Prescribing opioids for acute pain is associated with an increased likelihood of long-term opioid use. To minimise the initial opioid exposure, keep the duration of treatment as short as possible and the total dose as low as possible. This also minimises the risk of overdose and the likelihood of diversion/inappropriate use; however, severe untreated acute pain may lead to the development of chronic pain.

### Goal
The goal for prescribing opioids in acute pain should be a tolerable level of pain that facilitates optimal physical and emotional function and avoidance of complications.

### Before Prescribing Opioids
- Undertake comprehensive assessment.
- Promote and optimise non-pharmacological strategies for acute pain.*
- Optimise non-opioid therapy when benefits outweigh risks to maximise analgesia and reduce opioid requirements.
- Exercise caution when prescribing opioids for older or debilitated patients.
- Consider and address underlying anxiety and depression.

**Absolutely avoid**
- Co-proxamol.2,3

**Avoid**
- Compound analgesics.2 Prescribing separately gives flexibility in both adjustment of doses and in the selection of most appropriate combination.
- Modified-release opioid preparations.4
- Oxycodone as first line.
- Co-prescribing medications with sedating properties, whenever possible. In particular, avoid co-prescribing with benzodiazepines due to increased risk of potentially fatal overdose5 and with gabapentinoids due to increased risk of CNS depression.6,7

### Dose
- Refer to local acute pain guidelines.*
- Prescribe lowest effective dose of immediate-release opioid for the expected duration of the pain severe enough to require opioids.6
- Use age related dose if prescribing morphine or oxycodone.*
- Adjust dose for clinical factors such as renal or hepatic insufficiency and pain intensity.
- With prn opioids include maximum daily amount or frequency of doses.8
- Avoid making dose increases under pressure: A team decision for complex patients shares the load.

### Duration
- Each day of unnecessary opioid use increases the likelihood of physical dependence without added benefit.9

**Prescribe**
- For the expected duration of the pain severe enough to require opioids or until a follow-up appointment is scheduled. Duration of 3 days or less is usually sufficient. A duration of more than 7 days is rarely needed.5
- Aim to stop strong opioids commenced for post-operative pain within 7 days of surgery. Duration of opioid prescription post-surgery, not dose, is a more significant risk factor for subsequent opioid misuse.9
- Review diagnosis and treatment plan if severe acute pain continues longer than expected. Consider seeking advice.

**Avoid**
- Placing opioids on repeat prescriptions for acute pain - opioids should be a course of treatment with a definitive end date.
- Prescribing additional opioids in acute pain for the ‘just in case’ scenario.

### Provide Patient Information
- **Benefit and risks** of opioid therapy and alternative options.
- **How to use opioids.**
- **Driving impairment and opioid safety**
- Requirements for review and monitoring.
- **How to taper and discontinue opioids.**
- To take unwanted or unused opioids back to a community pharmacy or dispensary to minimise risks of diversion and inappropriate use.

### References
8. NICE NG 46, (2017). Controlled Drugs: safe use and management

### Further Information
*WSCCG Acute Pain Ladder or WSCCG Chronic Pain Ladder