LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

Discharge Medication for Enhanced Recovery Patients Following Primary Hip and Knee Arthroplasty

Introduction

This summary provides recommendations primarily on the provision of discharge medication for patients who have undergone hip or knee replacement as part of the enhanced recovery process.

Pain management is an important aspect of the enhanced recovery process. Provision of analgesic medication on discharge is one element of the overall enhanced recovery pathway following hip and knee arthroplasty.
NB: Refer to relevant Trust guidelines for details of the overall enhanced recovery process in hip and knee arthroscopy.

Background

Strong opioids are recommended in combination with non-opioid analgesia for managing high intensity pain immediately following total hip and knee replacement (THR, TKR).

Oxycodone is a semi-synthetic opioid with effects similar to morphine. It may be used in certain circumstances as an alternative to morphine for severe pain at step three on the WHO analgesic ladder.

Oxycodone MR (modified release) is currently used as part of the enhanced recovery process following hip and knee arthroplasty at the Luton and Dunstable Hospital. Oxycodone MR is a controlled release formulation. Immediate release (IR) capsules are also prescribed on a p.r.n. basis for breakthrough pain.

If the patient has previous sensitivities or allergies to oxycodone, prescribers should consider using Modified Release Morphine (e.g. MST®) and Immediate Release Morphine (e.g. Oramorph®) instead.

Developed by Enhanced Recovery Team in conjunction with Pharmacy Department June 2016 .
Approved by the Bedfordshire & Luton Joint Prescribing Committee (JPC) Nov 2016
Review Date: June 2018

Patients on long standing opioid therapy for chronic pain

Patients on admission, who take strong opioids for long standing pain (e.g. Fentanyl patches, Oxycodone MR, MST®, Zomorph®), ***should not*** be switched to alternative preparations except in exceptional clinical circumstances. Contact the pain service for advice.

- The patient should continue regular strong opioid during the intra-operative and post-operative period. This should be highlighted at pre-operative assessment and a pain management plan should be documented.
- Such patients should ***not*** be managed according to the standard enhanced recovery analgesic guideline. Patients should continue on their normal opioid dose and receive Patient Controlled Analgesia (PCA) until the morning after surgery.
- Following cessation of PCA the strong opioid dose may need adjusting to account for acute, post-operative pain. After the immediate post-operative period, responsibility for pain management would revert back the patient's GP following discharge.

On admission, patients may be prescribed gabapentin (stat dose) by an anaesthetist pre-operatively as part of the enhanced recovery process (unlicensed).

On the day of surgery, patients on enhanced recovery will most likely have been prescribed:

Regular Medication

- Oral paracetamol 1gram every 6 hours.
- Oxycodone MR 10 mg every 12 hours starting on the evening of surgery (taking into consideration patient co-morbidities, previous sensitivities, renal function - reduced dose if necessary). NB: Morphine is an alternative first line option.
- Omeprazole 20mg once daily whilst taking NSAID (if GI bleeding risk).
- Gabapentin (Unlicensed) 300mg TDS OR 100mg TDS if > 75years or impaired renal function (for 3 days). **Omit if severe renal impairment (CrCl < 10mL/min).**
- Ibuprofen 400mg tds (If NSAIDS tolerant – i.e. no recent history of NSAID induced asthma, GI problems; renal impairment or heart failure). Max 5 days.

As Required (p.r.n.) Medication

- Oxycodone IR (immediate release, liquid for in-patients) 5-10 mg every 2- 4 hours (starting at lower dose and frequency, and titrating upwards if necessary).
- Movicol 1-2 sachets as required.

If pain is well controlled, the dose of strong opioid (e.g. oxycodone MR *and* oxycodone IR p.r.n.) will be reduced during inpatient stay.

Developed by Enhanced Recovery Team in conjunction with Pharmacy Department June 2016 .
Approved by the Bedfordshire & Luton Joint Prescribing Committee (JPC) Nov 2016
Review Date: June 2018

Discharge Medication (Optimised for the Patient):

- Strong opioid for a maximum of up to 5 days post operatively e.g.
    - Oxycodone MR tablets 10 mg every 12 hours (reduced dose if necessary)
        - Supply enough to complete 5 day course.

      (Dose will have been reduced earlier if pain well controlled).
    - Oxycodone IR (immediate release capsules) 5-10 mg every 4 hours prn. Supply 28 x 5mg capsules (specify in words and figures)
- Movicol 1-2 sachets daily p.r.n. (for opioid induced constipation)
- Paracetamol 1g up to four times a day
- Gabapentin 300mg TDS OR 100mg TDS if > 75years or impaired renal function to complete 3 day course. **Omit if severe renal impairment (CrCl < 10mL/min).**
- Ibuprofen 400mg up to three times a day to complete 5 day course. (If NSAIDS tolerant – i.e. no recent history of NSAID induced asthma, GI problems; renal impairment or heart failure).
- Omeprazole 20mg once daily to complete 5 day NSAID course.

Follow-up Care:
Patients will be provided with an information leaflet on the management of post-operative pain and will be followed up by the Hospital at Home team until clips are removed around day 14. Pain management will be assessed and reviewed by this team and also by the Enhanced Recovery Team (by post-discharge phone call) during this 14 day post-operative period. Analgesia will be 'stepped-down' during this time and all analgesia will provided by the hospital. Strong opioids should not be required for ongoing prescribing by GP's.

Contact Details
For any queries during this 14 day post-operative period contact:

Enhanced Recovery Team on 01582 718169.
OR
Hospital @ Home surgical team on 07534960143 (answerphone if with patient, but will call back).

Developed by Enhanced Recovery Team in conjunction with Pharmacy Department June 2016 .
Approved by the Bedfordshire & Luton Joint Prescribing Committee (JPC) Nov 2016
Review Date: June 2018