(SD 266.32), mean FT 62.23s (SD 13.22s); strong positive correlation between FT and DAP (r=0.545; p=0.01). Mean FT during 1st procedure 18.1s, 2nd - 20.7s, 3rd - 23.43s. Mean DAP during 1st procedure 226.24cGycm2, 2nd - 257.33cGycm2, 3rd - 349.97cGycm2. FT and DAP positively correlate in each group. First epidural steroid injection time p=0.750, 2nd 0.767, 3rd 0.682 (p=0.01). First FT was longer in LBP for more than 2 years (p=0.05) n=38 (mean 25.4s); LBP less than 1 year n=36 (mean 22.51s) and LBP from 1–2 years n=26 (mean 14.32s). Mean DAP was higher during 3 procedures and LBP longer than 5 years (p=0.05).

**Conclusions** DAP is in uphill linear relationship with FT. Mean cumulative dose is 57 times lower than radiation dose for FEISI allowed by Society of Interventional Radiology of Europe. Patients with longer LBP have longer FT and higher DAP, probably due to severe degenerative spinal lesions.

## LB26 RECTUS SHEATH BLOCK AND MULTIMODAL ANESTHESIA FOR ANESTHETIC MANAGEMENT IN EMERGENCY ABDOMINAL SURGERY: A CASE SERIES

[1]M Toleska, [1]A Dimitrovski*, [1]M Burmuzoska, [1]L Mikjunovikj-Derebanova, [1]B Kiprijanovska, [2]N Toleska Dimitrovska. *[1]Ss.Cyril and Methodius Univesiry – Skopje/TOARILUC – KARIL, Skopje, North Macedonia, The Republic of; [2]Ss.Cyril and Methodius Univesiry – Skopje/UK for Thorcacic and vascular surery, Skopje, North Macedonia, The Republic of*

10.1136/rapm-2022-ESRA.545

**Background and Aims** Rectus sheath block (RSB) is a regional anesthesia technique, that provides somatic analgesia (without visceral analgesia) by blocking the ventral rami of the 7th to 12 th intercostal nerves with injection of local anesthetic in the space between the rectus abdominis muscle and the posterior rectus sheath.[1] It can be used as a part of multimodal analgesia together with usage of non-opioid drugs, such as lidocaine, ketamine and magnesium, given as a continuous intravenous infusion during midline incisions in emergency open abdominal surgeries.Multimodal analgesia is recommended for pain management following major surgery.[2]

**Methods** We are presenting four cases of emergency open abdominal surgeries where bilateral RSB was performed with 0.25% bupivacaine after induction to general anesthesia.All patients received 4 mg dexamethasone and a continuous intravenous infusion with 2 mg/kg/h lidocaine, 0.2 mg/kg/h ketamine and 20 mg/kg/h was given till the end of surgery.All patient received 1 gr metamizole at the end of operation. In the postoperative period pain was followed with Visual Analogue Scale (VAS) score 2, 6, 12, 24, 36, 48 and 72 hours after operation and analgesia regime included metamizole 1 gr four times a day.For pain of 6–10/10 1 mg/kg tramadol was given.

**Results** During surgery request for opioids was lower and pain scores in the first 72 hours after surgery were reduced too.

**Conclusions** Bilateral rectus sheath block with continuous intravenous infusion of lidocaine,ketamine and magnesium provides sufficient analgesia during emergency laparotomies, lower opioid requirements during and after surgery,prolong neuromuscular block and all patient were hemodynamically stabile.

## LB27 THE EFFECT OF PARAVERTEBRAL ANAESTHESIA ON QUALITY OF LIFE SCORES IN BREAST CANCER PATIENTS

A Chhabra*, V Seenu, R Parshad, A Dhar, P Sharan, RM Pandey, S Mohanty, S Mathur. *All India Institute of Medical Sciences, New Delhi, India*

10.1136/rapm-2022-ESRA.546

**Background and Aims** Breast cancer is the commonest cancer worldwide.(1) Multiple level paravertebral anaesthesia (PVA) provides excellent analgesia with minimal PONV (2); therefore, we wanted to ascertain if PVA would improve quality of life (QoL) at 2weeks postoperatively in these patients.

**Methods** We included female patients of > 18 years, of ASA I-III, scheduled to undergo breast cancer surgery after ethics committee approval. Three validated QoL questionnaires for cancer patients were administered preoperatively and 2 weeks postoperatively i.e. the European Organisation for Research and Treatment of Cancer - QLQ-C30 (primary outcome), BR-23, the FACT-B and WHOQOL-bref questionnaires. (3–5)

PVA group patients received USG, in-plane, PVA at T1-T6 levels together with Pecs-2 block and propofol sedation whereas the GA group received standard GA.

**Results** 65 patients were randomised: 34 in the PVA and 31 in GA group. Demographics were comparable except for younger age of PVA patients. At 24 hours lower pain scores (movement), lesser fentanyl consumption was observed in PVA patients [365 mcg (215, 595)] versus GA group [820 mcg (565, 1035)], P= 0.0001. QLQ-C30 scores at 2 weeks post-surgery (global health-QoL, physical, role, cognitive, social functioning) were significantly better in PVA as compared to GA patients after age and baseline score adjustment. Intra-group analysis revealed significant fall in body image, sexual functioning, breast, arm symptoms (QLQ-BR23 scores) and lower emotional, functional scores (FACT-B, WHOQOL-bref) in the GA group.

**Abstract LB27 Figure 1**

**Conclusions** Therefore, emotional, physical and functional quality of life was better maintained in PVA patients as compared to GA patients at 2 weeks post-surgery.

## 001 REGIONAL ANESTHESIA SAVES THE DAY WHEN INTUBATION IS BEST AVOIDED

Onur Kumcu.

10.1136/rapm-2022-ESRA.547

There're many benetits of using regional anesthesia(RA) but sometimes performing RA compared to general anesthesia(GA) has some life saving advantages. I would like to share one of our experiance.

51-year-old male patient presented with multiple rib, tibial and scaphoid fractures due to fall from tractor and planned for external fixation. He was 180 cm tall, weighed 120 kg, had a history of obstructive sleep apnea (OSA) and 60 pack-year of smoking. He wasn't operated before, not on any medications, not allergic to drug and didn't use cpap or oral device for osas.

He was found conscious, pulse rate(PR) 88/min, blood pressure(BP) 160/80mmHg and SpO2 94. Airway investigation revealed mallampati score 3, mouth opening 4cm, thyromental

distance 6cm and neck circumference 52cm. He had 6 score in El-Ganzouri airway difficulty score, 35 points in Ariscat score and 6 points in Stop-Bang score. His high scores implied he could suffer from pulmonary complications perioperatively and we might encounter difficulties with his airway protection. To avoid such problems, infraclavicular block with 20 ml of prilocain 2%+bupivacain 0.5% and spinal anesthesia with 1.8 ml of 0.5% hyperbaric bupivacain were performed for his tibial and scaphoid fractures while avoiding sedatives and opioids. Surgery lasted 130 minutes uneventfully and without any complaints from patient who was sent to orthopedics ward.

Patients with OSA are at increased risk of perioperative morbidity and mortality because of potential difficulty in maintaining a patent airway.[1]Patients have increased perioperative risk from OSA and are prone to respiratory and airway problems if opioids, sedatives and inhaled anesthetics are used.[1] RA for a difficult airway patient helps avoiding difficulty of awake fiberoptic intubation and bypasses the question of when and where to extubate the patient.[2] RA is recommended in patients with OSA and/or potentially difficult airways who present for surgery.[1 3]

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## 001 COST EFFECTIVENESS OF SPINAL CORD STIMULATION IN CHRONIC LOW BACK PAIN

10.1136/rapm-2022-ESRA.548

Low back pain (LBP) is a serious burden both for patients and the health care systems. One in five adults have LBP and approximately 90% will experience LBP at some point of their life. It has been the major leading cause of disability worldwide, it has impaired the quality of life (QoL) for the past several years and it is the most commonly cited reason for disability, lost work, and lost wages in industrialized nations. Comorbidities associated with chronic pain including depression, anxiety, and sleep disorders further add to this burden. Direct costs of LBP such as the cost of hospitalizations, surgeries, prescriptions and physical therapy are estimated to be hundred of billions of dollars per year in the US alone. The indirect costs such as lost wages for missing work, emotional impact of chronic pain and any treatment or aid are sought to help it, retraining for new jobs that are more tolerable for the patient, and even healthcare allocation opportunity costs are more difficult to calculate.

Failed Back Surgery Syndrome (FBSS), defined as spinal pain persisting or appearing after a surgical procedure that is meant to treat the pain, is prevalent in up to 19% of microdiscectomy patients and 40% of lumbar laminectomy patients. Lumbar fusions for degenerative spondylolisthesis and associated LBP have risen significantly over the past 20 years. As many as 40% of patients who receive lumbar fusions may continue to have unsatisfactory relief of their symptoms. Patients with chronic back pain after a fusion surgery are also deemed to have failed back surgery syndrome (FBSS). For patients with apparent imaging findings revision surgical treatment could improve symptoms. Nonsurgical treatments for patients with FBBS include conventional medical treatment (CMM) with analgesics, physical therapy, cognitive behavioral therapy and more interventional therapies such as the implantation of spinal cord stimulator. Proper clinical management of FBSS should aim not only to alleviate pain, but also to improve physical function, Health Related Quality of Life (HRQoL) and lower drug dependency. Since narcotic use in FBSS patients has become an issue accentuated by the ongoing opioid crisis, reevaluation of clinical approaches in the treatment of FBSS is important. Spinal cord stimulation (SCS) can be effective at reducing pain and disability while improving (HRQoL) among FBSS patients. There are some high quality studies that found SCS device implantation (SCSdi) to provide superior patient satisfaction when compared to reoperation in patients with FBSS. Additionally, it is also found that fewer patients chose to crossover from their SCS device to a re-operation, further establishing this treatment as patient-centric in addition to efficacious.

However SCS is still mostly recommended to FBSS patients only after CMM has failed and when the pain has a neuropathic component. In 2008, the National Institute of Health and Care Excellence (NICE) recommended the use of SCS for the treatment of neuropathic pain, including pain caused by FBSS . SCS is underutilized and this calls for an additional reevaluation in a real-world setting. First of all, it is important to also assess the costs but also the cost-effectiveness of this procedure.

In a study published in 2017, 122,827 FBSS patients were identified and of these, 5,328 underwent SCS implantation (only 4.34%), and 117,499 underwent conventional management from 2000–2012, across the United States. Long-term total annual costs for these patients were significantly reduced compared to patients with conventional management. Although implantation of a SCS system resulted in a short-term increase in costs at one year, the subsequent annual cumulative costs were significantly decreased long-term in the following 9 years after implantation. This study combined the largest group of FBSS patients studied to date along with the longest follow-up interval ever analyzed. Since SCS has repeatedly been shown to have superior efficacy to CMM in randomized clinical trials, the current study demonstrated improved long-term health economics at 1, 3, 6 and 9 years supports the long-term cost utility of SCS in the treatment of FBSS patients. Although placement of an SCS system was associated with an initial increase in total costs at the time of implantation, however there was a significant and sustained 68% decrease in cost in the year following SCS placement compared to CMM. There was also an aggregate time trend that for each additional year after SCS, cost decreased on average 40% percent annually, with follow-up up to 1, 3, 6 and 9 years post-procedure.

Elena Rojo et al in 2021 presented a real-world cost-effectiveness analysis of SCS vs CMM in the management of FBSS. They obtained data from a 2-year real-world study (SEFUDOCE) of adults diagnosed with FBSS who were treated with CMM or SCS. Incremental cost-effectiveness ratios (ICER) were estimated in terms of direct clinical cost