Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department

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Approved by the ACEP Board of Directors, June 14, 2012

Supported by the Emergency Nurses Association, July 18, 2012

This clinical policy was funded under contract 200-2011-M-38670 with the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury.

0196-0644/$-see front matter

http://dx.doi.org/10.1016/j.annemergmed.2012.06.013

[Ann Emerg Med. 2012;60:499-525.]

ABSTRACT

This clinical policy deals with critical issues in prescribing of opioids for adult patients treated in the emergency department (ED). This guideline is the result of the efforts of the American College of Emergency Physicians, in consultation with the Centers for Disease Control and Prevention, and the Food and Drug Administration. The critical questions addressed in this clinical policy are: (1) In the adult ED patient with noncancer pain for whom opioid prescriptions are considered, what is the utility of state prescription drug monitoring programs in identifying patients who are at high risk for opioid abuse? (2) In the adult ED patient with acute low back pain, are prescriptions for opioids more effective during the acute phase than other medications? (3) In the adult ED patient for whom opioid prescription is considered appropriate for treatment of new-onset acute pain, are short-acting schedule II opioids more effective than short-acting schedule III opioids? (4) In the adult ED patient with an acute exacerbation of noncancer chronic pain, do the benefits of prescribing opioids on discharge from the ED outweigh the potential harms?

INTRODUCTION

Pain is a major symptom of many patients presenting to the emergency department (ED), with up to 42% of ED visits being related to painful conditions.[1] Pain management has received increased emphasis in the past decade, including The Joint Commission's focus on patient analgesia[2] and increasing institutional emphasis placed on patient satisfaction surveys covering pain management. Much literature, including the most recent Institute of Medicine report on this topic, has stressed that health care providers have not done as well as possible in the area of pain management.[3] A possible unintended consequence of these efforts is the increase in prescription drug abuse, especially opioid abuse, the fastest-growing drug abuse problem in the United States.[4]

As part of this issue, there has been a startling increase in unintentional drug overdoses and related deaths since the late 1990s.[5,6] Reported overdose deaths involving opioid analgesics increased from 4,030 in 1999 to 14,800 in 2008.[7,8] Data from 2008 reveal that drug overdoses were the second leading cause of injury death in the United States, after motor vehicle crashes.[9] Currently, deaths from opioid analgesics are significantly greater in number than those from cocaine and heroin combined.[8]

The efforts of clinicians to improve their treatment of pain, along with pharmaceutical industry marketing, have been factors in contributing to a significant increase in the sale and distribution of opioids in the United States. For example, the sales of opioid analgesics to hospitals, pharmacies, and practitioners quadrupled between 1999 and 2010.[8] Drug sales and distribution data of opioids show an increase from 180 mg morphine equivalents per person in the United States in 1997 to 710 mg per person in 2010.[8,10] This is the equivalent of 7.1 kg of opioid medication per 10,000 population, or enough to supply every American adult with 5 mg of hydrocodone every 4 hours for a month.[8]

The dilemma of treating pain appropriately while avoiding adverse events is further complicated by insufficient data supporting the long-term use of opioids in the treatment of chronic noncancer pain. Although selective use of opioids in the treatment of acute pain is traditionally accepted, the treatment of chronic noncancer pain is more complex. Many authors have begun to question the routine long-term use of opioids for the treatment of chronic noncancer pain.[11-13] Multiple practice guidelines have been developed to address this issue.[14-19] However, most recommendations in this area are of a consensus nature, being based on experiential or low-quality evidence.

Data from 2009 show that there were more than 201.9 million opioid prescriptions dispensed in the United States during that year.[20] It is difficult to obtain reliable data concerning the degree to which this is an emergency medicine issue, but during 2009, in the 10- to 19-year-old and 20- to 29-year-old patient groups, emergency medicine ranked third among all specialties in terms of number of opioid prescriptions, writing approximately 12% of the total prescriptions in each age group. In the 30- to 39-year-old group, emergency medicine ranked fourth.[20] Although these data do not deal with total doses dispensed by specialty, it is commonly postulated that the population served in EDs as a whole is at high risk for opioid abuse.[21]

The significant increase in opioid-related deaths has raised the concern of many.[5,6,8] This problem has also been observed in the pediatric population.[22-24] Action at the national level includes the recent proposal from the Food and Drug Administration for the establishment of physician education programs for the prescribing of long-acting and extended-release opioids as part of their national opioid risk evaluation and mitigation strategy (the REMS program).[25] State efforts to address this issue have included the development of statewide opioid prescribing guidelines, such as those developed by the Utah Department of Health[17] and statewide ED opioid prescribing guidelines, such as those developed in Washington State by the Washington chapter of the American College of Emergency Physicians (ACEP) working with other state organizations.[16] Some individual EDs and emergency physician groups have also promulgated opioid prescribing guidelines. Some of these policies also deal with the necessity of patient education about the safe use and proper disposal of opioid medications. Early data indicate that, in some cases, these guidelines may decrease prescription opioid overdose.[26] Anecdotal experience suggests that public policies such as these may change patient perceptions of appropriate prescribing and mitigate complaints arising from more stringent prescribing practices. ACEP has approved related policy statements about optimizing the treatment of pain in patients with acute presentations and the implementation of electronic prescription drug monitoring programs.[27,28]