CORRESPONDENCE

The Quality of Postoperative Pain Therapy in German Hospitals

The Effect of Structural and Procedural Variables

by Prof. Dr. med. Winfried Meißner, Dr. Ing. Marcus Komann, Dr. med. Joachim Erlenwein,
Prof. Dr. med. Ulrike Stamer, and Prof. Dr. rer. physiol. André Scherag in issue 10/2017

Prescribing Behavior Is a Cause

US researchers invented the “dolorimeter” at the end of the 1980s. This instrument is used to rapidly gauge the subjective severity of pain (scale 0–10) by means of a questionnaire. Since 1990, opiate prescriptions in the USA have increased 10-fold and opiate-related deaths have more than quadrupled. Excess opiate use may be due to prescribing habits—for example, as a result of the rediscovery of oxycodone, a German preparation dating back to 1916. Barnett et al. (1) analyzed data from older patients who received treatment in emergency departments in the USA between 2008 and 2011 (conditions of illness/pain did not differ). The treating physicians were categorized into two groups. The first group included those who prescribed a high numbers of opiates (“high-volume opiate prescribers – 24%”). The second group included those who tended to prescribe fewer opiates (“low-volume opiate prescribers 7%). Long-term opioid use was significantly higher among patients treated by high-intensity prescribers than among patients treated by low-intensity prescribers. Furthermore, rates of long-term opioid use were increased among patients who had not previously received opioids and received treatment from high-intensity opioid prescribers. The data give rise to the suspicion that we prescribing physicians may be responsible for this catastrophic problem.

Meißner et al. (2) reported on the quality of postoperative pain therapy in German hospitals and concluded that, especially at university medical centers, pain therapy is inadequate. Dolorimeter values between 4.5 and 6 after different surgical procedures were reported in this setting. Younger age, female sex, and chronic pain were associated with a greater intensity of pain. Presumably, this problem can be solved only by even more opiate prescriptions.

It would be interesting to know if the opiate prescribing patterns in the different analyzed hospitals were different and whether or not the authors can provide information on the long-term effects of the pain therapies. The QUIPS register may contain more information relating to these questions. Ultimately, the enormous pressure from the pharmaceutical industry to prescribe opiates is also responsible for the opiate-abuse problem.

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Conflict of interest statement

The author declares that no conflict of interest exists.

In Reply:

Prof. Luft mentions the problems triggered by frequent prescription of opiates/opioids in the USA. He emphasizes rightly that this is (in part) caused by doctors’ prescribing habits and the marketing efforts of the pharmaceutical industry (1). With regard to our article he addresses two different problems: an increasingly common discussion topic relates to whether acute therapy with opioids, which is only intended for the acute postoperative phase, may evolve into long-term therapy, which was not originally intended (2)—especially as patients are discharged ever more quickly. Prof. Luft is right in that doctors are responsible for this—whether that is a result of not finishing acute treatment in hospital or non-indicated continuation of treatment after discharge.

We do not hold the view that the deficiencies in postoperative pain therapy that we discussed in our article should be remedied by prescribing more opiates. Even today, underprovision of opiates/opioids is probably rife in some hospitals and, in particular, in certain groups of patients. Another evaluation of QUIPS data showed that after cesarean sections, 62% of patients were not given any postoperative opioids at all in spite of severe pain, in settings where these were administered by medical staff (3). In our current analysis, however, we suspect that the possible deficiencies in hospitals providing higher levels of care were not caused by too few opioids but—at least in part—by poor communication, frequent staff changes, and a lower attention threshold vis-à-vis pain problems (4).

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