effect, there is a glaring and immediate need for alternative postoperative pain management in less involved operations.[2] As mentioned by Daniels et al. in their work, multiple studies have described non-opioid regimens in various procedures offering similar pain management to opioid regimens.[3,4]

Daniels et al.[1] did a great job collecting patient demographic characteristics such as age, body mass index, sex, race, preoperative depressive symptoms, and preoperative opioid use. It is mentioned in the limitations that the study was not sufficiently powered to show an association of patient satisfaction with demographic characteristics, and thus, nonsignificant findings do not eliminate a possible correlation.[1] We believe including more detailed demographic characteristics would have allowed further clarification regarding patient satisfaction. Additional demographic characteristics would also better clarify the results and aid readers in understanding the satisfaction of certain patient populations with postoperative non-opioid treatment. Because this was a single-center study and although limited generalizability was referred to as a limitation, it is crucial to have detailed information regarding not only the general location of the study (i.e., suburban, urban, or rural) but also the patient population that is being studied. Specifically, using patient socioeconomic factors in patient demographic characteristics would allow for a more complete understanding of patient satisfaction and a possible correlation.

In the current literature, patient education level has been shown to be correlated with opioid prescription use. Moreover, patients with a lower education level were shown to receive significantly more opioid prescriptions than their more highly educated peers.[5] Somewhat contrarily, patients in the higher income quartile were significantly more likely to be prescribed opioids than patients with a lower income.[6] These results were noted to be independent of sex and race.[5] With disagreement between studies linking social demographic characteristics to opioid prescriptions, inclusion of education, income, and other social determinants of health in patient demographic characteristics would help better clarify the demographic characteristics correlated with higher non-opioid satisfaction rates and allow readers to understand which patient population was being studied.

Nonetheless, we commend Daniels et al.[1] on their exceptional work in evaluating postoperative non-opioid patient satisfaction. Ultimately, though, we believe inclusion of additional demographic characteristics, such as patient education and socioeconomic status, would provide greater clarity and potentially provide correlation between patient demographic characteristics and patient satisfaction with postoperative non-opioid prescriptions. We invite any clarification that would help further support the authors' findings and propose additional dialogue for future projects.

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Author Response to "Regarding 'Patient Satisfaction With Nonopioid Pain Management Following Arthroscopic Partial Meniscectomy and/or Chondroplasty'"

We would like to thank the authors, Mehta and Gupta, for taking interest in our recently published article, "Patient Satisfaction With Nonopioid Pain Management Following Arthroscopic Partial Meniscectomy and/or Chondroplasty". Mehta and Gupta make an important

point by stating "patient socioeconomic factors in demographics would allow for a more complete understanding of patient satisfaction and a possible correlation." We agree, factors falling into this category such as education and income level are important variables that can be considered, and have been studied in regard to patient risk stratification for outcomes such as opioid use risk, coping, pain catastrophizing etc.

With regards to the inquiries posed by Mehta and Gupta, we are happy to be more specific about our practice as a busy urban academic hospital in the Northeast region of the United States. As with any study, including all possible demographic variables related to the outcome of interest is an important consideration in study design, but is not always achieved. Because we did not prescribe opioids to postoperative patients in this study, there was no socioeconomic bias to correlate with education level and prescription use and/or amount of opioid prescribed and income status. Regardless, we will certainly look for a correlation in future studies concerning satisfaction with non-opioid pain management. We also acknowledge the importance of these aforementioned variables and the role they could play in outcomes and study limitations, specifically when comparing a large academic center to a rural community hospital.

As concluded by our study, we believe that an orthopedic practice with patient demographics similar to those variables which we did include (age, BMI, duration of symptoms, sex, race, mental health status, current opioid usage) would have successful pain management with a nonopioid pain control strategy in patients that have undergone partial meniscectomy and/or chondroplasty. We look forward to additional studies that elect to explore other socioeconomic factors, as this would certainly add value to current evidence of pain management strategies, with the hopes of decreasing the utilization of unnecessary opioid analgesia.

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