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Abstracts presented at the 2018 WAGO Annual Meeting

Oral Presentations

Abstract #1

Preoperative opioid use in Gynecologic Oncology: A common comorbidity relevant to the perioperative period

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Objectives: Chronic opioid use is linked to increased requirement for postoperative opioids, opioid hyperalgesia, and greater perioperative morbidity.1-4 Our objective was to describe rate of preoperative opioid use and patterns of postoperative outpatient opioid prescribing in a cohort of gynecologic oncology patients.

Methods: Retrospective chart review of 448 gynecologic oncology surgeries done over one year at a single institution was performed. Preoperative opioid users (n = 97) were identified. Patient and surgical characteristics were abstracted for all patients, as was postoperative opioid prescription (type of opioid, number of tabs, number of oral morphine equivalents [OME]) and length of stay. For preoperative opioid users, type of opioid prescribed postoperatively was compared to type of preoperative opioid. Preoperative opioid users were compared to nonusers, stratified by surgery type. Mann-Whitney U test was used to compare medians of tabs and OME in postoperative prescriptions.

Results: Preoperative opioid prescriptions were found in 21% of cases. Median age was 57. Among preoperative opioid users, 24% had two or more opioid prescriptions prior to surgery. The majority of preoperative opioid users (51%) were maintained on the same agent postoperatively at the time of discharge, but 36% were switched to a different opioid and 7% were prescribed an additional opioid. Overall and in open surgeries, preoperative opioid users received higher volume postoperative prescriptions than nonusers, as measured by OME. The range of OME prescribed was much wider for preoperative opioid users (50-12000) than for nonusers (50-1800). There was no difference in postoperative prescription volume for minimally invasive surgeries or in length of stay between preoperative users and nonusers.

Conclusions: Preoperative opioid use is common in gynecologic oncology patients and should be considered a comorbidity in the perioperative period. Preoperative opioid use was associated with higher volume and wider range of postoperative prescription. Over 40% of opioid users were discharged with either an additional opioid or a new opioid, highlighting a potential missed opportunity to optimize opioid safety. Further research is needed to characterize the relationship between preoperative opioid use and perioperative outcomes and to develop strategies to manage pain effectively in this population without compromising opioid safety.

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Abstract #2

Disparities in the evolution of polypharmacy among women with ovarian cancer

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Objectives: Polypharmacy is defined as the use of 5 or more medications, and is associated with higher overall morbidity & mortality in non-gynecologic cancers. The objectives of this study were to determine the baseline prevalence of polypharmacy in a cohort of ovarian cancer patients, assess the evolution of polypharmacy from initial presentation to two years post-diagnosis, and to evaluate differences in polypharmacy between a comprehensive cancer center (CCC) and a public safety net hospital (SNH).

Methods: Women treated for ovarian cancer between January 1, 2011 and December 31, 2016 were included. Data were abstracted from the electronic medical record and included demographics, medical & treatment histories, and total number of medications taken at initial diagnosis and at 2 years post-diagnosis. Toxicity was determined using 2 criteria for medication safety: the Anticholinergic Burden Scale (ACB) and Beer's criteria. Statistical analyses were performed using chi square, paired t-test, and Cox proportional hazards models, with significance set at $p<0.05$.

Results: 151 patients were included (79 at CCC and 72 at SNH). There were no differences in age, stage, debulking success, number of medical problems, or proportion of non-white patients between CCC and SNH (all $p>0.05$). 47.4% of patients at CCC met criteria for polypharmacy at diagnosis compared with 19.4% at SNH ($p<0.001$). By 2 years post-diagnosis, 77.6% of patients at CCC met criteria for polypharmacy compared with 43.3% at the SNH ($p=0.001$). Patients treated at CCC took significantly more medications than those at SNH both at diagnosis (mean 5.11 vs 2.13, $p<0.001$) and at 2 years post-diagnosis (8.46 vs. 3.86, $p<0.001$). The proportion of women on high-ACB medications (score of ≥3) was similar between centers at diagnosis, but there was an increase across the 2-year continuum of new use of these medications in the CCC group only (7.7% at diagnosis vs. 18.5% at 2-years, $p=0.01$; SNH: 6.7% at diagnosis vs. 10% at 2 years, $p=0.63$). Significant increases in the number of medications meeting Beer's criteria were observed at both sites over 2 years ($p<0.001$). Polypharmacy was associated with worse overall survival (OS) in the CCC cohort (HR 4.93 [1.12-11.68], $p=0.03$).

Conclusions: Polypharmacy worsens as women go through ovarian cancer treatment, regardless of where they seek care. Polypharmacy appears more pronounced in women treated at a CCC; the reasons for this observation warrant further study.

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