

Supplementary Appendix 2. Full results

First round

For abdominal wall blocks, the first round produced no consensus on named variations of the transversus abdominis plane (TAP) block including the epigastric (7%), hypogastric (8%), upper (23%) and lower subcostal (20%) and ilioinguinal TAP (20%) blocks, and these were therefore excluded.¹⁹ Similarly, a range of named variations of the quadratus lumborum blocks were excluded, such as the posteromedial (22%), posterolateral (25%), transverse anterior (16%) and supra-iliac anterior (21%) quadratus lumborum block approaches.^{20–23} There was no consensus on naming quadratus lumborum block types 1, 2, 3 and transmuscular approaches all (32%, 32%, 23%, and 32%, respectively) when compared with the lateral, posterior, and anterior quadratus lumborum block approaches (53%, 71%, 58%, respectively).^{5 10 24–26}

For paraspinal approaches, there was no consensus on named variations of the erector spinae plane (ESP) block variants based on the vertebral level targeted (e.g. lumbar ESP), and it was agreed that this should not be part of the basic nomenclature, but should instead be added as a prefix where appropriate.²⁷ The midpoint transverse process to pleura (MTP), subtransverse process interligamentary plane (STIL), costotransverse foramen plane (CTF), and the multiple injection costotransverse (MIC) blocks achieved weak or no consensus on naming (51%, 18%, 25%, and 26%, respectively).^{28–31} Comments suggested that they all carried similarities in terms of the anatomical location of injection, and it was therefore proposed that they be harmonized into a single new name, the intertransverse process (ITP) block, for consideration in the second round. The rhomboid intercostal subserratus block (RISS) had no consensus (46%) and it was suggested that this was better presented as a single-injection approach, with the name reflecting this.³² There was no consensus on the

thoracolumbar interfascial plane (TLIP) block (35%) and the modified TLIP (21%) block names,^{33 34} and new names that were more descriptive of the anatomical site of injection were proposed for consideration; these were the “lumbar multifidus” and “lumbar longissimus” plane blocks, respectively.⁸ There was also no consensus on the naming of a range of cervical paraspinal plane blocks, and harmonization of these approaches was suggested under the new name “cervical paraspinal interfascial” plane blocks.^{35 36}

For chest wall techniques, variations of the serratus anterior plane block were presented, but there was limited consensus on both the name and the anatomical descriptions, with comments highlighting concerns regarding the lack of specificity of the name and descriptions.³⁷ There was also limited consensus on eight parasternal block approaches (Supplementary Appendix 1), which were proposed to be harmonized into the term “parasternal intercostal” plane blocks (deep and superficial).^{34 38–43} There was weak consensus on the naming of PECS I and II blocks,^{44 45} and therefore more anatomically descriptive “interpectoral” or “superficial pectoralis” plane blocks were proposed for the former, and the “pectoserratus” or “deep pectoralis” plane blocks for the latter.

Second round

The changes implemented for the second round led to $\geq 75\%$ agreement being achieved for eight abdominal wall, three paraspinal, but none of the chest wall block names. There was $\geq 75\%$ agreement in the anatomical descriptions in 11, three and nine block approaches in the same categories, respectively.

For abdominal wall blocks, there was no consensus on the lateral TAP block name (34%) and weak consensus on the midaxillary TAP block (67%) name. Similarly, there was no consensus with the posterior TAP block approach (31%) name, despite strong consensus (81%) for the

anatomical description. There was no consensus on the rhomboid intercostal subserratus plane block name and anatomical descriptions (29% and 47%, respectively), although the single-injection variant, the rhomboid intercostal plane block, achieved weak consensus for both the name and anatomical description (61% and 65%, respectively). There was no consensus on the external oblique fascial plane block name and description (36% and 44%, respectively).

For paraspinal approaches, there was strong consensus on the names and descriptions of the paravertebral (96% and 98%, respectively), ESP (100% and 98%, respectively), and retrolaminar (89% and 91%, respectively) blocks. The new harmonized ITP block received weak consensus on both the name and anatomical description (58% and 61%, respectively). There was either weak or no consensus on the lumbar multifidus, lumbar longissimus, or cervical paraspinal interfascial plane block names and descriptions.

For chest wall approaches, the serratus anterior plane (SAP) block name as a single undifferentiated term had 44% agreement, and comments noted the lack of specificity of this name. The more specific deep and superficial SAP blocks received weak consensus on names (64% and 62%, respectively), and strong consensus was achieved for the anatomical description of the deep SAP block (76%). However, strong consensus was not achieved for the anatomical description of the superficial SAP block (63%). There was weak consensus on the parasternal intercostal plane (PIP) block names, both deep and superficial (57% and 74%, respectively), but strong consensus on their anatomical descriptions. Only 39% of Collaborators agreed with the name PECS I, compared with the interpectoral plane block (54%) and the superficial pectoralis plane block (23%); the anatomical description, which was the same for all three, achieved strong consensus (79–94%). PECS II was presented for consideration as describing either a double-injection technique combining a superficial and

deep injection relative to pectoralis minor, or just the deep injection. The single-injection approach for PECS II achieved no consensus on all proposed names: PECS II (30%), pectoserratus plane block (49%) and deep pectoralis plane block (25%); however the anatomical description achieved strong consensus (57–76%). There was also no consensus on PECS II as the name of the double-injection technique (23%) or on the anatomical description presented (40%).

Collaborators were asked three additional clarifying questions in this second round. The first question asked whether the anatomical locations of injection for the posterior TAP, lateral QL, and transversalis fascia plane blocks were similar enough to warrant harmonization. The second question asked whether the anatomical locations of injection for the PECS II and deep SAP blocks were similar enough to warrant harmonization. The third question aimed to clarify whether the term used to describe the connective tissue plane that is targeted in these regional anesthesia techniques (the superficial, deep or muscle-related planes composed of connective tissue) should be “fascial plane”, “interfascial plane”, or simply “plane”. None of the clarifying questions achieved strong consensus in responses (Supplementary Appendix 1).

Third round

For abdominal wall blocks, the virtual round table led to strong consensus being achieved for the majority of block approaches. There was weak consensus on harmonizing the posterior TAP and lateral quadratus lumborum blocks (73%) into a single term, with strong consensus for lateral quadratus lumborum block as this unified term (80%). For the paraspinal blocks, there was also strong consensus on harmonizing the STIL, MTP, MIC, and CTF block techniques (84%) and strong consensus for the unified anatomical description (86%). However there was only weak consensus on accepting ITP (58%) rather than MTP (42%) as the unified name.

There was weak or no consensus on both the names as well as anatomical descriptions of the lumbar longissimus and multifidus plane block. The rhomboid intercostal plane block achieved weak consensus for the name (69%) but strong consensus for the anatomical description (81%). For chest wall blocks, the deep and superficial SAP blocks achieved strong consensus on the names, with 91% and 80% agreement, respectively. However, the anatomical description for the superficial SAP block only achieved weak consensus (52%). There was only weak consensus on the interpectoral plane block name (73%), although this was higher than the alternative proposal of superficial pectoralis minor block (56%). There was weak consensus on the pectoserratus plane block name (53%), but no consensus on deep pectoralis minor block (46%). Finally, there was strong consensus (78%) that the superficial, deep or muscle-related planes composed of connective tissue should be called fascial planes rather than interfascial planes (clarifying question three), although this does not apply to names, but only in reference to anatomical descriptions. The final results can be seen in Table 1.