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: 1.0–4.3) 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: 0.2–2.0) and higher median of mean pain 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 years1.

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 neof ormation 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
analgesic technique for pancreatic-duodenal resection, decreasing opioid consumption and improving pain control.

**B347 PATIENT FACTORS ASSOCIATED WITH OPIOID CONSUMPTION IN THE 30 DAYS FOLLOWING MAJOR SURGERY**

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10.1136/rapm-2022-ESRA.A421

**Background and Aims** New chronic opioid use may represent a common complication after elective surgery. As many as 71% of opioid pills prescribed after surgery go unused and may become a source of misuse, abuse, and diversion. The aim of this study was to determine preoperative patient characteristics independently associated with home opioid use during the first 30 postoperative days.

**Methods** 250 patients not taking opioids before major abdominal/thoracic surgery were included in this single-center prospective observational cohort study. Validated questionnaires to assess pain, catastrophizing, depression, anxiety, functional status, fatigue and sleep disturbance were applied preoperatively. Primary outcome was total opioid use in oral morphine equivalents (OMEs) assessed by self-report through phone calls at 2 weeks and 1 month after surgery. OMEs were standardized across all surgery types. Multivariable regression models were used to predict total OMEs consumed in the first 30 postoperative days.

**Results** The median total OMEs prescribed was 600 mg (IR 450 mg), while median opioid consumption was 187.5 mg (IR 475 mg). 32 patients (13.0%) did not take any opioids after discharge: 34 (13.4%) continued opioid use for 4 weeks. Older age, college graduate status and increased functional status were significantly associated with decreased opioid consumption (age: B coefficient -0.02 p=0.001; college graduate status: B coefficient -0.16 p=0.044; functional status: B coefficient -0.03 p=0.008). Higher anxiety scores were significantly associated with increased opioid consumption (B coefficient 0.05, p=0.002).

**Conclusions** There was a marked discrepancy between prescribed and consumed opioids. Age, college graduates more active, and less anxious patients consumed significantly fewer opioids during the first month after surgery. Physicians should consider adjusting postoperative prescribing amounts accordingly.

**B348 EFFECT OF CHRONIC PREOPERATIVE BET-A-BLOCKER USE ON PERIOPERATIVE OPIOID REQUIREMENTS IN PATIENTS UNDERGOING LAPAROSCOPIC COLECTOMY**

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10.1136/rapm-2022-ESRA.A423

**Background and Aims** Intravenous opioids represent the mainstay of pain management for patients undergoing laparoscopic colectomy, even if they are associated with adverse side effects. Intraoperative β-blockers (IBB) may reduce opioid needs in surgical patients. 1–4 but no data exist on the effect of the preoperative use of β-blockers (PBB) on opioid consumption. The aim of the study was to determine if PBB users have different opioid requirements and if PONV is less prevalent.

**Methods** The records of 45 patients undergoing laparoscopic colectomy were reviewed. Variables collected included pre-, intra-, and postoperative opioid use, PONV incidence, and pre-existing β-blocker (BB) prescription. Patients were stratified by BB use and the Wilcoxon Rank-Sum Test was used to assess differences in opioid requirements and PONV incidences.

**Results** Pre-, intra-, and postoperatively, no statistically significant differences in opioid consumption were found among the two groups (p=0.778, 0.400, and 0.248). PONV incidence was also not significantly different (p=0.726).

**Conclusions** Although IBB use reduce perioperative opioid consumption and PONV, this effect was not seen in patients already taking BB. One reason why those previously prescribed BB do not show the same results as IBB patients may be due to upregulation and increased sensitivity of β-adrenoceptors due to chronic BB use. Furthermore, the majority of patients who were prescribed BB had a history of myocardial ischemia which can cause increased catecholamines levels and upregulation of β-adrenoceptors.

While all this may explain the inconsistency between chronic BB and acute IBB use, the role of acute preoperative BB use in opioid-reduction is an unstudied topic that warrants further investigation.