Abstracts

Abstract 44 Table 1 Patients characteristics

Patient	Age	Gender	Injuries	ASA	Catheter level	Depth in space	Remarks
1	57	Male	8.3 rd -10 th	2	5 th	6 cm	
2	58	Male	8.4 th -9 th	2	5 th	1.5 cm	Single shot gives post op, catheter inserted post op
3	67	Male	8.3 rd -10 th	2	7 th	5 cm	Immediate transection of catheter later up, new catheter inserted post op
4	54	Male	1.3 rd to 3 rd	2	7 th	3 cm	
5	78	Male	1.3 rd to 3 rd	2	7 th	4 cm	Catheter migration and twisting occurred POD-1

Abstract 44 Table 2 Analgesia characteristics

Patient	LA Bolus	Day of catheter removal	Highest recorded pain score as measured	Optimal use (Timing)	NSAIDs use (Timing)	Others	Remarks
1	15 ml of 0.5%	AD	5/10	None	None	None	No complications for all patients
2	0.5% variable	remained on POD-2 except patient 5 (POD-1)	5/10	None	Acetaminophen (POD-2)	Paracetamol	
4			5/10	Opioidfree (POD-2)	Acetaminophen (POD-2)	Paracetamol, Tramadol	
5			5/10	None	Acetaminophen (POD-2)	Paracetamol, Tramadol, Suppositories in view of transdermal	

duration exceeding the BD dosing. RLB confers a better safety profile (less invasive, lower risks of pneumothorax, bleeding or epidural spread) to classical blocks. Erector spinae blocks (ES) though effective⁴⁻⁵, have not been attempted for plating. Reasons for RLB catheter are: insertion point away from surgical site; ability for peri-op analgesia via a catheter; good mobility; minimal hypotension; minimal nursing care; surgical satisfaction and same benefits to ES catheters. Insertion of these catheters as part of a holistic analgesia plan, from pre-op to post-op, as well as comparing to ES blocks, should be considered.

Conclusions The RLB confers similar analgesic efficacy but also minimal interruption to surgery and reduced complications, thereby a viable option for rib fracture plating analgesia.

45 INTRAOPERATIVE EPIDURAL ANALGESIA PRACTICES AND THEIR OUTCOMES IN MAJOR ABDOMINAL SURGERIES AT A TERTIARY CARE HOSPITAL

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Background and Aims There is considerable variation in practice among anesthetists at our center regarding intraoperative epidural analgesia. We intend to investigate association between site, concentrations, and dosing of local anesthetics (LA) used intraoperatively on blood pressures, motor block, pain scores and need for rescue analgesia.

Methods Ethical approval was taken from The Aga Khan University Ethics Review Committee(Ref#2020-3692-10675). 170 patients undergoing abdominal surgeries with epidurals as primary analgesic modality at a tertiary care center over twelve months were recruited.

Results Intraoperative hypotension was reported in 46.5%. Among factors evaluated for association with intraoperative hypotension, concentration of LA used was found to be statistically significant($p=0.02$ and 0.04). Patients who received intraoperative epidural boluses were more commonly reported

hypotensive on arrival in post anesthesia care unit(PACU) as compared to continuous infusion(17.8% vs 4.8% , $p=0.02$). Motor block was observed in 41.5% patients given continuous infusion vs 17.4% given boluses($p=0.02$). Bupivacaine, when used for intraoperative infusion caused more motor block (43.6% vs 34.5% , $p=0.04$) and hypotension(6% vs 0% , $p=0.04$) as compared to Ropivacaine. Patients given higher concentration of local anesthetic as intraoperative infusion(0.25% vs 0.125% and 0.1%) had higher frequency of motor block (58.3% vs 38.8% and 40% , $p=0.05$). Two-thirds of the patients had moderate to severe pain on arrival in PACU, and half of

Abstract 45 Figure 1

Abstract 45 Table 1 Intraoperative hypotension and associated factors. P value <0.05 was considered significant.

	Intraoperative Hypotension	
		P value
Frequency	79 (46.5%)	-
Epidural Site		
Thoracic N=110	50 (47.2%)	0.72
Lumbar N=60	29 (48.3%)	
LA used		
No loading N=8	4 (50%)	0.88
Bupivacaine N = 129	65 (50.4%)	
Ropivacaine N =33	15 (45.5%)	
Concentration of LA used for loading dose		
0.5% N=2	1 (50%)	0.02
0.25% N=101	49 (48.5%)	
0.125% N=50	21 (42%)	
0.1% N=9	1 (11%)	
Intraop epidural management		
Bolus dosing N= 23	11 (47.8%)	0.89
Continuous infusion N=147	68 (46.3%)	
Concentration of LA used for infusion		
0.25% N=12	10(83.3%)	0.04
0.125% N=113	48 (42.5%)	
0.1% N=20	8 (40%)	

Abstract 45 Table 2 Parameters after arrival in PACU and their association with intraoperative epidural practices. P value <0.05 was considered significant

	Hypotension		Motor Block		Pain score >4		Need for rescue analgesia	
		P value		P value		P value		P value
Frequency (N=170)	11 (6.5%)	-	35 (68.2%)		114 (67%)		84 (49.4%)	
Epidural Site								
Thoracic (N=110)	9 (8.5%)	0.22	36 (34%)	0.23	76 (69.1%)	0.44	51 (48.1%)	0.12
Lumbar (N=60)	2 (3.3%)		28 (46.7%)		38 (63.3%)		29 (48.3%)	
Intraop epidural dosing regime								
Bolus dosing (N=23)	4 (17.4%)	0.02	4 (17.4%)	0.02	16 (66.7%)	0.78	11 (47.8%)	0.877
Continuous infusion N=147	7 (4.8%)		61 (41.5%)		98 (66.7%)		73 (49.7%)	
LA used for infusion								
Bupivacaine N=117	7 (6%)	0.04	51 (43.6%)	0.04	77 (65.8%)	0.866	58 (49.6%)	0.99
Ropivacaine N=29	0 (0%)		10 (34.5%)		20 (69%)		14 (48.3%)	
Concentration of LA used for infusion								
0.25% N=12	1 (8.3%)	0.19	7 (58.3%)	0.05	8 (66.7%)	0.84	8 (66.7%)	0.472
0.125% N=113	6 (5.3%)		45 (38.8%)		76 (67.3%)		56 (49.6%)	
0.1% N=20	0 (0%)		8 (40%)		12 (60%)		8 (40%)	

patients required rescue analgesia. However, no association was found between pain scores and need for rescue analgesia with epidural site, dosing regime, LA and its concentration used for infusion.

Conclusions Intraoperative management of epidurals is an essential but overlooked component of perioperative pain management. Guidelines should be formulated for intraoperative epidural analgesic regimens to improve postoperative outcomes.

46 REGIONAL ANAESTHESIA WHERE YOU DON'T EXPECT: NEURAXIAL BLOCKADES FOR ENDOSCOPIC SUBMUCOSAL DISSECTION PROCEDURE (ESD)

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Background and Aims Endoscopic Submucosal Dissection (ESD) is an endoscopic procedure to remove gastrointestinal tumors [1]. It lasts 90 minutes or longer and general anaesthesia or deep sedation [2] are required to ensure comfort and immobility. Pain is evoked by intestinal insufflation and external compression manoeuvres. We evaluated the use of neuraxial blockades to perform colorectal ESD.

Methods With informed consent, we performed neuraxial blocks for five colorectal ESD. Spinal anaesthesia (SA) and combined spinal-epidural (CSE) anaesthesia at T11-T12 level with spinal bolus of 0,3% ropivacaine, 4 ml + fentanyl 20mcg. Epidural anaesthesia (EA) at T10-T11 level with bolus of 0,4% ropivacaine, 12 ml + fentanyl 50mcg. Data regarded: patient; procedure; anaesthetic technique; SpO₂; NIBP; intra-procedural pain (NRS); additional sedation or analgesia; patient's and operator's satisfaction.

Results All patients were elder and had comorbidities.

Tumour site: 1 rectum; 2 descending colon; 2 ileocecal valve.

Procedure's duration: between 120 and 375 minutes.

Anaesthesia: 2 SA, 1 CSE; 2 EA.

SpO₂: always stable between 97% and 100%.

NIBP: 2 episodes of mild hypotension were registered.

NRS: always 0; patients who received spinal anaesthesia complaint of abdominal pain after 200/240 minutes. They received additional IV fentanyl and deep propofol sedation.

Patients' and operators' degree of satisfaction: 4 or 5

Results are summarized in table 1.

Abstract 46 Figure 1

Abstract 46 Table 1

	PATIENT			TUMOR SITE	DURATION minutes	ANESTHESIA	SpO ₂ drops	NIBP drops	minutes after block						deep sedation	SFACTION (1-5)	
	AGE	GENDER	COMORBIDITIES						60	120	180	240	300	360		patient	operator
CASE 1	81	male	>3	descending	300	SPINAL	none	none	0	0	0	7	sed		after 240 min	4	4
CASE 2	73	male	3	rectum	375	SPINAL	none	10-20%	0	0	0	8	sed	sed	after 240 min	4	4
CASE 3	70	female	1	valve	265	EPIDURAL	none	>20%	0	0	0	0			none	5	4
CASE 4	66	male	2	valve	120	EPIDURAL	none	none	0	0	0				none	5	5
CASE 5	83	male	>3	descending	180	CSE	none	none	0	0	0				none	5	5