The European Society
of Regional Anaesthesia
& Pain Therapy
ESRA ITALIA

ESRA ITALIAN CHAPTER

30° NATIONAL MEETING

13-15 NOV 2025

NAPOLI
HOTEL RAMADA

Presidents:
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MZ EVENTS

W. Ciaschi

TRANSITIONAL PAIN SERVICE: MISSION POSSIBLE WITH NEW DRUGS?

UOC Anestesia - Rianimazione e Terapia Antalgica - Altissima Professionalità in Cure

Antalgiche - Servizio di Terapia Antalgica - Spoke II° Livello

Ospedale F. Spaziani - Frosinone

Il sottoscritto dichiara che negli ultimi due anni NON ha avuto rapporti di finanziamento con soggetti portatori di interessi commerciali in campo sanitario

INTRODUZIONE

Uncontrolled pain, readmission to hospital and persistent opioid use in patients discharged with complex pain reflect gaps in post-operative care.

10-20% of post-operative patients are discharged without appropriate specialist analgesic follow-up to manage their complex post-operative pain and adequately wean them from opioid drugs

These patients often seek re-prescription of medication, primary care and/or hospital admission.

Reducing persistent opioid use after surgery through the implementation of transitional pain medicine is a public health priority.

THE CURRENT STATE OF TREATMENT FOR PATIENTS WITH COMPLEX ACUTE POST SURGICAL PAIN

- Poorly controlled post-surgical pain is a risk factor for hospital readmission and increased use of healthcare resources.
- The development of **CPSP (CHRONIC POSTSURGICAL PAIN)** is thought to be the main factor determining the persistent use of opioids.

THE CURRENT STATE OF TREATMENT FOR PATIENTS WITH COMPLEX ACUTE POST-SURGICAL PAIN

Thoracic surgery	Limb amputation	Inguinal hernia repair
Mastectomy	Spinal surgery	Caesarean section
Craniotomy	Arthroplasty	Hysterectomy

- Younger age
- Lower income
- Comorbidities (diabetes, heart failure)
- Preoperative medications (benzodiazepines, antidepressants)

THE CURRENT STATE OF TREATMENT FOR PATIENTS WITH COMPLEX ACUTE POST-SURGICAL PAIN

- The situation is much more serious for patients who take opioids before surgery.
- Opioid-dependent patients typically leave hospital with a 100–300% increase in their opioid dose compared to baseline after major surgery, usually without appropriate follow-up or a plan for gradual withdrawal.
- The use of high-dose opioids in this context is closely related to increased mortality.
- **In all these cases, the incidence of CPSP ranges from 5% to 85%.**

THE CURRENT STATE OF TREATMENT FOR PATIENTS WITH COMPLEX ACUTE POST-SURGICAL PAIN

- **CPSP is considered a secondary disease and not just a symptom.**
- Chronic post-surgical pain is defined as pain that develops or increases in intensity after surgical procedures or tissue damage and persists beyond the healing process for at least three months after the initial event.
- In addition, patients with CPSP have a lower quality of life regardless of opioid use.

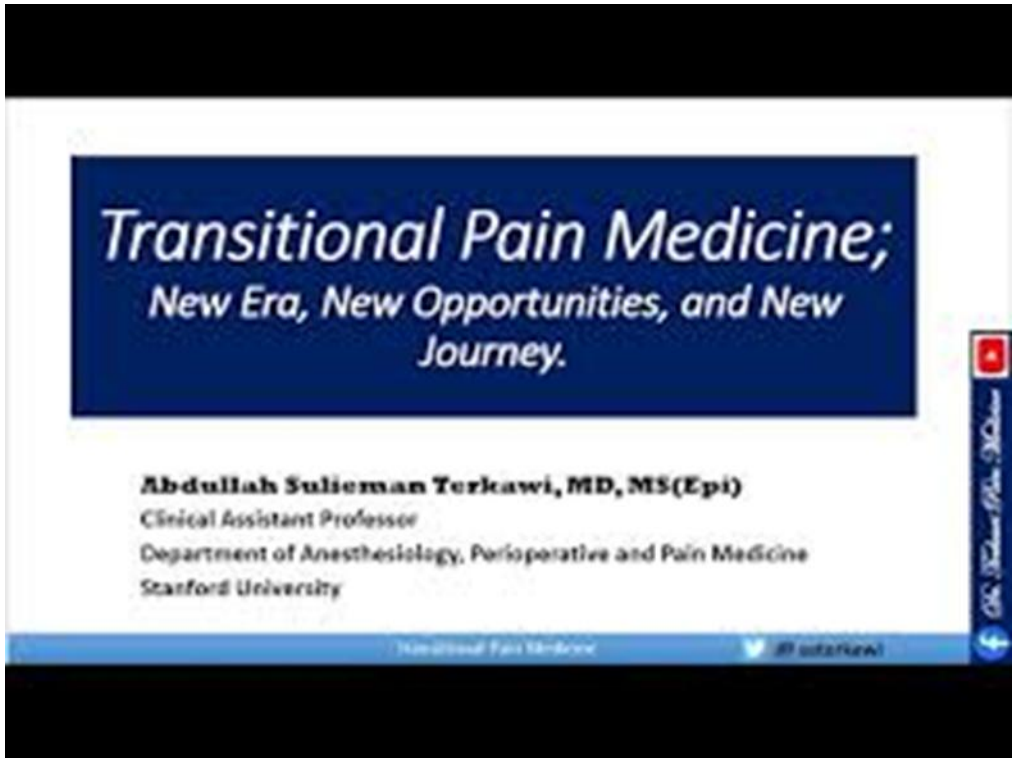
TPS: TRANSITIONAL PAIN SERVICE

- Anaesthetists
- Pain therapists
- Nurses
- Psychologists
- Physiotherapists trained in myofascial release
- Patient care coordinators

Transitional
PAIN SERVICE
Working together to relieve pain

TPS: TRANSITIONAL PAIN SERVICE

- Effective control of acute post-operative pain through the use of **“multimodal analgesia”** and judicious use of opioids with the aim of facilitating a reduction in post-operative opioid consumption.
- **Non-pharmacological interventions such as physiotherapy**.
- **Psychological therapy** based on pre-operative patient education, identifying patients at higher risk of developing CPSP



TPS: TRANSITIONAL PAIN SERVICE

There are two subgroups of patients treated by TPS:

A- Patients who have never taken opioids and who do not suffer from pre-existing pain have a 5-10% risk of developing moderate to severe CPSP.

B- Patients who present for surgery with pre-existing pain and are undergoing pre-operative treatment with opioids.

These patients face **“acute on chronic”** post-operative pain. They typically leave hospital after a prolonged stay on higher doses of opioids than before admission. They continue their opioid regimen without a reduction plan and often with a new medication threshold.

TPS: TRANSITIONAL PAIN SERVICE

TPS is structured around the perioperative continuum and continues to provide care to patients for up to 6 months after discharge.

TPS: TRANSITIONAL PAIN SERVICE

In this way, TPS aims to bridge the gap between preoperative, hospital and outpatient care for patients undergoing surgery.

The usual fragmentation of postoperative pain management between surgeons, anaesthetists, pain nurses and general practitioners is replaced by TPS.

MULTIMODAL ANALGESIA

- **Multimodal analgesia** includes:
- non-opioid systemic analgesics such as paracetamol
- non-steroidal anti-inflammatory drugs (NSAIDs)
- gabapentinoids (pregabalin and gabapentin)
- infusions of local anaesthetics (intravenous lidocaine)
- ketamine infusion
- medical cannabis

MULTIMODAL ANALGESIA

- Many of these drugs can be administered in the period immediately prior to surgery as part of **pre-emptive analgesia** to help reduce opioid use in the perioperative period.
- By acting on different receptor families along the nociceptive pathway, the multimodal analgesic regimens used in TPS optimise pain control through synergistic pharmacological effects that result in opioid savings.

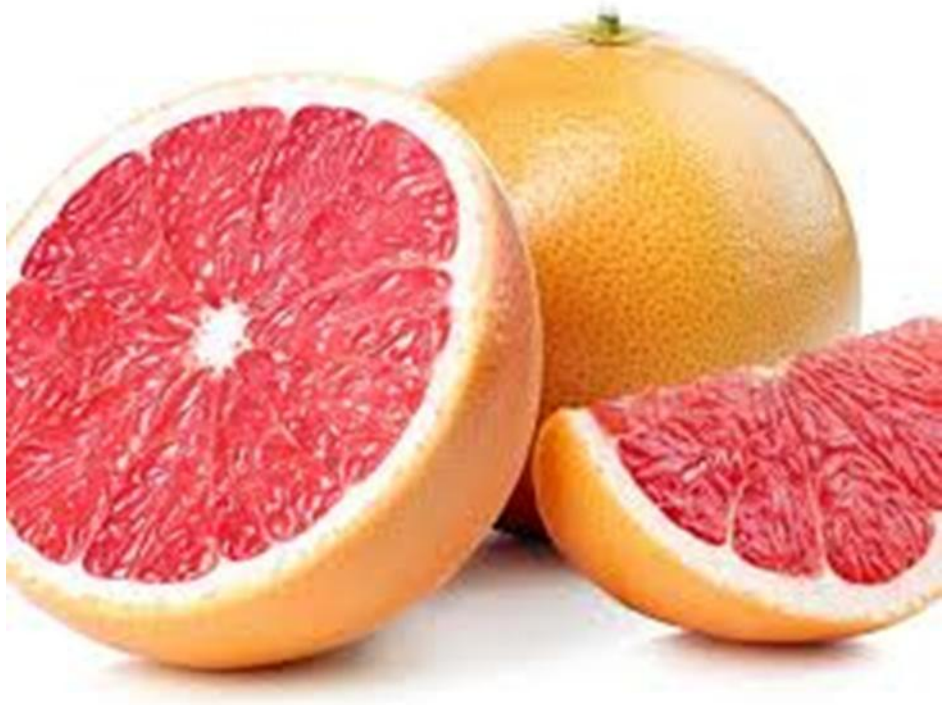
MULTIMODAL ANALGESIA

- **SUZETRIGINA** is a new non-opioid drug for the treatment of moderate to severe acute post-operative pain, approved by the FDA in the United States in 2025.
- It acts as a selective blocker of NaV1.8 sodium channels, which are involved in the transmission of pain signals from peripheral nociceptors to the central nervous system, and has a favourable safety profile, without the risk of addiction associated with opioids.

MULTIMODAL ANALGESIA

Side effects: itching, muscle spasms, increased creatine phosphokinase and skin rashes.

Contraindications: Concomitant use with potent CYP3A inhibitors is contraindicated and it is recommended to avoid grapefruit during treatment.



MULTIMODAL ANALGESIA

- Intravenous infusion of **LIDOCAINE (**2 mg/min > 70 kg; 1 mg/min < 70 kg) has proven to be a valuable analgesic adjuvant, leading to a reduction in post-operative pain and a lower use of opioids in the post-operative period.
- Lidocaine works by modulating pain signals and reducing inflammation in the body.

MULTIMODAL ANALGESIA

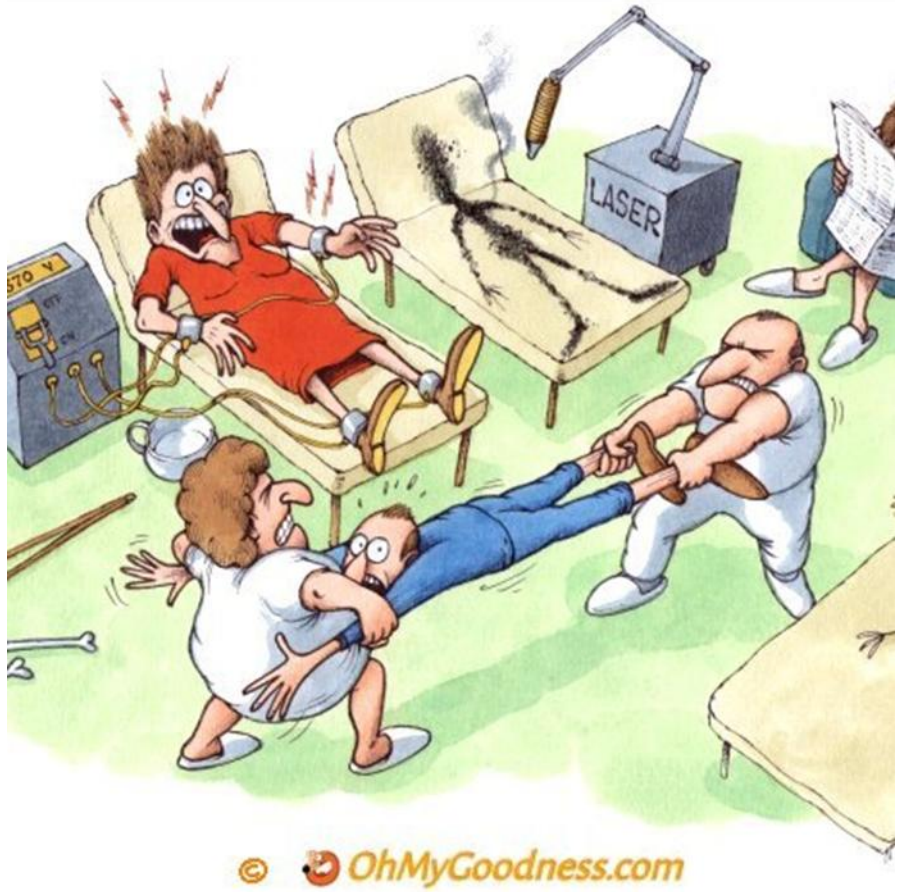
- **KETAMINE** (an NMDA antagonist) appears to be the pharmacological agent with the most positive and consistent preventive analgesic results. A comprehensive systematic review for the prevention of chronic pain after surgery in adults identified ketamine as the most reliable pharmacological agent for the prevention of CPSP.
- Low-dose ketamine infusions (i.e., 0.05–0.2 mg/kg/hour) administered outside the operating theatre to patients with pre-existing chronic pain conditions who typically take more than 80 mg of oral morphine equivalent per day in the post-operative setting did not result in any significant side effects for the patient.

MULTIMODAL ANALGESIA

- The liberal use of local-regional techniques including incision site infiltration, wound catheters and nerve blocks has been encouraged as part of multimodal analgesia.
- Single or continuous nerve blocks have proven particularly useful in limb surgery and are recommended for the management of acute post-operative pain.
- Similarly, central neuraxial blocks have been shown to have significant opioid-sparing effects following major abdominal, thoracic, and intra-abdominal vascular surgery.
- Neuromodulation and/or cry neuromodulation techniques may be used.

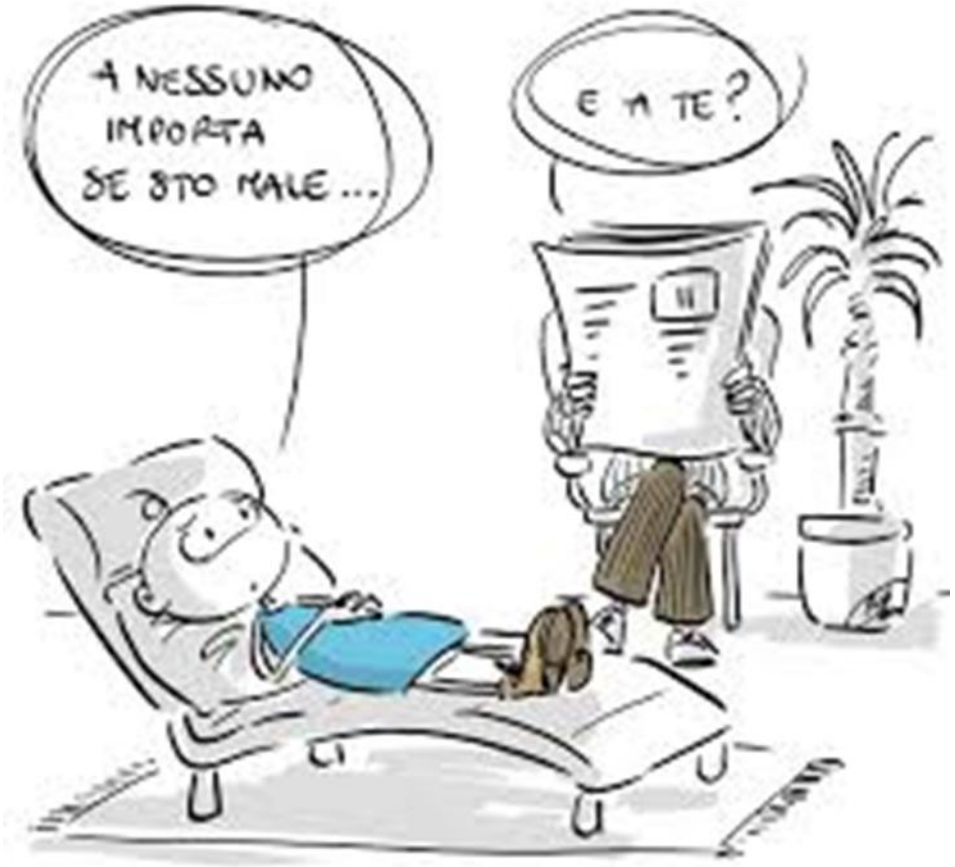
NON-PHARMACOLOGICAL INTERVENTIONS: PHYSIOTHERAPY

- Prehabilitation is the process whereby patients with reduced functionality prior to surgery are provided with targeted interventions to improve their physical abilities before major elective surgery.
- It includes physiotherapy, nutritional support, patient education and specific muscle training.
- Pre-rehabilitation appears to improve post-operative outcomes and functional recovery, resulting in a reduction in hospital stay duration in adults undergoing major colorectal, thoracic and breast surgery.



PSYCHOLOGICAL THERAPY

- The psychological basis of chronic pain is well established. In fact, several psychological risk factors have been linked to the chronicity of acute postoperative pain.
- These include increased vulnerability to pain trauma, pain catastrophising, preoperative anxiety disorders, and negative affective states, including depression.
- Therefore, psychological preparation and therapy are another key component of TPS.



OUTPATIENT CARE

- Upon discharge, patients are presented with a personalised pain management plan.
- Patients are then monitored for a period of 3 to 6 months in order to assess pain progression and successfully discontinue opioid medication.
- At the end of TPS treatment, patients are transferred to their general practitioner.

CONCUSIONS

- The goal of the TPS is to make significant progress in reducing the incidence of CPSP and persistent opioid use using this new approach to perioperative care.
- Comprehensive programs that combine new preventive pharmacological strategies, pre-rehabilitation, mindfulness, cognitive-behavioral therapy, etc., could positively influence the long-term path of patients after major surgery by improving their quality of life and drastically reducing healthcare costs.