Abstract 218 Table 1

Age	≥ 18 years
Indication	expedited, emergency or urgent laparotomy (HCEPOD definition), Primary procedure only
Cognition	Able to consent, Able to use PCA
Pregnancy	Not Pregnant
Renal	eGFR >30
Hepatic	PT <60sec, DBIL <2.5, Bilirubin <0.6g/dL or 10µmol/L

Abstract 218 Table 2

	RSC	No RSC
Included	61	61
Demographics		
Age Median (years)	72.5 (S.D. 78.2-66.8)	63 (S.D. 72.6-53)
Sex Male (%)	54	53
Sex Female (%)	46	47
Mean pain score	2.75	2.50
Outcomes		
Opioid consumption at 72h post-op (mg/kg)	93.5 (S.D. 76.3)	125.4 (S.D. 105.7)
Transverse thoracic plane blocks		
Paravertebral (%)	74 (74.7%)	74 (74.7%)
Ketamine (%)	20 (32.8%)	6 (9.8%)
Spinal (%)	27 (44.3%)	2 (3.3%)
Pain scores/VAS average		
1 hour	1.75	1.68
24 hours	1.80	1.70
72 hours	1.75	1.90

meeting local inclusion criteria for RSC at the Royal Liverpool University Hospital (table 1), September 2019 – March 2020.

Results 61 patients were included. 31 (50.8%) patients had RSC with 0.2% ropivacaine infusions running at an average 7.97 ml/h (S.D. 1.45) for a median 3 days. Median age was higher in RSC vs no RSC (72.5 vs 63 years). Patients with no RSC received alternative analgesic techniques including; spinal anaesthesia (1), transverse abdominis plane blocks (13) and IV lidocaine infusion (4). Despite this we noted a lower opioid requirement 72h post-operatively in RSC patients vs no RSC (mean 93.5 mg (S.D. 76.3) vs 125.4 mg (S.D. 105.7)), with lower average pain scores noted at 1, 24 and 72 hours in the RSC group (table 2). Ketamine use was more frequent in the no RSC group (20% vs 6.5%). 59 (96.7%) received an opioid PCA post-operatively.

Conclusions Lower opioid requirements associated with RSC is consistent with other studies including a 2019 Cochrane review. The infrequent use of spinal techniques (1.6%) may reflect concerns regarding safety in the emergency setting. Our results support available evidence, and suggest RSCs should be considered in emergency laparotomy

219 THE CHALLENGE OF OPIOID-FREE ANESTHESIA IN NEUROSURGERY: AN OBSERVATIONAL STUDY

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Background and Aims The use of opioids in the management of acute perioperative pain is very effective, but their use entails a series of adverse effects. Using OFA we avoid adverse effects. There are different studies (1) that indicate that the intra and postoperative use of opioids in patients with a tumor process could contribute to tumor progression.

Methods A retrospective observational study of patients over 18 years of age who were scheduled for elective craniectomy for a period of six months. This study was approved by the

Abstract 219 Figure 1

Abstract 219 Figure 2

local Ethics Committee (IP 20-1802). Anesthesia was induced with propofol, midazolam, and rocuronium. Maintenance was established with propofol. We make a scalp block (frontal, auriculotemporal, zygomaticotemporal, occipital nerves) with 0.3% ropivacaine and 1% lidocaine, using 2.5 ml for each of the nerves. VAS values were recorded at the end of the intervention after waking up the patient and morphine doses required during the first 24 postoperative hours.

Results 46 patients were recruited, 58.7% men and 41.3% women, mean age 58.65%. 76% of the patients underwent supratentorial craniectomy and 24% underwent infratentorial craniectomy. VAS 0 after extubation in 100% of patients. 75% of the patients didn't require postoperative morphine. 26% required postoperative morphine (mean dose of 4.1 mg in 24 hours). No patient presented complications secondary to the block.

Conclusions Although our study has limitations, there were no complications after the scalp block. We can conclude that due to the low rate of complications and the low postoperative consumption of opioids, we can use scalp block for neurosurgical.

220 COMPARISON OF PATIENT CONTROLLED VERSUS CONTINUOUS EPIDURAL ANALGESIA IN ADULT SURGICAL PATIENTS: A SYSTEMATIC REVIEW

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