Choices in postsurgical pain management may impact recovery after bariatric surgery

BARIATRIC

PATIENTS UNDERGOING BARIATRIC SURGERY ARE AT HIGH RISK FOR SURGICAL COMPLICATIONS DUE TO PREEXISTING MEDICAL CONDITIONS, INCLUDING[1-3]:

- Sleep apnea
- Insulin resistance and type 2 diabetes mellitus
- Hypertension
- Dyslipidemia
- Cardiovascular disease
- Stroke
- Gallbladder disease
- Hyperuricemia and gout
- Osteoarthritis

PAIN MANAGEMENT CHOICES AFTER BARIATRIC PROCEDURES MAY EXACERBATE SURGICAL RISKS AND COMPROMISE RECOVERY GOALS

Inadequate analgesia prevents early mobilization, which can hinder recovery by increasing the risk of[4]:

- DVT
- Pressure ulcers
- Respiratory complications, including pneumonia

99% of surgical patients have been found to receive postsurgical opioids[11]*

Reliance on opioids can exacerbate underlying health issues and increase the risk of:

- VTE (PE and DVT) with every 10-unit increment in body mass index[5]
- Respiratory depression (higher risk for those with obstructive sleep apnea) and sedation (fall risk)[6]
- ORAEs, including pruritus, nausea, vomiting, and delayed bowel function[6]

Underlying physiological differences associated with obesity predisposes patients to additional recovery-related challenges:

- Opioid metabolism and pain signaling issues result in the need for increasing amounts of opioids for pain relief[7,8]
- Addiction transfer after bariatric surgery can lead to substance and alcohol abuse disorders[9,10]

OPIOID MISUSE OR ABUSE CAN BEGIN FOLLOWING EXPOSURE TO OPIOIDS DURING BARIATRIC SURGERY

1 in 15 patients prescribed an opioid for postsurgical pain will **go on to long-term use**[12†]

Percentage of patients who continue to use opioids 1 year after bariatric surgery[14]:

Nearly 10% of opioid-naïve patients

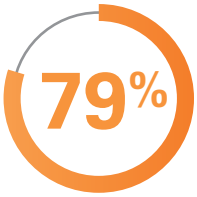
65% of patients who used opioids prior to surgery

0 to 105 pills are prescribed after bariatric surgery[13]

~25% of patients report **keeping unused pills at home**, leaving a substantial number of pills for potential misuse and diversion[13]

IF ASKED, PATIENTS WOULD CHOOSE TO RECOVER WITH AN ALTERNATIVE TO OPIOIDS[15‡]

of patients said they were **concerned about side effects, addiction, or dependence**



of patients said they **preferred a non-opioid** pain management option

*According to a retrospective study of hospital discharge data (N=37 031).
†According to a prospective, longitudinal study (N=109). Preoperative opioid use, self-perceived risk of addiction, and depression were each independent predictors of prolonged (6 months) opioid use after surgery.
‡From a survey of 500 adults in the US who had an orthopedic or soft tissue surgery and 200 US surgeons who perform these procedures.

DVT=deep vein thrombosis; ORAE=opioid-related adverse event; PE=pulmonary embolism; VTE=venous thromboembolism.

Opioid-reducing strategies are proven to enhance recovery after bariatric surgery

MULTIMODAL APPROACHES WITH OR WITHOUT ERAS PROTOCOLS HAVE DEMONSTRATED BENEFITS IN BARIATRIC SURGERY

Protocol implementation can positively impact recovery and reduce costs[16]

- **50%** shorter LOS[16]
- **40% to 61%** fewer opioids at 48 hours[17,18]
- **86%** fewer patients with itching, demonstrating an improvement in ORAEs[18]
- **Earlier ambulation,** which may reduce the risk of VTE (PE and DVT)[5]
- **50%** fewer cases of respiratory dysfunction in patients not taking morphine[19]
- **96%** of patients without postoperative nausea/vomiting[19]
- **19-hour** earlier return of bowel sounds and flatus[20]

THE ASA SUPPORTS THE USE OF OPIOID-MINIMIZING PAIN MANAGEMENT STRATEGIES AFTER BARIATRIC SURGERY

"Because of the high incidence of obstructive sleep apnea (OSA) in obese patients and other studies showing that morbidly obese patients have increased perioperative airway obstruction and desaturations even without OSA, the focus with regard to pain management has to be on opioid-sparing multimodal approaches."[4]

***—Best Practice & Research Clinical Anaesthesiology*, 2011**

"...regional analgesic techniques should be considered to reduce or eliminate the requirement for systemic opioids in patients at increased perioperative risk from OSA."[21]

"For superficial procedures, consider the use of local anesthesia…"[21]

—2014 Practice Guidelines for OSA

LOCAL AND REGIONAL ANALGESIA ARE IMPORTANT COMPONENTS OF OPIOID-REDUCING, MULTIMODAL PAIN MANAGEMENT STRATEGIES[22]

Local analgesic infiltration
directly targets pain at its source and is not associated with major side effects[23]

Local anesthetic field blocks
can effectively provide regional anesthesia in abdominal surgeries[24]

NEW MODALITIES, ALONG WITH LONG-LASTING LOCAL ANALGESIC PAIN CONTROL, CAN REDUCE THE NEED FOR OPIOIDS WHEN USED AS PART OF A MULTIMODAL PAIN MANAGEMENT APPROACH[25]

ASA=American Society of Anesthesiologists; ERAS=enhanced recovery after surgery; LOS=length of stay.

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