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Limited post-operative narcotic use in elective laparoscopic cholecystectomy

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Purpose:

To limit narcotics use

Cochrane review: multiple studies have shown postoperative pain can be managed with non-narcotic meds with good outcome.

Less medication related side effects:N/V, constipation, disorientation

Prevents substance addiction/abuse

Type of Study:

Randomized

Prospective study

Unblinded study

Purpose:

To limit narcotics use

Cochrane review: multiple studies have shown postoperative pain can be managed with non-narcotic meds with good outcome.

Less medication related side effects:N/V, constipation, disorientation

Prevents substance addiction/abuse

Study design:

Recruitment location :

Surgical care specialists,

Abington Surgical Associates

Site: Abington Memorial Hospital

Subject Recruitment : preop visit

No incentives

Criteria:

Inclusion criteria:

Age:20-95

Elective Laparoscopic cholecystectomy

Exclusion criteria:

Chronic renal failure(cr>1.3)

Chronic pain issues

True narcotic allergies (anaphylaxis, respiratory distress, urticaria)

Complicated medical course (intra-operative complication or problems with anesthesia)

Complicated course (pchole tube ; abscess)

Requiring inpatient stay

Two groups (Randomized)

Control Group (standard narcotics):

1. Local anesthesia - OR "TAP" block
2. Ketorolac 30 mg IV once postop
3. Acetaminophen 650 mg PO Q4h prn for mild pain (Max 4000 mg Daily)
4. Percocet 5/325 mg, 1-2 tabs PO Q4-6h prn for moderate-severe pain (Dispense 30 Tabs), not to exceed 4000 mg Acetaminophen daily when combined with prn Acetaminophen

Experimental Group (minimal narcotics):

1. Local anesthesia - OR "TAP" block
2. Ketorolac 30 mg IV once post-op
3. Scheduled Acetaminophen 975mg (3tabs x 325mg) PO Q6h (Max 4000 mg Daily) to start in phase 2 recovery room
4. Alternate w/ scheduled Ibuprofen 600 mg PO Q6h (Max 3200 mg Daily) to start 3 hours after acetaminophen dose
5. **Oxycodone IR 5mg PO Q4h for breakthrough pain (Dispense limited supply, e.g. 10 tabs)**

"TAP" Block: Peripheral nerve **block** in Transverse Abdominis Plane

Post op visit(2 weeks):

Short Questionnaire : post operative experience

Post operative outcome:

Number of narcotic pills used

Degree of pain control achieved

Patient satisfaction with pain control

Narcotic-related side effects

Time to return to work

Statistical Analysis:

Chi Square Analysis: All categorical variable

Analysis of Variance: All continuous variable

P-value set as <0.005

Sample size: 300

Conclusion:

Study is IRB Approved

Implementation and recruitment: In progress

Reference:

1. De U. Evolution of cholecystectomy: A tribute to Carl August Langenbuch. Indian J Surg 2004;66:97-100.
2. Brown JJ. Assessment, stratification, and monitoring of the risk for prescription opioid misuse and abuse in the primary care setting. Journal of opioid management 2011; 7(6):467-483.
3. National Vital Statistics System. Multiple cause of death file. Atlanta: Centers for Disease Control and Prevention, 2012.
4. Gurusamy KS, Vaughan J, Toon CD, Davidson BR. Pharmacological interventions for prevention or treatment of postoperative pain in people undergoing laparoscopic cholecystectomy. Cochrane Database Syst Rev. 2014 Mar 28;3:CD008261. doi: 10.1002/14651858.
5. Myers RP, Li B, Fong A, Shaheen AA, Quan H. Hospitalizations for Acetaminophen Overdose: A Canadian Population-based Study from 1995 to 2004. BMC Public Health. 2007;7:143. Epub 2007 Jul 05.