Managing Pain After Childbirth

A practical guide for clinicians implementing the COMFORT (Creating Optimal Pain Management for Tailoring Interventions after Childbirth) Clinical Practice Guideline

OPEN
Prevention. Treatment. Recovery.

OBSTETRICS INITIATIVE

Contents

This information was developed by the COMFORT Panel (FDA grant 1U01FD007803-01) and OPEN and shared collaboratively by the Obstetrics Initiative (OBI). This Clinical Practice Guideline is meant to apply to the majority of patients, and clinicians should use their judgment in establishing care plans, particularly for patients with complex pain.

The Problem

Childbirth is the most common reason for hospitalization in the United States. Until now, there were ***NO COMPREHENSIVE CLINICAL PRACTICE GUIDELINES*** on managing pain after childbirth.

To date, recommendations for pain management after childbirth have largely been limited to cesarean birth (CB), leaving a gap for the two-thirds of patients who undergo vaginal birth (VB). Recommendations have not adapted to the variety of additional procedures patients may undergo at the time of childbirth, like repair of advanced laceration, tubal ligation, or procedures to control hemorrhage. Nor have guidelines specified how to adapt care for those with complex pain management needs. Additionally, current pain management may sometimes fail to center patients' needs and preferences and miss opportunities to promote equitable, exceptional experiences for all patients.

Evidence shows:

Opioid prescribing after childbirth remains high and widely variable

- In Michigan, there is wide variation across hospitals in rate and amount of opioid prescribing after vaginal and cesarean birth[3]
- These differences exist even when accounting for patient factors, suggesting unwarranted variation[3]

Opioid prescribing for acute pain is excessive and risky

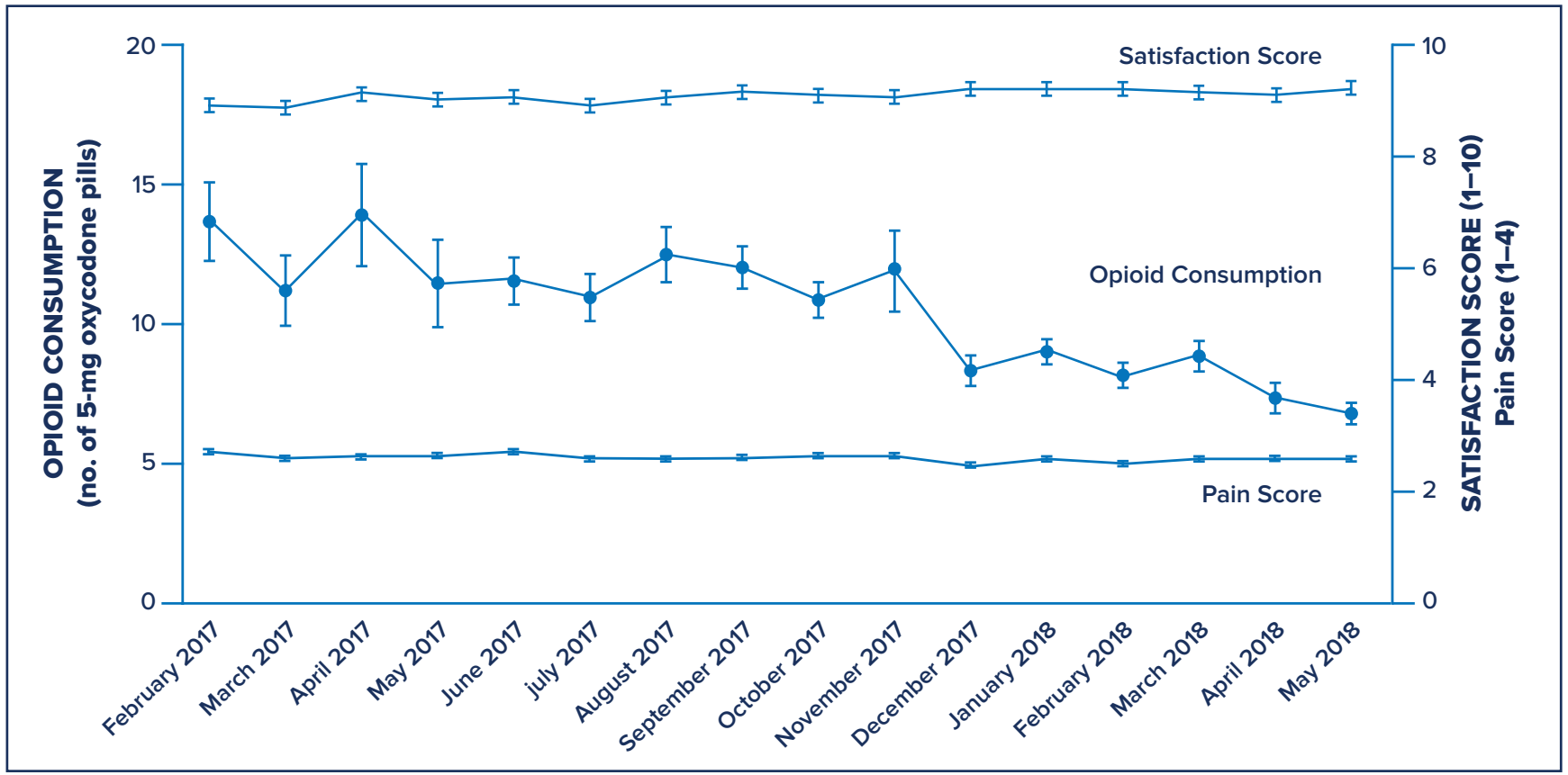
- ***EXCESSIVE:*** Only 20-50% of prescribed opioids are consumed after cesarean delivery in cohort studies[4,5]
- ***RISKY:*** Up to one in 75 pregnant individuals who receive an opioid at childbirth, and one in 25 who receive an opioid for acute pain in pregnancy, develop new persistent opioid use[6]

Significant disparities in pain management practices exist, resulting in suboptimal pain control for patients marginalized by racism, social determinants of health, language barriers, and substance use

- In the U.S., individuals who are Black, young, living in poverty, or affected by substance use disorder, are more likely to experience disrespectful maternity care–including paternalism, neglect of reproductive autonomy, and other dehumanizing treatment[7,8]
- Patients from historically marginalized groups have faced inequities in postpartum pain management such as receiving fewer pain assessments and receiving less opioid medication for the same pain scores when compared to White patients[9,10]

Clinical practice guidelines for acute pain after surgery successfully reduce opioid prescribing without compromising patient-reported pain scores or patient satisfaction[2]

- From an interrupted time series analysis of opioid prescription size, opioid consumption, and satisfaction among adults undergoing surgery in Michigan before and after release of postoperative opioid prescribing guidelines



The Solution

For all of these reasons, the FDA provided funding to develop a standardized Clinical Practice Guideline (CPG) for pain management after childbirth that:

PROMOTES EXCELLENT PAIN CONTROL

REDUCES HARMFUL OPIOID PRESCRIBING

PROMOTES MORE EQUITABLE, PATIENT-CENTERED CARE

To accomplish this goal, a rigorous, inclusive process was used to develop a new CPG.

SYSTEMATIC REVIEW

We reviewed over 2,000 articles on pain management following common birth procedures (e.g., vaginal birth, cesarean birth, postpartum tubal ligation) and populations with complex pain needs (e.g., history of substance use disorder, chronic pain).

While there is robust evidence for some aspects of postpartum pain management, including opioid-sparing protocols for vaginal and cesarean birth, we found significant gaps in the existing data, including lack of information on specific birth procedures, populations, and patient reported outcomes and experience measures.

CONSENSUS METHODOLOGY

To develop a rigorous CPG, We used an evidence-based eDelphi consensus method, the RAND-UCLA Appropriateness Method (RAM). We convened 20 interprofessional experts and 3 public members for the COMFORT Panel to develop a rigorous CPG based on evidence (where possible) and clinical expertise.

Consensus statements provide recommendations for opioid-sparing pain management and how to tailor strategies across populations and procedures.

PATIENT AND CLINICIAN VOICES

With a goal of promoting more patient-centered, equitable care, we conducted 30 patient and 21 clinician interviews to understand lived experiences with postpartum pain management, reactions to the consensus statements, and opportunities to utilize the new CPG to promote patient-centeredness and health equity in real world practice.

The COMFORT CPG elevates the diverse voices of patients and the people who care for them, offering clinicians key considerations for promoting patient-centeredness and health equity.

Together We Can Make A Difference

The COMFORT CPG is designed to promote **care standardization *and* personalization** of postpartum pain management.

Promoting Standardized Evidence-Based Practices and Personalized Decisions

The COMFORT CPG is designed to promote care standardization (i.e., all patients receive the same pain management choices supported by evidence) and personalization (i.e., patients and clinicians select from evidence-based options to create tailored care plans responsive to individual patient needs, preferences, and values). Offering everyone the same choices supported by evidence, and deciding on the best options through partnership between clinicians and patients, may help promote better clinical outcomes, better experiences of care, reduced risk of opioid harms, and more equitable outcomes for all.

EVERY PATIENT, EVERY TIME

Preparation for and education about postpartum pain and management option. For patients receiving opioid medication, information on the risks and benefits of opioid prescribing (including sedation, overdose, and persistent use), the effects on lactation, and safe disposal

Scheduled non-opioid medications (e.g. NSAID, acetaminophen) among those without contraindications

Non-pharmacologic strategies (e.g., mindfulness, abdominal binder, heat/ice therapy)

Opioid medication, if needed, prescribed within COMFORT CPG-concordant ranges

EVERY PATIENT GETS TO DECIDE

Assessment of individual factors (e.g., medical and social risks, preferences) that may affect pain management counseling and decision-making

Selecting simultaneous vs. staggered dosing

Selecting which strategies to use, if any

Electing whether to receive an opioid prescription, and if so, how many tablets within the recommended opioid prescribing range

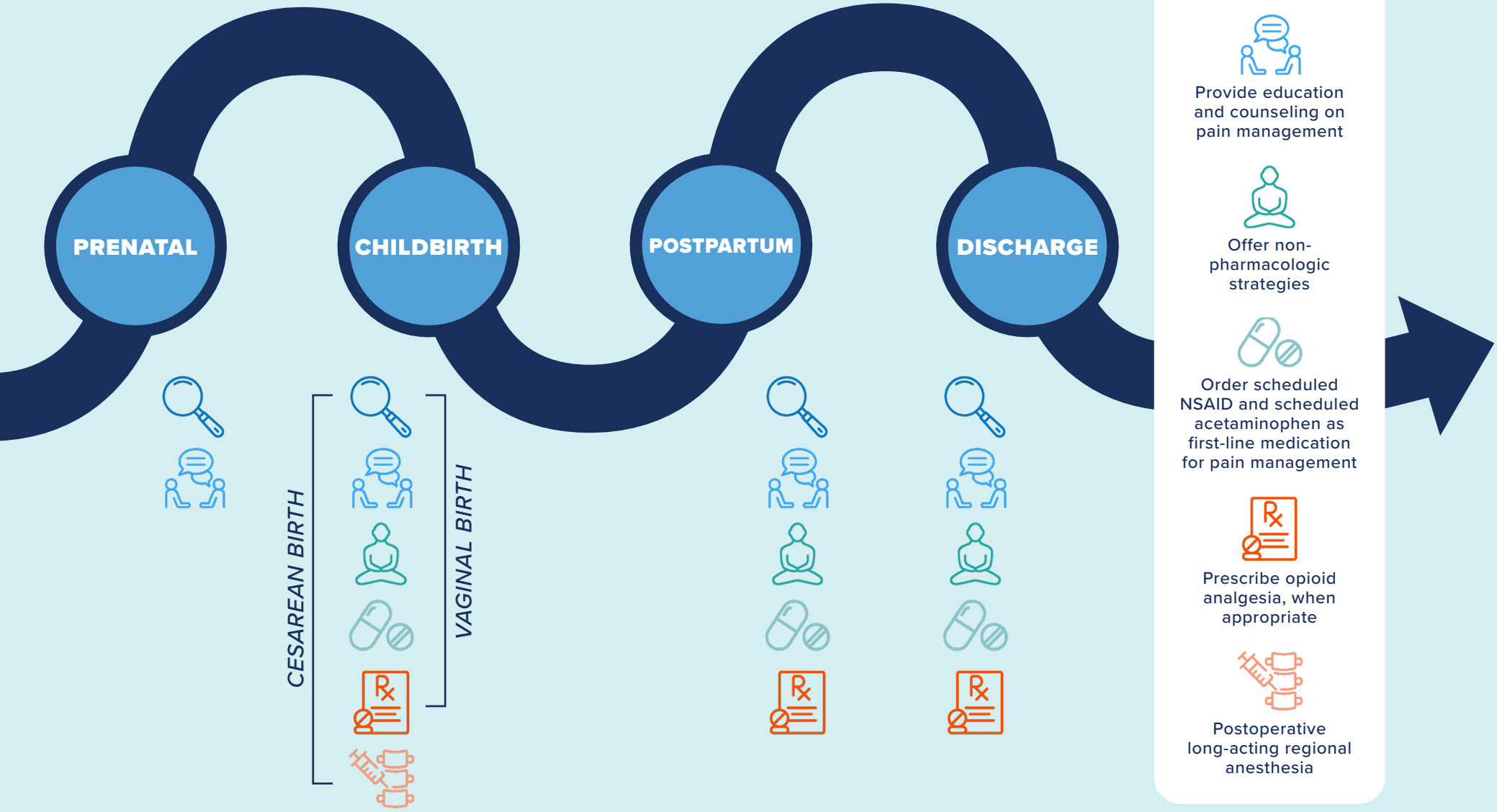
"...it seemed almost like they just gave me what they give to everyone and then let me go home... It wasn't asking pointed questions to get to the best answers for me." *(PATIENT)*

"..this would really standardize postpartum pain management... improve satisfaction with postpartum pain control... reduce the amount of opioids that are prescribed, reduce the amount of extra opioids in everyone's medical cabinets, and hopefully reduce the number of patients that have to see me for opioid use disorder" *(CLINICIAN)*

"...you do need the standardization in terms of, 'here are the main things that you need to do for everybody regardless.' But then also before you just check off a box, you have to consider the human that you're treating. And are there any patient factors that would change how you check that box?" *(CLINICIAN)*

POSTPARTUM PAIN MANAGEMENT

Providing comfort across pregnancy and birth



KEY

Assess/reassess for individual factors that may impact pain management

Provide education and counseling on pain management

Offer non-pharmacologic strategies

Order scheduled NSAID and scheduled acetaminophen as first-line medication for pain management

Prescribe opioid analgesia, when appropriate

Postoperative long-acting regional anesthesia

Patient-Centeredness and Health Equity

Our interviews with 51 patients and providers about acute pain management for peripartum patients documented experiences of unmet information needs, dismissive care, unresponsiveness to patient concerns and preferences, and failures to offer compassionate, respectful, humanistic care:

> **"My concerns were not taken seriously… you're not believed."** *(Patient)*
>
> **"I would've wanted to be listened to and just be talked to nicely, calm me down and try to tell me, 'Okay. It's just going to be for a while. You're going to be better. You're going to be okay."** *(Patient)*

Interviewees often noted the effects of **racism, classism, and other biases and social stigma on care delivery**, with overlapping systems of inequity creating exponential disadvantage for some individuals navigating peripartum pain management in the healthcare system:

"I can see that certain people are believed a little bit more about their pain [...] I've seen this in the Black population, [...] in the Hispanic population [...] in the Asian population, the East Asian population too." *(CLINICIAN)*

"...we all have bias... we all were raised in this racist, sexist, homophobic system." *(CLINICIAN)*

"Am I going to be treated differently because of my background or because I'm not American enough?" *(PATIENT)*

"I feel like they had reason to look down on me, because of my financial and social status." *(PATIENT)*

"I told her I hadn't had any medicine in the last 24 hours, and I was literally being ignored... this is how, especially with Black women, this is how we die after childbirth or during labors, is [sic] because no one's listening" *(PATIENT)*

Take Action to Promote Patient-Centeredness and Equity

These findings suggest an urgent need for clinicians to rectify current care disparities. We can take action by:

- Engaging in self-reflection and education about how biases and social stigma may influence clinical counseling and decision-making related to pain management
- Striving to build trusting, collaborative alliances with patients by offering non-judgemental, compassionate, respectful care that is responsive to patient's lived experiences, preferences, and values
- Offering universal anticipatory guidance about postpartum pain and standardized, evidence-based pain management may promote more equitable care and a better patient experience
- Personalizing pain management plans, using shared decision-making, to anchor individual patient needs, preferences, and values at the center of care decisions

Key Considerations

Look for Key Patient-Centeredness and Health Equity Considerations throughout this document to highlight important considerations for improving outcomes and the experience of care for all.

Assessing Individual Factors

BEST PRACTICE:

No two patients or birth experiences are identical. Therefore, pain management plans should be tailored to an individual's needs.

To establish a tailored postpartum pain management plan, first assess for individual factors that may influence how we treat pain. These factors include patient preference, mental health conditions, birth type, history of trauma and other health conditions like substance use and ability to receive non-opioid medications.

It is important to reassess factors, like mental health, history of trauma, and patient preferences throughout the pregnancy: through relationship and trust building, patients may gain greater comfort sharing these factors with their care team and these individual factors can evolve over time.

FACTORS	COMPONENTS	HOW DOES THIS INFLUENCE PAIN	HOW TO ASSESS
Patient Preference	Patient's beliefs, wishes, and values related to pain management	Some patients may want to avoid opioid medications; others may be concerned about managing their pain at home	Ask what is most important to you in managing your pain? What concerns do you have about opioid medications or pain?
Mental Health	Depression Anxiety	Mental health conditions may affect a patient's experience of pain and are associated with increased risk of new persistent opioid use following childbirth	Screening Tools: • Edinburgh Postnatal Depression Scale (EPDS)
History of Trauma	Post Traumatic Stress Disorder Intimate partner violence	Trauma can increase difficulty of pain management and may affect patient preferences for management options	Screening Tools: • Primary Care Screen for DSM-5 (PC-PTSD) • PTSD Checklist for DSM-5 (PCL-5)
Type of Birth	Vaginal Birth Vaginal Birth with additional procedures or lacerations Cesarean Birth	Operative procedures and advanced lacerations may be associated with increased postpartum pain	Delivery Summary Operative Report

FACTORS	COMPONENTS	HOW DOES THIS INFLUENCE PAIN	HOW TO ASSESS
Medications/ Substance Use	Potentially sedating medications Use of prescriptions like benzodiazepines, hypnotics, and sedatives	These medications increase the risk of respiratory suppression and persistent use with opioid prescribing	Medication Administration Record
	Substance Use: • Tobacco • Alcohol • Other illicit substances or non-medical use of prescribed medications	Substance use can both increase difficulty of pain management and also increase the risk of respiratory suppression and persistent use with opioid prescribing	Screening Tools: • TAPS • 4Ps
	Ability to receive Non-Opioid Medications: • Acetaminophen • NSAIDs	Patients who cannot take acetaminophen and/or NSAIDs may have higher baseline pain	Allergy list Patient discussion

Patient-Centeredness & Health Equity

"I would've felt so much more, I guess unique, for lack of a better word. I wouldn't have felt so like an assembly line, you're giving birth, you're getting one thing, and you're moving along. You know what I mean? It would feel more like someone was taking the time to ask actually how I'm feeling, give me options and then let me make the decision that's best for myself." *(Patient)*

Key Considerations

1. **Tailoring care to patients' individual needs helps them feel heard, included, respected, and cared for:** Patients welcomed the COMFORT CPG's call for tailoring, and described how, if executed well, it could improve their care experience.

2. **Using validated screening tools when appropriate is an important way to reduce clinician biases and promote equity:** Tools should be universally administered to identify all individuals with factors that may influence pain management and avoid further stigmatizing historically marginalized individuals.

Patient Education and Counseling

BEST PRACTICE:

A patient, and if desired, their support person, should receive counseling (ideally prior to the birth admission) that reviews expectations of pain experience and pain management options following all modes of delivery and complications.

Set clear expectations for pain experience

How pain management differs across mode of delivery and procedures

Even patients planning vaginal birth should receive information about the possibility of cesarean birth and pain management.

SAMPLE CONVERSATION STARTER:

- "We are committed to doing everything we can to support you in having a vaginal birth. Still, up to one-third of people will need a cesarean for a safe birth. Is it alright if we talk about what recovery would look like if you need a cesarean?"

Expectations for recovery after childbirth

Help patients know what to expect after birth, including normal and abnormal pain.

SAMPLE CONVERSATION STARTER:

- "Most patients report feeling 100% recovered 6 weeks after cesarean birth"
- "Some pain is normal. You should be able to walk and light activity but may be sore for a few days. This will gradually get better with time."
- "If your pain is suddenly severe, even with your home medications, it is important to call us."

Discuss effective medications for pain management

First-line pain management should include non-opioid and non-pharmacologic strategies

Acetaminophen and NSAIDs should be used together as first-line medications for postpartum pain unless contraindicated.*

SAMPLE CONVERSATION STARTER:

- "Tylenol® and Motrin® are the first medications we use to manage your pain after childbirth. By themselves, they are often enough to manage your pain."
- "Over half of patients who have a cesarean birth report their pain is controlled with just Tylenol® and Motrin®."

Offer a menu of non-pharmacological strategies that may improve the pain experience.

SAMPLE CONVERSATION STARTER:

- "Non-medication strategies like ice, heat, abdominal binders, and mindfulness, can be helpful 'add-ons' to other pain management strategies like Tylenol® and Motrin®. We can work together to pick what works best for you."
- "Ice for your perineum (bottom) or heat for your cramping can be very helpful when used with Tylenol® and Motrin® after a vaginal birth. An abdominal binder can help you be more comfortable after a cesarean birth."

Safer Opioid Use and Harm Reduction

Patients requiring an opioid prescription should receive information on how to safely use the medication and harm reduction strategies.

SAMPLE CONVERSATION STARTER:

- Use of prescription opioids ONLY to manage severe breakthrough pain that is not relieved by other alternatives
- Safety of limited opioid consumption for lactating moms, and the importance of watching for infant sedation and respiratory suppression
- Risks and side effects of opioid medications (constipation, sedation, respiratory depression, dependence, withdrawal, addiction, overdose)
- Not to use opioids at the same time as alcohol, benzodiazepines, muscle relaxers, sleep aids, or other medications that can cause sleepiness
- Appropriate use of naloxone, if prescribed
- How to safely store and dispose of opioids
- Discuss mental health and well-being to improve postpartum recovery
- Review and sign Start Talking form per MDHHS requirements

Patient-Centeredness & Health Equity

"...I didn't know what to expect... I feel like if I had a conversation with my provider about these things, of what to expect and have a solid plan, I feel like I would've been more at ease and comfortable with how things would possibly turn out." *(Patient)*

Key Considerations

1. **Provide comprehensive, clinician-initiated anticipatory guidance, prior to the birth hospitalization if possible, and in the patient's primary language:** This may help set expectations for postpartum pain, help patients feel more comfortable with pain management options, reduce anxiety, and promote patients' ability to participate in shared decision making.

2. **Include support people, if desired by a patient, in conversations about pain management:** This may help clinicians and families to better function as a team and help support people advocate for birthing individuals.

3. **Utilize non-judgemental, respectful language, acknowledge patients' lived expertise, and adapt educational content to each patient's informational needs.** This may help patients feel seen, cared for, and well-positioned to participate in shared decision-making.

First-line Medications to Manage Pain

BEST PRACTICE:
All patients without contraindication should be prescribed scheduled acetaminophen and an NSAID after childbirth to reduce pain.

Ibuprofen is the NSAID most studied in the postpartum period. Other NSAIDs may be appropriate if preferred by the patient or provider for dosing intervals or other considerations.

WHY?
There is a moderate to high level of evidence to support scheduled acetaminophen (Tylenol®) and ibuprofen (Motrin®) after both vaginal and cesarean birth for effective pain management and reduced opioid requirements.[1]

WHAT ABOUT LACTATION?
Acetaminophen and ibuprofen are both safe during breastfeeding. They are found in low concentrations in breast milk and are the first choice for pain management for lactating parents.

SIMULTANEOUS SCHEDULE*		
7am	Acetaminophen (1000mg) Ibuprofen (800mg)	**Why choose this schedule?** Simultaneous dosing may be easier to administer. **INPATIENT:** Simultaneous dosing may be easier to incorporate on busy floors or with high patient to nurse staffing ratios. **DISCHARGE:** Patients may choose this dosing to reduce burden or facilitate sleep.
3pm	Acetaminophen (1000mg) Ibuprofen (800mg)	
11pm	Acetaminophen (1000mg) Ibuprofen (800mg)	

STAGGERED SCHEDULE*		
7am	Acetaminophen (1000mg)	**Why choose this schedule?** There is limited evidence in non-obstetric patients to support staggering medications. **INPATIENT:** Patients with more breakthrough pain may benefit from staggered dosing. **DISCHARGE:** Patients with poorer pain control may consider this approach.
11am	Ibuprofen (800mg)	
3pm	Acetaminophen (1000mg)	
7pm	Ibuprofen (800mg)	

Cesarean Birth Considerations

For the first 24 hours postpartum, the first three doses of oral NSAID, can be replaced with three doses of Toradol 15 mg IV every eight hours

**Schedules are based on every eight hour dosing. Dosing medications every six hours may also be appropriate (e.g., acetaminophen 650 mg q6 and ibuprofen 600mg q6 together or staggered)*

SAFETY CONSIDERATIONS AND SIDE EFFECTS

	NSAID	ACETAMINOPHEN
Allergy 	• Hypersensitivity to NSAIDs or aspirin	• Hypersensitivity to acetaminophen
Cardiovascular 	• Diseases that impair platelet activity (hemophilia, thrombocytopenia with platelets <X, Von Willebrand disease) • Taking warfarin • Congestive Heart Failure	
Gastrointestinal 	• Short-term use (<=7days) is safe for most patients. • Long-term use risk is low (<2%) • History of peptic ulcers, gastrointestinal bleeds, or Helicobacter pylori infections, consider celecoxib (Celebrex) and/or use of a concomitant proton pump inhibitor (PPI, e.g. OTC omeprazole) • History of bariatric surgery	• Hepatic dysfunction or severe liver disease or cirrhosis
Renal 	• Acute kidney injury from NSAID use can occur in those with risk factors including pre-existing kidney impairment, or CKD with high cumulative doses (e.g. ibuprofen 700 mg/day) • Use with caution in patients with CKD	

BEST PRACTICE:
Prescribe acetaminophen and an NSAID at discharge.

Since acetaminophen and most NSAIDs are available over the counter and don't require a prescription, patients and support persons often do not receive instructions on how to use them after surgery. Following packaging instructions may result in underdosing. Additionally, some patients may not be able to pay out of pocket for medications. Universally prescribing acetaminophen and an NSAID can ensure: 1) patients know the right dosing; 2) non-opioid medications are used first-line; and 3) all patients have access to these medications.

Patient-Centeredness & Health Equity

"But telling me like, 'Oh, well you could go buy Tylenol and Advil,' and if I don't have that 10 bucks to buy it, then I'm going to just sit there and suffer in pain." *(Patient)*

"My pain management was really staying on top of that scheduled medicine. I was setting alarms. I had notebooks of when I took the last dose of even the over-the-counter medicines, [to avoid] playing catch up to pain..." *(Patient)*

Key Considerations

Clinicians should consider assessing for barriers to non-opioid medications, and providing resources and strategies to overcome them such as:

- **COST:** Provide prescriptions for acetaminophen and an NSAID to reduce out of pocket costs as these may be covered by insurance or consult social work to determine additional support options
- **COMPETING DEMANDS:** Provide strategies to increase adherence to using non-opioid medications such as encouraging setting alarms, timing medication with other routine activities (e.g., diaper change, infant feeds)

Non-Pharmacologic Strategies

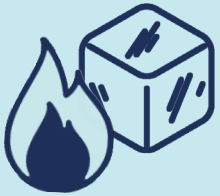
BEST PRACTICE:
Offer patients a menu of non-pharmacologic options that may help manage pain.

WHY?

While evidence for many non-pharmacologic strategies is limited, these interventions are low-risk with potential for benefit. In combination with other opioid-sparing strategies, non-pharmacologic interventions can potentially improve a patient's pain experience.

SAMPLE COMFORT MENU

Abdominal Binder*



Heat and/or Ice

Acupuncture
and/or Acupressure

Mindfulness

Music

Aromatherapy

*Recommended for cesarean birth patients only

Patient-Centeredness & Health Equity

"If you're a single mom, like I'm a single mom now, there is no time for mindfulness.... So while those are wonderful things, they're not realistic things for people whose situations are not a two-parent household, whose situations don't allow for them to have five minutes for themselves without a person and/or someone needing them." *(Patient)*

"You want to be pretty sensitive in how you're presenting it, because someone in pain is very likely to be hypervigilant to, 'I'm in horrible pain, and all you're telling me to do is smell this lavender oil. Why aren't you treating my pain?' And then the relationship is soured." *(Clinician)*

Key Considerations

1. **Clinicians should be aware of barriers to non-pharmacologic strategies, and provide resources and strategies to overcome them such as:**
   - **COST:** Consider providing patients with a COMFORT bundle (e.g., package including abdominal binder, reusable heating pad); provide low-cost resources for non-pharmacologic approaches (e.g., free meditation app, do it yourself aromatherapy).
   - **TIME:** Consider assessing a patient's ability and desire to engage in non-pharmacologic strategies. Where possible, suggest how interventions can be incorporated in daily activities (e.g., deep breathing while feeding baby).
2. **Clinicians should present non-pharmacological strategies as supplemental to routine postpartum pain management to avoid minimizing patients' pain:** Use caution and appropriate timing when offering non-pharmacological strategies. Consider emphasizing that these strategies may accompany first-line treatments used to manage pain, but should not replace them.

Opioid Prescribing

BEST PRACTICE:
Opioid stewardship practices can promote excellent pain management while minimizing the risks of opioid prescribing

Key considerations for routine postpartum patients:

	DO	AVOID
Opioid Selection	Prescribe oxycodone, morphine, or hydromorphone, for all patients regardless of lactation plans. Limit prescription size to 30mg/day of oxycodone or the equivalent (45 OME) in lactating patients.	IV opioids where possible • Due to improved efficacy of PO agents, providers should consider the use of oral analgesics, even when patients are written for a NPO diet. Prescribing opioids that contain acetaminophen (e.g. Norco®, Vicodin®, Percocet®) to minimize risk of acetaminophen overdose Prescribing codeine or tramadol for all patients regardless of lactation plans due to risk of ultrarapid metabolism and infant sedation.
Discharge prescribing	If an opioid is indicated at discharge, follow the clinician tool for discharge opioid prescribing	Preemptive opioid prescribing when there is uncertainty about a patient's postpartum pain needs
Co-Prescribing	Consider co-prescribing **naloxone** for ALL patients, particularly for patients at high risk, such as those with: • History of substance use/tobacco use • Chronic pain • Sleep apnea • Mental health conditions • Taking opioids for more than a few days	Prescribing opioids with other sedative medications (e.g., benzodiazepines, skeletal muscle relaxants)

Clinician Tool: Discharge Opioid Prescribing Recommendations

When an opioid is needed, use the COMFORT Panel prescribing ranges as the foundation for a shared decision-making conversation with the patient to determine the best prescription size. Starting from a standardized approach and then allowing for individualization helps to promote both equity and patient-centeredness.

Determine the opioid prescribing range based on:

1. Type of birth
2. Additional procedures

Determine the right prescription size: With the patient, determine the best prescription size within the appropriate range.

1. Assess/reassess for individual risk factors
2. Consider Patient Preferences and other non-opioid strategies
3. Pain Management at Time Discharge:
   - Pain Scores in 24 hours prior to discharge*
   - Medication Use in 24 hours prior to discharge*
   - Timing of Discharge

Clinicians should be aware of inequities in how pain is assessed and treated.

PRESCRIPTION RANGE (5 MG OF OXYCODONE)	
Routine Vaginal Birth and VBAC	0
3rd or 4th degree laceration	0-10
Postpartum sterilization with minilap	0-5
Cesarean birth discharged on POD2	0-15
Wound vacuum	0-15
Peripartum hysterectomy (additional)	0-10
Dilation and curettage	0
Uterine artery embolization	0
Postpartum endomeritis, antibiotic complete	0
For patients at risk of inadequate pain management (e.g., cannot receive NSAIDs/Acetaminophen): Consider prescribing closer to the upper range. For patients at risk of adverse effects of opioid medications (e.g., use of sedating medications, non-opioid SUD): Consider prescribing closer to the lower range.	

Patient-Centeredness & Health Equity

"...if the conclusion and what I got was the same, I still would've had that feeling of a) being heard, and b) being included in my own care... it doesn't really matter what the ultimate outcome is... it's more valuable to me, even above pain management, to feel like I'm in control of my health decisions." *(Patient)*

Key Considerations

1. **Standardizing opioid prescribing ranges for specific procedures and conditions can improve health equity:** Utilizing the COMFORT prescribing ranges may help ensure that all patients have access to appropriate opioid prescription options.
2. **Shared decision making – with decisions driven by patients – is the ideal way to select the final opioid prescription size:** Aligning opioid prescribing with a patient's wishes and lived realities may promote trust, autonomy, and a better patient experience of care.
3. **Anticipated activity upon discharge and risk of opioid abuse/misuse may affect postpartum pain needs:** Clinicians should be cautious when incorporating these factors into decisions about opioid prescribing given the known biases in determining how these factors might affect postpartum pain needs.

Case Example

You are preparing to discharge a patient on POD 2 who had a cesarean birth with no additional procedures. On further screening and assessment, this patient does not have any individual risk factors. The patient has been tolerating acetaminophen and ibuprofen using the simultaneous schedule during hospitalization. In review of hospital opioid consumption, the patient has only received one dose in the last 24 hours. The patient reports using a heating pad as needed and thinks it might help some.

1. Determine the prescribing range

Using the **type of birth and additional procedures and any individual risk factors**, you determine the appropriate range for the prescription size which you enter into the chart.

Cesarean birth
No additional procedures

PRESCRIPTION RANGE (5 MG OF OXYCODONE)								
Routine Vaginal Birth + VBAC	3rd or 4th degree laceration	Postpartum sterilization with minilap	**Cesarean birth discharged on POD2**	Wound vacuum	Peripartum hysterectomy (additional)	Dilation and curettage	Uterine artery embolization	Postpartum endomeritis, antibiotic complete
0	0-10	0-5	**0-15**	0-15	0-10	0	0	0
For patients at risk of inadequate pain management (e.g., cannot receive NSAIDs/Acetaminophen): Consider prescribing closer to the upper range. For patients at risk of adverse effects of opioid medications (e.g., use of sedating medications, non-opioid SUD): Consider prescribing closer to the lower range.								

2. Elicit and clarify the patient's preferences and values

Inquire about their concerns and priorities for postpartum pain management. This patient reports concerns about "getting addicted" because her sister developed opioid use disorder after a knee surgery. She is also really worried about being in pain since she has to climb a flight of stairs to get to her bedroom and the nursery.

3. Discussion between patient and clinician

The clinician reviewed with the patient that for similar patients being discharged two days after their cesarean birth are usually sent home with between 0 and 15 pills.

They discussed the patient's current pain and her concerns about opioid risks given her sister's experience. They reviewed her opioid use over the last 24 hours which includes no opioid in the last 12 hours. In conjunction with continued acetaminophen and ibuprofen use and non-pharmalogical strategies, the patient felt 5 pills would be sufficient.

Fewer tablets might be needed if:
- Fewer opioid doses in the hospital
- Good pain control in the hospital
- Higher concern for opioid risks

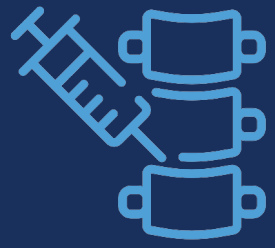
More tablets might be needed if:
More opioid doses in the hospital
Poorer pain control in the hospital

4. Discharge prescribing

Oxycodone 5 mg. Take every 4-6 hours as needed* Quantity: 5 tablets.
*To manage severe pain not relieved by acetaminophen and ibuprofen.

Acetaminophen 1000 mg – take every 8 hours.
Ibuprofen 800 mg – take every 8 hours. Take acetaminophen and ibuprofen together at the same time around the clock.

Use a heating pad as needed.



Inpatient-Only Strategies

BEST PRACTICE:
All patients should receive long-lasting regional analgesia after cesarean birth

Cesarean Birth

Patients who **receive** long-acting regional analgesia following routine cesarean birth **DO NOT BENEFIT** from additional inpatient pain management strategies like TAP block, surgical site infiltration with local anesthetic, or IV PCA.

Patients who **cannot receive** long-acting regional analgesia following cesarean birth, have complex pain management needs (e.g., patients with OUD, chronic pain), or have poorly controlled pain after birth **MAY BENEFIT** from additional inpatient pain management strategies.

Patient Controlled Analgesia with IV medications may be appropriate for patients who do not have adequate pain control with routine measures after cesarean birth or cannot receive routine pain control.

Transversus Abdominis Plane (TAP) Block, Ketamine infusion, surgical site infiltration with local anesthetic and perioperative gabapentin have uncertain benefit for patients who do not have adequate pain control with routine measures or cannot receive routine pain control after cesarean birth.

Considerations for practice:

- Ensure hospital is following the Society for Obstetric Anesthesia and Perinatology: Consensus Statement and Recommendations for Enhanced Recovery After Cesarean
- Patients who require general anesthesia or cannot receive long acting medications may have different pain management needs. Consult with anesthesia and/or acute pain service for management and recommendations.
- Patient Controlled Analgesia with IV medications should NOT be used as a first-line strategy.

Vaginal Birth

Surgical site infiltration with local anesthetic has uncertain benefits for patients who do not have adequate pain control with routine measures after vaginal birth.

Transversus Abdominis Plane (TAP) Block and Ketamine infusion are inappropriate, and long-acting regional analgesia, Patient Controlled Analgesia with IV medications, and perioperative gabapentin are likely inappropriate for patients who do not have adequate pain control with routine measures after vaginal birth.

Considerations for practice:

- Not for use in patients who have a vaginal birth.

Patient-Centeredness & Health Equity

"So I have patients who come in telling me, oh, the epidural's going to give me chronic back pain, and so they don't want it. And that's just a matter of, I think misunderstanding and a lot of work we have to do on patient education. Not only misunderstanding, but also mistrust of the healthcare system because they've probably been mistreated in the past." *(Clinician)*

Key Considerations

Counseling about peripartum pain management should include a discussion of the safety and efficacy of regional analgesia: Eliciting patients' concerns about regional analgesia can promote shared knowledge and trust.

Patients with Complex Pain Management: OUD and Chronic Pain

Clinicians should use a principles based approach to managing pain in patients with complex pain. Where possible, clinicians should offer patients COMFORT with some additions and specific considerations.

General Considerations:

1. Consider the heterogeneity of OUD and chronic pain, and tailor appropriately
2. Consider the altered pain management experience of patients with chronic opioid exposure
3. Wherever possible, utilize an interprofessional approach to care management including anesthesia, addiction medicine, and the patient's primary opioid/medication for opioid use disorder (MOUD) prescriber. Consider telemedicine if expertise is not readily available.
4. When using shared decision making to partner with patients; consider the significant stigma faced by patients with complex pain.
5. Clinicians should assess and address social drivers of health that disproportionately affect care access and outcomes for patients with complex pain.

Consider the following additions to the COMFORT Clinical Practice Guideline for patients with complex pain:

1. Education and Counseling
   - Educate patients and families with prenatal opioid use on the heightened risk of overdose in the postoperative and postpartum period
   - Patients with OUD and their families should be informed that treating pain is important for healing and recovery, and reduces rates of return to non-prescribed opioid use
   - Educate patients and families with prenatal opioid use on the risk of Neonatal Opioid Withdrawal Syndrome and neonatal respiratory suppression if breastfeeding while using opioid medications
   - Educate patients on long-term opioid therapy on how to return to their routine opioid regimen and manage pain
   - Patients should be counseled about the risks of taking opioid medications and sedating medications or substances (e.g., benzodiazepines, alcohol, cannabis) concurrently
   - Patients should be offered Naloxone at discharge and patients and family members/caregivers should be educated on its proper use

2. Non-opioid strategies
   - Consider extended courses of toradol (24 to 48 hours) during the postpartum admission to reduce pain in postpartum patients when not contraindicated
3. Non-pharmacologic strategies
   - When possible, connect patients with a therapist trained in Cognitive Behavioral Therapy prior to birth to prepare for postoperative/postpartum pain management
4. Inpatient strategies
   - Long-acting neuraxial opioids combined with NSAIDs and Acetaminophen is typically effective for pain relief in patients with opioid-tolerance, and is considered a best-practice for cesarean birth.
   - Because traditional pain management strategies are potentially less efficacious in patients with long term opioid therapy/OUD, alternative strategies may be considered on an individual basis in patients with insufficient relief. As these strategies lack evidence in pregnant/postpartum patients, patients receiving these management options should be closely monitored
   - IV-PCA with on-demand low-dose opioids. Basal opioid infusion should be avoided or used with continuous monitoring
   - Low-dose IV ketamine (potentiates the effects of opioids and reduces pain by blocking the NMDA receptor) and IV lidocaine
   - Transverse Abdominis Plane (TAP) Block
5. Opioid prescribing at discharge
   - Confirm existing opioid prescriptions with prescribing provider, patient, and PDMP where appropriate
   - Prioritize return to preprocedural regimen as soon as possible and coordination of prescribing with usual prescriber
   - Opioids should be prescribed on an as needed basis, rather than a continuous or set interval.
   - Prescribe only the quantity likely to be used, not to exceed 2-3 days, unless extenuating circumstances.
   - Discharge prescription size should be based on 24-hour prior to discharge oral opioid usage and the patient's patient control prior to discharge, recognizing daily dose will be decreasing

- Clinicians should prescribe immediate-release/short-acting (ie oxycodone, hydromorphone), as opposed to extended-release/long-acting opioids
- Close follow up to re-evaluate pain control is preferable to automatic refills, to provide a time for reevaluation of pain management

For patients receiving/requiring long-term opioid therapy or MOUD:

1. All pregnant patients with OUD should be offered MOUD (e.g., methadone, buprenorphine) during pregnancy. Hospital admissions may provide an opportunity to start MOUD for patients not yet receiving this treatment.
2. The choice of MOUD agent and dosages should be made with the use of an individualized, person-centered approach.
3. Due to limited evidence for Naltrexone in pregnancy, it is not a first line agent for MOUD in pregnancy. Postoperative/postpartum pain may be more difficult to manage with Naltrexone.
4. For patients who take MOUD, continue their dose during the hospitalization and at discharge; consider split dosing or temporary increases in dosing frequency (e.g., every 6-8 hours) during episodes of acute pain.
5. Avoid sedative/hypnotic medications (e.g., benzodiazepines) in patients on MOUD/long term opioid therapy due to the increased risk of respiratory suppression, but do not abruptly discontinue these medications in people who have established use.
6. Providers should consider how MOUD affects medications commonly used in pain management: MOUD may reduce the efficacy of full-agonist medications. Mixed opioid agonist/antagonists such as pentazocine, butorphanol, nalbuphine may precipitate withdrawal in patients receiving MOUD and should be avoided.
7. For patients maintained on buprenorphine, consider full mu agonists with a strong affinity (lower K binding coefficient) for the mu receptor (e.g.; hydromorphone).
8. Providers and health system leaders should work together to ensure that multiple forms of MOUD are available on hospital formularies to provide the most options for effectively managing postoperative/postpartum pain and for continuing preadmission MOUD therapy.

Patient-Centeredness & Health Equity

"So I think also with being an addict, a lot of times hospitals think you're drug seeking when you're telling them you're in pain and you need something for it. For example, during my pregnancy, my epidural came out and they didn't believe me. Then finally hours checking, they realized my epidural came out... I felt like I was being treated like I wasn't being taken seriously, and they just thought that I was trying to get drugs even though I had been clean ever since my pregnancy. So that was kind of my experience with it." *(Patient)*

Key Considerations

1. **Clinicians should receive education on how biases and social stigma may influence clinical counseling and decision-making related to pain management and work towards dismantling their effects:** Patients with OUD and complex pain experience significant biases that negatively affect their care, including being labeled as "drug seeking" when requesting assistance with pain management or having their pain undertreated.
2. **Standardize protocols for patients with complex pain:** Universal approaches may reduce stigma and inequities in pain management by ensuring patients with OUD and complex pain have access to the same evidence-based strategies as other patients.
3. **Tailor pain management plans to individuals' unique needs:** For patients with complex pain, include clear points of tailoring within standardized protocols to best address differences in pain management needs, risks of opioid exposure, and preferences.
4. **Shared decision making – with decisions driven by patients – is the ideal way to develop pain management plans for patients with complex pain:** This may reduce stigma and improve the patient experience by demonstrating respect and promoting individual self-efficacy for patients who have been marginalized by the health system.

Resources

MANAGING PAIN AFTER CHILDBIRTH

NON-MEDICATION PAIN MANAGEMENT

SAFE STORAGE AND DISPOSAL

LEARN THE FACTS: NALOXONE

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