EDITORIAL Owning the opioid crisis

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Our country, similar to many others, is still deeply affected by an opioid crisis but unfortunately, it's easy to divorce oneself and our practices from the problem. The causes and the victims are not part of our daily lives and, therefore, can remain almost invisible. But this mindset must change. We have to take responsibility for our part in the cause and acknowledge that the victims can easily be our friends and family. Opioid addiction today has a very different face. The majority of intravenous heroin abusers in today's society started their opioid use not on the street, as was common many years ago, but with a prescription from a physician.[1] Driven by an effective pharmaceutical marketing campaign and endorsed by scholarly articles attesting to the safety of opioids for acute and chronic pain of any nature, well-intentioned physicians liberally prescribed them to treat their patients. When the enormity of the risks became evident, we already had an ever-growing population tolerant, dependent, and addicted to opioids. Education and guideline recommendations soon followed and opioid prescribing for chronic non-cancer pain is now widely being addressed. Opioids, however, remain the mainstay treatment for acute pain following most surgical procedures. In the last five years, increasing evidence has revealed that up to 10% of patients prescribed opioids following surgical procedures will continue to fill opioid prescriptions 3–6 months later, long after tissue healing is complete. These sobering statistics include both major and minor procedures across many different surgical specialities, including urology. The most consistent risk factors for increased incidence are higher doses of opioids prescribed and for longer durations. In Canada, we perform over 2.5 million surgical procedures per year. That is a staggering number of vulnerable patients. We can no longer ignore the role that we play.

One of the often-stated challenges is finding an alternative to opioids. Multimodal analgesia has been repeatedly shown to be as effective as opioids for the majority of minor procedures. A recent systematic review found that non-steroidal anti-inflammatories (NSAIDs) have equivalent efficacy compared to opioids for treatment of renal colic, our prototypical acute pain condition.[2] In addition to the standard acetaminophen and NSAIDs, adjuvants such as pregabalin or gabapentin can often be effective for acute postoperative pain. Many procedures are amenable to regional anesthesia, which can minimize the need for other analgesics. There is increasing literature demonstrating the efficacy of other medications, such as intravenous lidocaine infusions, ketamine, and magnesium, in addition to infiltration of local anesthetics at the surgical site. Opioids should be the last medication added to this regime and the first one to be discontinued. When an opioid is prescribed, ideally it should be at the lowest dose possible, with minimal excess tablets at risk of being abused, shared, or diverted. This is not to say we should be endorsing suboptimal pain management, but rather a thoughtful, individual approach that spares opioids as much as possible by maximizing non-opioid therapy.

Setting realistic expectations around postoperative pain is an integral component of patient education, together with explanations of the various medications to use, when to use them, and how much to take. Patients will always prefer just one pill rather than multiple ones with varying schedules, none of which give them the equivalent instant relief of an opioid. But by educating patients on the risks of opioids and the benefits of multimodal therapy, we can hopefully improve compliance and prevent the desire to go to the "only pill that works for me" — namely an opioid. We have repeatedly heard concerns of undertreating pain if clinicians limit the amount of opioids prescribed. However, many studies investigating perioperative opioid prescribing have found that amounts prescribed far exceed patient need, and the more that is prescribed the more that is consumed, even after controlling for pain and other variables.[3] Furthermore, lowering the amount of opioids prescribed does not result in an increase in number of prescription renewals required.[4]

As above, it is not at all difficult to better manage our patients' postoperative pain with a keen eye on limiting the need for any prolonged opioid prescriptions. But this has to be a unified strategy involving surgeons, anesthesiologists, and family practitioners

in order to be effective. All disciplines have a role to play. Educating surgeons is an important first step, but it is not without its challenges. With the increased presence of anesthesiologist-driven acute pain management services in most larger hospitals, surgeons and trainees get less experience with various pain management modalities. A previous survey of urology residents in Canada found a concerning lack of knowledge and training in pain management,[5] a finding that was reproduced by another study presented at this year's CUA annual meeting. We need to have a more robust acute pain management curriculum for our students. We should include postoperative pain management disposition as part of the surgical safety checklist. Practice audits and feedback of individual prescribing patterns, such as one could potentially receive from organizations like the Narcotic Monitoring System currently tracking all opioid prescriptions in Ontario, could give practitioners useful information to improve their patient care. Additionally, initiatives at the institutional level, such as the "Stop Narcotics" program out of London, Ontario, would help clinicians adopt and navigate these new strategies.[4] Our patients and the public at large deserve nothing less.

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