Firearms and Alcohol

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In their study, "State Level Firearm Concealed Carry Legislation and Rates of Homicide and Other Violent Crime," Hamill and colleagues[1] attempt to answer the question of whether increased numbers of individuals carrying concealed weapons would result in increased gun violence. The authors state that their statistical technique is sufficiently rigorous to answer this question definitively and, as a result of their findings, that a recommendation to de-emphasize the role of concealed-carry in gun violence should be adopted by the surgical community.

Of course, it is to be expected that the article will not change anyone's mind who already has a position on gun control and that the usual arguments and competing statistics will be issued in response to the article.

Rather than add to the cacophony of opinions on this subject, I would suggest focusing on one aspect of concealed-carry firearms that, perhaps, everyone can agree on. An area of gun use that has great potential for human injury and death is the intersection of firearms and alcohol.[2]

State laws vary widely on the question of whether licensed gun owners can carry or operate guns while drunk. For example, here in New York, which has some of the most restrictive gun laws in the country, it is not specifically against the law to operate a gun while drunk. Recent changes in several state laws have actually increased the potential for drinking and gun access because those states have reversed laws that previously outlawed guns in establishments that serve alcohol.

Common sense would dictate that an inebriated person should not operate a gun or have a gun in their immediate possession. This straightforward change in existing law would have the potential to save many lives and would have no impact on responsible gun owners. As such, a recommendation from the American College of Surgeons to change existing law accordingly should be possible without undue debate.

REFERENCES

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2. Carr BG, Porat G, Wiebe DJ, Branas CC. A review of legislation restricting the intersection of firearms and alcohol in the US. Public Health Rep 2010;125:674–679.

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Integration of Transversus Abdominis Plane Block in the Multimodal Analgesia for Outpatient General Surgical Procedures

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We read with interest the article entitled "Standardization of Outpatient Procedure (STOP) Narcotics: A Prospective Non-Inferiority Study to Reduce Opioid Use in Outpatient General Surgical Procedures" by Hartford and colleagues.[1] We congratulate them. The authors used a STOP narcotics intervention in patients undergoing laparoscopic cholecystectomy and open hernia repair, which involved patient and healthcare provider education and multimodal analgesia with opioid reduction strategies. Although no differences were noted in the postoperative pain scores, the analysis showed a significant reduction in opioid prescription and improvement in pain control quality and patient satisfaction in the post-intervention group.

Multimodal analgesia with systemic nonsteroidal anti-inflammatory drugs and opioids, and local anesthetic infiltration has historically been the gold standard for postoperative pain management in outpatient general surgical procedures. The use of regional anesthesia, notably transversus abdominis plane (TAP) block, is, however, less appreciated. In 2013, we introduced laparoscopic-guided TAP block in our practice for pain management of laparoscopic cholecystectomy, and ventral and inguinal hernia repair. Laparoscopic-guided TAP block, which was first described by Chetwood and colleagues,[2] is a semi-blind technique that involves deposition of local anesthetic into the TAP under direct vision of the laparoscope.

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