



Setting Patient Expectations Regarding Postoperative Pain

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Opioid use has become a hot topic, increasingly making its way out of medicine and into the world of politics. Recently, President Trump signed bipartisan opioid legislation designed to address “prevention, treatment, and recovery” of the opioid crisis. The announcement of this legislation in *The Washington Post* reported 72,000 deaths from drug overdoses last year.¹ As health care providers, we can and should be involved in policy-making, but these changes are often slow. Further, legislation may have undesired and negative effects on our prescribing abilities and ultimately on our patients. Consider, for example, a chronic opioid user who requires surgery. This patient will likely require higher doses of analgesics than a patient who does not use opioids, yet the same prescribing restrictions may apply. Many physicians receive inadequate training in pain management and narcotic prescribing, and this has inadvertently contributed to the current problems with opioids.

During my hand fellowship training, some attending surgeons routinely prescribed 30 tablets of 5-/325-mg hydrocodone/acetaminophen, 30 tablets of 600-mg ibuprofen, and 1 day’s worth of antibiotics for patients undergoing minor outpatient hand surgery such as carpal tunnel release. When first in practice, I prescribed the same amount of narcotics for my own patients. However, I quickly realized that I had a poor understanding of how much pain patients experienced after surgery and

how many pain pills they were actually taking. I started asking about both of these at each initial postoperative visit. After minor procedures, most patients related having only mild or minimal pain, and I was surprised by the number of patients who left their narcotic script unfilled. This prompted me to closely examine my prescribing habits and review the literature on this topic. I began reducing the amount of narcotics I prescribed. Finally, I stopped prescribing narcotics all together for nearly all patients undergoing simple outpatient procedures.

Fortunately, a plethora of information is currently available in the orthopedic, surgical, and medical literature to help guide us as we seek to adequately manage our patients’ pain without overprescribing opioids. For example, a prospective, randomized, double-blinded trial comparing acetaminophen, ibuprofen, and oxycodone in the management of pain after open and endoscopic carpal tunnel release was recently published. The study found no statistical difference in pain levels or pill consumption after surgery between opioid and nonopioid groups, with the exception of greater average daily pain scores (rated 1 to 10) in the opioid group undergoing open carpal tunnel release compared with the nonopioid groups (3.4 vs 2.5 and 2.3, respectively). In all groups, overall number of pills consumed averaged 3 to 5. This suggested that, regardless of medication, no more than 5 to 10 pills should be prescribed.² Another recently published large prospective study evaluated opioid consumption following upper extremity surgery. It was concluded that patients are prescribed 3 times more opioids than needed. The authors provided general guidelines for opioid prescribing based on anatomy and type of procedure in an effort to prescribe “the optimal amount of opioids while avoiding dissemination of excess opioids.”³

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However, simply prescribing fewer opioids is only part of the solution. Partnering with our patients and having a plan to help them understand and manage postoperative pain is essential. Setting patient expectations regarding postoperative pain is a powerful way that surgeons can decrease the prescribing and the use of opioids. Discussing pain with our patients pre- and postoperatively provides useful information regarding how much pain is typical after specific procedures and how many opioids patients are taking, thus helping to shape our prescribing habits. Now that I have that understanding in my own patient population, preoperatively I discuss with all of my patients what to expect postoperatively. Clearly, some operations are more painful than others, and we talk about that. Patients' pain tolerances are different, so we also talk about that. We discuss that the expectation is not necessarily that they will be pain free, but rather that their pain will be adequately controlled. For larger, more painful operations, I say something like this: "This is a pretty painful operation. Most people need prescription pain medication for at least the first few days. It is very important that you do not get behind the pain, as it is more difficult to catch up. However, as soon as your pain is well controlled, you should start to cut back on the narcotic pain medication and transition to a combination of Tylenol and Motrin." This works well for most patients and helps them understand what to expect. For procedures for which I do not generally prescribe narcotics, such as carpal tunnel surgery performed under local anesthesia (a combination of lidocaine and bupivacaine with epinephrine and bicarbonate), my standard speech goes something like this: "The type of numbing medicine that I'm using should last you around 10 hours. When it wears off, you may have some burning, stinging, or mild pain in your palm—nothing that should be awful. If you need to take something for pain, Tylenol, Motrin, or a combination of both should be sufficient."

This approach of discussing pain and postoperative expectations with patients was highlighted in an abstract presented by Dayan et al⁴ at Anesthesiology 2017. They examined the expecta-

tations regarding postoperative pain of 223 patients undergoing neurosurgical, orthopedic, or general surgery procedures. Surveys were used to gather data on patients' anticipated pain levels at 1 hour and 1 day after surgery. Patients had significantly lower pain at 1 hour and 1 day after surgery than anticipated. This was especially true for patients undergoing regional anesthesia.⁴

Patients who expect more pain have more pain.⁵ Patients also anticipate more pain than they actually have,⁴ and surgeons continue to prescribe more opioids than patients take.⁶ It is our responsibility as surgeons to control our prescribing habits, understand the dynamics of our patient populations, and set expectations appropriately so that patients know what to expect and how to manage postoperative pain effectively with fewer opioids. In doing so, patients become partners together with us as we work to combat the rising opioid crisis.

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