



OPIOID PRESCRIBING GUIDELINES for OB/GYNS

In the past, OB/GYNs and other physicians were strongly encouraged to treat pain aggressively with opioids. It is now clear that the prescribing of opioids leads too often to side effects, dependence and addiction. At the same time, studies have shown that NSAIDs are as effective as opioids for treating many forms of pain, including acute postoperative pain. Further, multiple studies indicate that two-thirds of prescribed opioids go unused after cesarean section and benign gynecologic surgery.^{1,2,3} These guidelines, which are based on studies of analgesic needs post-operatively, attempt to balance the benefits and risks of opioids.

They recommend:

- » Managing patient expectations about pain after surgery;
- » Maximizing the use of non-opioid pain treatments pre- and postoperatively;
- » Avoiding the use of opioids for minor gynecologic procedures; and
- » Sharply limiting the duration of opioid use following major gynecologic procedures.

Managing Patient Expectations

Before surgery, discuss with patients the pain they may expect to have after the procedure.

Patients should be counseled that:

- » Pain immediately after surgery is normal and an expected part of the healing process.
- » Pain is worst in the first 1-2 days after surgery, but improves over time.
- » Most pain can be effectively managed with medicines other than opioids, such as NSAIDs, acetaminophen, gabapentin and topicals.

If opioids are being prescribed:

- » Opioids should be used only when other medicines have not adequately treated pain, and should be stopped when pain is manageable.
- » Opioids should be taken in addition to, not in place of, non-opioid pain medications in order to minimize the amount of opioids taken.
- » Opioids carry a risk of physical dependence, addiction and overdose.
- » Unused opioids should be disposed of safely to prevent misuse or diversion.

Written patient educational materials may be helpful to supplement this counseling.

Preoperative and Intraoperative Management of Pain

For cesarean sections:

Preoperatively, acetaminophen should be administered PR prior to start of procedure.

For major gynecologic procedures performed for benign conditions (regardless of incision type):

Unless contraindicated, patients should be given non-opioid analgesic medications (such as NSAIDs, acetaminophen, gabapentin) on a scheduled basis preoperatively.

For both obstetric and benign gynecologic procedures:

Consideration should be given to the applicability of following intraoperative medications and techniques, all of which have been shown to reduce the requirement for opioids:

- » Neuraxial or peripheral nerve blocks
- » Bupivacaine (regional and local infiltration)
- » Ketamine
- » Clonidine
- » Dexmedetomidine
- » Dexamethasone

Non-Opioid Treatments for Pain

There are many effective – and far safer – alternatives to opioids for treating pain. In the absence of contraindications, the following treatments should be first-line for patients following all surgeries:

Non-Opioid Pharmacologic Treatments

NSAIDs

Acetaminophen

Antidepressants

Topical medications

Non-Pharmacologic Treatments

Physical therapy

Cognitive behavioral therapy

Acupuncture

TENS units

Postoperatively, oral medications should be initially taken on a scheduled basis in order to maximize pain relief.



Refills and E-Prescribing

OB/GYNs may be concerned about under-treatment of pain, leading to requests for refills of opioid prescriptions.

However, multiple studies have demonstrated that only a small number of women request refills when up to 30 pills are prescribed.^{4,5}

If opioid prescription refills are needed, they are more easily done through e-prescribing. As of November 2019, e-prescribing of controlled substances is required in Pennsylvania.

Guidelines for Opioid-Naïve Patients

Obstetrics	Number of Pills* Recommended for Opioid-Naïve Patients at Discharge** (minimum-maximum)
Cesarean Section	6 (0-15)
Vaginal Delivery	0
Benign Gynecology	
Minor Procedure (ex: hysteroscopy, LEEP, dilation and curettage)	0
Minor Laparoscopic Procedure (ex: bilateral tubal ligation, ovarian cystectomy)	0 (0-3)
Minimally Invasive Major Procedure (ex: vaginal hysterectomy, laparoscopic hysterectomy)	5 (0-10)
Laparotomy (ex: total abdominal hysterectomy, abdominal myomectomy)	6 (0-15)

* pill = 1 tab of 5mg oxycodone or equivalent MME in short-acting opioid

** For patients discharged after post-op day 1, use of opioids in the 24 hours before discharge can further guide the amount prescribed.

Guidance for Patients with Chronic Opioid Use

- » **Do not increase opioids** above preoperative levels.
- » Before surgery, **set expectations** for anticipated pain, healing time and post-operative opioid use.
- » If surgery was performed to address chronic pelvic pain (such as hysterectomy for endometriosis), **consider taper as soon as acute pain is expected to resolve.**
- » If surgery did not address cause of chronic pain, **consider slow taper** and discuss with patient's prescribing physician.

See Philadelphia Department of Public Health's [Tapering Guidelines](#) for guidance.



REFERENCES

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