

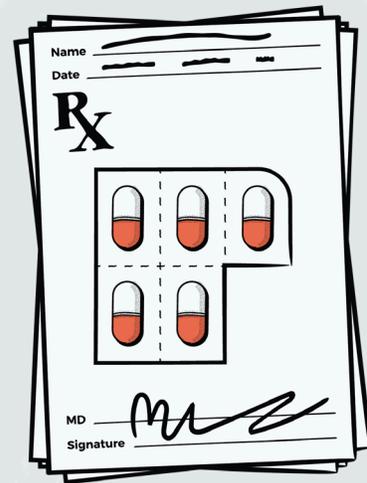
Acute Pain Management: Resources for Providers

Acute pain, often defined as pain lasting 4 weeks or less, may be experienced by patients of all ages due to a variety of different conditions. Decisions regarding pain management should be approached together by a provider and patient, with the selection of a pain management strategy that optimizes benefits while minimizing risks.

The recommendation statements offered here are intended to serve as a reference for providers in the management of acute pain. CDC reviewed and selected these recommendations from larger clinical practice guidelines based on their relevance to the acute pain condition of focus and the management of pain specifically in the acute setting.

Avoid Opioid Therapy When Possible

Long-term opioid use often begins with the treatment of acute pain. Even just three days of opioid treatment can increase the likelihood of chronic opioid use.¹ However, acute pain can often be managed without opioids.



Acute Low Back Pain

Low back pain (LBP) is very common, causing more global disability than any other condition.² LBP is frequently classified based on several clinical characteristics, including duration of symptoms. Acute back pain is often defined as lasting less than 4 weeks. Subacute back pain lasts 4 to 12 weeks. Most patients with acute or subacute low back pain improve over time regardless of treatment.³ If a patient seeks treatment, providers and patients should first consider nonpharmacologic treatments. These include superficial heat, massage, and spinal manipulation to relieve pain.³

If pharmacologic treatment is desired, providers and patients should select nonsteroidal anti-inflammatory drugs (NSAIDs) or skeletal muscle relaxants.³



Ankle Sprains

Ankle sprains are a very common musculoskeletal injury, with roughly half of all patients experiencing this injury seeking medical care.⁴ Pain related to most ankle sprains can often lessen within 2 weeks,⁴ and evidence shows that nonopioid treatments like acetaminophen or ibuprofen can be more effective than opioids in managing pain.⁵



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Acute Migraine

Migraines are a very common condition, with 15.3% of Americans aged 18 years or older reporting a migraine or severe headache in the previous 3 months.⁶ Migraines can be severely debilitating and are considered one of the main causes of disability worldwide.⁷

There are many effective, evidence-based migraine treatments.⁸ Clinicians must consider medication efficacy, potential side effects, and potential medication-related adverse events when prescribing acute medications for migraine.⁸

MEDICATIONS FOR TREATING ACUTE MIGRAINES

Specific medications, such as **triptans** and **dihydroergotamine**, are effective treatments for acute migraines.⁸

Effective non-specific medications include **acetaminophen, NSAIDs, sumatriptan/naproxen**, and the combination of **acetaminophen/aspirin/caffeine**.⁸

Although opioids, such as **butorphanol, codeine/acetaminophen, and tramadol (with or without acetaminophen)**, are probably effective, they are not recommended for regular use.⁸

Intravenous metoclopramide and **prochlorperazine** and **subcutaneous sumatriptan** should be offered to eligible adults who present to an emergency department with acute migraine.⁹

Injectable morphine and **hydromorphone** are best avoided as first-line therapy because of lack of evidence demonstrating efficacy and concern about **subacute or long-term sequelae**.⁹

To learn more about prescribing patterns for select acute pain conditions, refer to *Indication-Specific Opioid Prescribing for US Patients with Medicaid or Private Insurance*.¹⁰

Cited recommendations represent current best practices from professional organizations as evaluated by CDC and should not be considered CDC-authored or CDC-endorsed content, unless expressly stated. The information provided on this fact sheet is not intended to be a substitute for the medical judgment of a clinician caring for a specific patient and does not indicate an exclusive course of action or treatment.

¹ Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. *MMWR Morb Mortal Wkly Rep* 2017;66:265–269.

² Hoy D, March L, Brooks P et al. The Global Burden of Low Back Pain: Estimates from the Global Burden of Disease 2010 Study. *Ann Rheum Dis*. 2014 Jun;73(6):968–74.

³ Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline from the American College of Physicians (2017)

⁴ van Rijn RM, van Os AG, Bernsen RM et al. What is the Clinical Course of Acute Ankle Sprains? A systematic literature review. *Am J Med*. 2008 Apr;121(4):324–331

⁵ Chang AK, Bijur PE, Esses D et al. Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department: A Randomized Clinical Trial. *JAMA*. 2017 Nov 7;318(17):1661–1667.

⁶ Burch R, Rizzoli P, Loder E. The Prevalence and Impact of Migraine and Severe Headache in the United States: Figures and Trends From Government Health Studies. *Headache*. 2018 Apr;58(4):496–505.

⁷ CBD 2016 Headache Collaborators. Global, Regional, and National Burden of Migraine and Tension-Type Headache, 1990–2016: a Systematic Analysis for the Global Burden of Disease Study 2016. *Lancet Neurol*. 2018 Nov;17(11):954–976

⁸ Acute Treatment of Migraine in Adults: The American Headache Society Evidence Assessment of Migraine Pharmacotherapies (2015)

⁹ Management of Adults With Acute Migraine in the Emergency Department: The American Headache Society Evidence Assessment of Parenteral Pharmacotherapies (2016)

¹⁰ Mikosz CA, Zhang K, Haegerich T, Xu L, Losby JL, Greenspan A, Baldwin G, Dowell D. Indication-Specific Opioid Prescribing for US Patients with Medicaid or Private Insurance, 2017. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2765703?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=051120