EP024 DETERMINATION OF A NRS THRESHOLD VALUE FOR THE ADMINISTRATION OF ANALGESICS AT THE PACU

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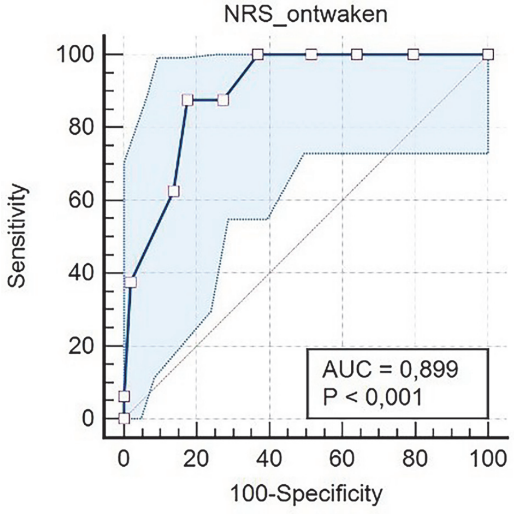
Background and Aims Several pain management guidelines recommend administration of analgesics based on patients' numeric rating scale(NRS) scores. This study aimed to identify which threshold patients prefer to receive analgesics with and without the risk of postoperative nausea and vomiting(PONV) in the post anaesthetic care unit(PACU).

Methods This study was approved by the institutional Ethics Committee. Patients scheduled for elective surgery under general anaesthesia were screened between August 2019 and April 2022. Immediately after awakening from anaesthesia, patients were asked to score their pain intensity using the NRS and whether they desired no analgesic, an analgesic with or without the risk of PONV. Receiver Operating Characteristic(ROC) curves were used to assess the specificity and sensitivity of different NRS scores for receiving analgesics. Upon leaving the PACU, patients were asked which NRS score they preferred as a threshold value to receive an analgesic with and without risk of PONV.

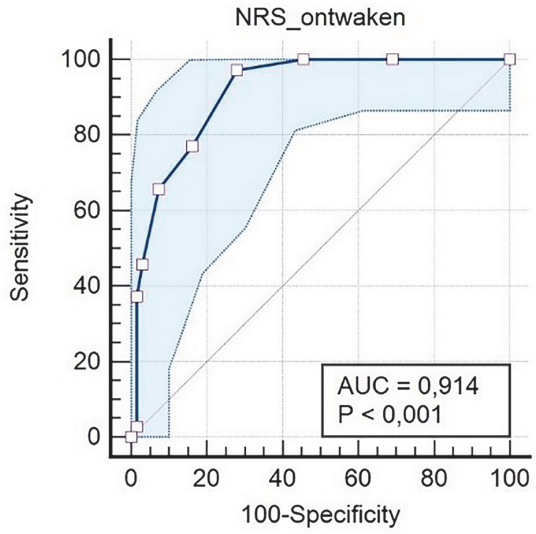
Results 120 patients were enrolled. ROC curves show that an NRS threshold of >2 should be used to treat patients with a mild analgesic and of >5 to administer a strong analgesic. In contrast, upon leaving the PACU, patients report a median NRS threshold of 5 to receive a mild analgesic and of 8 to receive a strong analgesic.

Abstract EP024 Table 1 Treshold values for the administration of analgesics at the PACU

	Mild analgesic (without risk of PONV)	Strong analgesic (with risk of PONV)
Awakening from anaesthesia arriving at PACU Optimal NRS threshold value calculated using ROC curve	>2	>5
Awake patient leaving PACU Preferred NRS threshold value by patients	5(4-6)	8(7-8)



Abstract EP024 Figure 1 Receiver operating characteristic (ROC) curve with the sensitivity and specificity for the different NRS cut-off points for a mild analgesic



Abstract EP024 Figure 2 Receiver operating characteristic (ROC) curve with the sensitivity and specificity for the different NRS cut-off points strong analgesic

Conclusions The thresholds perceived by patients to receive mild or strong analgesics are lower when patients are just awakening, compared to awake patients preferred threshold. We presume that sedatives might influence patients' ability to assess their need for analgesics.

ePoster session 1 – Station 5

EP025 LOCAL ANESTHETIC BUPIVACAINE BARICITY AND ADJUVANT FENTANYL IMPACT ON QUALITY OF LOW-DOSE SPINAL ANESTHESIA

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Background and Aims To evaluate the influence of bupivacaine baricity and fentanyl on quality of low-dose spinal anesthesia in knee arthroscopy.

Methods The research included patients (BMI>25), who underwent short-term knee surgery under low-dose spinal anesthesia. 3 groups formed: 7 mg/165cm(±1mg/5cm) isobaric bupivacaine +10μg fentanyl intrathecally (IF group); HF – 7 mg/165cm(±1mg/5cm) hyperbaric bupivacaine +10μg fentanyl; H – 7 mg/165cm(±1mg/5cm) hyperbaric bupivacaine alone. Groups compared for sensory/motor blockade extension and duration, haemodynamics, complications, pain-satisfaction rates.

Results The highest superficial[Th7] and deep[Th8-12] sensory blockade levels of operated limb at 60th min recorded in IF and HF groups. Lower sensory blockades[Th9; L1] detected in H group, compared with HF ($p=0.003$). Shorter ($p<0.0001$) sensory blockade caused by isobaric bupivacaine (-137.5 min), compared to hyperbaric with fentanyl. Lasting sensory blockade (+80 min) recorded in HF vs H group ($p<0.0001$). The motor blockade in groups HF and H was

deeper (Bromage3), but only Bromage2 in IF group with shorter duration (-122 min vs HF; -59.5 min vs H (p<0.0001)). On the opposite limb sensory blockade was higher in HF than in H group[Th9 vs L4] (p=0.006); in latter – without motor blockade. Pruritus manifested 30% with fentanyl use. One patient developed hypotension, single case of urinary retention and nausea observed (HF group).

Conclusions Isobaric bupivacaine with fentanyl in low-dose spinal anesthesia ensured shorter duration of sensory/motor blockade, but sufficient analgesia – therefore had advantages over hyperbaric bupivacaine. Co-administration of fentanyl to hyperbaric bupivacaine associated with prolonged action, effects on unoperated limb, and we would not recommend for outpatient knee arthroscopy.

EP026 CURRENT SITUATION OF RADIOFREQUENCY FOR THE TREATMENT OF LOW BACK PAIN ORIGINATING IN THE FACET JOINTS IN SPAIN

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

Background and Aims Radiofrequency (RF) is the main treatment for patients suffering from low back pain originating in the lumbar facet joints; since there is lot of variability in performing the technique, our objective is to analyse it current situation in Spain.

Methods We have performed a survey to analyse the situation of the use of RF to treat the lumbar medial branch; shared trough the Spanish pain society, 91 people answered it.

Results 13/91 perform one ultrasound-guided diagnostic block, 44/91 perform one fluoroscopy-guided block, 14/91 perform either one fluoroscopy or ultrasound-guided block depending on the patient and 6/91 perform two fluoroscopy-guided blocks. 55/91 do the parallel approach and 22/91 the perpendicular approach. 80/91 guide the RF with fluoroscopy, 8/91 with ultrasound and 3/91 combining ultrasound and fluoroscopy. 82/91 use conventional RF, 2/91 use cooled and 8/91 use pulsed. For cannula diameter, 12/91 use 22G, 39/91 use 20G, 42/91 use 18G and 3/91 use 16G. For active tip, 1/91 use 2mm, 15/91 use 5mm and 71/91 use 10mm. 11/91 use blunt-straight, 21/91 use sharp-straight, 25/91 use blunt-curved and 37/91 use sharp-curved. 6/91 apply the RF at 42°C, 8/91 at 45-60°C, 61/91 at 80°C, 12/91 at 85°C and 4/91 at 90°C. 3/91 apply 60 seconds of RF, 61/91 apply 90 seconds, 12/91 apply 120 seconds, 1/91 apply 150 seconds and 6/91 apply 180 seconds. 51/91 do one lesion, 16/91 two lesions and 15/91 three lesions.

Conclusions We need to stablish the best form to perform RF for treating low back pain originating in the lumbar facet joints.

EP027 CONVENTIONAL PALPATION VERSUS ULTRASOUND ASSISTED SPINAL ANESTHESIA IN OBSTETRICS: A RANDOMIZED TRIAL. PRELIMINARY RESULTS

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Background and Aims Spinal anesthesia in obese parturients is difficult yet there are no guidelines to direct best practice. Ultrasonography (US) is considered standard care for regional anesthesia. The aim of this study was to evaluate the benefits of preprocedural US scanning to improve the first-attempt success rate in obese parturients.

Methods After agreement from the local ethics committee and informed patient consent, we conducted a prospective, randomized controlled study including parturients over the age of 18 with a body mass index ≥30 kg/m2 and scheduled for elective cesarean delivery. Participants were randomized into 2 groups: a standard palpation group (standard group) and a pre-puncture US-guided neuraxial anesthesia group (US-group). The primary outcome was first pass success rate. The secondary outcomes were the number of punctures and intervertebral interspaces attempted, needle redirection, procedure Time, incidence of complications and patient satisfaction score. For all statistical tests, the significance level was set at 0.05.

Results Until now, 71 parturients were recruited: 33 in US-group and 38 in standard group. No clinically intergroup differences were noted regarding the demographic data. The US-group had a higher first-attempt success rate: 51.5% vs 28.9% in standard group but not significant statistically (p=0.052). There were no significant differences between the groups regarding the secondary outcomes. However, more time was required to perform the procedure in US-group (P <0.001) (table1).

Abstract EP027 Table 1 Spinal anesthesia details comparing the ultrasound and standard group

	STANDARD GROUP N=38	ULTRASOUND GROUP N=33	P VALUE
First pass success	11 (28.9%)	17 (51.5%)	0.052
Number of puncture attempts			0.70
1	29 (76.3%)	25 (75.8%)	
2	5 (13.2%)	6 (18.2%)	
≥3	4 (10.5%)	2 (6.1%)	
Number of intervertebral interspaces attempted			0.76
1	30 (78.9%)	28 (84.8%)	
2	7 (18.4%)	4 (12.1%)	
3	1 (2.6%)	1 (3%)	
Requirement of needle redirection			0.17
0	13 (34.2%)	17 (17%)	
1	5 (13.2%)	5 (15.2%)	
2	7 (18.4%)	7 (21.2%)	
≥3	13 (34.2%)	4 (12.1%)	
Traumatic procedure	9 (23.7%)	5 (15.2%)	0.36
Postdural puncture headache	0	0	
Development of back pain	3 (7.9%)	0 (0%)	0.24
Paresthesia	0 (0%)	1 (3%)	0.46
Patient satisfaction score			0.27
Not satisfied	7 (18.4%)	3 (9.1%)	
Satisfied	20 (52.6%)	15 (45.5%)	
Very satisfied	11 (28.9%)	15 (45.5%)	
Total procedure time (seconds)	72 (40; 144)	193 (122; 248.5)	<0.001

Table 1: Spinal anesthesia details comparing the ultrasound and standard groups

Conclusions Preliminary results demonstrated that preprocedural US didn't increase the first pass success rate. We