Dear Editor,

Erector Spinae Plane Block (ESPB from now on) is a technique introduced in clinical practice by Forero et al.,[1] in which local anesthetic is injected between the erector spinae muscle and transverse process. This block affects the dorsal and ventral rami of the thoracic and abdominal spinal nerves. ESPB can be performed at thoracic or lumbar level, making it feasible for breast, thoracic, abdominal, and orthopedic surgery.

Some studies suggest its use in nephrectomies; thus increasing its already astonishing potential, for instance, Canturk[2] and Kim et al.,[3] recommend it for analgesia following renal surgery in adults, as well as Aksu and Gürkan[4] in pediatric patients. Last, Santonastaso et al.[5] tried to provide intraoperative and postoperative analgesia through ESPB to a patient undergoing open partial nephrectomy. This amount of literature suggested us to try ESPB to manage intraoperative and postoperative pain in two patients undergoing laparoscopy nephrectomy. This technique is minimally invasive, so when compared to the open technique it presents less postoperative pain and shorter length of stay. We noticed, in addition, that in this surgery pain is well localized, with an almost band-like distribution; that’s why spinal anesthesia may block more dermatomes than necessary. ESPB could represent a good compromise between pain management and this kind of overtreatment.

The patients we chose to manage with this technique were both overweight (BMI 31 and 34); the block was performed at T9 level, using a convex ultrasound probe to identify the transverse processes [Figure 1]; patients were lying on the side not to operate and, using an in-plane technique with an echogenic needle, 20 ml of 0.5% ropivacaine were injected deep to the fascial plane of the muscle.

What we wanted to obtain was a decrease in invasivity and in the amount of opioids administered, both during and after surgery.

During surgery, both patients stayed stable from the hemodynamic point of view; no complications occurred, and both were back in their room after less than an hour in our recovery room.

For the first patient, highest NRS was 2, and pain was well controlled with paracetamol.

The second patient had highest NRS in postoperative period of 3. He was treated with paracetamol, too, because it was enough to soothe the pain.

ESPB allowed us to spare opioids, making a mini-invasive procedure like laparoscopic nephrectomy even less invasive. The patients’ length of stay was reduced, and they both reported comfort and satisfaction with their postoperative period.

Of course, analysis of two patients cannot reach statistical significance. Further studies are needed, but we believe that our experience gives us a hint about the increasing potential of ESPB in practical clinic.

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Conflicts of interest
There are no conflicts of interest.

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To the Editor,

Ultrasound-guided single-shot as well as continuous erector spinae plane blocks (ESPB) have been used to provide perioperative analgesia for total hip replacement (THR).[1,2] ESPB can also be performed with anatomical landmark-guided technique in case of unavailability of ultrasound machine in the operation theatre.[3] We report a case of successful landmark-guided continuous ESPB at the level of the L3 transverse process in a patient with ankylosing spondylitis for THR.

A 30-year-old male patient with sickle-cell trait was operated for left sided THR. He was admitted with history of pain, restriction of movements in both hip joints (left > right), and he was unable to sit for the last two years. He was diagnosed with ankylosing spondylitis with grade 4 sacroiliitis. His blood investigations were unremarkable. Airway examination was normal with adequate flexion and extension of cervical joints. The examination of the back revealed thoracic kyphosis and flattening of lumbar spine. The anaesthesia plan was to attempt a Subarachnoid block and/or epidural block first, and in case of difficulty or failure, the alternative plan was a continuous ESPB and general anesthesia with endotracheal intubation. A written informed consent was obtained for both regional and general anesthesia from the patient after explaining the procedures in detail.

The positioning of the patient for the lumbar puncture was extremely difficult as there was no flexion at spine or hip joints. The patient could not sit and could only lie straight in left lateral position without flexing the hip at all. Subarachnoid block was attempted multiple times at different spinal levels by different approaches by two experienced anaesthesiologists, but they failed. It was decided to administer general anesthesia with placement of ESP catheter for perioperative and postoperative pain management. For ESP catheter placement, an 18-gauge Tuohy needle was inserted perpendicular to skin at the level of the L3 spinous process, 3 cm lateral to the midline [Figure 1a]. The tip of the needle contacted the transverse process of L3 vertebra at a depth of 3.5 cm. Then the needle was gently withdrawn by 1–2 mm and 10 ml of local anesthetic (LA, 0.25% ropivacaine) was injected to open up the plane by lifting the erector spinae muscle. A 20-gauge catheter was introduced through the needle and 3 cm length of the catheter was inserted into

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