Student Reference for Case 110 – Patient in recovery post-op

LEARNER TASKS: You are the provider seeing the patient immediately post-op in the hospital recovery room after urgent appendectomy converted from laparoscopic to open during surgery.

Gather Data:

- Assess the patient's current pain
- Take a substance use history and assess risk for opioid misuse

Build Relationship:

- Discuss the risks and benefits of opioid and non-opioid pain management while in recovery.
- Prepare an evidence-based and patient-centered pain management plan that treats pain and maintains recovery.

Engage Patient in Care Plan:

- Assess the patient's insight and confidence in the ability to follow this plan
- Counsel the patient regarding the chronic nature of substance use disorder as a disease and demonstrate empathy.
- Recognize own bias in prescribing opiate medications to a patient with substance misuse disorder in recovery (use inclusive and supportive language)

CASE DETAIL

Name: Ryan Connor
Age: age as per SP (and gender) (goal 40's)
Marital Status: divorced, living with parents
Children: 2 children, living with ex-spouse
Occupation: mid-level manager

Setting: Patient is in recovery from opioid use disorder, no recent evidence of misuse and has a good relationship and regular follow up with PCP. You meet post-op hours after urgent appendectomy. Plan was for laparoscopic surgery but it had to be converted to open intraoperatively. Patient had general anesthesia, awoke 2 hours ago and surgeon told pt. that surgery was converted to open at that time. Pre-op the possibility of open surgery had been discussed but NOT the potential need for opiate medications to control pain. Patient is afebrile, BP is stable and complains of incisional pain. Patient appears uncomfortable and anxious. Pt. has received acetaminophen, gabapentin and COX-2 inhibitor also one dose of IV morphine from anesthesia.

SMALL GROUP FACILITATION

	Encounter Timing:	
iCELS staff will announce timing to assure the day flows correctly. ***Please make every effort to stay on time.***	0 min	• Staff announce time to prep for the case: direct learners to review materials and tasks.
	5 min	• The SP knocks and enters the exam room.
	17 min	• Staff give the 2 minute warning.
	19 min	• Staff announce the end of the encounter. • The SP will not participate in feedback but exit the exam room to complete a checklist. • You will begin debriefing.
	27 min	• Staff give the 2 minute warning to finish up debriefing.

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<table>
<tr><td>Use this space to record feedback notes, or any points to support ongoing learning.</td><td>+</td><td>Δ</td></tr>
<tr><td>Include these questions in your discussion.</td><td colspan="2">Debriefing:
• How did that feel for you? What went well? Where did you feel stuck?
• How can we help this patient use opioids if necessary while maintaining recovery?
• What are important steps in coordinating with the PCP?

You may not make it through all elements of the case – this is ok: use this experience to emphasize that the case is difficult, coordinating with the PCP and talking openly and concretely with patients about safe use of opioids in recovery may require more time to meet their particular needs. You may also finish early. If so, please use that time to share your personal experiences or discuss the key points in more detail.</td></tr>
<tr><td>Ask each learner to read a key point aloud.</td><td colspan="2">Key Points:
• A thorough substance use history must start with assessing use as a youth include family history, stressors, how patients obtain drugs (borrowing from friends or stealing), route and pattern of use and impact on their function (home, work and relationships) 15% of high school seniors reported medical use of prescription opioids (MUPO) and 8% reported non-medical use of prescription opioids (NUPO) in 2015. (McCabe S, et al., Trends in Medical and Nonmedical Use of Prescription Opioids Among US Adolescents: 1976-2015, Pediatrics March 2017).
• Patients with substance misuse disorder can be successfully treated for short-term pain using opiates (in combination with non-opioid treatment) while maintaining recovery when benefit outweighs risk (such as major surgery, trauma). This requires careful planning such as open discussion, engaging patient support systems (family, SO) to fill, hold and dispense prescribed opiate medications, close monitoring and ongoing recovery support. It is important to raise this possibility even in planned laparoscopic surgeries as sometimes conversion to an open procedure is required.
• People with a history of substance misuse may have a higher tolerance to pain medications even when they are in recovery, and thus may require higher doses for appropriate analgesia.
• Opiate misuse disorder is a chronic disease. Patients should be counseled to seek support to maintain behavioral change, identify triggers that may promote relapse, and set proactive plans should these arise.
• If initiated during hospitalization, the risks and benefits of prescribing oral opioids in these circumstances should be part of daily discharge planning discussions.
• Providers should recognize their own bias and discomfort in prescribing necessary short-term opiate pain medications to patients in recovery.</td></tr>
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