OPIOID-FREE: A BETTER WAY TO RECOVER

It's time to rethink the standard approach to patient care.

BY LAWRENCE ITELD, MD

Opioid use, misuse, and abuse in the United States has become a very important topic of discussion not just among health care practitioners, but within the media and around our dinner tables. The "opioid epidemic" has become a major public health crisis, culminating in local, state, and federal action and legal actions against pharmaceutical companies who are major producers of opioids. It is incumbent on health care practitioners to understand the impact that we have and what we can do to improve patient safety and have a positive impact on public health. So, how did we get here?

The first historical reference to opium dates all the way back to 3400 BC. Hippocrates recognized the medicinal benefits of orally administered opium. Morphine, isolated in 1806, was named for Morpheus, the god of dreams, indicating the powerful and perhaps seductive effects of the agent. A series of relatively rapid developments in science and medicine in the late nineteenth and early twentieth centuries set the stage for more widespread use of opioids. The hypodermic needle was developed in 1853, providing a method for rapid delivery of drugs, including opioids. In 1898, heroin was synthesized and promoted as a "less addictive" alternative to morphine—which we now know to be the complete opposite. The Smoking Opium Exclusion Act of 1909 banned "smoking opium" but did not regulate opium-based medications. The Harrison Narcotics Act of 1914 was the first measure to control narcotics trafficking and limited opium availability to small amounts, exclusively by prescription from doctors. With the establishment of the modern FDA in 1938, opioid drugs were placed under the purview of that agency. Oxycodone, arguably the most commonly used and best known opioid, was FDA-approved in 1950.

The early 2000s are now viewed as a turning point in both medical management of pain and the emergence of an opioid epidemic. OxyContin (oxycodone) was approved by the FDA and marketed by Purdue Pharma in 1996. The controlled release formulation was positioned as less addictive and perhaps less prone to abuse, compared to other opioid formulations. However, this did not prove to be the case. I guess we didn't learn from our experience with heroin.

Concurrent with perceived advancements in pain relieving drugs, a new focus on pain management evolved at the turn of the twenty-first century. Pain was designated a "Fifth Vital Sign" by the Joint Commission in 2001, when the body declared that pain was being under-treated. A culture emerged in which patients expected to avoid pain entirely (pain score = 0). This led to what is now acknowl-

FACTS ABOUT OPIOIDS IN THE US

- 10.5B opioid pills dispensed in 2017
- 17% of population given opioid prescriptions
- 1 in 12 opioid-naive patients will become persistent users
- ~3M new persistent opioid users in 2017
- 130+ deaths daily from overdose in 2017 (CDC)
- 83% of heroin users started with Rx meds

GOVERNMENTAL AND LOCAL ACTIONS

- October 2017. President Trump declares the opioid crisis a public health emergency
- October 2018. HR8/SUPPORT Act
- January 2019. Medicare limits 7-day supply for naive patients; Opioid care coordination alert for >90 MME/day
- Many local governments are enacting opioid prescribing guidelines and limitations
- 3- to 14-day supply
- MME limits
- CVS limited opioids to 7-day supply in 2017; Followed by most major chains.

RESOURCES

- facs.org/safepaincontrol
- opioidprescribing.info

edged as an overprescribing of opioid pain medications with a resultant increase in misuse and abuse. In 2017, 191 million opioid prescriptions were written in the US, resulting in 17 percent of the population having received an opioid prescription. This is enough pills that every American adult could have a month's supply of narcotic pain pills! That same year, there were three million new persistent opioid users and more than 130 deaths per day from opioid overdose (CDC). To put this in perspective, this is the equivalent of a 737 jet crashing each and every day.

A significant problem with current opioid prescribing behaviors is the issue of consumption versus diversion. Less than half of all opioids dispensed are used by the intended patient. This leaves hundreds of millions of pain pills, each year, that can be diverted and abused. Abuse of opioids may take the form of opioid use disorder, opioid abuse, dependence, or addiction, however the consequences are dire in each case.

PAIN MANAGEMENT AND PLASTIC SURGERY

Plastic surgeons have surely played some role in the opioid epidemic, and it is essential that we take stock not only of our actions historically but of our strategies for the future. Clearly, a reduction of opioid prescribing is needed.

Opioid-free recovery is possible; it's just not something we were ever taught during training. The goals of Opioid-Free Recovery are to:

- Decrease reliance on addictive medications with narrow therapeutic index
- Decrease risk of opioid related adverse events (ORAEs)
- Allow rapid return to function
- Improve patient experience.

To be clear, I am not advocating for complete elimination of opioid drugs. These agents continue to play a role in patient care. However, that role is narrow. Opioids continue to be indicated for use to manage end-of-life pain/hospice care, cancer pain, and severe acute pain.

The pain associated with aesthetic procedures lasts on average five days or less. For outpatient aesthetic procedures, the average duration of pain is less than four days. This is not a substantial hurdle for patients to surmount.

Pain is a subjective phenomenon, and the experience of pain will vary from one individual to another. Pain associated with aesthetic procedures may manifest as tightness, muscle spasm, throbbing and aching, burning and stinging, soreness, or—and much less commonly—sharp, shooting pains.

It is possible to manage and reduce the experience of pain associated with aesthetic procedures without the use of opioid drugs.

PREOPERATIVE MEDICATIONS

All medications taken 3 hours pre-op
Celebrex 200mg (not for facial procedures)
Gabapentin 300mg
Tylenol 1000mg PO
Emend 40mg PO

OPIOID-FREE PROTOCOL

Counseling. The key to successful implementation of an opioid-free protocol is appropriate counseling and patient engagement in the pre-operative period. Many patients today do not want to use opioids, either because of the side effects—they fear being nauseated, constipated, "groggy" and "out of it"—or because they worry about the potential

INTRAOPERATIVE PROTOCOL

Principles
Field blocks as early as possible
Avoid unnecessary trauma and bleeding
Anesthesia and PACU partnership
Regional Blocks
Breast/ Chest Wall
Abdominal Wall
Spinal/ Epidural/ Regional Blocks
Medications
<24 hours duration
Lidocaine/ Bupivicane with Epinephrine
Ropivicaine
>24 hours duration
Liposomal bupivicaine
Elastomeric pump

RECOVERY

Protocol
Medications
Early Activity
Encourage movement and ambulation
POD 1 Follow-up
Primary Medications
Celebrex 200mg BID for 7 days
Gabapentin 300mg TID for 5 days
Valium 5mg Q8-12 hours for 5 days (if manipulating muscle)
Tylenol 1000mg Q6 hours for PRN
Other Medications
IV Acetaminophen
IV Anti-inflammatory
Ketoralac
Ibuprophen

for addiction. Patients want a quick recovery and return to normal activities of daily living without feeling "drugged up." While it is certainly possible to responsibly use opioids without promoting the risk for addiction, why not respect these patient concerns by obviating the need for opioids?

Medication seeking behavior does not commonly present to an aesthetic plastic surgeon in the consultation phase, but it is something we need to always consider. A patient adamant about the need for opioids in the consult phase may be a patient you are better off not treating.

Patient expectation-setting is crucial. The opioid-free approach will be associated with some degree of discomfort and tolerable pain. Patients who know what to expect in terms of type, intensity, and duration of pain, however, are able to anticipate and bear that pain. The notion of completely pain-free treatments is a relatively novel convention and one that patients can be educated to understand is unreasonable. Emphasize that patients will receive non-opioid analgesics to help reduce pain to tolerable

(Continued on page 56)

(Continued from page 50)

levels and will be provided additional coping strategies. Some pain and discomfort is normal, but patients generally should be able to perform routine activities.

One way to transform conventional thinking about perioperative pain is to emphasize functional scoring rather than pain scores. Function can be assessed across a continuum that begins with tolerable pain that does not prevent activity and escalates to intolerable pain that interferes with the ability to communicate verbally. Most patients should expect to have tolerable pain or discomfort but that they will still be able to use their cell phone, go on social media, watch TV and movies, go for short walks, and prepare a light meal. This concept is discussed in the consult and pre-procedural periods and used in patient assessment post-procedurally.

Now that I have been using the opioid-free approach in my practice, I find it helpful to highlight positive patient reviews during consults to help new or potential patients understand what their experience may be like.

Medications. Strategies for medication use are generally outlined in the charts (above) and are different for each phase of treatment and recovery:

- Pre-operative medications
- Intra-operative techniques
- Post-operative strategies.

Rather than discuss specific strategies, I emphasize here that strategies all focus on non-opioid pain relievers, early intervention, and treatment delivery strategies that minimize trauma and associated pain.

Recovery. Non-opioid pain relief is instituted/continued immediately post-operatively and through an appropriate period. Increasing evidence and my own experience with patients confirms that early activity in the post-operative period is preferable to extensive inactivity. Encourage movement and ambulation as quickly as possible after a procedure.

Hand-holding is essential—although perhaps no more than when using opioid pain relievers. Be sure to remain in contact with patients and dialogue about their pain. Emphasize available coping strategies, adjust medications as needed, and remind patients that their pain will subside within a few days. Overall, we find that patients actually have less pain and an overall better experience when using these protocols when compared to traditional opioid-based regimens.

A LEARNING CURVE WORTH CLIMBING

The opioid-free approach to plastic surgery is not something to be implemented in one fell-swoop. Start by implementing strategies progressively, toward the goal of reducing or hopefully eliminating opioid prescribing in your practice. Even a stark reduction in opioid use will benefit patients and the health care system.

Track opioid prescribing in your practice and be sure to monitor consumption. Refrain from offering refills and trust your instincts when it comes to medication-seeking behaviors you suspect among your patients. Transition to less-addictive agents and use smaller doses.

As you transition from opioid-based treatments, learn from your patients. Early on, you will not see perfect results. Seek feedback and modify your approach in response to patient needs. There is a steep learning curve.

My experience has revealed that opioid-free treatment and recovery is possible. ■

Dr. Iteld is a speaker and consultant for Pacira Pharmaceuticals.

1. Sebai ME, Siotos C, Payne RM, Stone JP, Seal SM, Habibi M, Broderick K, Sacks JM, Manahan MA, Rosson GD. Enhanced Recovery after Surgery Pathway for Microsurgical Breast Reconstruction: A Systematic Review and Meta-Analysis. PlastReconstr Surg. 2019 Mar;143(3):655-666.
2. Rose KR, Christie BM, Block LM, Rao VK, Michelotti BF. Opioid Prescribing and Consumption Patterns following Outpatient Plastic Surgery Procedures. Plast Reconstr Surg. 2019 Mar;143(3):929-938.

LAWRENCE ITELD, MD
■ Plastic Surgeon, Chicago, IL
■ The author is happy to discuss his experience with colleagues. Email lhi@driteld.com