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Commentary: Not so fast...

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Grant and colleagues¹ present an expert opinion addressing the use of opioids in cardiac surgery. The authors discuss potential harm of opioid use and call for the broader application of “opioid-free” perioperative management. The history of opioids in cardiac surgery is fascinating, whereas the future is uncertain. A “cardiac induction” consisting of large-dose morphine (3 mg/kg) as the sole anesthetic is well described in the literature in the 1960s and discussed with humor among attendings and fellows in the operating room.² When the senior author was in residency (1987-1991), 200 cc of fentanyl was routinely administered to all patients undergoing cardiac surgery (yes...10 mg). Now, 30 years later, there are calls to eliminate opioids. How did we get here?

Advances in monitoring and diagnostics in cardiac anesthesia are unparalleled, yet the fundamental techniques at the core of our practice remain primitive. Grant and colleagues¹ discuss the emerging alternatives to opioid use (acetaminophen, calcium channel modulators, etc), all of which are fraught with their own set of limitations/side-effects/inadequacies. Are there viable alternatives to opioids in cardiac surgery that meet the goals of safety, adequate analgesia, and reliability? There is no evidence that a complete opioid-free strategy is tenable. We’ve simply put the cart before the horse. Perhaps the fundamental error is the question itself. Rather, let’s reframe the question to understanding which patients benefit from an opioid-free versus an opioid-sparing clinical approach. Younger, healthier patients undergoing minimally invasive cardiac surgery are excellent candidates for fascial plane blocks and opioid



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CENTRAL MESSAGE

Safe and sensible opioid use in cardiac surgery that allows for early extubation remains an important tool for intraoperative analgesia.

alternatives (nonsteroidal anti-inflammatory drugs, etc). Alternatively, patients with cardiogenic/circulatory insufficiency may benefit from a balanced opioid induction.

Risks and benefits of a patient-directed approach in the use of opioids in cardiac surgery are unknown. Why does the enhanced recovery after surgery pathway, although proven effective in gastrointestinal/oncologic/urologic surgery, have unreliable results in the cardiac operating rooms? These pathways and schemas fall short of broad clinical application because it is difficult to account for multiple complex surgical and patient variables. The focus of any opioid-related framework of perioperative systems and considerations should be patient-directed, rather than an unattainable aspiration of complete opioid elimination.

How do anesthesiologists keep patients safe from the dangerous effects of intravenous and inhalational anesthetics, paralytics, and vasopressors? We do this by careful, balanced titration, vigilance, and patient-directed approach to the use of drugs. This same level of safety can be achieved with opioids. We do not agree with Grant and colleagues’ statements that all opioids are “harmful,” nor with their hyperbolic statement that the “cardiac surgical enterprise is experiencing an opioid crisis.” We believe opioids, in rational doses that allow early extubation, remain an important, safe tool for intraoperative analgesia. Rather, further emphasis should be placed on opioid reduction in the immediate postoperative phase of care. Pain intensity after cardiac surgery significantly diminishes after the second day.^{3,4} Once extubation is accomplished, substantial analgesia via opioids should be quickly reduced. We feel the focus of an opioid-reduction technique should be on the postoperative period rather than intraoperative period.

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