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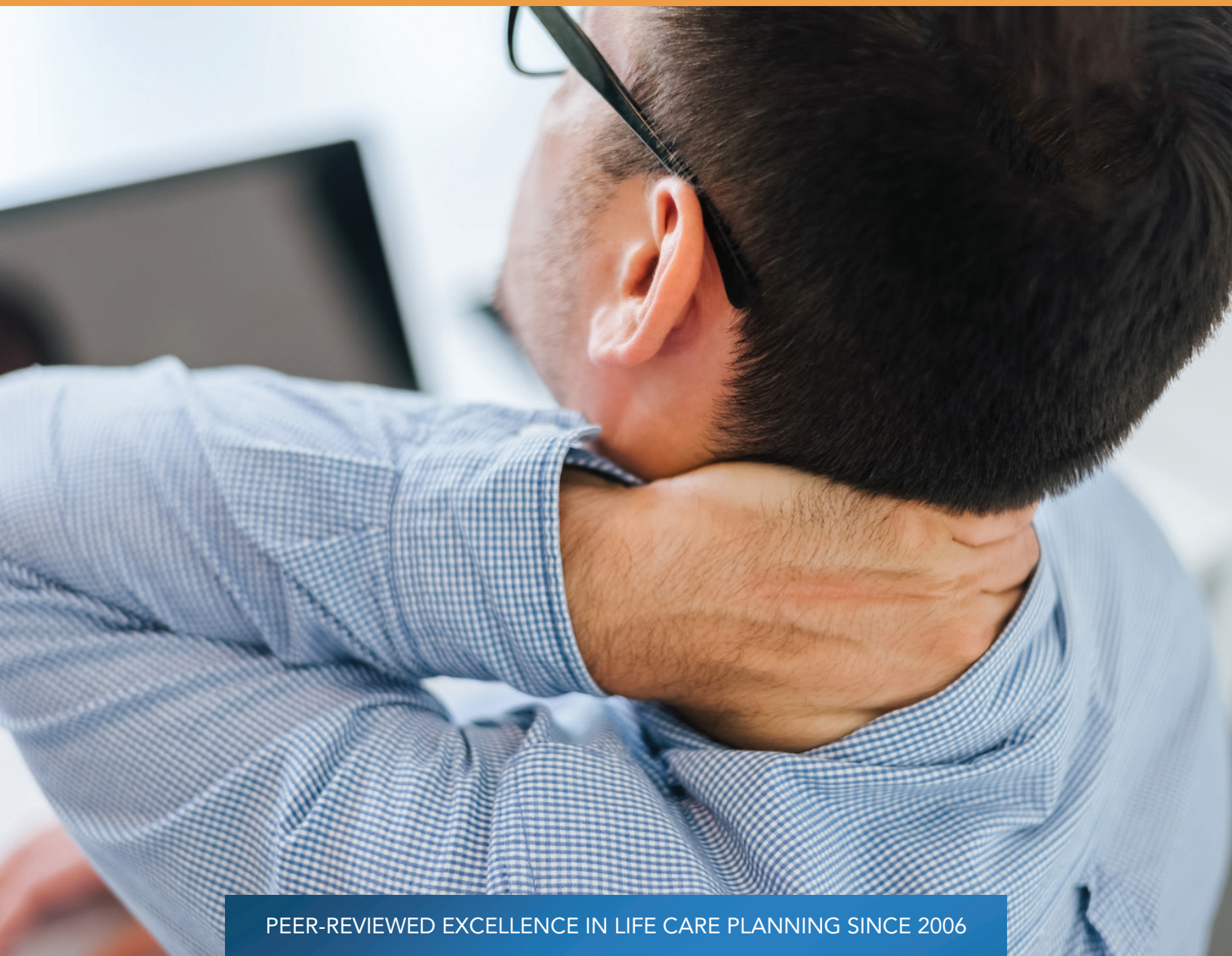
PAIN MANAGEMENT REVISITED



PEER-REVIEWED EXCELLENCE IN LIFE CARE PLANNING SINCE 2006

An Alternative to Opioids:

One Orthopedics Surgeon's Approach to Being a Part of the Solution.

By Jenn Masse

Keywords: Acute pain, Orthopedic Surgery, Orthopedic pain

NURSING DIAGNOSES TO CONSIDER
NANDA-I 2021-2023

1. **Domain 12.Comfort. Class1. Physical Comfort. Acute pain**
2. **Domain 1. Health Promotion. Class 2. Health Management. Readiness for enhanced health management**
3. **Domain 9.Coping/Stress Tolerance. Readiness for enhanced coping**

The word opioid is rarely used these days without words like 'epidemic' or 'crisis' following close behind. But how are Nurse Life Care Planners part of the conversation? I remembered a TED Talk I attended a few years ago, where an orthopedic surgeon laid out a pragmatic and strategic approach for narcotic-free surgical interventions. But where were these options in my reports? Had I ever had a conversation with a subject that involved navigating addiction alongside their care? So I found that physician, Dr. Jason (Jay) DeMarco, and asked for a bit of his time to pick his brain on the logistics of his approach.

The opioid epidemic is considered a public health emergency, with 136 deaths per day and climbing.

~ The National Center for Drug Abuse Statistics

Dr. DeMarco opened our conversation by noting that it would be hard to find someone not personally affected in some way by addition. He reflected on a couple of more memorable patients that shaped the way he practices, and he hopes conversations like ours would lead to more discussions regarding the navigation of addition in the medical field.

On that note, I queried how someone could find a doctor that offered a narcotic free or "narcotic-thoughtful" surgical intervention, and his answer was unfortunately disheartening.

Research regarding pain receptors continues to mature, leading to a larger understanding of opioid induced hyperalgesia:

If someone is talking surgery with a doctor, then most likely they have "married" them in the sense of providing surgery. Dr. DeMarco stated that patients would have to be their own advocates and ask tough questions of their physicians up front. Dr. DeMarco is up front that he does not prescribe narcotics for anyone that is not having surgery, period.

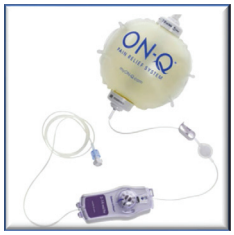
He then noted that the cultural shift from narcotic prescriptions has almost gone completely the other way – those who control their pain with narcotics can't get it prescribed. Prescribers know the DEA is watching, and while prescribing practices have changed, effective pain management has not been addressed.

But what are the nuts and bolts? The logistics and mechanics? As in, how do you manage the pain/who manages after the procedure/during recovery/etc.? Let's walk through a shoulder replacement as an example.

Dr. DeMarco's research supports his approach. Scan QR code for article:

Preoperatively, Dr. DeMarco reiterated the importance of having a "game-plan" conversation with the surgeon so that everyone is on the same page and that there are no surprises. He briefly touched on the multiple therapies patients can access, such as TENs units, dry needling, and cupping, just to name a few. Dr. DeMarco starts Celebrex, Tylenol, and sometimes gabapentin prior to surgery. In relation to our theoretical patient, an icing machine is the star of the show. Dr. DeMarco spoke to the benefits of proper cooling/icing and the top of the list was pain control.

On the day of surgery, the patient is given Celebrex and Gabapentin. Anesthesia places a dense nerve block that will cover pain for about 12-18 hours post-operatively. No specific certification is needed for catheter placement, as it is completed by either the operating physician or the anesthesiologist. Often, the catheter used when placing the initial block is left in place and utilized for the pump.



Before attaching, the On-Q bulb is filled with a bupivacaine-type medication that provides approximately 4ml an hour, or roughly 60-72 hours' worth of coverage, until empty.

Post-operatively, the patient will continue around-the clock Tylenol and/or Ibuprofen. Gabapentin and/or Celebrex type medications are available should the preoperative assessment and agreed-up gameplan warrant/call for it. After the patient goes home, the PA and On-Q rep are available for troubleshooting, with the operating surgeon as back-up. Three days after the procedure, the patient will pull the catheter out at home.

A multimodel pain management regimen include around-the-clock acetaminophen and an anti-inflammatory, both showing positive efficacy outcomes:

When asked what surgical procedures were off the table with this approach, he responded that most orthopedic procedures are completely doable, however, the spine can get tricky. When asked if there were contraindications for this approach (thinking comorbidities /age/etc.), Dr. DeMarco responded that those unable to take anti-inflammatories would be a concern, as would those with COPD (contraindicated due to certain blocks affecting the diaphragm), however obesity played no factor in the decision making.

Assuming Dr. DeMarco doesn't hit a home run every time he performs surgery, he supplies #10 tablets of narcotics for breakthrough pain. He noted that patients often had a hypersensitive response when the initial block wears off, and he found that is the rare time his patients might take a stronger medication. Per Dr. DeMarco, "One patient out of ten might take all prescribed narcotics for breakthrough pain."

Then I got to the bottom line, per se, and asked if narcotic-free management is a more expensive or less expensive approach for surgical interventions? Dr. DeMarco stated that it is more expensive in the short-term, but with a worthwhile long-term outcome.

So I challenged that and did some quick calculations, using the Charleston, SC area. Please note I did not include

preoperative clearance, the surgical procedure itself, or post-operative physical therapy. This pricing comparison is for pain management purposes only.

A prescription for Hydrocodone #60-90, 10/325mg, is $68.43 - $99.29. The total price range for the On-Q bulb, catheter, regional block/catheter placement, Ice Machine, and non-narcotic medication is $3,473.94 - $5,728.88.

As surgical interventions continue to be a part of our Life Care Plans and medical cost projections, we need to be making sure patients are aware of the options that will give them the most holistically positive outcome. Dr. DeMarco highlighted that surgery can quickly become an entryway into addiction and that nothing he does is novel or new. Addressing addiction when discussing surgery can promote a beneficial result for not only the patient and family but the system as a whole.

Associated links:

Jay DeMarco: Opioid Epidemic – One Fix from a Physician TED Talk

Pricing research:

Per On-Q representative for the local area:
On-Q pain pump total cost range: $15-$305
Catheter range, $30-$125

Pricing for regional block and ultrasound guided catheter placement:
Procedure: $318.28, including facility fee $1,581.26
Procedure: $399.80, including facility fee $3,451.20

Post-operative Ice Machine
Purchase option range: $2,755 - $4,599.99
Rental fee: $300, per two weeks

Around the clock Tylenol/Ibuprofen for 30 days, nightly Gabapentin for 30 days, using geographically filtered GoodRx retail pricing:
Gabapentin 100m g #30, $17.20
Tylenol/Ibuprofen, $30.48