Abstract 228 Figure 1

Abstract 228 Table 1 Opioid use in theatres and recovery during the first two weeks of November 2019. IVME=IV morphine equivalents, n=number of patients, median=median opioid use, PACU=post anaesthesia care unit

BSUH AREA	IVME (mg)	n	Median (min-max) (mg)
Theatre 1 (orthopaedic trauma)	555.5	30	20 (2.5-38)
Theatre 2 (complex ENT)	225.5	16	10 (5-30)
Theatre 4 (Emergencies)	806.5	43	20 (5-40)
Theatre 5 (Major gynaecology and general oncology surgery)	260.5	16	12.5 (5-30)
PACU	870	85	8 (2-45.4)

plethora of non-opioid adjuncts which may facilitate opioid-free or opioid-light anaesthesia and analgesia. Further work is required to investigate if anaesthesia and recovery opioid sparing protocols can improve patient outcomes.

229 INSTITUTIONAL ENHANCED RECOVERY PROGRAM QUALITY PAIN AUDIT

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Background and Aims Pain remains a major complaint in the immediate post-operative phase. Despite enhanced recovery protocols (ERP) and procedure specific pain therapy up to 80% of patients experience significant uncontrolled pain. Aim of this quality control pain audit was assessing pain intensity in institutional developed multimodal perioperative care pathways. Analyses of efficacy locoregional analgesia, management and protocol adherence. Determine possible improvements of guidelines and procedures

Methods Prospective data were collected on 118 patients undergoing six types of surgery. Pain scores were evaluated on

postoperative care unit (PACU) and first five days following surgery. Primary outcome was worst recorded pain score. Secondary outcomes included median pain on ward, incidence of postoperative nausea and vomiting, time to first mobilization. Following procedures were included: minimal invasive cardiac surgery, video assisted thoracic surgery, esophageal resection, total knee arthroplasty, laparoscopic colorectal surgery and robotic prostatectomy.

Results Numeric Rating Scale higher than three was observed in 89% of study population. At PACU esophageal resection showed worst pain scores despite neuraxial analgesia (Median: 7, IQR 5-8). Total knee arthroplasty resulted in worst pain scores on ward following surgery (median: 7, IQR 5-8). Disappointingly only 25% of patients received pain medication following institutional ERP guidelines. Current ERP-guideline are similar to ERAS guidelines found in literature.

Conclusions Multimodal pain therapy should become standard of care. Constant evaluation of pain guidelines are necessary. Audits and evaluation of protocol adherence next to clear guidelines and managing patient information, expectations are pivotal.

230 CLONIDINE AS AN ADJUNCT TO LEVOBUPIVACAINE FOR PUDENDAL BLOCK DURING PROCTOLOGICAL SURGERY: A PROSPECTIVE, RANDOMISED, PILOT STUDY

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Background and Aims Proctological surgery is associated with high-score postoperative pain (VAS>5) [1].

Pudendal block reduces pain and allows a faster return to normal activity [2].

Clonidine has been suggested to improve the quality and duration of peripheral blocks [3 4].

This study investigates whether adding clonidine to levobupivacaine in proctological surgery reduces postoperative consumption of analgesics.

Methods After local ethics committee approval and signed informed consent, adults ASA I/II, scheduled for proctologic