Preoperative Holding Area:
1. Oxycodone extended release 20 mg PO if <70 y.o. and 10 mg PO if ≥70 y.o.
2. Celecoxib 400 mg PO or 200 mg po if elderly or relative renal risk. Hold for renal disease.
3. Pregabalin 150 mg PO or 75 mg if elderly

Total Knee:
1. Continuous femoral nerve block catheter and single shot sciatic nerve block

Total Hip:
1. Single shot lumbar plexus nerve block. If unable to perform lumbar plexus, single shot femoral.

Total Shoulder:
1. Single shot interscalene (brachial plexus) nerve block OR continuous interscalene nerve block catheter.
2. If catheter placed, options are: D/C on POD #1 or #2 OR connect a disposable pump with local anesthetic at time of discharge that APS will manage for another 2-3 days via phone contact with patient at home.

Intraoperative:
1. General or spinal anesthetic
2. If spinal anesthetic for THA, consider giving 0.25 mg intrathecal morphine
3. No intraoperative ketorolac

Post Anesthesia Care Unit (PACU):
1. Initiate continuous femoral catheter with ropivacaine 0.1% at 7 ml/h or brachial plexus catheter with ropivacaine 0.2% at 7 ml/h
2. Preferred sequence for analgesic medication administration is:
   a. Ketorolac 15 mg IV x 1 PRN
   b. Percocet 5/325 1-2 tabs PO x 1 PRN
   c. IVP analgesics as normally ordered on PACU post orders. Start IVPCA before discharge to floor/unit.

Nursing Unit:
1. Acetaminophen 1000 mg PO TID.
2. Celecoxib 200 mg PO BID PO if <70 y.o. and 100 mg PO if ≥70 y.o. Hold for Crt >1.2 or if unknown Crt and multiple comorbidities.
3. If <70 years old, Oxycodone extended release 10 mg PO BID.
4. If <70 years old, Oxycodone 5-10 mg PO every 4h PRN.
5. If ≥70 years old, Oxycodone 2.5-10 mg PO every 4h PRN
6. Discontinue IV PCA POD #1 at 0800
7. For TKA: RN will discontinue femoral nerve block catheter POD #2 at 0600
8. TSA catheter: see above
Coordination:

1. Patients adhering to the above protocol will be managed by the Acute Pain Service (APS) for the first 24 hours after THA (expected duration of lumbar plexus single injection block), for the first 48 hours after TKA (while femoral catheter is in place), and for the first 24-48 after TSA (see above). APS will normally sign off service after these times and turn over pain management to the Ortho/Hospitalist teams.

2. If a patient refuses a block, the block is contraindicated, or the protocol needs to be modified due to allergy to protocol meds, the APS will still order and manage all pain meds for the first 24 hours. After the first 24 hours the APS will usually sign off service or will coordinate with the Ortho and Hospitalist teams the time frame for sign off and turnover of pain management.

3. If patient surgery (e.g., Bilateral TKA), medical condition, or preference requires an epidural catheter for post-op pain management, the above protocol will implemented as appropriate and the APS will manage for 24 hours with the epidural catheter discontinued in the afternoon of POD #1 (Bilateral TKA: leave catheter in for 48h), and turn over pain management to the Ortho/Hospitalist teams.

4. The Orthopedic team should order all home meds to continue as appropriate with the exception of short acting opioids and NSAIDS. These should not be re-ordered as they are included in the protocol meds. If a patient is on long acting opioids at home, they should most likely be re-ordered by Ortho as part of Medication Reconciliation. If there is any question about re-ordering home pain meds, discuss this with the Ortho team prior to placing orders.

References
