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Perioperative Pain Management

Scientists like to measure stuff. If you can measure it, its under your control.
Thus it is useful to MEASURE PAIN from morbid interest but also TO EVALUATE MANAGEMENT .

Various Tools:

- **Categorical Scale (mild, moderate, severe etc.)**
- **Numerical Scale (1 to 10)**
- **Visual Analogue Scale (put a tick along this line)**

Useful Rules of Thumb:

- **Use lots of different analgesics rather than higher doses of one analgesic.**
- **Treat pain aggressively and early, to prevent chronic pain.**
- **Wherever possible, use Patient-Controlled Analgesia (PCA)**
- **Epidural Analgesia reduces pulmonary morbidity post-op (eg. less atelectasis, less pulmonary infections due to better sputum clearance (if your massive abdominal wound doesnt hurt, you'll cough every time you feel like it), and has no major adverse consequences (**except epidural abscess, ~ 1 in 1000 and sometimes epidural haematoma in over-heparinised patients**)**
- **Epidural is is as safe as any method of traditional pain relief (arguable, depends on the anaesthetist)**

("a lumbar puncture is two frightened people connected by a needle")

...erm... so does my patient have an epidural abscess? The signs are
Back Pain, Fever, Leukocytosis; Staph Aureus = commonest organism

- ***To avoid this:***
  - ***DONT LEAVE CATHETER IN FOR LONGER THAN 3 DAYS***

NSAIDs guidelines:

- **For minor or moderate sugery.**
- **To DECREASE OPIOID REQUIREMENTS (opioid + NSAID synergy is good)**
- **These are the analgesics of choice for day-surgery procedures.**
- **AVOID IN SURGERY WITH HIGH RISK OF BLEEDING**
- **AVOID IN HYPERTENSION, HYPOVOLEMIA, PRE-ECLAMPSIA**
- **AVOID IN RENAL IMPAIRMENT**
- **COX2 selective drugs are not any better than the normal NSAIDs**

OPIOID guidelines: easy, just leave it to the patient (PCA)

- **Solves the problem of wildly variant individual requirements**

Ketamine: unique NMDA antagonist (and many other receptors)

- **Give together with morphine to reduce dose requirements (will need only half as much morphine, plus less nausea, less sedation, less pruritis, less urinary retention)**

TRAMADOL: weak mu-opioid and serotonergic action

- **Check with the consultant. There are pro-tramadol people, and there are anti-tramadol people. Overall it seems little better than aspirin, but it has less toxicity (apart from the much feared and untreatable "serotonin syndrome") and very low addiction potential. It was developed by the Nazis in response to the opiate boycott of Germany during the second World War, for use as an alternative to morphine.**