

Journal Club #1: October 14, 2025

ED OPIOID PRESCRIBING: SUMMARY

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PRESENTERS

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STUDY CITATION

Daoust R, Paquet J, Émond M, et al. Opioid prescribing requirements to minimize unused medications after an emergency department visit for acute pain: a prospective cohort study. CMAJ. 2024 Jul 15;196(25):E866-74.

STUDY SNAPSHOT

Design: Prospective, multicentre cohort study

Setting: 7 Canadian EDs (6 academic, 1 community)

Patients: 2,240 adults discharged from ED with opioid prescription for acute pain (<2 weeks duration)

Follow-up: 14 days using real-time medication diary + phone interview

Primary Outcome: Quantity of opioids consumed (converted to morphine 5mg tablet equivalents)

KEY RESULTS

Overall Findings

- Median consumption: 5 morphine 5mg tablets (IQR 1-14) over 14 days
- Median prescribed: 16 tablets
- Unused opioids: 63% of prescribed tablets remained unused
- Duration of use: 67% used opioids on day 1 → only 12% still using on day 14

Consumption by Pain Condition (14-day median)

| Pain Condition | Tablets Consumed | To Meet 80% of Patients' Needs |
|----------------|------------------|--------------------------------|
| Renal colic | 2 (IQR 0-6) | 8 tablets |
| Abdominal pain | 2 (IQR 0-6) | 8 tablets |

| | | |
|----------------|--------------|------------|
| Fractures | 9 (IQR 2-20) | 24 tablets |
| Back pain | 8 (IQR 3-18) | 21 tablets |
| Neck pain | 6 (IQR 2-16) | 17 tablets |
| Other MSK pain | 6 (IQR 2-15) | 16 tablets |

Note: No significant difference by age or sex

RECOMMENDED PRESCRIBING QUANTITIES

Full & Partitioned Prescriptions (14-day supply)

| Opioid Type | Renal Colic/Abd Pain | Fracture/Back/Neck/MSK |
|-------------------|----------------------|------------------------|
| Morphine 5mg | 8 (dispense 4) | 24 (dispense 12) |
| Oxycodone 5mg | 5 (dispense 3) | 16 (dispense 8) |
| Hydromorphone 1mg | 10 (dispense 5) | 30 (dispense 15) |
| Codeine 30mg | 9 (dispense 5) | 27 (dispense 13) |
| Tramadol 50mg | 8 (dispense 4) | 24 (dispense 12) |

Partitioned Dispensing Strategy:

- Prescribe recommended total quantity
- Request pharmacy dispense half initially
- Patient returns for remainder if needed
- Consider adding prescription expiration date (14 days)

STUDY STRENGTHS

- ✓ Large, multicentre cohort (n=2,240)
- ✓ Real-time diary reduces recall bias (validated: ICC 0.78)
- ✓ Prospective design establishes temporal relationship
- ✓ Includes diverse pain conditions
- ✓ Practical, implementable recommendations

STUDY LIMITATIONS

- X Selection bias (only 21% of eligible enrolled)
- X Predominantly Quebec (78%), French-speaking (86%), urban populations
- X Well-educated sample (68% college/university)
- X Small neck pain subgroup (n=65)
- X Hawthorne effect (knowing they're tracked may reduce use) and social desirability bias (taking fewer opioids to please their doctor)
- X Reasons for stopping opioids not recorded
- X No long-term follow-up for chronic opioid use

APPLICABILITY TO MANITOBA PRACTICE

Generalizable Elements:

- Pain physiology and opioid needs are universal across populations
- Multi-center Canadian study in similar healthcare system
- Condition-specific recommendations biologically plausible

Manitoba-Specific Considerations:

Urban Winnipeg EDs (HSC, St. Boniface, Grace):

- Recommendation: Implement reduced prescribing using study guidelines
- Partitioned dispensing feasible with pharmacy access
- Monitor outcomes through local QI data

Rural/Remote Manitoba:

- Caution: Limited pharmacy access may make partitioned dispensing impractical
- May need slightly higher initial quantities given barriers to refills
- Emphasize safe storage and disposal education
- Consider telehealth follow-up options
- Consider giving narcan kit concurrently

Indigenous Populations:

- Under-represented in study (no specific data reported)
- Engage community stakeholders before implementation
- Consider cultural safety in pain management approach
- May require modified protocols in Northern nursing stations

BOTTOM LINE FOR PRACTICE

Current Problem:

We are over-prescribing opioids. Typical ED prescription is 16 tablets; median patient uses only 5, leaving 63% unused and available for diversion/misuse.

Recommended Change:

INSTEAD OF: "Prescribe 30 oxycodone 5mg, refill x 1 prn"

TRY THIS:

For renal colic/abdominal pain:

- Rx: Oxycodone 5mg, quantity 5 tablets
- Sig: Take 1 PO q4h prn pain
- "Please dispense 3 tablets initially; patient may return for remaining 2 within 14 days if

needed"

For fractures/back pain/MSK injuries:

- Rx: Oxycodone 5mg, quantity 16 tablets
- Sig: Take 1-2 PO q4h prn pain
- "Please dispense 8 tablets initially; patient may return for remaining 8 within 14 days if needed"

Additional Strategies:

1. Co-prescribe non-opioid analgesics: Study showed high NSAID (44%) and acetaminophen (48%) use
2. Patient education: Counsel on expected pain course, safe storage, proper disposal
3. Reassessment plan: Clear instructions for returning if pain not controlled
4. Document rationale: Note condition-specific prescribing in chart

DISCUSSION POINTS

- Is the 80% threshold appropriate, or should we aim higher/lower?
- What are barriers to implementing partitioned dispensing in our setting?
- How do we balance harm reduction with ensuring adequate pain control?
- Should we collect local Manitoba data to validate these findings?
- Do we need different protocols for patients with substance use history?
- Should we be spending more time on prevention and education when prescribing opioids from the ED?

ACTIONABLE NEXT STEPS

- Review your current opioid prescribing patterns
- Consider reducing quantities for next appropriate patient
- Use an analgesic ladder and write out prescriptions for non-opioids even if available over the counter
- Consider decreasing Tylenol-#3 prescribing (15% population non-metabolizers; adding codeine 60mg to acetaminophen increases the proportion of patients achieving adequate pain relief by only 10-15% compared to the same dose of acetaminophen alone; similar efficacy to NSAIDs)
- Use condition-specific recommendations as starting point
- Discuss partitioned dispensing with pharmacy in appropriate patients (ie not patients from northern communities with limited access to pharmacy)
- Consider providing a patient handouts re: opioid use