REGIONAL ANAESTHESIA CAN PLAY AN IMPORTANT ROLE IN MULTIMODAL ANALGESIA FOR MASTECTOMY AND BREAST RECONSTRUCTIVE SURGERY

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Reconstructive surgery is discussed with the majority of women in the UK undergoing mastectomy either as an immediate or a delayed procedure. Acute postsurgical pain is commonly associated with both mastectomies and reconstructions¹. Risk of chronic pain is increased with inadequate pain management in the immediate post-operative period². Post-mastectomy pain syndrome is associated with severe pain after mastectomy and adds to an already psychologically devastating experience and negatively impacts the woman's quality of life³. The American Society of Anesthesiologists Task Force recommends use of multimodal analgesic strategies including regional blockade⁴.

A 62-year old female presented for mastectomy and immediate reconstruction with a deep inferior epigastric perforator (DIEP) free flap. She had bilateral erector spinae plane (ESP) nerve block catheters sited and right-sided Serratus Anterior block (SAP) prior to TIVA general anaesthesia.

Intraoperatively she received standard protocol analgesia. In the post-operative recovery area she was comfortable requiring no further analgesia. Post-operative analgesia included paracetamol, naproxen & pregabalin. The ESP catheters were bolused at midnight on the day of surgery, 6am and noon the next day with 20ml 0.125% bupivacaine with 1:400,000 adrenaline. Both catheters were removed following final bolus. No rescue analgesia was required until day 2 postoperatively.

ESP nerve block catheters, SAP nerve block, together with multimodal analgesia is a useful post-operative analgesic strategy for mastectomy and DIEP reconstruction. This patient had a 50% reduction in opiate requirement and we plan to undertake a larger case series using this strategy to refine our center's analgesic protocols for this patient group.

References:

1. Amaya F, Hosokawa T, Okamoto A, et al. Can acute pain treatment reduce postsurgical comorbidity after breast cancer surgery? A literature review. *Biomed Res Int*. 2015;2015:641508.
2. Andersen KG, Duriand HM, Jensen HE, et al. Predictive factors for the development of persistent pain after breast cancer surgery. *Pain*. 2015;156:2413–2422.
3. Butz DR, Shenaq DS, Rundell VLM, et al. Postoperative pain and length of stay lowered by use of Exparel in immediate, implant-based breast reconstruction. *Plast Reconstr Surg Glob Open*. 2015;3:e391.
4. American Society of Anesthesiologists Task Force on Acute Pain Management. Practice guidelines for acute pain management in the perioperative setting: an updated report by the American Society of Anesthesiologists Task Force on Acute Pain Management. *Anesthesiology*. 2012;116:248–273.