

WAGO 2025 ANNUAL MEETING

ORAL ABSTRACT



Finding the balance between effective and durable pain control in the perioperative setting.

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Objectives

To evaluate the efficacy of various locoregional pain control techniques in the perioperative setting for open abdominal surgery in gynecologic oncology patients.

Methods

After IRB approval, a retrospective chart review of all gynecologic oncology patients who underwent total abdominal hysterectomy and bilateral salpingectomy at UCLA in the last 6 years (2018-2024) was conducted. EMR data was collected including preoperative, intraoperative, and postoperative milligram morphine equivalent usage (MME), patient-reported postoperative pain scores, time to foley removal, time to ambulation, time to flatus, hospital length-of-stay, and postoperative complications. Comparisons were made between patients who received no long-acting analgesic (control) thoracic epidural placement, transversus abdominis plane (TAP) blockade, and quadratus lumborum (QL) blockade. Statistical analysis was performed using two-tailed t-tests.

Results

Total n of 113 was analyzed with notable differences observed in narcotic use and total MME. Intraoperatively, the epidural and TAP cohorts required significantly less MME compared to control (20 vs 13, $P = 0.02$ and 20 vs 15, $P = 0.043$, respectively). This was also true for total MME use on POD0 for epidural vs control (20 vs 9, $P = 0.0008$). However, this observation was no longer true by POD1. Although an initial reduction in MME use was observed in the epidural and TAP groups, those patients used narcotics for a longer duration with ~45% requiring narcotics past POD3, compared to 20% and 11% for control and QL block cohorts, respectively. The epidural group was also significantly delayed in time to ambulation and foley removal compared to control (4.7 vs 2.1 days to foley out, $P = 0.0004$; 2.4 vs 1.5 days to ambulation, $P = 0.001$). Median hospital length-of-stay was 2.9, 3.7, 4.7, 5.3 days for QL block, control, TAP, and epidural respectively. Patients who received a QL block had a significantly shorter hospital stay compared to epidural ($P = 0.02$).

Conclusions

Trends in the data suggest perioperative epidural placement may prolong hospital stay, increase narcotic use, and delay post-operative milestones without patient-reported pain control benefit. The QL block may be a promising modality for perioperative pain control in open gynecologic oncology procedures.