ERAS for Hip and Knee (THA and TKA) Arthroplasty – A Need to Look Beyond LOS

also in this issue

ERAS for Total Joint Arthroplasty: Past, Present and Future
Enhanced Recovery for Orthopedic Surgery
ERAS for Spine Surgery: A New Frontier
ANNUAL CONGRESS OF ENHANCED RECOVERY AND PERIOPERATIVE MEDICINE

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President’s Message

By Tong J (TJ) Gan, MD, MHS, FRCA, President

It is my great pleasure to announce the inaugural issue of the ASER Newsletter. Founded in 2014, ASER is a multi-specialty nonprofit organization with an international membership and is dedicated to the practice of enhanced recovery in the perioperative patient through education and research. We are experiencing a period of tremendous expansion and growth, as is evidenced by the great interest to implement the enhanced recovery pathway in hospitals around the country.

The ASER Mission is to advance the practice of perioperative enhanced recovery and to contribute to its growth and influences, by fostering and encouraging research, education, public policies, programs and scientific progress.

We have achieved much over the past 2 years, including:

- Annual ASER/EBPOM Congress
- ASER website
- ASER manual of Enhanced Recovery for Major Abdominopelvic Surgery
- Enhanced Recovery Implementation Guide
- Regional Leadership forums
- Perioperative Medicine as the official society journal

This newsletter aims to share information, best practices, sample protocols and members’ experiences in implementing enhanced recovery pathways. It serves as a forum for communication of the many activities of the society.

I would like to thank Dr. Thomas Hopkins, Lyla Hance and their committee for editing the newsletter and those who generously donated their time to contribute to this edition.

We want this newsletter to be valuable for you, so please share your feedback and suggestions to help us improve. Please forward it to friends and colleagues who you think will benefit from this newsletter.

Enjoy reading.

Tong J (TJ) Gan, MD, MHS, FRCA
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ERAS programs in total joint arthroplasty have been introduced worldwide in many centers with documented success and reduced length of stay (LOS) and morbidity. However, despite the achieved success, several challenges lie ahead. First of all “what is the optimal LOS?”, since there is a lack of documentation on the economic and safety aspects of same-day discharge vs next day in a general THA and TKA population vs the proportion of selected suitable patients. Although overall morbidity is reduced by ERAS, further studies on the relative importance of conventional risk factors needs to be clarified, since recent data question the relevance from standard risk assessment within traditional care. Still, a major problem is the need to improve pain management after discharge in relation to patient activity and optimal rehabilitation. In this context, further studies are required to preoperatively predict high-pain responders in subpopulations such as pain catastrophizers, preoperative opioid users and other pain “sensitized” patients. Also, more data are required on the otherwise documented risk of postoperative delirium especially with opioid-based pain management, but where a fully implemented opioid-sparing ERAS program may almost eliminate this problem. Although it is well-established that preoperative anemia should be diagnosed and treated, more focus on post-discharge anemia should be made, since it may impair rehabilitation and increase risk of organ dysfunction, but so far with sparse available data. Further data are required on thromboembolic complications and need for prophylaxis, since early mobilization with ERAS may reduce the risk. Importantly, readmissions and discharge destination must be clarified due to a huge discrepancy between individual institutions and countries and where readmission to “own institution” is insufficient because some patients may be readmitted to other institutions. Also, discharge destination, which has major economic implications, needs further evaluation, since discharge to a “nursing care facility” or “rehabilitation” institution is variable, and in some...
In summary, despite an obvious success of ERAS in THA and THA to reduce LOS and morbidity, several challenges lie ahead to improve post-discharge recovery.

References


ERAS for Total Joint Arthroplasty: Past, Present and Future

By Ellen M. Soffin, MD, PhD; Alana E. Sigmund, MD, FHM & Chad M. Craig, MD, FACP

In the companion article in this edition, we speculate whether Enhanced Recovery After Surgery (ERAS) protocols can be usefully applied to patients undergoing spine surgery. If ERAS for spine represents an emerging concept in orthopedic surgery, ERAS for total joint arthroplasty (TJA) represents the proof of concept. In contrast to spine surgery, elective hip and knee arthroplasty are high-volume, highly standardized surgical procedures typically performed in medically optimized patients. These conditions facilitate the implementation of clinical pathways or fast-track programs which lead directly to reductions in length of stay and improved outcomes.

For more than 30 years, there has been compelling evidence to support the use of packages of care to improve recovery after TJA. At Hospital for Special Surgery, Sharrock et al. transformed the care of our TJA patients by incorporating standardized perioperative interventions: universal receipt of epidural anesthesia, invasive goal-directed hemodynamic monitoring, epidural analgesia, pulse oximetry, and post-operative supplemental oxygen, with ICU-level of care for high-risk patients. These changes effected a reduction in mortality after total knee arthroplasty from 0.44% to 0.07% over a 10-year period. Importantly, there were no major changes in surgical technique over this interval, suggesting the bundle of interventions led to improved outcomes.

More modern fast track protocols reliably demonstrate cost savings and reductions in length-of-stay – often with discharge to home and without increased complications or readmission. The Hospital for Special Surgery clinical pathways for total hip or knee arthroplasty feature pre-operative patient education and discharge planning, pre-emptive analgesia, post-operative assessment by a physical therapist, and were educated about the planned day of discharge, wound care and physical therapy. They also received necessary equipment prior to admission, received spinal anesthesia, and also participated in early mobilization. A similar, although smaller, study in total knee arthroplasty showed similar results.

Finally, in a recent study of patients undergoing primary total hip arthroplasty, comparing patients in an enhanced recovery program to patients in the hospital’s standard-care program, the enhanced recovery group showed a decreased length of stay of 1.5 days with no increase in post-operative complications. In this program, patients underwent pre-operative assessment by a physical therapist, and were educated about the planned day of discharge, wound care and physical therapy. They also received necessary equipment prior to admission, received spinal anesthesia, and also participated in early mobilization. A similar, although smaller, study in total knee arthroplasty showed similar results.

While package of care studies in TJA show benefit for patients, they also have revealed that the two major approaches to standardized care in TJA, ERAS and clinical pathways, have basic differences in form and content. In contrast to ERAS in other surgical subspecialties, the majority of published pathways for TJA comprise intraoperative anesthesia, post-operative analgesia, and early mobilization as the basis of the care trajectory. Standardized ERAS components, including pre-operative education and nutritional optimization, goal directed fluid therapy (GDF) and audit are often conspicuous by their absence in TJA. A recent review of ERAS for TJA suggests that despite the established success of clinical pathways, there remain major opportunities to apply ERAS principles to patients undergoing elective joint replacement.
there is a large body of evidence to guide decision making in constructing pathways of care, there are equally large gaps in knowledge which suggest avenues for future work.

Many ERAS interventions are resource-intensive, so understanding which patients benefit from which components is of primary importance. The literature suggests that education programs could be most effective for anxious or socially isolated patients, although it remains to be seen if standardizing the content and method of delivery would have a positive effect for all patients. Likewise, the optimal analgesic regimen has yet to be determined, despite an abundance of choice: epidural, peripheral nerve block or catheter, local infiltration analgesia, and oral/intravenous multimodal agents all show analgesic efficacy and are opioid-sparing after TJA. Ultimately, these decisions might have to be made according to institutional practice and capability.

Because of the safety and efficacy of clinical pathways in TJA, we are increasingly offering surgery to patients who probably would have been denied surgery in the past. It has become routine to perform joint replacement for the elderly, morbidly obese, high ASA Physical Status, and/or chronic opioid dependent patient. Demand for same-day or same-admission bilateral TJA is also increasing. These changing patterns require increasingly creative strategies to understand and implement best practice. It may be the right time to standardize language in order to facilitate research and practice. “Clinical pathway”, “ERAS”, “Perioperative Surgical Home” and “Fast Track” are used interchangeably in...
the literature, and many terms lack a definition. In addition to standard language, we advocate that a principal goal should be a standardized ERAS pathway for TJA based on the best available evidence, and including audit. We submit that this process is most effective when it occurs at the Society level with adoption of consensus guidelines, as has been the case for ERAS in other surgical subspecialties.

References

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Enhanced Recovery for Orthopedic Surgery

By Arman Dagal MD, FRCA; Chad M. Craig, MD, FACP & Ruchir Gupta, MD

Total hip and knee replacements amount to nearly 1,000,000 surgical procedures annually in the United States and are expected to triple in volume by 2030. It is estimated that 7 million people are currently leaving with total hip or knee replacement in the United States alone. In addition to the joint replacement, spine surgery is amongst the costliest procedures in U.S. Between 1998 to 2008 the number of spinal fusion procedures increased by 137%. The spine care (direct and indirect) cost around $100 billion annually in the U.S. alone. Despite the apparent success of these surgeries, quality and cost remain variable across institutions.

Bundled Care and Health Care Delivery.

The Center for Medicare and Medicaid Innovation (CMMI) was created by the Affordable Care Act to tests innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care for the beneficiaries. The Bundled Payments for Care Improvement (BPCI) initiative is the product of the CMMI. Under this initiative hospital and physician services combined into a single payment, using episode based rather than the fee for service payment method. Bundled payments provide an incentive for the hospitals and its medical staff to improve coordination of care to improve value and eliminate unnecessary cost. Hospitals and its providers share the associated risk and financial penalties if they cannot control the cost and quality of care. In this new definition of the surgical episode also includes the post-acute care expenses up to 90 days from the surgery.

Along with the mission of value-based care, this year, Joint Commission launched a new Advanced Certification program for Total Hip and Total Knee Replacement. The Advanced (ERAS) concept emerged following the work of Henrik Kehlet, M.D., Ph.D 1992 on colorectal surgeries. ERAS is a model of coordinated care delivery of evidence-based care bundles, aimed at achieving perioperative optimization and reducing the adverse effects of the surgical stress response. A number of studies have examined the ERAS pathway care bundles for primary hip and knee replacement surgeries, with a recent review highlighting that such pathways can be applied to a wide variety of patients.

Aasvang et al. concluded in their study that ERAS can in fact be applied routinely to all hip and knee replacement patients in order to...
achieve 1–3 days hospital length of stay, a reduced incidence of cardiac and venous thromboembolism complications and reduced postoperative delirium and cognitive dysfunction. The authors further showed that the median length of stay can be decreased from 76.6 hours to 56.1 hours after implementation of the evidence-based orthopedic ERAS pathway (P < 0.001). This improvement was possible without a concomitant increase in readmission rates.

Another study compared 1500 primary hip and knee replacement patients on an ERAS pathway with 3000 patients using a traditional protocol. The authors found that the median LOS decreased from 6 to 3 days, saving 5418 bed days.5 The 90-day mortality rate was also significantly reduced, as well as transfusion requirements.

Other studies have found ERAS pathways feasible and safe for more complex groups of patients such as the elderly,5 with a decrease in LOS for patients aged ≥85 years, and no negative effects on morbidity and mortality rates.

Additionally, the beneficial effects of ERAS are not limited to the routine primary hip and knee replacements. More complex and surgically variable procedures such as revision joint replacement, shoulder replacement, and in non-elective procedures such as fractured neck of femur patients have found outcomes to be similar to those for primary total knee replacement with respect to LOS and morbidity,6 - where median LOS was 2 days, no morbidity within 3 months, low readmission rates, and high levels of patient satisfaction. Major spine surgery is another specialty area that the application of ERAS principles has potential to improve patient outcomes.7

When ERAS principles are incorporated into existing or new clinical pathways, they improve the value of care delivery. Risk-adjusted patient outcomes, patient safety, and optimizing the use of resources are used for performance and quality indicators.8 2009 meta-analysis suggested that clinical pathways and care organization have significantly impacted the quality of care in joint replacement surgery with reduced postoperative complications, shorter length of stay and potentially lower cost of care.9 Recent, large sample analysis on perioperative fluid administration variability in the hip and knee replacement surgeries concluded that both low and high fluid volumes associate with worse outcomes.10

Suggested orthopedic ERAS care bundles

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Conclusion

Evidence exists to support the increased use of ERAS pathways. High-volume orthopedic surgeries such as total joint arthroplasty as well as spine surgery are ideal for such clinical pathways. Such high-volume procedures also allow for individual centers to track data and feedback data to help optimize the future use of pathways. Adaptation of ERAS principles as part of integrated care pathways appear feasible and may effectively improve patient outcomes, satisfaction and reduce cost. ERAS concepts perfectly lines up with the accountable care organizational needs to create a platform for the transformational care initiatives. We encourage institutions to identify multidisciplinary service champions to develop ERAS pathway care. A number of professional organizations including the ERAS Society (erasociety.org), and American Society of Enhance Recovery (aserhq.org) provide guidelines and resources to help with development of such pathways at the institutional level.

References


ERAS for Spine Surgery: A New Frontier

By Ellen M. Soffin, MD, PhD; Alana E. Sigmund, MD, FHM & Chad M. Craig, MD, FACP

It is evident that Enhanced Recovery After Surgery (ERAS) has become an established and effective mechanism for perioperative care across surgical subspecialties. In our companion piece in the Newsletter, we propose total joint arthroplasty (TJA) as the quintessential orthopedic procedure to benefit from ERAS principles: There is already convincing evidence that clinical pathways effect cost savings and clinical benefits for TJA patients, including decreased length of stay and complications. In contrast, there is a paucity of data in the published literature and reports at the institutional level for the role of ERAS pathways in spine surgery. There is much in common between the spine surgery and colorectal surgery patient (where most ERAS evidence exists to date), including predicted systemic inflammatory response (SIR), length of stay, requirement for parenteral analgesics and complications (particularly ileus). Given the evidence and enthusiasm for ERAS, it is unexpected that spine surgery should remain so understudied with respect to ERAS protocols.

This inattention occurs despite compelling biochemical, clinical and economic arguments to support ERAS for spine surgery. First, major spine surgery is associated with predictable increases in stress hormones and inflammatory cytokines which may be associated with a host of postoperative complications, including thromboembolism, atrial fibrillation and delirium. Specific interventions have been demonstrated to reduce biomarkers of surgical stress and improve outcomes after spine surgery. For example, intraoperative administration of the alpha-2 adrenergic agonist, dexmedetomidine, lowers interleukin-10 and cortisol and improves quality of recovery after multilevel lumbar fusion. Preoperative steroids lower interleukin-6 and C-reactive protein after cervical laminoplasty without increasing the risk of wound infection or compromised healing. Minimally invasive surgical techniques are associated with lower levels of cytokines compared to conventional techniques up to 8 days post lumbar fusion. The overall safety and efficacy benefits of minimally invasive approaches have yet to be fully established in lumbar spine surgery, but represent an intriguing possibility for future research as a component of ERAS for spine pathways. The minimally invasive approach may indeed be the ERAS-for-spine analogy to the laparoscopic approach in ERAS-for-colorectal surgery, in terms of benefits on outcomes and biomolecular markers of surgical stress.

The second argument in favor of ERAS for spine surgery is an economic one. The demand for spine surgery and the cost of surgery are both increasing exponentially in the United States and abroad. Indeed, a recent economic report estimated the total annual cost for back pain in the United States (including diagnosis, treatment and rehabilitation) at over $50 billion US dollars annually, and costs are projected to increase 4.8% annually in the near term. According to the report, the demand for spine surgery is being driven by an aging population, an increase in the number of fusions being performed, and technical advances making complex surgery more commonplace. Given these pressures, any reduction in length of stay, no matter how modest, is likely to produce significant economic gains, as has been demonstrated repeatedly for ERAS in other surgical disciplines. As an illustrative example of potential economic gains, we can consider lumbar fusion: The hospital costs associated with lumbar fusion without instrumentation was recently reported in a cohort study to be approximately $14,700.00 US dollars. The average length of stay was 3.5 days in a sample of 77 patients. A reduction in length of stay of just 0.5 days per patient would...
achieve overall hospital costs savings of approximately $161,700.00 in this cohort alone.

The third argument should ideally be made on the basis of evidence to indicate improved outcomes, reduced complications and rising patient satisfaction associated with ERAS for spine. However, this evidence is currently scarce and there are no published accounts of comprehensive ERAS pathways for any spine surgery subtypes at this time. However, there is an extensive literature regarding components of care that classically comprise ERAS pathways, together with encouraging results on a range of clinically important outcomes. A full review is outside the scope of this commentary, but several observations can be highlighted: multimodal analgesic regimens incorporating acetaminophen, non-steroidal anti-inflammatory agents, anticonvulsants, and local anesthetics are opioid sparing, and associated with improved patient satisfaction, reduced length of stay, and better pain control than intravenous opioid-based therapy after spine surgery; a blood conservation strategy including the anti-fibrinolytic, tranexamic acid, reduces autologous blood transfusion without increasing the risk of thromboembolic events after major reconstructive spine surgery; identifying patients at risk of nutritional deficiency and optimizing nutritional status was associated with a faster return to nutritional baseline (or anabolic state) after major reconstruction surgery (>10 spinal levels); and intravenous fluid restriction is associated with less post-operative ileus after lumbar fusion irrespective of surgical approach. If follows that these examples could be used as the basis for ERAS for spine pathways. However, a closer examination of the state of the evidence base raises more questions than it answers and exposes significant gaps in research and knowledge: What is the role of pre-operative education and shared-decision making in the spine population? How can we standardize pathways for such heterogeneous patients, indications and surgical interventions? What is the role of epidural analgesia after spine surgery? Is early mobilization appropriate after major reconstructive procedures? These are just a very few of the questions that need to be answered urgently if ERAS for spine is to become relevant and useful. In order to most efficiently provide solutions, we advocate creating an ERAS for spine pathway that can be adopted according to institutional capability. At Hospital for Special Surgery, we have recently implemented an ERAS pathway for lumbar spine fusion. The pathway is based on current best evidence, but where evidence is lacking, we have implemented measures that have demonstrated efficacy in other ERAS protocols. We are currently enrolling patients in a prospective study to investigate the effect(s) of the pathway on patient centered outcomes. Additionally, we call for research and well-designed studies that focus on procedure-specific interventions, improving logistics, and fostering a culture of enhanced recovery across disciplines.

References
Over the past year, America's struggle with the growing opioid epidemic has swept national headlines. New reports estimate 78 people die every day in the U.S. from overuse of opioids. Adding to this problem is a surreptitious factor: surgery has become an unintentional gateway to this tragic epidemic. In fact, research shows that one-in-10 patients prescribed an opioid following surgery report becoming addicted to or dependent on the drug.

It's clear that we need to improve the dialogue between patients and surgeons related to postsurgical pain management – many patients are still unaware that they have choices, including non-opioid options. That's why ASER partnered with Pacira Pharmaceuticals to launch Choices Matter, a national, unbranded campaign designed to educate, empower and activate patients, caregivers and physicians to proactively discuss postsurgical pain management, including non-opioid options before surgery. The campaign provides an opportunity to drive consideration for non-opioid alternatives, which can potentially minimize or virtually eliminate the need for prolonged use of opioids after surgery.

The Choices Matter campaign launched August 1 in New York City, featuring a top orthopedic surgeon and professional athlete and television personality Gabby Reece. Gabby recently had her own knee replacement surgery without the help of prescription opioids, which made Choices Matter an especially relevant and timely campaign for her. The campaign website – PlanAgainstPain.com – features helpful tools for patients about to undergo their own surgeries, including a customized doctor discussion guide that allows patients to facilitate conversations about non-opioid options with their surgeons.

To-date, Choices Matter has generated nearly 240 media placements and more than 476.5 million media impressions. Highlights include a New York Times Letter to the Editor from ASER President, Dr. T.J. Gan, which leveraged key statistics from a national survey of patients and surgeons conducted by Pacira. Additional coverage was featured in USA Today, Good Day New York, U.S. News & World Report, CNBC-TV, Self.com, CBS New York and Parade.com.

PlanAgainstPain.com has generated more than 45,000 page views and 180 discussion guide downloads to date. While our efforts have sparked a national dialogue about alternatives to opioids, there is much more work to be done to combat this growing epidemic. For more information visit PlanAgainstPain.com.

References

Gabby’s Story
By Gabrielle Reece, Professional Volleyball Player, Sports Announcer, Fashion Model & Actress

Professional Athlete and Television Personality Gabby Reece Talks About Recovery After Surgery

The intense pain in my knee was starting to affect my life, especially when I exercised or played volleyball. When it got to a place where I knew I couldn’t make it better through training, nutrition or therapy, I decided it was time to get my knee replaced.

It has been a little over six months since I had my surgery, and recovery has been a long road for me. Prior to the procedure, I had made a personal decision not to take opioids. Although I was given a low-dose painkiller in the hospital, I knew I didn’t want to take a prescription home with me. I’m very respectful of the fact that opioids are addictive and, although I consider myself a strong person physically and mentally, I’m aware that addiction shows no discrimination when it comes to age, gender, ethnicity, lifestyle, etc. – it can happen to anyone. In fact, a recent survey found that one-in-10 patients prescribed an opioid following surgery report becoming addicted to or dependent on the drug. I’ve been proactive in trying to avoid that because it’s important to me to stay holistic as possible in my recovery through sleep, stress management, exercise and nutrition. What I didn’t know is that there are many options available for managing pain after surgery, including non-opioids.

Choices Matter is important to me because I believe we should all be advocates for our own health. This program is about giving patients the resources they need to make the most educated choice for them. That’s why I’m encouraging people to have a conversation with their doctor about alternatives to managing pain after surgery, including non-opioid options. Visit PlanAgainstPain.com to learn more and download a discussion guide that can help you or a loved one have this important conversation.