Response to “Comment on 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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We would like to express our thanks for giving us the opportunity to clarify some aspects of our study by responding to the issues that have been raised. We would also like to thank the authors for their interest in our study and for taking the time to express their concerns [1].

In the letter to the editor, the first concern was that when pain was assessed using the visual analog scale (VAS) in our study, the status of the patients was not clear. We agree that the status of the patients affects pain intensity. We also agree that pain intensity is expected to be higher during movement than at rest. However, in our study, all pain assessments were performed at rest. We believe that pain is routinely assessed by VAS at rest unless clearly stated otherwise (e.g., during movement or while coughing), as is evident in many previous studies that have not provided further clarification of the patient's status during pain assessment [1,2].

Concerning the second point, we agree that both the erector spinae plane block (ESPB) and transversus abdominis plane block (TAPB) are effective modalities for postoperative pain management as we clarified in our study. Our findings show that the ESPB provided better analgesic effect, which is consistent with a previous study that found that patients who received an ESPB had a VAS score < 3 in the first 24 h postoperatively [3], and required less time to perform successfully. These findings met the goal of our study, which was to compare the effectiveness and feasibility of both blocks.

Third, none of the patients in our study required a second rescue analgesic. We agree that the difference in nalbuphine consumption between the two groups was only equivalent to 2.94 mg of intravenous morphine. However, combined with the other statistically significant outcomes, such as a lower VAS score, longer duration to the first dose of rescue analgesic, and less time required to perform a successful block, the ESPB was found to be a more effective and feasible block than the TAPB.

Finally, we chose time to flatus or stool as our secondary outcome since we believe that, especially with gastrointestinal surgeries, factors other than the effectiveness of the block and the opioid-sparing effect, such as the duration of surgery, duration of abdominal insufflation, predisposing patient factors, and the sleeve gastrectomy technique used, can have a statistically significant effect on the incidence of nausea and vomiting [4]. Moreover, knowing that patient satisfaction and quality of recovery are greatly affected by the occurrence of early postoperative nausea and vomiting [5] compelled us not to choose this as a secondary outcome in our primary research hypothesis. Furthermore, we believe
that our study achieved our primary research objective, which was to compare the effectiveness and feasibility of both blocks in a challenging population.

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**Conflicts of Interest**

No potential conflict of interest relevant to this article was reported.

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