Wishaw General Hospital
Women's Services Directorate

Analgesia in the postnatal period

Relevant Staff Groups: Anaesthetists, Obstetricians, Midwives, Pharmacists
Key Words: Postnatal, Pain, Analgesia

Background

Analgesics provide the most effective pain relief when administered regularly and at adequate and timely dosages. These guidelines aid the management of pain experienced by women after caesarean section, forceps, ventouse or spontaneous vaginal deliveries. If the woman is delivered in theatre the anaesthetist will prescribe initial analgesia. Thereafter, or if she delivers on a ward, the obstetric staff will be responsible. Midwives will be able to prescribe paracetamol and non steroidal anti-inflammatory analgesics (NSAIDs) under midwife exemptions.

Pain should be assessed using the same pain scoring system as is used elsewhere in NHS Lanarkshire for assessing acute pain;

0 None
1 Mild
2 Moderate
3 Severe
4 Worst imaginable

Women must be made aware that stronger analgesics can usually be administered if the regularly prescribed analgesics are not providing adequate analgesia. Analgesia should be reviewed on an ongoing basis to determine if the prescribed analgesia is adequate and appropriate.

Warning:

There have been case reports of adverse incidents with maternal ultra-fast metabolisers of codeine. The result was a large increase in plasma opiate levels, a proportion of which passed to their child through breast milk leading to neonatal sedation. The licence of codeine has been withdrawn in breast feeding mothers in the USA and the MHRA has also recommended that this not be prescribed. The most appropriate weak opioid for breastfeeding mothers is Dihydrocodeine. With this in mind, dihydrocodeine is recommended throughout this guideline.

Recommended Analgesia

The following are recommended analgesic regimes. Any prescription should take into account the contraindications and precautions as detailed in the last section of this guideline.

Post Caesarean Section Analgesia

After spinal or epidural diamorphine;

Paracetamol 1gram orally or rectally prescribed regularly every 4-6 hours - maximum dose 4 grams in 24hours.

Diclofenac 100mg rectally at end of surgery, then diclofenac 50mg orally or rectally prescribed regularly every 8 hours - maximum dose by any route 150mg in 24 hours.

Dihydrocodeine 30mg 6 hourly as required

A certain proportion of patients lack the enzyme required to metabolise dihydrocodeine and will gain little analgesia from it. If a patient perceived no benefit from this then consider:

Exchanging dihydrocodeine for Oramorph 10mg 4 hourly as required.

If the above is inadequate;

Within 24 hours of caesarean section:

Contact the anaesthetist on-call (page 134).
The anaesthetist will decide on appropriate 'rescue analgesia'. This may involve IV morphine (administered by an anaesthetist or obstetrician) or IM morphine. PCA morphine may be considered.

Greater than 24 hours after caesarean section

Stop paracetamol and prescribe co-dydramol 10/500 2 tablets every 6 hours. The patient may still require dihydrocodeine as breakthrough analgesia (maximum 240mg in 24 hours).
If analgesia is still inadequate contact the obstetric SHO. If there are no obvious complications consider oral sevredol, oramorph or IM morphine.

After regional technique with NO spinal or epidural diamorphine administered and after general anaesthesia;

Paracetamol 1gram orally or rectally prescribed regularly every 4-6 hours - maximum 4grams in 24hours

Diclofenac 100 mg rectally at end of surgery, then diclofenac 50 mg orally or rectally prescribed regularly every 8 hours - maximum 150mg in 24 hours.

PCA morphine via 'Go-medical' disposable PCA pump, 1 mg every 5 minutes as required. PCA is usually required for 24 hours. Thereafter, dihydrocodeine 30mg orally as required 4-6

hourly should be prescribed and a **dose administered 2 hours prior to discontinuation of the PCA pump.**

Other Postnatal Analgesia

If repair of a large episiotomy or tear has been performed the prescription of regular paracetamol and diclofenac (unless either is contraindicated) and dihydrocodeine as required is recommended at doses recommended below.

Pain Score	**Analgesia**	**Analgesia**	**Analgesia**	**Analgesia**
Mild (0 or 1)	Regular Paracetamol 1gram orally or rectally 4-6. Maximum 4grams in 24hours	Previous column plus; regular diclofenac 50mg orally or rectally every 8 hours – maximum 150mg in 24hours	-	-
Moderate (2)	as above	as above	previous 2 columns plus; as required dihydrocodeine 30 mg orally every 4-6 hours	-
Severe, worst imaginable (3 or 4)	as above	as above	as above	but dihydrocodeine prescribed regularly contact obstetric SHO – consider sevredol 5-10mg or oramorph 10mg up to 2 hourly or morphine IM

Remember:
Always refer to British National Formulary (BNF) if unsure about appropriate prescription/doses.

If pain is worsening or 'severe' or 'worst imaginable' reconsider cause of pain. Determine if any other intervention is appropriate.

When morphine by any route is prescribed an anti-emetic should also be prescribed.
For advice about antiemetics refer to "Prescription of Antiemetics following Caesarean section" guideline.

Pain Relief for Discharge Home

Prior to discharge analgesic requirements **must** be reviewed. In general the above table should be followed. It is appreciated that women are being discharged home early in the post natal period but women should **NOT BE ROUTINELY** discharged home on codeine based analgesics.

Occasionally women will require stronger analgesia for discharge. It is preferable to discharge these women home on co-dydramol 10/500 (regularly or as required) and not codeine or co-codamol.
If this is required she should also be discharged home with regular diclofenac 50mg orally three times daily and a laxative (lactulose 10mls orally three times daily).

She should receive a 7 day supply of appropriate analgesics.

Contraindications and Precautions

Non steroidal anti-inflammatory analgesics (NSAIDs) are frequently used as part of the post natal analgesic regimen. Diclofenac is the NSAID of choice in the maternity unit. It can be administered orally with or after food or rectally if the woman is vomiting. NSAIDs can increase potential for bleeding and should be used with caution or avoided when there is significant haemorrhage.

Diclofenac should **NOT** be administered in the following situations;

- significant asthma
- history of hypersensitivity to NSAIDs or aspirin
- history of peptic ulcer disease
- moderate to severe pre-eclampsia.
- renal impairment or failure

Paracetamol should be used with caution if there is hepatic impairment.

When dihydrocodeine is prescribed regularly, a laxative should also be prescribed – lactulose 10mls three times daily.

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