Royal Hospital for Women (RHW)
GUIDELINE
COVER SHEET

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SUMMARY	These guidelines are for post operative pain management of gynae oncology patients - not to be used as a protocol, but for reference only.

Royal Hospital for Women (RHW) GUIDELINE

Health
South Eastern Sydney
Local Health District

Pain Management Guidelines- Gynae Oncology (2023) RHW GUID003

PRE-OPERATIVE

Risk assessment and education. High risk patients should have early referral to the Acute Pain Service (APS). Consider adding anaesthesia alert for patients with history of pain related adverse events (e.g. failed neuraxial, opioid replacement program).

INTRA-OPERATIVE and RECOVERY *

Anaesthesia	+/- Neuraxial/Regional	+ IV Analgesia	+ Antiemetics
TIVA and/or Volatile GA	Neuraxial Local Anaesthesia – SSS or epidural** +/- SS neuraxial morphine (intrathecal or epidural) +/- TAP block noting LA toxicity limits	+/- as appropriate: IV Ketamine, NSAID, Tramadol, MgSo4, Clonidine, Lignocaine#	Dual therapy Dexamethasone Avoid ondansetron

* unless contraindicated and according to procedural anaesthetist judgment/ # As per Business Rule/ **SSS single shot spinal

POST OPERATIVE PAIN MANAGEMENT PLAN

- Prescribe appropriate post-operative pain protocol (1,2,3 or 4 - As below)
- Complete single dose Neuraxial Morphine chart (may chart on Epidural Infusion /PIEB/PCEA chart).
- Add progress note to Powerchart summarising pain management plan. E.g. Expected number of days for PCA or Epidural
- **Add patient to Acute Pain Service PAIN LIST on EMR to ensure patient is reviewed by APS**
- Confirm need for Close Observation Ward Bed (Only patients with epidurals require this)
- Pain Protocol (Recovery): Nurses to set up PCA, Ketamine or Epidural regimen as ordered.

POST OPERATIVE (Day 0)

PCA + single shot neuraxial Morphine	EPIDURAL PIEB/PCEA	PCA + EPIDURAL PIEB #	PCA + /- Ketamine	Oral regimen
PCA Morphine, Fentanyl, Oxycodone, HYDROmorphone * ***NB: DO NOT prescribe sustained release opioids within 24 hours of Neuraxial Morphine***	PIEB bolus dose: 5-8mls/hr q 60mins depending on level of insertion and solution PCEA bolus dose 3-5ml q15 min Max hourly volume 28mls See epidural options# Requires input from consultant anaesthetist	As per Epidural PIEB. Omit PCEA bolus PCA Morphine, Fentanyl, Oxycodone, HYDROmorphone *	PCA Morphine, Fentanyl, Oxycodone, HYDROmorphone* Ketamine infusion	IR Opioids or Tapentadol Reserve MR/SR agents for high-risk pain patients. Avoid in opioid naïve patients

*See Hydromorphone prescribing policy
Programmed Intermittent Epidural Bolus – Patient Controlled Epidural Analgesia (PIEB-PCEA)
May be appropriate if pain not anticipated to be fully covered by epidural. F**actor hourly epidural fentanyl into PCA bolus**.
Epidural solution options: 0.1% Ropivacaine / 2mcg/ml Fentanyl **OR** Fentanyl, Adrenaline Bupivacaine 0.1% (FAB)

MULTIMODAL ADJUNCT ANALGESIA (REGULAR)

Paracetamol +/- NSAID. E.g. Celecoxib 100mg-200mg BD (Assuming no contraindications. Add stop date 3-5 days)

Neuropathic agents: Pregabalin Consider only for patients with chronic pain < 65yo give 50mg BD (1400 & 2200)
Gabapentin: Only for patients who are usually on this agent

CLINICAL REVIEWS FOR PAIN (ANAESTHESIA)

- Epidurals – check reported pain, sensory level (ice), motor block, site inspection (dislodgment, redness), temperature. If evidence of insufficient sensory block (too low) consider adjusting bolus dose. Use caution if patient is at risk of hypotension. Use PCA as adjuvant if epidural incompletely effective (opioid in epidural solution must be omitted). If sensory level is too high +/- inappropriate motor block, aspirate catheter to exclude malposition, reduce dose or remove catheter, as appropriate. Seek senior advice.
- Ketamine - if suffering dysphoria. A dose reduction may be indicated. May be administered by S/C if IV access is difficult.

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POST OPERATIVE (Day 1)

- Review by APS. Aim to cease PCA Day 1 and commence oral pain medications when oral intake established.
- Aim for multimodal oral regimen: Paracetamol, NSAIDS, Tramadol (IR) and opioids, as appropriate. Opioids should be on demand (PRN) immediate release (IR) for opioid naïve patients Oxycodone IR (Endone) (5-10mg) or Tapentadol IR (50mg -100mg q4- q6/24). Reduce doses in elderly/frail patients.
- Slow-release opioids are reserved for patients who have failed IR regimen: Oxycodone SR (Oxycontin) (10mg BD) or Targin (10/5mg BD) or Tapentadol SR (50mg -100mg BD)
- Duration of epidural to be determined on a case-by-case basis, minimum 2/maximum 5 days assuming effective.

DISCHARGE

- Paracetamol + NSAID (if nil contraindications) +/- oxycodone or tramadol IR PRN. Avoid SR/MR opioids. NSAIDS require stop dates. Supply patient consumer leaflet “Pain Management after Surgery” PLUS education.

NOTES

- Use relevant pain chart for prescribing and recording pain observations. No TAP block infusions or Pain busters to be used. For further information refer to individual protocols (Ketamine, PCA, SC Morphine and Epidural)

Revision	Approval history
1	Approved by District DTC on 02/11/23 Last reviewed 18/10/ 2023 by Acute Pain Services
1	Endorsed RHW Safety and Quality Committee 21/12/23