Abstract 212 Figure 2

Abstract 212 Figure 3

Conclusions We demonstrated that intrathecal diamorphine reduced post-operative opiate requirements and facilitated earlier mobilisation.

We concluded that the use of intrathecal diamorphine in combination with multimodal analgesia in colorectal surgery is safe and is comparable, if not marginally superior, to PCA in our institution.

We have also shown that despite a wide range of intrathecal diamorphine dosage (0.5–1 mg), there were no post-operative complications which is in keeping with anecdotal experience. Therefore, we feel that intrathecal diamorphine for perioperative analgesia for resectional bowel surgery is a safe and viable technique.

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PAIN MANAGEMENT AFTER LAMINECTOMY: A SYSTEMATIC REVIEW AND PROCEDURE-SPECIFIC POST-OPERATIVE PAIN MANAGEMENT (PROSPECT) RECOMMENDATIONS

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10.1136/rapm-2021-ESRA.213

Background and Aims With lumbar laminectomy increasingly being performed on an outpatient basis, optimal pain management is critical to avoid post-operative delay in discharge and readmission. [1, 4] The aim of this review was to evaluate the available literature and develop recommendations for optimal pain management after one- or two-level lumbar laminectomy.

Methods A systematic review utilizing the PROCEDURE-SPECIFIC Post-operative Pain Management (PROSPECT) methodology was undertaken [5]. Randomised controlled trials (RCTs) published in the English language from 1 January 2008 until 31 March 2020 – assessing post-operative pain using analgesic, anaesthetic and surgical interventions – were identified from MEDLINE, EMBASE and Cochrane Databases.

Results Out of 65 eligible studies identified, 39 RCTs met the inclusion criteria. The analgesic regimen for lumbar laminectomy should include paracetamol and a non-steroidal anti-inflammatory drug (NSAID) or cyclooxygenase (COX)-2 selective inhibitor administered preoperatively or intraoperatively and continued post-operatively, with post-operative opioids for rescue analgesia. In addition, surgical wound instillation or infiltration with local anaesthetics prior to wound closure is recommended (table 1). Some interventions – gabapentinoids and intrathecal opioid administration – although effective, carry significant risks and consequently were omitted from the recommendations. Other interventions were also not recommended because there was insufficient, inconsistent or lack of evidence (table 2).

Abstract 213 Table 1 Overall recommendations for perioperative pain management in patients undergoing lumbar laminectomy

Preoperative and intraoperative recommendations

Oral or IV paracetamol (Grade D)

Oral or IV NSAIDs/COX-2-specific inhibitors (Grade A)

Surgical wound instillation or infiltration with local anaesthetic (Grade A)

Post-operative recommendations

Oral or IV paracetamol (Grade D)

Oral or IV NSAIDs/COX-2-specific inhibitors (Grade A)

Opioids as rescue medication (Grade D)

COX-2, cyclooxygenase-2; IV, intravenous; NSAIDs, non-steroidal anti-inflammatory drugs

Table 2 Analgesic interventions that are not recommended for pain management in patients undergoing lumbar laminectomy

Intervention	Reason for not recommending
Dexamethasone	Limited procedure-specific evidence
Oral gabapentin/pregabalin	Significant risk for adverse effects
Intrathecal opioids	Significant risk for adverse effects
Epidural analgesia	Limited procedure-specific evidence and risk for adverse effects
Paravertebral block	Limited procedure-specific evidence
Surgical perineural infiltration	Limited procedure-specific evidence
Surgical wound local infiltration	Limited procedure-specific evidence
Corticosteroids	Limited procedure-specific evidence
Intravenous magnesium	Lack of procedure-specific evidence
Transdermal fentanyl	Limited procedure-specific evidence and risk for adverse effects

Reg Anesth Pain Med 2021;70(Suppl 1):A1–A127