The study by Mark et al presents the findings of a case-control cohort study of gynecologic oncology patients receiving ambulatory or minimally invasive surgery highlighting the effects of an ultrarestrictive opioid prescription protocol (UROPP). All patients receiving ambulatory or minimally invasive surgery were not prescribed opioids at hospital discharge unless they required more than 5 doses of oral or intravenous opioids in the 24 hours prior to discharge. Patients receiving laparotomy were prescribed either a 3- or 6-day supply of opioids at discharge based on whether they similarly required more than 5 opioid doses in the 24 hours prior to discharge. Overall, there were significant decreases in the mean number of opioid tablets prescribed at discharge comparing cases with controls after laparotomy (12.1 vs 43.6 tablets; \( P < .001 \)), after major laparoscopic or robotic operations (1.3 vs 38.4 tablets; \( P < .001 \)), and after ambulatory surgery (0.2 vs 13.9 tablets; \( P < .001 \)). In the context of an overall 89% reduction in dispensed opioids, the UROPP did not increase the number of refill requests within the first 30 days, postoperative visit pain scores in the first 2 weeks, or postoperative complications.

The authors described a promising strategy for markedly decreasing postoperative opioid prescribing without increasing pain. These actions greatly limit the potential for diversion and opioid misuse that can result from opioid overprescribing. In the context of the current opioid crisis, much attention is likely to be focused on the opioid prescribing aspects of the protocol. However, it is important to emphasize that the protocol encompasses more than personalized opioid prescribing. Patients received preoperative counseling related to postoperative pain management including discharge opioid prescribing per the protocol, opioid adverse effects, and nonopioid pain management strategies. Setting up expectations is likely to play a key role in improving postoperative outcomes. All patients participated in the enhanced recovery after surgery program for inpatient pain management (acetaminophen, gabapentin, cyclooxygenase-2 inhibitors preoperatively, and consideration of regional anesthesia). In addition, all patients were prescribed a 7-day supply of ibuprofen and acetaminophen at discharge. Successful implementation of ultrarestrictive opioid prescribing should only be carefully considered in the context of these other key components. There is wide variation in the use of multimodal analgesia protocols nationwide, and nonopioid pain management must be optimized to minimize opioid prescribing at discharge. With increasing regulations across the country limiting opioid prescribing for acute pain, these study results show the feasibility and safety of an approach to address these regulations for gynecologic oncology patients.

It is equally important to emphasize that 22 patients (3.5%) following UROPP implementation were removed from the analysis owing to protocol deviations. These cases involved larger excisions and patients with chronic opioid use prior to surgery. Chronic opioid users included in the analysis reverted back to baseline use within 30 days after surgery. It is unclear whether chronic opioid users excluded from the analysis had higher baseline levels of use, higher postoperative needs, or preoperative opioid tolerance that resulted in a protocol deviation. Preoperative opioid use was associated with increased mortality, morbidity, and postoperative health care use and research is needed to understand the effect of ultrarestrictive opioid prescribing in this high-risk cohort. With implementation of more restrictive opioid prescribing practices, it is important to fine-tune protocols...
to include preoperative risk stratification to identify patients at high risk for both persistent postsurgical pain and opioid use. This would allow for targeted referrals to perioperative pain management services, as well as initiation and continuation of multimodal analgesia throughout the recovery period after hospital discharge. Creating such a pathway would set up high-risk patients for success and provide an alternative pathway to protocol nonadherence and the associated negative connotations. The UROPP represents a management strategy for patients at low risk. However, a pathway should urgently be considered for patients at high risk for continued and escalated postoperative opioid use.

The cohort in this study included mostly female gynecological oncology patients receiving major or minor surgery, and inpatient opioid doses in the last 24 hours prior to discharge provided a simple and accurate association of postdischarge opioid needs. Future work to generalize these findings among patients receiving procedures associated with a higher risk of persistent postsurgical pain and/or opioid use are needed to determine appropriate thresholds for avoiding or initiating opioid prescribing after surgery. Marked reductions in opioid dosing have been reported using a tiered, operation-specific approach to outpatient hand and upper-extremity procedures.5 Thus, patient- and surgery-specific risk factors for persistent postsurgical opioid use should be considered in the implementation of restrictive opioid prescribing protocols. For example, depression increases the odds of chronic opioid therapy after lumbar fusion6 and is a risk factor for initiating chronic opioid use after total hip arthroplasty.7 Distinct interventions need to be developed for patients with depressive symptoms and other causes of persistent postoperative pain, opioid use, and opioid misuse (eg, preexisting chronic pain or substance use disorders).

Without further consideration of patient-specific risk profiles while implementing the enhanced recovery after surgery and surgery-specific opioid prescribing protocols, patients at highest risk for persistent postsurgical opioid use may be less likely to receive additional supportive interventions. It is interesting that no change occurred in opioid refill requests within 30 days after surgery (16.6% pre-UROPP and 16.5% post-UROPP), implying that the UROPP alone may not effectively prevent the development of persistent postsurgical opioid use among the highest-risk patients. Although much attention has focused on preoperative risk stratification, these study results imply that heightened opioid requirements in the immediate postoperative phase may signal worse outcomes and presents another opportunity to identify patients at risk for postoperative chronic opioid use. Future research is needed to ensure that ultrarestrictive opioid prescribing does not promote the development of either remote persistent postsurgical pain or opioid use. As acute postoperative pain is associated with the development of persistent postsurgical pain, and given consistent pain scores before and after UROPP implementation, it appears that this approach does not acutely place patients at heightened risk.

Overall, these study findings represent the importance of a cultural shift in postoperative opioid prescribing practices as the majority of patients receiving minimally invasive and ambulatory operations received no opioid prescriptions and recovered well with a 7-day supply of ibuprofen and acetaminophen. Ultrarestrictive opioid prescribing may represent a strategy for primary prevention of subsequent opioid misuse and the development of opioid use disorder. However, it remains unclear how this shift in prescribing practices will affect the development of new persistent opioid use among a minority of patients, escalated and prolonged opioid use among preoperative chronic opioid users, and patients with opioid use disorder presenting for operations. Future work to assess the generalizability, efficacy, and safety of ultrarestrictive opioid prescribing practices in the context of optimal nonopioid pain management are needed. Despite legislation to restrict opioid prescribing in the context of the current opioid crisis, clinicians must remember that the focus should not be restriction of opioids, but rather optimizing postoperative pain management, function, and recovery long after hospital discharge.
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REFERENCES


