

Postop analgesia in Saudi Arabia and the United States: A resident's perspective

Hashem N. Akbar, MD

Dr. Akbar is PGY-4 Psychiatry Resident, Tufts Medical Center, Boston, Massachusetts.

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I had the opportunity to experience first-hand acute postoperative pain management in both the United States and Saudi Arabia. In this article, I discuss some of the differences in how postop pain is managed in each location, potential reasons for these differences, how they may impact patients over time, and the psychiatrist's role in raising awareness about the hazards of overprescribing analgesic medications.

Vast differences in postop opioid prescribing

From personal observation and literature review, I was appalled by the amount of oxycodone tablets patients are typically discharged home with after a surgical procedure in the United States. Depending on the extent of the surgical procedure, opioid-naïve patients were routinely discharged with 40 to 120 tablets of oxycodone 5 mg. A ventral hernia repair or laparotomy was on the high end of how much oxycodone was provided, and a laparoscopic cholecystectomy or inguinal hernia repair was on the low end. At least one study has supported this observation, finding a wide variation and excessive doses of opioids prescribed postop.¹ Notably, among opioids obtained by postsurgical patients, 42% to 71% of all tablets went unused.² Nevertheless, prescribing in this manner became the standard for postop pain management—possibly in an effort to maximize patient satisfaction on surveys. Additionally, marketing and promotion by the pharmaceutical industry appears to have considerably amplified

the prescription, sales, and availability of opioids.³

Signing those prescriptions always left a bad taste in my mouth out of concern for the potential for initiating chronic opioid use.⁴ Personally, I would prescribe the lowest reasonable number of narcotic tablets for my patients, along with acetaminophen and ibuprofen, knowing that nonsteroidal anti-inflammatory drugs are sufficient for treating postop pain and will decrease opioid requirements, therefore minimizing opiate-induced adverse events.⁵ Overtreatment of pain with narcotics as first-line therapy is particularly problematic when treating postop pain in children after minor procedures, such as an umbilical hernia repair. Allowing children to resort to a narcotic analgesic agent as a first-line therapy had the potential to develop into an opioid use disorder (OUD) later in life if environmental factors tipped the scales.⁶

In the hospital in Saudi Arabia where I initially trained, surgery residents were not permitted to prescribe narcotics. The standard of care was to discharge patients with acetaminophen and ibuprofen. In cases where there was an indication for pain treatment with narcotics, stringent regulations were in place. For example,



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in my experience, which is corroborated by one study,⁶ special “narcotic forms” are required in the Middle East. In most of these countries, access to these forms is restricted.⁷ Moreover, pharmacists would only accept this special form when attested to by the surgery consultant (the equivalent of an attending physician in the United States). These consultants would typically write a prescription for 9 to 15 oxycodone 5 mg tablets. Patients receiving such medications were closely watched and followed up in the surgery clinic 3 to 5 days after discharge. Patients were also required to fill out a form detailing their contact information, including their home address and national ID number, to be able to pick up their prescription. Furthermore, apart from 2 Middle East countries, opioids were only available from hospital pharmacies, which were independent of the general hospital pharmacy in location and staff training.⁸

The psychiatrist's role

Adapting similar stringent practices for prescribing narcotics in the United States might reduce 1 risk factor for OUD in postop patients. Surgeons attempt to provide the

best care by maximizing analgesia, but psychiatrists see firsthand the consequences of overprescribing, and play a direct role in managing patients' OUDs. As psychiatrists, we have a duty to continue to raise awareness and alert other clinicians about the hazards of overprescribing narcotic analgesic agents.

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Clinical Point

Adapting similar stringent prescribing practices in the US might reduce 1 risk factor for opioid use disorder