(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.

Abstracts

Abstract 9 Table 2 VAS pain scores of the arm at rest and in abduction

VAS pain scores of the arm at rest and in abduction

VAS scores at rest	Group PECS (n=30)	Group ESP (n=30)	Group Control (n=30)	p*
1 h	3,3 ± 1,8 3 ^a (2-4)	4,3 ± 1,5 5 ^b (3-5)	5,9 ± 1,5 6 ^c (5-7)	<0,001
3 h	3,1 ± 1,2 3 ^a (2-4)	3,4 ± 1,2 4 ^a (2-4)	5,1 ± 1,4 5 ^b (4-6)	<0,001
6 h	2,3 ± 0,9 2 ^a (2-3)	2,8 ± 1,3 3 ^a (2-3)	3,9 ± 1,1 4 ^b (3-5)	<0,001
12 h	1,6 ± 0,8 2 ^a (1-2)	2,0 ± 1,0 2 ^a (1-3)	3,0 ± 1,1 3 ^b (2-4)	<0,001
24 h	1,1 ± 0,6 1 ^a (1-1)	1,2 ± 0,6 1 ^a (1-1)	1,9 ± 1,1 2 ^b (1-2)	0,002
3 month	0,1 ± 0,3 0 ^a (0-0)	0,0 ± 0,2 0 ^a (0-0)	0,4 ± 0,6 0 ^b (0-1)	0,008
VAS scores in abduction				
1 h	4,8 ± 1,6 5 ^a (4-5)	5,8 ± 1,7 6 ^a (5-7)	7,4 ± 1,4 8 ^b (7-8)	<0,001
3 h	4,7 ± 1,4 5 ^a (4-5)	4,9 ± 1,6 5 ^a (4-6)	6,5 ± 1,5 7 ^b (6-8)	<0,001
6 h	3,8 ± 1,4 4 ^a (2-5)	4,4 ± 1,7 5 ^a (3-6)	5,8 ± 1,3 6 ^b (5-7)	<0,001
12 h	3,1 ± 1,5 4 ^a (2-4)	3,5 ± 1,5 4 ^a (2-5)	4,6 ± 1,1 5 ^b (4-5)	<0,001
24 h	2,4 ± 1,1 3 ^a (1-3)	2,6 ± 1,3 2 ^a (1-4)	3,7 ± 1,6 4 ^b (2-5)	0,001
3 month	0,2 ± 0,4 0 ^a (0-0)	0,3 ± 0,5 0 ^a (0-1)	0,8 ± 0,6 1 ^b (0-1)	<0,001

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

analogue scale (VAS) pain scores of the arm at rest and in abduction at hours 1, 3, 6, 9, 12, and 24. In addition, the VAS pain scores in the third month following discharge were asked to evaluate the development of chronic pain.

Results Both VAS scores, intraoperative remifentanyl consumption, and postoperative 24-hour morphine consumption were lower in the ESP and PECS groups compared with the control group. The time to first request for analgesia via PCA was longer in the groups performed block compared with the control group. While the time to onset of block was found to be shorter in the PECS group, none of the patients needed rescue analgesia.

Conclusions The study demonstrated that the US-guided ESP and PECS block performed in patients who underwent breast cancer surgery provided effective analgesia for *acute and chronic pain*.

10 SPONTANEOUS REDUCTION OF ANALGESICS AFTER INTERVENTIONAL TECHNIQUE FOR LUMBAR CHRONIC PAIN, AS A MARKER OF IT'S EFFECTIVENESS

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10.1136/rapm-2021-ESRA.10

Background and Aims Interventional techniques for chronic lumbar Pain Release (ITPR) are widely performed but there's little evidence about how to assess its success. The aim of this study is to assess if quitting or reducing analgesics one month after an ITPR is useful as an objective measure of its success.

Methods 251 adult patients were included in this observational prospective study. Pain intensity (numeric rating score) and disability (Oswestry scale) were assessed via telephone before ITPR, and 1 month later. In addition, analgesics cessation or dose reduction was asked.

Abstract 10 Table 1

Table 1	Major Improvement	No Improvement
Cease medication	16 (48,48%)*	9 (4,23%)*
Same Medication	17 (51,52%)*	204 (95,77%)*
	Moderate Improvement	No improvement
Cease medication	20 (27,40%)*	5 (2,89%)*
Same Medication	53 (72,60%)*	168 (97,11%)*
	Major Improvement	No Improvement
Dose reduction	18 (54,55%)*	38 (17,76%)*
Same medication	14 (42,42%)*	176 (82,24%)*
	Moderate Improvement	No Improvement
Dose reduction	31 (42,47%)*	25 (14,45%)*
Same Medication	41 (56,16%)*	148 (85,55%)*

*Percentages are referred to total of each column

As success we considered major improvement when a 3 point in NRS and a 40% in Oswestry reduction was reported. Moderate improvement was considered to be a 2 point reduction and a 20% respectively. If either criteria were met, no improvement was assessed.

We calculated sensitivity, specificity, and predictive values of quitting or reducing medication, for each success criteria.

Results Number/percentage of patients meeting each criteria are shown in table no.1

Cease of medication showed a 95% and 97% specificity for major and moderate improvement. Sensibility was 48% and 27%. PPV was 64% and 80%. NPV was 92% and 76% respectively.

Dose reduction showed an 82% and 85% specificity for major and minor improvement, and 56% and 43% sensibility. PPV was 32% and 55%. NPV was 92 and 78%.

Conclusions 48,5% of those who had major improvement with an ITPR quitted spontaneously at least one analgesic of its daily medication. Also, it showed an 92,3% NPV and 64% PPV. Prevalence of major improvement was 13%.

Case report

11 ASYMPTOMATIC CEREBROSPINAL FLUID FISTULA FOLLOWING COMBINED SPINAL-EPIDURAL ANAESTHESIA IN A HEALTHY PARTURIENT

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10.1136/rapm-2021-ESRA.11

Background and Aims Cerebrospinal fluid (CSF) cutaneous fistula is a rare complication that can occur after a neuraxial anaesthesia technique. It can cause serious complications such as incapacitating headaches, cranial nerve symptoms, central nervous system infection and intracranial subdural hematoma.¹

Methods Description of a case report in the section below.

Results Case report: A healthy pregnant woman was subjected to a c-section after an uneventful combined spinal-epidural neuraxial block. On the second postoperative day, upon the removal of the epidural catheter, a fluid leakage was noticed emerging from the puncture site. The fluid was crystalline and had a measured glucose level of 83 mg/dL. The patient was completely asymptomatic. Following neurosurgery consultation,