Abstract EP112 Table 1 Patient demographics and baseline data

	Control (n=44)	Intervention (n=44)	Pvalue
Male sex, n (%)	31 (70.5)	25 (56.8)	0.268
Age, yr	51.5 (41.0-59.5)	53.5 (46.0-62.0)	0.416
Height, cm	166.2 ± 7.6	164.3 ± 7.5	0.243
Weight, kg	64.5 [57.0-71.0]	62.5 [55.0-74.0]	0.605
BMI,kgm-^{2}	22.4 [21.3-26.4]	24.1 [21.1-26.1]	0.997
ASA class, n (%)			0.084
II	8 (18.2)	3 (6.8)	
TTT	35 (79.5)	36 (81.8)	
IV	1 (2.3)	5 (11.4)	
Comorbidities, n (%)			
Hypertension	28 (63.6)	26(59.1)	0.827
Diabetes mellitus	9 (20.5)	12 (27.3)	0.617
Chronic liver disease	1 (2.3)	2 (4.5)	1.000
Pulmonary disease	2 (4.5)	**1** (2.3)	1.000
Others	11 (25.0)	12 (27.3)	1.000
Operation time (min)	222.9 ± 47.7	217.6 ± 40.8	0.582
Aneslhesia Lime (min)	277.4 ± 44.9	279.0 ± 46.8	0.874
Intraoperative remifentanil consumption (μg)	961.5 [654-1450]	800 [704-1030.5]	0.367

Values are mean ± SD or median [IQR] or number (percentage).
Abbrevialions: BMI, body mass index (calculaled as weight in kilograms divided by heighl in melres squared); ASA, American Society of Anesthesiologists; SD, standard deviation; **1. QR,** interquartile range.

Abstract EP112 Table 2 Postoperative analgesic consumptions, pain scores, and complications

Table 2. Postoperative analgesic consumptions, pain scores, and complications

	Control (*n*=44)	Intervention (*n*=44)	*P* value
Cumulative opioid consumption in 24h, mg oral morphine equivalent	187.5 (93–309)	160.5 (78–249.8)	0.285
Cumulative opioid consumption in 48h, mg oral morphine equivalent	249 (118.5–390)	196.5 (91.5–340.5)	0.367
Fentanyl consumption via intravenous PCA, μg			
0–6 hours	240 (90–320	150 (50–260)	0.296*
6–12 hours	120 (40–260	120 (50–180)	>0.999*
12–24 hours	160 (50–330	190 (50–350)	>0.999*
24–48 hours	130 (50–400	130 (10–370)	>0.999*
Time to first PCA attempt (min)	72 (60–90)	90 (66–105)	0.043
Nausea within 24h	16 (36.4)	17 (38.6)	1.000
Vomiting within 24h	2 (4.5)	4 (9.1)	0.672
Patients receiving antiemetics within 24h	1 (2.3)	2 (4.5)	1.000

Values are median (IQR) or number (percentage). PCA, patient-controlled analgesia.
**P* value after the Bonferroni correction.

Conclusions Anterior quadratus lumborum block did not reduce opioid consumption after living donor renal transplantation in the setting of multimodal analgesia. These findings do not support the routine administration of the anterior quadratus lumborum in this surgical population.

EP113 ANALGESIC EFFECTS OF ULTRASOUND-GUIDED PREOPERATIVE POSTERIOR QUADRATUS LUMBORUM BLOCK IN LAPAROSCOPIC HEPATECTOMY: A PROSPECTIVE DOUBLE BLINDED RANDOMIZED CONTROLLED TRIAL

RyungA Kang, Seungwon Lee, Soo Joo Choi, Sangmin Maria Lee, Tae Soo Hahm, Woo Seog Sim, Hyun Sung Cho, Justin Sangwook Ko. *Anesthesiology and Pain Medicine, Samsung Medical Center, Seoul, Korea*

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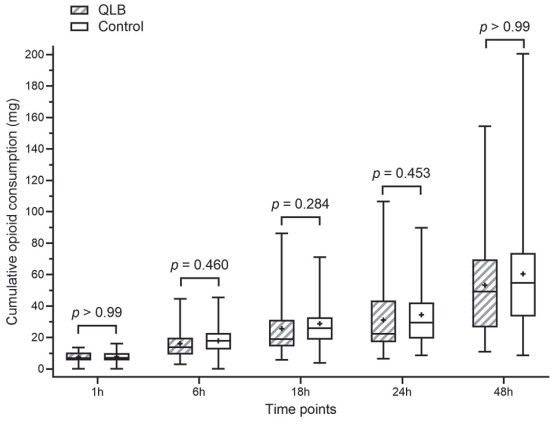
Background and Aims Posterior quadratus lumborum block is accepted analgesic strategy in abdominal surgery. We examined whether bilateral, single-injection posterior quadratus lumborum block with ropivacaine could improve on postoperative analgesia compared to 0.9% saline in patients undergoing laparoscopic hepatectomy.

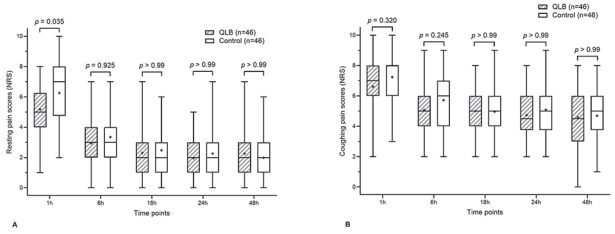
Methods Ninety-four patients were randomized to receive bilateral posterior quadratus lumborum block (20 mL of 0.375% ropivacaine on each side, 150 mg total) or control group (20 mL of 0.9% saline on each side). Primary outcome was cumulative opioid consumption during the first 24 h after surgery. Secondary outcomes included pain scores, intraoperative parameters and recovery parameters.

Results Mean cumulative opioid consumption during the first 24 h after surgery was 31.2 ± 22.4 mg in quadratus lumborum block group (n=46) and 34.5 ±

19.4 mg in control group (n=46, mean difference: -3.3 mg, 95% confidence interval, -12.0 to 5.4, p=0.453). Median resting pain score at 1 h post- surgery was significantly lower in quadratus lumborum block group (5 [4, 6.25] vs. 7 [4.75, 8] , p=0.035). There were no significant differences in resting or coughing pain scores at other time points and other secondary outcomes.



Abstract EP113 Figure 1 Cumulative opioid consumption converted to IV morphine equivalent dose (mg) during the 48 h after surgery. The solid lines in the box indicate the medians, symbol (+) indicates means, the boxes indicate interquartile ranges, and the whiskers indicate minimum to maximum. The individual P values result from a Bonferroni correction for multiple comparisons. Abbreviations: QLB, Quadratus lumborum block



Abstract EP113 Figure 2 Box and whiskers plot of the numeric rating scale (NRS) pain scores at rest (A) and coughing (B) during the 48 h after surgery. The solid lines in the box indicate the medians, symbol (+) indicates means, the boxes indicate interquartile ranges, and the whiskers indicate minimum to maximum. The individual P values result from a Bonferroni correction for multiple comparisons. Abbreviations: NRS, numerical rating scale; QLB, Quadratus lumborum block

Conclusions Bilateral posterior quadratus lumborum block did not reduce the cumulative opioid consumption during the first 24 h after laparoscopic hepatectomy.

ethics committee approval

EP114 HORNER'S SYNDROME: A RARE COMPLICATION IN A COMMON TECHNIQUE

[1]Ana Franco*, [2]Roberto Ameiro, [1]Nuno Lareiro, [2]Ana Martins. *[1]Department of Anesthesiology, Centro Hospitalar do Baixo Vouga, Aveiro, Portugal; [2]Department of Anesthesiology, Centro Hospitalar Vila Nova de Gaia/Espinho, Vila Nova de Gaia, Portugal*

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Background and Aims Horner's syndrome is characterized by miosis, partial ptosis, anhidrosis and apparent enophthalmos. After epidural analgesia, it is the result of the stellar ganglion blockade, suggesting a high level (C8–T4) of anaesthetic effects.

Methods We report a full-term parturient submitted to labor analgesia under epidural technique. We administered ropivacaine and sufentanil, which produced a relatively symmetric sensitive block at T6/T7. Fifteen minutes later we noticed the patient developed Horner syndrome. Upon detection of the symptoms, a dilemma arose on whether to keep the catheter, which was resolved through discussions with the patient. Together we decided to keep it in place for the following boluses. Two additional fractioned boluses were administered. The patient maintained an adequate sensitive block at T6/T7, had no additional neurological findings and kept hemodynamic stability throughout the entire period. The condition was reversed completely three hours later with no additional interventions.

Results Horner's syndrome is associated with epidural anesthesia and pregnancy: due to reduced epidural volume from uterine pressure and increased local anesthetic sensitivity. Symptoms tend to be mild, but cardiorespiratory arrest is a possible complication due to high sympathetic block and close vigilance should occur. In this case, the decision to administer further boluses was based on the cardiorespiratory stability, the relatively mild presentation and the patient's understanding of the situation.

Conclusions This case highlights the importance of careful technique and vigilant monitoring during epidural analgesia, as well as the necessity of considering patient comfort and autonomy in the decision-making process.

ePoster session 4 – Station 2

EP115 TRENDS IN EXPAREL USE FOR TOTAL HIP AND KNEE ARTHROPLASTY

[1]Ottokar Stundner*, [2]Haoyan Zhong, [2]Alex Illescas, [3]Crispiana Cozowicz, [4]Jashvant Poeran, [2]Jiabin Liu, [2]Stavros G Memtsoudis. *[1]Department of Anesthesiology and Intensive Care, Innsbruck Medical University, Innsbruck, Austria; [2]Department of Anesthesiology, Critical Care and Pain Management, Hospital for Special Surgery, New York City, USA; [3]Department of Anesthesiology, Perioperative Medicine and Intensive Care Medicine, Paracelsus Medical University, Salzburg, Austria; [4]Institute for Healthcare Delivery Science, Department of Population Health Science and Policy/Department of Orthopedics/Department of Medicine, Icahn School of Medicine at Mount Sinai, New York City, USA*

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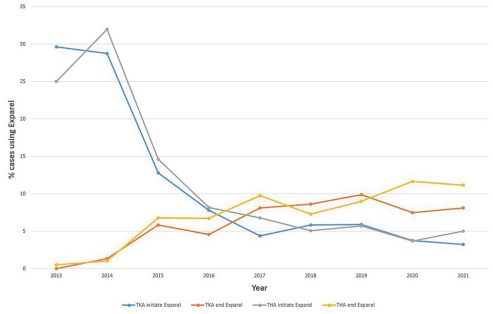
Background and Aims ExparelTM, a liposomal bupivacaine formulation, is a long-acting local anesthetic that can provide pain relief after total hip or knee arthroplasty (THA/TKA) when used for local wound infiltration or peripheral nerve blocks. At the same time, Exparel is a relatively expensive medication, and its use can increase healthcare costs. As population-level trend data remain rare, we aimed to investigate nationwide trends of Exparel use in the United States for THA/TKA.

Methods This study was approved by the institutional review board of the Hospital for Special Surgery (IRB#2012-050). We identified patients from the Premier Healthcare database who underwent elective THA/TKA using a standard set of International Classification of Diseases -ninth/tenth revision codes from 2012 to 2021. We examined the use of Exparel over time at both the patient and hospital levels.

Results Among 103,165 cases, Exparel use increased from 2012 to 2015 (0.36% to 22.8%), and decreased afterward (15.7% in 2021) (table 1). At the hospital level, 599 hospitals (59.7%) ever used Exparel during the study period. In 2013, 30% of hospitals started to initiate Exparel use, and the rate has been decreasing over time (compared to 3.1% hospital initiated Exparel use in 2021). In 2014, hospitals started to terminate Exparel (1.1%); this termination rate increased and peaked in 2019 (9.5%). (figure 1)



Abstract EP115 Figure 1 Exparel use trends on hospital level

Abstract EP115 Table 1 Exparel use trends on patient level

Table 1. Exparel use on patient level

	Year									
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total TJA cases	234,391	254,539	277,812	294,094	315,519	330,696	294,479	280,823	155,849	103,165
Cases using Exparel	845	15,235	57,145	66,997	68,195	67,000	54,003	49,013	26,651	16,169
% of cases using Exparel	0.36%	5.99%	20.57%	22.78%	21.61%	20.26%	18.34%	17.45%	17.1%	15.67%

Conclusions The use of Exparel peaked around the year 2014-2015 and has been decreasing afterward. The reason for hospitals stopping Exparel use may be related to recent evidence for its modest efficacy and should be studied further.

Stundner_NoticeOfIRBApproval

EP116 EFFECT OF REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION ON PAIN AND QUALITY OF LIFE IN POST-MASTECTOMY PAIN SYNDROME: A PROSPECTIVE RCT

Nishkarsh Gupta*, Bhatia Renu, Kataria Monika, Akanksha Singh, Sandeep Bhoriwal. *AIIMS, New Delhi, India*

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