Limited post-operative narcotic use in elective laparoscopic cholecystectomy

Prabhu Senthil-Kumar, MD
Abington Jefferson Health, prabhu.kumar@jefferson.edu

Tanya Olszewski, MD
Abington Jefferson Health, tanya.olszewski@jefferson.edu

Robert Josloff, MD
Abington Jefferson Health, robert.josloff@jefferson.edu

Kristin Noonan, MD
Abington Jefferson Health, kristin.noonan@jefferson.edu

Follow this and additional works at: http://jdc.jefferson.edu/patientsafetyposters

Part of the Medicine and Health Sciences Commons

Recommended Citation
http://jdc.jefferson.edu/patientsafetyposters/39

This Article is brought to you for free and open access by the Jefferson Digital Commons. The Jefferson Digital Commons is a service of Thomas Jefferson University’s Center for Teaching and Learning (CTL). The Commons is a showcase for Jefferson books and journals, peer-reviewed scholarly publications, unique historical collections from the University archives, and teaching tools. The Jefferson Digital Commons allows researchers and interested readers anywhere in the world to learn about and keep up to date with Jefferson scholarship. This article has been accepted for inclusion in House Staff Quality Improvement and Patient Safety Posters by an authorized administrator of the Jefferson Digital Commons. For more information, please contact: JeffersonDigitalCommons@jefferson.edu.
Limited post-operative narcotic use in elective laparoscopic cholecystectomy
Prabhu Senthil-kumar, MD, Tanya Olszewski MD, Robert Josloff MD, Kristin Noonan MD
Abington Memorial Hospital, 1200 Old York Road, Abington, 19001

**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

**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 (p chole 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 categorial 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:**