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## Pain Treatment and Opioids

*To the Editor:*

I am really pleased to see Dr. Jane Ballantyne's editorial "Repairing a Fractured Dream."<sup>1</sup> I have a very personal perspective on the issue of pain and its treatment because my son was addicted to OxyContin (Purdue Pharma, Stamford, CT) and died of an overdose of oxycodone and cocaine in 2006.

After my son's death, I realized how OxyContin especially, but also other potent prescription drugs, had become drugs of choice for many young people. They saw them as safe because doctors prescribed them. Most young people obtain the drugs from friends, who in turn get them from medicine cabinets, relatives, or doctors who, for example, would dispense large amounts for back pain. I have come to many of the same conclusions as has Dr. Ballantyne, simply by reading, talking to, and corresponding with other grieving parents and family members and learning of the vast amounts of opioids prescribed for many different conditions. Frequently I hear from friends and others about the supply of narcotic analgesics given to them after surgery. The amounts prescribed would last for weeks but are often not needed after 3–4 days.

The devastation caused by opioids affects not only susceptible people who may have a family history of addiction, but so many others who become dependent on, or addicted to, a drug prescribed to treat pain. We should be more careful. There is a presumption that opioids used to treat pain do not cause addiction, but that is simply not true.

It is encouraging that Dr. Ballantyne acknowledges the concerns with opioid treatment in general and chronic non-cancer pain in particular. My hope is that physicians and others who prescribe opioids will think carefully about the need for these medications and the amount to be prescribed.

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## Intraoperative Transesophageal Echocardiography Guides Liver Transplant Surgery in a Patient with Thrombosed Transjugular Intrahepatic Portosystemic Shunt

*To the Editor:*

Transjugular intrahepatic portosystemic shunt (TIPS) is common in patients presenting for orthotopic liver transplantation (OLT). More than 5,200 TIPS procedures were performed in the United States in 2008.\* In our institution, 18% of adult OLT recipients during the past 2 yr presented with TIPS. Whereas TIPS mitigates symptoms of portal hypertension, associated complications, such as thrombosis and migration, pose technical challenges during OLT.<sup>1–4</sup> We present a case of OLT in a patient with known thrombosed TIPS. Intraoperative transesophageal echocardiography (TEE) revealed cephalad migration of the TIPS into the inferior vena cava (IVC) and an attached thrombus extending toward the cavoatrial junction. These findings necessitated a modification of surgical technique to safely remove the TIPS and prevent thromboembolism. We demonstrate that TEE may provide important clinical information for intraoperative management of OLT recipients with TIPS.

A 47-yr-old Caucasian man with alcoholic cirrhosis complicated by hepatorenal syndrome presented for OLT. Eight weeks earlier, he underwent uneventful placement of a 10- × 80-mm Viatorr® (Gore, Flagstaff, AZ) coated stent for refractory ascites. Four weeks later he presented with massive ascites and acute renal failure (creatinine 2.9 mg/dl) requiring urgent hemodialysis for hyperkalemia (K 7.0 mM). Abdominal Doppler revealed occluded TIPS within right hepatic vein. Magnetic resonance imaging showed only that TIPS was in place. The patient remained hospitalized requiring hemodialysis.

On the day of OLT, the patient's Model for End-Stage Liver Disease score was 25. Intraoperative TEE (Acuson Sequoia, Oceanside, CA) confirmed absent flow within the TIPS but showed the superior end of the TIPS protruding into the IVC (fig. 1A, B) and a 2-cm thrombus extending

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