Arthroplasty Anaesthetic Regimen

April 2017

Pre-operative counselling on day of surgery	During the anaesthetic consultation on the day of surgery please state the following to the patient: 'That the patient is part of an enhanced recovery programme designed to reduce complications and shorten hospital stay.' 'The anaesthetic is designed specifically to provide good pain relief, prevent nausea and allow them to be mobilising and drinking as soon as possible after the operation.' 'On return to the ward they will be fit and safe enough to sit out of bed and mobilise later the same day.'
Pre-operative oral fluids	If the patient is fasted within the rule 'clear fluid up to 2 hours before' they should arrive for theatre euvolaemic.
Pre-operative Analgesia	Paracetamol 1g po stat <u>Consider</u> Gabapentin 300mg PO stat (Omit if already taking gabapentin or pregabalin or allergy/intolerance to gabapentin) **Both available from PACU Mod 3/4 and 5/6 if required**
Induction	Spinal +/- Sedation <u>Spinal</u> 2.5-3ml 0.5% Heavy Marcain +/- 10-15mcg intrathecal fentanyl
Intraoperative Fluids	Patient should be euvolaemic. Give maintenance fluid during operation limiting this to 1L of Hartmanns if possible controlling BP with an appropriate vasopressor .

Post-operative analgesia	<u>Local Anaesthesia</u> For THR and TKR the surgeon will infiltrate local anaesthesia during and at the end of the case as per an agreed protocol <u>Post-operative analgesia</u> **PACU** 'Rescue analgesia' – Morphine/Oxycodone 1-10mg iv **First po oxycodone PR dose given prior to leaving PACU and signed for on drug chart. Available in PACU Mod 3/4 AND 5/6** **Ward** <u>Regular Analgesia</u> 1. Paracetamol 1g iv/po qds Dose ↓to 500mg QDS PO if patient weight <50Kg 2. Oxycodone prolonged release (PR) 10mg-20mg BD PO For 3 days then step down to simple opioid. **Dose ↓ to 5mg BD if age >80years OR CrCl < 30mL/min. If CrCL < 15mL/min consider oxycodone immediate release (IR) liquid at low dose i.e. 1.25mg QDS plus prn** 3. Codeine phosphate 30-60mg QDS PO (When oxycodone PR stopped OR for use as discharge step down) 4. Ibuprofen 400mg TDS PO **Confirm No GI problems, No renal impairment, No heart disease, No interactions, Not on any other NSAIDs** **<u>Avoid PCA unless patient has chronic pain or OSA</u>**. Chronic pain patients often have unpredictable analgesic requirements and you may wish to consider a PCA as an alternative to regular oxycodone. Chronic pain patients should continue their pre-existing regular analgesia regimen –i.e. Transdermal patches and other strong opioid should continue. OSA patients may benefit from the added safety of regular sedation scores and saturation monitoring provided by PCA prescription.

	<u>PRN Analgesia</u> 1. Oxycodone (IR) 1.25-5mg 2-4 hourly (Max 60mg/24hours)
PONV	Ondansetron 8 mg 30 minutes prior to end of operation **PACU/Ward** Ondansetron 4mg tds max 12mg in 24 hours Cyclizine 50mg tds
Post-operative fluids	Prescribe 1ml/kg/hr for 12 hours and 1 x 250ml bolus stat if systolic BP 20% below normal.
Anaesthetist to PACU and PACU to ward handover	Please document: 1 hour after returning to the ward the patient is safe to sit out of bed with assistance (Check BP before mobilising). Patient can mobilise after 4 hours with trained ward staff.

Dr J Taylor

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