that punctures under fusion led the tip of the needle in the L4-L5 foramina.

Conclusions Bony and surface landmarks allow an accurate fusion of CT and US images of the lumbar spine and precise localizations and puncturing of lumbar neural foramina.

7 RELATIONSHIP BETWEEN COMORBIDITIES IN PATIENTS WITH CHRONIC LOW BACK PAIN UNDERGOING INTERVENTIONAL PAIN MANAGEMENT TECHNIQUES, AND PATIENT SATISFACTION AND CLINICAL RESPONSE

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10.1136/rapm-2021-ESRA.7

Background and Aims Response to Interventional Pain Management Techniques is often variable and unpredictable. This study aims to evaluate the association between comorbidities of 251 patients undergoing Interventional Pain Management Techniques (IPMT) for Chronic Low Back Pain (CLBP) with patient satisfaction and clinical response at 1 month after IPMT.

Methods

- This is a sub-study of a prospective longitudinal observational study (PRETI-Back, NCT NCT04451252).
- Adult patients who were prescribed a IPMT were eligible. Patients who refused to participate in the study and those who had intercurrent pathology that could interfere with the evaluation of pain were excluded.
- Approval has been granted by the ethics committee of our hospital.

Results No statistically significant differences regarding fibromyalgia, anxiety/depression, substance abuse disorder, diabetes, arthrosis, osteoporosis, rheumatic disease, obesity and other chronic pain were identified. The following findings were statistically significant. Patients with failed back surgery syndrome (FBSS) or neuropathic pain (NP) obtained a lower clinical response rate and lower percentage of patient satisfaction.

DICTAMEN DEL COMITÉ DE ÉTICA DE LA INVESTIGACIÓN con MEDICAMENTOS

D^a Camino Sarobe González, Secretaria Técnica del COMITÉ DE ÉTICA DE LA INVESTIGACIÓN con MEDICAMENTOS HOSPITAL GENERAL UNIVERSITARIO GREGORIO MARAÑÓN

CERTIFICA

Que se ha evaluado la propuesta de modificación sustancial del promotor referida al estudio observacional No-EPA:

Código PRETI-DOL-VI

TÍTULO: "Predictores de respuesta en técnicas intervencionistas en dolor crónico lumbar (PRETI-DOL). Desarrollo de un modelo predictivo. Estudio prospectivo de recogida de datos clínicos"

Modificación sustancial. Protocolo versión 5. Fecha: 24/05/20.

Promotor: Servicio de Anestesiología, Reanimación y Terapéutica del Dolor. Unidad del Dolor. Hospital General Universitario Gregorio Marañón.

y considera que, este CEIm actuando como comité evaluador, emite dictamen favorable y acepta que dicha modificación sea asumida por todos los participantes en el estudio.

Y HACE CONSTAR QUE:

1ª En la reunión celebrada el día 06 de julio de 2020, acta 17/2020 se decidió emitir el informe correspondiente al estudio de referencia.

2ª En dicha reunión se cumplieron los requisitos establecidos en la legislación vigente -Real Decreto 1090/2015 y Decreto 3994 de la Comunidad de Madrid- para que la decisión del citado CEIm sea válida.

3ª El CEIm, tanto en su composición, como en los PNT cumple con las normas de BPC (CPMP/ICH/ 135/95)

4ª La composición actual del CEIm es la siguiente:

Abstract 7 Table 1

		N (total=251)	Moderate improvement	Major improvement	A	B
COMORBIDITIES						
Fibromyalgia						
	YES	19	31.60%	10.50%	57.90%	84.20%
	NO	232	29.30%	13.40%	50.90%	78.40%
	P		0.50	0.53	0.36	0.4
Anxiety/Depression						
	YES	65	30.80%	12.30%	52.30%	80%
	NO	186	29%	13.40%	51.10%	78.50%
	P		0.45	0.5	0.49	0.47
Substance abuse						
	YES	5	60%	40%	40%	60%
	NO	246	28.90%	12.60%	51.60%	79.30%
	P		0.15	0.13	0.47	0.28
Failed back surgery syndrome						
	YES	55	16.40%	3.60%	36.40%	69.10%
	NO	196	33.20%	15.80%	55.60%	81.60%
	P		0.01	0.01	0.01	0.04
Diabetes						
	YES	38	31.60%	15.80%	47.40%	78.90%
	NO	213	29.10%	12.70%	52.10%	78.90%
	P		0.45	0.38	0.35	0.60
Arthrosis						
	YES	122	32%	14.0%	54.10%	82%
	NO	129	27.10%	11.60%	48.80%	76%
	P		0.24	0.29	0.24	0.16
Rheumatic disease						
	YES	12	41.70%	16.70%	50%	75%
	NO	239	28.90%	13%	51.50%	79.10%
	P		0.26	0.49	0.58	0.48
History of cancer						
	YES	12	66.70%	16.70%	75%	91.70%
	NO	239	27.60%	13%	50.20%	78.20%
	P		0.01	0.49	0.08	0.24
Obesity						
	YES	16	12.50%	6.30%	56.30%	87.50%
	NO	235	30.60%	13.60%	51.10%	78.30%
	P		0.10	0.35	0.44	0.30
Other chronic pain						
	YES	51	39.20%	13.70%	52.90%	76.50%
	NO	200	27%	13%	51%	79.50%
	P		0.06	0.52	0.46	0.38
Neuropathic pain						
	YES	114	21.90%	7%	43%	86.10%
	NO	137	35.80%	18.20%	58.40%	70.20%
	P		0.01	0.01	0.01	0.002
Neurogenic claudication						
	YES	81	23.50%	7.40%	48.10%	75.30%
	NO	170	32.40%	15.90%	52.90%	80.60%
	P		0.10	0.045	0.28	0.21

Also, patients with neurogenic claudication (NC) had a lower rate of major improvement (table 1).

Conclusions FBSS, NP and NC were associated with worse response to IPMT.

Further investigation is needed to address the importance of comorbidities in IPMT response, so as to be taken into account when individualizing management of CLBP.

8 KNEE PAIN: EXPERIMENTAL RADIOFREQUENCY

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10.1136/rapm-2021-ESRA.8

Background and Aims Knee osteoarthritis (OA) is a major cause of disability with growing impact in a more aging society. Conservative therapies have shown limited efficacy. After Total knee arthroplasty 15% to 30% of patients continue experiencing pain.

Radiofrequency ablation of genicular nerves is effective in relieving pain. Bony landmarks under fluoroscopic guidance

Abstract 7 Figure 1

(A) Image of knee at the level of femoral medial epicondyle for superior medial genicular nerve. US percutaneous placement of the needle between medial and lateral cortex of the femur in axial plane.
(B) Image of knee at the level of lateral femoral epicondyle for superior lateral genicular nerve. US percutaneous and peritendinous placement of the needle in axial plane of the knee.
(C) Image of knee at the level of femoral lateral epicondyle for superior lateral genicular nerve. US placement of the needle at 45° reflecting the crest between lateral and posterior sides in a transverse plane of the femur.

Abstract 8 Figure 1

have been used but, ultrasound is an alternative without any radiation exposure and visualization of genicular arteries and tendons.

Pulsed radiofrequency, is a safe causing neuromodulation of sensitive fibers without nerve damage, effective in neuropathic pain and better tolerated during treatment.

Methods A number of 3 patients with chronic knee pain and unsuccessful treatments were submitted to US-guided PRF of the superior medial, superior lateral, and inferior medial genicular nerves. The landmarks used were an adaptation of those described by Fonkoue L, et al.¹ in their anatomic study. The Brief Pain Inventory (BPI) and Western Ontario and McMaster Universities Osteoarthritis (WOMAC) scores were assessed before treatment, and at 30 days following the procedure.

Results All patients had a similar severity pain baseline – mean WOMAC score of 78.6 (range 75–81) and mean VAS score of 69 (range 65–72). All patients had a reduction of perceived pain and functionality with improvement of 35% in WOMAC score (mean 51.3) and 50.7% in BPI score (mean 35). No adverse outcomes reported.

Conclusions Our preliminary results suggest that US-guided PRF of genicular nerves is a safe and effective procedure that alleviates pain in patients with severe degenerative disease and we intend to continue to improve the technique.

Abstract 9 Figure 1

9

EFFECTS OF ULTRASOUND-GUIDED ERECTOR SPINAE PLANE BLOCK AND PECTORALIS NERVE BLOCK ON POSTOPERATIVE ACUTE AND CHRONIC PAIN IN PATIENTS WHO UNDERWENT BREAST CANCER SURGERY

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10.1136/rapm-2021-ESRA.9

Background and Aims In this study, the effects of ultrasound (US) guided erector spinae plane (ESP) block and pectoralis nerve (PECS) block on acute and chronic pain in patients who underwent breast cancer surgery were studied.

Methods Ninety patients were divided into three groups: the ESP, PECS and the control group (ethical approval number-24237859-207). All blocks were applied in the preoperative period using 30 ml of 0.25% bupivacaine (figure 1). The control group received no intervention.

The measures recorded were time to onset of block, intraoperative remifentanyl consumption, time to first request for analgesia via patient-controlled analgesia (PCA), morphine consumption in the first postoperative 24 hours, the number of patients who requested rescue analgesia, and the visual

Abstract 9 Table 1 Time to onset of block, intraoperative remifentanyl and postoperative morphine consumption, the time to first request for analgesia via PCA, and use of rescue analgesia by groups

	Group PECS (n=30)	Group ESP (n=30)	Group Control (n=30)	p*
Onset of block (min)	16 ± 5 15 (13-20)	22 ± 5 20 (20-25)	—	<0,001
The time to first request for analgesia via PCA (h)	3 ± 2,1 3 ^a (2-4)	2 ± 1,9 2 ^a (1-3)	1 ± 1,3 1 ^b (1-1)	<0,001
Postoperative morphine consumption (mg)	3,1 ± 1,4 3 ^a (2-4)	3,8 ± 1,9 4 ^a (2-5)	5,2 ± 1,4 5 ^b (4-6)	<0,001
Intraoperative remifentanyl consumption (µg)	258 ± 113 230 ^a (197-352)	280 ± 137 250 ^a (200-302)	432 ± 131 410 ^b (350-512)	<0,001
Use of rescue analgesia by groups				
Yes	30 ^a	24 ^b	19 ^b	0,001
No	0	6	11	

a-b-c: There is no difference between groups with the same letter. Data are presented as mean ± standard deviation and median (Interquartile range, IQR). *p <0.05 value was considered significant. PCA: Patient controlled analgesia.