

# Johns Hopkins experts create opioid prescribing guidelines for 20 common surgical procedures

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A Johns Hopkins expert panel of health care providers and patients have announced what is, to their knowledge, the nation's first set of operation-specific opioid prescribing guidelines. The guidelines are based on the premise that opioid prescribing limits should be based on the operation performed rather than a blanket approach. The ranges offered for each of 20 common operations generally call for reductions from the current rates of opioid prescription, and the researchers say that patients themselves favor using less of the drugs than physicians often prescribe.

In a report published August 14 in the *Journal of the American College of Surgeons*, the researchers explain the process of consensus reached by 30 surgeons, [pain](#) specialists, outpatient surgical nurse practitioners, surgical residents, [patients](#) and pharmacists.

"Prescriptions for pain meds after surgery should be custom tailored to the operation and a patient's needs and goals, but the hope is that these guidelines will help reset 'defaults' that have been dangerously high for too long," says Martin Makary, M.D., M.P.H., a professor of surgery and health policy expert at the Johns Hopkins University School of Medicine and the study's senior author.

The prescribing limits are designed to help prevent patients from receiving unnecessary opioid pills after surgery—a common way in which some people are introduced to opioids and later become addicted, with data showing that an estimated one in 16 surgical patients eventually become long-term users, says Makary. The guidelines are already being used to educate Johns Hopkins residents and surgeons and to replace the current e-prescribing defaults that appear in prescribing systems. A second expert panel of dentists has

also duplicated the effort for dental procedures.

Makary says the magnitude of the overprescribing problem can be best summarized in recent data showing that half of surgical patients who are not even taking opioids in the hospital the day before they go home are still given an opioid prescription.

Some organizations do offer guidelines for overall [pain management](#) but do not provide [procedure](#)-specific guidance for post-operative pain management and do not focus on patients receiving opioids for the first time, says Makary. "We should not be using the same opioid guideline for an open chest operation that we use for a lumpectomy."

Recent research offers evidence showing that 70 to 80 percent of opioid pills prescribed after surgery are not being used by patients, suggesting that they need far fewer opioids than they are prescribed.

Johns Hopkins researchers recognized the need for creating a consensus around guidelines for appropriate amounts of opioids. In efforts to develop such detailed guidelines, Makary and his colleagues convened 30 health care professionals from the Johns Hopkins Health System, split into six groups: surgeons, pain specialists, outpatient surgical nurse practitioners, surgical residents, patients, and pharmacists. Makary provided each panel member with relevant literature on addiction and other risks of opioids.

The panel then reviewed 20 common procedures in the areas of breast surgery, thoracic surgery, orthopaedic surgery and, cardiac surgery, among others such as open hysterectomies and cochlear implants. The panelists were asked to recommend a pain management opioid regimen for each procedure, assuming the patient was an average

adult who has not been previously exposed to opioids.

Drafts of the recommendations were shared with all 30 panel members and again during a full panel, in-person meeting two weeks later.

During the meeting, researchers asked the panel members to recommend an appropriate number of pills, each pill equivalent to 5 milligrams of oxycodone, for each procedure for the average adult patient procedure—assuming the patient's operation was uncomplicated and the patient did not suffer from chronic pain unrelated to the surgery.

At the meeting, each panelist explained their rationale for each recommendation, which was followed by a vote by all panelists on a broad set of prescribing recommendations.

Following the vote, researchers distributed results to the panel for final approval and comments.

Overall, the panel recommended a range from one to 15 opioid tablets for 11 of the 20 procedures, 16 to 20 tablets for 6 of the 20 procedures, and zero tablets for three of the 20 procedures.

Orthopaedic surgery procedures warranted the highest range of opioids, with the panel voting for a range of zero to 20 pills for three of the four orthopaedic procedures. Otolaryngology procedures, according to the panel, warranted the lowest range of opioids, with a suggested zero pills for cochlear implants and zero to 15 pills for thyroidectomies.

The panel also recommended that the minimum number listed in the table range for opioid tablets should be zero and the maximum should be 20.

Overall, patients who had the procedures voted for less opioid pills than the surgeons performing those operations. For example, one patient who underwent a knee scope and one patient discharged after a c-section believed non-opioid alternatives alone were sufficient pain management, whereas others on the panel voted for 10 and 15 opioids to be prescribed, respectively.

"Anywhere in range agreed upon by the panel represents a major improvement from current practice." Makary says, acknowledging the wide range in the survey results reflects the fact that a strict dosage template is unlikely to work because pain is a subjective experience, and there are no objective means of measuring an individual's pain or pain tolerance. He also acknowledges that the guidelines are neither binding nor the last word on efforts to reduce the overprescription of opioids.

Makary still hopes, however, that the team's efforts will likely decrease the amount of opioids prescribed for short-term acute pain.

"It's unfortunate guidelines haven't already existed. Giving patients dangerous opioid pills they don't need is part of how we got into this [opioid](#) crisis in the first place," he adds.

Provided by Johns Hopkins University School of Medicine

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