

## Appendix

### ***Clinical Recommendations for Managing Analgesia and Opioids in Surgical Patients\****

#### **Preoperative Period**

1. Ask about past and current use of, response to, and preferences for analgesics.
2. Check the prescription database, where available, for patients with a history of occasional or chronic opioid, benzodiazepine, or sedative-hypnotic use.
3. Assess risk for potential postoperative opioid oversedation and/or respiratory depression and difficult postoperative pain control.
4. Consider consultation with a specialist (e.g., one with expertise in pain management or addiction medicine), particularly in patients at risk for both oversedation and difficult postoperative pain control.
5. Consider consultation with a psychologist if the patient appears depressed or very anxious.
6. Develop a coordinated treatment plan, including a timeline for tapering perioperative opioids.
7. Identify which provider will be responsible for managing postoperative pain and prescribing opioids:
  - A. Generally, in opioid-naïve patients, any opioids prescribed during the first 6 weeks postoperatively should be managed solely by the surgeon.
  - B. Involve a postoperative pain service or chronic pain and addiction service for patients with a history of opioid use.
8. Inform patient and family of the perioperative pain management plan. Set expectations with them about realistic pain management goals, including functional recovery activities, need for multimodal treatment that includes cold compresses, acetaminophen, anti-inflammatories, and mild opioids.
9. Avoid new prescriptions of benzodiazepines, sedative-hypnotics, anxiolytics, or other central nervous system (CNS) depressants.

#### **Intraoperative Period**

1. Provide balanced multimodal analgesia, including adjuvant analgesics, when possible (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs], gabapentin, and local anesthetic infiltration).
2. Under specialist direction, ketamine, bupivacaine, lidocaine, and regional local anesthetic techniques can also help to minimize perioperative opioids and their side effects.
3. Provide sufficient intraoperative opioid doses to avoid acute withdrawal in patients who are on high doses of preoperative opioids.

#### **Immediate Postoperative Period**

1. Reserve the use of opioids for moderate to severe acute pain. If used, utilize the lowest possible dose as part of a multimodal regimen, including NSAIDs, acetaminophen, and non-pharmacologic therapies.
2. Monitor sedation and respiratory status in patients receiving systemic opioids for postoperative analgesia.
3. Use oral opioids for managing postoperative pain in patients who can tolerate them orally.
4. Use short-acting “as needed” (PRN [pro re nata]) opioids as the foundation for acute severe postoperative pain in the opioid-naïve patient.
5. Avoid therapeutic duplication of opioids consisting of >1 type of PRN short-acting opioid (e.g., oxycodone and morphine).

6. Consider scheduling nonopioids for steadier analgesia and to avoid multiple PRN opioids for pain.
7. Resume patient's prior pain regimen as soon as possible if he or she was previously on chronic opioids and is expected to continue these postoperatively.
8. Avoid new prescriptions of benzodiazepines, sedative-hypnotics, anxiolytics, or CNS depressants. If patient was previously on chronic sedatives, restart these at lower doses.
9. Initiate a bowel regimen as soon as possible postoperatively to minimize opioid-induced bowel dysfunction (constipation).
10. Never discharge the patient with more than a 2-week supply of opioids.

### **At Time of Hospital Discharge**

1. Avoid continuing or adding new prescriptions of benzodiazepines, sedative-hypnotics, anxiolytics, or CNS depressants.
2. Inform the patient and family which provider will be responsible for managing postoperative pain, including who will be prescribing any opioids. Ideally, only 1 doctor should prescribe analgesia.
3. Remind the patient of the dangers of prescription opioid diversion and the importance of secure storage of their medications. Sharing medications with others is never appropriate and is illegal.
4. Follow through with the agreed-on preoperative plan to taper off opioids that had been added for surgery as surgical healing takes place. The goal is always the shortest duration—not more than 6 weeks—and at the lowest effective dose.
5. Develop alternative arrangements locally for refills to reduce overprescribing at the time of discharge. The result will be much more responsible initial prescribing.

\*Adapted from the Interagency Guideline on Prescribing Opioids for Pain developed by the Washington State Agency Medical Directors' Group (AMDG). 3rd ed. June 2015.  
<https://www.doh.wa.gov/Portals/1/Documents/2300/2017/AMDG-Guidelines.pdf>