EDITORIAL

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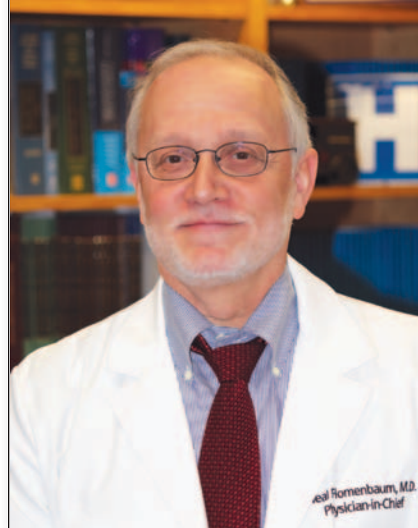

The Pain Continues

A spate of recent articles about the inadequacies of ED pain management and the problems resulting from pain med prescriptions reminded me of a long-ago comment by a hospital CEO that his "favorite" hospital complaint was "The food here is terrible and the portions are way too small."

Racial, ethnic, and age-related disparities in ED pain management are documented in two recent peer-reviewed studies. A report in the *Annals of Emergency Medicine* (published online ahead of print Oct. 25, 2011) titled "Older US emergency department patients are less likely to receive pain medication than younger patients…" analyzed 2003-2009 National Hospital Ambulatory Medical Care Survey (NHAMCS) data for more than 88,000 pain-related ED visits. After adjusting their analysis for severity of pain, sex, race, and ethnicity, the authors found that patients ≥ 75 years old only received analgesia for pain-related visits 49% of the time, compared with 68.3% for those between ages 35 and 54. Even among patients reporting severe pain, those ≥ 75 were 12.4% less likely to receive analgesics than the 35-to-54 age-group.

The situation is equally concerning at the other end of the age spectrum. For children, though, the main factors appear to be race and ethnicity, rather than age. A study presented at the Pediatric Academic Societies annual meeting in April (session 1655; April 28, 2012; Boston), "Racial and ethnic disparities in the management of pediatric abdominal pain," also utilized NHAMCS data from 2006-2009, adjusted for confounders. The authors found that among patients ≤ 21 presenting with abdominal pain, black children were less likely to receive analgesia than white children, even when the pain was rated ≥ 7 out of 10.

Both of these studies indicate very disturbing nonmedical influences that we may be bringing to work with us. But they should come as no surprise to anyone following the medical literature on pain treatment for the past decade. In a February 2008 editorial, "A painful reminder," I wrote about results of a 13-year study published in *JAMA* (2008;299[1]:70-78) that found that the use of opioid analgesics in 2005 was 12% higher than it had been in 1993. This suggested a more enlightened attitude toward pain management, except for black and Hispanic patients, who received opioids 7% less often than white patients.

One difference between the earlier and latest studies is a new deemphasis on opioids (as opposed to all analgesics) as indicators of serious attempts at pain management. The problems associated with the ED administration and prescribing of opioid analgesia, and some government initiatives to curb their proliferation, have been the focus of recent articles in the lay press. On April 30, the *New York Times* reported that "E.R. doctors face [a] quandary on painkillers" in deciding what and how much to give patients complaining of dental pain during off hours. Typically, such patients ask for small amounts of opioids "to take the sting off" until they can see a dentist. The lack of objective testing and definitive treatment for some painful conditions in overcrowded EDs is an ideal situation for drug seekers to exploit.

To curb the increasing number of ED pain med prescriptions, many states are considering or enacting measures that require EPs to consult registries of all opioid prescriptions previously filled by patients before prescribing new ones. Some states are also recommending or requiring EDs to post waiting room notices stating that only limited (3-day) courses of short-acting painkillers will be prescribed in the ED, and that no lost or stolen prescriptions will be refilled.

Where does all this leave us at present? To paraphrase the patient complaint about hospital food, The pain meds we prescribe are terrible; in some cases, the portions are way too small and in other cases we're giving them to the wrong people. **EM**