

### B312 AUDIT OF ENHANCED RECOVERY PROTOCOL FOR POST OPERATIVE THR AND TKR

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**Background and Aims** Background - Enhanced recovery(ER) is modern,evidence-based approach with focus on safe, effective analgesia with minimal side-effects which helps early mobility

Aims - to audit in postop period 1) pain scores 2) early mobilization 3) complication and delay discharges

**Methods** Methods - This is our ER protocol

1. exclusion criteria -patients
  - o Chronic pain patients who take regular, strong opioid prior to surgery.
  - o severe renal impairment (CrCl<30 ml/min)
  - o under the age of 18 years.
  - o adverse reactions to oxycodone
  - o Patient refusal.
2. Anaesthetic methods - Single shot spinal anaesthetic,+/- sedation,+/-diamorphine orGeneral anaesthetic(GA)
3. Postop order set-oxycodone MR and IR, Pregabalin, paracetamol,NSAIDs,PPI and laxative

Audit was conducted from June 2021- Sept 2021 after Audit registration in our NHS trust.

**Results** We have collected data from 32 patients

1. Type of anaesthesia – 30 patients had SA with Diamorphine range 300 – 500 mcg , 1 patient SA was converted to GA,1 patient had GA .Local infiltration was given in 26 cases
2. Mobilization – only 1 patients was mobilized by physiotherapy post op on the day of surgery , rest all were mobilized on day 1or 2
3. Pain score – most patients had minimal pain,3 patients had severe pain for which they had PCA
4. Dizziness – 3 patients complained of dizziness post op
5. Catherization – 12 out of 32 patients required catherization post op
6. Discharge – only 56% were discharge on day 2 or 3, rest were delayed

**Conclusions** We need to make some necessary changes in the ER protocol

1. Avoid opioids in SA,this will decrease dizziness and requirement of catheterization in the immediate post op period,
2. Train the nursing staff for early mobilization

### B313 THORACIC PARAVERTEBRAL BLOCK REPRESENTS BETTER ANALGESIC FEATURES THAN ERECTOR SPINAE PLANE BLOCK FOR PATIENTS UNDERGOING REDUCTION MAMMAPLASTY SURGERY

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**Background and Aims** Severe pain occurs after reduction mammaplasty surgery which may be prevented via preoperative

erector spinae plane block (ESPB) or thoracic paravertebral block (TPVB)[1,2]. We aimed to compare perioperative analgesic features of these two blocks.

**Methods** After Istanbul Faculty of Medicine Clinical Research Ethics Committee approval (2020/1423) fifty-eight macromastia patients were investigated retrospectively. Prior to surgery; patients were applied ESPB (n=28) on T4 level or TPVB (n=30) between T3-T4 levels. Pin-prick test covering T2 to T6 dermatomes was performed on midaxillary and midclavicular lines at certain time points during preoperative 30 minutes and postoperative 48 hours. Demographic data, postoperative comfort parameters (NRS pain scores, time to first pain, total analgesic consumption, sleep duration, nausea-vomiting incidence), and patient/surgeon satisfaction scores were evaluated.

**Results** Demographic data were similar (p>0.05) (Table 1). TPVB covered more dermatomes on midclavicular line at 30th minute (4[3–4] vs 3.5[2–4] on the right; 4[3–4] vs 3[2–4] on the left; p<0.05). TPVB represented more coverage during the postoperative 24 hours (p<0.05) but not at 48th hour (p>0.05) (Table 2). Pain scores were lower during the postoperative first 2 hours in TPVB group (p<0.05). Time to first pain (NRS≥4) was shorter in ESPB group (411 min vs 605 min; p<0.05). ESPB group consumed more paracetamol on postoperative 2nd day (0[0–2] g vs 1[0–2] g, p<0.05). TPVB group had more sleep on postoperative 1st day (p<0.05); and patients were more satisfied (p<0.05) (Table 3).

**Abstract B313 Table 1**

**Table 1:** Patient demographics, Surgical characteristics, Block application time, Durations of surgery and general anesthesia.

	ESPB (n=28, 48.3%)	TPVB (n=30, 51.7%)	p
<b>Age (year)</b> (Median (min-max))	46 (24-61)	44 (25-60)	0.827 <sup>a</sup>
<b>BMI (kg/m<sup>2</sup>)</b> (Mean±Std)	31±4.1	31.43±3.9	0.693 <sup>b</sup>
<b>ASA physical status</b> (n, %)			
1	3, 10.7%	5, 16.7%	0.721 <sup>c</sup>
2	22, 78.6%	23, 76.7%	
3	3, 10.7%	2, 6.7%	
<b>Duration of block</b> (min) (Median (min-max))	7 (4-12)	7 (4-15)	0.994 <sup>a</sup>
<b>Duration of anesthesia</b> (min) (Mean±Std)	154.6±30.5	157.2±35.2	0.772 <sup>b</sup>
<b>Duration of surgery</b> (min) (Median (min-max))	135 (90-200)	137.5 (85-220)	0.833 <sup>a</sup>
<b>Intraoperatif fentanyl requirement</b> (mcg) (Median (min-max))	0 (0-50)	0 (0-100)	0.1 <sup>a</sup>
<b>Breast reduction incision types</b> (n, %)			
Wise pattern	25, 89.3%	26, 86.7%	1.0 <sup>d</sup>
Circumvertical with short horizontal scar	3, 10.7%	4, 13.3%	
<b>Breast reduction pedicle types</b> (n, %)			
Superomedial pedicle	17, 60.7%	17, 56.7%	0.818 <sup>d</sup>
Inferior pedicle	6, 21.4%	6, 20%	
Superior pedicle	4, 14.3%	4, 13.3%	
Free nipple grafts	1, 3.6%	3, 10%	
<b>Weight of breast reduction</b> (g) (Median (min-max))	732 (600-1020)	732 (580-1076)	0.944 <sup>a</sup>

ESPB: erector spinae plane block, TPVB: thoracic paravertebral block, BMI: body mass index, ASA: American Society of Anesthesiologists.

a. Mann Whitney-U test, b. Student-t test, c. Pearson Chi-Square test, d. Fischer's Exact test