Comparing the management of acute pain after gynaecological surgery in regional hospitals in the UK and Sri Lanka

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For my elective, I travelled to Sri Lanka and spent 4 weeks in Mahamodara Teaching Hospital, a hospital that delivers specialist maternity care in the south of Sri Lanka. Over the four weeks I spent a lot of my time in theatre observing the gynaecological operations, practising existing clinical skills in anaesthetics, and collecting the results for my project. However I was also fortunate enough to attend ward rounds and examine patients there, and visit the labour ward, which seemed quite a popular place to be amongst the other medical students on their elective.

I decided to base my project in Sri Lanka on the management of acute pain after gynaecological surgery after doing a similar project in a hospital in the UK in Birmingham. More than 80% of patients who undergo surgical procedures experience acute postoperative pain (1), yet its inadequate management can lead to thromboembolic complications, cardiac and pulmonary problems, pressure sores and prolonged hospital stay, putting a strain on limited hospital resources and leading to poor patient quality of life (2)(3). Numerous reasons have been suggested as to why pain is under addressed and under managed, for example a lack of adequately trained health professionals, the misuse of guidelines, limited resources, and differing cultural attitudes towards pain itself (4). In fact, in the Sri Lankan College of Obstetricians and Gynaecologists' National Guidelines on the Management of Acute Pain, they list "patient is not complaining, so he is not in pain" and "our patients think pain after surgery is normal, so they do not complain" as reasons for the inadequate management of pain.

With the insight I gained into the management of postoperative pain from my project in the UK, I wanted to compare the practices I observed there with those in Sri Lanka. I designed a proforma that included any intraoperative and postoperative analgesia received by the patient, whether they were prescribed regularly or as required, and any additional procedures that were carried out for example transversus abdominis plane (TAP) blocks, spinals or local wound infiltration with local anaesthetic, and compared these with the local guidelines. From the gynaecology operations I observed in theatre, I found that intra-operatively patients were given morphine and diclofenac IV and all surgeons also administered bupivacaine 0.25-0.5% by local wound infiltration to avoid postoperative pain. Postoperatively, it seemed all patients were given regular paracetamol and diclofenac and were also prescribed IM pethidine as required.

These practices differed quite substantially from the UK, where intraoperatively all patients were also given IV paracetamol (which I was informed is not available in Sri Lanka) but also the anaesthetists had different preferences for

considering adjunctive analgesic procedures such as TAP blocks, spinals or local wound infiltration. Postoperatively, all women in the UK were offered PCA morphine, as well as regular paracetamol and ibuprofen, and oral morphine as required. There were clearly many more options for analgesia and for the management of acute postoperative pain in the UK hospital than the Sri Lanka hospital. Interestingly, although not part of my project, I observed a similar pattern of pain management on the labour ward. Although I have not undertaken my O&G placement in the UK yet, I am aware that all women receive Entonox and many women also receive epidurals, however in this hospital I did not observe women having either of these. It would be interesting to investigate this further and subjectively measure the amount of postoperative or labour pain these patients experience and compare it with the UK to see if and why there are any differences, and possibly make recommendations for pain management.

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References

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