

BEST PRACTICES: PART I

Niches Converging: Addiction Medicine and Peri-Operative Medicine as Domains of Internal Medicine

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A middle-aged woman with chronic back pain due to lumbar stenosis presents in advance of scheduled lumbar fusion. She currently manages her pain with acetaminophen, ibuprofen, and physical therapy. She is looking forward to improved pain control once she has recovered from surgery, though anticipates a hydro-morphone prescription on discharge. She has a family history—though no personal history—of addiction, and wonders how long she will need hydro-morphone post-operatively or how she will taper it down to completion of therapy.

Unsurprising to any reader, the United States is currently in the midst of an opioid epidemic. Numerous stakeholders have been identified, and the issue continues to garner significant attention in the medical literature and lay press. Significant attention has also turned to the burden of POST-operative opioid prescribing.

Surgery might be a pivotal index event at the apex of the slippery slope of dependence, addiction, overdose, and diversion. This occurs not just after major surgery with rates of new persistent opioid use estimated up to 6.5%¹, but also after minor procedures including dental work.^{1,2} Optimal use for post-operative opioids, though varying by procedure, may range from 4-15 days.³ However, 67-92% of patients reported unused opioids post-operatively, with no more than 9% of patients safely disposing of remaining opioids.⁴ Multiple recent studies now appear in the surgery literature, includ-

ing educational endeavors to better understand more appropriate post-operative opioid prescribing and curb excessive dispensations.

Now let us share a few other possible scenarios:

- *A young woman with a history of tricuspid valve endocarditis, attributed to past intravenous heroin abuse, is scheduled for tricuspid valve repair. She is in sustained recovery on buprenorphine-naloxone therapy. How should her buprenorphine-naloxone be managed peri-operatively?*
- *A middle-aged gentleman with alcohol use disorder is scheduled for hemicolectomy for newly diagnosed colon cancer. He has no insurance coverage for medication-assisted treatment (MAT) or outpatient substance use disorder (SUD) treatment, but has been able to wean his alcohol intake from six beers daily to two. How should he be managed peri-operatively?*
- *A middle-aged woman with an intracranial meningioma is scheduled for craniotomy and resection. She has been in stable recovery from past intravenous heroin use for nearly 20 years, but because of an intense fear of discrimination, she does not disclose her chronic buprenorphine-naloxone therapy, despite multiple pre-surgery visits and medication reconciliations. Post-operatively, she develops*

delirium, ultimately attributed to acute pain and opioid withdrawal. How could this situation have been prevented?

Often, people with substance use disorders are declined elective surgery because of discrimination or provider fears about outcomes in the setting of active substance use, fears of relapse, or concerns for difficult perioperative management. Peri-operative medicine is an art and a science requiring nuanced, compassionate, patient-centered risk/benefit discussions.

Please consider the following:

- What if surgery is not elective or emergent?
- How might acute pain and surgery affect recovery from a substance use disorder?
- How should post-operative opioid prescriptions be handled on discharge?
- How can the risk of post-operative SUD relapse be mitigated?
- How can systems assure that patients with opioid use disorder receive adequate pain management in the acute setting?

Hospitalization and acute illness can be a “reachable” moment to initiate and coordinate addiction care.⁵ Hospital providers and systems have a duty to provide evidence-based addiction care. Broadly, this means increasing provider knowledge, skills, and attitudes of addiction medicine so that patients are offered life-sav-

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ing medications for addiction, do not suffer untreated withdrawal, and receive inappropriate pain management. It means expanding addiction medicine consult services to academic medical centers⁵.

To quote one editorial regarding infectious disease specialists becoming addiction medicine specialists, “The history of medicine is, in part, the history of physicians stretching the scope of their practice to answer the pressing needs of their times.”⁶ With surgeons and other proceduralists identifying themselves as stakeholders in the issue, where does the general internal medicine physician enter the scene? In the last several decades, the internist, be it a hospitalist or a primary care physician, has matured into an expanding role in perioperative medicine. The internist has a unique role to play in assessing, optimizing, and managing multiple comorbid conditions before and after surgery. Additionally, addiction medicine, though it can be approached from multiple specialties and subspecialties, has seen an expanding presence by internal medicine. Is there room or potential for a convergence of these two internal medicine niches?

A nuanced, patient-centered preoperative medicine evaluation should account for any and all comorbid conditions that impact peri-operative risk. This includes substance use disorder, active or in remission. The internist in the pre-op clinic may be uniquely positioned to coordinate complex multidisciplinary care and transitions of care, and has a duty to provide

trauma-informed care that addresses both physical and social determinants. Specific challenges may include the following:

- How can providers better incorporate patient preferences when tailoring a plan for perioperative pain management?
- What counseling should patients receive about risks of opioids prior to surgery?
- How can addiction medicine providers best be included in the multidisciplinary management?
- Can MAT be initiated pre-operatively by a PCP or by a dedicated pre-op clinic?
- Should pre-op internists become buprenorphine certified?
- Should an otherwise healthy patient with a history of substance use disorder require a pre-op evaluation before the day-of-surgery?
- How should complications of substance use disorder (HIV, HCV, alcoholic liver disease, cardiac complications, comorbid psychiatric disease) be factored into the pre-op eval?
- Is there a role for pre-operative outpatient or post-operative inpatient addiction medicine consultation?
- How can compassionate, patient-centered care for patient with a history of addiction be provided in the peri-operative setting?

Peri-operative medicine and addiction medicine stand to prove their

important overlap. Awareness of the issue and attention to the matter are the first steps.

References

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