

Methods A Strengths, Weaknesses, Opportunities, and Threats (SWOT) matrix analysis following a Delphy methodology was conducted. A European model-based structure was designed, structuring an open staff point-of-care oriented programme, based on procedure-specific (PROSPECT) protocolization⁴. Strategic and Clinical Quality Indicators in Postoperative Pain Management (SCQIPP) and Quality of Recovery 15 scores (QoR-15) were added as two main endpoints. Four months before the implementation these scores were collected for comparison purposes. Visual Analog Scale (VAS), QoR-15, and SCQIPP scores were compared between these two periods.

Results 400 surgical patients were followed (24% total knee replacement (TKR), 13% thoracic surgery, 13% laparotomy, and 6% Pfannenstiel incision). Epidural and femoral catheters were the most used regional analgesia techniques (58% and 27% respectively). A significant VAS reduction was found in Pfannenstiel, lumbar and hip surgeries, along with a significant QoR-15 reduction in lumbar, hip, and oncologic gynecologic surgeries. Significant increases in SCQIPP scores were found in TKR, Pfannenstiel, open nephrectomy, and hip replacement surgeries.

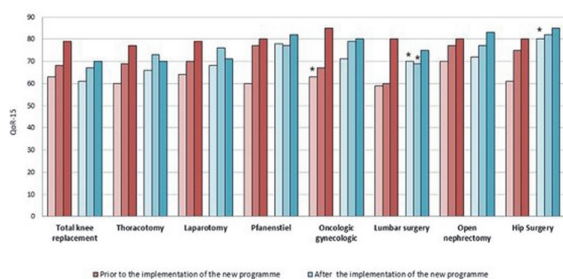


Figure 2 QoR-15 scores per procedure in the first 3 days after surgery. Four months before and after the implementation of the new programme (n = 400). *: p-value < 0,05 comparing groups prior and after implementation.

Abstract B339 Figure 2

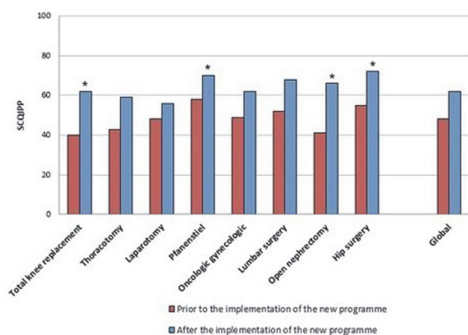


Figure 3 SCQIPP scores at discharge four months prior and after the new programme implementation (n = 400). *: p-value < 0,05 comparing groups prior and after implementation.

Abstract B339 Figure 3

Conclusions A SWOT-Delphy quality-oriented design methodology in a PAPMP allows to obtain higher rates of reduction in pain control and improves patient quality perception.

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THE COMBINATION OF ULTRASOUND-GUIDED RECTUS SHEATH BLOCK WITH RIGHT SUBCOSTAL TRANSVERSUS ABDOMINIS PLANE BLOCK IN LAPAROSCOPIC CHOLECYSTECTOMY

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Background and Aims We aimed to retrospectively study the efficacy of ultrasound guided rectus sheath block (RSB) in combination with right subcostal transversus abdominis plane block (TAP) for laparoscopic cholecystectomy as an effective intra and postoperative analgesic method.

Methods We studied 20 patient files, operated for laparoscopic cholecystectomy. All patients meeting the criteria were operated under general anesthesia using propofol, fentanyl and rocuronium. Following anesthesia induction, a bilateral RSB using 15 ml ropivacaine 0.375% on each side and a right subcostal TAP block using 20 ml ropivacaine 0.375% were performed. Intraoperative fentanyl dose was 2 mcg/kg for all patients. We evaluated all recorded numerical rating scores (NRS) charted, immediately postoperatively and 6 and 24 hours later. In addition, complaints of nausea, vomiting and constipation were recorded.

Results Intraoperative arterial blood pressure and cardiac rhythm trends, suggested stable hemodynamics and reflected effective analgesia in all cases. Median NRS scores immediately postoperatively were up to 1.5 and up to 3 in all following recording instances with no additional analgesics required, besides paracetamol that was administered every 8 hours. Nausea and vomiting was absent for all these patients and only 4 patients reported constipation over 3 days.

Conclusions Ultrasound guided combination of RSB with right subcostal TAP block is an effective and safe intra and postoperative analgesic method.

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PERIOPERATIVE INTRAVENOUS LIDOCAINE IN HIP SURGERY

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Background and Aims Hip pathology surgery, is a major health problem due to the aging of the population, mortality, and secondary functional dependency. Patients experience moderate to severe pain after a hip surgery. Achieving optimal postoperative analgesia allows initiation of rehabilitation early. Intravenous opioid analgesia is effective for rest pain but inadequate for dynamic analgesia with side effects. There is a growing interest in the use of non-opioid adjuvant analgesics. A drug with great potential is lidocaine. Our objective is to evaluate the role of perioperative intravenous lidocaine in the reduction of pain and improvement of postoperative results in hip surgery.

Methods A literature review was performed in the PubMed database using the keywords "intravenous lidocaine", "postoperative analgesia", and "hip surgery". Articles and reviews from the last 5 years were included. Studies in children under 18 years of age and pregnant were excluded.

Results

Abstract B341 Table 3

2008 Martin et al	2019 Baca Q et al
No significant differences regarding morphine requirements at 4h, 24h and 48h	Significant decrease in postoperative pain (30%), maximum pain (48%), and opioid consumption (39%).

Table 3. Evidence in hip surgery

Abstract B341 Table 1

Moderate level of evidence	Low level of evidence
Pain reduction	Reduction in opioid use
Reduction of nausea and vomiting	Shorter hospital stay
	Early recovery from paralytic ileus

Table 1. Clinical effects of perioperative intravenous lidocaine.

Abstract B341 Table 2

Plasma levels	Effects
0.5-5 mcg/ml	Desired clinical effects
> 5-8 mcg/ml	Minor adverse effects: perioral paresthesias, slurred speech, diplopia, tinnitus, metallic taste, lights or flashes, muscle twitching, and seizures
>15 mcg/ml	Major neurological effects: decreased level of consciousness, seizures, or coma
> 21 mcg/ml	Cardiotoxic effects: myocardial depression, arrhythmias, and cardiorespiratory arrest

Table 2. Plasma concentrations and adverse effects.

The reported benefits are included in Tables 1 and 2. Effects occur at low plasma concentrations during the infusion and persist for hours and even days afterward. The main mechanism of action is the reduction of inflammatory markers (leukotrienes-B4 and interleukin-1). The antinociceptive and antihyperalgesic action is multifactorial (like muscarinic, dopaminergic, and NMDA receptors). Despite its scientific evidence in multiple interventions, especially abdominal and urological, its evidence in hip surgery is scarce (Table 3).

Conclusions Perioperative intravenous lidocaine is strongly recommended in a wide variety of surgeries as a postoperative analgesic technique. However, it is not recommended in hip surgery because of the scarcity of studies and their contradictions.

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AUDIT OF POST OPERATIVE PAIN RELIEF FOLLOWING KNEE LIGAMENT RECONSTRUCTION AT WRIGHTINGTON HOSPITAL, A CENTRE OF EXCELLENCE FOR ORTHOPAEDIC SURGERY

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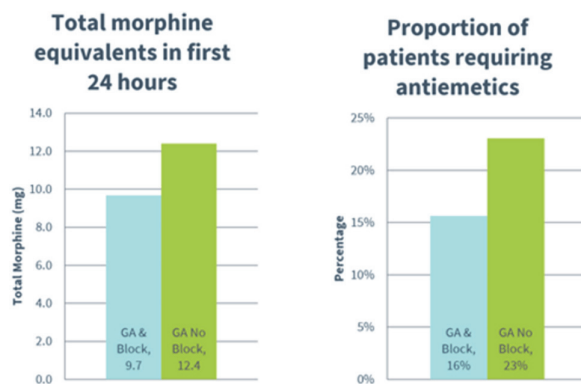
10.1136/rapm-2022-ESRA.416

Background and Aims Lower limb ligament reconstructions can be painful procedures¹. Central neuro-axial blocks and some regional techniques are relatively contraindicated as preserving

motor function aids rapid patient recovery and same day discharge². Analgesic techniques vary. The aim of the audit was to achieve a snapshot survey of current practice and relevant outcomes.

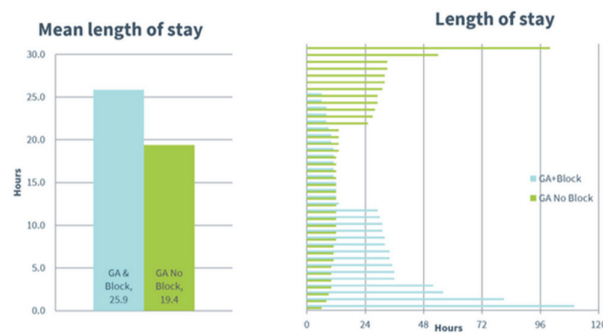
Methods With approval from the audit team the theatre database was searched for relevant procedures between April 2019 and March 2020. 97 cases were identified, of which 74 case notes were analysed. The following features were audited: anaesthetic time, theatre time, ASA, demographics, chronic pain history, anaesthetic technique, post-op pain, morphine requirements, antiemetic requirements and length of stay.

Results 95.9% of cases involved general anaesthesia and 4.1% spinal anaesthesia. 56.8% received no nerve block, 39.2% received an adductor canal block and 4.1% received a femoral nerve block. Mild/no pain was reported by 61.5% of patients without a nerve block and by 71.9% who did receive a nerve block. Patients who received a nerve block required less morphine within the first 24 hours (9.7mg vs 12.4mg) and less antiemetic therapy (16% vs 23%).



Abstract B342 Figure 1

Patients who received a block had a longer length of stay (25.9 hours vs 19.4 hours).



Abstract B342 Figure 2

Conclusions Just under half of cases received a nerve block. The use of adductor canal block is associated with modestly reduced post-op pain and consequently reduced morphine requirements and post-operative nausea. Adductor canal blocks are associated with increased length of stay. Patients were not randomised between techniques so differences in outcomes could be due to confounding factors.