Morphine PCA use after LSCS under general anaesthetic: a review of practice

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Introduction

Chronic pain after caesarean section is an important problem. 22% of patients experience ongoing pain after one year, with severe pain in the immediate postoperative period a risk factor for developing chronic pain[1]. NICE recognised that evidence for patient controlled analgesia vs oral analgesia following caesarean section under general anaesthetic is scarce[2]. Standard care as recommended in our tertiary centre after LSCS under general anaesthetic includes abdominal wall blocks, patient controlled analgesia with morphine, regular paracetamol and regular ibuprofen. A previous review in our hospital demonstrated that morphine PCAs are routinely taken down within 24 hours, with 50% being taken down after patient request. Reasons cited at that time were unwanted side effects and difficulty nursing a baby with a PCA. This follow up project reviewed morphine PCA use in this setting with a view to potentially introducing an oral alternative.

Method

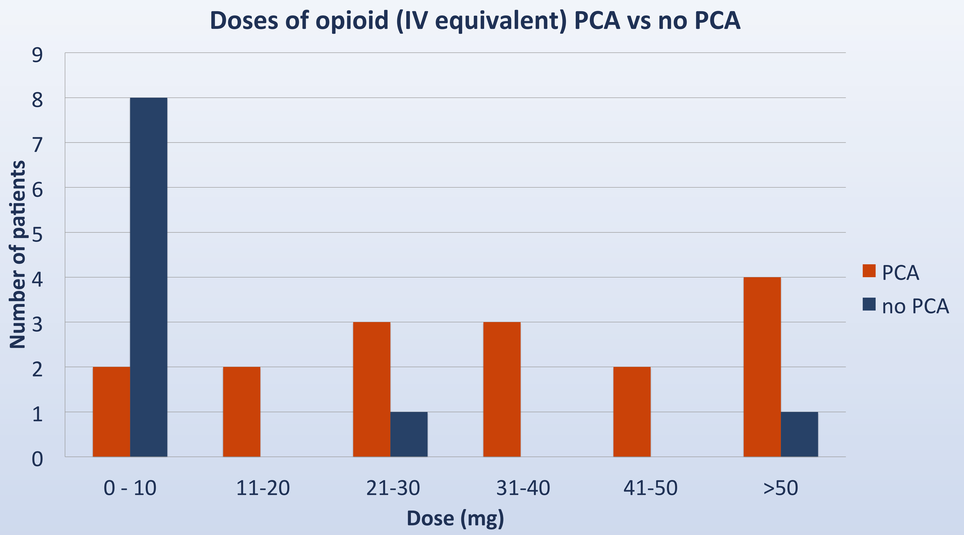
Retrospective data was collected from the notes of 39 patients who had a caesarean section under general anaesthetic between May and September 2021.

Use of neuraxial anaesthesia, use of PCA (duration of use, total opioid given, reason for stopping PCA and frequency of anaesthesia/pain review) and dose of alternative opioid (when PCAs not used) was determined.

Results

Of 39 patients, 12 had neuraxial opioid. Of the remainder, 59% had a PCA. Pain scores were not documented for any patient with no PCA. In patients with a PCA, mean duration of use was 24.8 hours. Oral opioid use of those who did not have a PCA was converted to the equivalent dose of IV morphine (see graph).

The decision to take the PCA down was made by the midwife in 17% of cases, the anaesthetist / pain team in 41%, the patient in 17% and the obstetrician in 5%; in the other 17% of cases it was unclear.



Discussion

We have demonstrated an inconsistency in provision of analgesia including PCAs following GA CS in our hospital. There is a substantial difference in opiate consumption between women with PCAs and those without. However, pain assessments are not consistently done and without this we do not know what the impact of this is on outcome.

A more standardised approach to post operative analgesia should be adopted and the team are going to review the possibility of moving away from PCAs to oral opiates in line with suggestions from NICE.

References

1. Niklasson, B, Georgsson Öhman, S, Segerdahl, M , Blanck, A. Risk factors for persistent pain and its influence on maternal wellbeing after cesarean section. Acta Obstet Gynecol Scand 2015; 94: 622– 628
2. https://www.nice.org.uk/guidance/ng192/evidence/f-opioids-for-pain-relief-after-caesarean-birth-pdf-9071941651