



Ultrasound-Guided Bilateral Erector Spinae Plane Block versus Tumescence Anesthesia for Postoperative Analgesia in Patients Undergoing Reduction Mammoplasty: A Randomized Controlled Study



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To the Editor

We read Oksuz et al.'s [1] study with great interest and after obtaining informed consent from the patient would like to share our experience of erector spinae plane block (ESPB) in a patient who underwent bilateral nipple areola-conserving mastectomy with concomitant implant reconstruction due to breast cancer.

The patient was a 37-year-old woman with a diagnosis of multicentric breast cancer on her right breast. Due to the patient's choice, she also wanted to undergo prophylactic nipple areola-conserving mastectomy with implant reconstruction to the contralateral side.

Preoperatively, the patient was sedated with midazolam 3 mg IV and then placed in the prone position for ESPB performance. The block site was cleaned with povidone-iodine. ESPB was performed to both sides with USG using 20 ml of 0.25% bupivacaine at the T4 level. Satisfactory local anesthetic administration was verified by ultrasonography (USG). The patient was placed in the supine position for general anesthesia by using propofol (2–3 mg kg⁻¹) and fentanyl (2 mg kg⁻¹) IV. Rocuronium

0.6 mg kg⁻¹ was administered IV for endotracheal intubation. General anesthesia was maintained by desflurane 6% and remifentanyl infusion. At the end of surgery, analgesia was provided with 50 mg dexketoprofen and 1 g paracetamol IV. There were no perioperative hemodynamic problems. Surgery lasted a total of five hours, and the expander implant reconstruction was performed posterior to the pectoralis major muscle. For the postoperative period, analgesia was provided using patient-controlled analgesia (PCA), and pain was assessed using a numeric rating scale (NRS) ranging from 0 (no pain) to 10 (the worst imaginable pain). In the recovery room, the patient was given a PCA device containing morphine 0.5 mg/ml⁻¹, set to deliver a 1-mg bolus dose of morphine, with an 8-min lockout time. On the ward, NRS scores were recorded at 1, 6, 12 and 24 h postoperatively. Incidences of nausea and vomiting, and total morphine consumption during the 24-h postoperative period were also recorded. A pain nurse was responsible for the postoperative follow-up. The patient received paracetamol 1 g IV every 8 h as part of routine pain treatment. NRS scores were always below 3, and the patient used only 5 mg PCA morphine in the postoperative period. The patient did not have nausea and vomiting. There was no need for rescue analgesics in the postoperative period.

Although there are controversial studies regarding the mechanism of action of ESPB, we believe that paravertebral and/or epidural spread might be more probable when the block is administered bilaterally. For this reason, we think that bilateral ESPB applications may be very effective in postoperative analgesia as in our case report [2].

Previous studies demonstrated that ESPB provides effective postoperative analgesia for breast surgeries [3]. Parallel to the findings of Oksuz et al., our case report also

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shows that bilateral breast surgery patients can benefit significantly from ESPB.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflicts of interest to disclose.

Human and Animals Rights This article does not contain any studies with human participants or animals performed by any of the authors.

Informed Consent For this type of study, informed consent is not required.

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