SURGICAL PAIN CONSORTIUM

The Best Practices for the Management of Surgical Pain

PAIN MANAGEMENT FOR ELECTIVE MAJOR BREAST SURGERY

Preoperative

- Gabapentin 300-600 mg, po 2 h, preoperatively
- Celecoxib 400 mg, po 2 h, preoperatively
- Local/Regional Analgesia Technique Options
  - o Paravertebral analgesia – continuous local anesthetic infusion
  - o PECS 1 and 2 blocks

Intraoperative

- Minimize intraoperative opioid dose
- Dexamethasone 8mg, IV
- Acetaminophen 1gm, IV, if not available 1.5 gm, po 2 h, preoperatively (if not receiving epidural analgesia)
- Local/Regional Analgesia Technique
  - o PECS 1 and 2 blocks by the surgeon, if not performed preoperatively or surgical site infiltration prior to closure
- If patient is opioid tolerant: ketamine infusion (0.25 mg/kg bolus followed by infusion 0.1-0.2 mg/kg/h discontinued approximately an hour before end of surgery)
- Lidocaine infusion as an alternative to regional analgesia (bolus 1.5 mg/kg followed by infusion 1.5 mg/kg/h start after induction of anesthesia and continue until the end of surgery or until discharge from the recovery room)

Postoperative

- If no paravertebral analgesia, IV-PCA morphine/hydromorphone, discontinue IV-PCA as soon as patient can tolerate oral analgesics
- Acetaminophen 1 gm, po q 6h scheduled
- Non-steroidal anti-inflammatory drug (e.g., meloxicam 15 mg, po once a day) or cyclooxygenase-2 specific inhibitor (celecoxib 200 mg, po, BID), scheduled, if no contraindication
- Gabapentin until discharge: 300mg po TID if creatinine clearance [CrCl] >60mL/min, 300mg po BID if CrCl 30-60mL/min, and 300mg po daily if CrCl <30mL/min
- For rescue pain relief: Oxycodone IR 10 mg po TID PRN. If unable to take oxycodone use tramadol 50 mg QID, prn, if necessary

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.