

Results After the implantation: the Womac Pain Index decrease from 60 to 25, Womac function from 58 to 20. In BPI scale: pain intensity passed from 6 to 3 and pain interference from 7 to 2. NO peri-operative

Conclusions This novel wireless neurostimulator proved effective in controlling a chronic knee pain, improving person's quality of life. The absence of a required subcutaneous unit is a clear advantage for the managing of this device, especially in the outpatient setting. However, it needs to be implanted by expert operators and requires a careful follow-up.

B237 SAPHENOUS NERVE BLOCK AND IPACK BLOCK IN AMBULATORY KNEE ARTHROSCOPY: CASE REPORT

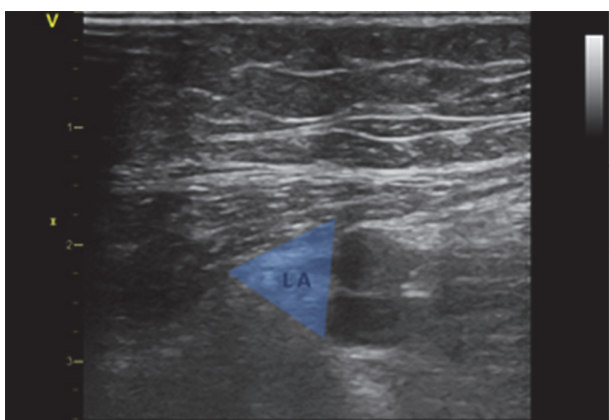
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10.1136/rapm-2022-ESRA.311

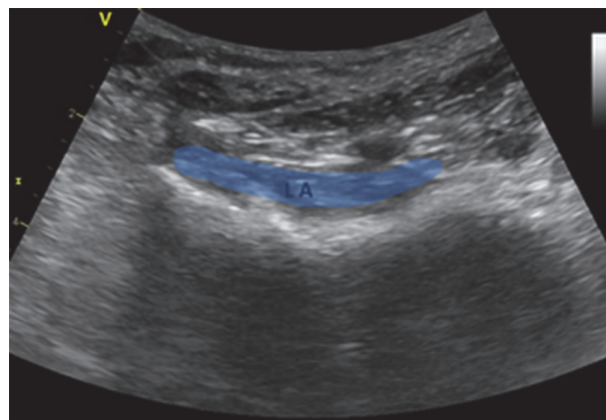
Background and Aims Pain and motor blockage are problems that can prevent early discharge from knee arthroscopy. On the one hand, the use of neuraxial techniques or peripheral nerve blockages that produce motor blockage prevents early wandering. On the other hand, the lack of use of regional anesthesia techniques can cause pain that prevents early discharge (1). The saphenous nerve block has been extensively described for this type of intervention because it exclusively generates sensory blockage (2–3). The use of IPACK block is practically not described in knee arthroscopy. However, in knee arthroplasty it is widely used since it generates sensory blockage improving analgesic efficacy and avoiding prolonged motor blockade of the sciatic nerve. (4)

Methods Case report. This is a 48-year-old man who undergoes knee arthroscopy for meniscopathy. The saphenous nerve block is performed with 37.5 mg of Levobupivacaine in 5 ml, and IPACK block with 100 mg of Levobupivacaine in 20 ml. Subsequently, general anesthesia is performed with a laryngeal mask and balanced anesthesia without further analgesic demands.

Results At the time of discharge, the patient encounters VAS 1–2/10, and a Bromage scale of IV/IV. The patient initiates early ambulation and is discharged without subsequent readmission.



Abstract B237 Figure 1



Abstract B237 Figure 2

Conclusions The combination of two purely sensitive blockages (saphenous and IPACK block) allows adequate analgesic control without motor blockade, ideal for ambulatory surgery. This could be the basis of future protocols for ambulatory knee arthroscopy.

B238 CONTINUOUS SPINAL ANALGESIA IN AN OPIOID DEPENDENT PATIENT – CAN IT BE THE ANSWER WE HAVE BEEN SEARCHING FOR?

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10.1136/rapm-2022-ESRA.312

Background and Aims Intrathecal analgesia is a powerful yet underused modality for refractory pain. Compared to epidural analgesia, it provides a quicker onset of effect and a denser sensory block, while reducing side effects and adjuvant requirements.

Methods A 43-year-old male with a history of chronic pain and opioid abuse was referred to the Pain Unit due to intractable pain following multiple surgeries due to lower limb trauma. Despite multimodal schemes, including epidural analgesia and a sciatic-popliteal perineural catheter, the patient reported pain greater than 7 out of 10 in the Numeric Rating Scale (NRS). In an attempt to improve analgesia and reduce opioid consumption, an intrathecal catheter was inserted and 2 mL 0.2% ropivacaine and 0.3 mg morphine were administered. Analgesia was maintained with intermittent boluses of 2 mL 0.2% ropivacaine every 2 hours. The patient significantly improved, reporting 0 out of 10 in the NRS. Systemic analgesia was optimized and a transdermal buprenorphine patch was initiated. The catheter was removed following 72 hours with optimal pain control.

Results Management of acute pain in patients with a history of chronic pain is challenging due to opioid dependence, tolerance and hyperalgesia, such that traditional postoperative analgesic schemes may fail. Intrathecal pain therapy is advocated for moderate and severe and intractable pain when other conservative therapies fail, appearing as an attractive and effective analgesic tool in patients with refractory pain, allowing optimization of long-term systemic analgesia.