Methods

This study was registered with the Clinical Trials Registry of India (CTRI/2019/06/019656) following approval from Max Healthcare Ethics Committee.

80 adult female patients (ASA grades I&II) undergoing modified radical mastectomy were randomly allocated into two groups to receive PECS block and ESP block with 30 ml of 0.375% Levobupivacaine, after induction of anaesthesia. Fentanyl was administered for postoperative pain relief via PCA pump.

Outcomes such as Numerical Rating Scale (NRS) scores to assess pain, time to first rescue analgesia, intraoperative and postoperative fentanyl requirement, incidence of PONV , patient satisfaction etc. were statistically analysed.

Results

Patients given modified PECS block experienced significantly better quality of analgesia and perceived the block to be more satisfactory with respect to pain relief and ability to sleep (p < 0.001). With PECS block, patients showed significantly lower mean NRS scores at 24-hours postoperatively (1.18 ±1.13 vs 2.65 ±0.98)(p<0.001) and total fentanyl consumed was considerably lesser (61.25 ± 41.58 mcg vs 183.75 ± 51.13 mcg)(p<0.001).

Conclusions

We found that modified PECS block provided superior postoperative analgesia than ESP block in patients undergoing MRM without any adverse effects.

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10.1136/rapm-2021-ESRA.217

Background and Aims

Ultrasound-guided (USG) Transversus Abdominis Plane (TAP) blocks are fascial plane blocks widely used because of their technical ease and analgesic implications in abdominal surgery.1 However, only a few small-scale TAP studies in laparoscopic nephrectomies for tumor removal exist, none in an outpatient setting.2 We assessed the impact of TAP on pain, PONV and other clinical outcomes when included in an ERAS pathway for extended ambulatory nephrectomies.

Methods

We performed a retrospective chart review of 209 ambulatory surgery patients who underwent partial laparoscopic and robotic nephrectomies using an ERAS protocol from 09/2016–12/2019. Preoperative TAP blocks were performed bilaterally with 20 ml of 0.25% bupivacaine or ropivacaine, 50 mcg clonidine and 2 mg dexamethasone. We assessed the association between preoperative administration USG TAP (51%) vs. no block (49%) on postoperative outcomes: intraoperative fentanyl, postoperative opioid consumption using morphine milligram equivalent units (MME), PONV rate and hours to first ambulation.

Results

Our results demonstrated a trend toward decreased intraoperative MME requirements in the TAP group vs no TAP (p=0.061). Patients receiving a TAP also required less postoperative narcotic (p=0.043). After adjusting for Apfel Score, age and operative time, the need for PONV rescue medication although not significant trended 8.6% higher in those without a TAP (95% CI -2.7%, 19%; p=0.11).

Conclusions

We found evidence that US guided bilateral TAP blocks are associated with a reduced need for postoperative narcotics in ambulatory laparoscopic and robotic nephrectomies with a trend toward decreased intraoperative MME requirements. ERAS pathways should consider including TAP blocks, even for these minimally invasive surgeries.

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10.1136/rapm-2021-ESRA.218

Background and Aims

Pain following emergency laparotomy can be difficult to manage and there is little evidence to guide best practice. We assessed current practice by reviewing analgesic modalities used within our department, including rectus sheath catheters (RSC).

Methods

This audit was authorized by local committee as not requiring ethical approval. Data collection was retrospective including all patients undergoing emergency laparotomy,