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CUSTOMER FOCUS
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PAIN RELIEF AFTER
GYNAECOLOGICAL SURGERY

EPIDURAL AND SPINAL ANAESTHESIA AND ANALGESIA

KING EDWARD MEMORIAL HOSPITAL
CENTRE FOR WOMEN'S HEALTH

KEEPING WOMEN WELL

Pain Relief after Gynaecological Surgery: Epidural and Spinal Anaesthesia & Analgesia

This information booklet is designed to explain more about the methods of postoperative epidural pain relief (epidural analgesia) and postoperative spinal analgesia, as they are used at King Edward after gynaecological surgery. **In all cases, you may choose these or any other method of pain relief after discussing the options with your anaesthetist.**

There will be some operations and some patients in whom a particular method will be strongly recommended by the anaesthetist, on the basis of their expert knowledge about what is either safest or of greatest benefit to you.

The following information provides answers to some commonly asked questions about pain and pain relief.

Q. How much pain should I expect after my operation?

Postoperative pain varies widely between different patients, both in how severe it is and how long it lasts. The amount of pain relief needed also varies widely. In general, after operations like laparoscopic hysterectomy, vaginal repair or vaginal hysterectomy the stronger pain-relieving drugs are needed for the first day or two (e.g. morphine or similar narcotic drugs, or local anaesthetic drugs); after abdominal operations like hysterectomy these drugs may be needed for two to four days, and after more major abdominal operations, such as for cancer surgery, for three to seven days.

As we now have improved methods of pain relief readily available, like patient-controlled intravenous analgesia and epidural analgesia, we rarely need to use intramuscular injections of pain-killers in the early stages of recovery from an operation.

Q. What are the advantages of epidural analgesia (EA)?

The biggest advantages of epidural analgesia over other methods are,

- the usually excellent levels of pain relief, which may allow some patients to be discharged from hospital earlier than if another method is used.
- that your pain is likely to be minimal or none at all while you are resting, although you may have some pain when you move or cough.
- that it allows you to move and walk with greater comfort.
- you are less likely to feel very drowsy.
- you will feel better and recover faster after the operation if you are able to avoid a general anaesthetic.
- your bowels return to normal functioning more quickly
- the small risk of developing certain post-surgery complications is reduced even further.

Although nausea and sickness can be a problem whatever pain relief method is used, the hospital protocols are designed to ensure you will be treated quickly and effectively if you are nauseated or sick.

It is expected that the epidural pain relief may need to be adjusted according to your needs, and the nurses in the hospital are trained to do this for you. If any further advice is needed, the anaesthetist on duty in the hospital will be called to help with your care. Occasionally, epidural relief proves unsatisfactory or the epidural catheter dislodges, and your pain relief will then be changed to another method.

If you do need, or decide to choose, a general anaesthetic, combining it with an epidural still provides important advantages after major surgery. The likelihood that you will need ventilation in an Intensive Care Unit is reduced as is the probability of post-surgery infection. Epidurals reduce the risk of heart attack in patients with angina, and the risk of pneumonia and lung problems in the very overweight or in those with lung disease (e.g. severe asthma, bronchitis or emphysema). It is also possible that patients who are seriously ill may have a better chance of surviving their surgery when an epidural is used, and studies are continuing to find out if this is true.

Q. How and when is an epidural put in?

This is the usual procedure for putting in an epidural:

1. When you arrive in theatre, and before you receive a general anaesthetic if you are having one as well, the anaesthetist will insert an intravenous cannula or 'drip' in your arm or the back of your hand. If you wish you can be given tablets (a 'premed') and/or drugs into your 'drip', to help you relax while the epidural is being placed.
2. A nurse will help you sit up or lie curled up on your side.

3. The anaesthetist will wash your back with antiseptic, cover it with a clean towel and numb the skin at the injection site with local anaesthetic (this may sting for a few seconds). *If you are very worried about this sting, please tell the anaesthetist when you are first visited on the ward and agree to the epidural, because it may be possible to place local anaesthetic cream on the spot before you leave the ward to go to theatre.*

4. You will feel a pressure or ache in your back as the epidural needle is inserted. There is usually little discomfort, but if you do find this painful, tell the anaesthetist. **It is important to stay in the same position and to not make sudden movements.** You may feel a twinge or ache in your back, bottom, hip or leg at some stage. This is normal and not dangerous - try to remain still.

5. After removing the needle, the epidural catheter (a very narrow tube) is taped onto your back, and local anaesthetic and other pain-relieving drugs injected into the catheter to start the anaesthetic.

Many operations, including vaginal surgery and abdominal hysterectomy, can be done under an epidural, spinal or combined spinal-epidural anaesthetic, without a general anaesthetic.

You may stay awake (and listen to music!), but most patients prefer to receive drugs in their 'drip' which allow them to doze throughout the operation. These drugs often make you forgetful for a short time, so that the next day you may not remember much at all about your trip to theatre. If you are having general anaesthesia as well, this will be commenced after you have been moved onto the operating table.

After the operation, you are likely to have heavy, numb legs for a couple of hours. Once normal strength and feeling has returned, you will be able to move well in comfort, and the next day the nursing staff will help you to get out of bed, shower and walk about. It is normal to feel dizzy when you first sit or get up, so take it slowly and do not try and get up without calling a nurse first.

Q. What is a spinal anaesthetic and postoperative spinal analgesia?

A spinal anaesthetic is similar to an epidural, but works more rapidly. It is a very reliable anaesthetic for many gynaecological operations, allowing the surgery to be done without you feeling anything and without using a general anaesthetic. It involves a single injection into the back through a very thin needle, but no catheter is left in place.

Although, by itself, a spinal is not as suitable as an epidural if you are likely to need several days of strong pain relief, it is possible to get many hours of excellent pain relief. This is achieved by injecting various pain-relieving drugs as well as local anaesthetic, and using additional suppositories or an occasional intramuscular injection of narcotic. This method may be suitable for some operations (for example bladder neck elevation or vaginal surgery), where tablet and suppository pain-relieving drugs work well by the second day. More commonly, spinal anaesthesia is combined with insertion of an epidural catheter in a single injection (this is called combined spinal-epidural anaesthesia), allowing prolonged pain relief if required. The insertion, side effects and complications of spinal anaesthesia and analgesia are similar to those of epidurals (see above and below).

Q. How are epidural pain-relieving drugs given after the operation?

The most common method is an epidural infusion. This uses a pump to trickle in solution continuously. The rate of the infusion can be changed to suit your needs and extra doses given by trained nurses when necessary.

An alternative suitable for some operations and patients is the use of patient-controlled analgesia. This allows you to press a button or plunger and safely give yourself doses of epidural solution to keep the pain controlled.

The third approach is for the nursing staff to give doses when needed. This is often used after the first day or two, when your pain is less and you are more active.

If it appears you no longer need epidural pain relief, the nurses can check that you are OK with tablet and suppository pain-killers only, and then remove the epidural catheter. Removing the epidural is easy and does not hurt.

Q. What other effects might epidural analgesia have on how I feel?

Other effects of epidural analgesia include,

- Lower blood pressure. In general this is an advantage, and as part of your normal postoperative care your blood pressure is always checked regularly.

  However, if for any reason the nursing or medical staff consider your blood pressure is too low, it will be increased using intravenous fluids and drugs.

- Itchiness (usually on the body) is a relatively common side effect which is not often bothersome. If it worries you, there are drugs which can be given to reduce or stop it.
- Tingling or mild numbness in your legs when you first wake up. You should tell the nurses if you find that heaviness in your legs does not go away after several hours. This is usually due to the local anaesthetic in the epidural solution, and the solution can be changed so that your normal strength returns.
- Mild tenderness from bruising at the epidural site is common but there is no long-term effect on your back.
- An infection in the skin where the epidural enters the back may develop in a small number of patients after a couple of days, and the epidural must then be removed. Sometimes a course of antibiotics will also be required.

Q. What are the complications of epidural analgesia?

A 'dural tap' is a complication of an epidural which arises if the epidural needle is inserted slightly deeper than planned. This occurs in about 1 in 200 patients at KEMH. It rarely causes any problem, except that you may develop a headache a day or two later. If it is a bad headache, the anaesthetist will talk to you about the various ways of relieving it.

Numbness in the chest and arms, affecting breathing, can occur, as can depression of breathing from the narcotic drugs in the epidural solution. Both can be detected by careful nursing care and monitoring long before they become a serious problem, and are then easily treated.

Serious complications from epidurals are very uncommon. The anaesthetists and the nurses in the hospital are trained to recognise and treat any problems, so that patients do not come to any harm.

Damage to a nerve from epidural use is possible but very unlikely (about 1 in 10,000 cases). If a nerve is injured, most commonly an area of skin becomes numb, but usually recovers with time. Although your spinal cord is not in danger from the needle insertion, the use of any type of anaesthesia, whether a general anaesthetic or epidural, carries some risks and there have been rare cases of complications including paralysis, brain damage, or death. The risk of this is very small, probably less than 1 in 100,000.

In 25 years of epidural and spinal use at KEMH (over 35,000 patients), no patient has died or come to serious permanent harm.

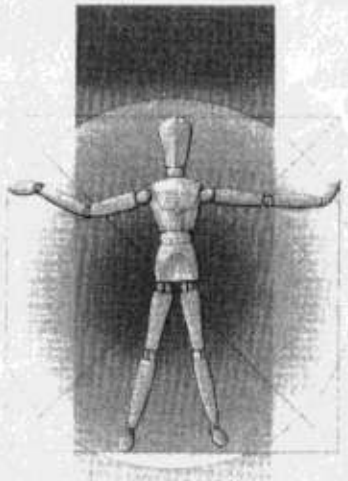
Q. What decision should I make about my pain relief?

Your anaesthetist will be happy to discuss all your options with you in detail, and answer all your questions.

Epidural analgesia is a highly effective way of relieving pain after surgery. If you are particularly worried about how much pain you might have, epidural analgesia is recommended. It may also have other potential advantages with respect to recovery from your operation, especially if you have medical problems or are having a major operation.

Epidural or spinal anaesthesia, or both, can be used without general anaesthesia for many gynaecological operations, thus avoiding the side effects and risks of a general anaesthetic. Alternatively, it is safe to combine an epidural with a general anaesthetic.

There are other good methods of pain relief which can be used after a general anaesthetic, and the risks of an epidural need to be considered when you make a decision about your anaesthetic and pain relief. Remember, though, that the anaesthetists and nurses here at King Edward Memorial Hospital are very skilled and experienced in epidural and spinal anaesthesia and analgesia, and that the more serious complications of these methods are rare. There are also serious risks associated with both the operation and with general anaesthesia, but we are lucky that the standard of surgical, anaesthetic and nursing care in Australia is second to none.



Pain Relief -
a Basic Human Right