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Optimizing Acute Pain Relief: Nonopioid Pharmacotherapy for Adults

Dr. Walker:
Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Robert Walker, and joining me to discuss nonopioid pharmacotherapy for acute pain in adults is Dr. Eric Schwenk. Dr. Schwenk is a Professor of Anesthesiology and Orthopedic Surgery and the Director of Acute Pain Management Service and Orthopedic Anesthesia at Thomas Jefferson University in Philadelphia.

Dr. Schwenk, thanks for being here today.

Dr. Schwenk:
Thanks a lot for having me.

Dr. Walker:
To start us off, Dr. Schwenk, can you tell us about the key principles of multimodal opioid-sparing analgesia and how they influence perioperative pain management strategies?

Dr. Schwenk:
Sure. So multimodal analgesia is basically the cornerstone of acute pain management at this point. We've come a long way from the days where we were very reliant on opioids, and it's kind of an opioid-first mentality in light of the opioid crisis as well as just a general desire to reduce the amount of opioids being used and, in particular, minimize their side effects—not just the respiratory depression and things like that that are fatal and serious but also some of the more bothersome side effects: the nausea, vomiting, the constipation, and sedation. It's quickly become kind of the standard. And multimodal analgesia at its core is basically the use of multiple medications from different classes with different mechanisms of action that are used together for a synergistic benefit, so you get improved analgesia compared to any of the individual agents alone, and you, hopefully, reduce opioid use at the same time and thereby reduce the side effects of opioids, but you can also reduce the side effects of any of the individual classes by hopefully keeping the doses at well-tolerated levels.

Dr. Walker:
And with that in mind, what are the most significant benefits worth emphasizing of integrating nonopioid analgesics into a multimodal approach for acute pain in those hospitalized patients?

Dr. Schwenk:
So one of the things is just improved pain control. I guess it's a fairly obvious thing, but there's pretty good evidence in multiple types of surgeries in the peri-op environment that multimodal analgesia results in improved pain control compared to using opioids alone or any other modality alone, so pain control will tend to be better, which is indirectly going to lead to improved patient satisfaction. Other things would be the actual reduction in opioids itself and all the side effects that go along with it. And we mentioned nausea, vomiting, constipation and itching, those sorts of things. Those things will all likely be reduced if you can reduce opioids in a substantial way.

Dr. Walker:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Robert Walker, and I'm speaking with Dr. Eric Schwenk about nonopioid pharmacotherapy for acute pain in adults.

Now if we zero in on a particular population, Dr. Schwenk, what's the recommended pharmacotherapy for patients without contraindications who experience post-op pain or nonsurgical acute pain?

Dr. Schwenk:
So it's a great question, and sometimes I like to just go back to the basics. Sometimes people forget the WHO analgesic ladder, which is a very old kind of framework to think about pain control. But basically, that framework directs us to start all patients without contraindications on acetaminophen and a nonsteroidal anti-inflammatory drug as just a baseline for pain control before we escalate up the ladder to agents that are potentially more risky or have other side effects and issues associated with them, so any patient without the contraindication or allergy should be getting acetaminophen and multimodal analgesia with nonsteroidal anti-inflammatory drugs around the clock.

I also just add the comment that they should be getting those drugs in a not as-needed fashion. They should be getting them scheduled because what happens is if those drugs are ordered as needed, then a lot of times if a patient has moderate or severe pain, the patient's nurse will go for the opioid or the apparently stronger drug first, and a lot of times the acetaminophen and the nonsteroidal will get skipped, and that's a problem sometimes. We're not necessarily saying that patient's pain is going to be all controlled with Tylenol alone, but those should form kind of the basis and the underlying background for all those patients, and then you sort of escalate up from there.

But there's lots of other medications classes that can be used. Local anesthetics, for example. Lidocaine infusions are a great tool that we use a lot to help with pain control, especially inflammatory pain, but lots of other pain as well, especially abdominal pain and things like that. It may help with bowel function. Ketamine and NMDA antagonists. Ketamine is kind of the prototypical one that is very effective for moderate or severe pain. For really severe pain in the hospitalized patients, ketamine is one of the strongest tools in our toolbox. So that's kind of the approach that we take at least to start off.

Dr. Walker:
Now if we take a step back and look at the bigger picture here, can you tell us how you tailor nonopioid analgesic options based on patient-specific factors and the expected degree of pain?

Dr. Schwenk:
Yeah. So I think there are certain factors that we know are associated with poorer pain control postoperatively. It depends on the invasiveness and the pain associated with that particular surgery. So like a like an ear, nose, throat surgery versus like a 5-level spinal decompression and fusion, it's going to be quite different in terms of the expected pain, right? So opioid tolerance.

But on top of the amount of opioid use is just the patient's kind of state and preoperative pain level. So if you talk to the patient preoperatively in the holding area before you go back for surgery and get a sense of how much pain is that patient experiencing on that day, that itself will be a predictor of potentially of how much medication will need to be used postoperatively.

Dr. Walker:
Before we close, Dr. Schwenk, is there anything else you'd like to leave with our audience today?

Dr. Schwenk:
What I would say is that in medicine and in this area as well, the pendulum always swings, so I think that when it became apparent that the opioid crisis was a big problem and a public health problem that needed to be tackled, the pendulum kind of quickly swung towards opioid sparing, reducing opioids, minimizing it, and I think it swung back a little bit since then. So there were lots of efforts to reduce opioid use on a chronic outpatient basis, but also in the hospital as well we extended some of these principles: Let's see what we can do to reduce it, substitute, minimize things. Opioid-free anesthesia is another popular thing that's been studied.

Dr. Walker:
With those final thoughts in mind, I want to thank my guest, Dr. Eric Schwenk, for joining me to discuss nonopioid pharmacotherapy for acute pain in adults.

Dr. Schwenk, it was great having you on the program.

Dr. Schwenk:
Pleasure being here. Hopefully, we can help some people and give them some useful information.

Dr. Walker:
For ReachMD, I'm Dr. Robert Walker. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.