Acute Postoperative Pain Management and Malfunctioning Epidural Catheter

Case Study

J.S., a 30-year-old male, was diagnosed with leiomyosarcoma of the small bowel with extension into the retroperitoneal space one month before admission. Abdominal x-rays and an ultrasound confirmed the presence of a 17 cm x 10 cm mass protruding from the edge of the jejunum and extending approximately 8–10 cm posteriorly up to the medial edge of the right kidney.

General anesthesia was required for the lengthy (i.e., four hours) radical resection of this large tumor, with epidural analgesia planned for postoperative pain management. In the preoperative holding area on the morning of surgery, an epidural catheter was inserted at J.S.’s thoracic spinal level of T-8. Accurate catheter placement was confirmed by administration of 5 ml of 2% lidocaine with epinephrine 5 mcg/ml and a subsequent mild sensory block from T-2 to T-6. General endotracheal anesthesia was induced and maintained with propofol and isoflurane intraoperatively. To effect analgesia, a 3 mcg/kg bolus of fentanyl was administered prior to surgical incision, followed by a constant IV infusion of 2 mcg/kg per hour.

During the final hour of surgery, the epidural catheter was activated with a bolus of 5 ml of 0.0625% bupivacaine with 40 mcg of preservative-free morphine per ml, followed by a continuous epidural infusion of 8 ml per hour. Following extubation, J.S. was transported to the postanesthesia care unit. He had a nasogastric tube, a Foley catheter, several surgical drains, and an epidural infusion. Upon awakening, he rated his pain (using a numeric rating scale of 0, which equals no pain, to 10, which equals worst pain) as 1–2, his vital signs and urine output were within normal limits, and he appeared comfortable.

Based on this initial postoperative pain assessment, the fentanyl infusion was discontinued, the epidural infusion was maintained at a rate of 8 ml per hour, and the patient was transferred to the oncology postoperative floor relatively comfortable, drowsy, and with normal vital signs. The pain service, responsible for the epidural catheter management, left the following orders for nursing care.

1. Give no narcotics or other central nervous system depressants except as ordered by the pain service.
2. Maintain the epidural infusion (0.0625% bupivacaine plus 40 mcg/ml morphine) at 8 ml per hour.
3. Inspect the catheter every shift. If blood or clear fluid is leaking, call the pain service.
4. Monitor the respiratory rate and sedation scale (1 = fully awake; 2 = drowsy, easily aroused; 3 = somnolent, difficult to arouse) every hour for 12 hours, then every four hours from the time of any bolus or change in the epidural infusion. Do a pain assessment (i.e., 0–10 scale) every four hours with vital signs.
5. Keep one ampule naloxone at the bedside, and maintain patent IV at all times during the epidural infusion.
6. Treat side effects as follows.
   a. If the respiratory rate is less than eight per minute and the patient is difficult to arouse, give naloxone 0.1 mg by IV push and repeat as needed until responsive; page the pain service to check the patient.
   b. If the patient is nauseated, administer ondansetron 4 mg via IV.
   c. For pruritis, administer diphenhydramine 25 mg via IV every eight hours.
   d. For urinary retention, give bethanechol 2.5 mg subcutaneously. Repeat once in 15 minutes as needed. If no voiding occurs after three to four hours, perform in-and-out catheterization.
7. Ensure the epidural catheter is taped securely before the patient turns in bed, sits up, or ambulates.
8. Maintain these orders in effect for the duration of epidural infusion.

The orders were signed by the physician on call for the pain service.

J.S. appeared to have adequate analgesia and normal vital signs until 11:30 pm, at which time the nurse responded to his frantic calls to find him literally crying with severe pain he rated as 10 and with extreme tachycardia and hypertension. The nurse first paged the physician on call for the pain service and then inspected the epidural catheter and site of insertion, which initially appeared normal. During administration of the bolus of medication ordered by the pain service, the nurse noted extravasation of fluid around the point of catheter entry into the skin, indicating dislodgement of the catheter. She quickly prepared an IV dose of hydromorphone, and on arrival of the pain service physician, began administering 0.5 mg doses via IV every five minutes until J.S.’s pain scores, pulse rate, and blood pressure began to return to baseline. When adequate analgesia had been obtained, the patient was supported in a sitting position and the epidural catheter was reinserted at the T-9 level, along with a bolus of 5 ml of the maintenance infusion solution, which was restarted at 8 ml per hour. Within 10 minutes, J.S. was extremely drowsy, he was difficult to arouse, and his respiratory rate dropped to six per minute. A pulse oximeter was applied, and his O2 saturation was 80%. Oxygen was started per nasal cannula, and naloxone 0.2 mg was administered via IV. A fluid bolus of 500 ml normal saline was given to compensate for a drop in blood pressure to 80/40. Fifteen minutes later, the patient was drowsy but arousalable, with a blood pressure of 100/60, respirations of 10 per minute, and a pain score of 0–1. The remainder of the postoperative course was problem free.

He was placed on IV opioid patient-controlled analgesia as a “bridge” to oral pain medication before discontinuing the epidural infusion on postoperative day four. He was discharged.

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Clinical Problem Solving

Responding to this clinical challenge are Charles Griffis, CRNA, MS, and Shelly Gierat, CRNA, MS. Both are nurse anesthetists in the Department of Anesthesiology at the University of California, Los Angeles, Medical Center.

What are the benefits associated with epidural analgesia?

S. Gierat: Pain management using epidural analgesia is appropriate for abdominal or thoracic surgical procedures because it produces a neuraxial sensory block of the trunk. With the ability of this technique to spare motor

The solutions offered to the clinical problems posed in this column are the opinions of the authors and do not represent the opinions or recommendations of the Oncology Nursing Society, the Oncology Nursing Forum, or the editorial staff.

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