



#6525: Clinical Indications for a Preoperative Pain Consultation: A Review of Registry Cases at an Orthopedic Specialty Hospital

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INTRODUCTION

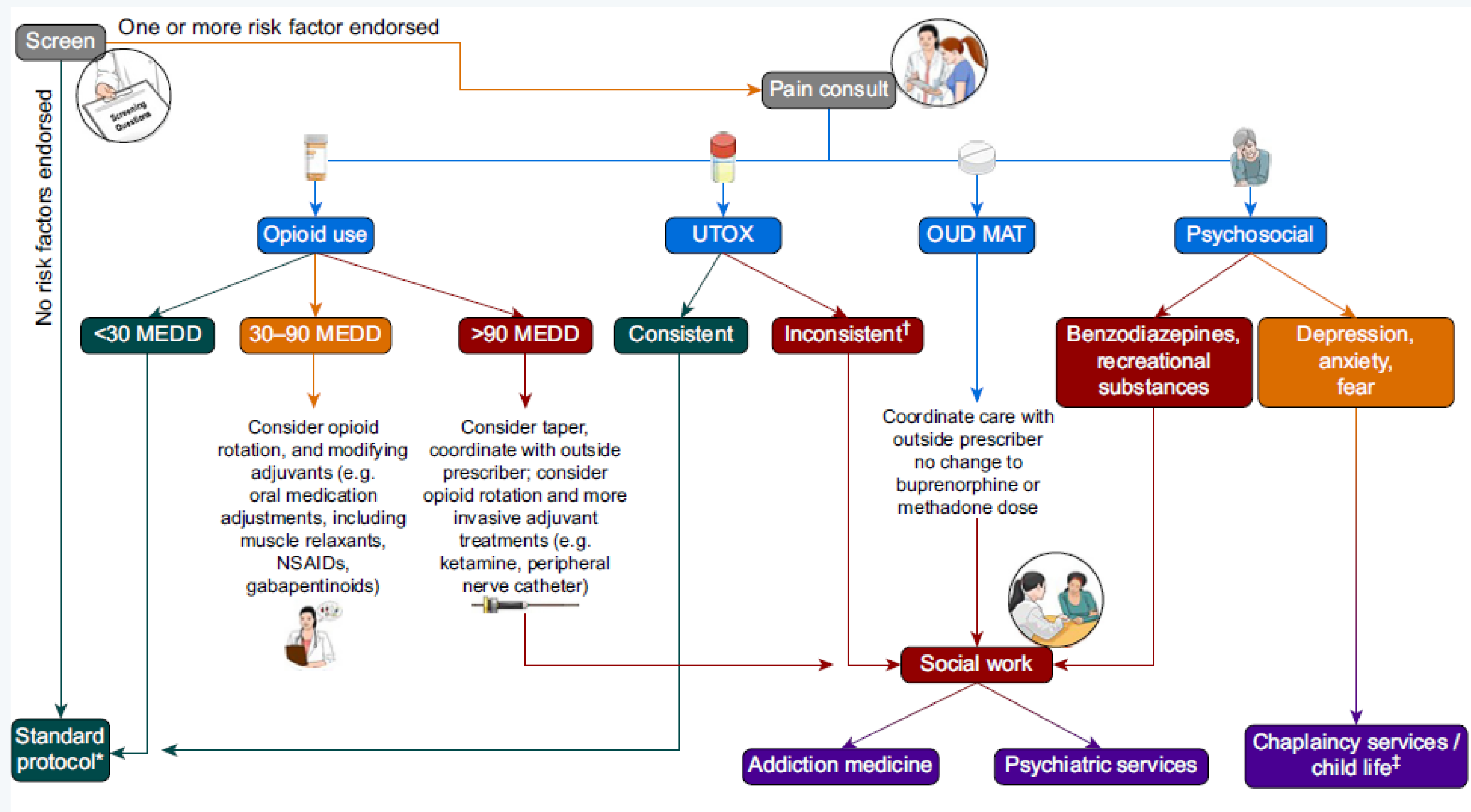
- Patients with a history of opioid tolerance, chronic pain and/or substance use disorder presenting for surgery are at increased risk for severe post-surgical pain and opioid-related adverse events.[1]
- Knowledge gaps exist in the perioperative pain management of these high-risk patients, but multiorganizational consensus emphasizes comprehensive and multidisciplinary care, including preoperative screening.[1]
- At HSS, patients with complex pain are referred to the Perioperative Pain Service (POPS) for a preoperative pain consultation where additional screening facilitates risk stratification.[2,3]
- Tailored multimodal pain management plans, incorporating regional anesthesia, are devised to optimize preoperative rehabilitation, postoperative pain control and mitigate adverse outcomes.
- To gain a richer understanding of the orthopedic surgical population presenting with complex pain, we performed a retrospective study leveraging an institutional registry[4] to characterize the indications for a preoperative pain consultation.

METHODS

After IRB approval, surgical cases requiring a preoperative pain consult at Hospital for Special Surgery between January 1st, 2024, and November 14th, 2024, were extracted from an institutional, Epic-based POPS registry. Patient demographics, medications, medical and surgical histories, and strings of text/ Epic smartphrases from consultation notes were extracted to identify clinical indications (**Figure 1**). Descriptive statistics were used to characterize this surgical population.

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RESULTS



IMPRESSION

PT is a 71 y.o. male with h/o back pain & chronic opioid use for pre-op pain evaluation. Pain management is indicated because of chronic opioid use, consult has been requested for preoperative pain management clearance and perioperative pain management. Discussed expectations for post-op pain and pain management options, due to opioid use, pt at risk for uncontrolled postop pain and prolonged hospitalization. Pt on high dose opioids >100MME, advised to minimize short-acting percocet in anticipation for surgery. Can continue oxycontin regimen at BID dosing. Will follow up with to coordinate care and discuss perioperative pain management plan. Pt counseled on risks of chronic opioid and polypharmacy use. Patient to f/u with PM MD within two weeks of hospital d/c. Pt made aware opioid rx upon hospital discharge will depend on date and quantity of last percocet fill. Patient is requesting hydromorphone post-op, discussed with patient national shortage of dilaudid and can be difficult to fill Rx once discharged home, although patient prefers dilaudid PO, he is amenable with trialing morphine or oxycodone IR PRN. Pt verbalized agreement and understanding.

Patient was seen as a part of the complex pain service. Patient has a history of uncontrolled pain. Patient was found to be using no illicit drugs. Patient was not referred to the Social Worker for counseling. Urine toxicology screening pending.

No absolute pain management barriers to planned surgery pending urine toxicology results.

Figure 1

Table 1. Patient characteristics

Sex, Female, n (%)	549 (55.8)
Age, mean (SD)	61.8 (11.9)
BMI, mean (SD)	30.0 (6.5)
Race, n (%)	
White or Caucasian	786 (80.0)
Black or African American	82 (8.3)
Other	63 (6.4)
Patient declined/ Unavailable	34 (3.5)
Asian	18 (1.8)
Ethnicity, n (%)	
Not Hispanic or Latino	883 (89.8)
Hispanic or Latino	71 (7.2)
Patient declined/Unknown	29 (3.0)

Table 2. Active opioid at admission**, n (%)

Buprenorphine/ buprenorphine-naloxone	54 (8.8)
combined opioid-NSAID/acetaminophen tablet	237 (38.8)
fentanyl patch	3 (0.5)
hydromorphone	9 (1.5)
methadone	15 (2.4)
morphine	28 (4.6)
oxycodone	158 (25.9)
oxymorphone	2 (0.3)
tapentadol	9 (1.5)
tramadol	96 (15.7)

**types and routes include oral, buccal, transdermal

RESULTS (continued)

- 983 cases required a preoperative pain consultation
- 40.1% (n=394) had a diagnosis of anxiety and 28.4% (n=279) had a diagnosis of depression
- 65.1% (n=640) and 34.9% (n=343) of pain consultations were office and telehealth visits, respectively.
- 79% (n=777) of patients had a history of or current chronic opioid use, 24.6% (n=242) reported illicit or unhealthy substance use, and 39.4% (n=387) had a history of uncontrolled pain; approximately 6.5% (n=64) reported all three issues.
- 6.0% (n=59) had toxicology findings inconsistent with reported use and 37% (n=364) were referred to a social worker specializing in complex pain for additional support.
- In patients with chronic opioid use, 78.6% (n=611) had an active opioid at surgical admission, with 80.4% (n=491) taking a combined opioid-NSAID/acetaminophen tablet, oxycodone, or tramadol, and approximately 11.3% (n=69) on buprenorphine, buprenorphine-naloxone or methadone (**Table 2**).

DISCUSSION

Most patients requiring preoperative optimization reported chronic opioid use, many experienced uncontrolled pain and 1 in 4 admitted to current or historical illicit substance use. Toxicology findings revealed discordance between self-reported and actual use of controlled or illicit substances in a small subset of patients, suggesting risky and polypharmacy behaviors. Though most patients had an active, short-acting opioid prescription at surgical admission, approximately 11% were on medication assisted treatment. Continued granular data collection through our registry[5] will enable the study of interindividual pain differences in patients with complex pain before and after surgery.

References →

