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5-21-2021

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The Journal of Minimally Invasive Gynecology

Editorial

Opioid Prescribing in Gynecologic Surgery − More Work to be Done

The significance of the opioid epidemic is well-established with over 70% of the nearly 71,000 drug overdose deaths in 2019 involving an opioid [1]. The role of perioperative opioid prescribing has come under scrutiny given that 5.9% to 6.5% of patients who undergo major or minor surgery become new persistent opioid users [2].

In this month's issue of JMIG, Wilson et al [3] expanded on the relationship between opioids and gynecologic surgery, particularly minor gynecologic surgery. Using a Canadian single-payer claims database from 2013 to 2018, over 130,000 opioid-naïve patients who underwent gynecologic surgery were evaluated. Approximately 75% of those patients underwent minor gynecologic surgery, defined as pregnancy evacuation, endometrial ablation, or hysteroscopy. There was a modest but significant decrease in perioperative opioid use, defined as filling ≥1 opioid prescription 30 days prior to 14 days after surgery, over the study period from 21.8% in 2013 to 18.5% in 2018 ($p<0.001$). Additionally, the authors found the total oral morphine equivalents (OME) prescribed decreased from 169.8 OME in 2013 to 165.4 in 2018 ($p<0.001$), and total OME for minor surgeries was 123.4.

Persistent opioid use, defined as having filled ≥1 opioid prescription between 91 to 180 days post-operatively, following surgery was found in 3.65% of patients overall. As expected, perioperative opioid use was identified in 21% of patients in this cohort and was an independent risk factor for persistent opioid use after surgery. Risk factors for persistent opioid use among those with perioperative opioid use included filling an opioid prescription prior to surgery, being healthier, having any mental health disorder, substance use disorder, or infertility, or undergoing pregnancy evacuation or hysteroscopy (as compared to open hysterectomy). Patients who filled a prescription in the upper quintile of total OMEs prescribed were also at increased risk.

It is well known that there is an opioid crisis. Identification of a problem, however, does not inherently fix it. While reassuring that the overall trend in opioid prescribing is decreasing, the clinical impact of this remains nominal. To illustrate this, the authors found that the reduction in opioid prescribing equates to one less pill prescribed per patient −roughly 23 tablets of oxycodone were prescribed in 2013 compared to 22 tablets in 2018. One can hardly argue this is a meaningful change.

Gynecologists must be able to translate this research into a call for action. So, how do we do that? Importantly, this study identifies many modifiable risk factors for persistent opioid use following surgery, and we can use these findings as guidance. As hysteroscopy and pregnancy evacuation were identified as independent risk factors for persistent opioid use among women with perioperative use, by simply eliminating opioid prescribing after these minor surgeries, we can spare our patients the unnecessary risks associated with opioid exposure. Additionally, we should aim to prescribe as few pills as possible when opioids are indicated, since those who filled a prescription in the highest quintile of total OMEs were at highest risk of developing new persistent opioid use. Surgeons and patients can be reassured that even when patients are given less opioids postoperatively, they remain similarly satisfied and are not more likely to request refills [4]; hence, a smaller, more individualized prescription size should be thoughtfully considered.

Strengths of this study include its large study population and its inclusivity of minor gynecologic surgeries, which has not been adequately studied. Additionally, the database includes a variety of socioeconomic and demographic variables, increasing the study's generalizability. Limitations inherently exist with using a large claims database, particularly that opioid prescribing does not equate to opioid consumption. Additional details regarding the prevalence of chronic pain conditions would be beneficial, as these are known risk factors for persistent postoperative opioid use [2].

While evidence-based guidelines do exist for opioid prescribing following cesarean section or hysterectomy [5], no explicit guidelines exist for minor gynecologic surgery. Future research should confirm the assumed minimal pain management needs following minor gynecologic surgery in order for evidence-based guidelines to be published. Additionally, incorporation of shared decision making with patients regarding their postoperative pain management plan is critical to meaningfully reduce perioperative opioid use.

Disclosure statement: Sawsan As-Sanie discloses receiving money paid to her institution for the following: NIH-DHHS-US-16-PAF06270 (R01 HD088712-05). She has also served as a consultant to Abbvie, Bayer, Myovant Sciences, and Eximis. Annmarie L. Vilkins declares no conflicts of interest and nothing to disclose. The views stated in this article reflect solely the view of the authors.

1553-4650/$ — see front matter © 2021 Published by Elsevier Inc. on behalf of AAGL.
https://doi.org/10.1016/j.jmig.2021.05.006

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Patient education regarding pain expectations after gynecologic surgery, the role of multimodal pain regimens, and the risks of opioid use should be reiterated, and resources on how to manage pain without the use of opioids should be provided. We applaud the authors for further recognizing the impact of the opioid epidemic within gynecologic surgery, and we hope the findings embolden our fellow gynecologic surgeons to take action within their own clinical practices.

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