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

	Hypotension	P value	Motor Block	P value	Pain score >4	P value	Need for rescue analgesia	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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10.1136/rapm-2021-ESRA.46

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; intraprocedural 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.

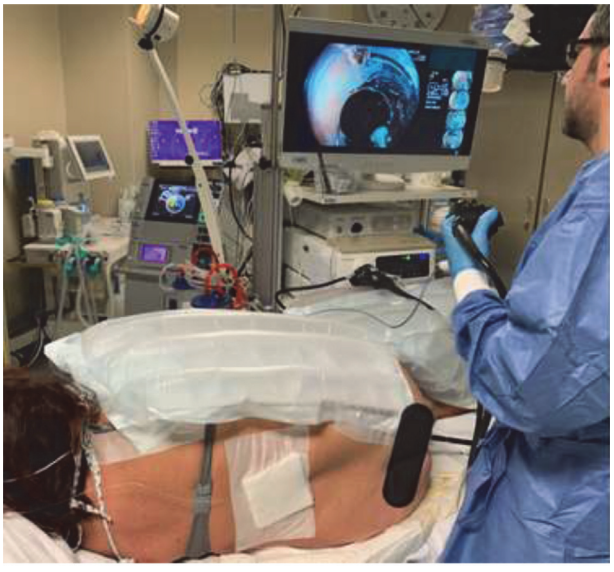
SpO2: always stable between 97% and 100%.

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	ANESTHESIA	SpO2	NIBP	minutes after block						deep sedation	SFACTION (1-5)	
	AGE	GENDER	COMORBIDITIES		minutes		drops	drops	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					none	5	5
CASE 5	83	male	>3	descending	180	CSE	none	none	0	0	0				none	5	5

Conclusions Central neuraxial blocks could be alternative techniques for colorectal ESD procedures, especially for fragile patients [3]. Procedure duration could not be accurately predicted, thus continuous epidural or CSE, should be preferred. Research trials are needed to corroborate our thoughts.

47 INCIDENCE AND MANAGEMENT OF POST-DURAL PUNCTURE HEADACHE AND ACCIDENTAL DURAL PUNCTURE FROM AN ONCOLOGY HOSPITAL: A 5-YEAR RETROSPECTIVE ANALYSIS

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10.1136/rapm-2021-ESRA.47

Background and Aims Accidental dural puncture (ADP) and post–dural puncture headache (PDPH) are epidural anaesthesia's complications. There's limited evidence in non–obstetric patients and no consensus management.

The aim of this study was to evaluate its incidence and approach in an institution where combined epidural-general anaesthesia is preferential.

Methods Retrospective analysis (SPSS V.26) was conducted of adult patients submitted to elective surgery with combined epidural-general anaesthesia and suffered ADP, april 2015–2020. Information about the patient's background, epidural procedure, PDPH management and clinical evolution was collected from clinical records.

Results 3237 patients have had a combined epidural-general anaesthesia, 31 suffered ADP (0,96%). 61,3% were female, 71% ASA II, mean age 59,61 years. 6 patients developed PDPH, 1 without previous ADP identification, resulting in an incidence of PDPH of 19,35%. This incidence was not statically different in patients in whom the catheter was resited (n=5) comparing to the ones that were not (n=1). All patients were treated conservatively, although not uniformly. The onset of headache was on average 48h (24–72h) postoperative and with an average duration of 48h (24–96h). 5 patients were submitted to prophylactic treatment for PDPH and only 1 developed PDPH; comparing to 5 in 26 that did not receive prophylactic treatment, although not statistically different. This study was approved by the Ethics Committee.

Conclusions The incidence of ADP and PDPH were lower than that reported in literature. Conservative treatment for PDPH was enough to manage this condition efficiently. The approach is not uniform, emphasizing the need of clinical protocol.

48 INTRAOPERATIVE INTRATHECAL MORPHINE FOR POSTOPERATIVE ANALGESIA IN OPEN ABDOMINAL HYSTERECTOMY FOR GYNECOLOGICAL MALIGNANCY

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10.1136/rapm-2021-ESRA.48

Background and Aims Open abdominal hysterectomy is one of the most performed oncological gynecological surgeries, with an expected moderate to high pain level.

The use of single shot intrathecal morphine (ITM) has an analgesic effect of up to 24h, with patients requiring fewer postoperative IV opioids.

The aim of this study is comparing the analgesic effects and adverse effects of ITM against IV morphine, in cancer patients submitted to open abdominal hysterectomy.

Methods Prospective observational study.

Data collection over a 1-year period.

Inclusion criteria comprised adults submitted to total or radical open abdominal hysterectomy, with total intravenous anaesthesia with intraoperative propofol and fentanyl. Patients with pre-induction ITM administration (100 to 300mcg) and postoperative analgesia with IV morphine patient controlled analgesia and paracetamol, were compared to a control group without spinal opioid.

Descriptive and comparative analysis for analgesic quality and adverse effects in the first 24 hour postoperative period was performed using SPSS software.

Results 36 patients were included in the ITM group and 44 in the control group. Comparative analysis found no significant association between ITM administration and lower static or dynamic pain scores. The ITM group had less PCA rescues ($p<0.001$) but a higher risk of postoperative vomiting (22% vs 2.2%, $p<0.01$).

Conclusions ITM administration resulted in significantly less PCA rescue, without perceived analgesic improvement compared with no ITM administration. Patients exhibited more side effects, such as nausea and vomit. Prescribing fixed antiemetics for the first 24 hours might be the best strategy to overcome these side effects.

49 COMPARISON OF ANTI-SHIVERING EFFECT OF INTRAVENOUS VERSUS INTRATHECAL TRAMADOL IN PATIENTS UNDERGOING LOWER LIMB SURGERY UNDER SPINAL ANAESTHESIA

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10.1136/rapm-2021-ESRA.49

Background and Aims Shivering occurs in 40–60 percent of patients under spinal anaesthesia. (1)

Prophylaxis with intravenous tramadol produces a dose-dependent reduction in the incidence of shivering. (2) Tramadol is a common intrathecal adjuvant, safely used in a dose up to 20 mg. Few studies tested the anti-shivering efficacy of intrathecal tramadol. (3,4) However, no study compared the anti-shivering effect of intravenous versus intrathecal tramadol. Therefore, we conceptualized this trial to compare the anti-shivering effect of intravenous versus intrathecal tramadol.

Methods This study was a randomized, double-blinded clinical trial that included 86 ASA I & II patients divided into two equal groups. It included patients aged 18–65 years who undergone lower limb orthopedic surgeries; that lasted less than two hours under spinal anesthesia. Our institutional ethical committee approved the protocol and was registered at PACTR (trial ID: PACTR202007664590852). Patients were allocated randomly into control (IV) group and interventional (IT) group. The Control group received intrathecal 15 mg bupivacaine then IV tramadol 25 mg in 5 ml normal saline. The interventional group received 20 mg tramadol added to15 mg bupivacaine intrathecally then IV 5 ml normal saline.