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Post-Operative Analgesia in Saudi Arabia and the United States: A Resident's Perspective

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Abstract

Objectives: To examine post-discharge pain management among general surgeons in Saudi Arabia and the United States and the process involved with dispensing opioids.

Methods: I participated as a general surgery resident and observed other general surgeons manage post-discharge pain in Saudi Arabia and the United States. I backed my observations using peer-reviewed data.

Results: There is a wide variation in post-discharge analgesia practices between surgeons in Saudi Arabia and the United States. General surgeons in Saudi Arabia routinely manage post-discharge pain with non-narcotic analgesics, while general surgeons in the United States routinely utilize narcotic analgesics. More stringent regulations for dispensing opioids are followed in Saudi Arabia compared to the United States.

Conclusion: General surgeons in the United States prescribe a higher number of opioids than in Saudi Arabia. More stringent regulations are followed in Saudi Arabia for dispensing opioid analgesics post-discharge.

Keywords: Addiction; Addiction research; Opioid; Analgesia; Addiction therapy

Introduction

Post-discharge pain management in Saudi Arabia and the United States are vastly different. In this article, I report significant differences that I have practiced and observed, potential reasons, how this may affect patients in the long run, and how physicians may play an impactful role.

Text

I was appalled by the number of oxycodone tablets patients were typically discharged home with after a surgical procedure in an academic institution I joined in the United States. Depending on how extensive the surgical procedure was, we routinely discharged opioid naïve patients post-operatively with a paper bag containing 40 to 120 tablets of Oxycodone 5 mg. A ventral hernia repair or laparotomy is on the high end, and a laparoscopic cholecystectomy or an inguinal hernia repair is on the low end. Studies have backed my observation and found a wide variation and excessive doses of opioids prescribed post-operatively [1]. Further, among opioids obtained by surgical patients, 42% to 71% of all tablets went unused [2]. Nevertheless, prescribing this way was part of a surgical resident's duties. I presumed it to be an effort to maximize patient satisfaction on surveys, which might eventually drive up the number of patients walking into the surgery clinic. Additionally, marketing and promotion by the pharmaceutical industry have considerably amplified the prescription sales and availability of opioids [3]. Be that as it may, signing those prescriptions had always left a bad taste in my mouth out of concern for setting forth a case of chronic opioid use [4]. I always tried to get away with prescribing the lowest possible number of tablets, risking having to answer to the chief of service for not prescribing "adequately." Overtreatment of pain with narcotics as a first-line was particularly unpleasant when the head surgeon asked me to write narcotic prescriptions for a child after a minor procedure like an umbilical hernia repair. I always thought that permitting children to resort to narcotic analgesics as a first-line will create a pleasurable feeling that might later be sought and even develop into an opioid use disorder or heroin use if enough environmental factors tip the scales [5].

I couldn't help but imagine how outrageous supervisors would receive this if I were still in Saudi Arabia. Narcotics prescribed by a surgery resident were simply not permitted in the community hospital where I was a part of. The "standard of care" was discharging patients post-operatively only on Acetaminophen and Ibuprofen. In less common cases where narcotics were indicated for analgesia, stringent regulations were implemented. For instance, I observed, and one study corroborates, that special "narcotic forms" were required in the Middle East, and in most of these countries, access to these forms is restricted [6]. Further, the pharmacist only accepted this special form when attested by the surgery consultant (equivalent to an attending physician in the US). Consultants would typically write a nine to fifteen tablet prescription of Oxycodone 5 mg. We would also monitor these patients closely by having them follow up in the surgery clinic two to four days post-discharge. Patients picking up narcotics from the pharmacy would also need to fill out another form detailing their contact information, including home address and national ID number, to pick up their 2-to-4-day prescription. Furthermore, apart from two Middle East countries, opioids were only available in hospital pharmacies [7]. I found these pharmacies independent of the general hospital pharmacy in location and staff training.

Conclusion

Higher number of opioids are prescribed by general surgeons in the United States than in Saudi Arabia. More stringent regulations

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are followed in Saudi Arabia for dispensing opioid analgesics post-discharge. Adapting similar stringent practices around prescribing narcotics in the United States may protect post-operative patients from one risk factor for developing an opioid use disorder. Surgeons are well-intentioned and aim to provide the best care by maximizing analgesia. However, addiction specialists play a direct role in managing patients' opioid use disorders. Part of the physician's moral obligation is to bridge the gap between prescribers and the long-term effects these prescriptions may have on patients. Physicians have a duty to society to educate on the risks and ramifications of overprescribing narcotic analgesia.

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