Background and Aims
Major spinal surgery is a painful procedure requiring very high doses of intraoperative and postoperative opioids [1]. The majority of patients wake up in severe pain with many experiencing side effects from high opiate use [2]. Our primary aim was to investigate if an intraoperative intravenous infusion of ketamine and lidocaine mixture, when added to TIVA practice, improves pain scores in recovery and decreases the opioid amount used perioperatively.

Both groups received perioperative Multimodal Analgesia MMA: Paracetamol, Clonidine, Magnesium Sulphate and Ketamine boluses (only for the first group, as for the second, Ketamine was added to the infusion).

Methods
A retrospective review of the medical records of patients undergoing major spinal surgery at RNOH was conducted.

The patients were divided into two groups based on the type of main medications received:

- **Group 1**: MMA plus Opioids
- **Group 2**: MMA plus Opioids plus KLI

Opioid doses were converted to morphine equivalents daily.

Results
Pain scores were significantly lower in Group 2, on average, 3 points lower than in Group 1. The opioid doses used in the Group 2 were over 3 times lower than those observed in Group 1. Median opioid dose for the first group was 24 [IQR 12,33] compared to median of 6 [IQR 0,18] for Group 2. Median time to wake up was 3 minutes in Group 2 compared to 20 mins in Group 1.

Conclusions
Our pilot study concluded that Ketamine/Lidocaine infusion significantly decreases the pain scores in recovery and the doses of opioids used postoperatively in the first 24h.

### Abstract B334 Figure 1

## Abstract B334 Figure 2

### Abstract B335

**Efficacy of ASAP multidisciplinary algorithm on early postoperative complications in elderly inpatients for hip fracture: a retrospective before-after study with interrupted time-series analysis**

10.1136/rapm-2022-ESRA.410

Background and Aims
Hip fracture (HF) exacerbates loss of autonomy in the elderly. Several studies focus on improving outcome by intervening on one single aspect of perioperative management. We aimed to observe whether a multidisciplinary management algorithm rather than a single change to a single aspect of perioperative management had an impact on early 7-days postoperative complications (EPOCs). The implemented algorithm (“ASAP” = Advice, Surgery, Analgesia, and Pharmacology) included orthogeriatrician care, delay to surgery <12 hours (DOS), supra-inguinal fascia iliaca block (SFIB), and therapy’s adaptation, i.e. avoiding perioperative anti-cholinergic drugs.

Methods
Patients were divided in 2 cohorts according to date of admission. Pre-ASAP cohort included HF from January 1st, 2019, to December 31th, 2019; post-ASAP cohort included HF from January 1st, 2020 (date of ASAP implementation), to December 31th, 2020. After approval by our ethics board, a prospective before-after analysis of retrospective data was conducted assuming EPOCs as primary outcome. EPOCs were stratified according to Clavien-Dindo classification into minor (grade 1) and major (grades 2/3/4). Results
249 consecutive patients admitted with HF were included in this before-after analysis. Interrupted time-series (ITS) and Kaplan-Meier analyses from 134 (pre-ASAP) and 115 (post-ASAP) patients demonstrate that ASAP algorithm reduces all EPOCs (Figure 1–2).
Background and Aims External oblique fascial plane block (EOIB) is a relatively new block that targets both anterior and lateral cutaneous branches of the thoracoabdominal nerves by injecting the local anesthetic between the external oblique and intercostal muscles. Multiple indications have been described to perform EOIB. Here, we aimed to report the use of EOIB as a rescue analgesia method in laparoscopic (L/S) upper abdominal surgeries.

Methods Although the multimodal analgesia regimen was applied during the surgery, the pain status of patients with NRS score > six was defined as “unbearable” and EOIB was performed over the 6th and 7th ribs as rescue analgesia in the postoperative care unit (PACU). Our cases were laparoscopic (L/S) cholecystectomy (2 patients), L/S sleeve gastrectomy, L/S Nissen fundoplication, and L/S hiatal hernia repair. Ultrasound (US) guided EOIB was performed with 25 ml of the local anesthetic mixture (bupivacaine 0.5%, 10 ml lidocaine 2%, and 15 ml saline) for each side. Pain scores and bilateral sensorial examination were recorded over time.

Conclusions SFIB is the most effective aspect associated with EPOCs reduction in HF following the implementation of our multidisciplinary ASAP algorithm.

Table 1: NRS scores in PACU

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Operation</th>
<th>NRS score before</th>
<th>NRS score after</th>
<th>The time between NRS scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Cutaneous Blockade</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Right anterior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>anteriory line</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>M</td>
<td>Cholecystectomy</td>
<td>8</td>
<td>2</td>
<td>35 Min</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>Cholecystectomy</td>
<td>7</td>
<td>2</td>
<td>40 Min</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>Cholecystectomy</td>
<td>7</td>
<td>2</td>
<td>40 Min</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>Hiatal Hernia</td>
<td>5</td>
<td>3</td>
<td>40 Min</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>Sleeve Gastrectomy</td>
<td>8</td>
<td>3</td>
<td>40 Min</td>
</tr>
</tbody>
</table>