

Analgesia Practices After PAS Delivery: Impact of New Guideline

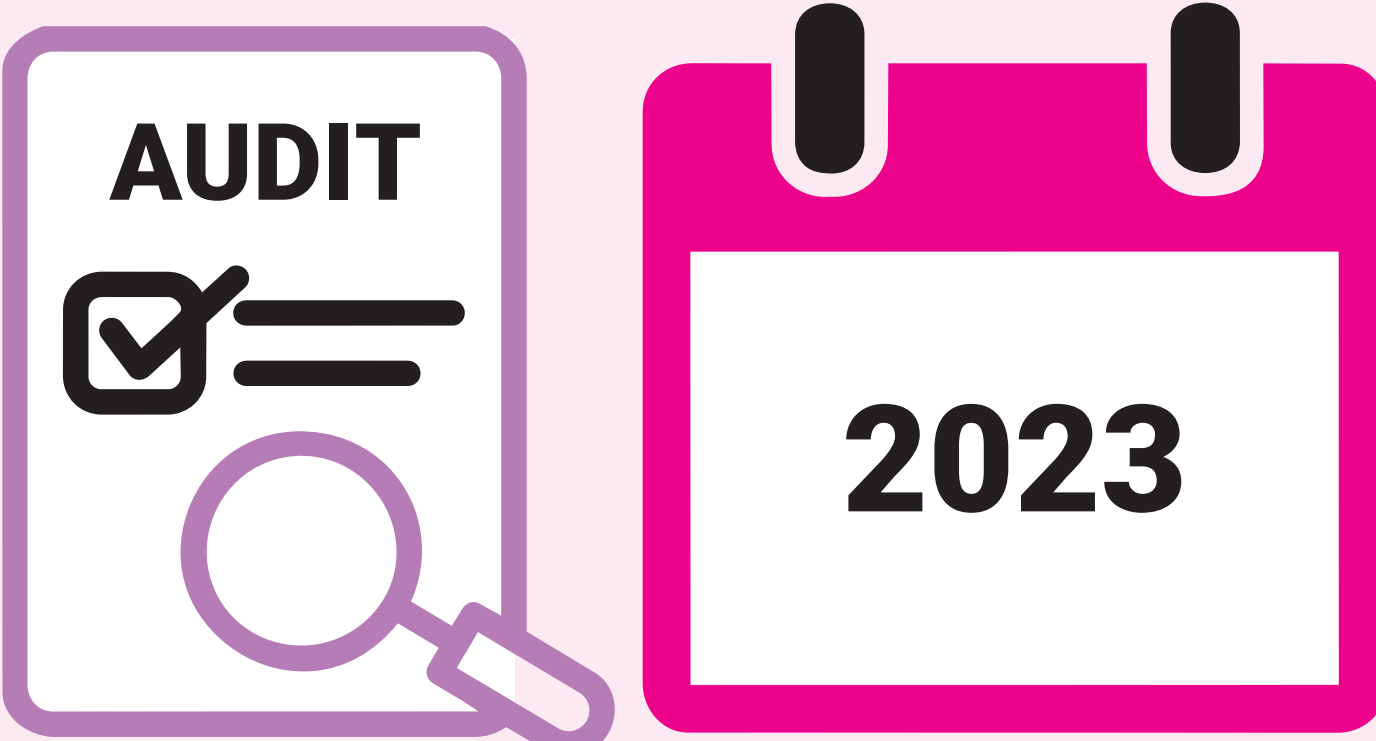
Authors: Kirsty Lisa McCrorie | Malcolm Broom



Introduction

Placenta Accreta Spectrum (PAS) disorder often necessitates operative delivery with midline laparotomy and hysterectomy, resulting in significantly greater and more prolonged postoperative analgesic requirements than standard caesarean delivery [1]. As a regional tertiary centre, Princess Royal Maternity Hospital (PRMH) manages a regular cohort of women with severe PAS.

An initial audit in 2023



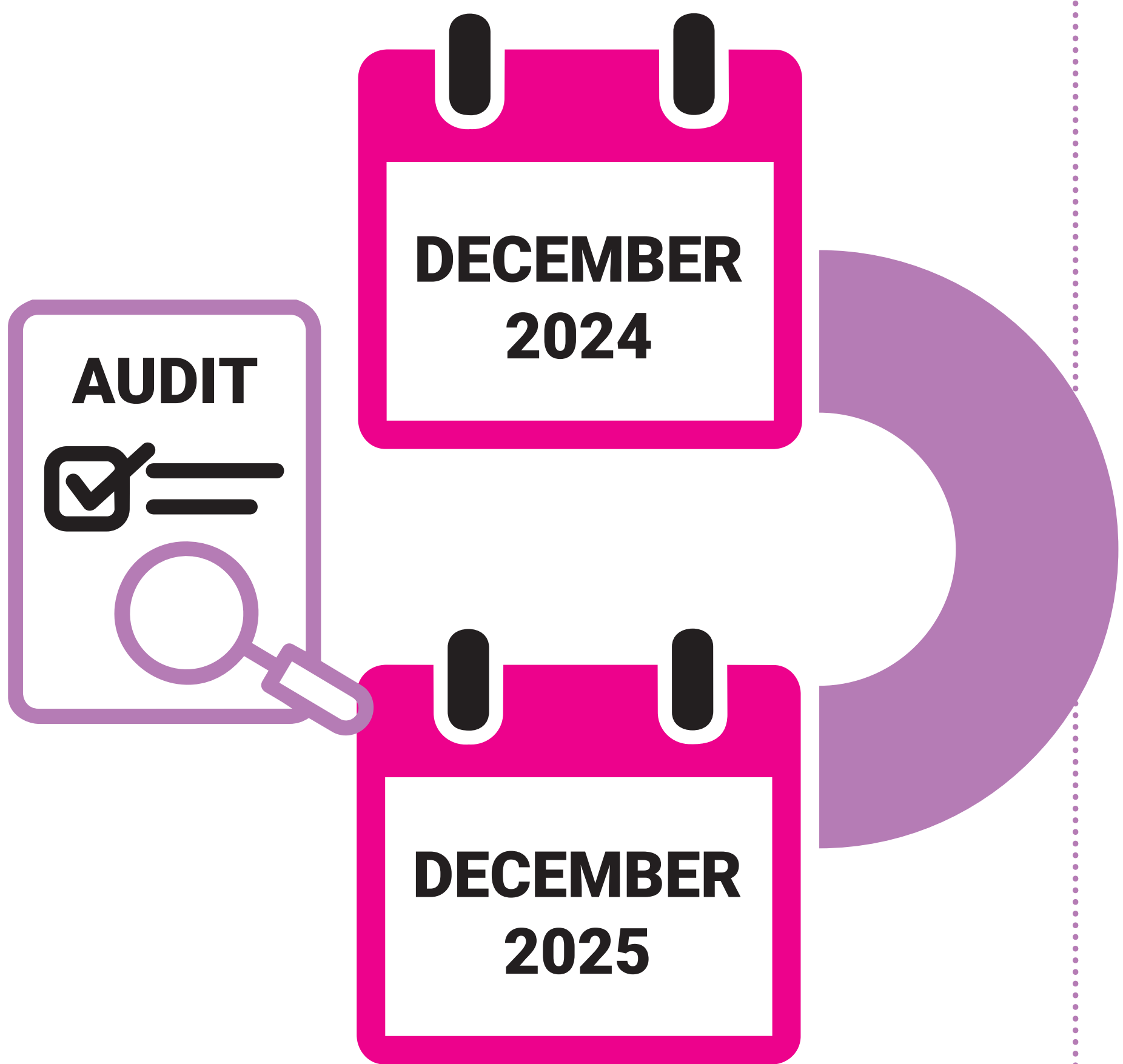
demonstrated marked variation in postoperative analgesic prescribing.

This project aimed to evaluate the impact of introducing a standardised postoperative analgesia guideline through a closed-loop re-audit.

Methods

A retrospective review of electronic and paper case notes was undertaken for all PAS patients delivering at PRMH in 2023, reviewing postoperative analgesia from days zero to three. Following this, a local PAS postoperative analgesia guideline was

introduced (Figure 1). Key recommendations included: continuation of epidural analgesia postoperatively when combined spinal–epidural (CSE) techniques were used; early prescription of patient-controlled analgesia (PCA), particularly for postoperative days two and three; higher-dose and longer-duration modified-release oral opioids; and increased utilisation of postoperative regional anaesthetic techniques.



A retrospective re-audit was conducted for all PAS patients delivering between December 2024 and December 2025. Analgesic prescribing and regional techniques were reviewed and compared with the initial audit.

Results

Compared with the 2023 audit, significant improvements in multimodal analgesia prescribing were observed following guideline implementation.

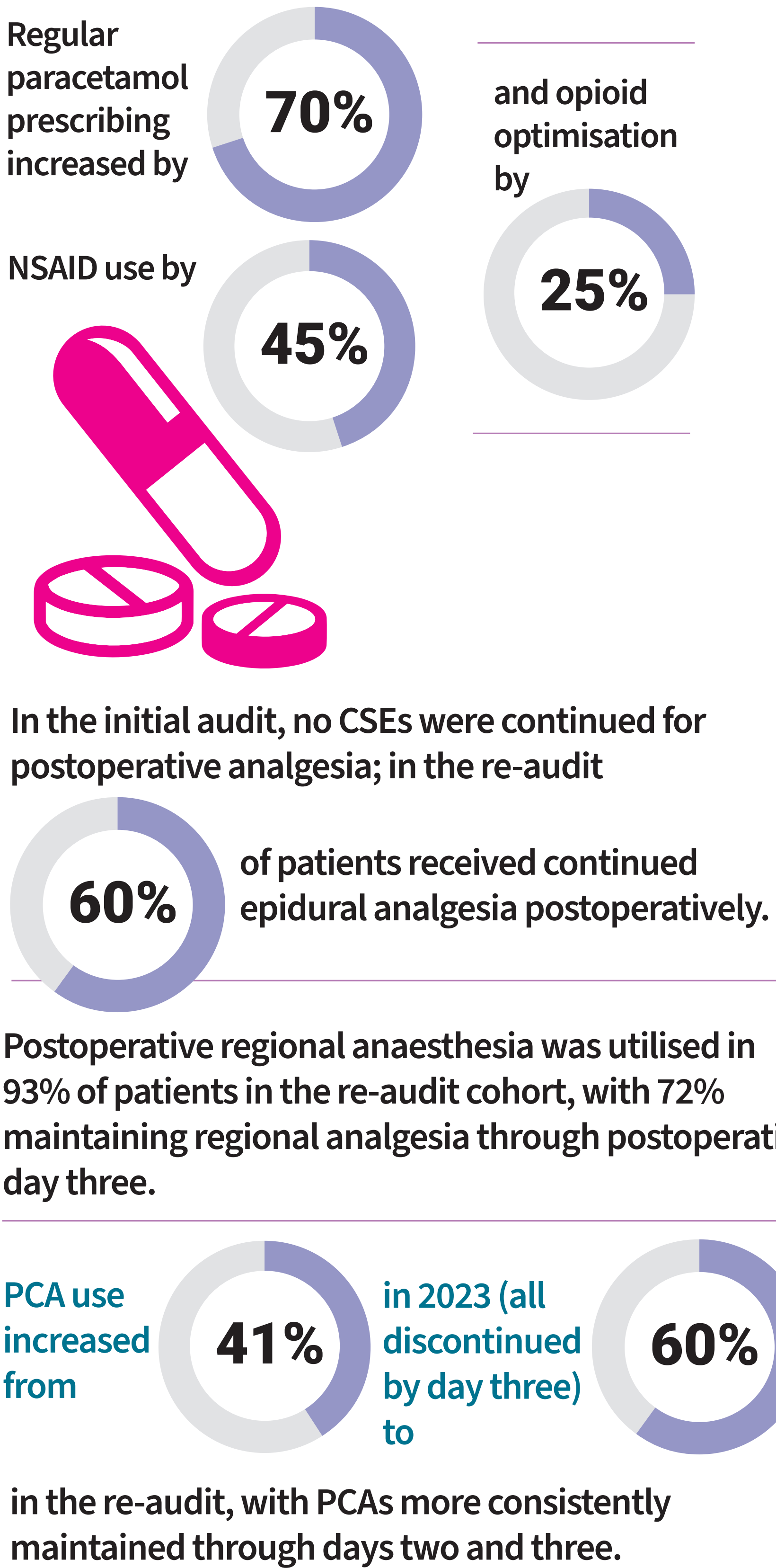


Figure 1. PAS Analgesia Guidance

Intrathecal opioid +/- epidural
- Consider using epidural post-op, if CSE - Run as a normal labour analgesia regime - Consider 0.25% levo for breakthrough
Consider PCA for 36-48 hrs
- Then step-down → long-acting oral morphine - Plus immediate release breakthrough - Usual adjuncts
If no PCA (and also post-PCA), consider higher doses of zomorph for longer
30mg BD for 2-3 doses 20mg BD for 2-3 doses 10mg BD for 2-3 dose - Plus immediate release breakthrough - Usual adjuncts
Rectus Sheath catheters
- Run for 48-72 hrs - Could flush with saline and then start once epidural is removed, if using epidural

Summary of analgesia options

Epidural → rectus sheath catheters + PCA or oral morphine → oral morphine until 72-96 hrs post-op

Rectus sheath catheters + PCA → oral morphine until 72-96 hrs post-op

Usual adjuncts (NSAIDs when appropriate) + immediate release breakthrough

Twice daily pain score, and review

Discussion

Implementation of a standardised PAS postoperative analgesia guideline led to improved consistency in prescribing, increased use of multimodal analgesia, and greater utilisation of regional techniques and PCAs. These changes better reflect the prolonged and escalating analgesic requirements of this patient group, particularly beyond the first postoperative day. A structured guideline provides a useful baseline for postoperative analgesia while allowing individualisation based on surgical and patient factors.

References:

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