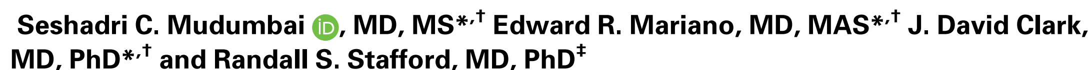
Pain Medicine, 00(0), 2020, 1–2
doi: 10.1093/pm/pnaa308
Letter to the Editor

OXFORD

Collateral Damage as Crises Collide: Perioperative Opioids in the COVID-19 Era



Seshadri C. Mudumbai, MD, MS*,† Edward R. Mariano, MD, MAS*,† J. David Clark, MD, PhD*,† and Randall S. Stafford, MD, PhD‡

*Anesthesiology and Perioperative Care Service, Veterans Affairs Palo Alto Health Care System, Palo Alto, California; †Department of Anesthesiology, Perioperative and Pain Medicine, Stanford University School of Medicine, Stanford, California; ‡Department of Medicine, Stanford University School of Medicine, Stanford, California, USA

Funding source: Internal departmental funds supported this article.

Conflicts of interest: There are no conflicts of interest to report.

Dear Editor,

Postponement or cancellation of all elective surgeries and nonessential procedures was a key policy response to the rapidly increasing number of COVID-19 cases to limit transmission and preserve hospital capacity [1]. As we near the end of this first surge in many states, professional societies and other agencies have suggested an initial focus on resuming outpatient surgeries (Phase 1) followed by more complex inpatient surgeries (Phase 2) [2, 3]. Despite the intense focus on COVID-19, the opioid epidemic has not gone away. As elective surgeries ramp up, appropriate attention must be paid to the management of perioperative opioids. Persistent post-operative opioid use remains one of the most common and serious long-term risks of undergoing an operation [4].

As elective surgery resumes, we are concerned about a different kind of surge—an increase in perioperative opioid overuse and abuse, especially in two groups of surgical patients:

- **Uninfected patients whose elective surgeries were delayed by the pandemic:** This large group represents much of the surgical backlog given the duration of this pandemic. With patients apprehensive about SARS-CoV-2 exposure risks and seeking to limit their contact with the health care system, more opioids may be prescribed to avoid the need for return visits. This prescribing pattern can create a new unwanted reservoir of unused opioids within at-risk populations and trigger persistent post-operative opioid use. Because of shelter-in-place restrictions, more family members may also be in the home of the opioid-consuming patients and may be tempted to use opioids for nontherapeutic indications. Integrative pain therapies requiring clinic visits (e.g., physical therapy, acupuncture, massage) will also be limited due to exposure risks and scarce resources. Finally, due to the economic disruption with this first surge, large numbers of patients are now unemployed or economically destitute. In this setting, opioids may be more likely to be misused as self-medication for anxiety and depression.
- **Patients recovering from a recent COVID-19 infection:** Initial epidemiologic data on COVID-19 indicate a spectrum of disease, from mild (no or mild pneumonia); severe (e.g., with dyspnea, hypoxia, or >50% lung involvement); to critical (e.g., with respiratory failure or shock). However, patients with recent severe or critical COVID-19 infections may be more susceptible to opioid-induced ventilatory impairment. Studies also note increased risks of COVID-19 complications in the following groups:

Older patients (>65 years).
Males vs females.
Patients with underlying cardiovascular disease with increased risk of in-hospital death .
Patients in poorer socioeconomic strata.
Patients in communities of color.

There is significant overlap between these risk factors for COVID-19 complications and risk factors for persistent post-operative opioid use.

As physicians, other health care providers, and hospitals navigate this new terrain, opioid management goals similar to those in the pre–COVID-19 era can be articulated. These include precision opioid prescribing, close clinician and patient coordination, and use of telehealth visits to address safe storage and disposal of unused opioids. Patient-specific opioid prescribing and tapering efforts for surgical patients have been underway and are

Published by Oxford University Press on behalf of the American Academy of Pain Medicine. This work is written by a US Government employee and is in the public domain in the US.

promoted by surgical, anesthesiology, and primary care societies. These efforts include the use of multimodal approaches (e.g., nonopioid analgesics, regional anesthesia) to minimize intraoperative and immediate postoperative opioid needs. Coupled with opioid titration prior to hospital discharge, discharge prescriptions can account for patient-specific needs and minimize leftover pills. Early coordination among members of the perioperative team (surgeon, anesthesiologist, primary care physician) can shape patient expectations for pain management and opioid use. With telehealth now the primary mode for outpatient management, explicit consultations are necessary to track opioid use after discharge. While addressing the large, unmet surgical needs associated with the first surge of COVID-19, physicians, other health care providers, and hospitals will again face the challenge of promoting rational opioid use with careful attention to perioperative opioid stewardship.

References

1. Centers for Medicare & Medicaid Services (CMS). CMS adult elective surgery and procedures recommendations: Limit all non-essential planned surgeries and procedures, including dental, until further notice. 2020. Available at: https://www.cms.gov/files/document/covid-elective-surgery-recommendations.pdf (accessed May 2020).
2. American College of Surgeons, American Society of Anesthesiologists, Association of periOperative Registered Nurses, and American Hospital Association. Joint statement: Roadmap for resuming elective surgery after COVID-19 pandemic. 2020. Available at: https://www.asahq.org/about-asa/newsroom/news-releases/2020/04/joint-statement-on-elective-surgery-after-covid-19-pandemic (accessed May 2020).
3. The White House Coronavirus Task Force. Guidelines for opening up America again. 2020. Available at: https://www.whitehouse.gov/openingamerica/ (accessed May 2020).
4. Anderson TA, Ahmad S. Defining and reducing the risk of persistent postoperative opioid use. Anesth Analg 2019;129(2):324–6.