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BOOTS and UTES: Bringing Opiates Off the Streets and Undertaking Excess Scripts

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Introduction: Opioid diversion and misuse present significant problems in modern medicine, claiming over 250,000 lives since 1999, with prescription opioids as a major culprit for opiate misuse. Currently, there are no well-described, data-driven processes to educate surgeons on reducing opiate prescribing. We aimed to design and implement a novel opiate reclamation and prescription reduction program for surgeons to reclaim unused medication and decrease prescribing using individual provider data.

Methods: We performed a prospective collection of all unused opiate pain medication for general surgery postoperative patients from July 15, 2020 to January 15, 2021. Patients brought unused opiates to their follow-up appointments where they were counted and disposed of in a secure drug take-back bin. The reclaimed medication was then totaled, analyzed and reported to the providers, who then determined whether to change prescribing habits.

Results: During the reclamation period, 168 surgical cases were performed, with a total of 12,970 morphine milligram equivalents (MME) opiate prescribed by 5 physicians. Among these cases, a total of 6,077.5 MME (46.9%) were reclaimed, equivalent to 800 5-mg tabs of oxycodone. Based upon these data, surgeons subsequently decreased opiate prescribing by 30.9% during the next 6 months, and by repeating the protocol, reclaimed an additional 3,150 MME during the second analysis period on top of their already reduced prescribing.

Conclusion: Continuous monitoring of the medication returned by patients can now be used to inform providers' prescribing practices, decrease the amount of opiates in the community, safely reclaim unused opiates, and improve patient safety.

Can Video-Based Telehealth Examinations of the Abdomen Safely Determine the Need for Abdominal Imaging?

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Introduction: There is little evidence on the reliability of the video-based physical examinations. Our objective was to evaluate the safety of a physician-directed abdominal exam using video.

Methods: This was a prospective, blinded observational study of patients >19 years presenting with abdominal pain to an academic emergency department (ED). In addition to usual care, patients had a video-based telehealth examination by an emergency physician. Both telehealth and in-person clinicians were asked about the need for abdom-

inal imaging in the patient (yes, no). Thirty-day chart review searched for subsequent hospitalizations or procedures. We used descriptive and bivariate statistics to compare the clinicians' decisions on imaging.

Results: Fifty-six patients were enrolled, with a mean age of 45 years (SD=17.9), 55.4% were female. The telehealth and in-person clinicians agreed on the need for imaging in 77% of the patients (95% CI: 64%-87%). Of the 13 patients for whom there was disagreement on need for imaging, the telehealth physician recommended imaging for 7 (54%). For the study patients who underwent a procedure within 24 hours of the ED arrival (n = 3, 5%) or on 30-day follow-up (n = 7, 13%), neither the telehealth physicians nor in-person clinicians missed timely imaging.

Conclusion: The telehealth and in-person physicians agreed on need for imaging for most of the patients. Importantly, the telehealth physicians did not miss imaging for patients who needed urgent or emergent surgery. Further study is warranted to determine how to safely deploy video-based telehealth for patients with abdominal pain.

Cholecystectomy Is Riskier in Male Patients

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Introduction: While cholecystitis has a female preponderance, some observe a trend towards more challenging disease in male patients. The confluence of sex and patient acuity has not been thoroughly investigated. We hypothesize that men present with worse disease compared with women, as evidenced by higher rates of open surgery and higher resource consumption.

Methods: An inpatient registry from a 5-hospital system was queried for cholecystectomy procedures not associated with neoplasm or malignancy. Cases from 2015 to 2021 were included. Demographics, clinical and outcome variables were analyzed. Univariate analysis and multivariate logistic regression were performed. The data were de-identified before analysis and deemed exempt from IRB review, and were analyzed using R within R-Studio.

Results: There were 2789 cholecystectomy patients, 1616 (58%) were women and 1173 (42%) were men. Demographics and baseline health characteristics differed across sex. Univariate analysis highlighted that males experienced more harms (1.35 vs 1.14; p = 0.002), more open approaches (18% vs 11%; p < 0.001), longer inpatient lengths of stays (median: 4 vs 3 days; p < 0.001), higher hospital cost (\$15,694 vs \$13,173; p < 0.001), increased laboratory orders (37.65 vs 30.01; p < 0.001), higher MS-DRG weight (2.104 vs 1.842; p < 0.001) and greater mortality risk (56% vs 36%; p < 0.001). Further, multivariate analysis found male cholecystectomy patients were correlated with higher instances of open surgical approach (OR: 1.80; p < 0.001), hospital readmission (OR: 1.50; p = 0.008), and higher cost (β : \$981; R^2 : 0.27; p = 0.006).

Conclusion: Inpatient male cholecystectomy patients present with worse disease and require more hospital resources.