Letter to editor in a reply to a previous letter to editor concerning our previous study entitled:

The Feasibility and Efficacy of erector spinae plane block versus Transversus Abdominis Plane Block

In Laparoscopic Bariatric Surgery: A Randomized Comparative Trial

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Running title: ESP versus TAP Blocks In Laparoscopic Bariatric Surgery

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This article hasn’t been presented in previous conferences.

The Authors declare that there is no conflict of interest.

This study was funded by Department of anesthesia, surgical ICU, and pain management, faculty of medicine, Cairo University, Cairo, Egypt.

IRB number: MD-250-2020

Clinical trials registration number: NCT04417179
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the feasibility and efficacy of erector spinae plane block versus transversus abdominis plane block in laparoscopic bariatric surgery: a randomized comparative trial

- Letter to the Editor -

We would like to thank you for giving us the opportunity to clarify some aspects of our study by responding to the issues raised by you. We would also like to thank you for your interest in our study and for taking the time to express your concerns.

In the letter to the editor, the first concern was that it wasn’t clear the status of the patients when pain was assessed by the visual analogue scale (VAS). We agree that the status of the patients would affect the pain intensity. We also agree that pain intensity is expected to be higher in movement than at rest. However, in our study we assessed pain at rest. Concerning the point you raised about confusion about whether VAS was assessed at rest or during movement, we believe that pain is assessed by VAS routinely at rest unless mentioned otherwise, like during movement, or at cough, as used in many previous studies without further clarification of the patient status during pain assessment [1,2].

Concerning the second point, we agree with you as we clarified in our study that both erector spinae plane 7 block (ESPB) and transversus abdominis plane block (TAPB) are an effective modality of postoperative pain management. We discovered that ESPB provided a better analgesic effect, which agrees with a previous study that found that patients who received ESPB had a VAS less than 3 in the first 24 hours postoperative [3], with less time to perform a successful block, which was the goal of our study to compare the effectiveness and feasibility of both blocks.
Third, none of our patients required a second rescue analgesic. We agree that the difference in nalbuphine consumption between both groups was only equivalent to 2.94 mg of intravenous morphine. However, combined with other outcomes such as statistically significant lower VAS, longer duration of first rescue analgesic dose, and time required to perform a successful block, makes ESPB a more effective and feasible block than TABP.

Finally, we selected time for flatus or stool as a secondary outcome, as we believe that nausea and vomiting can be affected by other associated factors, especially in gastrointestinal surgeries, rather than only the effectiveness of the block and the opioid sparing effect, as the surgery time, time of abdominal insufflation, predisposing patient’s factors, and even the technique of sleeve gastrectomy can have a statistically significant difference in the incidence of nausea and vomiting [4]. Moreover, knowing that patients’ satisfaction and the quality of recovery are greatly affected by the occurrence of early postoperative nausea and vomiting [5] compels us to not choose them as secondary outcomes in our primary research hypothesis. Furthermore, we believe that our study has achieved our primary research objective in comparing the effectiveness and feasibility of both blocks in that challenging population.
References


