Opioid prescribing patterns among postpartum women

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TO THE EDITORS: We read with great interest the article by Badreldin et al,[1] which found that opioids were commonly prescribed among postpartum women regardless of the amount of pain reported prior to discharge. We would like to present some of our perspectives.

First, the authors compared postpartum women at discharge who reported pain score of 0 of 10 with those who reported pain score of >0 of 10. It is worth noting that unidimensional scales, such as visual analog scale scores or numerical rating scale, could result in bias and may not represent a significant measure of objective pain intensity. Previous studies have indicated that reductions in pain scores of around 30-40% are needed in order to reflect clinically useful improvements in pain.[2] In other words, women with a pain score of 3 may be in the same pain intensity category as those with a pain score of 0. For this reason, we consider that using a pain score of 3 might be a better cutoff for comparison at the time of discharge.

Additionally, the authors concluded that the oral morphine milligram equivalents (MME) prescribed at discharge (discharge-MME) was similar among patients following both vaginal and cesarean deliveries without regard to inpatient MME and pain score experienced before discharge. Nevertheless, women with vaginal delivery who experienced less pain received larger discharge-MME. This was a remarkable finding. We look forward to hypothesis and/or in-depth analysis of this issue by the authors. Previous studies found that there were significant differences in opioid discharge-MME according to the provider type.[3] We wonder if the authors could show the subanalysis based on demographics, clinical characteristics of patients, and types of health care providers.

Finally, the authors stated that a lack of standardization among providers was responsible for the wide range of opioids prescribed to postpartum discharged women. However, there have been successful, innovative lawsuits against physicians for the under-prescription of opioid pain medications.[4] The potential of being sued for refraining from prescribing opioids rather than for doling them out prematurely may be a bigger concern for providers.

We would welcome comments by the authors, as this would further support the findings of this important research. ■

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REPLY

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We appreciate the interest of Dr Zhang and colleagues in our work.[1]

We agree that pain remains very challenging to objectively and consistently measure, with no one method that is clearly correct, although believe that our approach was a reasonable one. We dichotomized reported pain score as a means of capturing a clinically meaningful difference (no pain vs any pain). We also evaluated these data in a continuous fashion using Spearman correlation. Among women who had a vaginal delivery, the correlation between the total amount of morphine milligram equivalents (MME) prescribed at discharge and pain score was Rho −0.007 ($P = .768$). Among women who had a cesarean delivery, the correlation between the total amount of MME prescribed at discharge and pain score was Rho 0.001 ($P = .959$). These data further emphasize that there appears to be no meaningful relationship between pain score and the amount of opioid prescribed at discharge.

Dr Zhang and colleagues highlight the finding that, among women who received an opioid prescription at discharge, women who underwent a vaginal delivery and who received no inpatient opioids during the last 24 hours of

hospitalization actually received a discharge prescription of significantly greater amount (median 240 [interquartile range 120-300] MME) than those who did use inpatient opioids during the last 24 hours of hospitalization (median 150 [interquartile range 100-300] MME, $P = .001$). We agree that this finding is remarkable, and provides further evidence that current prescribing practices are not tied to patient-specific measures of pain. Additional work by our team suggests that both provider and patient factors are related to the amount of opioids prescribed at discharge.[2]

The current opioid epidemic and widespread attention to overprescribing may very well result in under-treatment of pain, which can have negative consequences for providers (lawsuits) and, more importantly, patients (suffering). This fact highlights the importance of the findings in our article—namely, that prescriptions seemed unmoored from the actual amount of pain a woman was experiencing—and the need for further research to guide appropriate prescribing practices and greater reliance on objective criteria. ■

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Cervical cerclage for women with shortening cervix while on progesterone

Check for updates

TO THE EDITORS: We read with great interest the recent study by Enakpene et al[1] in which 75 women with a shortening cervix while on progesterone therapy were given the option of either continuing with progesterone or having a cervical cerclage in addition. Cervical cerclage was associated with a significantly higher gestational age at term and significant reduction in the risk of preterm and severe preterm birth.

For the last 2 years, we have been applying a similar strategy. We offer cervical length (CL) measurement at the time of routine second-trimester ultrasound scan, and women with CL of 10–25 mm are observed with weekly scans for 4 weeks. If shortening of the cervix to <10 mm is detected during this period, the option of cervical cerclage is given.

We prospectively studied 38 women (1.8% of the screened population) who had initial mid-trimester CL measurement of 10–25 mm and were given prophylactic vaginal progesterone (200 mg/d). In 5 of them (13%), the cervix shortened to <10 mm during follow-up evaluation, and a McDonald cerclage was placed. Among the women whose CL remained at ≥10 mm, 6 women (18%; 95% confidence interval, 9–34) delivered at <37 weeks gestation, and 1 woman (3%; 95% confidence interval, 0.5–15) delivered at <35 weeks gestation. All 5 women on cerclage delivered at >37 weeks gestation.

Vaginal progesterone is effective in the reduction of the risk for preterm birth in women with cervical length of <25 mm,[2] but its effectiveness appears to be decreasing rapidly for lengths <10 mm.[3] It is not certain what the optimal follow-up should be after the initiation of prophylactic progesterone, neither what the best option is when progesterone appears not to work. Based on these small numbers, it is likely that women whose cervical length remains ≥10 mm during the first month on progesterone therapy may be at low risk for preterm birth, especially at <35 weeks gestation, and they may represent the group of women in whom progesterone works. On the other hand, women in whom the cervix becomes extremely short while on progesterone therapy may be at high risk for adverse outcome,[1] and it seems that placement of cervical cerclage in this subgroup of women may significantly improve their prognosis, if done while they are still asymptomatic. A corollary of these observations is that regular follow-up evaluation of CL in the immediate period after the onset of prophylactic progesterone may be of value, because it may allow for timely additional intervention in cases of a shortening cervix. ■

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