Summary of

Opioid Prescribing Practices for Perioperative Pain

Preoperative

- Evaluate the patient thoroughly, including history and physical:
  - Ask about past and current use of analgesics, including response to and preferences for.
  - Check the Prescription Monitoring Program (PMP) for drug history.
  - Assess risk for potential opioid over-sedation/respiratory depression and difficult postoperative pain control, and then communicate the results to the team.
  - For high-risk patients, consider consulting with a specialist (e.g. pain, addiction, behavioral health).
- Develop a coordinated treatment plan, including a timeline for tapering perioperative opioids, and identify the provider responsible for managing postoperative pain and prescribing opioids.
- Share the treatment plan with patient and family, including setting realistic expectations for pain management, functional recovery, and timely return to preoperative opioid dose (if any) or lower.
- Avoid escalating the patient's opioid dose or starting new prescriptions of benzodiazepines, sedative-hypnotics, anxiolytics or other central nervous depressants before surgery.

Intraoperative

- Provide balanced multimodal analgesia, including adjuvant analgesics, when possible.
- If patients are on high-dose opioid preoperatively, provide sufficient intraoperative opioid doses to avoid acute withdrawal.

Immediately Postoperative

- Reserve opioids for moderate to severe pain.
- Monitor sedation and respiratory status in patients receiving systemic opioids for analgesia. Prepare to change or reduce opioids or administer naloxone in patients who develop excessive sedation or respiratory depression.
- Use short-acting, *as needed* (PRN) opioids as the foundation for acute severe postoperative pain.
- For opioid-tolerant patients, do not add or increase extended release or long-acting opioids.

At Time of Discharge

- Avoid writing new prescriptions of benzodiazepines, sedative-hypnotics, anxiolytics or other central nervous system depressants.
- Remind the patient and family about which provider will be managing postoperative pain, including who will prescribe any opioids, and the timeline for tapering postoperative opioids.
- Follow through with the agreed-upon coordinated treatment plan for pain management. In most cases, prescribing opioids for postoperative pain should follow the guidance in Table 1. For exceptional cases that warrant opioid treatment, the provider should prescribe no more than a 2-week supply and then re-evaluate the patient before refills.
- Counsel the patient on safe use, secure storage and prompt disposal of leftover opioids through community-based drug take-back programs, DEA-approved take back program, or FDA guideline for safe disposal of medicine.

Evidence-Based Duration of Opioid Prescriptions on Discharge Following Surgery

Table is based on data showing that these opioid prescription durations are adequate to treat postoperative pain in >75% of patients without refills.

Type I – Expected rapid recovery

Dental procedures such as: extractions or simple oral surgery (e.g., graft, implant).

- Prescribe a nonsteroidal anti-inflammatory drug (NSAID) or combination of NSAID and acetaminophen as first-line therapy.
- If opioids are necessary, prescribe ≤3 days (e.g., 8 to 12 pills) of short-acting opioids in combination with an NSAID or acetaminophen for severe pain. Prescribe the lowest effective dose strength.
- For more specific guidance, see the Bree Collaborative Dental Guideline on Prescribing Opioids for Acute Pain Management at **www.AgencyMedDirectors.wa.gov**.

Procedures such as: laparoscopic appendectomy, inguinal hernia repair, carpal tunnel release, thyroidectomy, laparoscopic cholecystectomy, breast biopsy/ lumpectomy, meniscectomy, lymph node biopsy, vaginal hysterectomy.

- Prescribe non-opioid analgesics (e.g., NSAIDs and/ or acetaminophen) and non-pharmacologic therapies as first-line therapy.
- If opioids are necessary, prescribe ≤3 days (e.g., 8 to 12 pills) of short-acting opioids in combination with an NSAID or acetaminophen for severe pain. Prescribe the lowest effective dose strength.

Type II – Expected medium-term recovery

Procedures such as: anterior cruciate ligament (ACL) repair, rotator cuff repair, discectomy, laminectomy, open or laparoscopic colectomy, open incisional hernia repair, open small-bowel resection or enterolysis, wide local excision, laparoscopic hysterectomy, simple mastectomy, cesarean section.

- Prescribe non-opioid analgesics (e.g., NSAIDs and/ or acetaminophen) and non-pharmacologic therapies as first-line therapy.
- Prescribe ≤7 days (e.g., up to 42 pills) of short-acting opioids for severe pain. Prescribe the lowest effective dose strength.
- For those exceptional cases that warrant more than 7 days of opioid treatment, the surgeon should re-evaluate the patient before a third prescription and taper off opioids within 6 weeks after surgery.

Type III – Expected longer-term recovery

Procedures such as: lumbar fusion, knee replacement, hip replacement, abdominal hysterectomy, axillary lymph node resection, modified radical mastectomy, ileostomy/colostomy creation or closure, thoracotomy.

- Prescribe non-opioid analgesics (e.g., NSAIDs and/ or acetaminophen) and non-pharmacologic therapies as first-line therapy.
- Prescribe ≤14 days of short-acting opioids for severe pain. Prescribe the lowest effective dose strength.
- For those exceptional cases that warrant more than 14 days of opioid treatment, the surgeon should re-evaluate the patient before refilling opioids and then taper off opioids within 6 weeks after surgery.

Patients on chronic opioid analgesic therapy

Elective surgery in patients on chronic opioid therapy

- Prescribe non-opioid analgesics (e.g., NSAIDs and/ or acetaminophen) and non-pharmacologic therapies as first-line therapy.
- Follow the recommendation above for prescribing the duration of short-acting opioids following a particular surgery (e.g., 3, 7, or 14 days). An increased number of pills per day may be expected compared to an opioid naïve patient. Patients on chronic opioid therapy should have a similar tapering period as opioid naïve patients postoperatively. Prescribe the lowest effective dose strength.
- For exceptional cases that warrant more than 14 days of opioid treatment after discharge, the surgeon should re-evaluate the patient before refilling opioids. Within 6 weeks after surgery, taper off opioids to same total daily dose prescribed pre-operatively.

AMDG agency medical directors' group
A collaboration of state agencies, working together to improve health care quality for Washington State citizens.

See full guideline at
www.AgencyMedDirectors.wa.gov

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