and rescue analgesia requirement (p<0.001) were evaluated at all hours, there was a statistically significant decrease in Group T.

Conclusions It was seen that a more effective analgesia could be created with TFPB compared to LIB after varicocelectomy surgery.

B345  INTENSITY OF ACUTE POSTOPERATIVE PAIN AFTER ALTERATION OF MULTIMODAL ANALGESIA PROTOCOL

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Background and Aims Multimodal analgetic approach uses a combination of different classes of analgesic, opioids, adjuvants, loco-regional invasive techniques. Optimization of the multimodal approach is essential for better postoperative pain outcomes.

The aim of study was to analyse postoperative pain in years between 2018 and 2021 after a modification of multimodal analgesia protocol.

Methods A retrospective cross-sectional study of patients who underwent different orthopedic surgical procedures. Pain intensity was evaluated by using a Visual Analogue Scale (VAS). All patients were asked about pain four times a day. A total of 376 patients were included in the study.

Results On the operation day higher median of mean pain was after knee replacement 4.0 (IQR: 2.5–5.5) and the same after spine surgery, lower median of mean pain was after rotator surgery 2.0 (IQR: 1.0–4.4). On the first day after surgery higher median of mean pain was after knee replacement 4.0 (IQR: 2.0–5.4) humerus osteosynthesis 4.0 (IQR: 2.3–5.4) and rotator surgery 4.0 (IQR: 2.0–5.4), lower median of mean pain was after hip replacement 2.0 (IQR: 1.0–3.0) and revision surgery 2.0 (IQR: 1.0–4.3). Lower median of mean pain on the second postoperative day was after hip replacement 0.5 (IQR: 0–2.0) and higher median of mean after knee replacement 4.0 (IQR: 2.0–5.5).

Conclusions The results show that the leading position in higher pain scores remains after knee replacement surgery. The lowest pain scores were after hip replacement, then rotator, and revision surgeries.

B346  MORE INTRAFASCIAL, LESS INTRAVENOUS: EXTERNAL OBLIQUE INTERCOSTAL BLOCK FOR RESCUE ANALGESIA AFTER PANCREATODUODENECTOMY

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Background and Aims Even if pancreatoduodenectomy is a demolishing and painful procedure, it remains the only strategy for pancreatic head tumors; unfortunately, the survival rate is about 40% within 5 years.

The most common anesthetic strategy is still general anesthesia, with opioid pain control.

Methods A 72-year-old patient with hypertension was diagnosed with a pancreatic head neofomation and underwent pancreatoduodenectomy under general anesthesia and bilateral TAP block.

In the recovery room, the patient had NRS 6; after obtaining informed consent, a bilateral external oblique intercostal block was performed. The lateral and anterior cutaneous branches of the spinal nerves are main the target in surgeries performed with a subcostal incision.

A linear probe positioned between the midclavicular and anterior axillary lines was used, at the level of the sixth rib. The transducer was then rotated to obtain a paramedian sagittal oblique view. 15 mL of 0.5% ropivacaine was injected between the plane of the external oblique and the intercostal muscles bilateral (Figure 1; Figure 2).

Results The external oblique intercostal block demonstrated good coverage for subcostal incisions, immediately and after 24 hours.

After 1, 3, 6, 12 and 24 hours, the NRS values never overtake 4 on a scale from 0 to 10.

Conclusions The external oblique intercostal block seems to give excellent analgesia for the upper abdominal segments as rescue anesthesia after major abdominal surgery. Probably, together with the tap block, it can be used as a perioperative.