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CORR INSIGHTS

CORR Insights®: Does Preoperative Psychologic Distress Influence Pain, Function, and Quality of Life After TKA?

Dana C. Mears MD, PhD

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Where Are We Now?

Although total joint arthroplasty of the knee and hip are recognized as highly successful procedures to relieve pain and improve function, a sizable group of patients fail to achieve an improvement after their surgery. An unfavorable result may arise following intra or postoperative complications, and may be more likely in patients with preoperative medical comorbidities or particular psychological risk factors. Regardless of the causes, we know that complications will happen, and as more procedures are performed — surgical volumes appear to be increasing [1] — there will be a greater number of both unhappy and pleased patients. A crucial feature of TKA is the arduous and painful postoperative therapy, which is critical to a patient achieving pain relief and restoration of function. Physical therapy may be more than some patients can tolerate, particularly patients with certain psychological comorbidities, such as uncontrolled depression and anxiety. Preoperatively identifying patients with psychological issues that place them at risk for chronic pain or clinical dissatisfaction after TKA remains a formidable challenge for the arthroplasty surgeon. This characterization would permit a referral of the patient to an appropriate counseling service, and a deferral of the surgery until the problem has been suitably addressed.

Where Do We Need To Go?

This article documented the favorable impact of a TKA upon preoperative psychological distress whereby a successful TKA was accompanied by an improvement in mental health. For the practicing arthroplasty surgeon, the opportunity to improve the health (and odds of surgical success) of a patient who possesses a psychological disorder is welcome news, since we know that these patients are at risk. Psychiatric conditions, (schizophrenia, depression, anxiety), medical conditions with psychiatric or cognitive symptoms, (multiple sclerosis, a prior cerebrovascular accident, or dementia), opioid dependence, and recreational drug use all are common enough in our practices, and decision-making with patients who have these conditions always is complex. Nevertheless, the results of the current study point to a major challenge for the orthopaedic surgeon who must distinguish the patient with preoperative psychological distress for whom TKA might be an effective psychological therapeutic measure, from a patient with a chronic psychiatric disorder (along with an

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D. C. Mears (✉)
Greater Pittsburgh Orthopedic Associates, 5820 Centre Avenue, Pittsburgh, PA 15206, USA
e-mail: mearshouse@prodigy.net

opioid dependency) that might compromise the results of surgery. The article provides an introductory basis for future, more elaborate investigations that would address these crucial considerations.

How Do We Get There?

Arthroplasty surgeons must be able to distinguish between patients with psychiatric comorbidities likely to result in persistent pain and clinical dissatisfaction from those that are actually likely to improve as the result of the pain relief surgery can provide in order to guide patients in the former group to appropriate nonsurgical interventions, while providing timely surgical intervention to the latter group.

For practicing orthopaedic surgeons in high volume practices, the use of currently available quantitative scales like the Hospital Anxiety and Depression Scale is impractical; they are unfamiliar to most, and they are time-consuming to use. The current investigation provides insight as to how such evaluations might be conducted effectively, but we still need more efficient tools, as well as guidelines about when and how to employ them.

References

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