

Tramadol 150 mg/24h. If pain did not decrease, we administered tramadol 50 mg iv. Pain intensity using a visual analogue scale was recorded at 1, 2, 8 and 24h after the end of surgery. Side effects were recorded (nausea, vomiting, drowsiness).

**Results:** Pain scores were not significantly different between groups ( $21 \pm 2.7$ ,  $19 \pm 2.8$ , respectively;  $p > 0.01$ ). Side effects incidence was significantly higher in group T (nausea and/or vomiting 7/28 vs 2/26, somnolence 8/28 vs 3/26).

**Conclusion:** In the immediate postoperative period after quadrantectomy for breast cancer, carried out using fentanyl during anaesthesia, the association of paracetamol and Tramadol does not improve analgesia compared with Tramadol alone, but side effects are significantly reduced when the association of paracetamol and tramadol.

645

#### PREOPERATIVE ORAL ADMINISTRATION OF DEXTROMETHORPHAN AND/OR ETORICOXIB FOR PAIN MANAGEMENT AFTER LAPAROSCOPIC SURGERY

P. Sriprajittichai\*, O. Kyokong, S. Charuluxananan. *Department of Anesthesiology, Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand*

**Objective:** To compare analgesia after laparoscopic surgery (LS) between preoperative oral dextromethorphan (DM), etoricoxib, and their combination.

**Method:** 66 patients, 18–65 years with physical status I-II undergoing elective LS under general anesthesia (GA), were randomly allocated. Group D received DM 60 mg, group E received etoricoxib 120 mg and group DE received the combination of DM 60 mg and etoricoxib 120 mg. Everyone were given the same GA protocol and received morphine patient-controlled analgesia (PCA) for 24 hours. Morphine used during 24 hours and numerical pain rating scale (NRS) at rest and on coughing at 0, 2, 6, and 24 hours after surgery were analyzed. Adverse events were also analyzed.

**Results:** Mean total morphine used during 24 hours after surgery (14.6, 13.3, and 10.9 mg in D, E, and DE group respectively), mean total morphine used per body weight during 24 hours (0.26, 0.21, and 0.18 mg/kg in D, E, and DE group respectively), NRS at rest and on coughing in three groups were not statistically different. There was no statistically significant difference in side effects among the groups except dizziness (40%, 9.1% and 30% in D, E, and DE group respectively) ( $p = 0.032$ ).

**Conclusion:** Oral DM 60 mg, etoricoxib 120 mg, and their combination before LS did not alter the 24-hour postoperative morphine consumption significantly. NRS at rest, on coughing and other adverse events were not statistically different except dizziness which was less in etoricoxib group.

The financial support was provided by Ratchadapiseksompotch Fund.

646

#### POSTOPERATIVE PAIN MANAGEMENT AND SLEEP DISORDER IN POSTPARTUM AND GYNECOLOGY WARDS IN MAIN REFERRAL HOSPITAL, IRAN UNIVERSITY OF MEDICAL SCIENCES

S. Taavoni\*, H. Haghani, M. Fekrat. *Iran University of Medical Sciences, Pain Research Group of ACECR, Tehran, Iran*

Post operative pain management can be achieved by continuous assessment and education of all related staffs. This study was done with the aims of identifying correlation between sleep disorder and average of pain, pain during night, use of drug, and type of surgery.

**Methods:** In this correlation study by consequence sampling, 177 volunteer patients hospitalized in postpartum ward with small operation (SO) and gynecology wards with large operation (LO) of one of the main public teaching referral hospitals of Iran University of Medical Sciences in Tehran, were interviewed (Year 2005). Descriptive and inferential statistics (t-test & Tukey) were used.

**Results:** 24.29% had an average pain score of 9–10. The highest group had a rate of awakenings during the night more of than 4 times higher (52.54%), had sleep disorder during hospitalization (56.49%), sleep disorder because of pain and other factors (50.28%), and sleep disorder just because of pain (25.42%). There were significant differences between the two groups in the field of: Average of pain during hospitalization ( $P = 0.000$ ), night pain ( $P = 0.000$ ), and patients' satisfaction of pain management ( $p = 0.024$ ). Also there were correlation between reasons of awakenings with: Average of pain during hospitalization ( $P = 0.000$ ), night pain ( $P = 0.001$ ), and awakenings rate ( $P = 0.001$ ) (t-test).

**Conclusions:** In this study we found misconceptions of opioid and sedative order as PRN. It is necessary to plan a pain relief continue education program, assessment and evaluation.

647

#### TRANSDERMAL BUPRENORPHINE FOR POSTOPERATIVE PAIN MANAGEMENT IN A PATIENT ON METHADONE MAINTENANCE THERAPY – CASE REPORT

A. Valentim\*, Fã. Vaz, B. Carvalho, J. Nunes. *Hospitais da Universidade de Coimbra, Coimbra, Portugal*

**Background:** Acute postoperative pain management in opioid tolerant patients is difficult. Methadone is the most widely delivered maintenance therapy for heroin patients. Its use is not allowed for analgesia purposes in Portugal. We report a postoperative analgesia with intravenous and transdermal buprenorphin (BPN) in a patient on methadone (MTD) maintenance therapy (MMT).

**Case report:** A 38-year-old man was admitted to the emergency department with acute abdomen. He was enrolled in a MMT. He was a HIV/AIDS patient taking anti-retroviral drugs. Exploratory laparotomy was performed under general anaesthesia. We started 35 µg/h transdermal BPN after the beginning of surgery and before the end of surgery we administered 0.3 mg intravenous BPN. Postoperative analgesia was performed with 1 g of intravenous Paracetamol TID and 0.15 mg of intravenous BPN as needed. We recorded VAS, sedation scores and vital signs. In the postoperative period, the patient was pain free. No side effects. On the 4<sup>th</sup> postoperative day the transdermal patch was removed and MTD reintroduced. The patient was discharged on the 5<sup>th</sup>.

**Discussion and Conclusions:** Management of postoperative pain in a patient on MMT is difficult. The most common approach is to maintain the daily dose of MTD and give short acting opioid and non-opioid analgesics. Since MTD was not available, we decided to use BPN for postoperative pain. BPN is used not only to treat chronic pain but also acute pain. The combination of transdermal BPN background analgesia with intravenous BPN allowed the relief of pain.

648

#### PAIN COMMUNICATION: HOW ACCURATE ARE OBSERVERS IN EVALUATING PAIN IN OTHERS?

K. Helsen<sup>1\*</sup>, S. De Meersman<sup>1</sup>, S. De Peuter<sup>1</sup>, J. Vlaeyen<sup>1,2</sup>.  
<sup>1</sup>University of Leuven, Leuven, Belgium; <sup>2</sup>Maastricht University, Maastricht, Netherlands

**Background and Aims:** Communication of pain occurs as a function of characteristics of the sender, the perceiver, and the situation (Hadjistavropoulos and Craig, 2002). In our study, we wanted to investigate how accurate observers are in evaluating pain in others. Moreover, we examined the putative influence of pain catastrophizing, fear of pain and empathy on the accuracy of pain estimations in others. In addition, feasible gender differences in accuracy were studied.

**Method:** A sample of undergraduate psychology students and healthy volunteers completed Dutch versions of the Pain Catastrophizing Scale, Fear of Pain Questionnaire and the Interpersonal Reactivity Index. Afterwards, they were asked to