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EDITORIAL COMMENT



When the COVID-19 fog settled on our country the Opioid Epidemic was slowly responding to several public health measures: physicians had demonstrably slowed opioid prescribing for acute pain events, regulations on prescribing buprenorphine had eased, and many states had rightly begun to tout their successes. Then the virus changed everything.

Preliminary numbers have shown the COVID-19 pandemic in 2020 has spurred another surge in the opioid epidemic.¹ A majority of states have reported an alarming rise in opioid overdose deaths, many due to more lethal synthetic opioids. Once again, and with a renewed sense of urgency, a surgeon's role in the crisis needs to be scrutinized.

Utilizing the Surveillance, Epidemiology, and End Results – Medicare data from 2007-2015, the authors reviewed 4,538 patients undergoing partial or radical nephrectomy for kidney cancer and discharge opioid prescriptions. They sought to evaluate associations of the total dose of discharge opioid prescriptions with prior opioid exposure, hospital readmissions, and post-operative long-term opioid use.

Patients were stratified by total dose of discharge opioid prescriptions into 3 exposure groups based on tertiles: 1-199 oral morphine milligram equivalents (MME) (low), 200-300 MME (moderate), and >300 MME (high). They identified high opioid prescriptions being associated with prior exposure, younger age, rural residency and open surgery. High opioid prescriptions were also at an increased risk of long-term opioid exposure (41%). Importantly, they did identify an increased 90-day readmissions associated with high opioid prescriptions which has also been seen in the general surgery population.²

Alarming, during the study period, the total MME prescribed upon discharge for opioid-naïve patients increased by 68%. A trend that is both worrisome and hard to rationalize. It is highly likely that the authors underestimated post-operative opioid since only 7 days were computed. The limitations of the the Surveillance, Epidemiology, and End Results -Medicare data, acknowledged by the authors, clearly lacks insight into some critical data points.

Another concerning finding was the wide variation in opioid prescriptions among providers. Whereas some providers gave little opioid others appeared to give negligently large amounts. One hopes, as the AUA prepares a White Paper on opioid prescribing, that this variation will not persist for long. Unfortunately, if history is prologue, that is unlikely to happen.

The authors are to be commended in their evaluation to provide insight into the behavior of urologists' opioid prescription habits after nephrectomies. At our institution, we instituted a multipronged behavioral intervention which decreased the median oral morphine equivalents at discharge from 200 to 0 in nephrectomy patients regardless of whether surgery was performed open or using minimally invasive methods.³ If our institution, and others, have effectively stopped giving opioids for kidney surgery it begs the question on why nationwide urologists haven't curbed their enthusiasm for opioid prescribing. Hopefully, the vice grip of the COVID virus can change the hearts of kidney surgeons as the rise in opioid deaths ascends on a grave new trend line.

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