CLINICAL GUIDELINE

Colorectal Enhanced Recovery After Surgery, RAH

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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	Enhanced Recovery After Surgery (ERAS) Colorectal Post-Operative Analgesia	Review Date	October 2027
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Aim of Guideline

Enhanced Recovery After Surgery (ERAS) for colorectal patients to provide adequate pain relief with minimum side effects to promote early mobility and return of bowel function

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The following are suggested guidelines for patients on the ERAS programme

Laparoscopic Abdominal Surgery

- Account should be taken of the individual analgesic requirements of each patient
- Consideration should be taken for the use of an abdominal wall local anaesthetic block such as an extra-peritoneal block performed by the surgeon or an ultrasound guided transversus abdominal plane (TAP) block.

60ml of levo-bupivacaine 0.25% is an appropriate local anaesthetic (maximum dose of 2mg/kg)

- Regular and PRN oral oxycodone (shortec)/morphine is the preferred method of analgesia for patients on the ERAS pathway. Note that the patient may have received intra-operative spinal opioid in which case the patient should be admitted to HDU post-operatively and my not require regular opioids
- Patient Controlled Analgesia (PCA) with either morphine or oxycodone or subcutaneous oxycodone/morphine can be used as an alternative
- All patients should have an anti-emetic prescribed
- Ibuprofen/naproxen may be prescribed at the discretion of the medical team
- Analgesic requirements should be reviewed at least once daily
- The risk of nausea and vomiting, the presence of paralytic ileus and the resumption of oral fluids and diet are also factors to consider with regard to the use of oral analgesia

Open Abdominal Surgery

- Account should be taken of the individual analgesic requirements of each patient
- Consideration should be taken for the use of an abdominal wall local anaesthetic block. Rectus sheath catheters placed by the surgeon or by the anaesthetist guided by ultrasound is the preferred option. This should be attached to a pump delivering intermittent boluses of local anaesthetic
    - Initial bolus: 40 – 60ml of 0.25% levo-bupivicaine (maximum 2mg/kg)
    - Intermittent bolus: 20 – 40ml 0.125% 4leco-bupivicaine 4 hourly via a pump (e.g. BD Pain Manager Pump). **If there is a shortage of levo-bupivicaine, please consider continuing with an intermittent bolus using ropivacaine 0.2%**
- Regular and PRN oral oxycodone (shortec)/morphine is the preferred method of analgesia for patients on the ERAS pathway. Note that the patient may have received intra-operative spinal opioid in which case the patients should be admitted to HDU post-operatively and my not require regular opioids

- PCA morphine/oxycodone or subcutaneous oxycodone/morphine can be used as an alternative
- All patients should have an anti-emetic prescribed
- Ibuprofen/naproxen may be prescribed at the discretion of the medical team
- Analgesic requirements should be reviewed at least once daily
- The risk of nausea and vomiting, the presence of paralytic ileus and the resumption of oral fluids and diet are also factors to consider with regard to the use of oral analgesia

Day of theatre

- Check whether the patient has had any analgesia prior to theatre, **especially paracetamol.** (NB this may not be recorded on HEPMA as the patient may have taken this at home)

Post-operative

- Continue regular opioids until post-operative day 1 or 2 dependant on the needs of the individual patient
- Review analgesia daily
- Review nausea and vomiting daily
- Review bowl movements daily

Opioid prescription dose guideline (oral route)

Oral morphine solution

Age (years)	Dose
<15	**Seek medical advice**
<70	5mg – 10mg
>70	2.5mg – 5mg
>80	2.5mg

Oxycodone (shortec)

Age (years)	Dose

<15	**Seek medical advice**
<70	5mg – 10mg
>70	1.25mg – 2.5mg
>80	1mg – 2mg