

Analgesia after delivery in Placenta Accreta Spectrum disorder

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Introduction

Placenta Accreta Spectrum (PAS) disorder mandates operative delivery. At the more severe end of the spectrum, midline laparotomy and hysterectomy are required, and analgesia requirements are higher than following a standard caesarean delivery. As a regional tertiary centre, Princess Royal Maternity Hospital undertakes regular deliveries of women with severe PAS disorder. A standardised approach to anaesthetic management is desirable [1], however, the optimum analgesic approach is unclear, and will vary between individuals, due to the extent of disease, and the nature of the delivery. We aimed to evaluate current approaches to postoperative analgesic management in PAS patients.

Methods

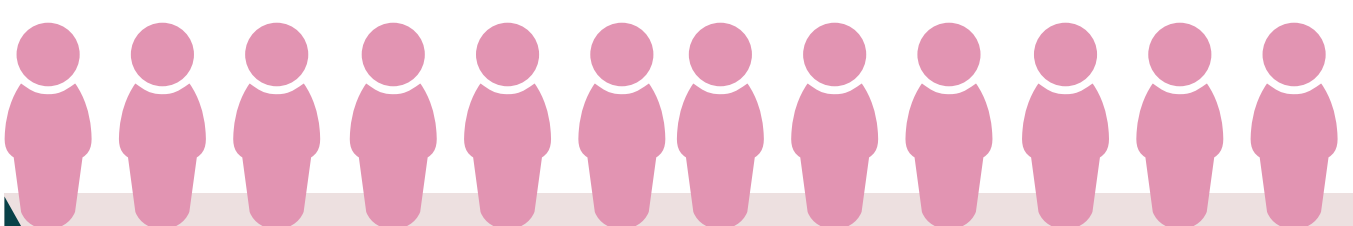
A retrospective review of electronic and paper case notes was undertaken for all PAS patients who delivered at Princess Royal Maternity Hospital, Glasgow, during 2023. Data on postoperative analgesia for days zero to three was collected.

Results:

Twelve charts were reviewed. All patients had a midline laparotomy and 10 had hysterectomy. Anaesthetic management was: five spinals, with planned GA conversion, six CSEs (two GA conversions), and one GA. All neuraxial techniques included opioids (diamorphine or morphine 300mcg). Intraoperative analgesia was variable between cases, with a minority receiving paracetamol, NSAID, or clonidine as part of multimodal analgesia in theatre. Opioids used included remifentanyl, morphine, fentanyl and alfentanil. Rectus sheath catheters were sited in six patients (Figure 1). No epidurals were utilised for postoperative analgesia. Five patients received a PCA, all discontinued by day-3. Initial, or stepdown oral analgesia varied. Some patients received the usual post caesarean protocol, others received higher, Zomorph doses, for longer. Paracetamol and NSAID prescribing was inconsistent.



In all 12 patients, there was an increase in opioid requirements on days two and three.



On day-3 all patients still required Zomorph with additional breakthrough Sevredol.



Seven patients required an increase in analgesia on day-3.

What was our post-operative management?

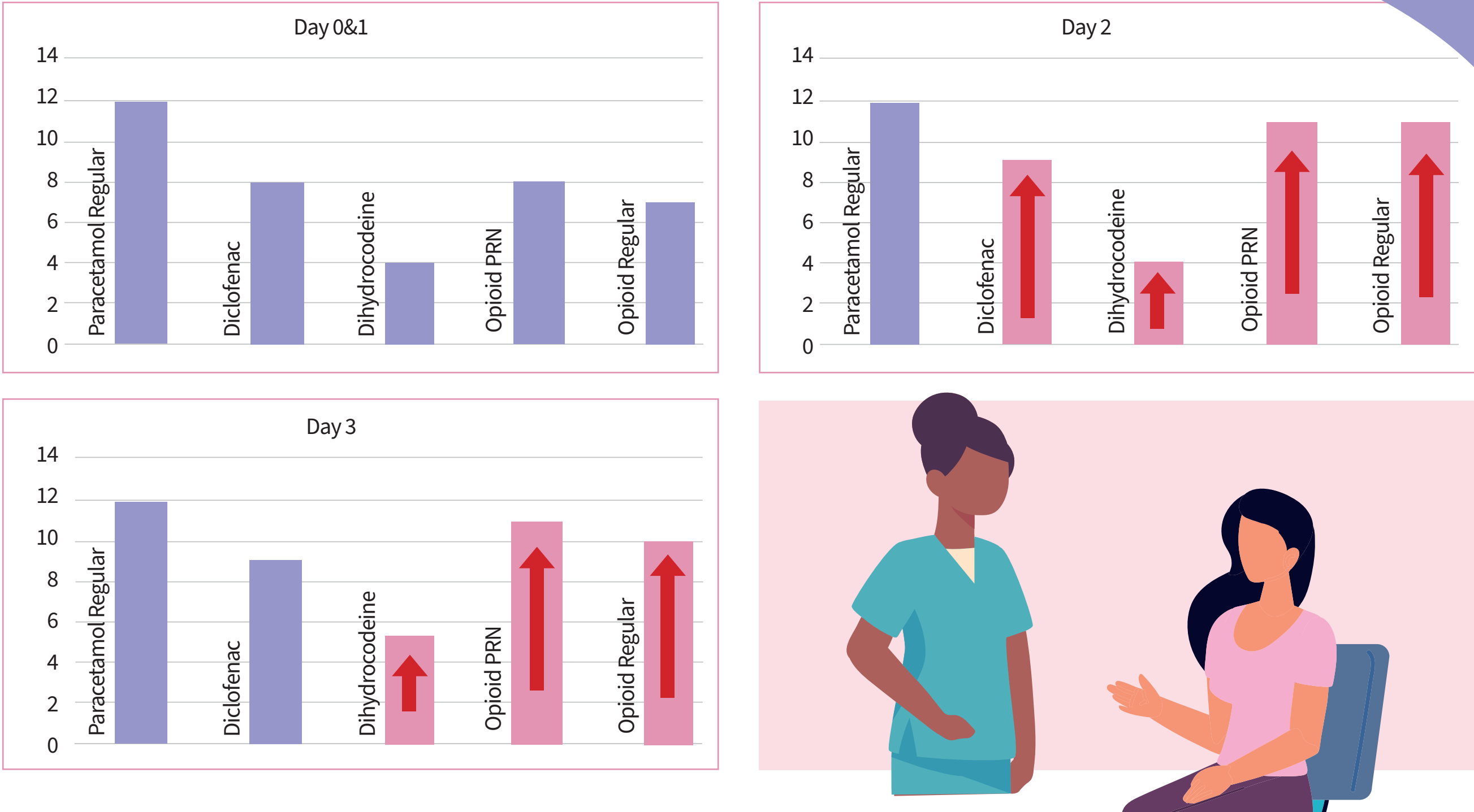


Figure 1:
illustrative
timeline of
multimodal
analgesia

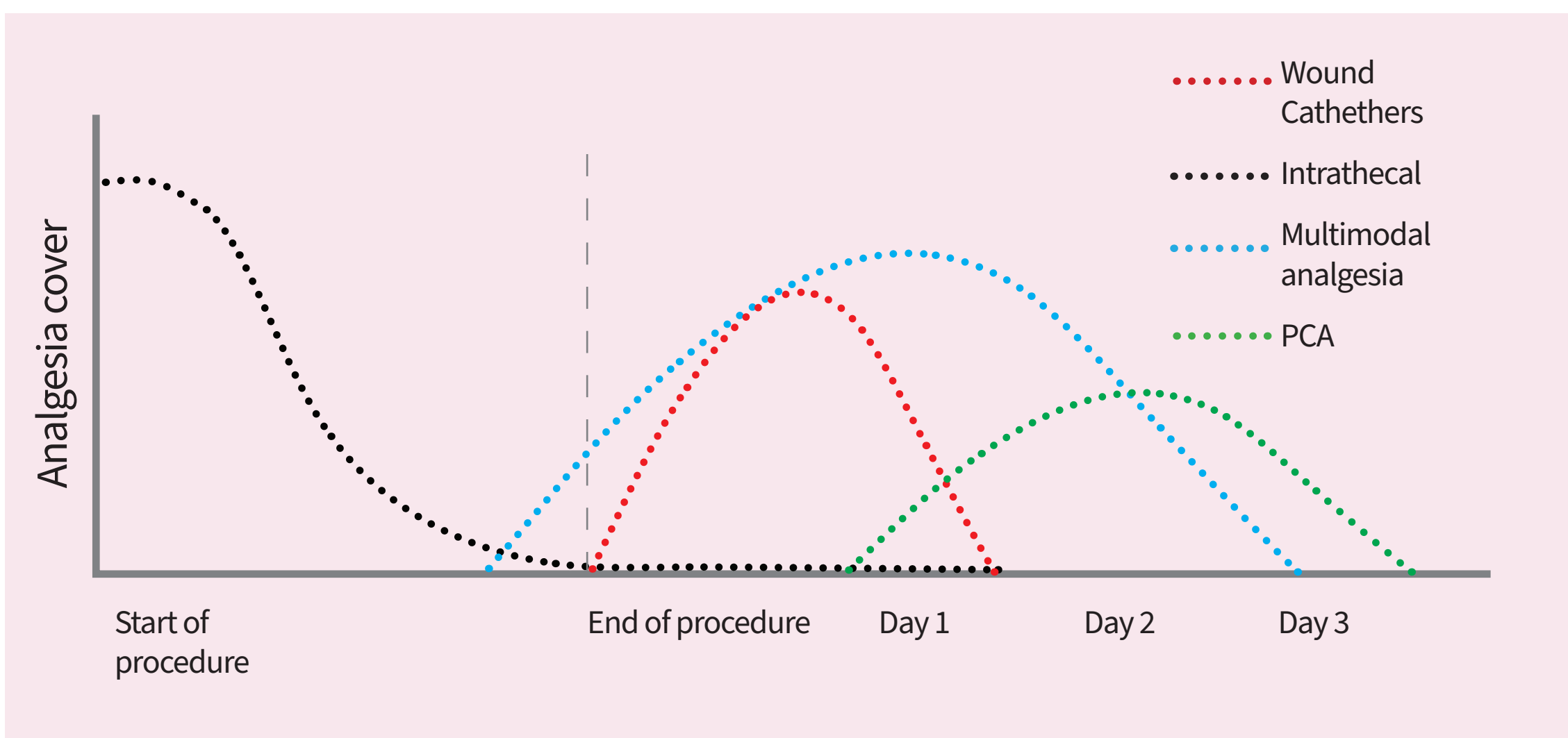
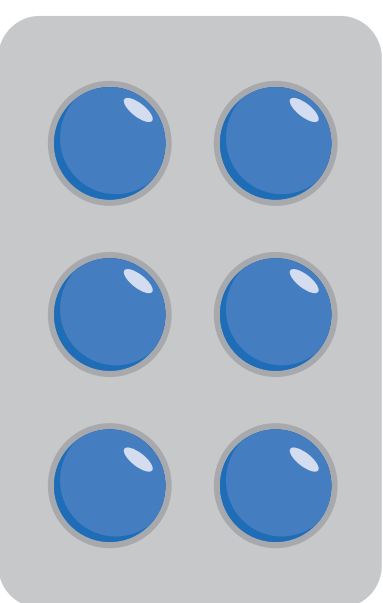


Figure 2

Intrathecal opioid

Consider using epidural post op if CSE

Consider PCA post op for 36-48 hours

Step-down from PCA needs to involve long acting oral morphine with immediate release breakthrough

If no PCA, higher doses of zomorph should be prescribed for longer

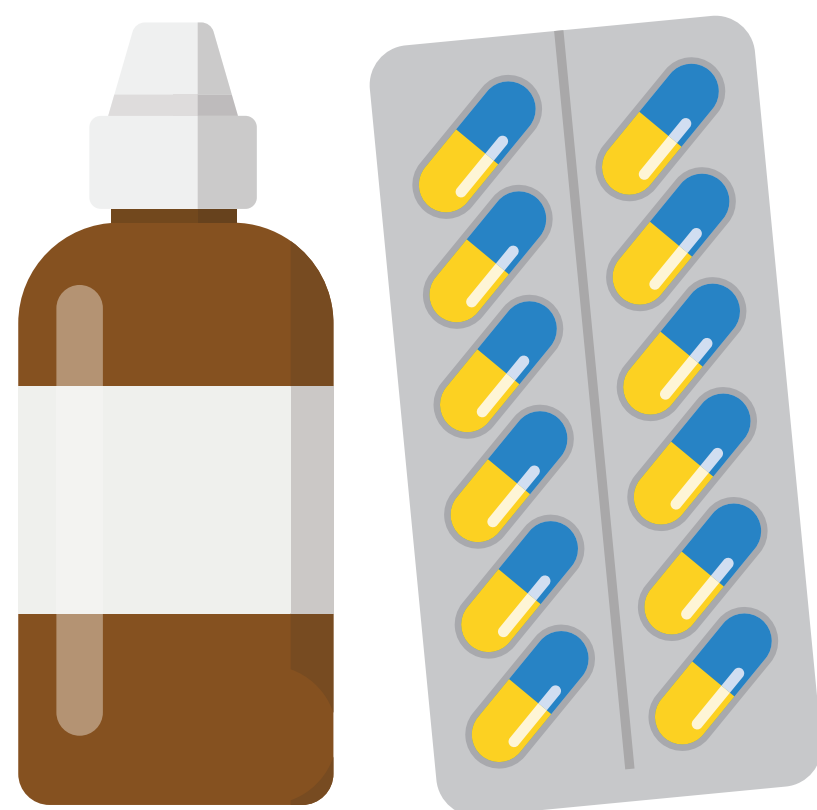
- 30mg BD for 2-3 doses, 20mg BD for 2-3 doses 10mg BD for 2-3 doses
- Plus breakthrough
- Usual adjuncts (paracetamol + NSAID unless contraindicated)

Rectus sheath catheters

Twice daily review

Discussion:

Postoperative analgesia prescribing is inconsistent. This group of patients requires more analgesia compared to a standard caesarean, and for a longer period. Analgesic requirements remain significant by day-3, and this should be considered, particularly with regards to timing of 'step-down' analgesia. Patients with rectus sheath catheters appear to require less analgesia on days two and three. A standardised guideline may be useful as a baseline for postoperative analgesia prescribing, from which individual adjustments can be made (Figure 2).



References

- Placenta praevia and placenta accreta: Diagnosis and management (Green-Top Guideline no. 27A) RCOG.