

Erector spinae plane block in breast surgery

To the Editor

Having read carefully the original article by Swisher *et al* on the analgesic effectiveness of erector spinae plane block compared with paravertebral block in breast surgery,¹ we make few comments regarding (1) the study design, (2) the time point of pain assessment and (3) the pain management protocol.

1. The non-inferior margin is crucial for sample size calculation in a non-inferior study design. In this study, a score of 1.25 and 2 mg morphine were used as the margin of pain score and opioid consumption, respectively. However, only the former value has been proven to have a clinically important difference.² Would the authors provide some evidence about the margin of opioid consumption? Would a difference of 2 mg morphine really have meaningful values clinically?
2. One of the primary endpoints was the Numeric Rating Scale (NRS) pain score in postanesthesia care unit (PACU), but the exact time point for pain assessment was not indicated. How long was the time interval for patients staying in PACU? Because the pain score will likely decrease after opioid therapy, it is necessary to evaluate pain intensity at a predefined time point. Moreover, was the pain score assessed at rest or with movement? These issues should also be mentioned.
3. It was reported that a standard PACU opioid algorithm was used in this study, but we are confused about the description 'intravenous fentanyl 25 µg for NRS pain scores of less than 5' and 'oxycodone 5 mg for NRS of 4–6'. What was the target NRS pain score you allowed: 4 or 5? Why is an NRS pain score of 4–6 suitable for oxycodone usage? Would any opioids be given if the NRS pain score is 3 or below and what kind of opioids should be used?

We sincerely hope the authors can provide further explanations of these points to make their results clearer and more compelling.

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