**Background and Aims** Chronic knee pain secondary to osteoarthritis affects millions of patients worldwide. Radiofrequency ablation (RFA) of genicular nerves is an effective and minimally invasive intervention for chronic knee pain. This report aims to describe the applied technique and evaluate its efficacy for the management of osteoarthritis-induced chronic knee pain.

**Methods** The study involved ten patients, admitted to the Pain Department of GHAN, complaining about chronic knee pain, clinically unresponsive to conservative treatment. During the procedure, patients were placed supine, with the knee flexed around 30°. Anesthesia was provided with subcutaneous lidocaine over the sites of cannulae insertion. A 100mm, 20-Gauge RF-Cannula (DIROS) with a 10mm active tip was placed percutaneously down to the junction of the femoral shaft and lateral epicondyle (Superion Lateral Genicular N.), another at the medial aspect of the distal femoral diaphysis (Superior Medial Genicular N.) and a third at the junction of the tibial diaphysis and medial condyle (Inferior Medial Genicular N) until bone is contacted. After confirming the correct placement of the cannulae tips via fluoroscopic images and via conduct sensory and motor testing, RF-thermocoagulation was initiated at 75°C for 180 seconds. Then, dexamethasone was injected through cannulae to prevent postprocedural pain and neuritis.

**Results** Pain intensity was evaluated two weeks and three months post-procedurally, using the pain VAS. All patients referred VAS-score 6/10 in the second week. At 3 months, 9/10 patients referred no pain, while one patient referred VAS-score 4/10.

**Conclusions** Genicular nerves’ RFA is a safe and efficient intervention for chronic knee pain management.

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**DEVELOPING A MULTI-DISCIPLINARY SERVICE FOR NEUROMODULATION AND NEUROABLATIVE SURGICAL TREATMENTS FOR CANCER PAIN**

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**Background and Aims** Cancer pain services have been adversely impacted by Covid-19. Patients are experiencing disruptions and delays in their treatment, leading to cancer progression and an increased need for more advanced pain interventions.

To address this, we developed a multi-specialty neuromodulation and neuroablation service comprising a monthly clinic of pain and neurosurgery consultants and nurse specialists and weekly multi-disciplinary team meeting to optimise the provision of advanced treatments for cancer pain.

We retrospectively evaluated patients referred to our service with an aim to select those patients with a worse prognosis earlier to maximise their benefit from such treatments (Figure 1).

**Figure 1: Decision pathway for neuroablative surgical procedures**

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Abstract B389 Figure 1

Abstract B389 Figure 2

Abstract B390 Figure 1
Methods 58 patients were reviewed in the clinic over an 18-month period. This included a range of oligometastatic (79%) and polymetastatic (21%) presentations.

Cancer treatments such as radiotherapy and chemotherapy were outlined as well as the current analgesia patients were using to manage their pain.

A composite body map was generated, summarising the frequency of pain reports at different anatomical locations (Figure 2).

Figure 2: A composite body map displaying the frequency of pain reports at different sites.

Results

81% trialled anti-neuropathic agents and 58% antidepressants. 29% of patients had an opioid consumption of greater than the maximum oral equivalent of morphine recommended by the British Pain Society (>120mg/daily). 74% patients were selected for advanced pain management procedures.

Conclusions Our data highlights the need and utility of a multi-specialty neuromodulation and neuroablative cancer pain service, which aligns with the recommendations made in the recently published Framework for Provision of Pain Services for Adults Across the UK with Cancer or Life-limiting Disease.

TIEZTE SYNDROME: CONSERVATIVE AND INTERVENTIONAL TREATMENT OF A RARE CHRONIC PAIN SYNDROME

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Background and Aims Tietze syndrome is characterized by swelling of sternocostal junction and is a rare cause of unilateral thoracic pain. The pain may radiate in the arms, and can be prescribed as stabbing, dull or tingling. Here we report the case of a 64 year-old woman, presenting in our outpatient pain management center two years ago.

Methods The woman was referred to our center by a thoracic surgeon, with the diagnosis of Tietze syndrome. She reported pain (intensity 8/10 almost constantly) with neuropathic elements (DN4 6/10) that started 18 months prior and worsened over time. The pain was located around the 2nd sternocostal joint and radiated in the upper right hemisternum. She had already been treated with the maximum daily doses of NSAIDS, pregabalin and p.o. opioids with minimal effects. Imaging of the area (CT, MRI) showed no pathological findings.

Results Since the patient had already been treated with numerous p.o. medications with no relief, we decided to perform a PEC I block under ultrasound guidance. 15 ml ropivacaine 0.375% and 8mg of dexamethasone were injected and no complications were reported. A significant improvement was reported, with the patient grading her pain 2–3/10. After 3 months her pain gradually began to increase, and is scheduled for a new PEC I block, and will be assessed for potential RF ablation of the intercostal nerves.

Conclusions Rare chronic pain syndromes many times pose challenges in the efficient management of the patient. If the pharmacological approach does not aid, invasive methods could provide a better result.