**APMS Evidence-Based Pain Management Recommendations**

APMS patients are those who are at high risk for or are experiencing uncontrolled pain. Patients falling into that category (moderate to severe pain) should receive the following:

1.  Every patient should be on acetaminophen unless contraindicated, such as with hepatic disease.  This should be in the form of a combination product, such as Norco (hydrocodone/APAP) or Percocet (oxycodone/APAP), unless the patient has failed therapy with hydrocodone and/or oxycodone.  If that is the case, consider PO morphine (equipotent dosing to hydrocodone) plus acetaminophen separately.

2.  Every patient should be on ketorolac or another NSAID unless contraindicated, such as with renal disease or high risk for bleeding. If a contraindication exists with an NSAID, consider a COX-2 inhibitor, unless contraindicated.  In elderly patients undergoing surgeries with high risk of postoperative renal dysfunction (such as thoracotomies), if ketorolac is not initially ordered at a reduced dose, then re-evaluate kidney function on POD 1 and consider adding ketorolac if renal function did not decline.

3.  For patients who take opioids chronically, order their home doses on admission to be started immediately post-operatively if it is highly likely they will be able to take PO shortly after surgery.  If they will most likely have to remain NPO for a period of time after surgery, initiate PCA with a basal rate during their NPO period.  In order to determine the basal rate, the BSW pharmacy homepage has a link to an opioid conversion calculator (<http://clincalc.com/Opioids/>). Perform the opioid conversion and the basal rate should be the IV equivalent of approximately 1/3 to 1/2 of the daily PO dose. The breakthrough demand dose should exceed the 24 hour equivalent to their PO dose in order to effectively cover their postoperative pain in addition to their baseline chronic pain.  Convert the PCA back to PO as soon as the patient is taking PO dependably. (If you have any questions regarding these conversions, please contact APMS staff or any of the PMT/APMS nurses.)

4.  Use your adjuncts effectively.  If there is a neuropathic component, add gabapentin or pregabalin.  If they have anxiety, withdrawal, or muscle spasms with persistently high pain scores, consider adding anxiolytics for opioid synergy or muscle relaxants.  If they are having uncontrolled pain and poor sleep, consider adding low-dose nortriptyline, which is effective for both with few side effects.

5.  Always ask "Do you feel like your pain is well-controlled?"  This is a different question than, "Are you having pain?" Some have chronic pain.  They may report a pain score of 6, which means that they are having moderate pain, so you may assume their pain is not adequately controlled.  However, if their usual daily pain score at its very best is a 6, then they may perceive that their pain is well controlled at a 6 out of 10.  If they are usually pain free, then a pain score of a six means you have some work to do.  You need the patient's perspective in order to meet their needs.  Also ask, "Do you feel like we are doing everything we can to manage your pain?"  They are more likely to report non-timely medication dosing or inadequate duration of action for this question.  If nursing is busy and the patient has to wait an hour each time they ask for pain medication, discuss this with the nurse or consider starting a PCA.  If they say their intermittent dosing is not lasting long enough, consider more frequent dosing or changing the medication from a shorter acting opioid (fentanyl) to a longer acting opioid (morphine or hydromorphone).  You can't fix a problem that you don't know exists.

6.  Communication is key.  If the patient reports dissatisfaction with their pain tell them what you are doing to try to fix it.  Ask the APMS nurse to pay special attention and follow up with those patients first after rounds and notify you if the pain is not improved.  Also, you must let the primary team know when you make changes to opioid dosing on rounds, especially adding a basal rate.  They may be aware of adverse effects (hypersomnolence, nausea) that may not have been reported to you.