**Episode 21: Journal Club – August 2017**

Dr. Joe Chappelle: Hello everyone, and welcome back. I’m Joe Chappelle and you’re listening the OB/GYN Podcast. This is episode 21, this is our Journal Club for August 2017. And with me today to go through our paper are two very special guests. The first you know him, he’s Dr. Jerry Ballas from Houston. Hello, Jerry.

Dr. Jerry Ballas: Good evening.

Dr. Joe Chappelle: Good to have you.

Dr. Jerry Ballas: Good to be back.

Dr. Joe Chappelle: And then our other guest you should also know well now, and that is Dr. Sara Kim from Stony Brook. Welcome, Sara.

Dr. Sara Kim: Hello. Good to be back.

Dr. Joe Chappelle: Alright. Today, we are going to be taking a paper from the Green Journal. This is from July 2017 and is entitled *Patterns of Opioid Prescription and Use After Cesarean Delivery*. Brian Bateman is the lead author on this, and it comes from a whole bunch of different hospitals together. But before I get started going through this paper, do you guys have any opening thoughts about this? Obviously, it’s a very sensitive, timely issue everyone’s talking about right now.

Dr. Sara Kim: Yeah, I totally agree. I think this is a very good paper for us to start to have a discussion about, just because, as the paper describes, we’ll get to it as well, is that I think we’re facing an opiate epidemic, where abuse is definitely on the rise, and I think it’s starts the discussion of what is our responsibility as physicians in maybe potentially contributing to this possible epidemic.

Dr. Jerry Ballas: Absolutely. And I also, on three different levels, driving in the other day to work, there was an NPR as a story about the opioid crisis and the latest figure that came up that something upwards of 90 some odd million dollars were spent by the pharmaceutical industries that produce opioids to directly market to physicians and so forth, which I thought was pretty telling. And then, of course, at work, we’re embroiled in kind of a patient care conference in terms of pain management and opioids, so it’s definitely a hot topic, and definitely something that, especially for practitioners in a surgical field, we need to be open and start discussing more about our prescribing habit.

Dr. Joe Chappelle: Yeah. This is not in this paper, but other ones have discussed this. This is very much a problem of our own making, and I don’t mean Ob/Gyns, I mean medicine in general. When we started talking about the pain as being a vital sign, everyone had to have their pain well controlled, you go down that path a little too far and you end up exactly where you are. So anyway, we, in Ob/Gyn, prescribe probably – I know I shouldn’t say that. We do a lot of c-sections so therefore we ©[[1]](#footnote-1)prescribe a lot of narcotics, so I don't know if we’re the highest prescribing physicians in the country, but we have to be pretty close as a collective. So, I think it’s definitely a topic for us.

Dr. Jerry Ballas: Oh. Absolutely, and by sheer numbers, the paper even mentions it’s the most commonly performed surgical procedure in the United States on an annual basis, so even by just volume, we are definitely on the forefront of prescribing pain medication.

Dr. Joe Chappelle: Exactly. Let’s get started with our paper. I’ll start with the introduction, as we usually do. They start off basically saying what we just said, that we have an epidemic, it’s reaching crisis stage, if it isn’t there already, and we do have a place to play in it. A couple things, some are in here and some aren’t, but 75% of opioid abusers start by taking a friend’s or relative’s left over medication, and they do stress something like that, but they don’t have that exact number in there. But they do have some other numbers. 66% do not dispose of their leftover narcotics appropriately, 20% report sharing with their friends, of those who do have leftover. So, it’s definitely… not only are we worried about the woman, we’re also worried about the people around here, it’s like a negative halo effect from giving a package of pills to somebody.

Dr. Sara Kim: Yeah, and I wonder… the paper goes into it a little bit later. But as physicians, do we have a responsibility to counsel patients on how to dispose of them? Because it’s saying that a lot of pills are left over, but I wonder how much of that is patients don’t even think about that they need to actually dispose of this, and do they even know how to correctly dispose of the medication that we are prescribing them?

Dr. Jerry Ballas: Go through your own medicine cabinet, I guarantee you, you are going to find NyQuil from 1998. Nobody throws anything out until they do one big spring cleaning. So, it’s definitely an interesting idea to bring to the mind, the proper removal of all expired medications, but let alone medications that you are not using, especially like an opioid.

Dr. Sara Kim: Right.

Dr. Joe Chappelle: Yeah. You could get into trouble with a lot of these things, even. Kids taking blood pressure medication or whatever is laying around, anything can be dangerous. But unfortunately, opioids have such an addictive effect that that’s really where we get in trouble. So, I think they do a pretty good job here of laying our why they wanted to look at this. And then they talk about, their second to last paragraph is really about this. We really don’t have any data here, we have no information to even base a study on. Let’s say we wanted to do an intervention where we’re going to decrease the number of opioids that we were prescribing or women were using, but we don’t even have the baseline stats to even design that study. And that’s where this really came in, that’s what they were trying to do here.

Dr. Sara Kim: Yeah. And I think they clearly state the objective, which I thought was well stated in the beginning, and I think they constantly try to come back to their objective throughout the paper.

Dr. Joe Chappelle: Yeah. I’m going to disagree with you for a second, because I’m not really sure they defined their objective in the manuscript.

Dr. Jerry Ballas: Well, I think they define it in a way by stating that there is no good research out there or good data on prescribing habits, and so I think by reiterating that, they’re placing their paper at the forefront of at least giving that descriptive nature of how we are prescribing. For me that’s where they fill… they keep mentioning how they’re filling that void of no baseline data for how we prescribe.

Dr. Joe Chappelle: I agree with you. We talk about papers, and Jerry and I have talked about this in the past. We look at two things. One is the study itself and then how that study is portrayed on paper, and I’m a stickler in general for objectives. One of the few things that I find very, very important, because I need to know how to interpret their study. They do have a good objective in their abstract, which we’ll go back to later, but their abstract says, “To define the amount of opioid analgesics prescribed and consumed after discharge after cesarean delivery.” That’s perfect. Concise, wonderful. I think that should have been included in their introduction, because I don’t really see that in the introduction. Which doesn’t really hurt their study, is just for me it’s just a matter of protocol.

In any case, moving on to their methods. First of all, they did six different university hospitals, which means they had to go through six different IRBs, so God bless them. And coordinating that is not easy. And when you look at their numbers, this must have been done in a pretty short amount of time. But in any case, their inclusion criteria were all women who underwent caesarean delivery, which is nice, so they did not separate by planned or unplanned, and we can talk about, later, whether we think that biases the results at all. Their exclusion criteria are pretty simple. They took non-English speakers out. Anyone with a lack of capacity, who was younger than 18 also were not included. And then, the last one was hospital stays greater than seven days, and they said because people who were there more than seven days may have had more complicated courses, and therefore different pain needs. They were also looking at women two weeks after they were discharged, but if you’re in the hospital for a week after you deliver, now we’re talking three weeks, so it does muddy the waters. The seven days seems kind of random to me, they just chose a day, which is okay. Do you guys have any thoughts on the inclusion/exclusion?

Dr. Jerry Ballas: No, I think they’re pretty straightforward.

Dr. Sara Kim: Yeah, agreed.

Dr. Joe Chappelle: Alright. So then, the way they actually did the study. This is very simple. They called the patients two weeks afterwards by telephone, but- sorry, before they left the hospital, they get verbal consent to call them, and they called them two weeks later. Then, if they weren’t there, they tried them again every day over the course of five days, and if they didn’t answer, they were lost to follow up. Then they asked them standardized questions and recorded their answers. Pretty straightforward.

Dr. Jerry Ballas: Speaking to your six different IRBs, amazing they dedicated an entire paragraph going over the different ways they contacted women and where they were allowed to opt-out and so forth. I don't know whether it was necessary or not, but I was a little worried where they start with “consent procedures differed”, et cetera. Not sure you needed that. Maybe there was something there where the reviewer sent back saying something to that effect.

Dr. Joe Chappelle: Yeah. Dr. Kim and I are involved in a very similar study at the moment, which we started before this paper came out. It’s a little discouraging. But in any case, the way we solved it is we got telephone consent when we called them and then recorded that. Which again, it’s still not ideal, and the IRB gives a little bit of a hard time about that. They always prefer to have written consent. So, there aren’t many good ways of doing this kind of study, but what they did seemed fine.

Dr. Sara Kim: Yeah.

Dr. Joe Chappelle: One little note, they used REDCap to do their data collection, which is not new anymore, but it’s a big rising trend in data collection. It’s a secure web based application that’s HIPPA compliant, you can put all your research in, as opposed to doing it in Excel and locking the file and whatever the other old ways of doing it. So, it’s becoming very popular for people who don’t know about it.

Dr. Jerry Ballas: Yeah, we’re definitely using it for some of our research, especially for international work, broadening your institution’s involvement. REDCap has become very commonplace.

Dr. Joe Chappelle: Yeah. Stony Brook I think bought an institutional license for it, so anyone at Stony Brook can use it, which is nice. So, moving on to the results, they took 1,065 women who underwent caesarean delivery and considered them for inclusion. 55 did not consent, 35 met the exclusion criteria, 252 were unable to be reached, which left them with a total of 720 women. The average age was 30.7. 60% were white. 77% were privately insured, which is important, I think. 45% labored before the caesarean delivery. 37.5% had a repeat caesarean delivery, and we can guess that the rest of those were primary caesarean deliveries were for breech or what have you. 14% were smokers and less than 5% had a history of alcohol or other substance abuse issues, which again, is probably important for this kind of study. Over 98% had epidural or spinal. And then we get into the pain stuff.

The median maximal pain score – which is not confusing at all – at hospital discharge was 5 with interquartile range of 3 to 6. Now, the way that interquartile range works, for people who don’t know, is they take the median, so that’s 5, that’s the exact middle. It’s the 50 percentile right in the middle of the group. And then divide on either side into 25% and 25%, so it’s like a median of median, if you will. What it tells you is that 75% of the women were between 3 and 6, so that’s how that works. During the first week, the median was now 4, which a 2 to 5 interquartile range. And then the week 2, presumably, where they were calling women it was 1 to 2 with an interquartile range of 1 to 3, so as suspected, the pain goes down as you get distant from surgery, so that was nice. At least we know nothing funky is going on.

Of the 720 women, 85% reported filling their opioid prescription, so that’s 15% that didn’t, which I thought was a pretty decent number for women who didn’t even fill it. And most of them, they basically said they didn’t need it or didn’t want it or they didn’t like the way it made them feel, which I think anyone who does obstetrics has heard a woman say exactly that. Then we get into what was actually prescribed, and this is interesting. Most of them used oxycodone, about 8% used hydrocodone or Vicodin. And then the number prescribed was interesting. Most of the women got 40, and then some of the women got 30 or less. In our hospital, and Jerry you can tell me what you do down in Houston, but we routinely use 30 as our number, which I even thought that was too high, and apparently we’re not that bad.

Dr. Jerry Ballas: Yeah, 30 used to be the default, and I can tell you we’ve switched over to NSAIDs and Tylenol #3 for the most part, for most of a c-section women.

Dr. Joe Chappelle: Wow. That’s good.

Dr. Jerry Ballas: Yeah. Yeah, it’s good. There’s definitely, you could imagine, a few that slip through that maximum median pain that we have to convert to, but we’ve taken upon ourselves to almost do an about face on opioids and stuck to the T3s for the most part.

Dr. Joe Chappelle: Inpatient as well or just outpatient?

Dr. Jerry Ballas: Inpatient as well.

Dr. Sara Kim: Wow.

Dr. Joe Chappelle: Wow. Good for you. Alright, we’ll hold on to that until the end of the conversation here, we can talk more about that, I want to hear more. So then, getting into the rest of the results here. They dispense 40, that was the median, interquartile range was 30 to 40. Most women, again, median it was 20 of number of pills used with an interquartile range of 8 to 30. So, the average leftover was 15, with an interquartile of 3 to 26, so a little variation in the used and leftover, but the median was still 20, so we know that 20 is probably okay. Let’s see, they then broke it down into 3 segments: those who got 40, those who got between 30 and 40 and those who got less than 30. And they looked at some of the differences.

There was no difference in pain satisfaction or satisfaction with pain control despite the number of Rx, which I think that Dr. Kim and I, not that we want to give away our secrets here, but we have been seeing the same thing in our study. 5% requested a refill, which is a pretty low number. Looking at who thought they had too little and who thought they had too much, 15% in the less than 30 thought they had too little versus basically the same in the other two groups, which was 10 or 9, so about a 5% difference. And then too much, the less than 30 and the 30 to 40, both about 21% thought they had too many and 36% in the dispensed 40 group thought they had too much. Which again, Dr. Kim and I can say is about what we’re seeing as well.

Dr. Sara Kim: Right.

Dr. Joe Chappelle: Then, they did, it’s called a negative binomial model which, for all intents and purposes, we’ll think of as a regression, where they basically take all the confounders and they put it all together and they see what shakes out. And basically, nothing mattered. Pain at discharge, maternal age, labor before section, smoking, antidepressant use, benzodiazepine use, type of anesthesia, length of stay, opioid type, NSAID use or hospital that they delivered out made no difference in whether they thought they had too much or too little. Anything else in the results, anything you think I glossed over or missed that you guys want to bring up before we move on?

Dr. Jerry Ballas: I think, you kind of alluded to, I don’t know if you’re going to get to it later, but the distribution of patients, at least… And again, this I think will catch the eye of people that work in different academic centers or different patient populations, but the proportion of privately insured, the fact that they did not use any non-English speakers, I can tell you right off the bat, in my practice where I’m at, how applicable this information is, is kind of difficult to take as a one to one comparison. Now, whether those factors overall really make a difference? I’m not too sure, but that is one thing that popped out at me looking at the centers that were involved and the patient makeup. The majority were white, privately insured, and English speaking. I can tell you that’s pretty much the opposite of my patient population down here in Houston.

Dr. Joe Chappelle: Absolutely. Whenever we look at a paper, you have to say, is this study population my population? Even if you believe exactly everything they said was right, they did their study well and they got their results and you trust it, that still doesn’t mean it’s applicable to you and what you do on a daily basis, because you have to look at the population. I will say that one of our residents here at Stony Brook last year did a study looking at how safe women felt after same day discharge for hysterectomy, laparoscopic hysterectomy, and they found that the five people who identified themselves as primarily Spanish speaking were basically the only five who felt that they didn’t have enough support when they went home. There are cultural differences that need to be taken into account. And again, not to say that that would make a difference in this, but it might.

Dr. Jerry Ballas: Cultural awareness of pain? I think it can actually be a huge part of this in terms of whether women feel like their pain is being adequately addressed, on each end of the spectrum. Those that never feel like their pain is never adequately addressed or those that will not complain of pain no matter what. So, there is definitely a cultural component that this paper may miss. And I don't know why it’s bothering me, but does the age seem to be a little older than you would expect or am I just… I mean, I’m fine with that, because I had kids at an older age, so this makes me feel comfortable and part of the norm. But it seemed like an older age, and I don't know if that matters or if anyone else feels…

Dr. Joe Chappelle: Well, I think it may be an effect of both the racial breakdown and also the privately insured. The whiter and more privately insured your population is, on average, the older they’re going to be when they’re delivering.

Dr. Sara Kim: I think that’s a trend now, where people are having children a little bit later, and I agree, it’s potentially a reflection of the demographics of the patient population involved in this study,

Dr. Jerry Ballas: Exactly. I was going to say that overall, we say the patients are getting older and so forth, but remember, I think, again, that’s a cultural phenomenon, because my patient population, again, there’s older women having babies, but they already started having babies when they were young, so it’s an interesting thing that popped out in my mind, too.

Dr. Joe Chappelle: I didn’t catch that, that was good. Alright, so, moving on to the discussion, and then I think the three of us are going to have our own little discussion, it feels like. But going on to their discussion, they state that, first off, we don’t know what normal usage is, that’s why they wanted to do this. Again, that caesarean delivery is the most commonly performed surgery in the U.S., and if each woman gets 16 extra pills than she needs, that’s equal to 20 million extra pills of narcotics per year, which is a sobering thought. And then, they also found that the more pills that were prescribed, the more were used, regardless of whether the patient felt that she had good pain control or not, so that’s important. And then we start getting into the nebulous stuff. So, that’s all the stuff that they can say based on their data here, and then they start questioning, okay, well, what are the effects, are women taking extra pills if it’s not going to change how they feel about their pain? Do we get more abuse? Do we end up with more addicts that way? And the second thing again is all these 20 million extra pills and what is that doing? Where are they going? Are they really just sitting in a medicine cabinet for five years and then being thrown out or are they being used? And of course, we don’t know that.

Then the last thing and then we’ll get into our discussion here, is talking about limitations. A couple of limitations here. The first is recall bias. They are calling people and asking them about how their pain was a week before. They’re asking them how many pills they have left, if they don’t have the bottle with them, they’re asking them to estimate how many they have left, so there is some recall bias. I don't know if it’s that important but it’s there. And then, this this is what Jerry was getting to, their selection bias. They selected these women, first of all, based on the hospital they’re in, so they can’t do anything about that. But then also, there’s women who they couldn’t follow up. Maybe those women couldn’t follow up because they were in more pain and they couldn’t get to the phone. I mean, that sounds kind of silly, but maybe. So, there’s definitely a little selection bias going on there as well.

Dr. Jerry Ballas: Absolutely, it’s about 25% if you look at it. 20 to 25% of non-follow up, they weren’t able to reach. Again, you can interpret that in any specific way, but that is a huge amount of people that you’ve got to wonder, if you performed a caesarean delivery on somebody, how two weeks later, you’re unable to reach them. I don't know if that speaks towards just our fractured medical system or these patients, in particular in this patient population. It’s hard.

Dr. Joe Chappelle: The issues I kind of want to talk to the two of you about, and I want to get into Jerry’s Tylenol #3, the experiment they’re doing down there. What can we do… First of all, we know there’s an opioid issue. Even just if there’s 20 million extra pills a year, we know we’re contributing to it in some way. Maybe it’s not huge, probably is. But what can we do to stop this? Some of the issues are we want women to be satisfied with their pain control, we don’t want that many women to feel like they have to call us for a refill, because that puts a barrier to that. So, we want to affect change in the number of pills we’re prescribing while at the same time making sure we’re not decreasing the quality of our patient care. So, how do we go about doing that?

Dr. Jerry Ballas: I can tell you from our experience, what spurred it on actually, was the state of Texas changed scheduling for narcotic prescribing, so it actually became almost a protocol-driven change in paradigm because we didn’t have enough providers with triplicates that could truly keep up with the amount of residents patients we were discharging, if that makes any sense. And so, they changed the scheduling on our Norco and Vicodin to make it much more stringent, where every single one of them needed to have a triplicate, couldn’t be ordered any other way. And so, it actually was somewhat burdensome. But it actually spurred on a discussion amongst attendings as to, do we need to be prescribing all of this across the board like we used to in residency, pretty much stamp prescriptions, read, 30 day supply, here’s your Vicodin, head out at the door. So, we actually started really talking about how do we prescribe our pain medication?

And so, beyond pain scores, we actually started actively managing expectations. That’s actually the big buzz word in a lot of pain control circles, is managing patient expectation. And this starts during the prenatal course. When you start talking to patients about pain management during labor, pain management if you need a c-section, you talk about pain management immediately after, you get them ambulating early, you get them eating early, you get them moving to their regular routine earlier, and that’s part of the expectation. And this study actually speaks to that. By virtue of giving more pills, in some way, you are telling women, “Expect to have more pain, and so you’ll probably take more medication.” That’s how I read that one graph, Figure number 3. You give more, people are going to take more, because you’re the doctor. You’re prescribing this for a reason, right? So, if you’re going to give me 40 pills, well you must know what’s going on, I may need 40. I think a lot of pain management comes to managing expectations.

Dr. Sara Kim: After the change with not prescribing narcotics, how has the pain satisfaction been for the patients? Has it stayed the same?

Dr. Jerry Ballas: We have not noticed any big differences, there haven’t been any… nothing from the nurses. Usually the first line is going to be nursing. Nursing is going to let you know that their patients are calling them more often, their patients are suffering, they’re going to advocate for the patient. And we really have not seen that. We haven’t been… I haven’t looked at data from the nursing side, whether they’ve objectively been recording more instances of inadequately controlled pain, but I can tell you at least, subjectively or anecdotally, from resident interactions, and I do a lot of postpartum rounds, that we’ve barely skipped a beat in terms of discharging patients timely or having any big events postpartum.

And it’s interesting where a lot of the discussion actually comes from is managing our patients who come in with a history of chronic pain or women who are on, say, methadone for addiction or they’re in some sort of recovery program. We actually learned a lot from them in terms of managing expectations and preparing them and thinking of alternative medications in order to help them along. Something like anesthesia, using Toradol more liberally at the end of procedures in order to give that extended non-steroidal effect. Also using Duramorph, to give more to prolong at least immediate post-operative effect to allow us early ambulation afterwards and get them moving around and limiting that expectation of sitting in bed still, not moving, in order to save themselves…

Dr. Joe Chappelle: And what do you do with your NSAIDs? Do you do around-the-clock scheduled or do you do PRN?

Dr. Jerry Ballas: I personally will do scheduled, I will tell the residents to keep it scheduled, especially NSAIDs, those anti-inflammatories, that is the majority of where their pain is going to be coming from. And so, I will schedule. Obviously individualize it to patients with, say, preeclampsia with renal involvement et cetera. If we need to pull out experimenting with new things like tramadol, different types of medications that can also help.

Dr. Joe Chappelle: And then the Tylenol #3 you do PRN?

Dr. Jerry Ballas: PRN, mm-hmm.

Dr. Joe Chappelle: Yeah, interesting. We are… I don’t want to give away my secrets, but we’re doing another study here where we are doing exactly– well, not exactly that, but we are changing from PRN to scheduled Tylenol and ibuprofen to see what effect that has on inpatient opioid use, and the opioids being PRN. Now, the opioids being basically given by the nurses, like, “You should take this,” then if it is, then it won’t be effective at all. But if it’s really patient-driven, you would expect to have some difference if the ibuprofen, especially, is around the clock.

One of the interesting things that Dr. Kim, who’s doing a lot of these phone calls for our study here, found that no matter how many pills the women used, how many pills they had left, how many pills they were prescribed, almost every single woman said something along the lines of, “Yeah, but I have really good pain tolerance.”

Dr. Sara Kim: Right. Yeah, that’s been the theme, every time I call, it’s like, “Oh, well,” even if they used everything or even with patients who have asked for a refill, they say, “Well, I have really high pain tolerance, but I needed this.” So, I think I agree with you Jerry in the sense of, I guess, expectations and patients’ perspective of pain. I think patients’ perception of pain is obviously different for how we view their pain, and also that might be what sets them up in terms of what their expectations are. If they expect to have a lot of pain, they’re going to say, “Well, I tolerated that, so I have actually high pain tolerance,” when in reality, that’s probably the same amount of pain that most other people may still be experiencing. I think that the way they view their pain, it’s interesting how that colors their possible opioid use.

Dr. Jerry Ballas: I think what also bothered me about the– Not bothered, but caught my eye about the older population in this study, was how do you manage the younger patient, who as we know, expectation of this kind of pain has no real basis for this, and those seem to be the tougher ones to really convince that they’re okay, You’re going to be okay, you need this medication when you need it, but you don’t need it around the clock. Those are the patients I tend to have the more difficult interaction.

Dr. Joe Chappelle: I think the next step, and again, this is something that Sara and I are working on, is we’d like to be able to give overall less narcotics, or maybe even switch to Tylenol 3, I’ll have to think about that, because if we do it right now it’s going to mess with our study. Let’s not do that. But in any case… A little bit of a joke. Little bit. So, can we reduce the number for most people but then have some way of predicting who’s going to need more based on… what are the factors that we can come up with? Whether it be inpatient opioid use, or other things just to say, okay, 95% of you get 20 or 15 maybe even, but these women who hit this threshold, we know you’re going to need more so let’s give you more so that we don’t get those refill request. Or maybe we should say the refill requests aren’t bad, and as long as we make an easy way for a woman to get that refill that’s not a barrier, they don’t call at 10 o’clock at night and no one can do it for them, then maybe we give everyone 15 and 20 and say, hey, if they need refills then we’ll sort that out and just make the system better.

But I think there is some… I think what you talked about there Jerry, is perfect. You got a stimulus to say, let’s rethink how we do this, let’s rethink our assumptions around pain control and see if we can do it differently. And I think what the paper says to me is, okay great, we’re thinking about it, and how many are we actually using? There were women in here who got 80 pills. That’s a lot.

Dr. Jerry Ballas: Oh, yeah.

Dr. Sara Kim: That is a lot.

Dr. Joe Chappelle: We had one woman in our study that had 180 pills prescribed. 180. And she was not a chronic pain patient, she was a standard patient. So, you got to think about what we’re doing as a whole and think of ways of reevaluating the system that we’ve created around pain control and how can we alter that.

Dr. Jerry Ballas: Right. Another thing I thought about too is something non pharmacologic that you can see from other literature and other aspects from our specialty even, is something as simple as a callback. I remember distinctly in Stony Brook as a resident, the callback lists were long. Oh, my God. I remember managing the callbacks and thinking, this is just the biggest torture for us. But it did reduce the amount of people that, I believe, came back to our ER or got readmitted, and I think it actually could play well into managing expectation, having phone calls to your post-op patients and listening to them and explaining to them and validating their concerns, but at the same time reinforcing that they are getting better. And to hear that from a physician or even a nurse practitioner or somebody from the practice could actually help to, I think, reduce how much pain medication women feel they need.

Dr. Sara Kim: I definitely agree on that aspect. It’s definitely something to think about, just because when I did call these patients back and they were like, “Oh, you’re a doctor from Stony Brook,” they were willing to answer my questions on the survey but also just to talk about what they’ve been feeling, how the postpartum course has been, they had a lot of questions, and overall they all were very appreciative of the fact I called them, although for me, I just appreciated them answering my questions on the survey. So, it made me realize that these patients, especially probably with the primary section, it’s their first baby, they have a lot questions about like, “Am I allowed to take this medication? How much pain am I supposed to feel post-op day six or seven?” So, I agree, it’s just a matter of, a lot of it is time issues a little bit too. As residents it’s difficult to call every single postpartum patient. I try to do it for my study, but it’s definitely a good point, but something for logistical purposes, you have to think about how we can actually come into fruition.

Dr. Jerry Ballas: Oh, right. Absolutely. These are outside the box thoughts that… It’s a hard sell, even for private practice. Yes, residency, but private practice having this kind of ability as well. You have to span everything pharmacologic, non-pharmacologic, to try to bridge this gap. Women become an island after delivery, we all know that, both socially, medically, they’re stuck with a lot of bad advice after they deliver, and bad resources. We all know this. If you go to the mommy blog universe, there’s some crazy stuff out there, and let alone listening to your friend, your mom, your sister, all who went through pregnancy, all who, honestly, probably either forgot or they’ve created some sort of illusion around their pain experience and probably aren’t all that helpful. And so, to have somebody objective that was involved in care or somewhat close to what they went through to be able to touch base with them, I think it’d go a long way.

Dr. Joe Chappelle: There’s plenty of models for this, and there are actually places that do this already for postpartum, whether section or vaginal, where they get assigned basically a home health nurse who will call them, if they feel like they need to actually go there, they’ll go and see them. And that cuts down on ER visits, it cuts down on even stopping breastfeeding, all these things get improved just by simple someone checking, calling, and saying, “Are you alright?” But that goes against, unfortunately, in the United States, where we don’t want to pay for preventative healthcare. We only want to pay for emergencies because there’s more money in it. This is where I think a dollar spent on the front end saves you $10 on the back end.

Dr. Sara Kim: Agreed.

Dr. Joe Chappelle: So, the fact that you do something like that down in Houston, Jerry, gives me hope that other places are trying out different things as well. And I hope it’s okay, Jerry, maybe at the end or in the show notes, if we can get some contact information for you, so if any of our listeners want to contact you about the program you did there and how it worked and maybe they want to do something similar in their own place.

Dr. Jerry Ballas: No, absolutely. And we’re actually having – not to plug this – we’re having a conference down here in Houston, and I may be speaking at a session about our multipronged approach to pain control, and then the National Perinatal Association that I’m president elect of now, in 2018 in March, we’re having our annual conference in Loma Linda about substance use in pregnancy, but part of it is going to be about legal substance use and how do we manage that kind of changing paradigm and treating women’s pain both during and after the delivery. So, it is an interesting topic to me.

Dr. Joe Chappelle: Good. So, definitely get that for anyone who wants to contact Dr. Ballas on that. To finish up on our paper here, I just want to read their last line, because I really think it’s a great little call to arms here. It says, “Given the frequency of cesarean deliveries in the United States, obstetricians can play an important role in decreasing the supply of opioid medication introduced into communities and should adopt more judicious prescribing patterns and counsel women about the importance of safe leftover medication disposal.” I think it’s exactly what we’ve been saying the whole time. To be clear, I think this is a very well-written paper. It’s nothing complex, it’s not going to change the world, but it’s saying we have a problem, what’s our current state, and at the end saying, we are in a position to really help, here. We may not feel like we are, because we’re not on the first line of the opioid crisis in general, except perhaps in pregnant women who have opioid issues. But we actually can prevent that ourselves just by doing some simple things. And so, I thought that was a very nice way of ending their manuscript.

Dr. Jerry Ballas: Absolutely. And I could actually see… it may not be a complex paper, it may not be world altering, but I can see this paper being brought up as a reason to at minimum, change some postpartum prescribing practices and say, hey, look at this paper, maybe the person doesn’t need more than 20. Let’s institute a 15 to 20 pill max and then have some sort of follow up that will see if these women are doing okay with just that amount. I think that paper really… That number comes out to me is this don’t go any more than 20 because there’s absolutely no benefit to it.

Dr. Sara Kim: Yeah, I mean, it doesn’t offer specific guidelines, per se, but I do think the paper definitely is a way to start a discussion in different places as to what are we doing right, right now, and what can we do differently to not contribute to this opioid epidemic. And how do we go about, I guess, having the discussion with maybe patients, like you guys are doing down there, where even during the prenatal visits, start the discussion about how do we counsel people about pain expectations and what to do afterwards with the medication as well. So, I do think that this paper is a good way to start discussions in different places.

Dr. Joe Chappelle: Alright. I think that we all very much liked this paper, which is unusual so far in our three journal clubs.

Dr. Jerry Ballas: Six thumbs up.

Dr. Joe Chappelle: So, unless anyone has any other thoughts about this particular paper, I think I’m going to call this journal club to a close.

Dr. Jerry Ballas: Hear, hear.

Dr. Sara Kim: Agreed.

Dr. Joe Chappelle: Hopefully, we’ll have these two people back for other journal clubs, this was fun. Look for next week, I hope to have the first episode of polycystic ovarian syndrome out, which I’m having a lot of fun putting together, so I hope you enjoy it as well.

Dr. Jerry Ballas: Polycystic ovarian what? Hold on.

Dr. Joe Chappelle: I know, you MFM types.

Dr. Jerry Ballas: The maternal fetal medicine doctor is going to back away from the microphone.

Dr. Joe Chappelle: You’re really going to like that episode, Jerry, I promise. And then I believe we’re going to have a new voice come in, probably later this month or next month, talking about antenatal steroid use during pregnancy, which I know Jerry will like to listen to, so that’ll be exciting.

In any case, thank you everyone for listening. We’ll see you back soon. Until then, thank you very much. Good night guys.

Dr. Sara Kim: Good night.

Dr. Jerry Ballas: Good night.

1. [↑](#footnote-ref-1)