Preventing Opioid Addiction: Treating Acute Pain Safely - Frankly Speaking EP 51

Transcript Details

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Dr. Frank Domino:

Nick is a 24-year-old on your schedule today. He sprained his ankle over the weekend while playing basketball. He's miserable with pain and has to travel for work. He wants something, to "Help me get functioning fast". You want something that isn't going to lead to any problems, including opioid dependence. What do you do?

Hi, this is Frank Domino, Professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. Joining me today is Alan Ehrlich, Associate Professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School, and Executive Editor at DynaMed. Alan, thanks for coming.

Dr. Alan Ehrlich:

Thanks, Frank. You know, Frank, that was a really interesting intro you had. This is a very typical patient, and it's obviously something we're all really concerned about, because of the opioid crisis. We certainly have one here in Massachusetts, and in neighboring New Hampshire, and it's really a nationwide problem. Really, what are the options for treating Nick in a situation like this?

Dr. Domino:

Well, I think, in the past, if Nick came into my office, I'd give him all the recommendations we normally use for acutely sprained ankles. I'd make sure he didn't meet any of the criteria for the Ottawa rules, and if he didn't, I wouldn't get an X-ray. And I'd have him use a compression

bandage, keep it elevated, ice or heat, whichever he preferred, and I'd probably prescribe an NSAID. His case is somewhat compelling, in that he needs to keep functioning. He's gotta travel for work and he wants to feel better fast. And so I think I need to think a little bit more broadly about what to do. In the past, I'm certain, if he went to a variety of providers or an emergency department with his request, he might have walked out the door with 10 to 14 days of an opioid, but maybe that's not necessary now.

Dr. Ehrlich:

Yeah, I can certainly see a patient like this being given Tylenol Number 3, or hydrocodone, or something like that. But in terms of the effectiveness of various treatments, what does the data show?

Dr. Domino:

Well, there was a really wonderful paper published in the journal JAMA earlier this year, that compared an opioid plus acetaminophen to acetaminophen plus ibuprofen, and they were found to be equally effective. And they tried a variety of acetaminophen/opioid combinations. They compared a 1,000 mg of acetaminophen plus 400 mg of ibuprofen to acetaminophen plus hydrocodone or codeine, and found that they were, at two hours, equally effective at controlling pain. What was really wonderful, was that the acetaminophen/ibuprofen combination had the fewest side effects, and although it's not statistically significant, had the best outcomes with regard to pain management. Now, this was a study done in the emergency department for acute extremity pain.

This patient has an acute extremity pain and it seems quite simple. Is there any danger or risk to this combination? Probably not. Acetaminophen at a 1,000 mg, taken four times a day, is unlikely to cause liver disease in a young person. Ibuprofen, in someone without a history of a GI bleed or renal insufficiency, again, very low risk. What this study did not show is, how did this combination do over the course of three to five days while this patient's acutely uncomfortable?

Dr. Ehrlich:

Really, there weren't any functional outcomes, it's just a question of acute pain relief that they were looking at?

Dr. Domino:

Yes, yes. It was mostly acute pain relief.

Dr. Ehrlich:

I'm not normally advising patient to take both acetaminophen and ibuprofen. Typically, when I see a patient, I suggest to take one or the other, often based on comorbidities or their preferences. Why did they think of giving both of them together? What was the logic there? Did they talk about that?

Dr. Domino:

They absolutely did. There's a long data set demonstrating that this combination is effective in a variety of settings. It's been found to be efficacious in emergency departments in the past. It's very effective in children, both for pain management and for fever suppression, and in particular, when using for fever in children. Alternating doses actually increases the risk of adverse events. You should be giving acetaminophen and ibuprofen together. There's great data that shows that it's highly effective in post-op pain, as effective as opioids, and it's even effective in chronic pain. And we have systematic review data that shows it's effective both for post-op pain and for dental pain. I think the combination of acetaminophen and ibuprofen together is something that's going to gain popularity, because the synergy that occurs with the two of them seem to be very effective at pain control with very, very low risk of opioid dependence.

Dr. Ehrlich:

That sounds pretty good, but really, Frank, how much risk is there to a short course of opioids? Is that something that we should be concerned about?

Dr. Domino:

Well, earlier this year, there was a wonderful paper that just looked at what the influence of a prescription of opioids could have on long-term dependence. And it's very interesting, if you give a patient one day's worth of oral opioids, the chance that they're gonna be dependent upon those opioids at 12 months is 6%, or one in 15 people. You may say, "Gee, Frank, one day of opioids, no big deal." If you give them a 10-day supply of opioids, the chance that they'll be dependent upon an opioid at 12 months is 20% or one in five people. In my mind, this study shows that we have the potential to prevent opioid dependence, by just changing how we prescribe, that if you give a patient a 31-day of opioids, one in three people will be opioid-dependent at one year. I think when we think about the opioid crisis, we as clinicians have to realize some of this responsibility falls in our lap. And just like with antibiotics, and their appropriate use, I think appropriate use of pain medication should be that we focus on what's the least likely to cause harm, and then only add other agents if we absolutely have to.

Dr. Ehrlich:

Wow, Frank, that data [chuckle] can be pretty scary when you think about some of those risks. That certainly ties in with some of the legislation, such as we've had here in Massachusetts, where physicians are limited in terms of how many days of opiates they can prescribe for a first prescription, to obviously try and prevent people from becoming dependent.

Dr. Domino:

It's interesting. Since this paper's come out, I have used this combination in three patients in my office. And I realize that's just an n of three, it's a very small number. But not a single person called me back and said, "Hey, I'm suffering. Can you give me something more?" I know, personally, when I've had fairly significant musculoskeletal surgery, I've used this combination instead of opioids, because of some of the adverse effects they provided me, and have had absolutely perfect pain control. I encourage our listeners to think of it more, when they see acute injury, treat with the medication that's equally effective, and the least likely to do harm, and then only add on from there.

Dr. Ehrlich:

I think that makes a lot of sense, Frank. One of the things for me, as a prescriber, is the fact that I have to go into the Prescription Monitoring Program every time I want to write a prescription for opioids, for someone like Nick. And so having an option that's just as good, that doesn't make me go through additional steps, is something that's very attractive.

Dr. Domino:

And I would hope that somewhere out there, there's some energetic and open-minded pharmaceutical company that might wanna make this a simple combination that we can prescribe, and not have to worry about getting two different bottles and combining it all. I could see this being a very effective next generation of how we go about treating pain.

Dr. Ehrlich:

Very interesting data that you presented today, Frank. Thanks a lot.

Dr. Domino:

Thanks, Alan, for coming. Practice pointer: Acetaminophen at 1,000 mg combined with ibuprofen 400 mg, is as effective as acetaminophen combined with opioids for the management of acute musculoskeletal pain. Join me next time, when we discuss the new hypertensive guidelines recently published and somewhat controversial.