



- **FACT SHEET No. 1**

## **What the Public Should Know About Pain After Surgery**

More than 300 million surgeries are performed worldwide each year. These range from brief minor office procedures to multi-hour operations upon crucial organs in fragile patients. Pain after surgery used to be seen as inevitable, something to be endured. In fact, almost half of postsurgical inpatients surveyed in the latter part of the 20<sup>th</sup> century reported episodes of severe postsurgical pain. Long-term pain after surgery emerged as a topic deserving systematic study only about 25 years ago, in part through IASP's efforts.

Recent alignment of patients' calls for improved comfort after surgery with clinicians' interests in promoting shorter and trouble-free postoperative hospital stays has transformed the practice of postsurgical pain control. At the same time, minimally invasive surgical techniques and new methods to manage postsurgical pain more effectively and with fewer side effects allow more outpatient procedures or prompt discharges home after a short hospital stay. Nevertheless, increased assessment of pain in daily practice has revealed that pain often persists long after surgery.

### **In sum, yesterday's approach to pain after surgery:**

- Accepted that pain would often be severe because traditional surgical techniques used large incisions and damaged surrounding "innocent" tissues
- Encouraged a fatalistic approach to in-hospital pain
- Did not address pain of recently discharged surgical patients who were self-managing (or having families manage) pain at home
- Focused on simple regimens with frequent side effects, such as "morphine as needed"
- Did not collect data to uncover patterns of pain persisting long after surgery
- Addressed in-hospital problems with pain care using whatever staff was free at the moment

### **In contrast, today's approach to pain after surgery:**

- Assumes that nearly all pain after surgery can—and should—be managed to optimize physical and emotional function
- Assesses pain intensity at rest and with relevant activity to tailor pain therapy to rehabilitative needs, usually aiming for mild intensity but with notable exceptions such as in severe trauma with altered mental status
- Identifies in advance those patients who may require special attention; e.g., because of behavioral issues or presurgical therapy with opioids
- Integrates pain control and other aspects of preparing for and recovering from surgery such as activity or nutrition and fluid intake
- Adopts a “multimodal” approach that combines several types of medication and (when feasible) local anesthesia to reduce reliance on one single mode of treatment; e.g., opioids with their many side effects
- Takes into account patient differences in the experience and report of pain, preferences among possible treatments, and response to therapy—reflecting factors such as gender and ethnicity
- Continues patient assessment post-discharge to recognize and treat persistent pain and other undesired surgical consequences as early as possible
- Recognizes (in some countries) that management of acute pain such as after surgery has become a medical subspecialty owing to the growth of knowledge and specialized techniques such as regional anesthesia

### **What should you and your family do to secure the greatest benefit from these recent advances?**

- Discuss with your surgeon whether the proposed procedure is likely to produce pain and, if so, how intense it is likely to be, for what duration, and what is the plan to manage it. Some operations carry a higher risk of persistent postsurgical pain than others
- Call to the attention of the surgeon or other team members (anesthesiologist, nurse, physiotherapist, pharmacist) relevant aspects of the medical history or current status such as prior pain problems, current pain therapies, and conditions such as adverse reactions to medications
- Ask:
  - Who will formulate my personal “pain plan” (even if it is just a standard protocol of proven effectiveness in previous patients who have had the same operation)?
  - Will my pain plan be “multimodal”? That is, will it combine different types of pain-relieving medicines and/or local anesthesia such as an epidural or nerve block in order to decrease reliance on a single medication such as morphine?

- What steps will be taken to anticipate my possible need for higher than normal opioid dosing to control my pain (for those patients receiving opioid treatment preoperatively)?
- Who will monitor the pain plan and adjust or change it if I need this?
- What are the plans for my pain control after I am discharged from the hospital?
- If pain persists after I am discharged, who can I turn to, day and night, if my pain plan is inadequate to support my rest and recovery (if deep breathing or physical therapy does not work, for example), if my pain medication causes unacceptable side effects, or if pain resurfaces or worsens?

This guidance encourages patient and family-centered care based upon evidence and shared decision-making. Other Fact Sheets in this series prepared for IASP's 2017 Global Year Against Pain After Surgery focus on specific patient groups (such as children or older persons) and operations (such as after trauma or for cancer).

## AUTHORS

Daniel B. Carr, MD, DABPM, FFPANZCA (Hon)  
 Professor of Public Health and Community Medicine  
 Professor of Anesthesiology and Medicine  
 Founding Director, Tufts Program on Pain Research, Education and Policy  
 Boston, Mass., USA

Bart Morlion, MD, PhD, DESA  
 Director of the Leuven Center for Algology & Pain Management  
 University Hospitals Leuven, KU Leuven, Belgium  
 Hon. Assoc. Professor, University of Groningen, Netherlands

## REVIEWERS

Oscar A. DeLeon-Casasola, MD  
 Professor of Anesthesiology and Medicine  
 Senior Vice Chair, Department of Anesthesiology, University at Buffalo, Jacobs School of Medicine  
 Chief, Division of Pain Medicine and Professor of Oncology  
 Roswell Park Cancer Institute  
 Buffalo, New York, USA

Lars Arendt-Nielsen, Dr Med Sci, PhD, FRSM, FIAMBE  
 Director, Professor, Center for Sensory-Motor Interaction  
 Department of Health Science and Technology  
 School of Medicine, Aalborg University  
 Aalborg, Denmark



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**As part of the Global Year Against Pain After Surgery, IASP offers a series of Fact Sheets that cover specific topics related to postsurgical pain. These documents have been translated into multiple languages and are available for free download. Visit [www.iasp-pain.org/globalyear](http://www.iasp-pain.org/globalyear) for more information.**



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