

CASE AND COMMENTARY

Should “Pain Clearance” Be Routine for Elective Surgery?

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Abstract

For elective surgery, preoperative planning for patients with comorbidities tends to address risk stratification, cardiac clearance, and anticoagulation. This commentary suggests that chronic opioid use should be normalized as a comorbidity requiring “pain clearance” prior to elective surgery. Doing so would likely enhance team communication, optimize patient care, decrease stigma, and facilitate care transitioning and long-term planning.

Case

A 58-year-old construction worker has long-standing pain and arthritis from a complex ankle fracture sustained in his twenties. His pain has been made tolerable by twice-daily oral opioids, which his primary care physician has been prescribing him for the past 10 years. There have never been concerns about his substance use practices or diversion. This patient also takes warfarin anticoagulation daily for atrial fibrillation. His orthopedic surgeon suggests he undergo ankle fusion surgery to improve his function and help remediate pain.

Commentary

When suggesting elective surgery for a patient, a conscientious surgeon will screen for factors that affect anesthetic approach, surgical tactic, or postoperative care. Cardiac history, such as arrhythmia or heart attack; diagnoses such as anemia, uncontrolled diabetes, or sleep apnea; and behaviors, such as smoking, are those for which screening regularly occurs in a surgeon’s office. For elective surgery, a health care team has time for medical optimization and **care coordination** prior to surgery.

When a patient takes warfarin for arrhythmia, the use of a preoperative checklist is triggered¹ to investigate the indication for anticoagulation therapy, verify an appropriate therapeutic target, consider whether anticoagulation suspension or bridge is prudent and who would manage it, and strategize lab follow-up and monitoring. Unless a perioperative plan is fully addressed and dutifully documented, elective surgery simply cannot happen at many institutions. This plan is generally embraced by surgical and anesthesia staff and enforced by administration. After all, risk of a thromboembolic event when interrupting anticoagulation must be weighed against risk of bleeding and

transfusion when continuing anticoagulation, both of which can affect patient outcomes, mortality, and morbidity.¹

Surgeons have obligations to screen patients for preoperative opioid use and plan for perioperative pain management with rigor, just as they would for other comorbidities. **Stigma** and bias surrounding substance use marginalize patients with opioid use history and enshroud the patient-physician relationships in unease and ambiguity.^{2,3} Formulating opioid use as a routine element of a patient's clinical history, however, normalizes preoperative queries about any patient's opioid use and thus destigmatizes it. Routinizing and normalizing opioid use queries would help physicians execute their duty to approach patients who do have an opioid use history with nonjudgmental regard.⁴

Surgeons' Roles

First, physicians have a duty to learn about a patient's medical history and apply what's relevant in it to that patient's present clinical situation. A surgeon planning an intervention must understand and consider any medical therapy that could influence potential risks and benefits. Opioids, regardless of whether they are prescribed or obtained illicitly, will influence a patient's perioperative management and postoperative recovery. Because opioid use is linked to surgical complications, including infection, delayed healing, higher costs, and poorer outcomes,^{5,6,7} a surgeon is obligated to seek all relevant information about a patient's opioid use.

In the wake of the opioid epidemic, there are now many patients taking opioids prior to elective surgery. Preoperative opioid use has been consistently estimated in about one-quarter of patients, with the highest prevalence among orthopedic patients.^{5,8} Yet many physicians admit lacking confidence in how to safely prescribe opioids, how to appropriately screen for opioid use, and even how to **talk to patients** about opioid use.⁹ Surgeons do not consistently screen for preoperative opioid use or use prescription drug monitoring programs.^{10,11}

We suggest that routine opioid screening would not only be a useful perioperative tool to improve individual patients' perioperative care but also help destigmatize opioid use, making it easier for patients to talk about and easier for care teams to address. For example, when screening reveals that a patient uses or has used opioids, that patient should be indicated for a "pain clearance" protocol, just as patients with a history of cardiac disease are indicated for cardiac clearance. Standardizing screening would also likely help address known biases in opioid prescribing predicated on a patient's race, sex, or class.¹² Routinizing and normalizing opioid use screening could also function as a decision aid, which could be used to educate patients about opioid use and help them make perioperative pain management decisions according to their values.

Collaborative Preoperative Pain Management

In the case, the patient's opioid history and corresponding modifiable risk could be addressed by engaging the expertise of a variety of specialists. At large, tertiary academic health centers, for example, there are abundant opportunities for surgeons to collaborate with colleagues in pain management, regional anesthesia, and behavioral psychiatry. Were the patient in the case screened for opioid use as a routine matter before elective presurgery, his twice-daily oral opioids would be identified as a medication used to manage a chronic condition. Identifying a patient's opioid use history would then trigger a referral to a perioperative pain clinic, overseen by an

anesthesiologist trained in pain management. In a pain clinic setting, a patient's opioid use history would be detailed and confirmed in the patient's health record, urine toxicology screening would be done regularly as a matter of normal routine, and partnership with the patient's prescriber and pain management team would be reliably established. When appropriate, a patient's opioid intake would be modified to fit into a surgical care and long-term **pain management plan**. Helping the patient form realistic expectations about postsurgical pain reduction would also be part of this plan.

Ankle fusion is generally expected to reliably relieve arthritic pain due to motion in the posttraumatic joint, but fusion surgery would not address extant neuropathic pain. Thus, it can be important to preoperatively prepare a patient to expect to postoperatively be weaned from opioid-based pain medications and instead transition to multimodal and nonpharmaceutical pain management strategies. By leveraging regional anesthesia resources, a plan to minimize intraoperative narcotics can be made and case coverage can be scheduled. Postoperatively, it might be reasonable to wean some patients off opioids completely over an anticipated recovery duration. For other postoperative patients, returning to preoperative baseline levels of opioid use might be reasonable. A surgical preference against using anti-inflammatory medications would also inform multimodal approaches to managing a patient's post-operative pain. In nearly any postoperative situation, a patient's surgeon and pain management clinician each have follow-up obligations to their patient to ensure appropriate recovery progression.

Conclusion

In summary, physicians have obligations to both solicit information about and plan for perioperative care of patients who use opioids. Opioid management can be optimized and destigmatized by physicians treating opioid use as they do other substances (eg, anticoagulants) that can affect a patient's perioperative status and postoperative recovery.

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Editor's Note

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