

EDITORIAL

Requirement of Pain Services

Technically the role of an anaesthesiologist has been to help relieve pain in order to facilitate surgical procedure. Traditionally and more commonly this is done when patient is asleep (anaesthetised). Why not to alleviate pain when the patient is awake?

I fully agree with the article of the editor, Lt. Col. Tariq Hayat Khan in the last issue of "Anaesthesia, Pain and Intensive care" journal, that our hospitals should be equipped with indoor and outdoor pain service. Some authorities dislike the word 'clinic', such as diabetic clinic, vascular clinic, liver clinic etc. so we suggest that the word 'Pain Service' should be used instead of 'Pain Clinic', particularly in military hospitals. The word 'pain clinic' and similar other clinics are being used and will continue to be used in the civil hospitals. In the military hospitals anaesthetists should run a pain service for the benefit of the ailing humanity. The suffering must be reduced to the minimum level by the combined efforts of all specialties. In the developed world, anaesthesiologists get special training in the subject of pain, and are responsible to run pain services in major hospitals. The anaesthesiologists in our country are similarly trained in pain. In fact pain is included in the curriculum for the postgraduate examinations of anaesthesiology by College of Physicians & Surgeons of Pakistan, hence our anaesthesiologists should not be kept away from the opportunity to practice pain. Let them show their skill out side the operation theatre too.

Despite the newness of this concept and the paucity of resources, pain service may be established very conveniently and at the minimum possible cost in our hospitals, if the aims, scopes and the level are predetermined and the available resources fully explored and utilized. Pain service may comprise of both indoor and outdoor services for the patients.

Indoor services can be provided to trauma patients, postoperative and cancer patients. Some painful conditions like sciatica, facial neuralgia etc may need hospital admission, for which beds may be allocated to the pain service specialist or the patients may be admitted in either the medical or surgical ward at the specialist's discretion

As far as the outdoor service is concerned, pre-anaesthesia clinics are already functional in all good hospitals of our country and these should be utilized

fully without any additional cost being incurred. Thus making full use of expertise of the anaesthesiologist to its maximum potential and avoiding setting up a separate pain service to treat patients with intra-operative, post operative, traumatic, obstetric, chronic and cancer pain is very much possible. Using intrathecal opioids can also treat Intractable, chronic, non-malignant pain e.g., ischaemic pain, back pain or intractable angina.

None of the currently available opioids is completely safe. However, extensive international experience has shown that patients can receive spinal opioids for post-operative analgesia on regular rounds to the wards by the anaesthesiologist, provided that trained personnel and appropriate guidelines are available. The importance of a good acute pain service to provide the safe and effective use of spinal opioids cannot be overemphasized.

Multi modal analgesia is a new concept in pain management and this refers to a combination of various analgesia modalities in postoperative pain management. It results in better analgesia with a concomitant reduction in adverse effects, which in turn allows faster recovery and earlier hospital discharge. Different modalities used are pre-emptive analgesia with local anaesthetic, wound infiltration and peritoneal instillation of local anaesthetic.

In the past, patients were often told that nothing more could be done. Now it has become a routine for the general practitioners or consultants to refer patients with chronic pain to a specialist pain clinic for assessment and possible management of the pain; and for help and advice in living a better life inspite of the pain.

Multi disciplinary pain clinics have teams of doctors, psychologists, nurses, physiotherapists, occupational therapists and others. They may run pain management group programs that aim to teach a group of patients with similar problems, about pain, how best to cope with it and how to live a more active life. Some clinics may offer acupuncture and other complimentary therapies.

Thus in the end I will once again stress that we need to make a beginning at setting up specialist pain clinics in our hospitals and involving more and more health personnel in the management and alleviation of

pain. One may be fearful of pain, but he must not be afraid of pain service.

Persistent, unrelenting pain prevents people from working and carrying out their normal pattern of life. It has a terrible impact on the person, his family and society in general. Now let us all join hands to combat pain. Let us all bequeath a heritage of relief and pleasure to aching humanity.

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QUICK ACTION PLANS

Massive Blood Transfusion

DEFINITION

Depends upon:

1. Rate-- administration of 10% of blood volume in less than 10 mins (i.e. > 1 unit every 10 mins in an adult)
2. Volume-- acute replacement of half initial blood volume.

PREPARATION IF MASSIVE TRANSFUSION EXPECTED

1. 2 x 14\16G iv access sites.
2. Facility to:
 - a) warm blood and fluids
 - b) administer fluid under pressure.
 - c) measure suction loss/weigh swabs.
3. Standard GA monitoring
Also consider:
 - a) CVP
 - b) arterial monitors for BP and gases.
 - c) urinary catheter.
4. Consider possibility of hemodilution and / or 'Cell saving'.

INTRAOPERATIVE MANAGEMENT

1. After 8 units of blood, when further transfusion likely, send blood sample for FBC, coagulation profile, U&E, Ca²⁺. If significant delay in receiving result is likely, and microvascular bleeding is a problem give 4 units FFP at this stage. Aim to correct INR to <1.8 with FFP. Cryoprecipitate may be required to correct low fibrinogen; aim 0.5-1g/L. Platelet transfusion is likely if >15 unit transfusion is required, aim >100x10⁹/L. Use of clotting factors should ideally be delayed until torrential bleeding is stopped surgically.
2. Repeat blood tests and arterial gases every hr (or more frequently if concerned) if rapid transfusion continuing.
3. If using plasma reduced red cells or red cells with optimal additive (SAGM), give 500ml colloid (e.g Haemaccel) per 2 units of blood. If more than 50% blood volume replacement, consider using 4.5% Human Albumin Solution if available.
4. Check acid-base status regularly, if possible, and consider correcting base deficit greater than 10mmol/L or pH<7.2 with 50mmol boluses of sodium bicarbonate.