SURGICAL PAIN CONSORTIUM

The Best Practices for the Management of Surgical Pain

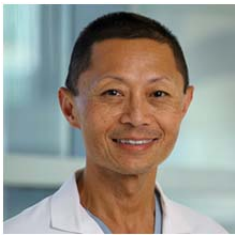
TOTAL HIP ARTHROPLASTY

MULTIMODAL PAIN MANAGEMENT RECOMMENDATION

THE 2015 SPC HIP WORKING GROUP

John W. Barrington, MD
Orthopedic Surgeon
Plano Orthopedic Sports Medicine & Spine Center
Plano, TX 75093
Role: Surgical Group Leader

Roger H. Emerson, MD
Orthopedic Surgeon
Texas Center for Joint Replacement
Plano, TX 75093
Role: Surgical Group Leader



Michael Huo, MD
Professor, Orthopedic Surgeon & Joint Replacement Specialist
University of Texas Southwestern Medical School
Dallas, TX 76039
Role: Surgical Pain Advisor

Alexander Sah, MD
Orthopedic Surgeon
Dearborn-Sah, Institute for Joint Restoration
Fremont, CA 94538
Role: Surgical Pain Advisor

Girish P. Joshi, MBBS, MD, FFARCSI
Professor of Anesthesiology and Pain Management,
University of Texas Southwestern Medical Center,
Dallas, TX 75390
Role: Surgical Pain Advisor

Preoperative

- Patients who are on chronic opioid medications should be left on their medications, yet the exact dosing strategy is controversial.
- Gabapentin 600 mg, PO or pregabalin 50-75 mg, PO 2-3 hours preoperatively
  - o Consider giving 300mg, PO gabapentin the night prior to surgery in addition to 600mg. PO gabapentin day of surgery.
- Celecoxib 400 mg, PO 2-3 hours preoperatively (if on celecoxib regimen, continue same dose)
- For patients who are on non-specific NSAIDs, recommend changing patient to a COX-2 specific inhibitor prior to surgery.
- Consider oxycodone CR 10mg, PO, if no contraindications [alternatively Tramadol ER 200 mg, PO]

Intraoperative

General or Spinal anesthesia

- Dexamethasone 8 mg IV after induction of anesthesia
- Acetaminophen 1 g IV
- Ondansetron 4 mg IV at the end of case
- Intravenous NSAID (only if an NSAID or celecoxib was not given preoperatively)
- Tranexamic Acid (TXA) 1 g at induction of anesthesia and 1 gm at the end of surgery
- At the end of surgery, surgeon should perform periarticular infiltration, please refer to Joshi GP, Cushner FD, Barrington JW, Lombardi AV, Springer BD, Stulberg BN. Techniques for periarticular infiltration with liposomal bupivacaine for the management of pain after hip and knee arthroplasty: a consensus recommendation. *J Surg Ortho Adv* 2015; 24: 27-35.

Postoperative

Immediate Postoperative:

- Acetaminophen 1 gm IV q 8 hours (until able to take PO), IV may be repeated after 4 h, if necessary
- Celecoxib 200 mg, PO BID OR a traditional NSAID (i.e., ibuprofen, naproxen or meloxicam)
- Gabapentin 300 mg PO TID / pregabalin 50-75 mg BID until discharge
  - o Doses should be modified according to creatinine clearance [CrCl]
- IV bolus opioids or oral opioids for breakthrough (rescue) pain relief

Postoperative in Hospital and Post-discharge (one-two weeks):

- Acetaminophen 1 gm, PO q 8 hours
- Celecoxib 200 mg, PO BID OR a traditional NSAID (i.e., ibuprofen, naproxen or meloxicam)
- Tramadol or or Opioids (hydrocodone/acetaminophen) for rescue (caution acetaminophen dose should not exceed 4 gm/day)

These recommendations should be utilized as a foundational resource for perioperative pain management. The attending physician should make appropriate modifications based on their expertise on a patient-to-patient basis.