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

surgery under general anesthesia, were enrolled in a prospective, randomized, double-blind, single-centre, pilot study [NCT04530903].

Group. 1 received an ultrasound-pudendal block using 75µg of clonidine per side; group.2 0.5 ml of NaCl 0.9% per side; both groups received 10 ml of levobupivacaine 0,25%.

Primary outcome: total consumption of tramadol in PACU. Secondary outcomes: time between block and first analgesic demand; tramadol request within 24h; postoperative pain; satisfaction.

Continuous data were compared via T-test or Wilcoxon signed-rank test; means±st.deviation or medians are reported. For count data, Pearson Chi-Squared test was performed to compare proportions. $P < 0.05$ was considered significant.

Results Demographics and surgical data were comparable between groups. The groups were not statistically different for the primary outcome (group.1:100 mg; group.2:450 mg; $P = 0.1677$).

55.6% of group.2 requested tramadol in PACU ($P = 0.09677$) compared to 12.5% of group.1.

Within 24h, group.1 required more Tramadol ($P = 0.05$).

VAS longitudinal analysis showed a group-time effect with significantly higher pain within 24h in group.1 ($P = 0.0477$).

Satisfaction was not statically different between groups.

Conclusions Adding clonidine to levobupivacaine in pudendal block did not improve postoperative analgesia.

A large-scale study is needed to further support these results.

231 INFECTION AFTER KNEE ARTHROPLASTY, DO WE KNOW ALL RISK FACTORS?

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Background and Aims Non-steroidal anti-inflammatory drugs (NSAIDs) inhibit cyclooxygenase and it causes granulocytic function suppression (1). These effects could be found in relation to the increased incidence of infections and higher risk of bleeding (2).

Aim of this study was a descriptive analysis of risk factors for total knee arthroplasty, in order to evaluate the relationship between NSAIDs and perioperative infection (4).

Abstract 231 Table 1 Variables collected

Allergies
Personal history
Surgical history
Treatment with NSAIDs before and after the intervention.
Septic / aseptic replacement.
Joint liquid microbiology
Microbiology knee prosthesis
Antibiotic treatment
Administration of tranexamic acid
Type of anesthesia
Analytical parameters: Hb, leukocytes, platelets, PCR.

Methods A descriptive observational study in 25 patients medical records who were scheduled for total knee arthroplasty in University Hospital of Valladolid. The following variables were collected (table 1). The study was aprobed by Hospital Clínico

Abstract 231 Table 2 Baseline clinical epidemiological characteristics of the sample

	n/N (%)
Female	17/25 (68%)
Diabetes Mellitus	7/25 (28%)
Hypertension	11/25 (44%)
Dyslipidemia	10/25 (40%)
Cardiopathy	10/25 (40%)
Obesity	4/25 (16%)
Periarthral infiltration	4/25 (16%)
Intraoperative administration of tranexamic acid	16/25 (64%)
Locoregional anesthesia	23/25 (92%)

Abstract 231 Table 3 Distribution of risk factors in both groups (septic/aseptic)

		ASEPTIC		SEPTIC	
		n	Percentage	n	Percentage
Gender	Men	7	50,0%	1	9,1%
	Female	7	50,0%	10	90,9%
Allergies	NO	11	78,6%	10	90,9%
	YES	3	21,4%	1	9,1%
Diabetes Mellitus	NO	10	71,4%	8	72,7%
	YES	4	28,6%	3	27,3%
Hypertension	NO	8	57,1%	6	54,5%
	YES	6	42,9%	5	45,5%
Dyslipidemia	NO	10	71,4%	7	63,6%
	YES	4	28,6%	4	36,4%
Cardiopathy	NO	8	57,1%	7	63,6%
	YES	6	42,9%	4	36,4%
Obesity	NO	12	85,7%	9	81,8%
	YES	2	14,3%	2	18,2%
Periarthral Infiltration	NO	12	85,7%	9	81,8%
	YES	2	14,3%	2	18,2%
Tranexamic acid	NO	3	21,4%	6	54,5%
	YES	11	78,6%	5	45,5%
Anesthesia	General	0	0,0%	2	18,2%
	Intradural	14	100,0%	9	81,8%