CO's CURE:

Hospital Medicine and Inpatient Family Medicine

Discuss functional goals for pain, set realistic expectations and use empathic language. Use clinical judgement when applying these guidelines, which are a supplement (not a substitute) for the work-up and treatment of the underlying cause of pain. Whenever possible, offer non-pharmacologic comfort items like movies, music, games, massagers, etc. Continue outpatient chronic opioid therapy in opioid-tolerant patients if appropriate and after confirming use with PDMP. Modify the pain plan as appropriate at discharge. The following recommendations may not be appropriate for patients on hospice, with sickle cell crisis, cancer-related pain or peri-operative pain.

Pleuritic Pain

For pneumonia, pulmonary embolism, inflammatory pleurisy or uncomplicated rib fracture

First-Line Therapy:

Heating pad

Hold pillow during splinting

Ibuprofen 400-600 mg PO Q 6 hr*

Acetaminophen 1000 mg PO TID

Lidocaine 5% topical patches 1-3 TD daily

Second-Line Therapy:

Ketorolac 15 mg IV Q 6 hr x 5 days max as alternative to oral NSAID*

Consultation for nerve blocks if rib fracture with refractory pain and/or risk of respiratory deterioration

Extremity Pain

For cellulitis, deep vein thrombosis or neuropathy

First-Line Therapy:

Elevate the extremity if appropriate

Acetaminophen 1000 mg PO TID

Ibuprofen 400-600 mg PO Q 6 hr*

Gabapentin 100-300 mg PO 1-3x daily

Lidocaine 5% topical patches 1-3 TD daily if localized pain with intact skin

Second-Line Therapy:

Ketorolac 15 mg IV Q 6 hr x 5 days max as alternative to oral NSAID*

Lidocaine 1 mg/kg/hr IV infusion over 24 hours if severe neuropathy or ischemia

If chronic neuropathy, consider adding duloxetine 30 mg PO daily

Pain Pathways by Indication continued

Abdominal Pain

For non-pregnant patients without a gastrointestinal bleed, perforation or obstruction. Suspected etiology should guide appropriate pain treatment.

First-Line Therapy:

Heating pad

Bowel regimen if constipation

Ambulation

Acetaminophen 1000 mg PO/PR TID

Famotidine 20 mg IV BID

Simethicone 80 mg PO QID

Carafate 1 g PO AC and QHS

Ketorolac 15 mg IV Q 6 hr x 5 days max*

Ondansetron 4 mg IV/PO Q 6 hr PRN, prochlorperazine 5 mg IV/PO Q 6 hr PRN, or metoclopramide 5 mg IV/PO Q 6 hr PRN if nausea

Second-Line Therapy:

Haloperidol 1-2 mg IV/PO Q 4 hr PRN if uncontrolled nausea

Dicyclomine 10-20 mg IM/PO TID

Capsaicin 0.075% topical cream TID

If chronic pain, add duloxetine 30 mg PO daily or amitriptyline 10 mg PO QHS. Consider outpatient pain psychology or pain specialist referral.

Musculoskeletal Pain

For joint/arthritis and muscular/myofascial pain

First-Line Therapy:

Heating pad or ice

Menthol topical cream QID

Acetaminophen 1000 mg PO TID plus Ibuprofen 400-600 mg PO Q 6 hr*

Cyclobenzaprine 5 mg PO TID

Therapeutic mobility and exercise, PT or OT consult if pain is limiting function

Second-Line Therapy:

Ketorolac 15 mg IV Q 6 hr x 5 days max as alternative to oral NSAID*

Lidocaine 5% topical patches 1-3 TD daily

Diclofenac 1% gel 2-4 g Q 8 hr if not on IV or PO NSAIDs

Gabapentin 100-300 mg PO 1-3x daily

If chronic pain, add duloxetine 30 mg PO daily. Consider outpatient pain psychology or pain specialist referral

Consider specialty consult for septic and/or acute autoimmune arthritis

Third-Line Therapy:

Ketamine 25-50 mg PO Q 8 hr PRN for complex regional pain syndrome after failing opioid therapy

Renal Colic

For nephrolithiasis pain

First-Line Therapy:

Heating pad or ice

Ketorolac 15 mg IV Q 6 hr x 5 days max*

Acetaminophen 1000 mg PO TID

Second-Line Therapy:

Cyclobenzaprine 5 mg PO TID

Tamsulosin 0.4 mg PO daily until stone passage

Lidocaine 1 mg/kg/hr IV infusion over 24 hours

Desmopressin 0.4 mg PO daily when NSAIDs are contraindicated

* *Evaluate gastric ulcer risk prior to starting NSAIDs, especially if on concomitant therapeutic anticoagulation.*

These treatment pathways are not intended to, nor should they, replace clinician judgement or clinical expertise. They are a guide to treatment options that may be considered, in the context of a patient's clinical condition and comorbidities, for the treatment of patients in pain.

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