Response to the letter for the article - Observational study to assess the effectiveness of postoperative pain management of patients undergoing elective caesarean section

Sir,

I thank the authors for the interest shown in our published article[1] and look forward to the ongoing research on non-opioids pharmacokinetics at parturition, to illustrate the impact of pregnancy on paracetomol disposition.[2] As rightly pointed by them: 'Effective analgesia after cesarean delivery needs pharmacokinetic input.' Treating postoperative pain after cesarean section poses specific challenges, such as, opioid induced sedation, interference with mother and child interaction, and transfer of sedative compounds in the breast milk. The ibid limitations of opioids have encouraged introduction of co-analgesia, in the form of non-steroidal anti-inflammatory drugs (NSAIDs) and paracetomal, to reduce the opioid consumption, and also the use of the NSAIDs has been shown to improve the pain scores.[3]

Despite major advances in the understanding of the pathophysiology of acute pain and introduction of multimodal analgesia, it is difficult to acheive the standards recommended by the Royal College of Anaethetist (RCoA).[4] The standard suggests that > 90% of women should score their worst pain as < 3 on a Visual Analog Scale (VAS) of 0-10. In our observational study, we found that 39.8% of women had VAS

score of >3.[1] Literature search revealed that others too have failed to achieve this target.[5,6]

I endorse the views expressed in the letter that there is a need to encourage caregivers to consider pharmacokinetic and pharmacodyamic studies in the field of peripartum analgesia, as many of the commonly used drugs have not been evaluated for their pharmcokinetic properties during pregnancy, ands hence the set standrads have not yet been acheived.

Another way to improve the postopertative pain relief is benchmarking,[7] which is a process in which organizations evaluate various aspects of their own procesessess in relation to the best practice, usually in their own setups. This allows the individual units to develop plans and adopt the best practice. The aim of our observational study was also to observe the pain management strategy and review areas requiring improvement. We recommend that the caregivers be encouraged to evaluate their own practices, as many patients do not recieve adequate postoperative pain relief because the staff fails to routinely assess the pain and provide pain relief.[8]

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