Trauma Discharge Medications

Multi-modal Pain Regimen

All patients should receive a 14-day prescription for ALL multi-modal medications they have been **receiving inpatient**

- Acetaminophen (Tylenol) 500mg 2tabs q8h Qty: 84 -OR- 500mg 2tabs q6h Qty: 112
- Methocarbamol (Robaxin) 500mg 1tab q8h Qty:42 -OR- 500mg 2tabs q8h Qty:84 -OR- 500mg 2tabs q6h Qty:112
- Neurontin (Gabapentin) 300mg 1tab q8h Qty: 42
- Ibuprofen 600mg 1tab q8h Qty: 42 *Avoid in spinal fusion (If patient is receiving > 50MME/day opioids at discharge ask Neurosurgery if NSAIDs are an option)

All attempts should be made to wean patient from opioids prior to discharge in a stepwise manner. Patients that have received opioids in the last 24 hours prior to discharge should be sent with a 7-day or less prescription and education should be provided regarding pain control. Use the table below as a guide for opioid prescribing.

Prior 24-hour Oxycodone (mg)	Prescription	Qty	Max. MME/day
50 - 60mg	Oxycodone IR 5mg 1-**2** tabs PO q6h PRN pain	50	60
40 - 50mg	Oxycodone IR 5mg 1-**2** tabs PO q6h PRN pain	40	60
30 - 40mg	Oxycodone IR 5mg 1-**2** tabs PO q8h PRN pain	30	45
20 - 30mg	Oxycodone IR 5mg 1 tab PO q6h PRN pain	20	30
10 - 20mg	Oxycodone IR 5mg 1 tab PO q8h PRN pain	10	22.5
< 10mg	Oxycodone IR 5mg 1 tab PO q12h PRN pain	5	15

**For opioid naïve patients (no outpatient opioid Rx within the last 60 days) Walmart pharmacies and Alabama Medicaid WILL NOT dispense/fill Rx sig with > 50 MME/day. Medicare, UHC, BCBS, CVS, Walmart and AL Medicaid WILL NOT dispense > 7-day prescription for opioid naïve patients. Please prescribe accordingly to avoid unnecessary phone calls. If you are hand writing Rx please write as above, if you are e-scribing a range (i.e 1-2 tabs) place the higher tab amount in the Rx and write a comment in 'Special Instructions" with range.

***If you feel like your patient will require more than a 7-day course of opioids following discharge you have the option to e-scribe a second Rx with the 'Earliest Fill Date' 8-days from discharge. A secondary prescription should not extend past their first scheduled follow up with Trauma, Neurosurgery, or Orthopedic Surgery.

****If your patient is receiving Hydrocodone (Norco) use Norco at discharge and adjust scheduled Acetaminophen accordingly not to exceed 3-4g/day.

Murphy PB, Kasotakis G, Haut ER, Miller A, Harvey E, Hasenboehler E, Higgins T, Hoegler J, Mir H, Cantrell S, Obremskey WT, Wally M, Attum B, Seymour R, Patel N, Ricci W, Freeman JJ, Haines KL, Yorkgitis BK, Padilla-Jones BB. Efficacy and safety of non-steroidal anti-inflammatory drugs (NSAIDs) for the treatment of acute pain after orthopedic trauma: a practice management guideline from the Eastern Association for the Surgery of Trauma and the Orthopedic Trauma Association. Trauma Surg Acute Care Open. 2023 Feb 21;8(1):e001056. doi: 10.1136/tsaco-2022-001056. PMID: 36844371; PMCID: PMC9945020.

TQIP Best Practices Guidelines for Acute Pain Management in Trauma Patients. https://www.facs.org/media/exob3dwk/acute_pain_guidelines.pdf

Bowel Regimen

Any patient who receives an opioid pain prescription must go home on one or more of the following:

- Docusate 100 mg PO every 12 hours
- Senna 2 mg PO every 12 hours
- Polyethylene glycol 3350 17 g PO every 12 hours
- Bisacodyl suppository 10 mg rectally daily PRN for no bowel movement

Home Medications

All home medications should be reconciled on admission/during tertiary and restarted as appropriate at discharge. Any medication that was started inpatient such as blood pressure or anti-diabetic (newly diagnosed diabetics) medication should be prescribed at discharge with a month-long supply. The patient should be provided follow up with their Primary Care Provider within 7-10 days.

DVT Prophylaxis

Patients who remain significantly immobilized due to injury will continue anticoagulation after discharge from the hospital, regardless of their disposition (i.e. home, skilled nursing facility, acute rehab). Specific subgroups are as follows:

Spinal cord injury (complete or incomplete motor paralysis)

- Patient going home will be prescribed *Enoxaparin 40 mg daily*
- Patients being discharged to a rehab facility where they will have support for twice daily injections, continue inpatient DVT prophylaxis regimen (*Enoxaparin 30mg twice a day or 0.5mg/kg twice a day for BMI > 30*).
- Spinal cord injury patients should be treated for **3 months from initial injury.**

Pelvic/acetabular fractures and/or lower extremity long bone fractures and/or any fracture that results in the patient having significantly impaired mobility (weight bearing status other than WBAT on bilateral lower extremities)

- Patients going home or to a rehab facility: *Aspirin 81mg BID x 21 days*

Ley EJ, et al. Updated guidelines to reduce venous thromboembolism in trauma patients: A Western Trauma Association critical decisions algorithm. The Journal of Trauma and Acute Care Surgery. 2020. Nov;89(5):971.

Major Extremity Trauma Research Consortium (METRC); O'Toole RV, Stein DM, O'Hara NN, Frey KP, Taylor TJ, Scharfstein DO, Carlini AR, Sudini K, Degani Y, Slobogean GP, Haut ER, Obremskey W, Firoozabadi R, Bosse MJ, Goldhaber SZ, Marvel D, Castillo RC. Aspirin or Low-Molecular-Weight Heparin for Thromboprophylaxis after a Fracture. N Engl J Med. 2023 Jan 19;388(3):203-213. doi: 10.1056/NEJMoa2205973. PMID: 36652352.

Prevention of Venous Thromboembolism in Individuals with Spinal Cord Injury: Clinical Practice Guidelines for Health Care Providers, 3rd ed.: Consortium for Spinal Cord Medicine. Top Spinal Cord Inj Rehabil. 2016 Summer;22(3):209-240. doi: 10.1310/sci2203-209. PMID: 29339863; PMCID: PMC4981016.