Post Oesphagectomy Analgesia

Introduction

It is critical to recovery that analgesia is sufficient to allow deep inspiration, coughing and mobilisation.

Both open and minimally invasive approaches will return from theatre with regional anaesthesia in place (Thoracic Epidural and Paravertebral respectively). All patients should receive regular IV paracetamol.

Where possible systemic opioids should be avoided as these provide sub-optimal analgesia and have potential to cause respiratory depression and cough suppression that promotes chest complications and sedation and emesis that can hamper mobilisation.

It is not uncommon for patients to experience sharp pains in the chest wall associated with chest drains and the thoracotomy wound; **this is not a sign that the regional anaesthesia has failed.**

Please follow this step by step guide to optimise analgesia.

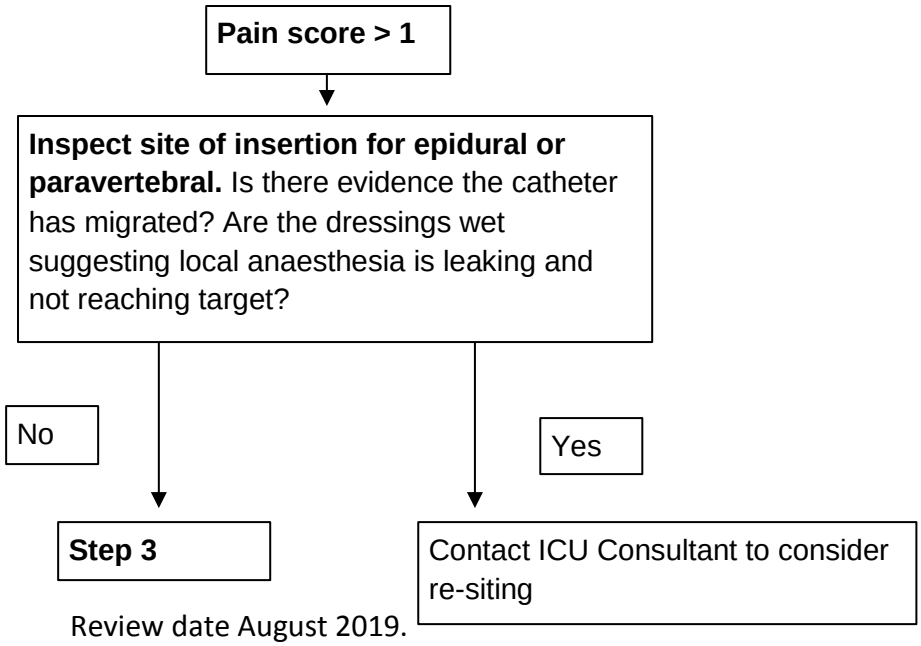
Step 1

Assess and Record Pain Score

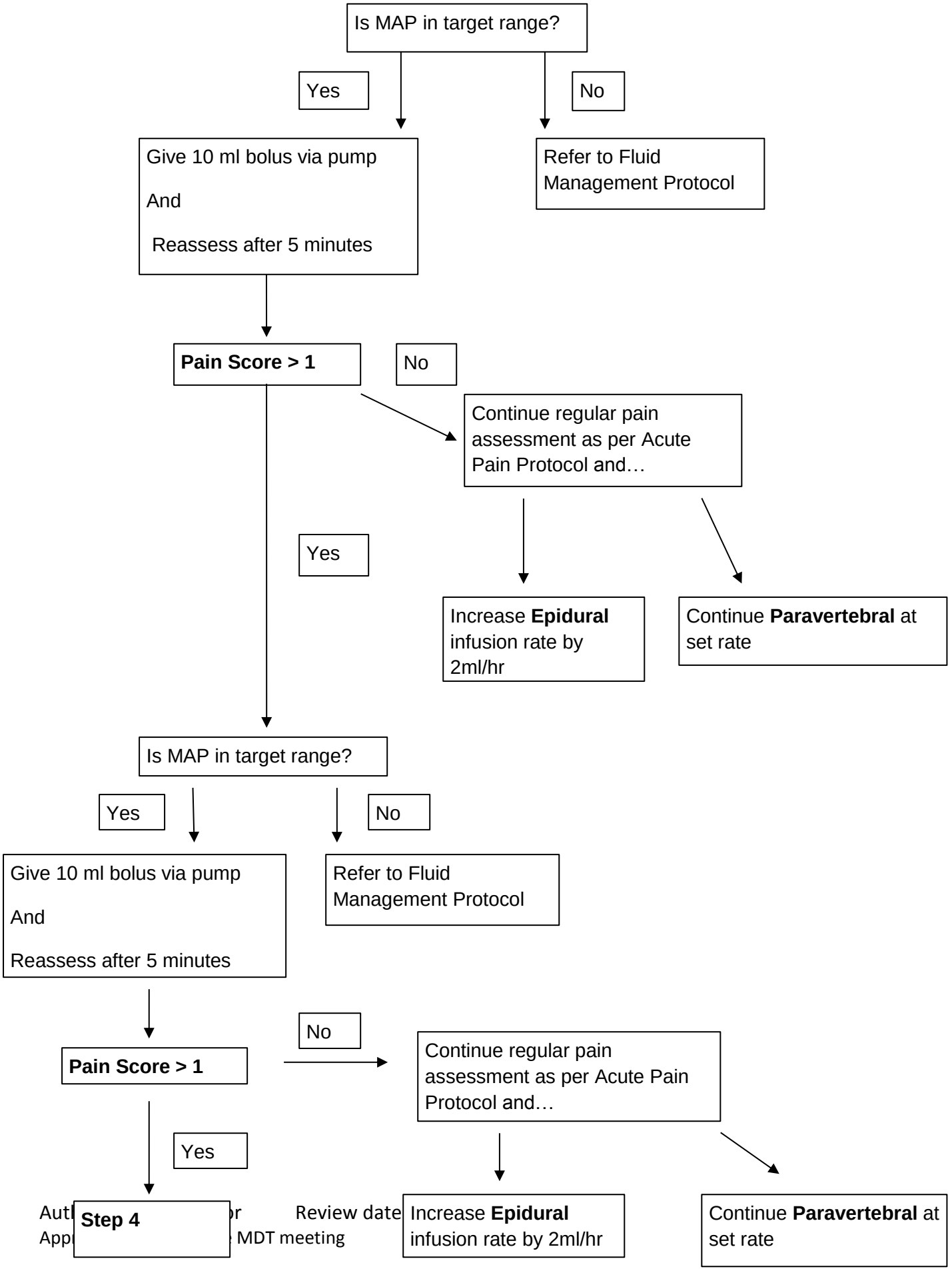
0 = No pain at rest or movement / coughing
1 = Mild pain on movement / coughing
2 = Moderate pain at rest, severe pain on movement / coughing
3 = Severe pain at rest

Record Blood Pressure, Heart Rate, Respiratory Rate and Oxygen Saturations

Step 2



Step 3



Autl or Review date
App MDT meeting

Step 4

If the epidural catheter has migrated or come out, or epidural analgesia is not adequate despite administering a bolus as per previous steps, consider the following:

Consider resiting the epidural : Discuss with ITU Consultant. Risks versus benefits of this will depend on various factors such as number of days since surgery, level of discomfort, patient preference, any contra-indications (anticoagulation, sepsis etc).

Consider use of : Parecoxib (where suitable)

Tramadol

Step 5

Consider Commencing Ketamine Infusion.

IV ketamine is for short term use only, usually for a maximum of three days.

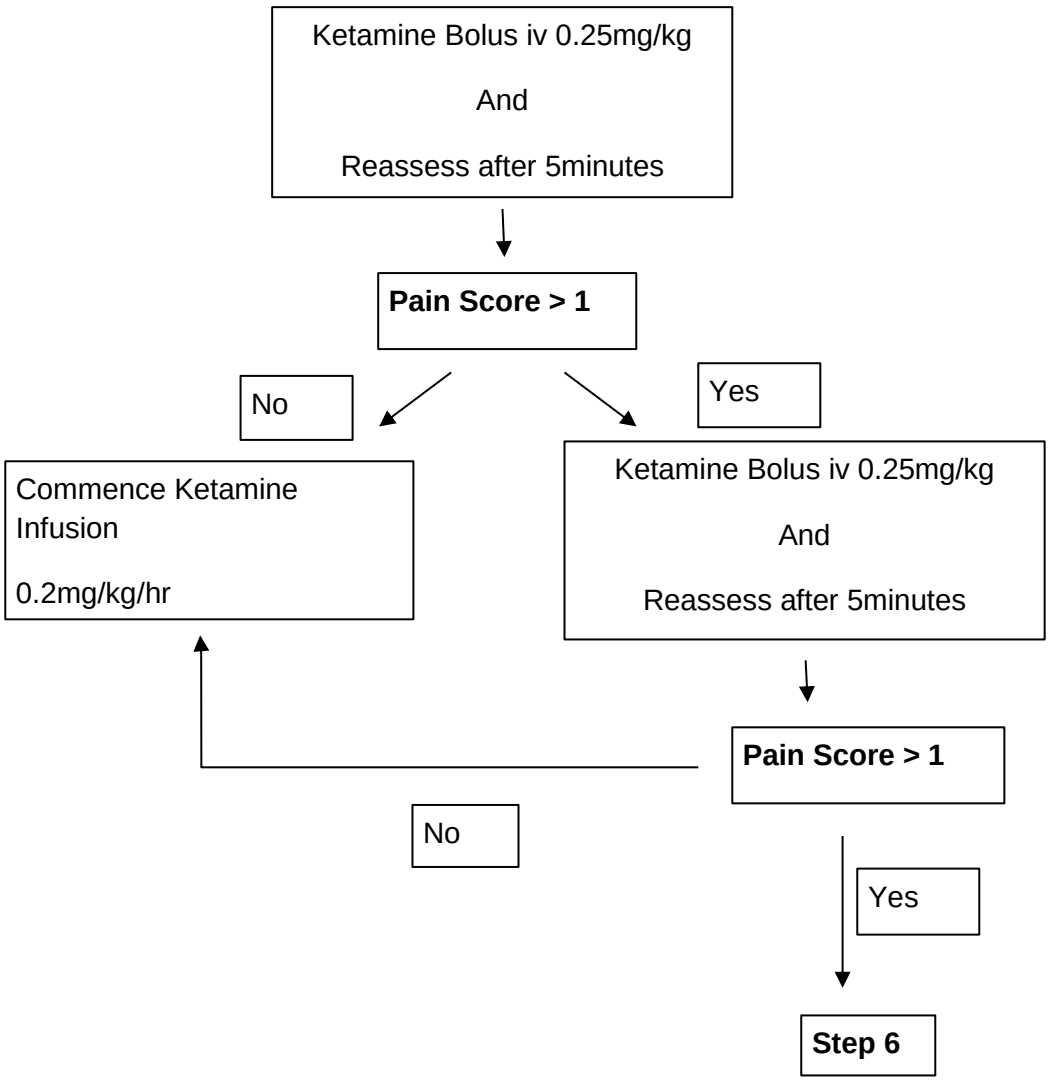
IV ketamine must be discontinued when discharged from a critical care setting.

Contraindications

- Allergy to ketamine
- Acute porphyria

Cautions

- Raised intracranial pressure
- Raised intraocular pressure
- Uncontrolled hypertension
- Ischaemic heart disease
- Known psychiatric conditions, especially schizophrenia
- Confusion
- Epilepsy
- Warn patients about dysphoric side effects



Step 6

Commence iv opioid

Give bolus of iv morphine/oxycodone 1-20mg in 2-5mg aliquots.

Commence morphine/ oxycodone PCA and switch existing epidural to bupivacaine only.