Authors

Dr Sarah Mortimer

Email sarahmortimer@doctors.org.uk

Phone - 07973 663 413

Department of Anaesthesia, North Bristol NHS Trust, Bristol. UK

Co-author - Ms D N Wigg, Danielle.Wigg@nbt.nhs.uk. Pharmacist, North Bristol NHS Trust.

Title

**We need to talk about pain in pre-operative assessment!**

Background

It is recognised that patients receiving high doses of opiate analgesia prior to surgery suffer a higher rate of post-operative complications and greater post-surgical pain, thus placing a disproportionate demand on the acute pain service after surgery. Pre-emptive pain management and/or pre-operative opiate reduction may lower the incidence of these detrimental effects and the burden of more complex post-operative pain management on acute pain services but, at our institution, the number of patients requiring such intervention is unknown. Furthermore, the pre-existing level of intervention is likely variable and the proportion of patients receiving such management is unrecognised.

Aims and objectives

To assess the existing level of intervention and potential demand for dedicated pre-operative planning for post-surgical analgesic management or pre-operative opiate reduction in patients with complex analgesic requirements undergoing pre-operative assessment in a large tertiary referral centre.

Methods

The study was approved by the quality improvement committee. This was a prospective study comprising data collected by pharmacists over a two-month period (November 2018-January 2019) in a pre-operative assessment clinic that reviews approximately 400 patients per week. All patients scheduled for elective non-neurological surgery were seen by a specialist nurse (escalated to anaesthetic review where necessary). Patients then underwent a consultation with a pharmacist who transcribed and reviewed medication charts. Patients were defined as having complex pain needs if prescribed analgesia other than paracetamol, ibuprofen and/or codeine. For each patient, the attending pharmacist recorded the combination of pre-operative drugs and opiate doses. Patients were also questioned by the pharmacist as to whether they could recall any discussion about management of their post-operative pain in the clinic.

Results

Forty-eight patients were defined as having complex pain needs (29 orthopaedic, 8 urological, 5 gastrointestinal, 2 vascular, 1 gynaecological and 1 plastic surgery) equating to approximately 2% of the pre-operative assessment clinic caseload. Of these patients, 23 (48%) were taking Gabapentanoids. Forty-five (94%) were taking opiate analgesia, with doses ranging from 5mg morphine equivalent per 24 hours to 340mg morphine equivalent per 24 hours. Eleven patients (23%) were taking doses greater than 100mg morphine equivalent per 24 hours. Of the 48 patients, only 5 (10%) recalled a discussion about post-operative pain management with either a nurse, anaesthetist or pharmacist. Only 2 of 11 patients taking over 100mg of morphine equivalent had a discussion regarding post-operative pain management.

Conclusion

The number of patients currently passing through pre-operative assessment with complex pain needs is relatively low compared to overall activity and thus could allow for management in a more dedicated manner. The majority of these patients are for planned orthopaedic surgery which could allow for more efficient flagging of such cases. Currently, large analgesic requirements and the challenges of post-operative pain relief are not being addressed in pre-operative assessment clinic which presents an opportunity to pre-emptively optimise care for these patients and potentially reduce subsequent demand on the acute pain service.

Agreement

I am the sole owner and have rights of all the information submitted and it has not been published or presented at any other meeting.

I have received Quality Improvement approval from the trust.

There are no conflicts of interest