Fibers) that transmit impulses from the site of transduction
       • Cell body is located in dorsal root ganglia (DRG), DRG is located in the vertebral foramen
       • Projections travel to the dorsal horn to synapse with second-order neurons, as well as interneurons, sympathetic neurons and others.
    2. Second Order Neurons
       • Located in the dorsal horn of the spinal cord (wide-dynamic-range neurons (WDR) and nociceptive-specific (NS) neurons)
       • Axons cross midline and ascend contralaterally to reach the thalamus
    3. Thalamic Nuclei
       • Site of synapse for second order neurons and third order neurons
       • Third order neurons send projections to the sensory cerebral cortex (postcentral gyrus)
MODULATION

• Process whereby neural activity may be altered along pain transmission pathways

• Several different types

• A major site of modulation occurs within the dorsal horn of the spinal cord via a multitude of neurotransmitters (1st - 2nd order neurons)

• Modulation can result in minimizing pain or enhancement of pain signaling
ASCENDING PATHWAYS

Ascending Pathways:

- Localization, intensity, type of pain stimulus
- Arousal, emotion; involves limbic system, amygdala, insula, cingulate cortex, hypothalamus
- Mediate descending control of pain (feedback loop)

- Spinthalamic
  - To association cortex
  - Postcentral gyrus (somatic sensory cortex)
  - Ventral posterior lateral nucleus
  - Thalamus: Central lateral nucleus
  - Pons
  - Medulla
  - Spinal cord

- Spinoreticular
  - To association cortex
  - Postcentral gyrus (somatic sensory cortex)
  - Reticular formation of pons
  - Reticular formation of medulla
  - Mesencephalic reticular formation

- Spinomesencephalic
  - Reticular formation of midbrain
  - Superior colliculus
  - Periaqueductal gray matter
PATHWAYS

ASCENDING

- The Spinothalamic tract
  - The major ascending pathway for information about pain, temperature, and “simple” touch
- The Spinoreticular tract
  - Ascends and transmits sensory information about the affective quality of pain (unpleasantness and fear of further injury)
- The Spinomesencephalic tract
  - Ascending tract that travels to the brain where it integrates somatic sensation with visual and auditory information.
DESCENDING PATHWAYS

DESCENDING MODULATION

Internal regulation system:
- can literally turn afferent input (including nociceptive input) up or down like volume control

Image: Ossipow MH; Pain Pathways: Descending Modulation. Ed. Larry H Spier; Encyclopedia of Neuroscience 2009 Elsevier Ltd.

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PATHWAYS

• DESCENDING
  - Descending modulatory neural pathways aim to reduce pain perception
    • inhibiting pain transmission in the dorsal horn
    • Periaqueductal gray (PAG) and rostral ventromedial medulla (RVM) receive descending projections from a variety of cortical and limbic sites involved in pain processing
    • Activation of these structures results in anti-nociceptive effects
MODULATION

• Spinal Modulation
  - Gate Control Theory which suggests that input along low-threshold A-beta fibers inhibits the responses of WDR cells to nociceptive input

• Supraspinal Modulation
  - Descending modulation of nociception at the supraspinal level can have both inhibitory and facilitatory effects on primary afferent neurons in the dorsal horn
PERCEPTION

- Perception is the final stage of the pain-signaling process
  - Neural activity in the somatosensory transmission results in a subjective sensation of pain.

- Cognitive therapy
- Mindfulness
- Hypnosis
- Meditation
- Coping Strategies
TREATING PAIN

How can we manipulate traffic?
ACCURATELY CATEGORIZE PAIN

• **Neuropathic** - Sharp, burning, electrical, poorly localized
  - Damage to nerve structure itself

• **Nociceptive** - Dull, aching well localized
  - Mechanical (pressure, swelling, incision, tumor growth)
  - Chemical (excitatory neurotransmitter, toxic substance, ischemia, infection)
  - Thermal (burn)

• Accurately determining the underlying etiology of pain
NEUROPATHIC AGENTS

• Can be classified based on main mechanism of action
  1. Modulation of sodium channels
  2. Modulation of calcium channels
  3. Enhancement of GABA
  4. Reuptake inhibition
AGENTS TARGETING SODIUM CHANNELS

- Involved in generation of nerve action potentials
  - Lidocaine 5% in pliable patch
    - FDA approved for Postherpetic neuralgia
  - Carbamazepine
    - FDA approved for Trigeminal Neuralgia
  - Topiramate (also Ca channel blocker)
    - Used for migraine HA, post-stroke central pain
CALCIUM CHANNEL MODULATORS

- Gabapentin and Pregabalin
  - Amino acid derivatives of GABA
  - Bind to alpha-2-delta subunit of N-Type calcium channel
  - Results in inhibition of calcium influx
  - Increased expression of this subunit has been found in DRG after peripheral nerve injuries
GABA MODULATION

• Baclofen
  - GABA-B
  - Slower acting channel
    - Increased Potassium efflux, causing hyperpolarization and decreased sodium channel activation
  - Muscle relaxant associated with least degree of sedation in the elderly
TRICYCLICS

• Action:
  - Mixed (↑ 5-HT & NE at synapse)
  - Increase descending inhibition of ascending pain signals

• Indication:
  - Neuropathic pain

• SE:
  - dizzy, sedation, anticholinergic
### TRICYCLIC S

#### TABLE 15-2  Tricyclic Antidepressants (TCAs)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Usual Start Dose</th>
<th>Average Dose</th>
<th>Maximum Dose</th>
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<tbody>
<tr>
<td>Amitriptyline (Elavil)</td>
<td>10–25 mg qd</td>
<td>75–150 mg qd</td>
<td>300 mg/day</td>
</tr>
<tr>
<td>Amoxapine (Asendin)</td>
<td>25 mg bid</td>
<td>75–200 mg bid</td>
<td>600 mg/day</td>
</tr>
<tr>
<td>Clomipramine (Anafranil)</td>
<td>25 mg qd</td>
<td>150–250 mg qd</td>
<td>250 mg/day</td>
</tr>
<tr>
<td>Desipramine (Norpramin)</td>
<td>10–25 mg qd</td>
<td>75–150 mg qd</td>
<td>300 mg qd</td>
</tr>
<tr>
<td>Doxepin (Sinequan)</td>
<td>10–25 mg qd</td>
<td>75–150 mg qd</td>
<td>300 mg qd</td>
</tr>
<tr>
<td>Nortriptyline (Pamelor)</td>
<td>10–25 mg qd</td>
<td>75–150 mg qd</td>
<td>200 mg qd</td>
</tr>
<tr>
<td>Protriptyline (Vivactil)</td>
<td>5 mg qd</td>
<td>10 mg tid</td>
<td>60 mg/day</td>
</tr>
</tbody>
</table>

**Desipramine, Nortriptyline, Imipramine, Doxepin, Amitriptyline**

Fewest AEs

Most AEs
DULOXETINE, MILNACIPRAN

Action:
- Increased SNRI, but still SSRI
- Increase descending inhibition of ascending pain signals

Indication:
- Neuropathic pain
- FDA approved for diabetic neuropathy, fibromyalgia
NSAIDS

• “Anti-hyperalgesic”
  - Works to decrease post injury sensitivity
  • Surgical, cancer, musculoskeletal, arthritic, menstrual pain
  - Antipyretic
  - Anti-inflammatory
COX 1 AND COX 2

- COX 1
  - Constantly produced
  - Vital to fine tuning physiologic processes such as hemostasis and protection of gastric mucosa

- COX 2
  - Induced by inflammation, trauma
  - By neurotransmitters, growth factors, and cytokines.
  - IL1β is a key factor in inducing COX 2 formation in the periphery as well as in CNS
ACETAMINOPHEN

• Mechanism of action:
  – Incompletely understood
  – Inhibits COX 1/2 but also primarily inhibits COX 3 (found in brain and spinal cord)
  – Inhibits prostaglandin synthesis in inflamed tissues
OPIOIDS

- **Agent whose action is mediated by binding to an opioid receptors**
  - G-protein coupled rec → block voltage gated Ca channels
  - Inhibition of excitatory neurotransmission
    - Spine: dorsal hom – substantia gelatinosa
    - Supraspinal: periaqueductal gray matter, nucleus accumbens, cortex, amygdala

- **Endogenous Opioids**
  - β- endorphins → μreceptor
  - Enkephalins → δreceptor
  - Dynorphins → κreceptor
OPIOIDS

• Effects
  - dose dependent analgesia

• Side Effects
  - euphoria, respiratory depression, nausea, vomiting, decreased gastrointestinal motility, urinary retention, tolerance, dependence, histamine release, miosis, and/or anorexia, biliary spasm
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


- Pain management in the perioperative setting refers to actions before, during, and after a procedure that are intended to reduce or eliminate postoperative pain before discharge.

- Purpose:
  - Reduce the risk of adverse outcomes in the perioperative setting
  - Maintain the patient’s functional abilities
  - Maintain the patient’s psychologic well-being
  - Enhance the quality of life for patients with acute pain during the perioperative period
PRACTICE GUIDELINES FOR ACUTE PAIN MANAGEMENT IN THE PERIOPERATIVE SETTING:
PREOPERATIVE

• Patient evaluation and planning is integral to develop a proactive individualized plan

• Patient factors to consider
  - Type of surgery
  - Expected severity of postoperative pain
  - Underlying medical conditions (e.g., presence of respiratory or cardiac disease, allergies, etc)
  - Patient’s preferences or previous experience with perioperative pain
PRACTICE GUIDELINES FOR ACUTE PAIN MANAGEMENT IN THE PERIOPERATIVE SETTING:
PREOPERATIVE

• Appropriate adjustments or continuation of medications to avert an abstinence syndrome

• Patient education for optimal use of patient-controlled analgesia (PCA) and other sophisticated methods, such as patient-controlled epidural analgesia should be discussed with patient and family
BUPRENORPHINE (SUBOXONE/SUBUTEX)

- Tx of acute pain in patients taking buprenorphine is challenging
  - High receptor binding affinity, long half-life, and partial agonism of buprenorphine → inhibits traditional opioids → uncontrolled postoperative pain and serious adverse events
- Limited data on optimal treatment strategies for these patients
- Not all experts agree that buprenorphine therapy requires discontinuation before elective surgery
BUPRENORPHINE (SUBOXONE/SUBUTEX)

• Stop?
  - During the highly stressful period, risks relapse

• Continue?
  - Elevated but *indeterminate* opioid requirement to compete with *strong* μ-receptor buprenorphine binding

• If stopped when do I restart?
  - If reliant on opioid therapy for pain control, buprenorphine can induce withdrawal
BUPRENORPHINE (SUBOXONE/ SUBUTEX)

- Preoperative planning is key
- Decision will rely on:
  - Patient
  - Nature of surgery
  - Daily Buprenorphine dose
  - Last administered dose
  - Perioperative care team
BUPRENO RPHINE (SUBOXONE/SUBUTEX)

Still Taking Buprenorphine
- Continue buprenorphine
- Do NOT routinely prescribe supplemental opioids
- Do NOT change the buprenorphine dose
- Consider adjuncits – NSAIDs, membrane stabilizers, acetaminophen, local anesthetic agents, regional anesthetic techniques

Off Buprenorphine
- Surgical team should contact buprenorphine providers and confirm they are aware of surgery and have a plan to reinstitute therapy
- Assess amount of time since last dose. If the following dose/time intervals are met, treat with traditional opioids using opioid-tolerant dosing:
  - 0-4 mg per day – stop x 24 h before surgery
  - >4-8 mg per day – stop x 48 h before surgery
  - >8-12 mg per day – stop x 72 h before surgery
  - >12 mg – requires preoperative management plan with buprenorphine provider

Still Taking Buprenorphine
- Cancel surgery – Maybe better: postpone or schedule surgery such that the following requirements can be met
- Patient should return to buprenorphine provider and be placed on short-acting opioid or be weaned off before surgery. A plan for follow-up and reinstitution of therapy should be established.
  - 0-4 mg per day – stop x 24 h before surgery
  - >4-8 mg per day – stop x 48 h before surgery
  - >8-12 mg per day – stop x 72 h before surgery

Off Buprenorphine
- Anticipate patient’s opioid requirements will be similar to opioid-tolerant or highly-tolerant patient
- Surgical team should ensure appropriate outpatient follow-up with buprenorphine provider
- Consider adjuncits – NSAIDs, membrane stabilizers, acetaminophen, local anesthetic agents, regional anesthetic techniques
**Buprenorphine (Suboxone/Subutex)**

<table>
<thead>
<tr>
<th>Still Taking Buprenorphine</th>
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<tbody>
<tr>
<td>- Surgeons should contact the physician prescribing buprenorphine and ensure that he or she is aware of surgery</td>
</tr>
<tr>
<td>- Continue the buprenorphine for postoperative pain</td>
</tr>
<tr>
<td>- Do NOT routinely prescribe supplemental opioids</td>
</tr>
<tr>
<td>- Consider adjuncts – acetaminophen and/or NSAIDs</td>
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</tbody>
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<thead>
<tr>
<th>Off Buprenorphine</th>
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<tbody>
<tr>
<td>- Assess the amount of time since last dose of buprenorphine</td>
</tr>
<tr>
<td>- If ≥5 days off buprenorphine, treat with traditional opioids; may require tolerant or highly-tolerant doses</td>
</tr>
<tr>
<td>- Surgeons should contact the physician prescribing buprenorphine and ensure that he or she is aware of surgery</td>
</tr>
<tr>
<td>- After postoperative pain normalizes, the patient may work with his or her physician to reinstitute buprenorphine therapy</td>
</tr>
</tbody>
</table>

**Urgent/Emergent Surgery**

<table>
<thead>
<tr>
<th>Preoperatively:</th>
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<tbody>
<tr>
<td>Surgical team should assess anticipated postoperative pain and opioid requirements</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minimal to No Pain</th>
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</thead>
<tbody>
<tr>
<td>Yes - Ask patient if he or she is still taking buprenorphine</td>
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<table>
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<tr>
<th>Moderate to Severe Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - Ask patient if he or she is still taking buprenorphine</td>
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</table>

| 1. Discontinue buprenorphine |
| 2. Start PCA – Will likely require high doses; may require some continuous opioid infusion. However, would avoid high-dose, continuous opioids and instead allow the patient to use PCA. Consult APS, PCA to be managed by Acute Pain Service (APS). |
| 3. Patient should be in a monitored setting with close nurse monitoring (ICU, or monitored/moderate care setting) |
| - Duration of ICU/monitored setting time will vary |
| - Acetaminophen around the clock (ATC) |
| - Consider gabapentin or pregabalin |
| 4. Regional anesthesia – consider continuous catheters |
| 5. Maximize adjuncts |
| - Dexmedetomidine for ICU patients used according to ICU protocols |
| - Acetaminophen around the clock (ATC) |
| - Consider gabapentin or pregabalin |

**Still Taking Buprenorphine**

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<thead>
<tr>
<th>Off Buprenorphine</th>
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<tr>
<td>- Anticipate patient’s course to be similar to tolerant patient</td>
</tr>
<tr>
<td>- Surgeons should ensure appropriate outpatient follow-up</td>
</tr>
</tbody>
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University of Michigan Health System
Patients Maintained on Buprenorphine for Opioid Use Disorder Should Continue Buprenorphine Through the Perioperative Period

T. Anthony Anderson, Ph.D., M.D.; Aurora N. A. Quaye, M.D.; E. Nalan Ward, M.D.; Timothy E. Wilens, M.D.; Paul E. Hilliard, M.D.; Chad M. Brummett, M.D.

Figure 1 Perioperative Buprenorphine Protocol.
BUPRENO RPHINE (SUBOXONE/SUBUTEX)

• Recommendation to taper patients to 12 mg buprenorphine
  - Buprenorphine receptor occupancy
  - Brain PET scans of radiolabeled carfentanil in buprenorphine-treated heroin-addicted persons confirm a dose response curve of reduced mu opioid receptors
BUPRENORPHINE (SUBOXONE/ SUBUTEX)

- 0 mg - 100% available receptor
- 2 mg - 59% available receptors
- 16 mg - 20% available receptors
- 32 mg - 16% available receptors
PRACTICE GUIDELINES FOR ACUTE PAIN MANAGEMENT IN THE PERIOPERATIVE SETTING: INTRAOPERATIVE

• Multimodal intraoperative use of analgesics of both surgical and anesthesia team
  - IV Acetaminophen/NSAIDs
  - Intra-Op Infusions
    • Dexmedetomidine, Ketamine, Lidocaine
  - Pre/Post incisional wound infiltration
    • Lidocaine, Bupivacaine, Ropivacaine, Liposomal bupivacaine
  - Regional nerve block
    • Intercostal, brachial plexus, lumbar plexus, ilioinguinal, Epidural
  - Intraarticular blockade
  - Epidural or Intrathecal administration of opioid
PRACTICE GUIDELINES FOR ACUTE PAIN MANAGEMENT IN THE PERIOPERATIVE SETTING: POSTOPERATIVE

• Goal to streamline medication regimen to promote patient recovery
  - Pain scores do not tell the entire the story
  - Focus around improved function, mood/affect and rest
  - Goal to stabilize patient on oral multimodal pain regimen with plan for discharge
CDC GUIDELINES 2016

• Novel points raised
  – Evidence of long-term opioid therapy remains limited
  – ER formulations were associated with greater risk of nonfatal overdose
Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioid and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate these into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently and at the same time.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

*All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care, except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.*
NJ PRESCRIBING GUIDELINES FOR TREATMENT OF ACUTE AND CHRONIC PAIN

• Guidelines do not apply to patients who:
  - Currently are in active treatment for cancer
  - Receiving hospice care
  - Any medications that are prescribed in the treatment of substance abuse or opioid dependence (medication assisted treatment)
NJ PRESCRIBING GUIDELINES FOR TREATMENT OF ACUTE AND CHRONIC PAIN

• PRIOR TO ISSUING AN INITIAL PRESCRIPTION FOR ACUTE OR CHRONIC PAIN
  - Document a thorough medical history, including the patient’s experience with non-opioid medication and non-pharmacological pain management approaches and substance abuse history
  - develop a treatment plan, with particular attention focused on determining the cause of the patient’s pain
  - Review the Prescription Monitoring Program
NJ PRESCRIBING GUIDELINES FOR TREATMENT OF ACUTE AND CHRONIC PAIN

• No authorized prescriber can issue an initial prescription for a Schedule II controlled dangerous substance or any opioid drug, which is a prescription drug, in a quantity exceeding a five-day supply for treatment of acute pain. (even post op pain)
  - The law does NOT address what constitutes a 5-day supply; however it does provide that any prescription for acute pain shall be the lowest effective dose of immediate-release opioid drug.
**OPIOID ADVERSE EFFECTS**

- 5-19% addiction risk in chronic opioid therapy
  - Portenoy RK, and Foley K. Chronic use of opioid analgesics in non-malignant pain: report of 38 cases. Pain 1986;25171-186 (5%)
  - Chronic pain, rates are much higher than initially thought
  - Does use in acute setting lead to addiction?

NJ PRESCRIBING GUIDELINES FOR TREATMENT OF ACUTE AND CHRONIC PAIN

• Whether prescribing opioids for acute or chronic pain
  - You are now required to include a note in the patient’s medical record that there was a discussion about the risks

  - This discussion must occur prior to the initial prescription
    • Advised to be documented with any subsequent office visits and Rx as well
NJ PRESCRIBING GUIDELINES FOR TREATMENT OF ACUTE AND CHRONIC PAIN

• 3 major points
  - the risks of addiction and overdose and dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants leading to fatal respiratory depression
  - the reasons why the prescription is necessary
  - alternative treatments that may be available
OPTIMIZING PERIOPERATIVE PAIN AND OPIOID VIGILANCE

• Focus should be on developing a perioperative plan unique to that patient

• Patients should have realistic pain expectations going into surgery by having an honest conversation with their doctors

• Patient goals should be well established focusing on function rather than pain scores

• Overall opioid guidelines are a positive - use them

Thank you