

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 Postoperative analgesia after TAH remains a challenge. In our hospital, we commonly use one of two protocols: parenteral analgesia with intravenous DIB or regional analgesia with epidural DIB supplemented with parenteral analgesia. The study compares the analgesia achieved in the first 48 hours and describes complications.

Methods We collected data from January-2022 to March-2023 using The Acute Pain Management Team database, with patient consent. 60 cases of oncological or non-oncological TAH were randomly selected, in a 1:1 proportion (parenteral vs epidural analgesia). The parenteral group received a 2mL/h DIB for 48h with metamizole and tramadol and the epidural group received a 5ml/h DIB for 27h with 0.1% ropivacaine. Both groups received intravenous acetaminophen 1g-qid and ketorolac 30mg-tid; morphine was used as rescue analgesic. Pain scores, rescue medication and complications at 24 and 48h were collected.

Results There are no demographic differences between both groups (table 1). Surgical diagnosis varied ($p=0.001$), as well as a tendency towards longer hospitalization in the epidural group ($p=0.009$). Post-operative visual analogue scores at rest and in movement were comparable in the first 48h, as well as total morphine consumption ($p=0.354$), nausea and vomiting ($p=0.195$).

Abstract #36462 Table 1 Characteristics of study population

	Epidural group (n=30)	Parenteral group (n=30)	P-value
Age (years)	51.0 (17.0)	48.5 (7.0)	0.147
Weight (kg)	70.0 (19.0)	68.0 (17.0)	0.728
Height (cm)	160.0 (8.5)	162.5 (8.0)	0.672
BMI (kg/m ²)	27.3 (4.9)	26.4 (7.5)	0.600
ASA I/II/III, n	3/23/4	3/24/3	0.781
Surgical diagnosis:	13/17	2/28	0.001
oncological/non-oncological			
Duration of the surgery (min)	109.5 (78.8)	115 (47.3)	0.363
Length of hospital stay (days)	3.0 (1.0)	3.0 (0.0)	0.009

Abstract #36462 Table 2 Pain scores and rescue medication; IR – interquartile range; m – minimum, M – maximum

	Epidural group (n=30)	Parenteral group (n=30)	P-value
Pain score rest at 24h	0.0 (IR 2.0, m0, M8)	0.0 (IR 0.0, m0, M7)	0.065
Pain score movement at 24h	3.0 (IR 3.0, m0, M8)	3.0 (IR 2.0, m0, M9)	0.838
Pain score rest at 48h	0.0 (IR 1.0, m0, M5)	0.0 (IR 0.0, m0, M3)	0.211
Pain score movement at 48h	2.0 (IR 3.0, m0, M6)	2.0 (IR 2.0, m0, M5)	0.421
Total morphine consume 48h (mg)	0.0 (IR 0.0, m0, M36)	0.0 (IR 0.0, m0, M6)	0.354

Abstract #36462 Table 3 Complications after 48h

	Epidural group (n=30)	Parenteral group (n=30)	P-value
Nausea and vomiting	1	5	0.195
Hypotension	1	0	-
Headache	1	0	-
DIB-associated paresthesia	3	-	-

Conclusions We conclude that intravenous DIB and epidural DIB are comparable in the management of postoperative pain of TAH. Morphine consumption and side effects were comparable, but significant paresthesia was seen in the epidural group. The authors recognize the small sample bias, but highlight the importance of good pain management with a less invasive technique. However, epidural technique should be considered for high-risk cases.

#36227 PAIN ASSESSMENT AND MANAGEMENT: UNDERSTANDING THE BARRIERS. A SURVEY OF CAREGIVERS AND PATIENTS AT BIZERTE ACADEMIC HOSPITAL, TUNISIA

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10.1136/rapm-2023-ESRA.619

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

Background and Aims Pain management plays a crucial role in patient care and should be a fundamental priority in therapeutic interventions. This survey aimed to assess the perspectives of caregivers and patients regarding pain management by evaluating professional practices, obstacles to analgesia, and patient satisfaction.

Methods A descriptive cross-sectional study was conducted among healthcare caregivers and patients. Three comparative questionnaires were used to collect data.

Results A total of 109 professionals (32 doctors and 77 nurses) and 36 patients participated in the study. The majority of nurses (79%) and physicians (85%) reported systematic pain assessment, with 32% and 50% respectively using a standardized tool. Doctors demonstrated regular checking of prescription compliance (68%) and treatment adaptation (89%). Caregivers actively sought possible side effects (90%). Barriers to analgesia were identified by 64% of doctors and 42% of nurses, including challenges related to tailored pain medications, limited time, and insufficient training. Inadequate knowledge and apprehensive attitudes towards opioid side effects were noted as limiting factors. Patient responses revealed that 75% reported being assessed and managed for pain, but 60% believed that their reassessment was inadequate. Only 33% expressed complete satisfaction.

Conclusions Our findings indicate inadequate pain management practices, highlighting the need of a dedicated pain control committee as an active catalyst and coordinator of pain treatment. This committee aims to integrate pain management as a routine hospital care practice, employing a structured and collaborative approach. The key objectives include increasing awareness, developing educational programs, and providing clinical training.

Ultrasound guided RA (UGRA)

#36317 OVERCOMING THE CHALLENGES OF REGIONAL ANAESTHESIA IN TANZANIA

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10.1136/rapm-2023-ESRA.620

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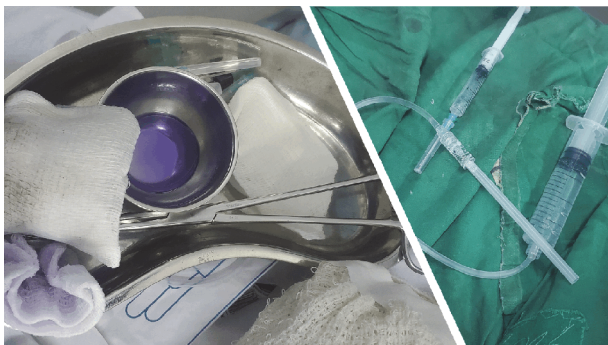
Background and Aims I recently spent six months working at Bugando Medical Centre, a tertiary referral hospital in Mwanza, Tanzania. During my time there, I had the opportunity to perform and teach ultrasound-guided regional anesthesia to other anaesthesia providers.

Methods Despite the well-known benefits, regional anesthesia was not widely used due to various challenges including: * Lack of expertise: very few trained regional anesthesia providers. * Lack of equipment: Safe regional anesthesia requires ultrasound machines, regional block needles and drugs, which was often unavailable in Tanzania. * Lack of resources: Regional anesthesia can be expensive, and LMICs often have limited funding for 'non-essential' services * Lack of trust: Surgeons and patients were not too familiar with regional techniques and were reluctant to utilise it. (Gupta, A.; 2016)

Results Despite these barriers, regional anaesthesia became a valuable tool for providing safe and effective anaesthesia at Bugando. Some ways to overcome these barriers and advance regional anaesthesia including: * Training more regional anaesthesia providers. * Providing access to equipment such as ultrasound machines and needles. * Increasing funding for regional anaesthesia. * Educating surgeons and patients about the benefits of regional anaesthesia. (Mukherjee, S., 2017)



Abstract #36317 Figure 1 Ultrasound scanning practice session on real persons



Abstract #36317 Figure 2 Equipment used for regional anaesthesia (spinal sterile set and 22G spinal needles)

Conclusions Regional anesthesia in Tanzania was challenging due to a lack of resources, infrastructure and trained personnel. However, with a short training program, it became an essential tool for providing safe and effective anaesthesia. By turning challenges to opportunities, we increased the use of

regional anesthesia, thereby improving the safety and quality of anaesthesia care provided. (O'Connor, B., 2018)

#36039 MULTIPLE BLOCK ANALGESIA FOR COMPLICATED SHOULDER SURGERY

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10.1136/rapm-2023-ESRA.621

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

Background and Aims A 59yr old male came with complaints of difficulty in left shoulder movement since 8months associated with pain. On MRI, it was diagnosed as diffuse large B cell lymphoma measuring 20X22X82mm with healed pathological fracture of left proximal humerus. He was advised for left proximal humerus excision with shoulder arthroplasty.

Methods On the day of surgery, patient was shifted to OT, monitors connected, IV cannula established. Patient did not want to undergo surgery with regional anaesthesia. Hence surgery was done under general anaesthesia. With this extensive surgery and as patient had previous history of pain, multiple blocks was planned in order to give pain relief postoperatively.

Results 0.25% bupivacaine was used in multiple ultrasound-guided blocks for analgesia and later extubated. -10ml used for selective upper trunk brachial plexus block to target dorsal scapular nerve and lower subscapular nerve. -5ml used for superficial cervical plexus block to target supraclavicular nerve. -15ml used for supraclavicular brachial plexus block to provide analgesia to area supplied by lateral pectoral nerve, suprascapular nerve and axillary nerve. -5ml given as intra-articular infiltration posteriorly as posterior part of shoulder have high concentration of mechanoreceptors. Additive Inj. Dexamethasone 6mg IV given to prolong the analgesia. Post-Operative patient had a VAS score of 1/10 and continued to have pain relief for the next 36hours.