



Position Statement

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Care of Patients with Chronic/Persistent Pain in the Emergency Care Setting

Description

Chronic pain is pain that persists beyond normal expected healing.¹⁻³ The pathophysiology associated with chronic/persistent pain makes it difficult to treat and compels patients to seek medical intervention.^{4,5} Patients with chronic/persistent pain often turn to the emergency department (ED) for treatment of acute exacerbations. While it is difficult to discern the actual number of patients who seek treatment for chronic/persistent pain in EDs using national databases, researchers estimate that 10–16% of ED visits are due to chronic/persistent pain.³ Given that there was a total of 137.8 million ED visits in 2014,⁶ the approximate number of ED visits for chronic/persistent pain is calculated to be between 13 and 22 million visits.

Even though these estimates of ED utilization may be conservative, they provide some idea of the impact that chronic/persistent pain has on the ED, not including patients with chronic pain exacerbated by trauma or injury. The ED, which was designed for episodic treatment of acute conditions, is not the ideal setting for managing chronic healthcare problems because of limited ability to follow-up after discharge and fragmented care transitions.^{3,7} Additionally, ED providers, unlike providers who see patients on a regular basis, have limited information available to them when patients present for treatment, and this can lead to treatment plans that may be counterproductive.^{3,8,9}

Opioids have become one of the most prescribed medication classes; the number of prescriptions for opioids increased fourfold from 1999 to 2010.^{10,11} The upsurge in opioid prescribing started in the 1990s when opioids, which were previously reserved for acute and cancer pain, began to be prescribed for chronic/persistent noncancer pain.^{10,12} Opioids were advertised as a safe, effective method for chronic/persistent pain management.^{10,13,14} Their availability and affordability (in terms of direct consumer cost) compared with other options such as massage therapy, acupuncture, and cognitive behavioral therapy made them the go-to choice for chronic/persistent pain management.^{7,12} The liberal prescribing practices for opioids have been associated with an increase in opioid overdoses.^{11,15} In 2016, there were over 40,000 overdose deaths attributed to opioids.¹⁵ The high mortality associated with opioid use has created a national awareness of the dangers associated with long-term opioid use and national efforts to curb opioid use.^{2,10}

ENA Position

It is the position of the Emergency Nurses Association that:



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1. Pain is what the patient says it is and when the patient says it is occurring.
2. Education regarding the care of patients with chronic/persistent pain is essential for emergency nurses to provide safe and quality care.
3. Emergency nurses support the use of evidence-based assessment tools appropriate for selected patient populations with chronic/persistent pain.
4. Patients with chronic/persistent pain require a comprehensive pain assessment that includes an assessment of how physical or social function is affected in addition to a numerical rating score.
5. Emergency nurses collaborate with other healthcare professionals, which may include, but are not limited to physicians; risk management, case management, and pain management specialists; and alternative care providers, in the development of treatment guidelines for the management of the chronic/persistent pain patient in the emergency setting.
6. Thorough documentation is an essential form of effective communication and one of the building blocks for safe and therapeutic care of patients with chronic/persistent pain.
7. Emergency nurses care for chronic/persistent pain patients in a manner consistent with the emergency nursing code of ethics, which emphasizes human dignity and respect.
8. Development of a frequently updated interstate prescription drug monitoring program is needed to promote emergency department safe prescribing practices for opioids in the treatment of chronic pain.

Background

Chronic pain is pain that persists after healing is expected to have occurred, usually longer than three months, and it often occurs without any identifiable cause.^{1,2,3,16} Chronic/persistent pain, unlike acute pain, does not have any apparent biological purpose.¹⁷ Over time, chronic/persistent pain is associated with changes in the way the brain processes pain signals and these changes may have a role in the maintenance of pain.¹⁸ Chronic pain can be difficult to treat, necessitating multiple visits for care from multiple providers.

Chronic/persistent pain that is not well controlled can affect physical and psychological functioning.^{2,13} In an effort to manage chronic/persistent pain, opioids, which were previously reserved for acute and cancer pain, began to be prescribed with increasing frequency in the 1990's.^{10,12} During this time there was also an expectation from regulatory agencies that pain would be addressed and managed; pain became known as the fifth vital sign.¹³ The focus on pain and change in opioid prescribing for



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chronic/persistent pain had several unintended consequences. Opioids became the first and, in some cases, the only treatment for chronic/persistent pain. This led to higher opioid prescribing: more prescriptions were written,¹¹ for a longer duration, and at higher opioid dosages.² The higher opioid prescribing led to an increased number of opioid overdoses.^{11,15}

Approximately 25% of patients with chronic/persistent pain receive their medications from the ED.⁷ While patients with chronic/persistent pain may seek treatment in EDs, the ED is not an ideal setting for the treatment of chronic/persistent pain. The ED, which is structured to perform “fast-paced assessment and treatment” of patients,³ is not an environment that is conducive to performing the multidimensional assessment that is needed prior to prescribing opioids for chronic pain.⁷ Although EDs are always open, providers work in rotating shifts and do not directly communicate with primary care providers. This leads to poor continuity and coordination of care that is essential in the treatment of chronic pain. Rayner et al.¹⁹ found, in a cross-sectional study of patients (n = 1204), a high prevalence of depression (60.8%) associated with chronic pain. When associated with chronic pain, depression led to increased healthcare utilization and decreased pain acceptance¹⁹ – meaning that patients with depression were more focused on eliminating or avoiding their pain. Rayner et al.¹⁹ suggest that treating depression is important in the successful management of chronic pain.¹⁹ However, EDs, which are focused on stabilizing immediate life-threatening complications of disease and traumatic injuries, do not have the capacity to adequately assess for comorbid conditions like depression that may complicate chronic pain treatment.

The increased awareness of opioid misuse, addiction, and overdose has made some providers reluctant to prescribe opioids. While some patients who are discharged from EDs with opioids are at increased risk for opioid misuse, defined as taking more than the prescribed number or amount of opioids, obtaining additional opioids without a prescription, or using the opioids to treat conditions other than pain,²⁰ this does not apply to all patients. Each patient is unique in their response to pain and the treatment of pain⁷ and there are known gender differences in pain and pain treatment.²¹ Opioids, while they should not be the first option or used in the long-term management of chronic pain, should not be completely excluded either. Blanket policies prohibiting the prescription of opioids for chronic pain may lead some patients to search for alternative options for pain control. Dart et al.,²² in a secondary analysis of data obtained from the Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS) System, found that heroin use increased when prescriptions for opioids decreased, suggesting drug substitution.

There are no easy answers when deciding to prescribe or not prescribe opioids for chronic pain. Current evidence suggests that there is no significant difference in pain-related function for moderate to severe chronic back, hip, or knee pain ($p = .58$).²³ Furthermore, adverse medication related symptoms were more common in those patients who received opioids ($p = .03$).²³

However, there are certain instances when opioids may be deemed to be the most effective method of pain control. In these instances, the benefits and risks of opioids must be considered individually for

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each patient prior to writing a prescription. Misconceptions about the risk opioids pose still exist,²⁴ and it is the responsibility of healthcare providers to discuss these risks and alternative treatment options with patients prior to prescribing opioids for chronic pain. Risk mitigation involving state prescription drug monitoring programs, where available, may be of assistance in determining patients who could be at increased risk for opioid misuse^{7,25} and should be used. It is important that providers be aware that some combinations of medications such as opioids and benzodiazepines are risky combinations that put patients at increased risk of diversion.²⁵

Self-reported pain is subjective, and vital signs may not be a reliable measure to quantify the amount of pain someone is having.¹⁶ Self-reported pain occurs however the patient expresses it.¹⁶ As professionals, it is important that emergency nurses continue to use evidence-based methods for assessing and documenting pain. All patients have the right to be treated in a professional manner and to be educated on their condition and available treatments even if opioids are not indicated. Todd et al.²⁶ found that more than three-fourths of patients who visited an ED desired information on pain management and specialty referral. Providing this education and referral to patients conveys that emergency nurses care and believe patients have pain.

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