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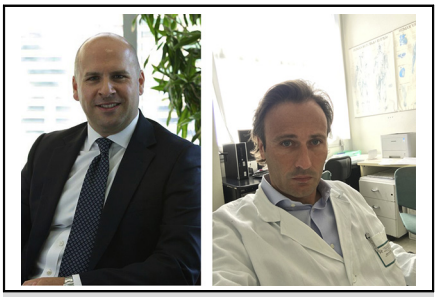
Commentary: Long-term postoperative pain monitoring and management? The solution is digital

Marco Scarci, MD, and Federico Raveglia, MD



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CENTRAL MESSAGE

Failure in postoperative pain management still affects quality of care. Strategies to improve it cannot be other than patient-tailored. E-health represents the future in patient–doctor communication.

This article by Hazewinkel and coworkers[1] really piqued our interest because it focused on long-term postoperative pain in thoracic surgery by investigating, for the first time, the incidence of readmissions to emergency department (ED) after hospital discharge. Its strength certainly lies in choosing this outcome rather than the more common pain scales; indeed, regardless of the intensity of the referred pain, every postoperative access to the ED is already a negative quality of care indicator. If the research goal was interesting, the results are even more so, since 41 of 277 patients returned to ED for pain, of whom 50% returned in the first 30 days and the remaining 10% between 100 and 150 days from discharge. The authors could also estimate risk factors for pain-related ED visit, although these results are less surprising, since thoracotomy and pain during the hospital stay resulted in being the most important variables.[2]

Addressing this study, we cannot ignore that the results, which are not too encouraging, concern in particular the authors' personal experience and may differ from department to department. However, focusing on their follow-up protocol, some general considerations can be drawn.

The first is about the pain management in the ward. It is once clearer that optimization of therapy during the very first postoperative days protects against chronic pain. In our experience, assistance by an acute pain service is essential.[3]

The second relates to high-risk patients. Since their characteristics are easily identifiable, they deserve special attention, not just at discharge. The authors themselves suggested a deficiency of pain medication due to lack of prescription or pain management education.

This refers to the third topic. What is the correct timing for the first visit to the outpatient clinic? The authors scheduled it at 10 to 14 days after discharge, as it probably happens in all thoracic surgery departments. However, many patients visited the ED before their first visit or paradoxically immediately after.

The first category of patients suggests the need for a medical consultation outside of a scheduled visit whereas the second category questions the quality of the visit itself. Indeed, the first visit is usually adversely affected by shortage of time during which the surgeon is more focused on other activities (suture removal, radiograph reviewing, and histologic examination discussion), and patients themselves may be more focused on diagnosis and further treatment than the pain experienced at present.

In our opinion, the correct strategy should be tailored to patients both as regarding medicine administration and medical consultations. If such a model was utopistic until recently, today the advent of e-health has made it possible. We recently collaborated with the European Society of Thoracic Surgeons in the development of a quality of life application (app) in a cohort of patients with cancer undergoing lung resections.[4] We observed good early compliance of patients operated on with the app, which allowed us to

From the Department of Thoracic Surgery, ASST Monza, San Gerardo Hospital, Monza, Italy.

Disclosures: The authors reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Received for publication Sept 2, 2021; revisions received Sept 2, 2021; accepted for publication Sept 3, 2021; available ahead of print Sept 22, 2021.

Address for reprints: Marco Scarci, MD, ASST Monza, Via Pergolesi 33, Monza 20900, Italy (E-mail: marco.scarci@mac.com).

JTCVS Open 2021;8:677-8

2666-2736

https://doi.org/10.1016/j.xjon.2021.09.004

determine the evolution of surgery-related quality of life in the postoperative period. We strongly believe that monitoring symptoms remotely represents the road to strive for reduce hospital appointments and help to establish early patient-support programs in the future.

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