PAIN MANAGEMENT · FOR RESIDENTS & JUNIOR DOCTORS

Multimodal Analgesia

A Pocket Guide

A Dr. Priyamvada Goel educational resource — for residents, students, and curious patients.

Multimodal analgesia uses two or more agents or techniques with different mechanisms to achieve better pain control with fewer side effects. It is the standard of care.

Why multimodal

- Opioid-only regimens cause sedation, nausea, ileus, respiratory depression, and tolerance.
- Combining a non-opioid base with regional techniques reduces opioid requirement by 30–60% in most surgical populations.
- Better pain control is associated with earlier mobilisation, shorter stays, and reduced chronic pain.

The non-opioid base

- Paracetamol 1 g IV/PO 6-hourly — almost always the foundation. Watch hepatic dose.
- NSAIDs (e.g. ibuprofen, ketorolac, parecoxib) — powerful adjuncts; caution in renal impairment, peptic ulcer disease, asthma sensitivity, and the elderly.
- Gabapentinoids — selective use for neuropathic pain components; sedation is a real cost.

Regional blocks worth knowing

- TAP block — abdominal wall surgery.
- Erector spinae plane block — thoracic, breast, upper abdominal.
- Femoral / adductor canal — knee surgery.
- Interscalene — shoulder surgery.
- PECS I/II — breast surgery.

Opioid stewardship

- Choose the smallest dose of the shortest-acting agent that controls pain.
- PCA is excellent for moderate-to-severe pain when patients can use the button.
- Reassess at every shift; step down as soon as the patient allows.

Pain assessment

- Use a numeric rating scale every shift; document at rest AND with movement.
- Treat function (cough, mobilise, deep breathe), not just the number.
- Reassess after any intervention within 30 minutes.