

VII: Perioperative Care

24. Perioperative Analgesia in Major Oncology operations for the prolepsis of persistence of Chronic Neuropathic Pain

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Abstract: Perioperative Analgesia in Major Oncology operations for the prolepsis of persistence of Chronic Neuropathic Pain might include intravenous infusion of analgesics, concomitant drugs as well as invasive techniques in all surgical stages. Achieving highly effective analgesia presupposes the interdisciplinary collaboration of the surgeon and the anesthesiologist with the patient.

Purpose: To give prominence to the benefits of analgetics for the oncology patient undergoing surgery after having received appropriate perioperative treatment and starts analgesic protection from the time preceding surgical incision to the patient's complete recovery, as far as prevention of chronic neuropathic pain is concerned.

Materials & methods: Thorough review of scientific literature in scientific databases (PubMed, Scopus, hesmo.org, uicc.org, Signa Vitae) which are consistent with the way our department functions and in compliance with the protocols concerning the prolepsis of persistence of Chronic Neuropathic Pain in major oncology operation patients.

Results: Major analgesic outcomes and avoidance of persistence of chronic neuropathic pain, by taking into consideration the fact that postoperative oncology patients suffer from respiratory depression after invasive analgesia techniques. Also, we are prepared to reduce the use of opioids and their adverse effects, following the procedure below: (1) Choose, when allowed, a combination of general and epidural anesthesia to achieve maximum intraoperative and postoperative analgesia. (2) Intravenous administration of non-steroidal anti-inflammatories, paracetamol, dexamethasone 8mg, NMDA receptor antagonist (Ketamine 30 mg) before incision as well as local infusion of Ropivacaine 2% solution. (3) Intravenous infusion of lidocaine, fentanyl, remifentanyl, morphine, tramadol, Mg, ketamine, during surgery by adjusting doses per patient and operative time. (4) Particular caution is suggested in the immediate postoperative period so as to avoid transition from acute postoperative pain to chronic neuropathic pain. Continue drop by drop administration of ropivacaine 2% from epidural catheter. Our armamentarium includes paracetamol, tramadol, dexketoprofen, oxycodone per os, PCA morphine, pain busters (paired drainage catheters with elastomeric pumps) of ropivacaine 2%, patch lidocaine and block nerve conduction. A medical record of the postoperative analgesic course of our patients is kept and completed by our medical and nursing staff.

Conclusions: Perioperative analgesia is our key concern in all oncology patients undergoing major surgeries, so as to prevent persistence of chronic neuropathic pain, taking into consideration the impaired health status of patients with acute pain conditions.