Perioperative care pathways

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Perioperative challenge

12.5 million operations / year in the UK

82% of this is elective surgery

10% of the annual NHS budget

Record high witing lists - Autumn 2023 the waiting list for elective surgery = 7.77 million people

Why should we be involved perioperatively?

Poor pain control post operatively

11% severe pain in the 1st 24hrs post op

37% moderate pain in the 1st 24hrs post op

BJA 2016; 117: 758–766

Chronic Post Surgical Pain (CPSP)

Pain lasting more than 3 months after surgery (ICD 11, Pain 2019; 160: 45-62)

Median incidence 20-30% at 12 months

Varies with type of surgery

EJA 2015; 32: 725-34

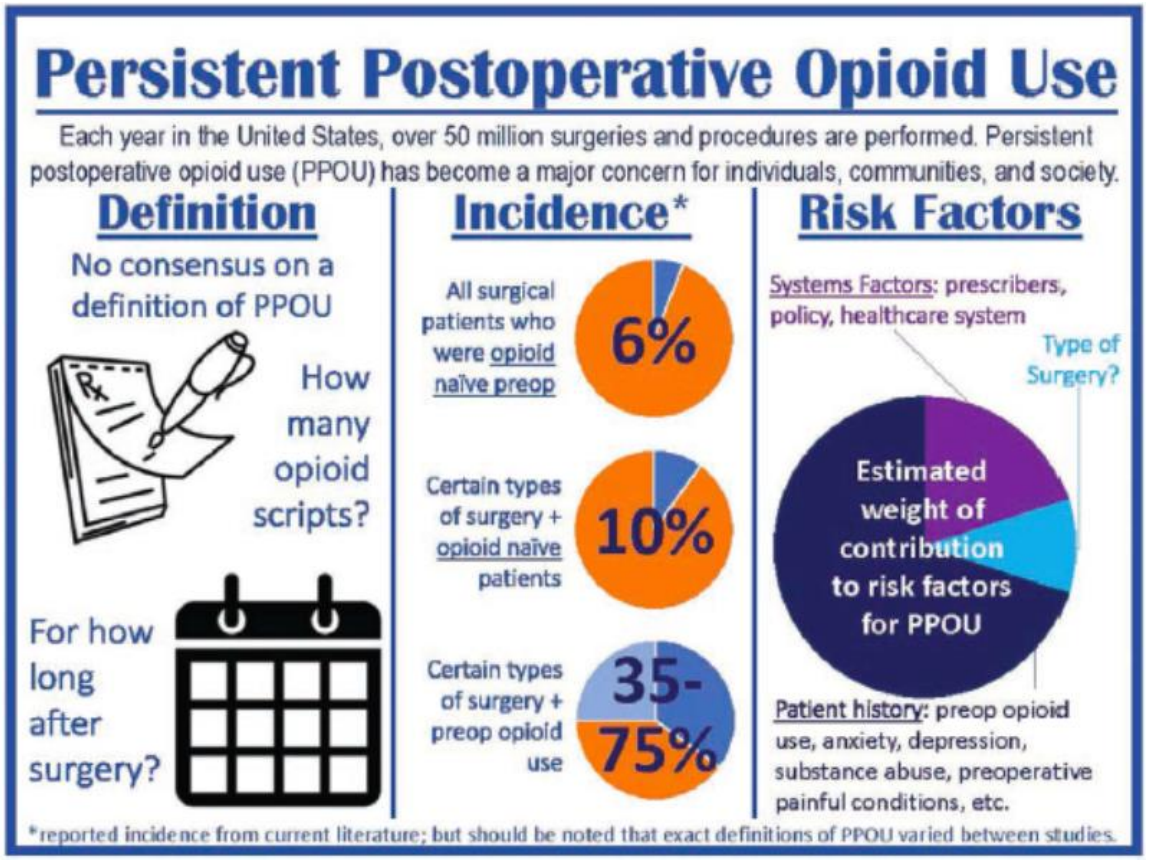
Persistent Post Operative Opioid Use (PPOU)

Opioid use more than 3 months after surgery

6-10% of opioid-naive patients

35–75% of patients with previous opioid exposure

Anesthesia and Analgesia 2019; 129: 543–52. 24



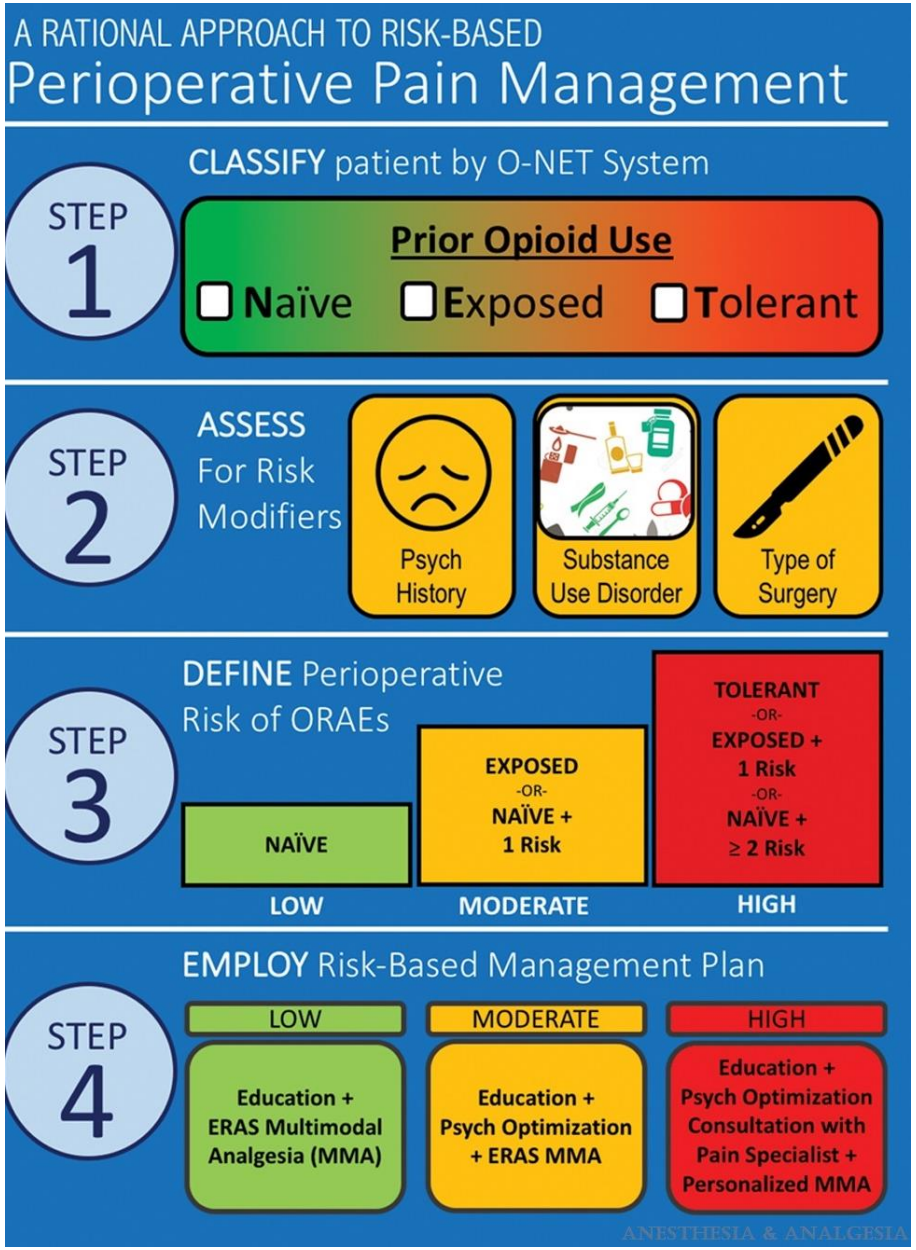
- Anesthesia and Analgesia 2019; 129: 543–52. 24

Main risk factors

- Pre-existing chronic pain
- Pre-existing opioid use
- History of anxiety / depression
- Pain catastrophising
- Type of surgery e.g. limb amputation, TKR, sternotomies
- Severe pain post operatively

Edwards et al, Anesth Analg 2019

Risk stratification



Pre op LTHTR

Four pre op questions done on the ePR by the pre op nurses to identify high risk patients:

- History of chronic pain?
- Oral morphine equivalent of > 60mgs / 24hrs?
- Does the patient have excessive fears or worries about pain post-op? (“catastrophising”)
- History of anxiety and depression? (if yes alone doesn’t populate the inpatient pain work list)

Via the surgical team / pre op

- Specific operations eg limb amputations, scoliosis surgery

Potential Interventions

Pre op interventions

- **Education**
- **Inpatient pain team review** – telephone, face to face
- **Specialist chronic pain services** eg opioid optimisation, pain management
- **Psychology input** – telephone, face to face

Alert the anaesthetic team to high-risk patients

- Multimodal analgesia
- Regional anaesthesia

Post op in hospital interventions

- **Inpatient pain team** review
- Inpatient pain team **psychology** review

Post discharge interventions

- **Transitional pain service** – high risk patient follow up
- Chronic pain team referral > 3-6 months persistent pain

All patients need education and management of expectations pre op

- Videos
- British Pain Society Leaflet / QR codes
- Linking into surgery school
- Education for pre op and anaesthetic teams

Education

British Pain Society Patient Leaflet – available as a free download

Managing pain after your surgery

This leaflet explains what you can do to prepare for going home after surgery and to help your recovery. It describes the medicines used to reduce pain, and how to use them safely while you recover.

Systematic Review and Meta-Analysis

PAIN®

Can perioperative psychological interventions decrease the risk of postsurgical pain and disability? A systematic review and meta-analysis of randomized controlled trials

Putu G. Nadinda[a,b,*], Dimitri M.L. van Ryckeghem[a,c,d], Madelon L. Peters[a]

Psychological interventions significantly reduced:

- **Acute pain**
- **Disability**
- **CPSP**

Interventions delivered after surgery more effective than before

Interventions delivered by a psychologist more effective than those delivered by another healthcare provider

Need for more research to determine which specific type of intervention the most beneficial

British Journal of Pain
Volume 15, Issue 2, May 2021, Pages 163-174

https://doi.org/10.1177/2049463720926212

Article

The role of the psychologist in the inpatient pain service: development and initial outcomes

Chandran Jepegnanam, Eleanor Bull, Sujesh Bansal, David McCarthy, Maureen Booth, Elizabeth Purser, Tecla Makaka, Gemma Shapley, Jo Cooper, Jill Probert, and Zoey Malpus

Fewer admissions
Fewer bed days than the control group
Using NHS figures for admission and excess bed day costs, equates to a potential difference in inpatient treatment costs of £528,969

Chronic and complex pain workload of inpatient pain services (CHIPS) – a national audit - Preliminary analysis of a complete dataset.
Dr Mark Rockett et al

Aw publication

- “Adding a psychologist to an inpatient pain service may result in a clinically significant saving of approximately 960 bed days a year per hospital. Potentially, this represents a gross saving of £315,000 per annum”

Post operative markers for intervention post discharge

- Patients that are referred multiple times to the inpatient pain team
- Patients that are highly distressed about their pain post operativey
- Patient on high dose opioids at discharge especially MR opioids (which should be avoided in acute pain anyway)

Journal of Pain Research

Dovepress

open access to scientific and medical research

Open Access Full Text Article

PERSPECTIVES

The Toronto General Hospital Transitional Pain Service: development and implementation of a multidisciplinary program to prevent chronic postsurgical pain

Post discharge – Transitional pain service

Katz et al 2015

Toronto Transitional Pain Service:

“Transitional pain care is focused on treating patients who are at risk of transitioning from acute to chronic pain after surgery with the aim of preventing the development of CPSP, persistent opioid use, and related disability”

Referral criteria

How to guide available on their web site

Referring Guidelines

Table 2. Referring guidelines for admission to the TPS at Toronto General Hospital as outlined by Katz et al. [4,7].

Pre-operative "pain alert"
• Pre-surgical chronic pain • History of drug abuse • Currently on opioid, methadone, or buprenorphine maintenance therapy
Severe postsurgical pain
• Prolonged Acute Pain Service stay • Surgical patients with repeat Acute Pain Service consultation • Medically stable postsurgical patients with complex pain problems that prevent discharge
High postsurgical opioid consumption
• Consumption of > 90 MME/day (MME = morphine milligram equivalents) • Methadone or buprenorphine patients without a community pain specialist • Patients discharged with a prescription for a long-acting opioid • Interventional postsurgical procedures (e.g., stump catheters postamputation)
Emotional distress
• Depression • Anxiety • Pain catastrophizing • Other psychosocial concern(s) identified by questionnaires or Acute Pain Service/Transitional Pain Service member

For additional details please refer to:

Katz J, Weinrib AZ, Clarke H. Chronic postsurgical pain: From risk factor identification to multidisciplinary management at the Toronto General Hospital Transitional Pain Service. *Canadian Journal of Pain*. 2019;3(2):49-58. doi:10.1080/24740527.2019.1574537

National Standards Current and pending

Anaesthesia Clinical Services Accreditation (ACSA) – The 2023 standards include pre operative identification of patients at high risk of pain compliactions and suggest interventions. This is a level 1 standard (mandatory).

Association of Anaesthetists Great Britain and Ireland (AAGBI) consensus statement for the perioperative management of pain complications – accepted for publication

Guidelines for the management of patients at high risk of pain related complications perioperatively from **The Royal College of Anaesthetists** via Faculty of Pain Medicine (FPM) with representatives that include The Royal College of Surgeons, Centre for Perioperative Care (CPOC) and The British Pain Society – aiming for publication early 2025

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Any questions