



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

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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.

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#34788 AMPUTATION PAIN QUALITY IMPROVEMENT PROJECT

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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

continue to drive toward our short term goals and will later compare before and after rates of phantom limb pain.

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#36332 OPIOID- SPARING ANESTHESIA/ANALGESIA IN COMPLEX INTRA-ABDOMINAL SURGERY: A CASE REPORT

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Background and Aims Opioids are widely utilized agents for pain control, both intraoperatively and postoperatively. However, due to the abundance of adverse effects associated with their use such as nausea, vomiting, respiratory depression, ileus, delayed gastric emptying and pruritus, the use of opioid-sparing and opioid-free techniques have gained growing interest as part of a multimodal analgesic approach. In this context and in the era of an ever-increasing opioid epidemic, regional anesthesia and analgesia techniques are an interesting supplementary alternative aiming at minimizing opioid use.

Methods In this report, we present the use of an opioid-free general anesthesia modality in conjunction with a thoracic epidural technique in an elderly patient with comorbidities who underwent pancreatoduodenectomy. The anesthetic technique was based on the Mulier protocol. In specific, 0.1 mcg/kg dexmedetomidine, 0.1 mg/kg ketamine and 1 mg/kg lidocaine were administered as a bolus, followed by a continuous infusion of a mixture of dexmedetomidine 0.1 mcg/kg/h, ketamine 0.1 mg/kg/h and lidocaine 1 mg/kg/h throughout the operation. Before skin incision, an additional bolus of ketamine 0.5 mg/kg was administered, followed by 40 mg/kg of magnesium and 8 mg of dexamethasone. The anesthetic was supplemented by a low thoracic epidural. Intraoperatively and postoperatively, complete avoidance of opioids was achieved.

Results We demonstrated a paradigm of complete avoidance of systemic intravenous administration of opioids intraoperatively and postoperatively in an elderly patient with comorbidities scheduled for pancreatoduodenectomy.

Conclusions An opioid-free anesthetic is feasible and can be delivered successfully even in open gastrointestinal surgical procedures, where analgesia has traditionally relied on the use of opioids.

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#35053 EXTERNAL OBLIQUE INTERCOSTAL FASCIAL PLANE BLOCK FOR PATIENTS UNDERGOING LIVER TRANSPLANTATION: A CASE SERIES

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Application for ESRA Abstract Prizes: I apply as an Anesthesiologist (Aged 35 years old or less)

Background and Aims In patients undergoing liver transplantation, postoperative pain control can be challenging since a neuraxial block is contraindicated with ongoing coagulopathy. This led us to investigate the utility of ultrasound-guided external oblique intercostal (EOI) blocks in this patient population. Local anesthetic is injected in the fascial plane between the external oblique and intercostal muscle at the T6 and T8 levels, bilaterally, for somatic coverage of the 'chevron' incision. Here, we present a small comparative case series.

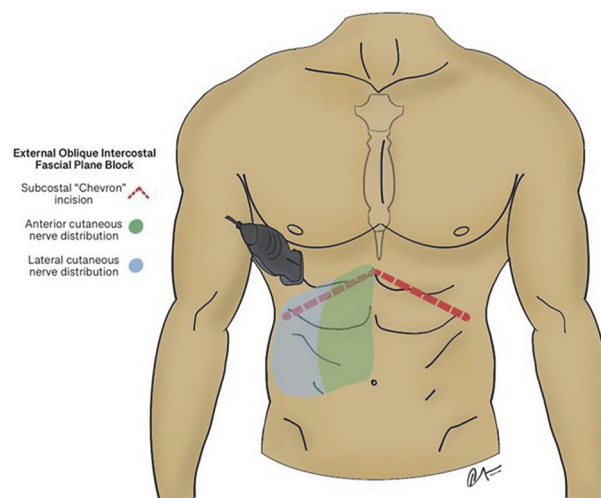
Methods This is a retrospective chart review comparing the postoperative opioid utilization of five patients with and without the EOI block.

Results The average oral morphine equivalents (OME) for POD 0, 1, 2, and 3 were 39mg, 70.5mg, 28.4mg, and 12.3mg in the EOI group and 71.8mg, 109.1mg, 85.5mg, and 53.5mg in the control group (table 1).

Abstract #35053 Table 1 Comparing the postoperative opioid utilization of five patients with and without the EOI block

Case series	Patient group	POD 0 (OME)	POD 1 (OME)	POD 2 (OME)	POD 3 (OME)
Patient 1	Block	20 mg	85 mg	59.5 mg	24 mg
Patient 2	Block	0 mg	7.5 mg	7.5 mg	7.5 mg
Patient 3	Block	52 mg	102.5 mg	45 mg	15 mg
Patient 4	Block	95 mg	82.5 mg	0 mg	0 mg
Patient 5	Block	28 mg	75 mg	30 mg	15 mg
Average consumption of OME in Patients 1 - 5		39 mg	70.5 mg	28.4 mg	12.3 mg
Patient 6	Control	140 mg	145 mg	52.5 mg	60 mg
Patient 7	Control	34 mg	80 mg	90 mg	60 mg
Patient 8	Control	100 mg	152.5 mg	110 mg	55 mg
Patient 9	Control	20 mg	110 mg	130 mg	40 mg
Patient 10	Control	65 mg	58 mg	45 mg	52.5 mg
Average consumption of OME in Patients 6 - 10		71.8 mg	109.1 mg	85.5 mg	53.5 mg

All 10 patients were extubated in the operating room at the conclusion of surgery. Patients 1 - 5 received a bilateral external oblique intercostal nerve blocks at T6 and T8 with 20 mL of liposomal bupivacaine and 30 mL of 0.25% bupivacaine. Patients 6 - 10 did not receive any regional anesthetic. Patients 1 - 10 were all started on hydromorphone PCA on POD 0 per institutional liver transplant protocol. POD - Post operative day, OME - Oral morphine equivalents, Mg - Milligram.



Abstract #35053 Figure 1 This animation depicts the location of a typical subcostal 'chevron' incision along with ultrasound probe placement for the EOI fascial plane block. The expected sensory distribution of blockade is seen extending from midline to the lateral abdomen from anesthetizing the lateral and anterior cutaneous branches of the intercostal nerves. Illustrator: Kishan Patel, MD