PS41(G) Position statement on acute pain management Background Paper 2022

Short title: Acute pain BP

1. Purpose of review

The purpose of this revision was to update the guideline with evidence-based or, where there is limited evidence, expert consensus-based recommendations since it was last reviewed in 2013, and to broaden its scope to include more information about the more comprehensive concept of analgesic stewardship. It was prompted by the significant increase in clinical knowledge and greater recognition of the need to review safe management of the patient from preadmission to post discharge.

2. Scope

Recognising that acute pain is managed in a range of settings, including outpatients and in the community, with differing availability of monitoring, it was decided that the accompanying position statement should apply only to the prescribing of analgesics for acute pain within hospital settings. It is intended to apply to all forms of acute pain, whether surgical or non-surgical.

Although it is intended to apply to all specialists of the college as well as trainees and SIMGs, it should provide a helpful resource to acute pain services and all doctors prescribing analgesics for acute pain.

3. Background

Significant advances have been made in the management of acute pain, although in some patients it remains suboptimal. Effective analgesia is not just humane but will assist the patient in the in their recovery. All patients should have access to effective and safe forms of pain relief that are appropriate to their clinical situation. This revision of PS41(G) aims to optimise care related to management of acute pain and to develop a framework for the provision of high-quality management.

Originally published as a guideline, it was decided to re-write PS41(G) as a position statement on acute pain management to emphasise the college's expectations of doctors involved in the management of acute pain. It was also decided to incorporate and update information that was previously in two stand-alone college statements: *Statement on principles for identifying and preventing opioid-induced ventilatory impairment (OIVI)* and *Position statement on the use of slow-release opioid preparations in the treatment of acute pain*.

Significant patient harm continues to occur because of treatments used to manage acute pain, both in hospital and after discharge. In many instances that harm is preventable. Effective and safe management individualises treatment regimens informed by patients and their carers, and is dependent on developing and maintaining close liaisons with all involved staff, ensuring that they have relevant and current knowledge and are trained and skilled. The addition of an analgesic stewardship appendix aims to cover the relevant information (which can be easily updated) and guide effective and safer management of the patient with acute pain – see section 5.

It was recognised that there are some differences between Australia and New Zealand in medication availability and approved indications for some medications.

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4. Framework for acute pain management

The delivery of safe and individualised patient care in the management of acute pain is underpinned by a framework that promotes:

- Attributes and abilities of members of multidisciplinary teams involved in patient care. Education is key for this component and may need to be tailored to the role for each discipline throughout their training and subsequent professional development.
- An understanding of the role of psychological, social and environmental factors, as well as patient attitudes and beliefs, in the experience of pain and outcomes of acute pain management.
- The ability to assess, monitor, and document analgesic efficacy and adverse effects, such as OIVI, as well as activation of effective interventions if required.
- Insights when implementing pharmacological therapies including individual risk-benefit assessments.
- Facilities and services that meet the requisite governance and staffing needs to provide high quality care.
- The development and implementation of regular quality assurance and quality improvements processes.

5. Analgesic stewardship

The concept of opioid stewardship has become increasingly well-recognised and aims to better manage patients even before admission through to after discharge. It aims to achieve a balance between the administration of safe and effective analgesia, which will facilitate patient recovery and restoration of function, while minimising the risk of opioid-related harms to the patient and others.

However, as the management of acute pain extends beyond solely opioids, the more comprehensive consideration of analgesic stewardship was deemed appropriate. This was developed as an appendix to PS41(G), which serves the purpose of maintaining the position statement as a succinct document, as well as facilitating the ability to deliver updates. This appendix addresses the use of non-opioid and adjuvant analgesic medications – both important components of multimodal analgesia – as well as opioids.

Given the extensive literature relating to the management of acute pain, and to minimise the number of references listed, it was agreed that *Acute Pain Management: Scientific Evidence* (Schug et al, 2020) would be the key resource for the appendix, and that the majority of additional references would be more recent and include a number of guidelines and reviews rather than cite individual papers included in these publications.

The appendix within the accompanying position statement PS41(G) covers the use of systemic medications to manage acute pain and not non-pharmacological techniques or regional analgesia. For information on the safe use of the latter refer to PG03(A) *Guideline for the management of major regional analgesia* (PS03).

A number of points related to the use of opioids in the management of acute pain were discussed in detail. These included:

- The ability to identify patients who were at risk of opioid-related harms, especially OIVI. While there is some evidence that certain patient groups may be at higher risk of OIVI, it was recognised that many patients who come to harm have no identifiable risk factors. Therefore, it was felt that all patients should be considered to be at risk and monitored accordingly.

- The place of long-acting opioids in the management of acute pain was considered at length. The evidence in general shows that the use of long-acting opioids for management of acute pain does not lead to better pain relief, but that it is associated with a higher risk of OIVI. However, these data are often taken from large databases involving a variety of different patient groups. It is not possible to accurately conclude whether the risk of OIVI is higher or lower in specific patient populations as the complication is not sufficiently common for comparisons to be made in formal trials. To acknowledge that long-acting opioids may occasionally have a place in the management of acute pain, the agreed recommendation is that 'Routine prescription of long-acting opioids for the management of acute pain is best avoided unless there is a demonstrated need, close monitoring is available, and a cessation plan is in place'.

  This is similar to the college's Choosing Wisely recommendation which applies to all prescribers of opioids, whether in hospital or in the community, and which states, 'Avoid routine prescription of slow-release opioids in the management of acute pain unless there is a demonstrated need, close monitoring is available, and a cessation plan is in place'. This also aligns with the Australian Commission on Safety and Quality in Health Care (2022) *Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard* https://www.safetyandquality.gov.au/publications-and-resources/resource-library/opioid-analgesic-stewardship-acute-pain-clinical-care-standard
  which says 'Modified-release opioid analgesics cannot be safely or rapidly titrated and their use in acute pain should be exceptional and not routine'.

  The term 'close monitoring' was used to indicate that OIVI remains a risk and that it is not appropriate to use long-acting opioids in preference to immediate-release opioids in situations where there are too few nurses to monitor the patient properly. The monitoring should be relevant to the time to peak effect of the opioid prescribed.

- Use of continuous opioid infusions was also discussed as, while they are known to increase the risk of OVI, especially in adults in general ward settings, it was recognised that they are used for management of acute pain in some patients, including young children and in some other selected patients.

Finally, it was recognised that management of analgesia needs to be tailored to the needs of individual patients. Specific information about acute pain management in some specific patient groups, listed below, can be found in the latest edition of *Acute Pain Management: Scientific Evidence*. Melbourne: Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. From: https://www.anzca.edu.au/safety-advocacy/advocacy/college-publications

a. Children
b. Pregnant or postpartum patients
c. Elderly patients
d. Aboriginal and Torres Strait Islander People
e. Māori
f. Other ethnic groups and non-English speaking people
g. Patients with sleep-disordered breathing
h. Patients with concurrent hepatic or renal disease

i. Opioid-tolerant patients
j. Patients with a substance abuse disorder
k. Patients with cognitive behavioural and/or sensory impairments

6. Summary

PS41(G) has been reviewed in the context of the significant advances in acute pain management since its last review in 2013. To better reflect the college's expectations the accompanying document has been revised and presented as a position statement rather than a guideline. While both are advisory documents it was agreed that doctors managing acute pain would derive greater benefit from an awareness of college expectations.

An additional section on analgesic stewardship has been developed and added as an appendix to the accompanying position statement.

Related ANZCA/FPM documents

PS01(PM): Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain
PG03(A) Guideline for the management of major regional analgesia (PS03)

References

The main source of information for PS41(G) was *Acute Pain Management: Scientific Evidence 2020* (Schug et al, 2020) with additional references listed in the PS41(G) Analgesic Stewardship appendix. The suggested structure for stewardship was taken from Levy et al (Levy et al, 2021).

Schug SA, Palmer GM, Scott DA et al (2020) *Acute Pain Management Scientific Evidence 5th edition.* Melbourne, Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. Available from: https://www.anzca.edu.au/safety-advocacy/advocacy/college-publications Accessed December 2020

Levy N, Quinlan J, El-Boghdadly K et al (2021) An international multidisciplinary consensus statement on the prevention of opioid-related harm in adult surgical patients. Anaesthesia 76(4): 520-36.

Process of document review

The initial draft was developed by the Document Development Group and Expert Group.

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