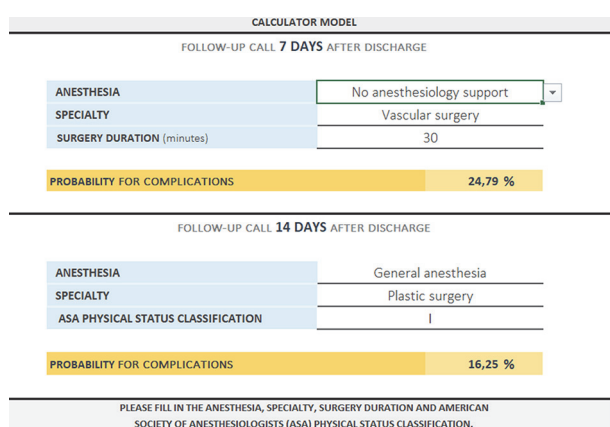


Abstract #36093 Table 1 Incidence of complications registered in the follow-up call (the incidence rate is presented in brackets)

Complication	Follow-up call	
	7th day after s. (n=384 ¹)	14th day after s. (n=223 ¹)
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)

¹ - 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 INDIVIDUAL ANAESTHETIST VARIATION IN PAIN EXPERIENCE OF DONOR NEPHRECTOMY PATIENTS

Karen Mackintosh*, Nikole Runciman, Samantha Joliffe, Iain Thomson. *Anaesthetics, Queen Elizabeth University Hospital, GLASGOW, UK*

10.1136/rapm-2023-ESRA.601

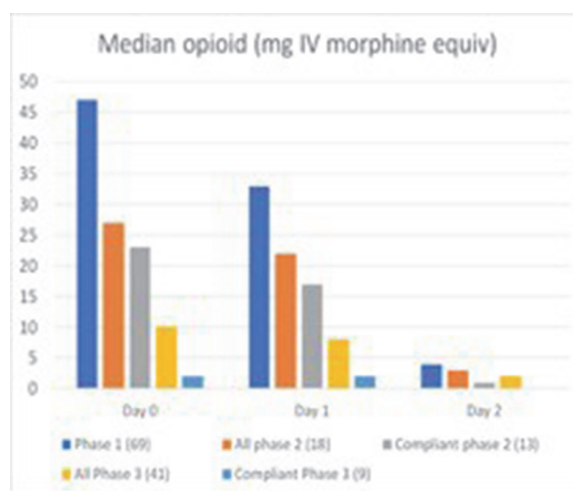
Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

Background and Aims Enhanced recovery after surgery (ERAS) protocols have shown to improve patient outcomes in donor nephrectomies. The Donor Nephrectomy Improvement

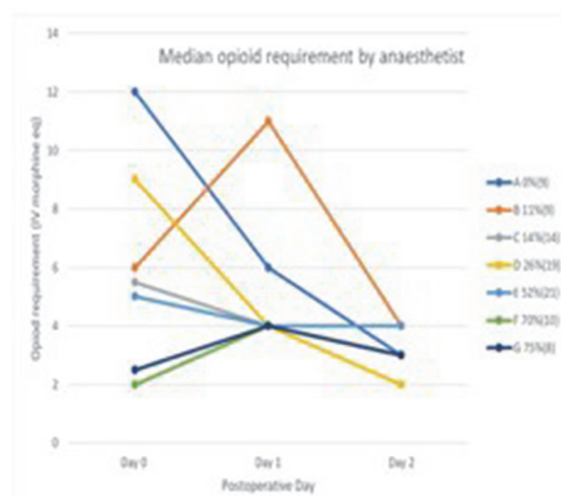
Programme at our hospital aided formation of ERAS guidelines in 2020. The first 3 phases of the project used to standardise anaesthetic technique have shown great improvements in the patient experience (figure 1, 2). We aim to see if the improvements from the previous 3 phases have been maintained, and 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



Abstract #35868 Figure 1 Donor nephrectomy analgesia guidelines

Conclusions The ERAS programme and technique guidelines have hugely reduced variation in pain experience from phase 1 to 4. However, the variety between individual anaesthetists that remains can be explained, in part, by a lower degree of adhering fully to current guidance, with non-compliance associated with worse outcomes. Results have been fed back to the individual anaesthetists.

#36208 DEVELOPMENT OF A PREDICTIVE MODEL TO RISK STRATIFY PATIENTS AT INCREASED RISK OF SIGNIFICANT POSTOPERATIVE PAIN

¹Azriel Chang*, ^{2,3}Hon Sen Tan, ^{2,3}Chin Wen Tan, ⁴Rehena Sultana, ^{2,3}Farida Ithnin, ^{2,3}Alex Tiong Heng Sia, ^{2,3}Ban Leong Sng. ¹Duke-NUS Medical School, Singapore, Singapore; ²Department of Women's Anaesthesia, KK Women's and Children's Hospital, Singapore, Singapore; ³Anaesthesiology and Perioperative Sciences Academic Clinical Program, Duke-NUS Medical School, Singapore, Singapore; ⁴Centre for Quantitative Medicine, Duke-NUS Medical School, Singapore, Singapore

10.1136/rapm-2023-ESRA.602

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 The main barrier preventing optimal pain management is the inability to identify and manage patients at elevated risk of significant pain in a timely manner, thereby compounding pain-related morbidity. Our aim was to develop a predictive model for pain score at postoperative 13-36th hours by analysing data from our centralized enterprise analytic platform (eHIntS).

Methods We analysed postoperative data retrieved from eHIntS in 667 patients between January to July 2020, comprising demographic, type of admission, method of surgery (minimally invasive/open), duration of surgery, procedure code, pain scores at PACU, postoperative pain scores at 0-12th hours (at rest, on movement), number of analgesia attempts at postoperative 12th hour, and delivered analgesia at postoperative 12th hour.

Results A total of 102 (15.3%) patients had at least one pain score of >3 at postoperative 13-36th hours, with average and maximum pain score of 2.4 (SD 0.9) and 5.0 (SD 1.4), as compared with those having pain scores 0-3 at postoperative 13-36th hours (average: 1.3 (SD 0.6); maximum: 2.4 (SD 0.9)). The multivariable model showed that Malay race as compared with Chinese, having ovarian surgery, increased PCA morphine dose at 12th hour, and having higher maximum pain score at movement at postoperative 0-12th hours were independently associated with maximum pain score on movement at postoperative 13-36th hours >3 (significant pain), with an AUC of 0.731.

Conclusions This model needs to be verified and validated in a larger and more diverse dataset to increase the predictive power of the model.

Attachment 2022-2505 20220922 NR.pdf

#34788 AMPUTATION PAIN QUALITY IMPROVEMENT PROJECT

Richard Robley*, Jonathan Wright. Anaesthetics, University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK

10.1136/rapm-2023-ESRA.603

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 Due to closure and redirection of several vascular units in our area and our expertise in endovascular surgery, we experienced a large increase in our vascular surgery population in 2018. This came with high levels of acute pain on the ward. In 2019-2020 we audited anaesthetic and analgesic techniques via questionnaire. Regardless of anaesthetic or single shot nerve block, our rate of severe pain 24 hours after lower limb amputation was extremely high at 76%. We aim to eliminate severe(7-10) pain and have 80% of patients with good pain management(score 0-3) in order to start physiotherapy on day 1 postop.

Methods We recommended higher oramorph doses, anticipatory morphine prescribing, routine acute pain nurse review day 1 postop and routine surgical placement of sciatic or tibial nerve catheters with 10ml/h 0.125% levobupivacaine via epidural set and pain bomb. We also switched to an electronic notes system, where pain score 0-10 is regularly recorded with other observations. This year we used this to retrospectively audit pain in 108 patients (after 10 exclusions for lack of data).

Results 95 had nerve catheters, only 6(7.41%) had severe(7-10) pain and 71(74.74%) had good(0-3) pain control. 13 patients did not receive nerve catheters but pain management had still improved, with 2(15.38%) in severe pain and 7 (53.85%) with good pain control.

Conclusions The difference between patients with and without nerve catheters did not reach statistical significance, but we