control and patient satisfaction (P<.001).4 Our findings were further substantiated by recent evidence demonstrating the efficacy of transversus abdominis plane block in enhancing postoperative recovery and minimizing opioid requirements in patients undergoing major surgical procedures such as living donor hepatectomy.3

To date, the adopted prescription opioid control policies for acute pain in patients undergoing surgical procedures are in large part driven by common sense and focus mainly on the duration of use, which is often linked with risks of dependence and unused medication diversion. Nonetheless, measures limiting prescribing may not be in the best interest of every patient, as many patients require no opioids, whereas others who have contraindications to nonopioid analgesic agents or lack access to timely follow-up may require longer treatment. Although more evidence is awaited, additional efforts should be devoted to improve patient education and to use effective alternatives to opioids. Moreover, an individualized approach to opioid prescription based on procedure-specific and risk rather than days’ supply, particularly in opioid-naive patients, seems more appropriate.

In Reply—The Importance of Educational Interventions and Regional Analgesia in Tackling the Opioid Crisis in the United States

Overprescribing opioids has true risks for our patients. A study by Sanger et al1 found that more than half of patients in a methadone maintenance treatment program were introduced to opioids through a prescription. This carries particular relevance for surgeons, who prescribe a significant portion of all opioids, including many for patients with a history of exposure.2,3 Optimal prescribing practices therefore toe the delicate line between providing adequate pain control and minimizing the risk of medication misuse and abuse.4 This has important implications for the patient and society as a whole.

We agree with Hamid and Khan, who rightly point out that both provider and patient education are mandatory to make the successful transition to multimodal postoperative pain control protocols for surgical procedures. Education must also be provided for nurses, pharmacists, and others who interface with patients during their postoperative care to ensure a smooth transition and to reinforce expectations.5,6 At our institutions, efforts have been made to educate all members of the surgical team through department-wide presentations on our role in the opioid crisis. However, the importance of physician overprescribing cannot be overstated. Howard et al7 found that the quantity of opioids prescribed by physicians postoperatively was an independent risk factor for the quantity of opioids consumed. Thiel et al8 prospectively surveyed nearly 2500 patients who underwent various surgical procedures at Mayo Clinic (Rochester, Scottsdale, and Jacksonville campuses). They found that more than 75% of patients had leftover opioids and more than 60% of prescribed pills went unused. This and other studies emphasize the discrepancy between provider and patient expectations regarding postoperative pain management. Without proper prescribing practices, any change in demand through patient education would simply widen the gap of unused opioids.

The question of how to best address this disconnect is not entirely clear. In addition to enhanced recovery protocols, it seems logical to find ways to standardize postoperative pain control. Others9 have found success with postoperative prescribing guidelines. On the basis of the observed variation in opioid prescribing practices at our institutions, we became determined to take steps toward a more consistent approach. Recently, we also created a tiered guideline for postoperative opioid prescribing after common urologic surgical procedures. This was based

Hytham K.S. Hamid, MRCSEd

Department of Surgery
Soba University Hospital
Khartoum, Sudan

Department of Surgery
Mayo University Hospital
Castlebar, Ireland

Potential Competing Interests: The authors report no competing interests.


http://dx.doi.org/10.1016/j.mayocp.2019.03.007
on historical prescribing data and consensus from members of an “opioid task force” (consisting of urologists, anesthesiologists, nurses, pharmacists, and health services researchers). In yet unpublished data, we found that significantly lower quantities of opioids were prescribed in the first 3 months after guideline implementation. However, it should be noted that we do not advocate a one-size-fits-all approach to postoperative pain control, as has been suggested by some, including those who feel that most patients should not be prescribed opioids postoperatively. Rather, we believe that a more standardized approach to prescribing creates a framework on which providers can make informed decisions on the basis of patient-specific factors. Further success with this and other endeavors that seek to prevent personal and society harms from opioids will require buy-in from all parties involved.

Matthew J. Ziegelmann, MD
Department of Urology
Mayo Clinic
Rochester, MN

Elizabeth B. Habermann, PhD
Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery
Mayo Clinic
Rochester, MN

Matthew T. Gettman, MD
Department of Urology
Mayo Clinic
Rochester, MN

Potential Competing Interests. Dr Gettman serves as a consultant for Intuitive Surgery, COVR Medical, Levita Magnetics, and Vizient. The other authors report no competing interests.


http://dx.doi.org/10.1016/j.mayocp.2019.03.006