

Abstract B316 Table 1

	Patient No1	Patient No2	Patient No3	Patient No4
Age	69	54	81	62
Gender	Female	Male	Male	Female
BMI	33	24.6	29	35
ASA	3	2	3	3
Procedure	PPPD	PPPD	WHIPPLE	WHIPPLE
Operative time	6 hours	6 hours	5 hours	4hours
Mobilising	POD2	POD0	POD1	POD0
Sleeping	POD0	POD0	POD0	POD0
Return of bowel function	POD4	POD2	POD4	POD3
Transfusion	NO	NO	NO	NO
IV/IM/PO opioids	NONE	NONE	NONE	NONE
Postoperative delirium	NO	NO	NO	NO
NRS>4 at any time postop	NO	NO	NO	NO
Index	Grade II	Grade II	Grade II	Grade II
Complications Clavien-Dindo				
DGE	Grade B	Grade A	Grade B	NONE
POPF	NO	NO	NO	Grade B
Ileus	NO	NO	NO	NO
Chest infection	NO	NO	NO	NO
Re-operation	NO	NO	NO	NO
Length of stay	14 days	9 days	13 days	11 days

Table 1. Patients, perioperative characteristics and outcomes.
 ASA: American society of Anaesthesiology score, PPPD: Pylorus Preserving Pancreatoduodenectomy, POD: Postoperative Day, IV: Intravenous, IM: Intramuscular, PO: Per os, NRS: Numerical Rating Scale, DGE: Delayed Gastric Emptying, POPF: Postoperative Pancreatic Fistula

Results None of the patients received parenteral or oral opioids either intraoperatively or postoperatively. All patients remained pain-free during their hospital stay and achieved ERAS outcomes early. Three patients developed DGE. Otherwise the patients had an uncomplicated recovery.

Conclusions Our protocol achieved an opioid-free experience, with the advantage of avoiding opioid side effects which may interfere with early surgical outcomes especially after pancreatic surgery. Future studies on models of enhanced recovery anaesthesia and analgesia and their effect on surgical and oncological outcomes are therefore recommended.

B317 PERSISTENT POST-SURGICAL PAIN AFTER TOTAL ABDOMINAL HYSTERECTOMY AT A TERTIARY CARE HOSPITAL OF A LOW-MIDDLE INCOME COUNTRY

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Background and Aims Persistent post-surgical pain (PPSP) is pain that lasts for 3 months or more after a surgical procedure, excluding other causes of pain. There has been considerable work in high income countries on incidence and factors related to PPSP. However, there is scarce knowledge about PPSP in low- and middle-income countries (LMICs). We assessed the prevalence of PPSP after total abdominal hysterectomy (TAH), its intensity and effect on daily routine.

Methods It was a prospective cross-sectional study. Approval was obtained from the institution's Ethics Review Committee. Patients undergoing elective TAH were recruited. A pain nurse called the patients three months after surgery and asked about presence of pain, its location, type, degree and associated factors. Patients who reported pain at three months were called again a year later.

Results During the study period 119 patients underwent TAH. At discharge, 74 (61.3%) were satisfied with their pain management. Three months later, 15 (12.6%) patients reported pain. Pain was mild in 13 and moderate in two patients. At

one-year follow-up, two patients (1.6%) reported pain that was mild to moderate in intensity. Pain disturbed sleep in both patients and disturbed daily life routines in one patient.

Conclusions There is scarce knowledge about prevalence of PPSP in LMICs. In our patient population, 12.6% reported pain three months after TAH, while at one year, 1.6% patients reported mild to moderate pain. Multicenter studies are recommended for determining the overall prevalence in our patient population and for getting directions for making targeted efforts towards its prevention and treatment.

B318 OPIOID SPARING EFFECTS OF INTRAVENOUS AND ORAL ACETAMINOPHEN IN HIP FRACTURE PATIENTS: A POPULATION-BASED STUDY

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Background and Aims Patients who sustain hip fractures are at high risk for opioid related adverse events. Acetaminophen (APAP) and specifically intravenous acetaminophen (IVAPAP) have been proposed as part of many opioid-sparing multimodal analgesic pathways. The aims of this study are to describe the current use of IVAPAP and APAP in hip fracture patients and elucidate the effectiveness of IVAPAP and APAP on opioid utilization and opioid-related adverse effects.

Methods This retrospective cohort study used the Premier Healthcare database and included patients undergoing hip fracture repair surgery from 2011 to 2019. Primary exposure was use of APAP or IVAPAP. The primary outcome was opioid utilization over the hospital stay; secondary outcomes included opioid-related adverse effects, length and costs of hospital stay. Mixed-effects models measured the association of IVAPAP/APAP and outcomes. We report effect estimates and 95% confidence intervals (CI).

Results Among 649,960 hip fracture repair surgeries 16.4% (106,315) received 1 dose of IVAPAP. Upon adjusting for all relevant covariates, the use of >1 dose of IVAPAP on the first postoperative day (POD1) was associated with a 6% reduction in opioid use (95% CI -8%, -4%) compared to patients who did not receive IVAPAP. Patients who received > 1 dose oral APAP on POD1 one had a 14% reduction in total opioid use (95%CI -15%, -13%), (Table 1).

Abstract B318 Table 1

Intravenous APAP vs. no APAP	POD0				POD1				POD>1			
	1 DOSE		>1 DOSE		1 DOSE		>1 DOSE		1 DOSE		>1 DOSE	
	ESTIMATE	P	ESTIMATE	P	ESTIMATE	P	ESTIMATE	P	ESTIMATE	P	ESTIMATE	P
Total Opioid	1.02 (0.91, 1.15)	<.001	0.92 (0.75, 1.14)	<.001	0.82 (0.63, 1.06)	<.001	0.68 (0.54, 0.86)	<.001	1.86 (1.38, 2.49)	<.001	3.43 (2.77, 4.25)	<.001
Respiratory	0.95 (0.87, 1.03)	<.001	0.86 (0.73, 0.99)	<.001	0.83 (0.72, 0.94)	<.001	0.68 (0.57, 0.80)	<.001	1.23 (0.98, 1.53)	<.001	1.81 (1.38, 2.36)	<.001
Length of Stay	0.97 (0.96, 0.98)	<.001	0.97 (0.96, 0.98)	<.001	0.93 (0.91, 0.95)	<.001	0.88 (0.87, 0.91)	<.001	1.29 (1.28, 1.30)	<.001	1.85 (1.81, 1.88)	<.001
Adjusted Cost	1.0 (95% CI 1.0)	0.999	1.0 (95% CI 1.0)	0.754	0.98 (0.96, 1.0)	<.001	0.98 (0.92, 0.97)	<.001	1.28 (1.2, 1.3)	<.001	1.36 (1.31, 1.4)	<.001
Geometric Mean	1.02 (0.91, 1.15)	0.524	0.92 (0.75, 1.14)	0.192	0.82 (0.63, 1.06)	0.007	0.68 (0.54, 0.86)	<.001	1.86 (1.38, 2.49)	<.001	3.43 (2.77, 4.25)	<.001
Nonlinear	0.95 (0.87, 1.03)	0.024	0.86 (0.73, 0.99)	<.001	0.83 (0.72, 0.94)	<.001	0.68 (0.57, 0.80)	<.001	1.23 (0.98, 1.53)	<.001	1.81 (1.38, 2.36)	<.001
Nonlinear	1.0 (95% CI 1.0)	0.964	0.97 (0.96, 0.98)	0.005	0.93 (0.91, 0.95)	<.001	0.88 (0.87, 0.91)	<.001	1.29 (1.28, 1.30)	<.001	1.85 (1.81, 1.88)	<.001

[1] For continuous outcomes, the estimate is presented as % of change, and 95% CI.
 [2] For binary outcomes, the estimate is presented as Odds Ratio and 95% CI.
 [3] Geometric mean refers to geometric mean of continuous variables and median for categorical variables.
 [4] We performed multilevel multivariable logistic regression models with a random intercept term that varied at the level of each hospital to account for correlation of patients within hospitals as they are likely to receive similar care. Models were adjusted for all available variables which included age, gender, race, insurance type, hospital location, hospital size, number of cases per year, type of fracture, type of anesthesia, use of NSAIDs, Gabapentin, Cox-2 inhibitors and tramadol. Clavien consistency index, and respiratory distress and substance abuse, glucose intolerance, nausea and vomiting and sepsis.