



**Figure 1** Simplified schema of the proposed classification: (1) erector spinae muscle, (2) transverse process, (3) neck of rib, (4) intertransverse ligament, (5) superior costotransverse ligament, (6) retroparavertebral space and (7) paravertebral space.

We are currently witnessing an implosion in reporting new interfascial blocks, which certainly add new perspectives to regional anesthesia, but at what cost?

The erector spinae plane block (ESPB) represents an example of the difficulty of adopting an appropriate nomenclature. Dr Murouchi<sup>2</sup> was the first to draw attention to this difficulty as ESPB may be identical to retrolaminar block and that a different name for the same maneuver could be quite ambiguous and misleading. Both techniques share the same target, which is the deep plane of the erector spinae muscle (ESM), but they differ concerning the location of needle tip contact.<sup>3</sup>

Since then, new approaches have been described<sup>4-6</sup> yielding new nomenclatures and leading us to question what truly defines an ESPB.

We are fully aware that the current nomenclature should not be discarded in favor of alternate terms unless some clear advantage is gained; thus, we aim to propose a simple approach to organizing the actual knowledge concerning the ESPB and related alternative blocks.

Instead of focusing on the exact location of the needle tip contact when naming the block, we propose switching focus onto the region where the local anesthetic (LA) is deposited. Thus, our block will be part of one block category (figure 1):

The ESPB: involves all the blocks where LA is delivered in any part between the deep surface of the ESM and the plane constituted from the transverse process (TP) and its intertransverse ligament but without crossing the latter. Consequently, the classical description of ESPB as a regional anesthesia technique in which LA is injected between the the ESM and the TP should be revisited.

The retroparavertebral block: LA is deposited in a region (which has not been named anatomically) between the intertransverse ligament and the paravertebral space. This block will therefore include the described midpoint TP to the pleura,

## Erector spinae plane block dilemma

To the editor,

We read with interest the recent letter written by Tulgar *et al*,<sup>1</sup> ‘Should Erector Spinae Plane Block Applications Be Standardized or Should We Revise Nomenclature?’, which raised several important points. We would like to congratulate the authors for the opportunity they offer for an open and thorough discussion within the anesthetology community to hopefully create a consensus around the definition and the defining parameters of an interesting matter.

the sub-TP interligamentary plane block and the multiple-injection costotransverse block.

The paravertebral block: lying in between the superior costotransverse ligament posteriorly, and the parietal pleura in the thoracic level or the psoas major muscle in the lumbar level anteriorly.

As a result, the 'sacral ESPB'<sup>7</sup> cannot be considered an ESPB as the anatomical structures mentioned earlier cannot be properly identified, and this is in keeping with the recent observation of Hamilton.<sup>8</sup>

Having a harmonized definition, we believe it is possible to improve clarity of what defines an ESPB. It would further create the possibility to harmonize the experimental requirements for future studies and to facilitate a clear dialog between clinicians. However, we fully realize the challenges of attaining this objective. Moreover, until there is a consensus, we believe it is beneficial to combine efforts for achieving a broadly accepted revision of the nomenclature.

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