

(from the talk by Professor Rowbotham, an anaesthetist.)

Although much of this subject might appear irrelevant to chronic pain patients, there are some points that are of importance.

Firstly, on the issue of patient-controlled analgesia (PCA): which involves morphine connected to an intravenous drip, and the patient presses a button when they feel the pain increasing. This is often used after major surgery.

Professor Rowbotham stressed that both staff and patient need to be aware that the risk of succumbing to addiction is negligible: in fact, he has never seen a case of a patient becoming addicted through use of PCA, but he knows of some prescribers who have become addicts!

Secondly, epidural analgesia is now a mainstay of pain relief after major surgery or trauma. However, Professor Rowbotham expressed concern about what he described as

“very high likelihood of life-threatening events”

during use of epidural analgesia and this view was concurred with by the previous speaker, Dr. Eastwood, who cited 3 near-deaths in his hospital despite strict protocols (which are not in place in all hospitals).

Neither speaker made reference to the longer-term adverse effects which include arachnoiditis.

Amongst the short-term adverse effects (the epidural space being only a potential space and highly vascular): inadvertent intravenous injection, which if unnoticed can result in lethal doses of local anaesthetic, infection (abscesses, meningitis), bruising (subdural haematoma) dural tap (piercing the dura and entering the subarachnoid space) which causes severe headache and may necessitate application of a blood patch.

Epidural anaesthetic usually uses a combination of opioids and local anaesthetic.

The opioids carry a risk of causing respiratory depression, urinary retention, nausea and vomiting and itching. The local anaesthetic effectively causes a sympathetic block and this can cause lowered blood pressure and decreased response to fluid loss (important if the operation involves significant blood loss).

In addition, it may cause motor weakness which can mask any damage to the spinal cord.

Local anaesthetic nerve blocks may be used for operations such as hernia repair.

However, these wear off after 4-5 hours, so it is important that the doctor give the patient a supply of painkillers to take home (especially in day-care cases).

Another class of drugs used are what are known as Non-steroidal anti-inflammatory drugs (NSAIDs) such as brufen. These can cause gastrointestinal problems, sometimes serious, though not commonly in the acute setting (say, around the time of an operation.)

What is less well known is that 10-20% of patients will have a history of reduced renal (kidney) blood flow and this can cause serious problems in surgery if there is a loss of blood volume, although there may be no problem in day to day life.

Other problems with NSAIDs include blood thinning (decreased platelets) which may a problem in surgery, and also NSAIDs can exacerbate asthma.

The Royal College of Anaesthetists has issued some guidelines over the use of NSAIDs peri-operatively.

In summary, it recommends that NSAIDs alone are insufficient for pain relief after major surgery but if used in conjunction with opiates, may enhance the quality of pain relief from the opiates, decrease their side-effects and reduce the dose requirement.

They are the drug of choice in day-cases. They may increase blood loss slightly but this should not inhibit their use in most cases, but they should be given after surgery rather than before if there is concern. They may also have interactions with other drugs.

Caution is required if using NSAIDs in the elderly, diabetics, those with vascular, cardiac, or kidney disease and should be avoided in renally-compromised patients.