

ABSTRACTS

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All authors have certified that, where appropriate, studies have been conducted with the approval of the relevant Human Ethics Committee or Animal Experimental Review Committee. Presenting Author is in BOLD. Edited by DG Lambert.

Perioperative analgesia for colorectal cancer patients

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Persistent postoperative pain is estimated to account for at least a quarter of consultations at UK pain clinics and is well-documented in survivors of cancer surgery¹. Opioids are often prescribed for the management of postoperative pain despite the development of tolerance, dependence and hyperalgesia as a result of chronic use². The chronic usage of opioids worldwide contributes to significant death and disability. Deaths due to chronic opioid usage in North America have been described as an epidemic and becoming a new chronic opioid user has been reported as being the most common complication following elective surgery³. Attention to pain management in the perioperative period through the use of multi-modal opioid-sparing techniques facilitates recovery and may reduce chronic use of opioids. We sought to examine current practice in intraoperative approaches to opioid usage for colorectal cancer patients at our Trust.

Utilising data collected for the Perioperative Quality Improvement Programme (PQIP) from September 2018–March 2020, we conducted a local retrospective observational study. It included all patients recruited who underwent complex-major operations for colorectal cancer.

Data from 120 patients were analysed. Intraoperatively, 74(61.7%) received an opioid-sparing adjunct. Neuraxial techniques and local anaesthetic infiltration were the most commonly used, in 64(53%) and 24(20%) patients respectively. Other adjuncts used in 1-to-3 cases each (0.8–2.5%) included regional techniques, IV paracetamol, gabapentinoids, ketamine, NSAIDs and lignocaine. 48(40.6%) of 118 patients were discharged from hospital on new opioid prescriptions. 36(48.6%) of those who received an opioid-sparing adjunct intraoperatively were discharged with an opioid prescription. 15(32.6%) patients who did not receive an opioid-sparing adjunct intraoperatively were discharged with an opioid prescription.

Over 40% of patients undergoing surgery for colorectal cancer were discharged with a new opioid prescription. In over a third of cases, opioid-sparing adjuncts were not administered intraoperatively. The provision of intraoperative opioid-sparing adjuncts does not appear to have reduced the incidence of opioid prescription at discharge. Further understanding of the attitudes to opioid-sparing techniques amongst anaesthetists and reasons for variation in practice would be beneficial locally as well as research to investigate the longer-term effects of intraoperative practice on chronic opioid usage.

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References

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Effects of 6-hydroxymelatonin in human macrophage model of inflammasome activation in conditions mimicking sepsis

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Sepsis is defined as life-threatening organ dysfunction caused by a dysregulated inflammatory host response to infection, characterised by cytokine release and oxidative stress. Caspase-1 activation and interleukin (IL-1 β) release are classical indicators of inflammasome activation. 6-hydroxymelatonin (6OHM) is the main metabolite of melatonin and has potent antioxidant and anti-inflammatory activity. However little is known about its mode of action. The aim of this study was to investigate the effects of 6OHM in a human macrophage model of inflammasome activation under conditions mimicking sepsis.