Conclusions Our data highlights the prevalence and severity of pain on the AICU with a clear link to commonly performed procedures, especially moving and rolling. This suggests that pre-procedural analgesia may be an effective method for improving pain control on the AICU.

**THE EFFECT OF LESSER PALATINE NERVE BLOCK ON IMMEDIATE POST-TONSILLECTOMY PAIN IN PEDIATRIC POPULATION**

C. Pereira, MJ Quelhas*, Al Castro, S Pé D’Arca. Unidade Local de Saúde de Matosinhos – Hospital Pedro Hispano, Porto, Portugal

Background and Aims Tonsillectomy is a common surgical intervention performed in the pediatric population, and post-operative pain is the main cause of morbidity following surgery [1,2]. Due to its innervation, lesser palatine nerve block (LPNB) may alleviate post-tonsillectomy pain. In this study, we evaluated the effect of the LPNB on postoperative analgesia in children undergoing adenotonsillectomy.

Methods Following informed consent, consecutive pediatric patients presented for adenotonsillectomy were randomly assigned to one of two groups: the intervention group receiving a bilateral LPNB (1–3 ml Ropivacaine 0.375%), and a control group. Both groups received the same iv analgesic postoperative (pethidine) protocol. Variables analyzed included postoperative pain scores (NRS) in the immediate postoperative period, time to rescue analgesia, total pethidine needs and PACU stay. Data analyzed using IBM-SPSS Statistics; Spearman correlation, Kruskal-Wallis, Chi-square or Fisher tests where appropriate (p<0.01).

Results A total of 42 patients were included in the analysis. No statistical difference was found between groups concerning demographic data, intra-operative analgesic doses, maximum NRS pain evaluations, rescue analgesia or PACU stay (Table 1). A significant correlation was found between maximum NRS pain scores and rescue analgesia in the PACU, as would be expected (Figure 1).

Conclusions In the studied population and considering the multimodal analgesia protocol used, the LPNB, does not seem improve postoperative pain control, or to reduce PACU rescue analgesia. Further studies would be necessary, with a larger sample size, to discern differences between groups [3].

**A REVIEW OF ANALGESIC AND ANAESTHETIC STRATEGIES USED IN TOTAL SCAPULECTOMIES AT THE ROYAL ORTHOPAEDIC HOSPITAL, BIRMINGHAM**

1V Padmanabhan*, 2B Smith. 1Worcestershire Acute Hospitals NHS Trust, Worcester, UK; 2The Royal Orthopaedic Hospital NHS Foundation Trust, Birmingham, UK

Background and Aims Total scapulectomy is a rarely performed orthopaedic oncological operation but as a specialist bone sarcoma unit we perform on an average, two such operations a year. There is a paucity of literature on optimal regional analgesic strategies to optimise post-operative pain management.1

We set out to review the notes of patients who had undergone a total scapulectomy over the last twenty years evaluating the trends in analgesic techniques and post-operative pain.

Methods Our oncology database identified forty total scapulectomy patients between 2001 and 2021 and of the available notes the anaesthetic charts, medication charts and post-operative pain scores were reviewed.

Results Sixteen sets of notes were available, the majority had either been destroyed due to the time since the operation or are in inaccessible storage. Two patients were under sixteen years old and were excluded. The patient group was heterogeneous and analgesic techniques used were varied. The earliest cases either used a morphine infusion or local anaesthetic infiltration.

More recently a combination of interscalene (ISB) and erector spinae blocks (ESP) have been preferred along with multimodal analgesia.

The best post-operative pain scores were found where local infiltration was combined with regional nerve block and catheter infusion than either alone.

Conclusions It is difficult to draw significant conclusions due to the small sample size but a combination of multi-modal analgesia along with local anaesthetic infiltration, regional nerve blocks and post-operative infusions appears optimal. The scapula has complex innervation from C3 to T5 and combination of ISB and ESP requires further prospective evaluation.2