



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