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SP69 ACUTE PAIN MANAGEMENT: NEW GUIDELINES ARE NEEDED

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10.1136/rapm-2022-ESRA.75

Acute pain represents an incredible and difficult challenge in medicine. Most of the physicians are especially concentrated on postoperative pain, forgetting hundreds of other causes responsible for acute pain conditions, both of surgical and medical clinical interest. For an organic and adequate evidence-based management, several guidelines have been published.

Exploring PubMed for ‘acute pain guidelines’, it is possible to find over 2,000 papers just for the last 10 years. The history of guidelines in acute pain starts much before than the last 10 years. It goes back especially to the ‘90s, with all the interest related to multimodal analgesia and organization of acute pain services. As said before, the huge majority was related to the postoperative pain management. In particular, there were 2 great groups, in Copenhagen (Denmark) and in Orebro (Sweden) that generated an increasing interest on the topic. The first group at the beginning of the ‘90s started to highlight the concepts on the importance to treat postoperative pain and the potentialities to obtain a good analgesia with the simultaneous use of different analgesics (‘balanced’ or ‘multimodal’ analgesia). The other one, in the same period of time, was more addressed to demonstrate how important (crucial) was the organization based on nurses, to obtain a rewarding management of postoperative pain.

After that, hundreds of evidence-based guidelines and recommendations have been published. We will analyze the most relevant. Also, we will focus the attention on the real influence of all those publications and guidelines on the on-bed assistance, and on the change of epidemiological data related to acute pain. At the end, we will propose some new vision that should be implemented, thank to technological developments, if we really want to have an impact on the incidence of acute pain and pain chronification.

SP70 ANESTHESIA FOR ELITE ATHLETES

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10.1136/rapm-2022-ESRA.76

Anesthesiologists are increasingly confronted with athletes in a perioperative setting. The right choice of type of anesthesia technique, pain management of injuries, specific physiologic adaptations of the athlete and knowledge of prohibited substances are eminent for a correct approach of this subpopulation.

An anesthesiologist should recognize the most common benign ECG findings in athletes like bradycardia, isolated left ventricle hypertrophy on voltage criteria and early repolarization as normal features in the athlete’s heart. Isotonic physiology typically produces four chamber dilation. In contrast, isometric stress creates high intravascular pressure leading to left ventricular hypertrophy. Preoperative evaluation should also identify possible consumers of performance-enhancing drugs. Intraoperative points of interest for the anesthesiologist are mainly avoiding drugs on the prohibited list of the world anti-doping agency (WADA). Post-operative and chronic pain management are still developing fields in this population. The International Olympic Committee (IOC) proposed treating acute pain with a combination of paracetamol, NSAIDs, topical analgesics, injectable NSAIDs and local anesthetics. It may be suggested that chronic pain management in elite athletes could benefit from treatment in specialized multidisciplinary pain clinics.

Although elite athletes are amongst the fittest people on earth, unique characteristics of this population requires careful preoperative evaluation and perioperative management. Chronic pain management in athletes is a developing field with a need for further expert.

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B1 NOVEL SELECTIVE BLOCK OF THE POSTERIOR BRANCH FROM THE MEDIAL FEMORAL CUTANEOUS NERVE FOR DIAGNOSIS AND TREATMENT OF CHRONIC NEUROPATHIC PAIN – A CASE REPORT

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10.1136/rapm-2022-ESRA.77

Background and Aims The medial femoral cutaneous nerve (MFCN) is known to innervate the anteromedial knee area.^{1,2} A selective block of the anterior branch from the MFCN (MFCN-A) but not the posterior branch (MFCN-P) has been described.^{3,4} We present an ultrasound-guided technique for blockade of the MFCN-P. Post-hoc analysis of data from a randomized, controlled trial showed that the MFCN-A or MFCN-P may innervate the distal part of the medial lower leg and even the medial malleolus (MM) which has never previously been described.⁴ We present a case of cutaneous neuropathy in the “classical saphenous nerve territory” on the medial side of the lower leg and MM, where a selective MFCN-P block was used for diagnosis and treatment of the neuropathic pain.⁵