Results 205 patients underwent open abdominal surgery, 410 had laparoscopic/combined surgery. There was no difference in analgesics administration between sexes. In the complete cohort a larger proportion of females reported CPS/CPS ≥ 5.5 (OR 2.3, p<0.0001). However, epidural anesthesia in open abdominal surgery reduced pain in all patients and eliminated sex differences. BMI<35, Muslim religion and intraoperative ketorolac were associated with reduced postoperative pain (in trend, p=0.06). CAES/CPS ≥ 4 was associated with female sex (OR 2.6, p<0.0001), and tramadol administration (OR 3.5, p=0.036).

Conclusions Females reported higher postoperative pain and opioid-related adverse-effects after abdominal surgery. Epidural reduced pain intensity and eliminated sex differences. We attribute the higher opioid-related adverse-effects in females to a higher exposure to tramadol adjusted to weight. Our results support using epidural analgesia during and after open abdominal surgery in men but especially in women, as well as considering lower doses of tramadol in women as part of multimodal analgesia.

Attachment 592-15 – RESULTS FROM THE IMPLEMENTATION OF A PCEA PROTOCOL FOR POSTOPERATIVE PAIN.pdf

Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

Background and Aims Patient controlled epidural analgesia (PCEA) aims to give patients increased autonomy, while tailoring dose to minimize adverse effects. Our Acute Pain Service (APS) developed an institutional protocol for PCEA with ropivacaine 1 mg/mL, optional morphine 20 mcg/mL, bolus 4 mL, lockout 30 min, and infusion 4-8 mL/h. A quality and safety assessment was performed nine months after implementation.

Methods Data collected by the APS was retrospectively reviewed for pain control and local anesthetic consumption at postoperative days one and two, adverse events, and patient satisfaction. Electronic health records were also screened for adverse events. The audit was considered exempt from Ethics Committee approval.

Results PCEA was used in 81 patients following upper and lower digestive, thoracic, gynecologic, urologic, and retroperitoneal surgery. Epidural morphine was used in 83%. Median numeric rating scale for static pain on day one was 0 (IQR 2), and for dynamic pain 3 (IQR 2). Median static pain on day two was 0 (IQR 1), and dynamic pain 3 (IQR 2). Mean volume infused was 107 mL (SD 55 ml) at day one and 117 mL (SD 58 ml) at day two. Hypotension (23%) and nausea and vomiting (19%) were the commonest adverse events. Off-hours anesthesiologist intervention was required in 20% of patients. Of 69 patients inquired, 96% were satisfied with the analgesia.
Abstracts

**CONCLUSIONS**

An institutional protocol facilitates adequate continuous improvement. An organized APS and stakeholders’ education are crucial for implementation. Pain control and patient satisfaction were good. Future adjustments to the protocol might decrease adverse events.

**CONTINUOUS BILATERAL ERECTOR SPINAE PLANE BLOCK PROVIDES EFFECTIVE POSTOPERATIVE ANALGESIA AFTER OPEN UPPER ABDOMINAL SURGERY, A CASE SERIES REPORT**

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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

**Background and Aims**

Managing postoperative pain after an open hepatobiliary surgery often presents a challenge. Use of regional anesthetic techniques is common to reduce opioid consumption and its associated side effects. Thoracic epidural analgesia is considered to be the gold standard for this type of surgery, however, it might be contraindicated due to abnormal coagulation, patient refusal, etc. In this study we evaluated the efficacy of continuous bilateral erector spinae block (ESPB) in this setting.

**Methods**

ESPB was performed in 10 adult patients scheduled for open hepatobiliary surgery in whom thoracic epidural was contraindicated due to abnormal coagulation profile or patient refusal. Procedures included Liver-Lobectomy, Hepato-pancreato-biliary, Whipple and exploratory laparotomy. ESP catheters were inserted under US guidance at the level of T5-T6. At the conclusion of surgery, patients received a bolus of 10ml of 0.25% bupivacaine into each ESP catheter followed by a continuous infusion of 0.1% bupivacaine at 12-16mL/h into both catheters. Patients also received non-opioids around the clock for multimodal pain control. We used the maximal VAS score in every 8 hours for the whole duration of infusion which varied and opioid consumption was monitored.

**Results**

Patient demographics, type of surgery, contraindication for epidural, postoperative pain scores till the end of infusion, overall duration of infusion, opioid consumption over 48 hours are shown in table 1. All patients had successful placement of ESP catheters, no complications were noted. Pain scores were markedly low as well as opioid requirement.

**Conclusions**

Continuous ESPB is a feasible and effective technique for providing analgesia following major open abdominal surgery.

**UTILIZING HIGH DOSE KETAMINE FOR THE TREATMENT OF REFRACTORY, POSTOPERATIVE, PHANTOM LIMB PAIN FOLLOWING TOTAL SHOULDER WITH PROXIMAL HUMERAL REPLACEMENT FOR TRANSDERMAL OSSEOINTEGRATION SURGERY**

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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

**Background and Aims**

Although several studies have demonstrated efficacy of low-dose intravenous ketamine infusions in the perioperative period, there is little to no research investigating the use of high dose ketamine boluses for phantom limb during the acute postoperative period. This case demonstrates the success use of high dose ketamine to alleviate acute, postoperative, phantom limb pain following electrode implantation and total shoulder with proximal humeral replacement for transdermal osseointegration, after failing all other traditional postoperative phantom limb pain regimens.

**Methods**

Direct patient care as well as retrospective chart review.

**Results**

The patient was extubated in the OR and admitted to the ICU postoperatively, for pain control and started on the following pain regimen by the acute pain service: Ketamine gtt at 0.3mg/kg/hr, Subutex 8mg TID, Robaxin 500mg QID, Acetaminophen 1g TID, Lyrica 75mg TID, and IV Dilaudid 0.5 mg q3H PRN for breakthrough. Over the course of the next eight days patient also received daily IV ketamine boluses by a Physician, in 20mg increments, every 10 minutes for up to 5 doses, titrated to effect. The patient received between 60-100 mg of ketamine total during each ‘bolus session’ which occurred twice a day.