



Analgesics for acute pain

The opioid epidemic continues to rage with the crisis now officially a non-funded "[Health Emergency](#)".

Thus far, national efforts to curb the epidemic have resulted in a [recente guideline](#) for chronic pain management courtesy of the Centers for Disease Control and Prevention, yet robust comparative data to support effective non-opioid alternatives for acute pain are lacking. Studies to date have examined [acute perioperative pain](#) and postoperative [dental pain](#), leaving many questions unanswered surrounding treatment of pain in acute care settings.

Recent [research](#) by Chang, et al. published in JAMA last November helps change this.

In their double-blinded, randomized trial of 411 patients with acute extremity pain presenting to the emergency department, pain responses were not significantly different two hours after administration of non-opioid treatment (ibuprofen 400 mg plus acetaminophen 1000 mg) or one of three opioid and acetaminophen combinations (acetaminophen plus 5 mg oxycodone, 5 mg hydrocodone, or 30 mg codeine). Pain declined in all groups regardless of therapy assignment.

Additionally, while 18% of all participants received a rescue analgesic within the two-hour assessment period, morphine equivalents of rescue medication were not significantly different between groups.

So, can we start avoiding opioids altogether in the management of acute pain?

Not necessarily. Importantly, neither outcomes beyond two hours nor adverse effects were measured.

One option might be to use a prediction model to assess those at greatest risk of opioid addiction or abuse, as suggested in an [editorial](#) by Kyriacou, for whom non-opioid analgesia may be best suited.

Development of such a model would be a welcome addition to our pain management "toolkit".

This study does provide welcome reassurance that initial pain reduction in the emergency department is similar between a non-opioid analgesic combination and that of an opioid/ acetaminophen combination.

Given [the correlation](#) between long-term opioid use and the quantity of one's first opioid prescription, Chang's findings are welcome and timely and may represent an application of Slow Medicine to thoughtfully treat acute pain while minimizing iatrogenic risks.

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