Managing Acute Pain for Those in Recovery

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Objectives

Participants will experience an improved comfort in treating acute pain in patients who have addiction

Participants will be able to name non-opioid treatments and opioid treatments to be used depending on a variety of painful situations

Participants will understand how to screen for other conditions that may affect pain perception

A Case

Jordan is a 45-year-old with opioid use disorder (OUD) treated with buprenorphine presenting with a displaced ankle fracture. He reports 9/10 pain, appear anxious, and ask for IV pain medication. A staff member says, “They are drug-seeking.”

What is your immediate clinical approach?

Questions

What reactions or concerns come up for you?

What information do you need before selecting treatment?

What are the risks for undertreating pain?

How can we provide analgesia without stigmatizing the patient?

- How comfortable are you treating severe acute pain in a person with active or history of addiction?

A request for analgesia is not evidence of deception or addiction-related behavior. Patients with addiction may have severe pain, opioid tolerance, withdrawal, trauma history, and prior experiences of dismissed or undertreated pain. Use the same diagnostic rigor and humane response used for EVERY patient.

Think of it as “relief seeking.”

Fundamentals

Acute pain is real whether or not a patient has a SUD, takes prescribed opioids, or has a history of nonmedical substance use.

Addiction is not synonymous with tolerance, physical dependence, or drug-seeking behavior.

People taking opioids regularly may require higher doses or more frequent dosing for analgesia because of opioid tolerance.

More Fundamentals

Withdrawal can amplify distress and pain symptoms; treating withdrawal and treating acute pain are related by not interchangeable tasks.

Undertreatment can cause suffering, loss of trust, premature discharge, unsafe self-treatment, and disengagement from care.

A multimodal plan generally combines pharmacologic and nonpharmacologic strategies, rather than forcing a false choice between “opioids only” and “no opioids.” CDC specifically recommends nonpharmacologic and nonopioid options when appropriate for people with OUD and pain.

Assumptions to Avoid

Avoid	Use Instead
“Drug Seeking”	“What is the patient’s pain condition, treatment history, and safety risk?”
“They have addiction, so opioids are contraindicated.”	“Can nonopioid measures adequately treat this pain? If not, can a time-limited opioid plan be used safely?”
Their maintenance medication covers pain.”	“Buprenorphine or methadone for OUD may not provide sufficient analgesia for a new injury or procedure.”
“Pain score alone determines treatment.”	“Use pain severity, function, diagnosis, exam, trajectory, and safety assessment.”

Replace Stigmatizing Phrases

Avoid	Use Instead
“Addict”	“Person with Substance Use Disorder” or “Person with OUD.”
“Clean/dirty urine”	“Positive/negative result.”
“Frequent flyer”	“Patient with frequent health-care utilization.”
“Manipulative”	Describe the observable behavior and UNMET NEED

Assess Pain

SCREEN BROADLY

Identify Urgent Diagnoses

Before attributing symptoms to addiction, rule out time-sensitive causes of pain:

- Trauma, fracture, compartment syndrome, spinal cord compression
- Acute coronary syndrome, aortic pathology, mesenteric ischemia
- Ectopic pregnancy, testicular torsion, ovarian torsion
- Sepsis, necrotizing infection, epidural abscess
- Acute abdomen, bowel obstruction, perforation
- Severe headache with neurological deficit, meningitis, intracranial hemorrhage.

Conduct a focused pain assessment

Use a structured approach

- Site and story: Location, onset, mechanism, prior episodes, radiation
- Severity and function: Pain score plus ability to breathe deeply, sleep, walk, eat, participate in examination, or perform essential activity
- Quality: Neuropathic descriptors (burning, electric, tingling, numbness), inflammatory or mechanical patterns; visceral or colicky pain
- Exam and trajectory: Vitals, focused PE, red flags, imaging/labs, are symptoms worsening
- Previous response: What has worked or caused adverse effects before?

Collect a History without Judgement

Key questions:

- "What substances do you use, if any? This helps me give you safe and effective pain treatment."
- "Are you taking buprenorphine, methadone, naltrexone, or other prescribed opioid?"
- "When was your last dose? What dose and schedule do you normally follow?"
- "Have you had withdrawal symptoms today?"
- "What pain medicines have helped or harmed you in the past?"
- "Have you had an overdose, sleep apnea, or serious reaction to sedating medications?"

Verify maintenance treatment and coordinate with other prescribers, but do not delay urgent analgesia while waiting for verification

Screen for Conditions Affecting Pain Perception

Pain is influenced by more than tissue injury. Consider:

Domain	Conditions or factors to screen for	Why it matters
Substance-related	Intoxication, withdrawal, opioid tolerance, recent overdose, polysubstance use	Can alter pain reporting, respiratory risk, medication needs, and monitoring
Psychiatric	Anxiety, depression, PTSD, panic, suicidality, catastrophizing	May amplify distress and pain experience; may require parallel treatment
Sleep and fatigue	Insomnia, obstructive sleep apnea, sleep deprivation	Can worsen pain and raises sedation risk with opioids
Neurologic	Neuropathy, radiculopathy, migraine, central sensitization	May shift treatment toward neuropathic or migraine-specific therapies
Medical	Renal disease, liver disease, GI bleeding risk, anticoagulation, pregnancy, infection	Determines NSAID, acetaminophen, regional anesthesia, and opioid safety
Social and trauma-related	Housing instability, interpersonal violence, trauma history, inability to obtain medications or follow up	Affects feasibility, safety, trust, and discharge planning

General Treatment Principles

FOR ACUTE PAIN

General Treatment Principles

Treat the underlying cause when possible: reduction, drainage, immobilization, antibiotics when needed, migraine therapy, or surgical consultation

Match treatment to pain mechanism and severity

Use scheduled nonopioid therapies when appropriate, rather than relying solely on as-needed rescue medication

Add nonpharmacologic interventions early

Reassess both pain and function after each intervention

Avoid therapeutic nihilism: nonopioid-first does not mean nonopioid-only

Non-opioid Options

Treatment	Best-fit Situations	Practical cautions
Acetaminophen	Many musculoskeletal, dental, postoperative, and nonspecific acute pain syndromes	Account for all combination products, use lower limits or avoid in significant liver disease/ heavy alcohol use as clinically apropriate
NSAIDs: ibuprofen, naproxen, ketorolac	Inflammatory pain, fractures, sprains, renal colic, dental pain, postoperative pain	Consider renal function, GI bleeding/ ulcer risk, anticoagulation, cardiovascular risk, pregnancy, and dehydration
Topical NSAID or lidocaine	Localized musculoskeletal pain; selected neuropathic pain	Lower systemic exposure, ensure intact skin and appropriate indication

Non-opioid Options

Treatment	Best-fit Situations	Practical cautions
Local anesthetic infiltration	Laceration repair, abscess drainage, focal injury	Consider buffering, adequate wait time, and maximum safe dose
Regional anesthesia or nerve block	Fractures, rib pain, hip pain, extremity procedures	Requires clinician skill, equipment, and monitoring, may markedly reduce opioid needs
Ketamine, low-dose analgesic use	Severe acute pain, opioid tolerance, painful procedures, selected trauma cases	Use institutional protocol, consider psychosis, uncontrolled hypertension, and monitoring needs

Non-opioid Options

Treatment	Best-fit Situations	Practical cautions
Gabapentenoids or selected neuropathic agents	Clear neuropathic component, such as burning/ electric pain	Sedation and misuse potential; avoid routine use for nonspecific acute pain and use caution with opioids
Migraine-specific therapy	Acute migraine	Consider antiemetics, triptans, and other migraine-directed protocols when clinically appropriate
Ice, heat, elevation, splinting, immobilization	Injury-related and musculoskeletal pain	Pair with medication, ensure correct diagnosis and neurovascular reassessment

Non-opioid Options

Treatment	Best-fit Situations	Practical cautions
Breathing, reassurance, positioning, trauma-informed communication	All acute pain states, particularly anxiety-amplified distress	These are adjuncts-not substitutes for analgesia
Suzetrigine (Journavx)	Adults only moderate to severe acute pain	Works on peripheral pain sodium channels, used up to 2 weeks, very expensive and requires a PA

Back to Jordan

Reasonable treatment plan:

- Reduction or immobilization and elevation
- Ice if appropriate
- Acetaminophen plus an NSAID when not contraindicated
- Hematoma block or regional block if available
- A short-acting opioid for severe pain not controlled with the above
- Clear reassessment: “Can the patient tolerate imaging, splinting, and safe discharge?”

Opioids

WHEN INDICATED

Normalize Appropriate Opioid Use

Opioids may be appropriate for severe acute pain, major trauma, postoperative pain, burns, painful vaso-occlusive episodes, or pain that remains function-limiting despite appropriately selected nonopioid therapies. Evidence and guidance support considering opioids for acute pain when needed, generally for a short duration.

Safe Opioid Principles

Continue and verify the patient

Safe Opioid Principles

In patients with opioid tolerance, titrate to effect and reassess frequently; standard opioid naïve doses may be inadequate.

Develop a clear plan: dose, interval, reassessment target, duration, and stop/step-down strategy.

Avoid combining opioids with benzodiazepines, alcohol, or other sedatives when possible; if unavoidable, use heightened caution and monitoring.

Safe Opioid Principles

Assess sedation, respiratory status, oxygenation, and risk factors such as sleep apnea, renal/hepatic impairment, advanced age, or concurrent sedatives.

Offer naloxone and overdose-prevention education at discharge when opioid risk is elevated.

Check the prescription drug monitoring program as part of safety planning, but never use it as a reason to withhold indicated emergency treatment.

For Patients Receiving MOUD

Situation	Clinical approach
Buprenorphine for OUD	Generally continue it; coordinate with the prescriber. Use multimodal analgesia and, for severe pain, add appropriately titrated short-acting opioid analgesia if needed
Methadone for OUD	Continue the verified maintenance dose; it prevents withdrawal but may not provide adequate acute analgesia. Add multimodal treatment and short-acting opioids if indicated
Naltrexone	Determine formulation and last dose. Opioid blockade can make routine opioids ineffective; severe pain may require specialty consultation and monitored strategies
Active OUD not in treatment	Treat pain and assess for withdrawal. Offer or arrange evidence-based OUD treatment; CDC notes that buprenorphine or methadone treatment for OUD can also help with concurrent pain management in this setting

Caution!!

Do not make a patient “earn” analgesia by accepting nonopioid medications first. Instead, explain the plan with transparency:

“We will treat your pain now. We will use several approaches, assess each intervention and how well you can function, and adjust treatment safely. Because you take opioids regularly, we will use a plan that is tailored to you with multiple approaches.”

Some Take-Homes

1. Believe, assess, and treat pain. Addiction changes the care plan; it does not invalidate pain.
2. Use multimodal analgesia. Combine diagnosis-specific treatment, nonopioid medications, local/regional methods, physical measures, and opioids when clinically necessary.
3. Screen beyond the pain score. Look for withdrawal, tolerance, psychiatric distress, trauma, sleep problems, medical contraindications, and urgent alternative diagnoses.

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