**Mapping Current Pain Services for Patients Undergoing a Hysterectomy**

**Background**

Whilst there is an abundance of literature regarding pain management for patients undergoing hysterectomy, there are currently no guidelines. We sought to ascertain current pain management in this cohort of patients at our trust.

**Aims and Objectives**

The aim of this Quality Improvement project was to map current practices regarding pain management for patients undergoing a Hysterectomy and to identify areas that could be improved.

**Method**

A retrospective data collection was conducted from the local databases including acute pain services between April 2015 to March 2016 of all patients admitted for a hysterectomy.

The number of cases, indications for surgery, surgical technique, length of stay, peri-operative analgesia and pain outcomes were recorded.

Process mapping was conducted and the current patient pathway was analysed.

**Results**

There were total of 67 hysterectomies performed (23 laparoscopic, 44 open) with an average patient age of 52 years.

Post-operative analgesia management demonstrated that 73% of open cases had a patient controlled analgesia device (PCA).

The majority of laparoscopic cases (87%) only had oral analgesia.

Other pain management strategies considered intraoperatively were transversalis plane (TAP) block, ilio-inguinal block and combined spinal and epidural (CSE) in 8 patients, all of whom had a PCA post operatively.

The pain team reviewed 28 patients (27 on PCA). Mean PCA duration was 1.6 days and mean PCA usage was 56.3mg total. The commonest side effect was nausea.

The commonest surgical indication was uterine fibroids (40%) and majority of cases were planned, only 1 case was an emergency.

Median length of stay (LOS) in open versus laparoscopic was 3 and 1 day respectively. Mean LOS in open with PCA was 5 days versus mean LOS in open without PCA was 3.25 days.

Overall complication rate was 24%, with the most common being pain related side effects, however surgical complications were the main cause of prolonged length of stay (>5 days).

**Conclusion**

Our findings suggest;

1. Increasing number of laparoscopic cases are being done within the trust however open cases still predominate
2. The use of PCA was limited to just over 24 hours in most cases and usage measured by total Morphine was minimal
3. A large proportion of patients were managed on oral analgesia post operatively

Improvements included aiming for <23-hour discharge in laparoscopic cases, providing specific recommendations regarding tailoring PCA use to reduce unnecessary prescriptions and side effects and to streamline patients from pre-op assessment to gynaecology workshop. These workshops are being conducted but awareness and content was not known by the anaesthetic nor gynaecology teams. They aim to provide information about the patient pathway including analgesic options.

The current patient information leaflet was noted to be out of date including the pain team information and this is now in the process of being updated.

Findings were disseminated at a local MDT audit meeting and departmental newsletter and notification emails to pre-op and gynaecology workshop teams.

Table 1: Peri-operative pain management

|  |  |  |  |
| --- | --- | --- | --- |
|  | Open  | Laparoscopic  | PCA |
| PCA  | 32 | 3 | - |
| Spinal  | 2 | 0 | 0 |
| TAP block  | 6 | 0 | 6 |
| Ilio-inguinal block  | 1 | 0 | 1 |
| CSE | 1 | 0 | 1 |
| Only oral analgesia  | 10 | 20 | - |