Abstract 213 Table 2 Analgesic interventions that are not recommended for 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

Conclusions Perioperative pain management for lumbar laminectomy should include paracetamol and NSAID- or COX-2-specific inhibitor, continued into the post-operative period, as well as intraoperative surgical wound instillation or infiltration. Opioids should be used as rescue medication post-operatively. Future studies are necessary to evaluate the efficacy of our recommendations.

214 VIRTUAL REALITY HYPNOSIS ON COLD PAIN PERCEPTION IN HEALTHY VOLUNTEERS

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Background and Aims Over 200 millions of surgeries are performed each year, these may lead to postoperative pain mainly managed with opioid prescription [1]. It is recommended to decrease the use of opioids by adding at least one non-pharmacological pain management modality in the treatment [2]. Virtual Reality and hypnosis are examples of such.

The aim of this study was to measure the pain intensity and unpleasantness perception at rest and during virtual reality hypnosis (VRH) in healthy volunteers.

Abstract 214 Table 1 Demographic data of the 41 healthy volunteers included

	Sex (Male, %)	Age (years)	Education (years)	Stanford score (/12)	STAI Trait (/80)	STAI State CTRL (/80)	STAI State VIBO (/80)
Test / moy	53	41.28	4.80	5.97	36.85	28.17	22.43
SD	13.43	7.09	3.03	8.63	6.58	6.64	6.64

Abstract 214 Figure 2

[illegible]

Abstract 214 Figure 1

Methods With Ethics Committee agreement (CPP-ILE-DE-FRANCE III, approval date 04/02/2020), healthy volunteers were prospectively included to receive nociceptive cold stimulations at rest, without VRH (Control condition) and during VRH with HypnoVR*software (Oculus Rift® headset, Oculus VR) (VRH condition). Three intensities (Visual Analog Scale (VAS) = 0/10, 2/10, 4/10) of cold stimulations were applied 3 times each (stimulation duration: 20 seconds, separated by 1 minute) on participant's wrist with a thermode. Intensities were chosen beforehand by applying various cold intensities that subjects scored on a VAS. Maximal pain intensity and unpleasantness perception were collected after the end of each condition and then compared.

Results A total of 41 healthy volunteers were analyzed (demographic data: table 1). There is a significant decrease in pain average intensity and unpleasantness perception in VRH compared to control group ($2,46 \pm 1,59$ vs $3,66 \pm 1,84$; $p < .0001$ and $3,06 \pm 2,06$ vs $2,21 \pm 1,70$; $p < 0,0001$ respectively) (figure 1).

Conclusions VRH (HypnoVR*) managed to decrease cold pain intensity (-33%) and unpleasantness (-40%) perception in healthy volunteers. These results need to be confirmed in clinical setting.

215 OPIOID CONSUMPTION AND NEUROPATHIC PAIN IN ADJUVANT ANAESTHESIA WITH DEXMEDETOMIDINE AND LIDOCAINE

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Background and Aims Combination of opioid analgesics and analgesics with other mechanisms of action has synergistic analgesic effect and therefore the consumption of opioid analgesics could be decreased. It is known that dexmedetomidine and lidocaine both have opioid sparing effects, but the influence of dexmedetomidine in laparoscopic intestine resections has not been observed yet. In this study we investigated reduction in opioid consumption in patients receiving additional lidocaine or dexmedetomidine.

Methods Within the study we observed: (i) fentanyl consumption, (ii) consumption of piritramide on the first and the second postoperative day, and (iii) cognitive function before and after the operation and neuropathic pain two months after the operation. 59 participants were randomly allocated into three groups. The anaesthesia type in the control group (CG) was continuous propofol infusion and fentanyl boluses. Continuous intravenous infusion of dexmedetomidine ($0.5 \mu\text{g/kg/h}$) and lidocaine (1.5 mg/kg/h) was added to dexmedetomidine (DG) and lidocaine group (LG), respectively.

Results There was no reduction in fentanyl consumption among the groups. We noted significantly lower consumption of piritramide in LG compared with CG on the first postoperative day ($p=0.019$), and in LG compared with DG on the second postoperative day ($p=0.003$). There were no differences in changes in cognitive function before and after the surgery and appearance of neuropathic pain two months after the surgery.

Conclusions Lidocaine and dexmedetomidine reduced intraoperative propofol consumption but failed to decrease fentanyl

demand. Lidocaine reduced piritramide consumption postoperatively.

216 COMPARING THE EFFICACY AND SAFETY OF USG GUIDED MODIFIED PECTORAL BLOCK VS. ERECTOR SPINAE BLOCK FOR POSTOPERATIVE PAIN MANAGEMENT IN PATIENTS UNDERGOING MODIFIED RADICAL MASTECTOMY

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Background and Aims Breast cancer accounts for 25–32% of all female cancers in India¹. Modified radical mastectomy (MRM), a common surgical procedure, comprises 31% of all breast surgeries performed². A postoperative plan incorporating regional nerve blocks provide efficient analgesia, early mobilization, recovery, and prevention of chronic pain³.

This study aims to compare the efficacy and safety of modified pectoral nerve (PECS) block and Erector Spinae Plane (ESP) block for pain management in patients undergoing MRM.

Abstract 216 Figure 1

Abstract 216 Figure 2