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Editorial Open Access

"Postoperative Pain Control in Patients Already on Intraspinal Drug Delivery for Chronic Pain": A Revisit of the Still Ignored Dilemma

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The introduction of intrathecal opioids has been considered one of the most important breakthroughs in pain management in the past three decades. By infusing a small amount of opioid analgesics into the cerebrospinal fluid in close proximity to the receptor sites in the spinal cord, profound analgesia may be achieved while sparing some of the side effects caused by high dose systemic opioids. Intraspinal drug delivery (IDD) has been increasingly utilized since 1980's, initially in patients with cancer pain, and subsequently in patients with chronic, intractable non-malignant pain. Along with this significantly increased utilization of IDD for severe nonmalignant pain, the subpopulation of patients with implantable Intraspinal infusion pumps has increased substantially.

However, there have not been any guidelines, recommendations, or even consensus statements from all major pain societies either within or outside US, pertaining to the utilization of opioids for postoperative pain control when these patients need to go through surgical procedures such as hip or knee replacement etc. The previous outcry (2007) in attempt to bring about a consensus opinion in helping dealing with these difficult situations was unfortunately ignored [1].

The same old questions are: When patients who are on intrathecal opioid infusion for chronic pain go for surgical procedures such as hip replacement or knee replacement, etc., what should be done with their intrathecal opioid regimen? Do we go up, come down, continue, or discontinue their routine intrathecal opioid infusion before surgery? What should we do for their postoperative pain afterwards? Can we still use routine modalities such as intravenous patient-controlled analgesia (IV PCA) or epidural analgesia in such patients for their postoperative pain control? Can we use additional intrathecal opioid for postoperative pain control since the patients already have intrathecal catheters implanted?

One clinical approach has been: keeping the intrathecal opioid infusion the same pre- and post- surgery, while utilizing IV opioid PCA for post operative pain [1]. Over the past 7-8 years, over 60 patients, while on the same routine intrathecal opioid infusion regimen for chronic non-malignant pain, underwent surgical procedures such as lumbar fusion, cervical fusion, total hip replacement, total knee replacement, etc, and received IV opioid PCA (morphine, hydromorphone) for post operative pain, without encountering any complications or side effects of opioid overdose. (Personal observation) This approach has also been utilized by some other interventional pain specialists who manage chronic pain patients on IDD therapies. (Dr. J. Patrick Couch, Dr. Tao Chen, personal communications) It seems reasonable to assume that the routine intrathecal infusion satisfies the opioid requirement for the chronic pain component, while the IV opioid PCA meets the additional opioid requirement for acute postoperative pain due to surgery.

In late 2008, Grider et al [2] reported their experience of successful perioperative pain control in 3 patients on routine IDD for chronic pain, while using IV PCA opioids for perioperative pain

To the best of my knowledge, there has been no other literature besides the above two references [1,2] address such situations. Interestingly, both of the above reports concurred on maintaining same IDD infusion dose for chronic pain while initiating IV PCA opioid for acute postoperative pain. However, this conclusion obviously should not be interpreted as "standards of care".

The lack of literature, guidelines, recommendations, or consensus statements have resulted in physicians including pain specialists, anesthesiologists, and surgeons having little clues when dealing with these special situations. This is especially important from medical-legal standpoint, as complication/adverse effects do happen, even if good medicine is practiced.

Obviously, further research work and team effort in formulating some practical guidelines are in dire need, to help our patients and ourselves. The purpose of this editorial is, hopefully, to bring about some overdue attention and some research effort to help us tackle this increasingly encountered but "neglected" dilemma.

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