Volume 36 | e-Supplement 57 | June 2019
www.ejanaesthesiology.com

European Society of Anaesthesiology ESA

EJA

European Journal of Anaesthesiology

Euroanaesthesia 2019
The European Anaesthesiology Congress

Abstracts Programme
Vienna, Austria, 1 - 3 June

Wolters Kluwer

European Journal of Anaesthesiology
Volume 36 | e-Supplement 57 | June 2019

Abstracts

EUROANAESTHESIA 2019

The European Anaesthesiology Congress

1 - 3 June 2019
Vienna, Austria

Wolters Kluwer

13AP07-7
Patient's perception of anaesthesia and the role of anaesthesiologist: a Brazilian survey

Quintao V.[1], Campos L.[2], Dias K.[2], Oliveira M.[3]
[1]*Hospital das Clinicas HCFMUSP, Faculdade de Medicina, Universidade de Sao Paulo - Sao Paulo (Brazil),* [2]*Faculdade de Ciencias Medicas de Minas Gerais - Belo Horizonte (Brazil),* [3]*Santa Casa de Belo Horizonte - Belo Horizonte (Brazil)*

Background and Goal of study: Anaesthesia is still a major concern for patients, although, since 2006, Brazilian's medical regulation board recommends a preanaesthetic assessment before surgery, preferably as an outpatient basis, which could decrease such concerns and increase knowledge about the role of an anaesthesiologist. The aim is to evaluate the patient's knowledge, concerns, and fears related to the anaesthesiologist and anaesthesia.
Material and Methods: Prospective and cross-sectional study with a 50 items survey applied to patients in a preanaesthetic clinic of a major hospital in Belo Horizonte, Brazil.
Results: We included 441 patients. Of those interviewed, 81.7% had undergone surgery before under anaesthesia, with the majority under general anaesthesia (47.7%). The majority (63.4%) did not know which anaesthetic technique was planned for the surgery evaluated on the ongoing preanaesthetic assessment. When asked which anaesthetic technique the patient would choose, 37.5% opted for general anaesthesia and 34.5% did not know, with most of those patients (86.1%) accepting the anaesthesiologist's recommendation, even otherwise different. Regarding the patient's knowledge of an anaesthesiologist's attributions, most answered that he/she is responsible for making the patient sleep deeply (83.6%) and for monitoring the vital signs during surgery (37.4%). On the other hand, most answered that the nurse is responsible for waking up the patient (33.5%) and the surgeon (46.8%) is responsible for determining the fasting time. The majority (56%) considered anaesthesia a safe procedure, and 78.7% considered false that anaesthesia often results in brain damage. Regarding anaesthesia-related fears, such as being unconscious during surgery, speaking personal secrets, waking up during surgery, decreasing mental capacity after surgery, postoperative nausea, and exposal (being naked) during surgery, the majority replied they were not concerned. On the other hand, most answered they were very worried about the anaesthesiologist's experience and qualification to take care of them during surgery and in an emergency situation, as well as staying in the ICU for a long time, being paralyzed after anaesthesia, and not waking up after surgery.
Conclusion: Patients should be informed about anaesthesia safety and anaesthesiologist's attributions. Also, the patient should be involved early in the preanaesthetic assessment to demystify those unnecessary fears and concerns.

.....

13AP07-8
Validation of the Richards-Campbell Sleep Questionnaire in postoperative patients.

Boduliev O.[1], Sorokina O.[2]
[1]*Ukrainian Medical Stomatological Academy - Poltava (Ukraine),* [2]*Dnipropetrovsk Medical Academy of Health Ministry of Ukraine - Dnipro (Ukraine)*

Background and Goal of Study: Along with pain, sleep disturbances cause the greatest discomfort in patients during the first few days after surgery. The incidence of insomnia in postoperative patients may reach 50%. Because of high costs and complexity of implementation the polysomnography remains inaccessible for a routine sleep assessment. Instead, scoring scales are cheap, and can be easily included into routine nursing care. The English version of RCSQ is characterized by high sensitivity, specificity, reliability and correlation with polysomnography in intensive care patients. The aim of the present study was a validation of the RCSQ in population of postoperative patients.
Materials and Methods: Translation of the English version of RCSQ into Ukrainian was done by two independent translators, followed by a series of back translations to ensure accuracy. The study included 31 patients after general surgery. The age was 26-68 (50,7 ±5,4) years. The Ukrainian version of RCSQ was applied to all patients. The mean of the 5 RCSQ items comprised a total score. A 10-h polysomnography during night was also performed.
Cronbach's alpha was used for reliability analysis. Sensitivity and specificity of the translated version of RCSQ were calculated. Pearson's coefficient was used to assess correlation between RCSQ and total sleep duration, sleep onset latency, REM duration by polysomnography.
Results and Discussion: Insomnia was present in 11 subjects (36,4% male and 63,6% female) . The rest 20 subjects (45,0% male and 55,0% female) did not have insomnia . Ukrainian version of RCSQ showed high reliability (Cronbach's alpha 0,91). The sensitivity for diagnosis of postoperative insomnia was 87,14% and specificity 84,32%. The RCSQ correlation coefficient with total sleep duration for polysomnography was 0,68; with sleep onset latency – 0,82; with a REM duration – 0,73.
Conclusions: The obtained results indicate the validity of the RCSQ in sleep quality assessment and insomnia diagnosis in postoperative patients.

13AP07-9
The Brief Measure of Emotional Preoperative stress (B-MEPS) as a new predictive tool for Postoperative Pain: A Prospective Observational Cohort Study

Schifino Wolmeister A.[1], Lourenzon Schiavo C.[1], Cadore Stefani L.[1], Caumo W.[1], Kuntz Nazario K.[1], Stahlschmidt A.[1]
[1]*HCPA - Porto Alegre (Brazil)*

Background and Goal of Study: Surgery can be considered a powerful external stressor causing the organism a cascade of physiological and psychological reactions as a protective, coordinated, and adaptive response to sensory inputs from the environment and internal inputs from the body. Recently, we've used the item response theory to developed an instrument to assess the preoperative individual psychological vulnerability based on emotional stress, the Brief Measure of Emotional Preoperative Stress (B-MEPS). We hypothesized that high preoperative stress, evaluated by B-MEPs result, is associated with higher postoperative pain levels and poor rehabilitation in patients submitted to intermediate or major surgery.
Materials and Methods: prospective, observational, cohort study of adult patients undergoing major surgery from March 2017 to March 2018. Preoperative assessment before the surgery included: demographic questionnaire; the BMEPs and Central Sensitivity Inventory; experimental pain tests and serum biomarkers collection. Postoperative evaluation until 48h of rest and movement-evoked pain, consumption of morphine and Quality-of-Recovery's scale.
Results and Discussion: 150 patients were included in the cohort. Using the latent class model, we found 23 (15%) patients had high emotional preoperative stress. Variables significantly related to preoperative stress were: previous psychiatric diagnosis and Central Sensitization Inventory result. Mean evoked-movement pain in the first 12 to 48h was 95-105% higher than at rest pain. A mixed model for repeated measures showed a sustainable effect of B-MEPS as movement pain predictor, independently of demographic data, comorbid conditions, preoperative pain test, type of anesthesia, and surgical duration. Previous chronic pain, cancer surgery, and pre-operative pressure pain tolerance were also independent predictors of postoperative movement pain. Moderate to severe postoperative evoked-movement pain was the only significant predictor of poor rehabilitation in 48 hours after surgery.
Conclusions: Results confirm that a brief screening method of the preoperative emotional state could detect individuals prone to experience severe postoperative pain. To translate this finding into possible beneficial changes in the perioperative assistance, the next step is to plan specific interventions considering the level of emotional preoperative stress assessed by the B-MEPS tool.

.....

13AP07-10
Rates and causes of last-minute surgery cancellations: A Lebanese University Hospital experience.

Richa F.[1], El Hage C.[1], Chalhoub V.[1], Dagher C.[1], Yazbeck P.[1]
[1]*Hotel-Dieu de France Hospital, Saint-Joseph University of Beirut - Beirut (Lebanon)*

Background and Goal of Study: Surgery cancellation reduces operating room efficiency and increases costs. Last-minute surgery cancellation (LMSC) is the commonly used measure in the operating room (OR) of major hospitals to assess performance [1]. The aim of this observational, retrospective study is to identify the rate and reasons of LMSC of elective surgery in our hospital.
Materials and Methods: Operating room records of elective surgery were retrospectively reviewed over 2 months. Data collected from OR listings were: Surgeries scheduled, performed and cancelled, timing and causes of cancellation (avoidable and non-avoidable). The "LMSC" is defined as the procedures cancelled over 24 hours before surgery.
Results and Discussion: In the study period, 1711 patients > 18 years-old were scheduled for elective surgery which 163 (9.5 %) were cancelled. The majority of LMSC were potentially avoidable (75.47%) by timely identification of medical problems: 42.95% were identified preoperatively (incomplete complementary exams 6.75%, change in surgery indication 1.23%, patient refusal 4.91%, non-compliance to stop chronic medications 6.75%, lack of hospital bed reservation 6.75%, lack of third-party payment approval 14.11%, by the specialist consultant doctor 2.45%); intraoperatively (lack of OR time 10.43%, lack of bed at hospital 3.68%, by the surgeon 6.13%, replacement by an urgent case 1.84%, lack of surgery material 7.98%, absence of fasting 1.23%); postoperatively (lack of bed in the intensive care 1.23%). The non-avoidable causes of LMSC (24.53%) were: worsening a chronic illness 2.45%, acute changes in baseline medical disease 9.2%, the patient did not attend 11.04%, death of the patient 0.61% and unknown cause 1.23%.
Conclusions: Determining the major avoidable contributors to LMSC is an essential step to decrease it. The number of LMSC can be decreased by improving communication between patient, doctors and nurses. More studies should be carried out at regular intervals to find the causes of LMSC in order to improve the functioning of the OR.
References:
1. Morris AJ, et al. Anesth Analg 2017;125:268-271.