

Role of Intrathecal Opioids for Retroperitoneal Sarcoma Resection

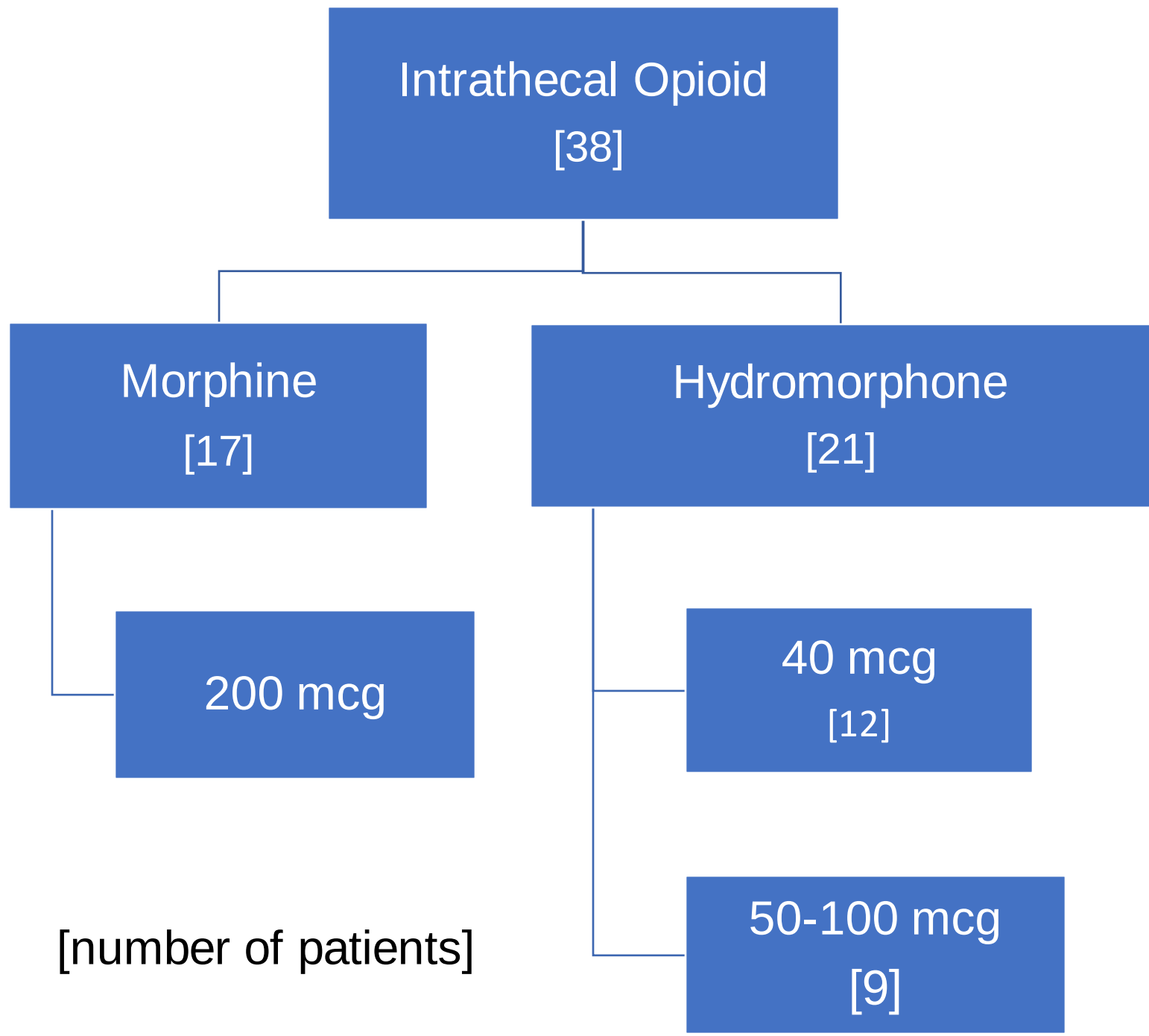
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INTRODUCTION

- Enhanced Recovery After Surgery (ERAS) pathways highlight the importance of postoperative analgesia including multimodal analgesia and the minimization of systemic opioid use.
- We aimed to describe the efficacy of intrathecal (IT) morphine in comparison to IT hydromorphone in patients undergoing retroperitoneal sarcoma resection requiring multi-visceral resection.
- Hypothesis: Patients who receive preoperative IT morphine will have improved postsurgical pain control compared to those who receive preoperative IT hydromorphone.

METHODS

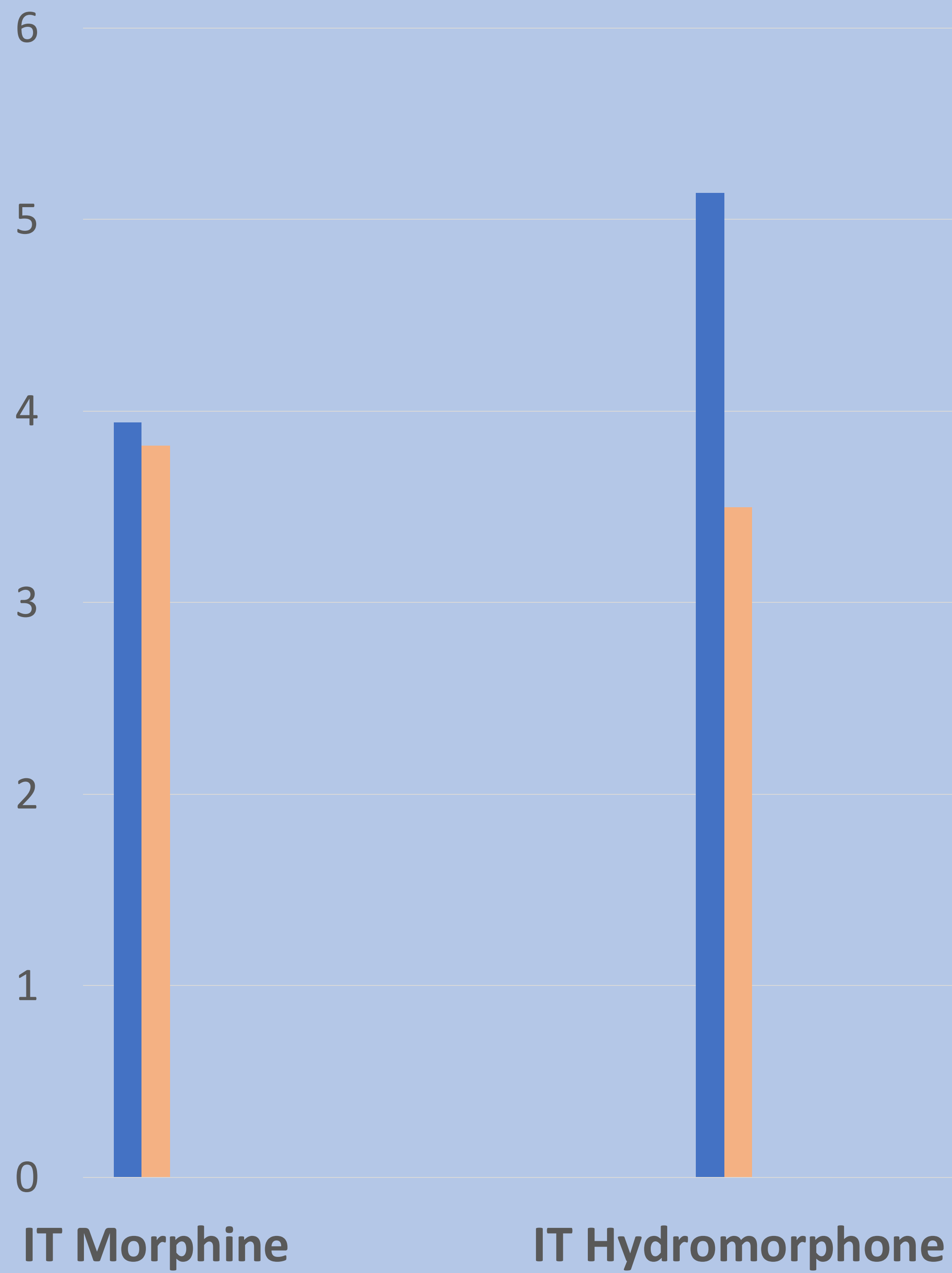
- Inclusion criteria: patients 18-80 years old undergoing retroperitoneal sarcoma resection requiring multi-visceral resection who received preoperative IT opioids between October 2021 through November 2023.
- Exclusion criteria: patients with contraindications to spinal anesthesia and opioids, chronic pain syndromes, and chronic opioid use.
- Primary endpoints: pain scores (0-10) at 24 hours and 48 hours post IT injection.
- Secondary endpoints: morphine milligram equivalents (MME) 24 and 48 hours post IT injection, length of hospitalization (days), and adverse events.



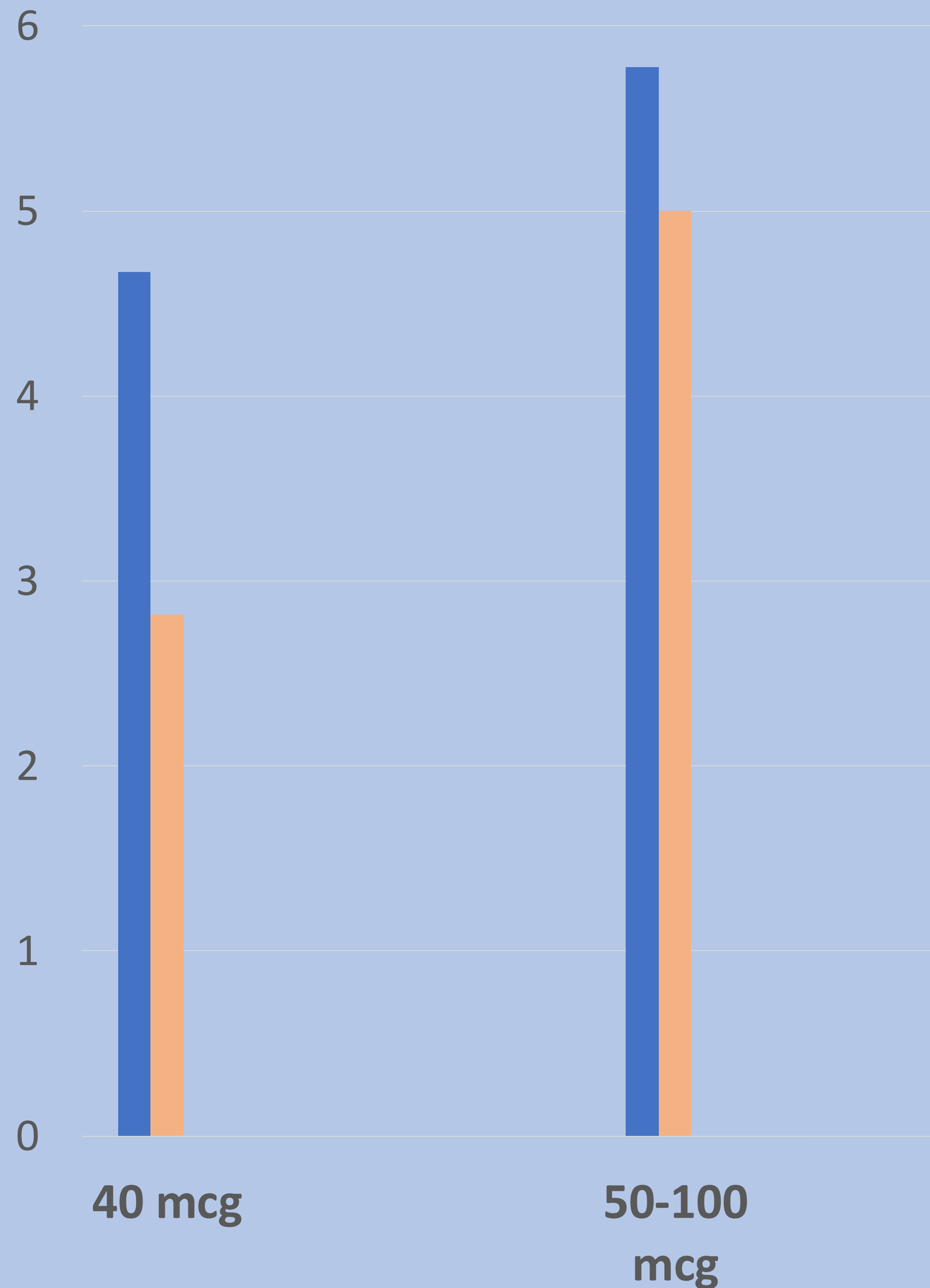
RESULTS

Average Pain Scores

IT Morphine vs IT Hydromorphone



IT Hydromorphone



24 hours post injection
48 hours post injection

IT Opioid	MME 0-24 Hours	MME 24-48 Hours
Morphine 200 mcg	106.9	43.1
Hydromorphone 40 mcg	110.8	28.9
Hydromorphone 50 – 100 mcg	134.3	50.7



IT Opioid	Length of Stay (days)
Morphine	6.31 ***
Hydromorphone	5.47 ***
*** = significant finding P=0.0375	

IT Hydromorphone	Length of Stay (days)
40 mcg	4.05
50-100 mcg	7.36

DISCUSSION

- This retrospective study demonstrates that intrathecal opioids are a safe and effective option for patients undergoing retroperitoneal sarcoma resection requiring multi-visceral resection.
- Limitations of this study include overall small sample size. In addition, selection of IT medication and dose were determined by the anesthesiologist for their respective patients. This may lead to potential bias in the anesthesiologist in the opioid and dose they thought worked best for postoperative pain control.

CONTRIBUTORS

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