Letters

COMMENT & RESPONSE

Opioid Prescription Patterns After Rhinoplasty

To the Editor We read with great interest the study by Sethi et al on Opioid Prescription Patterns After Rhinoplasty.[1] The authors' scientific methodology was creative and insightful. As you know, we published a similarly titled study in November of 2017.[2] To our knowledge, this was the first study in our field to discuss the impact of opioids and scientifically suggest a methodology for altering prescribing patterns. The study by Sethi et al is remarkable in that it used a public resource available to physicians in almost every state: prescription drug monitoring programs (PDMPs). While noting that the overall refill rate is lower than a physician would expect is important, we feel the cornerstone of our role in the epidemic lies in 3 separate realizations.

First, each physician must actively incorporate pain management into his or her surgical discussion and plan. This discussion should entail prior opioid use history, postsurgical pain expectations, and frequent postoperative visits. We offered a detailed algorithm in our study[2] and feel it is important not to overlook. This process should also entail a review of each surgeon's prescribing patterns and an analysis of opioid use in our unique patient populations.

Second, we feel it is important to highlight the unique tool at the cornerstone of your study. Although PDMPs have been around in the written form since the late 1930s, digitization has seen their efficacy and importance increase in recent decades.[3] Given that there is no interstate sharing of data or federal database, each physician should be aware of the laws that govern his or her state. We hope that regulatory agencies are able to further integrate; however, in the meantime, the responsibility of knowing the laws falls on the physician.

Finally, we would like to highlight that most prescription drug abuse is not from the patient who originally received the drug, but rather via diversion of appropriately prescribed pills.[4] A discussion on a suitable means of safeguarding and disposal of the narcotics should always be held. As our studies show, many of our prescribed pills go unused and though we can prescribe less, we will never be able to get patients the exact number of pills needed. Perhaps, once again, programs that incentivize proper disposal of unused medical prescriptions may benefit society as a whole.

Once again, we applaud your efforts and wanted to highlight important viewpoints that our studies jointly bring to light. We encourage all surgeons to incorporate a pain management discussion algorithm into their practices.

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