

Multimodal analgesia — anaesthetic room card

Many small levers beat one big one. Schedule the foundation; keep opioid as rescue.

5	OPIOID — RESCUE ONLY Written with a stated ceiling and a step-down plan. Repeated rescue doses = a failed plan, not a difficult patient.
4	LOCAL INFILTRATION Surgeon infiltrates the wound before closure. Always available, always cheap, frequently forgotten.
3	ADJUNCTS IV lidocaine infusion · low-dose ketamine · dexamethasone · gabapentinoids in SELECTED patients only.
2	REGIONAL Epidural · spinal · intrathecal morphine · fascial plane block. The biggest opioid-sparing lever you have. 2025: alternatives to epidural are accepted for open surgery.
1	FOUNDATION — SCHEDULED, NOT PRN Paracetamol + NSAID together unless contraindicated. More effective than either alone. 'As required' means 'not given'.

Write these five things in the notes and say them at Sign out

#	Component	Example
1	Technique	Light GA + bilateral subcostal TAP
2	Regional block and expected duration	TAP with 0.25% bupivacaine, expect 10-14 h
3	Scheduled non-opioid analgesics	Paracetamol 1 g QDS + ibuprofen 400 mg TDS, regular
4	Rescue analgesia and its ceiling	Morphine 2.5 mg IV PRN, max 10 mg in 4 h, review if >2 doses
5	PONV agents given and what to give next	Dexamethasone 8 mg + ondansetron 4 mg given; next line metoclopramide 10 mg

Why this matters on the ward. Opioids cause ileus, nausea, sedation, urinary retention and immobility — and each of those blocks a different ERAS element. But uncontrolled pain is equally damaging: it drives the stress response, prevents deep breathing and mobilising, and can become chronic. The goal is not less analgesia. It is the same analgesia from more, smaller levers.