

Efforts to minimize painkillers after surgery appear to be working

4 September 2019, by Michael Kim



Many hospitals are implementing new procedures to replace prescribing opioids after surgery. Credit: [Dmytro Zinkevych/Shutterstock.com](https://www.shutterstock.com/author/dmytro-zinkevych)

The opioid epidemic has been wreaking misery and death across the nation for years. In 2017 alone, opioid overdoses killed more than [47,000 people](#) – [10,000 more deaths](#) than were caused by traffic accidents that year.

For many people who abuse opioids, the problem begins with [opioid prescriptions](#) from their doctors for [pain relief](#). Government data show that [21%-29% of patients](#) who are prescribed opioids go on to misuse them, and [8% to 12% develop an opioid abuse disorder](#). From 2016-2017, [800,000 people used heroin](#) for the first time, according to the U.S. Department of Health and Human Services, with [80% starting](#) with prescription drugs.

Many hospitals have begun to take steps to minimize the amount of opioids prescribed after [surgery](#) by managing [pain](#) through alternative methods. Research suggests that these programs can [reduce the need for opioids after surgery](#) and can reduce both post-surgical complications and the average length of hospital stay.

At Keck Medicine at the University of Southern

California, I'm the director of our program to reduce [opioid](#) prescriptions and manage pain in other ways. I have spent the past year leading our enhanced recovery team to design and implement various pathways that have significantly reduced the opioid burden in our [surgical patients](#). Here's how these programs look in practice.

New practices, less pain

We have modeled our program to manage pain after others that were developed originally to improve outcomes and shorten hospital stays after colorectal surgery. These programs, called Enhanced Recovery After Surgery, or ERAS, involve a range of measures, such as employing many different ways to reduce pain, and early mobility.

We have found that these protocols are easy to enact and can be as simple as giving the patients non-narcotic pain relievers in the days leading up to surgery to prep the body prior to surgery.

Some of the other methods include:

- Ensuring the patients and their families have clear understanding and expectations about post-surgical pain management
- Making sure a patient has plenty of fluids and carbohydrates
- Using a nerve block during surgery
- Encouraging the patient to get up and walking within a day after surgery
- Sending the patients home with no opioid prescriptions, or with a prescription for a very small number of pills.

We have partnered with clinicians across the health care continuum. The process involves physicians, nurses, [physical therapists](#), occupational therapists, case management, nutrition, pre-op management and social work.

While we have not yet published the results of our programs in an academic journal, I can say that these practices produced very tangible results; the post-operative opioid usage decreased by 50% in our division of thoracic surgery and by 60% in our department of urology.

The hospital's division of cardiac surgery also reduced the use of post-operative opioid use by 45% for patients undergoing minimally invasive valve-replacement procedures. We anticipate publishing data on this finding as well. Some of our patients have gone through pre-op, surgery and post-operative care without the use of opioids at all and without any undue pain.

Other hospitals have reported success, too.

The [University of Pittsburgh Medical Center](#) cut the number of post-surgical opioid prescriptions in half.

A [Cleveland Clinic](#) pilot program to reduce opioid prescriptions in new mothers following Cesarean sections immediately reduced opioid use by two-thirds, and opioid-free hospital stays more than tripled.

A year after the [University of Virginia](#) implemented its ERAS protocol for patients undergoing thoracic surgery, it reduced the use of post-surgical morphine equivalents by more than half, reduced length of stay by two days, and even cut hospital operating costs.

These practices go beyond minimizing opioid prescriptions and can contribute to better overall patient care. For example, at Keck Medicine, our preliminary results show that we have been able to decrease the length of patient stay by up to 21% and have reduced complications from [atrial fibrillation](#), or irregular heart beats that can lead to stroke, blood clots and heart failure, in thoracic surgery to less than 10%. We have also decreased intensive care stay for head and neck surgery by as much as one day. Also, we have cut by two days the length of time that catheters need to remain inserted into the bladders of post-operative urological patients. This is important because the [risk of infection increases](#) the longer a catheter remains inserted.

Advocating for patients

An integral piece of the success is patient education. Most patients are so overwhelmed when they are about to undergo surgery and may be unaware that there are procedures to help limit opioid usage. And those who hear about opioid-minimizing practices may fear potential post-operative pain and may not consider that option.

It is important to educate patients well before their surgeries so they know their expected level of pain after their surgery and the different medication and procedures in place to minimize that post-operative pain. This kind of education is key in empowering patients to make informed decisions regarding opioids and their health.

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