**Background and Aims** Acute post-operative pain management can be challenging due to subjective nature of pain and difficulty in assessing in patients who are sedated after general anesthesia. This study aimed to assess postoperative pain by use of both subjective and objective parameters.
**Methods** Patients aged 18-60 years, ASA I/II and posted for elective lower abdominal surgery of atleast 4 hours were included. Consent refusal, emergency surgery, history of chronic pain was the exclusion criteria. Subjective markers (VAS, satisfaction score) and objective marker (pupil diameter) were recorded at baseline and at consecutive hours postoperatively (6, 24, 48 hours). Objective marker CNTN1 was measured at baseline and at 48 hours postoperatively.
**Results** After ethical approval, 40 patients were studied. Mean ±SD age was 46.13±11.43 years. VAS score postoperatively at 6, 24 and 48 hours were 3.72±0.87, 3.48±0.87, 1.48 ±0.50 respectively, showing significant decline at all time intervals. Satisfaction score also improved significantly at 6, 24, 48hours. Mean ± SD of pupil diameter at baseline, 6, 24 and 48hours postoperatively was 4.64±0.94, 5.27±0.86, 5.08 ±0.77, 4.6±0.89 respectively. CNTN1 at baseline and at 48hours was 0.21±0.026 and 0.19±0.028. We found positive and statistically significant correlation between VAS score and pupil diameter at all time intervals.
**Conclusions** VAS score correlated well with pupillary diameter. Thus pupillary diameter can be chosen as an objective measurement of postoperative pain severity.
**Attachment** Adobe Scan 17 May 2023.pdf

## #35886 FEASIBILITY AND EFFICACY OF ULTRASOUND GUIDED CERVICAL SYMPATHETIC PLEXUS BLOCK WITH CONTINUOUS INFUSION OF LOCAL ANESTHETICS TO TREAT ACUTE POST-SURGICAL PAIN AFTER TRANSORAL ROBOTIC SURGERY HEAD AND NECK SURGERY

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10.1136/rapm-2023-ESRA.599

**Please confirm that an ethics committee approval has been applied for or granted:** Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

**Application for ESRA Abstract Prizes:** I don't wish to apply for the ESRA Prizes

**Background and Aims** Rising oropharyngeal cancer among men and women is a documented public health concern. Surgical treatment and post-surgical care of these patients are very challenging and among them odynophagia in the first 2 weeks after surgery is highly concerning. In addition to suffering that is caused by pain, poor oral intake and hence inability to take oral pain medications keeps these patients bound to hospital and is the cause of readmission and Emergency room visits during 1st 2 weeks after surgery. The goal of this study is to examine feasibility and efficacy of utilizing continuous infusion of local anesthetics to lower cervical sympathetic plexus (Stellate ganglion) for treating acute postoperative pain in patients undergoing TORS for treatment of HNC.
**Methods** Post induction catheter placement of Stellate ganglion and infusion of local anesthetics for up to 2 weeks in 45 patients underwent TORS for oropharyngeal tumor resection. Results compared with historical data, 32 patients.
**Results** Patients who received a SGB had a statistically significant reduction in MME on POD 0, 2 and 3. MME use in SGB group was lower on POD 1 as well, however this did not reach statistical significance. There were no statistically significant differences in MME use between the two grousp beyond POD3 and there were no statistically significant differences in PONV or average VAS pain scores between the two groups
**Conclusions** It is feasible and somewhat effective to use SGB block for treatment of acute pain after oropharyngeal tumor resection. No complication was noticed directly or indirectly related to SGB.
**Attachment** ethics_IRB.pdf

## #36093 A STEP FORWARD TO POSTOPERATIVE PAIN MANAGEMENT IN OUTPATIENT SURGERY: A PILOT STUDY

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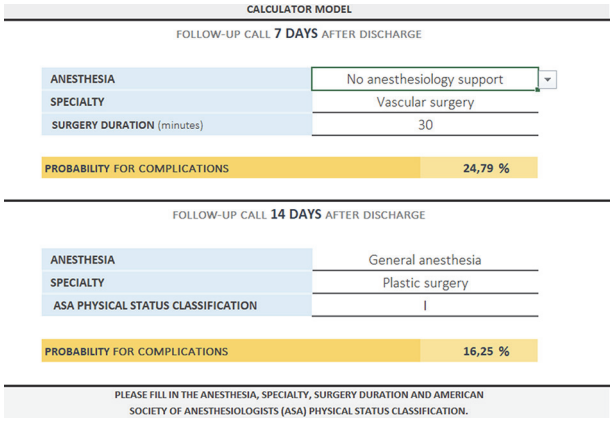
10.1136/rapm-2023-ESRA.600

**Please confirm that an ethics committee approval has been applied for or granted:** Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission
**Background and Aims** In Outpatient Surgery (OS), post-discharge follow-up calls are essential for identifying complications, including pain. Currently, there is a lack of scientific evidence to support the validation of follow-up protocols adjusted to patients' specificities. This study aims to develop an individualized follow-up model.
**Methods** We performed a retrospective, single-center study, including patients undergoing OS at a tertiary hospital in Portugal, for three months. Follow-up calls were performed on the 7th and 14th days after discharge. Were analyzed sex, age, surgical specialty, anesthetic technique, American Society of Anesthesiologists physical status classification, surgery duration, and complications. A binary logistic regression was adjusted for the complications detected in each call.
**Results** 785 and 741 answered the 1st and 2nd follow-up calls, respectively. Complications were reported in 47.1% (n=370) and 29.8% (n=221) of these calls, respectively, with pain having the highest incidence rate: 44.7% in the 1st call, 26.6% in the 2nd (table 1). The type of anesthesia, surgical specialty, and, in the 1st call, surgery duration were independent risk factors for complications (p≤0.004). A model that predicts the detection of complications in each call was created (figure 1).

**Abstract #36093 Table 1** Incidence of complications registered in the follow-up call (the incidence rate is presented in brackets)

| Complication | Follow-up call | |
|---|---|---|
| | 7th day after s. (n=384[I]) | 14th day after s. (n=223[I]) |
| Mild pain (NS 1-3/10) | 314 (40.00) | 179 (24.16) |
| Moderate pain (NS 4-6/10) | 31 (3.95) | 14 (1.89) |
| Intense pain (NS 7-10/10) | 6 (0.76) | 4 (0.54) |
| Sensory disorder (no FI) | 3 (0.38) | **7 (0.94)** |
| Sensory disorder (with FI) | 2 (0.25) | 1 (0.13) |
| Nausea/vomiting | 4 (0.51) | 0 (0.00) |
| Headache (without DP) | 1 (0.13) | 1 (0.13) |
| Post-DP headache | 4 (0.51) | 1 (0.13) |
| Suture dehiscence | 2 (0.25) | **5 (0.67)** |
| Purulent drainage (surgical site) | 5 (0.64) | 4 (0.54) |
| Blood drainage (surgical site) | 6 (0.76) | **6 (0.81)** |
| Bruise (surgical site) | 4 (0.51) | 1 (0.13) |
| Urinary retention | 2 (0.25) | 0 (0.00) |

[I] - Multiple follow-up calls recorded several complications; DP - dural puncture; FI - functional impairment; NS - numerical scale; s. – surgery.




**Abstract #36093 Figure 1** Calculator model

**Conclusions** This study recognized the influence of several variables in the incidence of post-discharge complications and emphasized that pain was the most frequently reported complication. According to it, the type of anesthesia, surgical specialty, and surgery duration should be considered when establishing individualized follow-up plans. In our reality, no follow-up calls are routinely performed after the 7th day, meaning some patients probably should be accompanied for a longer period.

**Attachment** I.BX8_CES (1).pdf

## #35868 INDIVIDIAL ANAESTHETIST VARIATION IN PAIN EXPERIENCE OF DONOR NEPHRECTOMY PATIENTS

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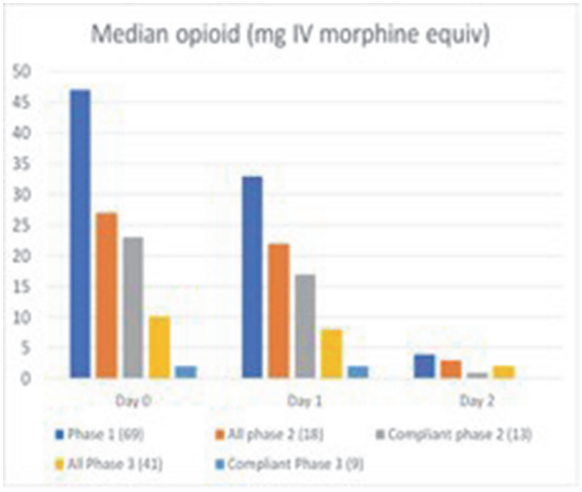
10.1136/rapm-2023-ESRA.601

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

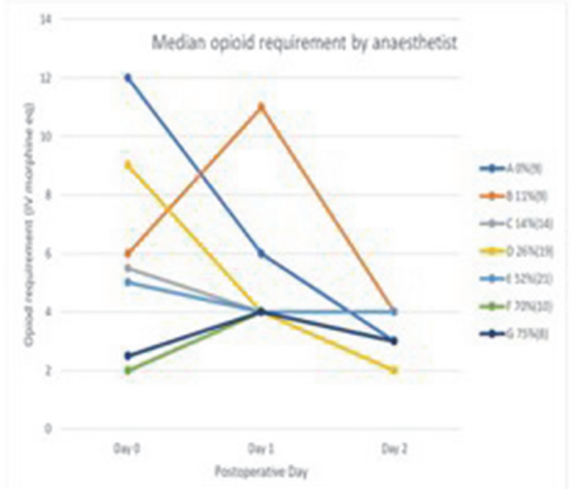
**Background and Aims** Enhanced recovery after surgery (ERAS) protocols have shown to improve patient outcomes in donor nephrectomies.The Donor Nephrectomy Improvement Programme at our hospital aided formation of ERAS guidelines in 2020. The first 3 phases of the project used to standardise anaesthetic technique have shown great improvements in the patient experience (figure 1, 2). We aim to see if the improvements from the previous 3 phases have been maintained, and what the results from individual anaesthetists are.

**Methods** Ethical approval was not required as per the local audit committee. A retrospective search conducted from the Renal Transplant Database identified 109 donor nephrectomy patients from the introduction of the ERAS guidance over a 22-month period. Clinical notes were analysed reviewing: compliance with the guideline; length of stay; mobilisation day and intravenous morphine equivalents 48 hours postoperatively. Individual anaesthetists were only included if they had performed >5 cases. A case was deemed 'compliant', if all intraoperative/postoperative guidance was followed precisely.

**Results** The percentage of cases the anaesthetist was fully compliant with the guidelines varied from 0-75% (figure 3). From figure 3, there is a correlation between high compliance and lower opioid use, a result repeated when analysing maximal pain scores.




**Abstract #35868 Figure 2** Opioid requirements in first 3 phases




**Abstract #35868 Figure 3** Comparison of median opioid requirement by anaesthetist