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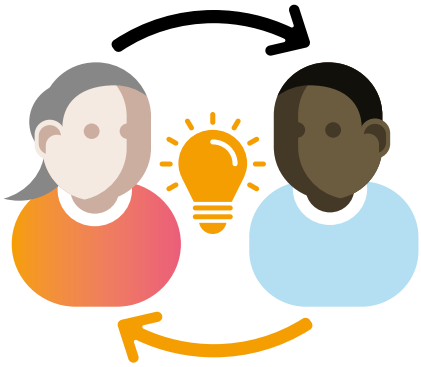
HOW TO AVOID RISK ASSOCIATED WITH MEDICATION MANAGEMENT

By David C. Markel, MD, The CORE Institute

In light of the current opioid epidemic in our nation, physicians involved with the treatment of both chronic and acute pain are closely examining prescribing practices and medication management. As an orthopedic surgeon focused on total hip and knee replacements, I am familiar with the complexity of managing pain and pain medication for my patients. As a rule, I try not to prescribe opioids prior to surgery, and our practice has a well-defined pathway for managing prescription refills up to 6 weeks post-surgery. However, there are no guidelines to direct surgeons regarding outpatient opioid prescribing.

I believe many of the problems our nation currently faces in regards to both opioid use and chronic pain stem from a lack of education and consistency around how we diagnose and treat chronic joint pain and post-surgical pain. Unfortunately, current surgical training curricula do not include the management of chronic pain in standard competencies. In addition, primary care physicians (PCPs) who along with emergency room (ER) physicians see the vast majority of arthritis patients first, do not receive musculoskeletal health education. In order to avoid the medication management risk, we need to educate all the providers involved in patient care including PCPs, ER physicians, pain management physicians and surgeons, monitor the treatment options we are using for chronic pain patients, and provide feedback to one another on our experiences. It needs to be collaborative pain management.



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There are a number of studies on the impact of current pain management treatments that may help inform us about some of the medication management risks. In a study titled "Preoperative and Postoperative Opiate Use by the Arthroplasty Patient," that appeared in the *Journal of Arthroplasty in 2016*, the authors investigated the use of opioids in patients undergoing total joint arthroplasty.[1] Noting that surgeons are likely to see more patients taking opioids on initial presentation, the study reviewed data collected on opiate use from 3 months pre-op to 12 months post-op on 367 patients, who were grouped by preoperative opiate use. Patients with ≥2 opiate prescriptions filled per 6-week period before surgery were considered chronic opiate users.

The results revealed that at one year post-op, 64% of chronic opiate users were still being prescribed opiates compared with 22% of the control group ($P < .001$). Thirty-one percent of the chronic opiate users were discharged to an extended care facility compared to 21% of the control group ($P = .123$). Of all the opiate prescriptions, 77% were written by a practitioner other than the surgeon. This study confirms the idea that opioids are frequently prescribed by providers other than the surgeon both prior to and after surgery, and underscores the need for a better-defined treatment algorithm for total hip and knee replacement patients. The study also shows that patients taking multiple opiates or more potent opiates pre-operatively filled more prescriptions post-operatively and that chronic use of opioids negatively influences discharge disposition.

As providers, we need more clarity around what the approach should be for managing pain and pain medication. It is common that surgeons see patients who have had their arthritis managed by narcotics for a long time. This may be because some PCPs are reluctant to send patients for surgery or to surgeons – they may be seeing someone with serious cardiac issues for whom it may be easier to just write a prescription, or may think that referring a patient to a surgeon for consult means the patient will necessarily have surgery. It could also be that they are unaware of alternative options such as steroid injections or cooled radiofrequency ablation. It's important to remember that not everyone gets referred to surgery; we treat plenty of patients who do not receive joint replacement.

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Another complication besetting the treatment pathway is that often patients with chronic joint pain haven't been given a solid diagnosis. Pain management physicians, orthopedic surgeons and PCPs need to align on how we're managing chronic pain patients so patients are on a defined path from the beginning. That path may include activity modification, physical therapy, anti-inflammatories, injections or cooled radiofrequency ablation – all of which may be used over an extended period of time for some patients. Involving an orthopedic surgeon earlier in the process may also help establish a solid diagnosis and allow for the initiation

David C. Markel, MD, has a consulting/speaking/financial relationship with Avanos Medical, Inc.

1. Zarling, Bradley J., et al. "Preoperative and postoperative opiate use by the arthroplasty patient." The Journal of arthroplasty 31.10 (2016): 2081-2084.

There are inherent risks in all medical devices. For more detail on indications, cautions, warnings and contraindications, click here.

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