

PREOPERATIVE DECISION ALGORITHM FOR PREGABALIN

Is the planned surgical procedure associated with postoperative pain?

YES

NO

AVOID PREGABALIN

Surgery- e.g. Amputation, joint arthroplasty, spine etc

Surgery in a site of chronic pain
Chronic neuropathic pain
Opioid use preoperatively
Postoperative pain with hyperalgesia
Experience of poorly controlled pain

Intrathecal opioids- adjust the dose of intrathecal morphine or pregabalin

YES

NO

AVOID PREGABALIN

Continuous epidurals-
Prostatectomy
Laparotomy,
Aortic Sx,
Nephrectomy etc.- no added benefit from pregabalin

Regional- epidural or spinal morphine
Increasing age > 70yrs
Sleep Apnea
Kidney function insufficiency

Severe RISK

AVOID PREGABALIN

Creatinine Clearance(mL/min)	Pregabalin dose & frequency
>60	50mg q8h
30-60	25mg q8h
15-30	25mg q12h
<15	25mg od

- Preop dose remains unchanged
- Patients on dialysis may receive Pregabalin 25-50 mg q12-24h on days of dialysis only

NO RISK

Mild to Moderate RISK

PRESCRIBE PREGABALIN:
50- 75mg preop, then 50mg q8h
Individualize, carefully titrate to benefit- side effect profile, Advise for 5 days and reassess, make a plan to **STOP!**

PRESCRIBE PREGABALIN WITH CAUTION:
25- 50mg preop, then 25mg q8h;
Individualize, carefully titrate to benefit- side effect profile, Advise for 5 days and reassess, make a plan to **STOP!**

Avoid Benzodiazepines as sedative premed!

Note:

- This algorithm is based on the TOH- APS *experience* and is currently only supported by Level II and Level III *evidence*
- The initiation of Pregabalin should be made where the effects can be closely monitored- when in doubt check for renal function and supplement O2/ monitor SpO2.
- The most frequent side-effects are augmentation of opioid- induced sedation and respiratory depression. If these appear- assess, resuscitate and reverse any opioids with Naloxone as per protocol.
- The termination of Pregabalin should be individualized, there is currently no *evidence* but accumulating *experience* supporting use beyond 3 days.