ICU admission may reduce PoCs incidence. To optimize allocation of limited resources, clinical scores to detect patients at high risk of PoCs are needed. Aim of the study was to implement and validate a new score to assess the risk for PoCs (the “Anesthesiologically and Surgical Perioperative Risk Assessment”, ASPRA score), in order to provide a reliable tool to discriminate patients who might benefit from postoperative ICU admission.

Materials and Methods: Risk factors for PoCs were identified on a systematic search on PubMed database. Key words were “postoperative complications” and “risk factors”; related MeSH terms were included. Considered papers were those in English, published from 1/1/2000 to date. A score between 0 and 3 has been given to each risk factor, depending on strength and independence of association to PoCs. To validate the score, a retrospective survey was done on all patients electively admitted to a general ICU for postoperative monitoring from 1/1/10 to 31/08/10. PoCs were registered and patients were divided in two groups, complicated and uncomplicated. ASPRA score was obtained for each patient summing the single scores of all risk factors for PoCs. To test the score, a ROC curve was done and the area under the curve (AUC) calculated. Based on the ROC analysis, sensitivity and specificity rates were calculated for each ASPRA score, as the capability to test PoCs.

Results: On 176 patients included in the validation process, 122 had postoperative complications. Mean ASPRA score in the complicated and control groups were 7.5 and 5 respectively (p< .001). The AUC from ROC analysis was 0.77 (p< .01,see Fig.1). ASPRA score of 6 showed a sensitivity and specificity of 77.9% and 70.4% respectively in predicting PoCs.

Conclusion(s): At the preliminary validation, the new ASPRA score resulted moderately accurate in discriminating between postoperatively complicated and uncomplicated patients. Score’s cutoff of 6 showed the best sensitivity/specificity in predicting postoperative complications. Further prospective investigations is required to validate the score on a larger patients population.

1AP2-9
Implementation of nausea and vomiting protocol in the ultrafast-track cardiac anaesthesia
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Background: Postoperative nausea and vomiting (PONV) is an important cause of postoperative morbidity and can delay patient recovery. The aim of this study was to evaluate the efficacy of PONV prophylaxis according to risk factors in ultrafast-track cardiac anesthesia and its influence in fast-track recovery.

Methods: A threephases cohort study was designed (n=90 in each phase). A protocol of PONV prophylaxis according to Apfel risk score modified for cardiac anesthesia was designed (inhaled inhalation, female under 65, non-active smoker, PoCs antecedents). During 1st phase the prophylaxis given was: 1 point no treatment; 2 points dexamethasone (DMX) 4mg in induction; 3 points DMX 4mg + haloperidol (HAL) 1mg in induction; 4 points DMX 4mg + HAL 1mg in induction + ondansetron 4mg at the end of the surgery. During the 2nd and 3rd phase prophylaxis was increased by one point. The anesthetic protocol was: induction with sevoflurane 2%, fentanyl (2-4mcg/Kg) and rocuronium (0.6mg/Kg). Maintenance with sevoflurane and remifentanil (0.15-0.3mcg/Kg/min). At the end of extracorporeal circulation, morphine (0.1mg/Kg), dexketoprofen and metamizol were given. Local anesthetic perfusion was used as postoperative analgesia. All patients were extubated in the operating room. Incidence of PONV before (BOF) and after (AOF) oral feeding and the hours between extubation and oral feeding were evaluated. Data are presented as mean ±SD and percentages (x² test for qualitative and t student for quantitative data, p< 0.05).

Results: A total of 197 patients were enrolled (21 in 1st phase, 89 in 2nd phase and 87 in 3rd phase). The 1st phase was abandoned because of the high incidence of PONV. All groups were comparable regarding demographic, comorbidities, type of surgery, operation time and total amount of opioid doses. Table shows incidence of PONV. There was a statistically significant difference between 1st phase and 2nd and 3rd, but there were no significant differences between 2nd and 3rd phase.

<table>
<thead>
<tr>
<th>Specialty (number of operating theatres)</th>
<th>Mean theatre start time (standard deviation, number of sessions)</th>
<th>Difference in mean theatre start times (2010 - 2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plastics</strong> (5)</td>
<td>08:00:00 (00:25:46,61)</td>
<td>-00:06:53</td>
</tr>
<tr>
<td><strong>ENT/Ophthalmic</strong> (3)</td>
<td>08:40:46 (00:13:33,92)</td>
<td>00:00:27</td>
</tr>
<tr>
<td><strong>Major General Surgery (3)</strong></td>
<td>08:26:52 (00:23:54,59)</td>
<td>-00:06:38</td>
</tr>
<tr>
<td><strong>Gynaecology</strong> (3)</td>
<td>08:30:16 (00:17:38,59)</td>
<td>-00:01:37</td>
</tr>
<tr>
<td><strong>Others (5)</strong></td>
<td>08:21:36 (00:20:08,20)</td>
<td>00:07:21</td>
</tr>
</tbody>
</table>

Conclusion: The results suggest that the lists started earlier in plastics, major general surgery and gynaecology (range 1.5 minutes to 7 minutes approx.) and late in ENT, ophthalmics and other theatres (range 30 seconds to 7 minutes approx.). Null hypothesis was accepted as the differences were not found to be significant in any group (p value > 0.05).

This study is the first study which clearly demonstrates that safe surgical check lists do not have any significant impact on theatre start time i.e. theatre efficiency and productivity.


1AP3-2
Burnout syndrome in Spanish anesthesiologists
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Background and Goal of Study: Burnout (BO) syndrome was described by Maslach in 1981 as an individual’s abnormal response to chronic emotional stress characterized by three components: emotional tiredness/exhaustion (E), depersonalisation (D) and low personal realization (PR); it have had little research in anesthetic population.

The largest publication about BO in anesthesia (1) shows high levels of E, D and low levels of PR in 20, 20 and 36% of respondents respectively.