Test your practical understanding of Balancing Comfort and Safety in Post-Op Management

1. Simple conversations before surgery to educate your patient about pain after surgery and setting realistic expectations for the healing process may lead to less pain, less depression, an increase in appropriate activity, and lower healthcare utilization.
    A. True
    B. False

> True: It is important to discuss with your patient realistic expectations about their post-op pain timeline and functional recovery. Help your patients set realistic goals based on daily functioning and not just pain severity. Be sure your patients share their fears about pain and healing and be alert to mental health concerns that can heighten pain perception and are associated with higher post-op pain. The PHQ-2 (Patient Health Questionnaire 2-item depression scale) and the GAD-2 (Generalized Anxiety Disorder 2-item scale) offer quick screens for depression and anxiety. Simple, caring conversation nuggets may help reduce the negative influence of maladaptive coping strategies such as catastrophizing.

2. SCRIPTS (The South Carolina Prescription Drug Monitoring Program) provides a quick check pre- and post-op to screen for patterns of escalating or chronic opioid use and the use of benzodiazepines and other controlled substances.
    A. True
    B. False

> True: A quick check of SCRIPTS (as little as 1 minute) provides a snapshot of current and past controlled substances dispensed to your patient, including a detailed profile of controlled substances by prescription and a look at opioid use in morphine milligram equivalents per day (MME/day) over time. The report also provides details on naloxone administration for overdose rescue by first responders. See SCRIPTS (PDMP Reports) Quick Tricks and Tips to assist with a quick report review

3. Non-drug strategies for managing surgical pain are NOT an essential part of multi-modal pain management
    A. True
    B. False

> False: Behavioral and physical non-drug strategies are the foundation of multi-modal pain management and have demonstrated clinical benefit or potential clinical benefit (e.g.,

reduced pain, reduced anxiety, increased patient satisfaction) as part of pre- and post-op pain management. Non-drug options, often used in combination, help create an optimal mindset, improve patients' participation and feelings of control, and balance comfort and safety. The Joint Commission requires accredited hospitals to provide non-drug options for pain management in an effort to reduce the need for opioid medications. Music therapy, acupuncture, and TENS have studies that specifically report reduced medication use. There are also studies that report significantly reduced opioid use with guided imagery as adjunct therapy. Ensuring a good night's sleep is a key part of every patient's pain management plan and recovery.

4. Key points to note about non-opioid and opioid meds in multi-modal pain management include
    A. Scheduled around-the-clock non-opioid meds help patients stay ahead of severe pain and minimize opioid use.
    B. Non-steroidal anti-inflammatory meds (NSAIDS) and acetaminophen (APAP) in combination provide better pain control than either alone (e.g., ibuprofen 600 mg and APAP 1000 mg three times daily).
    C. Post-op opioid prescribing (dose and duration) should be adjusted based on typical pain expected for that surgery.
    D. Instructions for appropriate tapering of opioids prescribed for acute post-op pain should be included in every post-op pain management plan that includes an opioid.
    E. All of the above

All of the above: Optimize non-drug options, schedule around-the-clock non-opioid meds (e.g., NSAID + APAP), and use appropriate anesthesiology techniques (e.g., regional anesthesia) to minimize opioid use, reduce adverse effects, and improve pain control. The duration of around-the-clock dosing depends on the surgery type. Surgery type and anticipated typical pain and rate of recovery should determine if an opioid will be prescribed and the pill count for the post-op discharge prescription (the number of pills in the discharge prescription has been shown to impact the number of dosage units taken after surgery). One quick method to determine pill count is looking at the previous 24 hours of use to help determine how many dosage units may be needed; if no opioids were used, no opioid prescription is needed. There is no data to help inform same-day discharges. Having an opioid tapering plan in place can help the patient successfully discontinue the opioid when it is time. No meds are without risks; all meds prescribed for pain after surgery should have a plan for a stop date.

5. Just like any other patient, patients on chronic opioids for pain and patients with OUD need post-op pain management.

A. True
B. False

True: Management of acute post-op pain in patients on chronic opioids for pain and patients on medications for OUD (MOUD) should be coordinated pre- and post-op with their primary care provider and specialist. Both patients on chronic opioids for pain and MOUD patients on buprenorphine or methadone (opioid agonist medications) may have increased pain sensitivity due to opioid tolerance and require higher doses of opioids to achieve the same analgesic effect as a lower dose in opioid-naïve patients. More recent guidance and expert opinion recommend continuation of the MOUD opioid agonist throughout the perioperative period, as treatment disruption can increase relapse risk. Utilizing additional opioids short term on top of their baseline when needed for acute pain has not been shown to increase the risk of relapse (previously, the thought was that adequate pain management would easier to obtain if the opioid agonist was discontinued prior to surgery). Continuation of opioid agonists contrasts with discontinuation of naltrexone, the MOUD opioid antagonist also used to treat alcohol use disorder. Monitor patients who have paused naltrexone therapy for surgery because they may experience increased sensitivity to opioids that can increase their risk of respiratory depression.