Depression and Medication Side Effects: Is Your Depression Due to Something You Are Taking? - Frankly Speaking EP 89

Transcript Details

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Dr. Frank Domino:

Cathy is a 56 year old patient in your practice who calls you the day after she had Bunion surgery. She states the block wore off during the night and now she's in severe pain. She started taking the opioids the surgeon gave her, but they're just not doing anything for her. She asked the surgeon if she could take an anti-inflammatory to help and was told no, that NSAIDs actually alter and delay the healing process. Hi, this is Frank Domino, Professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. And joining me is Jill Terrien, Associate Professor and Director of the Nurse Practitioners Program at the University of Massachusetts Medical School's Graduate School of Nursing. Jill, does this story sound familiar?

Jill Terrien:

It sounds very familiar, Frank, and thank you for bringing it up. I'm wondering just off the top, how should we approach Cathy's pain, and how should we look at it post-operatively?

Dr. Domino:

Patients don't come to us necessarily for the management of their post-op pain, but when

we know we're referring patients and they're probably gonna need pain, it opens the door for us to talk about managing that pain both before and after the surgery. So, in Cathy's case, what I probably should have done is talk to her about the importance of starting pain medication before the block wore off, maybe before the procedure she could have taken some acetaminophens that was in her system, or an NSAID, and then afterwards she should be taking medication while she's not having pain to help try to prevent the sudden onset of severe pain once the anesthetic wore off. In my mind, we probably have a responsibility in helping better inform our patients how to approach their pain, both prior and immediately after the surgery.

Jill Terrien:

I mean, I think that's excellent 'cause it's preventative. And how much time does that take to let the patient know what the process is of their pain and how they should manage it. So how effective are non-opioid agents? How do they compare?

Dr. Domino:

Well, so this is one of those areas where I think we can make, again, a very big difference in our patients' lives. We have wonderful data that shows combining acetaminophen with a non-steroidal anti-inflammatory gives you as good, if not better pain control than opioids for acute musculoskeletal pain. It's one of those things that we assume, "Gee, treating with an opioid that's gonna give the patient the best pain relief." And actually, it's a fallacy. Think about how NSAIDs work, they stop the inflammatory process at the site of the injury. Opioids work by clouding your sensorium to the pain. It alters the central nervous system rather than the source of pain. So I always recommend patients take an anti-inflammatory, and anti-inflammatories combined with acetaminophen are synergistic, that's why so many opioids are also combined with acetaminophen, because they tend to have a synergistic effect on pain. My typical preference is to tell patients to take about a 1,000 milligrams of

acetaminophen, and either 800 milligrams of ibuprofen, or 500 milligrams of naproxen every six hours. That combination will give you wonderful pain relief, stops the pain at the site where they're having trouble, and is very safe and effective. So that's my take on it.

Jill Terrien:

And how many days do you actually have them do a routine such as that? I know it's gonna probably depend on what they had done and what their pain is like.

Dr. Domino:

Sure, well, if someone was going in for surgery, I'd have them take those two medication, a combination of acetaminophen and an anti-inflammatory. Maybe start the day before or a couple hours before their procedure, as long as it's within the window that anesthesia says is okay. And then I would have them do that every eight hours, say for the next three to five days after surgery, and I would use the opioid that they're going to get for breakthrough pain. So I would try to do it up front, and I would use the opioid only if they've started noticing worsening pain thereafter. And the NSAID, you can do that three, five, seven days, especially if they're healing from a bony injury without any danger at all.

Jill Terrien:

So, Frank, what about NSAIDs and nonunion of fractures?

Dr. Domino:

Okay, so I've had multiple musculoskeletal injuries and have been told repeatedly by my surgeons that NSAIDs delay healing. And so there was a very recent study that was published in the Musculoskeletal Injury Literature that looked at what drugs increase the risk of fracture nonunion, and sure enough, NSAIDs do... Acute use of NSAIDs does increase the risk of fracture nonunion to the very same degree as acute use of opioids.

They both increase the risk of fracture nonunion, that risk is very small. The drugs that increase the risk the greatest for fracture nonunion is chronic use of opioids, or chronic opioid users have the highest risk of developing a fracture nonunion.

So this is a myth that needs to be busted. We need to get the word out that NSAIDs offer the same risk, acute NSAID use offers the same risk as acute opioid use. And therefore, we should probably choose the safer drug first. And acute use of NSAIDs, unless the patients is elderly or has this horrible renal insufficiency, is unlikely to cause any serious problem over a week or two weeks, even five weeks. It's only when their use is for over six weeks where they start increasing GI bleed risk. Whereas, opioids as we know, once you've used it for more than five days your risk of dependence goes up logarithmically.

Jill Terrien:

Significantly, yes. And I'm just wondering, and so I just think about, I think Frank both you and I have been practicing for many years. I remember when NSAIDs were like the foundation with your pain control along with opioids, especially for orthopedic procedures. So now we've got to turn the tide back the other way. And I think we have a really big job ahead of us because the thinking has been, "No NSAIDs with surgical procedures that involve the musculoskeletal system."

Dr. Domino:

Yep, I think you're right. I think we have to go back to how we did before. We need to do this professionally in the primary care world, where we remind our patients of this beforehand. And if a patient says, "Gee, my surgeon told me X, Y, or Z," I think we need to reach out. I actually sent this paper to my colleague who operated on Cathy and said, "Gee, she called me because she was having severe pain and told me you said this. Based upon this paper I told her she really needs to be aggressively using NSAIDs to control her pain. If

she gets a nonunion, well, that's a known adverse effect of treating pain, whether it's with the NSAID or with the opioid."

Jill Terrien:

And so how was that call received? Because I think we don't communicate enough with our specialty providers and in sharing information or even asking questions. So I think we have to be not afraid to communicate.

Dr. Domino:

Well, I think you're absolutely right. Our job's primarily to be our patient's advocate in this case. And I'm glad she called me. At first I was a little annoyed, but then I was glad she called me, and when I called my peer, I said, "Gee, I'm really worried about chronic opioid addictions," and so forth, and she told me that, and I read this in the literature, "This seems like a really well done study. What's right? Is using opioids first line, or is it okay for me to give her this?" I kind of put the onus on them to tell me I was wrong, instead of me telling them they were wrong. And they had the same professional courtesy that I wanna extend to them. They said, "Gee, let me look at it. I hadn't seen that data, we were only taught about NSAIDs."

Jill Terrien:

Great, so how did it work out for Cathy, Frank?

Dr. Domino:

Well, she was thrilled, she was pleased to use the non-steroidal anti-inflammatory rather than the opioid for pain. She was having less constipation, less dry mouth, and felt more secure walking around in her crutches, and she had very good pain control and didn't need the opioid after the second day. So I think overall it worked out well.

Jill Terrien:

Great.

Dr. Domino:

Well Jill, thanks for discussing this case with me. I know Cathy appreciated my help, and hopefully our friends in the operative world will change their behavior a bit.

Jill Terrien:

Thanks, Frank.

Dr. Domino:

Practice pointer: Using non-steroidal anti-inflammatories increase the risk of fracture nonunion to the same degree as opioids do. Choose the safer drug, use NSAIDs on a scheduled basis to control pain, and save opioids for breakthrough pain. Battling burnout practice pointer: Communicate with your peers, both in primary care and in specialty practice, asking them about best practices and your thoughts on what you might be doing to improve your patient's care. Join us next time when we discuss early introduction of solids to the breast fed infant. And for more timely, relevant, and practical medical education, check out pri-med.com.