SURGICAL PAIN CONSORTIUM™

The Best Practices for the Management of Surgical Pain

Management of Pain After Elective Laparoscopic Bariatric Surgery

STRATEGIC ADVISORY GROUP

The Advisory Group members of the Surgical Pain Consortium are key thought leaders that represent the specialties of anesthesiology, surgery, pharmacy, nurses, and management. Members are added as the scope of The Surgical Pain Consortium's efforts grow.

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The Best Practices for the Management of Surgical Pain

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Management of Pain After Elective Laparoscopic Bariatric Surgery

PREOPERATIVE

- Acetaminophen 1.5 gm, po, 2 h prior to surgery
- Celecoxib 400 mg, po, 2 h prior to surgery

INTRAOPERATIVE

- Acetaminophen 1 gm, IV (if not given preoperatively)
- Dexamethasone 8 mg, IV after induction of anesthesia (if no contraindications)
- Ketorolac 30 mg, IV at the end of surgery (if no contraindications, and celecoxib not given preoperative)
- Port site infiltration
- Intraperitoneal instillation of bupivacaine or ropivacaine may be considered if basic analgesic technique (acetaminophen + NSAIDs + surgical site infiltration) is not possible
- Field blocks performed by the surgeon using high volume of local anesthetic solution

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SURGICAL TECHNIQUE

- Mini-port (≤ 5 mm), costs and complications, need to be taken into consideration)
- Low intra-abdominal pressure (<12 mmHg)
- Saline lavage under the diaphragm followed by suction at the end of surgery
- Deliberate aspiration of pneumoperitoneum under direct vision
  - Open the port and press the abdomen. Could use the suction irrigator placed under the diaphragm.
  - If suction is attached to the trocar, it could suck omentum or bowel into the trocar.

POSTOPERATIVE

- Acetaminophen 1 gm, po 6-8 h, scheduled
- Conventional NSAIDs (e.g., meloxicam 15 mg, po, once a day) or COX-2-selective inhibitors (celecoxib 200 mg, twice a day), if no contraindications
- For rescue pain relief: Oxycodone IR 10 mg po TID PRN. If unable to take oxycodone use tramadol 50 mg QID, prn

These recommendations are not intended to supersede clinical judgment or individual patient choices or values. Ultimately, clinical decision-making must always be customized to the individual situation.