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Clinical guidelines support NSAIDs like naproxen for a broad range of pain states

General pain management, osteoarthritis, and low back pain

Condition/ Indication	Recommendations (with strength/level of evidence where available)	Supporting Guidelines
Pain Management, General	For non-neuropathic, noncancer pain, use NSAIDs and acetaminophen as first-line classes of medications, following standard dosing schedules when clinically appropriate.	**US Health and Human Services Pain Management Best Practices (2019)[1]**
Osteoarthritis	Oral NSAIDs are conditionally recommended* as first-line pharmacologic management of knee, hand, and hip osteoarthritis.	**American College of Rheumatology: Recommendations for the Use of Nonpharmacologic and Pharmacologic Therapies in OA of the Hand, Hip, and Knee (2012)[2]**
	NSAIDs are superior to acetaminophen for treating moderate to severe OA. (Evidence rating: A†)	**American Academy of Family Physicians (AAFP) Osteoarthritis: Diagnosis and Treatment (2012)[3]**
	Oral or topical NSAIDs or tramadol should be used in patients with symptomatic knee osteoarthritis. (Strength of recommendation: strong‡) No recommendation can be made for or against the use of acetaminophen, opioids, or pain patches. (Strength of recommendation: inconclusive‡)	**American Academy of Orthopaedic Surgeons: Evidence-Based Guideline for Treatment of OA of the Knee (2nd Edition; 2013)[4]**
	Oral nonselective NSAIDs are recommended as a first-line pharmacologic therapy for knee-only OA or for multijoint OA in people without comorbidities. (Quality of evidence: good)	**Osteoarthritis Research Society International: Guidelines for the Non-Surgical Management of Knee Osteoarthritis (2014)[5]**
Low Back Pain	NSAIDs, opioids, and topiramate are more effective than placebo in the short-term treatment of nonspecific chronic low back pain. (Evidence rating: A§) There is no difference between different types of NSAIDs, and no evidence that acetaminophen is better than placebo.	**AAFP: Recommendations for Mechanical Low Back Pain (2018)[6]**
	Consider medications with proven benefits in conjunction with back care information and self-care. Assess severity of baseline pain and functional deficits, potential benefits, risks, and relative lack of long-term efficacy and safety data before initiating therapy. (Strong recommendation, moderate-quality evidence§) For most patients, acetaminophen and NSAIDs are first-line medication options. NSAIDs are recommended for acute (<4 weeks) and subacute or chronic (>4 weeks) treatment.	**American College of Physicians and the American Pain Society: Joint Guidelines for Low Back Pain (2007)[7]**

*ACR conditional recommendations: the majority of informed patients would choose the recommended management, but many would not, so clinicians must ensure that patients' care is in keeping with their values and preferences.
†AAFP evidence rating A: Consistent, good-quality patient-oriented evidence.
‡AAOS recommendations: Strong: benefits of the approach clearly exceed the potential harm, and/or the quality of the supporting evidence is high. Inconclusive: lack of compelling evidence, resulting in an unclear balance between benefits and potential harm.
§The panel strongly recommends that clinicians consider offering the intervention to eligible patients based on benefits clearly outweighing risks.

Please see the reverse for recommendations in migraine, dysmenorrhea, and dental pain

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Clinical guidelines support NSAIDs like naproxen for a broad range of pain states

Migraine, dysmenorrhea, and dental pain

Condition/ Indication	Recommendations (with strength/level of evidence where available)	Supporting Guidelines
Migraine	For acute treatment of migraines, use NSAIDs (including aspirin), nonopioid analgesics, acetaminophen, or caffeinated analgesic combinations (eg, aspirin + acetaminophen + caffeine) for mild to moderate attacks. (Established efficacy*)	**American Headache Society Consensus Statement (2019)[8]**
	NSAIDs are a first-line treatment for mild to moderate migraine. The choice of medication should be based on availability and adverse effect profile. (Evidence rating: A†) Strong evidence supports use of acetaminophen and oral NSAIDs as first-line treatments for mild to moderate migraine attacks. In placebo-controlled trials, acetaminophen was less effective than NSAIDs but did not cause gastric irritation or antiplatelet effects.	**AAFP Acute Migraine Headache: Treatment Strategies (2019)[9]**
Dysmenorrhea	NSAIDs should be used as first-line treatment for primary dysmenorrhea. (Evidence rating: A†)	**AAFP Guidelines: Diagnosis and Initial Management of Dysmenorrhea (2014)[10]**
	Most adolescents with dysmenorrhea have primary dysmenorrhea and will respond to empiric treatment with NSAIDs, hormonal suppression, or both. Because NSAIDs interrupt cyclooxygenase-mediated prostaglandin production, they are considered a first-line treatment option.	**American College of Gynecology: Opinion on Dysmenorrhea and Endometriosis in the Adolescent (2018)[11]**
Dental Pain	NSAIDs have been shown to be more effective at reducing pain than opioid analgesics, and are therefore recommended as first-line therapy for acute pain management.	**American Dental Association Oral Health Topics: Oral Analgesics for Acute Dental Pain (2019)[12]**
	Oral and maxillofacial surgeons should prescribe NSAIDs as first-line analgesic therapy, and avoid starting treatment with long-acting or extended-release opioid analgesics.	**American Association of Oral and Maxillofacial Surgeons (2017)[13]**

*More than 2 Class I trials based on American Academy of Neurology scheme for classification of evidence.
†AAFP evidence rating A: Consistent, good-quality patient-oriented evidence.

References: 1. US Department of Health and Human Services (2019, May). Pain management best practices inter-agency task force report: updates, gaps, inconsistencies, and recommendations. https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html. Accessed July 18, 2019. **2.** Hochberg MC, Altman RD, Toupin April K, et al. American College of Rheumatology 2012 recommendations for the use of nonpharmacologic and pharmacologic therapies in osteoarthritis of the hand, hip, and knee. *Arthritis Care Res (Hoboken)*. 2012;64(4):465-474. **3.** Sinusas K. Osteoarthritis: diagnosis and treatment. *Am Fam Physician*. 2012;85(1):49-56. **4.** American Academy of Orthopaedic Surgeons Board of Directors. Treatment of osteoarthritis of the knee evidence-based guideline. 2nd edition. May 18, 2013. https://www.aaos.org/cc_files/aaosorg/research/guidelines/treatmentofosteoarthritisofthekneeguideline.pdf. **5.** McAlindon TE, Bannuru RR, Sullivan MC, et al. OARSI guidelines for the non-surgical management of knee osteoarthritis. *Osteoarthritis Cartilage*. 2014;22:363-388. **6.** Will JS, et al. Mechanical low back pain. *Am Fam Physician*. 2018;98(7):421-428. **7.** Chou R, Qaseem A, Snow V, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann Intern Med*. 2007;147:478-491. **8.** American Headache Society. AHS Consensus Statement: The American Headache Society position statement on integrating new migraine treatments into clinical practice. *Headache*. 2019;59:1-18. **9.** Mayans L, Walling A. Acute migraine headache: treatment strategies. *Am Fam Physician*. 2018;97(4):243-251. **10.** Osayande AS, Mehulic S. Diagnosis and initial management of dysmenorrhea. *Am Fam Physician*. 2014;89(5):341-346. **11.** American College of Obstetricians and Gynecologists Committee on Adolescent Health Care. ACOG committee opinion: dysmenorrhea and endometriosis in the adolescent. *Obstet Gynecol*. 2018;132(6):e249-e258. **12.** American Dental Association. Oral Health Topics: Oral Analgesics for Acute Dental Pain, updated May 22, 2019. https://www.ada.org/en/member-center/oral-health-topics/oral-analgesics-for-acute-dental-pain. Accessed June 12, 2019. **13.** American Association of Oral and Maxillofacial Surgeons. Opioid prescribing: acute and postoperative pain management. https://www.aaoms.org/docs/govt_affairs/advocacy_white_ papers/opioid_prescribing.pdf. Accessed March 21, 2019.

Please see the reverse for recommendations in general pain management, osteoarthritis, and low back pain.

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