## 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.

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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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It is reliable, pragmatic, performed solely by surgeons, and obviates the need for ultrasound skills.

In 2 subsequent randomized controlled trials in patients undergoing laparoscopic cholecystectomy and total extraperitoneal repair of inguinal hernia, we demonstrated that laparoscopic-guided TAP block is superior to our previously used local anesthetic infiltration in terms of immediate postoperative pain scores, patient satisfaction, rescue opioid requirements, and postoperative nausea.[3,4] In analogy to the results of Hartford and colleagues,[1] the improvement in pain control and reduction in opioid requirements were more evident in patients undergoing hernia repair.[4] However, in our case, this could possibly relate to collection of data during the learning phase of the technique in the first trial.[3] We also used a standardized postoperative analgesic regimen of a combination of acetaminophen and nonsteroidal anti-inflammatory drugs, and an educational strategy in which patients were encouraged for early ambulation and to taper down the use of oral opioids to the minimum in hospital and at home. These interventions facilitated hospital discharge within 3 hours post surgery in patients undergoing total extraperitoneal hernia repair, and enabled us to discharge 80% of laparoscopic cholecystectomy patients within 24 hours of admission.[3,4] Similar results were obtained in a recent study by Warren and colleagues,[5] using an ultrasound-guided TAP block in patients undergoing open ventral hernia repair within an enhanced recovery after surgery program.

We believe that integration of the TAP block as an effective component of the STOP multimodal analgesia strategy in the study by Hartford and colleagues[1] and perhaps using the long-acting liposomal bupivacaine, would have yielded a significant difference in the postoperative pain scores, and would have further reduced the opioid requirements in the postoperative period. Therefore, we encourage the authors to do a similar study following incorporation of the TAP block into their practice.

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# Surgical Repair of Occult Inguinal Hernia?


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We read the article, "Radiologic reporting and interpretation of occult inguinal hernia," by Miller and colleagues,[1] with great interest. There are several aspects of the article with which one might take issue.

First, the authors' premise that symptomatic hernias that cannot be palpated on examination are occult inguinal hernias is flawed. It is our belief that hernia and inguinodynia are distinct diseases. That being the case, a symptomatic hernia that cannot be palpated is not a symptomatic hernia, it is inguinodynia. The fact that a synchronous hernia may or may not be present is not necessarily relevant.

Second, the authors' definition of a hernia is overly broad. Their statement, "discovery of preperitoneal fat extending through the fascial defect would be considered a hernia; however, an isolated cord lipoma within the scrotum only and without visible extension from the preperitoneal fat would not be considered a hernia," is difficult to understand. By definition, a cord lipoma is an extrusion of preperitoneal fat that protrudes through the external ring lateral to the cord structures. If the fat is isolated to the scrotum only, it is not a cord lipoma. Per the authors' definition, all cord lipomas are hernias. In point of fact, although some cord lipomas may cause hernia-like symptoms, cord lipoma and inguinal hernia are separate and distinct entities.

Third, the authors' central point seems to be that they have trained a radiologist to interpret cross-sectional imaging in a nonstandard manner, and the radiologist now does so in a reproducible manner. They then explore the patient's groin, identify a hernia, and conclude that