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Commentary: Saying whoa to the woe of heart surgery

Marc W. Gerdisch, MD, FACS, FACC, FHRS

As we have become increasingly aware of the threat created by opioid medications administered following cardiac surgery, programs have pursued various alternate methods of analgesia and practices aimed at reducing opioid use. In their descriptive paper, “Changing the Default Option in the Electronic Medical Record Reduced Postoperative Opioid Prescriptions After Cardiac Surgery,” Einarsson and colleagues¹ demonstrate the significance of a simple measure impacting prescription dosing and as a consequence, patient exposure. Certainly, it is a mechanism that is easily reproducible and should be enacted by us all. However, perhaps more importantly, we should directly address the reason for using powerful pain medications. Opioid reduction should be a natural consequence of a multifaceted approach to eliminating pain at its source, so as to avoid medicating the entire patient. For Franciscan Health, it began when we mastered the use of cryoanalgesia for minimally invasive heart valve surgery. With the advent of this technique, patients who underwent mini-thoracotomy were consistently extubated in the operating room and recovered comfortably. When combined with our practice of performing erector spinae blocks and using intravenous acetaminophen and oral gabapentin, most of the more general discomfort was addressed as well.

Then came the challenge of accomplishing the same results for patients who undergo median sternotomy. We had participated in a randomized control study

Patient 3 weeks following sternotomy heart surgery hitting fast pitch.

CENTRAL MESSAGE

Avoiding pain is better than pain control.

demonstrating better healing, greater mobility, and less discomfort for sternotomy patients undergoing complete rigid plate fixation of the sternum.² Based on those findings, we employed rigid plate fixation for every patient undergoing sternotomy. When it became obvious that patients were substantially more comfortable, we undertook to change the entire postoperative experience, aggressively increasing mobility, limiting opioid orders to the first 8 postoperative hours, and rigorously preparing patients to be discharged home instead of extended-care facilities.³ The results were dramatic. For patients without a history of chronic opioid use, postoperative opioid administration decreased by 99% for minimally invasive and 87% for patients who underwent sternotomy. Only 8% of those same patients were prescribed narcotics at discharge, and discharge to extended care facilities fell from 30% to 10%. Mobility and comfort can be restored in the operating room at the time of heart surgery, leading to abolition of the need for powerful and addictive narcotics. Our goal should not be simply to take away the pain medicine, but to take away the pain.

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From Cardiothoracic Surgery, Franciscan Health, Indianapolis, Ind.

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Address for reprints: Marc W. Gerdisch, MD, FACS, FACC, FHRS, Cardiothoracic Surgery, Franciscan Health, 5255 E Stop 11 Rd, Suite 200, Indianapolis, IN 46237 (E-mail: mgerdisch@openheart.net or jeanne.berkowitz@biolexica.com).

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