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PROXIMAL FEMUR FRACTURE ANESTHESIA TECHNIQUE – DOES IT REALLY MATTER?

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Background and Aims Hip fracture (HF) is common in emergency departments admission Mortality can reach 32% one year after surgery and delirium may affect 41% post-operative. Search for improved benefits from spinal (SP) or general anesthesia have shown inconsistent results. We aim to test if peripheral nerve blocks (PNB) with general inhalational anesthesia (GA), avoiding muscle relaxants and reducing opioids usage, may improve survival and delirium after HF repair when compared to spinal.

Methods Hospital Ethics approval and patient informed consent were obtained. HF patients were randomized to Femoral and Lateral Cutaneous nerve block (PNB) with GA versus SP for surgical repair (Hip prosthesis, dynamic screw or femoral

Abstract 89 Figure 1

Abstract 89 Table 1 Group characteristics

	Gender (M/F)	ASA (IV)*	Age (Y) [†]	Weight (Kg) [‡]	T_Surgery (h) [§]
GA/PNB n=28 (49.1%)	6/23	1-4 (4)	80,8	61,2	44,5
SPINAL n= 29 (50,1%)	2/26	2-3 (0)	83,8	58,7	30,8
p [§]	0,144	0,942	0,210	0,368	0,044**

* ASA range (n ASA IV patients)

[†] Mean values

[‡] Time to surgery (hour)

[§] Statistically significant if p<0.05

** t-test

Abstract 89 Table 2 Results

	Hipotension n (%) [†]	T_hipotension (min) [‡]	3D_delirium n (%) [§]	1Y mortality n (%) [§]
GA/PNB n=28	16 (55,2%)	9,5	11 (39,3%)	7 (24,1%)
SPINAL n=29	5 (17,9%)	15	9 (36,0%)	3 (10,7%)
p ^{**}	0,004 ^{††}	0,243	0,805	0,170

[†] Patients with systolic blood pressure <90mmHg

[‡] Duration of hipotension

[§] Patients with positive CAM delirium screening up to 3 days post surgery

[§] Number (%) deaths at 1 year post surgery

^{**} Statistically significant if p<0.05

^{††} Chi-Square

naïl). Clinical data was collected throughout peri-operative period. CAM test was used to assess delirium and one year follow-up to assess survival. Descriptive statistics was used to characterize the sample and parametric and non-parametric tests were used to assess differences between groups.

Results Groups demographics are in table 1. All ASA 4 patients were on the GA/PNB group, but the Man-Whitney test shows no difference in ASA distribution overall. Overall, 37% of patients had delirium up to 3 days after surgery and one year mortality was 19.3%. Table 2 shows the differences between PNB/GA and SP groups.

Conclusions Overall survival and delirium rates are within the literature range. Although a trend to higher 1year mortality can be seen in the BNP/AG group, we did not find statistical differences in outcomes using peripheral nerve block/general inhalational anesthesia vs spinal. A larger study is needed to confirm these findings

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PREEMPTIVE MULTIMODAL ANALGESIA FOR POSTOPERATIVE PAIN MANAGEMENT: A RANDOMIZED CONTROLLED TRIAL- CASE STUDY

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Background and Aims PREEMPTIVE analgesia is an antinociceptive treatment that prevents establishment of altered processing of afferent input, which amplifies postoperative pain. The concept of preemptive analgesia was formulated by Crile 1 at the beginning of the previous century on the basis of clinical observations.

Purpose: To assess the efficacy of a novel preemptive multimodal analgesic regimen for reducing postoperative pain and complications.

Methods To give Pregabalin (Lyrica) 75 mg 2 hrs or more before surgery then 75 mg QHS for 3days postoperative, to be reassessed by APS team if extension needed. No valium with lyrica. To add Celecoxib (if not contraindicated) 200–400 mg tablet 1 hour before surgery then 200 mg BID for 3 days only. Ranitidine 150 mg BID could be added. Surgical site-specific regional analgesia whenever possible. PCA morphine can be used if indicated and as a backup plan for breakthrough pain. Then post.op, Pregabalin, Celecoxib, Solpadeine 2 tablets Q6hrs or TID.

Results 30 patients came calm pre-op., smooth for GA, RA blocks, other 10 patients little anxious. All patients examined second day; 30 patients had smooth sleep, no pain after regional blocks, needed PCA morphine 1–5 mg (10 patients). Other 10 patients continued only on oral tablets.