Managing your pain after your operation
Information for patients
Introduction

This booklet is about how we can help treat any pain you might have during your stay in hospital and afterwards when you go home.

The Inpatient Pain Service is made up of nursing staff and consultant anaesthetists who have specialist knowledge of pain and how to manage it.

Tell us about your pain

You should always tell a nurse or doctor about your pain before it becomes unbearable. The longer you wait, the worse the pain may get. It can then be more difficult to take the pain away.

Some people need more pain relief than others, so do not be afraid to tell someone if you are still in pain even after we have given you pain medicines. The nurses know that patients vary a lot in their need for pain relief. You need to be comfortable enough to take deep breaths, cough and be able to do exercises with the physiotherapist.

Ask for explanation

During your stay in hospital you may hear some words about pain that you do not fully understand. Please ask the nurses to explain any words we use if you do not know what they mean.
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Pain assessment

You will be asked by the nurses looking after you to describe your pain on a score of 0 - 3. This means:

0 = No pain
1 = Mild Pain
2 = Moderate Pain
3 = Severe Pain

You may have different scores when you are resting to when you move around. It is important to let the nurse know both scores, so that we can give you appropriate medicines to reduce your pain.

Some people take regular painkillers at home. Please tell the doctors and nursing staff if you take regular painkillers.

Painkillers

Painkillers are medicines which relieve your pain. There are several types which may be used, depending on how severe your pain is.

These are some examples:

- Paracetamol – good for mild to moderate pain and works well with other painkillers e.g. NSAIDs (non-steroidal anti-inflammatory painkillers) such as ibuprofen and weak opiates, such as codeine.
- Anti-inflammatory painkillers – examples of these are ibuprofen (Brufen, Nurofen) and diclofenac (Voltarol). These work by reducing inflammation and can be used with other painkillers such as paracetamol and codeine. This type of painkiller is unsuitable for some people; the doctor will ask you some questions before it is prescribed.
• Weak opioids – codeine, tramadol (for mild to moderate pain).
• Strong opioids – morphine, oxycodone (for moderate to severe pain).
• Local anaesthetics – these work by making the area feel numb so that you don’t feel any pain.

A combination of the above painkillers may work better than taking one on its own. They must be taken at regular intervals to be most effective.

Your nurse can arrange for a pain nurse to visit you if you are having any particular problems with managing your pain.

**How painkillers can be given**

There are many ways we can treat your pain. The doctors and nurses will recommend the best pain treatment for you and may use one or more of the following methods.

**Orally**

This means taking painkillers by mouth. If you have difficulty in swallowing tablets some painkillers can be given as a liquid. Some tablets are better absorbed if they are dissolved under the tongue. You need to be able to drink and not feel sick in order to take painkillers by mouth. It may take up to 30 minutes for them to have an effect.

**Patient-controlled analgesia (PCA)**

This is where you, the patient, are in control of giving yourself a set amount of painkilling medicine to help control your pain. You will be given a handheld button which is connected to a computerised pump. The pump has a syringe containing the medicine and this is connected to a vein in your arm. You can press the button when you feel the pain coming on. The pump will then give you a dose of the painkilling medicine.
The anaesthetist, specialised pain nurse or ward nurse sets the pump. It will be programmed so you will not be able to give yourself too much medicine.

The nurses on the ward will check the pump and record your pain score every two hours. Sometimes you might feel sick. If this happens, your nurse can give you something to help relieve this.

If you are to have physiotherapy, get out of bed or do anything that may cause you pain, it is best to press the button ten minutes beforehand. You should then be more comfortable during the activity.

Local anaesthetic blocks

Local anaesthetic blocks are commonly used to manage pain after trauma or surgery to your arms, legs or chest. An injection of local anaesthetic is given to numb the nerves in the area where the pain is. These injections should give you relief for about eight hours after your operation. Sometimes the anaesthetist will want the block to last longer and will connect the local anaesthetic infusion to a pump. This will continue to give you painkiller over a set period of time.

Occasionally, the block may not work. If this happens we will give you some other form of painkiller.

Please remember, the block may make your limbs feel heavy and difficult to move. Some people also get pins and needles as the block wears off. This is nothing to worry about and the symptoms will wear off gradually.
TAP block (Transversus Abdominis Plane)

A TAP block is another method of giving pain relief to patients who have had abdominal surgery. In a TAP block the nerves to the abdomen are anaesthetised by injecting them with local anaesthetic. This can help to reduce the amount of painkillers you need after your operation. TAP blocks are injected during your surgery.

Occasionally, the block may not work. If this happens you will be given alternative painkillers.

Your anaesthetist will discuss a TAP block with you if they feel it would be appropriate for you.

Rectal analgesia

Sometimes you may be given a painkiller in the form of a suppository which is inserted into your back passage. Painkillers work very well when given by this method. It can take up to 20 minutes to work but the effect can last for a long period of time. It is very helpful when you cannot have medicines by mouth. It is not painful to have medicine this way and it will not cause diarrhoea.

Entonox (gas and air)

If you need to have a procedure that may be painful, such as a dressing change, then you may be offered the use of a pain relieving gas called Entonox. It is a powerful painkiller which acts very quickly, within 1-2 minutes. It wears off equally as quickly when you stop breathing the gas. Common side effects are sickness and drowsiness.

If you do experience pain during the night there are always nurses on the ward who can help with pain relief. The medicines you are given during the day to relieve your pain are also available at night. You must tell the nurse if you have pain so
they can help you feel more comfortable. This in turn will give you a better night’s sleep and aid your recovery.

**Epidurals**

The nerves from your spine to your lower body pass through an area in your back close to your spine called the “epidural space”.

Epidurals can be used during and/or after surgery for pain relief.

To give an epidural the anaesthetist injects local anaesthetic through a fine plastic tube (an epidural catheter) into the epidural space. As a result, the nerve messages are blocked. This causes numbness. The effect of this can vary depending on the amount of local anaesthetic injected.

An epidural pump allows local anaesthetic to be given continuously through the epidural catheter. Other pain relieving drugs can also be added in small quantities.

The amounts of drugs given are carefully controlled but you may be able to press a button to give a small extra dose from the pump. Your anaesthetist will set the pump to limit the dose which you can give, so overdose is extremely rare.

When the epidural is stopped full feeling will return, normally within 6 hours.
How is an epidural done?

Epidurals can be put in:

- when you are conscious (fully awake)
- when you are under sedation (when you have been given a drug which will make you drowsy and relaxed, but still conscious)
- during a general anaesthetic (when you have been given a drug to make you fully asleep).

These options can be discussed further with your anaesthetist.

1. A needle will be used to put a thin plastic tube (a cannula) into a vein in your hand or arm for giving fluids (a drip).

2. If you are conscious, you will be asked to sit up or lie on your side, bending forwards to curve your back. It is important to keep still while the epidural is put in.

3. Local anaesthetic is injected into a small area of the skin of your back.

4. A special epidural needle is pushed through this numb area and a fine plastic tube called a catheter is passed through the needle into your epidural space. The needle is then removed, leaving only the catheter in your back.
What will I feel?

• The local anaesthetic stings briefly, but usually means that the procedure is painless.
• It is common to feel slight discomfort in your back as the catheter is inserted.
• Occasionally, an electric shock-like sensation or pain occurs when the needle or catheter is inserted. **If this happens, you must tell your anaesthetist immediately.**
• A sensation of warmth and numbness gradually develops, like the sensation after a dental anaesthetic injection. You may still be able to feel touch, pressure and movement.
• Your legs will feel heavy and become increasingly difficult to move.
• You may only notice these effects for the first time when you recover consciousness after the operation, particularly if your epidural was put in when you were anaesthetised.
• Overall, most people do not find these sensations to be unpleasant, just a bit strange.
• The level of numbness and weakness gradually goes down over the first day after the operation.

What are the benefits of an epidural?

• If your epidural is working properly, you will have better pain relief than other methods, particularly when you move.
• There may be reduced complications of major surgery, e.g. nausea/vomiting, leg/lung blood clots, chest infections, blood transfusions, delayed bowel function. This is because you will be more able to move around, take deep breaths and cough freely.
• You may be able to return more quickly to eating, drinking and full movement, possibly with a shorter stay in hospital compared to other methods of pain relief.
If I have an epidural how do the nurses look after me on the ward?

- At regular intervals, the nurses will take your pulse and blood pressure and ask you about your pain and how you are feeling.
- They may adjust the epidural pump and treat side effects.
- They will check that the pump is working correctly. They will encourage you to move, eat and drink; according to the surgeon’s instructions.
- The Pain Relief Team doctors and nurses will also visit you, to check your epidural is working properly.

When will the epidural be stopped?

- The epidural will be stopped when you no longer need it for pain relief or after 4 days. After 4 days, the risk of infection increases and the benefit of having an epidural decreases.
- A few hours after the pump is stopped, the epidural catheter will be removed, as long as you are still comfortable.
- The epidural will be stopped and the catheter will be removed if it is not working properly. It may be possible to insert another epidural catheter if necessary.

Can anyone have an epidural?

No. An epidural may not always be possible if the risk of complications is too high. The anaesthetist will ask you if:

- you are taking blood thinning drugs, such as warfarin
- you have a blood clotting abnormality
- you have an allergy to local anaesthetics
- you have severe arthritis or deformity of the spine
- you have an infection in your back.
Side effects and complications of epidurals

All the side effects and complications described can occur without an epidural.

Side effects are secondary effects of a treatment. They occur commonly and may be unavoidable. Although they may be unpleasant (for example, feeling sick), they are not usually dangerous.

Complications are unwanted and unexpected events which are known to occur occasionally due to a treatment. Serious complications are rare or very rare.

Permanent nerve damage is a very rare, serious complication of having an epidural. It can also happen if you do not have an epidural. You can read more about this on the Royal College of Anaesthetists (RCoA) website. www.rcoa.ac.uk

The risk of complications should be balanced against the benefits of having the epidural and compared with alternative methods of pain relief. Your anaesthetist can help you do this.
Very common or common side effects and complications

**Inability to pass urine:** The epidural affects the nerves which supply the bladder so a catheter (tube) will usually be inserted to drain urine away. A catheter is often necessary after major surgery even if you do not have an epidural. It helps to keep a close check on your rate of urine production. If you have a working epidural you won’t be able to feel the catheter, which will normally be left in for a few days. Bladder function returns to normal after the epidural wears off.

**Low blood pressure:** The local anaesthetic affects the nerves going to your blood vessels, so blood pressure always drops a little. Fluids and/or drugs can be put into your drip to treat this. Low blood pressure is common after surgery, even without an epidural.

**Itching:** This can occur as a side effect of pain-relieving drugs which may be mixed with the local anaesthetic in your epidural. It can be treated with anti-allergy drugs.

**Feeling sick and vomiting:** These can be treated with anti-sickness drugs. These problems happen less often with an epidural than with most other methods of pain relief.

**Backache:** This is common after surgery, whether you have an epidural or not. It is not related to having an epidural. It may be caused by lying on a firm flat operating table.

**Inadequate pain relief:** Sometimes, it may be impossible to place the epidural catheter, the local anaesthetic may not spread adequately to cover the whole surgical area, or the catheter can fall out. Other methods of pain relief are available if your epidural fails.

**Headaches:** Minor headaches are common after surgery, with or without an epidural.
Occasionally a severe headache occurs after an epidural. This may be because the lining of the fluid filled space surrounding the spinal cord has been accidentally punctured. This is called a ‘dural tap’. The fluid leaks out and causes low pressure in the brain, particularly when you sit up. If this happens, it may be necessary to inject a small amount of your own blood into your epidural space. This is called an ‘epidural blood patch’. The blood clots and plugs the hole in the epidural lining. This will cure the headache in the majority of cases. For more information please see ‘Headache after an epidural or spinal anaesthetic’ on the Royal College of Anaesthetists (RCoA) website. http://www.rcoa.ac.uk/document-store/headache-after-epidural-or-spinal-anaesthetic

Uncommon complications

**Slow breathing:** Some drugs used in the epidural can cause slow breathing and/or drowsiness, requiring treatment.

**Catheter infection:** The epidural catheter can become infected and may have to be removed. Antibiotics may be necessary. It is very rare for the infection to spread any further than the insertion site in the skin.

Rare or very rare complications

Other complications, such as convulsions (fits), breathing difficulty and damage to nerves are rare. Permanent disabling nerve damage, epidural abscess (infection), epidural haematoma (blood clot) and cardiac arrest (stopping of the heart) are very rare indeed. In comparison, you are more likely to die from an accident on the roads or in your own home than suffer permanent damage from an epidural. These risks can be discussed further with your anaesthetist and more detailed information is available.
What if I decide not to have an epidural?

It is your choice. You do not have to have an epidural.

There are several alternative methods of pain relief that work well. You may be offered the machine which allows you to control your pain relief yourself (Patient Controlled Analgesia, or ‘PCA’).

There are also other ways in which local anaesthetics can be given and you may be able to take pain-relieving drugs by mouth.

Every effort will always be made to ensure you are comfortable.

Using your own pain relieving strategies

Many people use strategies at home to relieve pain. We have found that if you continue them in hospital it can help to reduce the amount of pain you experience. Our aim is to support you in using your strategies, as well as giving you information about other possible techniques. Please note that for safety reasons, heated pads are not allowed.

Mobilising (getting up and moving around)

This is part of rehabilitation in hospital. However, some people find that moving around can also help to reduce their pain. Unless there is a reason for you to stay in bed, please feel free to get up and move around. You may wish to ask the nurse or physiotherapist about how much you can do.
Positioning

If you have a special pillow or cushion that helps to relieve pain, please feel free to bring it into hospital. You should also check with the staff the suitability of any positions you usually find help to relieve pain.

Advice about leaving hospital

- Before you leave hospital the doctor will prescribe pain-relieving medicines if you still need them.
- The discharging nurse will advise you how and when to take your medicines.
- Always read the label for instructions on how to take the medicine and any precautions you need to know about.
- Store medicines safely out of reach of small children.
- Get rid of unwanted medicines safely and properly.
- Do not mix over the counter painkillers with medicines you have been prescribed while in hospital.
- Do not exceed the recommended dose stated on the packet.
- Please ask questions if you do not understand any instructions you have been given.
How do I ask further questions?

If you have any questions or concerns about the management of your pain while you are in hospital please talk to the nursing staff or your anaesthetist.

For those patients who have uncontrolled pain or complex pain related issues you may need to be referred to the Inpatient Pain Team.

If you have any further pain problems or a new type of pain when you have returned home, please talk to your own doctor.
Useful organisations

There is more information about anaesthetics and pain management on the website:

Royal College of Anaesthetists
Churchill House
35 Red Lion Square
London WC1R 4SG
Phone: 020 7092 1500
Fax: 020 7092 1730
e-mail: info@rcoa.ac.uk
Website: www.rcoa.ac.uk
The RCOA is responsible for the standards in anaesthesia, critical care and pain management throughout the UK.

Association of Anaesthetists of Great Britain and Ireland
21 Portland Place
London WC1B 1PY
Phone: (+44) 020 7631 1650
Fax: (+44) 020 7631 4352
E-mail: info@aagb.org
Website: www.aagbi.org
This organisation works to promote the development of anaesthesia and the welfare of anaesthetists and their patients in Great Britain and Ireland.
If you need an interpreter or need a document in another language, large print, Braille or audio version, please call 01865 221473 or email PALSJR@ouh.nhs.uk

Inpatient Pain Team
The epidural information is taken from “Epidurals for pain relief after surgery”, The Royal College of Anaesthetists and The Association of Anaesthetists of Great Britain and Ireland, May 2008, with their permission.
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