The Dynamics of Managing Acute Postoperative Pain in the Current Opioid Sparing Environment

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Summary Statements Regarding Postoperative Pain Rx with a
Focus on the Impact of Scheduled Analgesics Versus No Scheduled Analgesics Related to The Management of In-hospital Acute Postoperative Pain Management

Disclosure

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Nothing material to disclose on this subject

PAINWEEK

Learning Objectives

- Explain how to create a patient-specific structured time contingent post operative hospital pain management plan.

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- Timely pre-surgical discussion and structured decremental changes (opioid naïve v. tolerant). Create a patient-specific, patient focused, patient centered, personalized time contingent Rx plan.
- Pathways: transmission, transduction/conduction, perception, modulation
- Scheduled analgesia v. anesthesia
- Focus: diminish pain and suffering in quality and quantity through scheduled analgesic Rx plan. Diminish fear/anxiety of pain and improve postop functionality, ADLs, PT/OT performance; personal past experience and preferences; diminish pharmacotherapy iatrogenic effects, etc. (constipation, GU, CNS, neuro, pulmonary, cardiac events); Address: nociceptive, neuropathic pain, reduce, LOS facilitated by initiating a structured time contingent scheduled dosage regimen.
- Addressing these focused events. “Predict and control.”

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- Initially: PMHx, PSHx, P_{Ψ}Hx, social Hx, Rx Hx (Rx, OTC, phytopharmacueticals), “Allergies v. S/E’s,” PPMP, (multisource medications), OLD Rxs, friends, spouses, internet, external to USA travel, laboratory, EKG evaluation, (QTc)
- Multimodal pharmacotherapy, scheduled structure, overlapping intervals, PRN’s for BTP to decrease higher doses of scheduled opioids, comorbid painful syndrome/DX (often patient amalgamated), neuroaxial opioids, ESI, IT routes.

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- Pharmacotherapy: (time contingent structured Rx plan with an exit strategy for BTP)

APAP (IV, PO)

NSAIDS (ketorolac IV, PO NSAIDS), w/ or w/o anesthetics

AD – SNRI

SMR – Tizanidine, Orphenadrine, baclofen

AED – Gabapentinoids, (avoid for foot/ankles surgery) topiramate

NMDA: ketamine (IV), MG^{++}, N_20, DM.

Opioids: PO, Buccal, IV schedule doses, with limited short acting for BTP.

Anesthetics: Na+ channel blockers IV (short or long acting), topical, micro needles patch.

Tx plan exit strategy: 5 to 7 days up to 10 days (extensive procedures, simulate home routine (ECF/NH)

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- Time contingent plan (arise, asleep), nocturnia, periods of antecedent pain.
- Insurance/PBM coordination.
- Time schedule for decremental change to lowest effective dose to participate in home, patient without precipitating abstinence or withdrawal behavior
- Stop all former historical opioid pain medications once at home or before Tx initiation
- Maintain bilateral open dialogue with patient/family/care givers following hospital discharge

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Case 1

- 1) A 49 y/o male 73" H, 270#, BM±=33 presents for TKR due to sports trauma injury
- Vocation: MBA, JD, CPA CEO of 180 person firm.
- Avocation: Runner, basketball, biking, gym, golf weekends
- Pain 4-10/10 a function of movement, comfortable with 4/10, achy, dull, neuropathic, nociceptive
- PMHx: Migraine, hyperchol, GERD, OSA (CPAP – none compliant)
- PSHx: Abd. hernia (repair - wt. lifting), clavicle repair from sports injury, ankle FX (repair, running)
- Allergies: NKDA, FA, EA, No RX side effects reported

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Case 1 (Cont)

- SOC Hx: Married, 2 children, ETOH (states 1.5 oz whisky/ day 7d/wk) (must stop), nicotine Hx (cigars 1/day 7/week) (must stop), cannabis (weekend 1/d), SRDU – denies
- PΨHx – denies; DIMS (sleep 11pm 3A/d).
- Note: Spouse and pt describe on cellphone and laptop "all the time", confirmed by house staff & nursing, OT/PT
- OTC: Ibuprofen (2x200mg Ø 6 hr PRN, not daily), DPH- to stop use.
- Herbals: Melatonin
- PPMP: Hydrocodone and Oxycodone alternates monthly with 2 different prescribers with different practices
- Labs: WNL, Cr.8, LFT's: WNL
- Test: QTc 412, EKG = NSR
- INPT TX plan: PT/OT Pharmacotherapy to transfer to ECF for PT/OT in 2 days.

PAINWEEK

Case 1 (Cont)

- Pt “needs”: Expressed: “I do not want to ask for medications or “buzz” the nurses for it, discussed structured time component to plan and rational.
- Plan: 1) schedule Rx plan in full
  2) schedule the Tx plan with plans for BTP
  3) use PRN to evaluate needs for outpatient ECF/N.H. PT
  4) use PRNs and request pt. to flu with same PCP for opioids if needed for functionality.
  5) CPM of presurgery and add gabapentinoids and SMRs, opioids 5-7 days

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Case 2

- A 61 y/o female, 64” 192# BM±=33
- S/P (R) Hip Fx due to fall at home while doing housework
- Pain 8-9/10 dull, achy, throbbing, stabbing, 10/10 with movement
- PMHx: osteoporosis hypercholesterolemia, DM (type 2, diet) FMS, IBS
- PSHx: breast Bx(-), TAH, Appy
- Allergies/ S/E’s 6-keto opioids = CNS, neuro, CV hypertension, GU, GI events
- PΨHX: denies; aside DIMS, tearful about this fall, feels hopeless, helpless
- SOCHx: Solitary living, EtoH (6 oz. wine/noc) nicotine: Ø, cannabis: Ø, SROu: Ø, has one cat
- PPMP: reviewed

PAINWEEK

Case 2 (Cont)

- Routine: arise 6am, asleep 10pm, nocturie once
- RxHx: STATing (use every other day), oral hypoglycemic (less than compliant)
- OTC: D3, APAP, NSAIDS (not sure of doses of drugs)
- Herbals: garlic, ginger, ginseng (to stop), turmeric, melatonin
- Labs: CMP-WNL
- Tests: EKG=NSR, QTc=410
- Note: Resistance to medication “use reflects weakness” Has teenage grandchildren who visit

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Case 2 (Cont)

- Plan: 1) Stop all home use OTC/Rx for pain
  2) Stop herbals-rationale given
  3) Opioids LA Q 8 to 12 hrs (abuse deterrent)
  4) APAP 500mg Q 8 hr PRN pain
  5) Small dose short acting opioids Q 8hr PRN for BTP
  6) In pt small dose IV opioids for pain which is unresponsive to above Tx
  7) SNRI for pain, FMS, tearfulness (have social worker see pt)
  8) Low dose gabapentinoids
  10) scheduled NSAID IV of 6 hours

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Case 2 (Cont)

- Choices: 1) PRN doses only
  2) Timed doses of Rx plan, stop herbal/OTC at home
  3) Scheduled Tx plan with PRN for BTP
  4) Refer back to PCP within 5 days of outpatient post OP pain meds

PAINWEEK

References

- There are no formal references utilized in this presentation as it was developed based on personal/professional experience.

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