

low-middle income country further poses significantly challenges. The importance of clear communication between healthcare policy officials, administrators and clinicians is crucial and cannot be over-emphasized.

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## Conflicts of interest

The authors declare no conflicts of interest.

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## Perspectives on Pecs I block in breast surgeries



Dear Editor,

I read the article about the clinical investigation of Pecs I block in breast augmentation surgeries, published recently, with profound interest.<sup>1</sup> I greatly appreciate the authors for the wonderful clinical investigation of Pecs I block in breast augmentation procedures. I wish to present my perspectives on that article which I believe would make more clarity on this topic.

The authors of this study have observed that Pecs I block was not superior to placebo in postoperative pain relief when the patients themselves participated as their own control, too. They have also concluded that the role of Pecs I block should be “reconsidered” in breast augmentation surgery as well as in breast cancer procedures.<sup>1</sup> However, I strongly believe that Pecs I (pectoral component of Pecs II) block has definitely some role to play in postoperative pain relief in breast surgeries, particularly in breast augmentation procedures. This is because of the fact that the pectoral nerves do play a role at least in the “Myofascial” aspect of the pain, although they do not innervate the skin and subcutaneous tissues of the breast.<sup>2</sup> Furthermore, Pecs I block alone would not be sufficient in breast cancer surgeries involving the lateral aspect of the breast with or without axillary dissection as it would cover mainly the medial aspect of the breast only. Hence, it is misleading to state that Pecs I block needs “reconsideration” in breast cancer surgeries too as the surgeries would vary between patients in both extent of the incision as well as in depth (multidimensional).

We have to provide a Pecs II block (Pecs I plus pectoralis minor-serratus anterior injection), or Pecs I block plus a serratus anterior plane block (SAPB) for extensive breast surgeries involving the lateral aspect of the breast, axillary dissection. Here again, I believe that the pectoral component of Pecs II (i.e. Pecs I) would at least contribute 30% of the pain relief.

The authors have stated that this study was the first one to analyze the role of Pecs I block in breast augmentation procedures.<sup>1</sup> However, another study by Ekinci M et al. indeed got published in February 2019 itself which also evaluated the efficacy of Pecs I block in the same procedure.<sup>3</sup> Ekinci M et al. have compared 20 mL versus 30 mL of bupivacaine 0.25% with placebo and observed that both 20 mL and 30 mL groups have significantly reduced the fentanyl consumption when compared to the placebo group in contrast to the current study. Also, there was no statistically significant difference between 20 mL and 30 mL groups with regard to fentanyl consumption.<sup>3</sup> Nevertheless, the main difference is that Ekinci M et al.<sup>3</sup> have not used the same subjects as control too as used in this study which I agree as “unique” feature of this study.


To conclude, we have the option to choose the various interfascial plane blocks available in the last decade such as Pecs blocks, erector spinae plane block (ESPB), SAPB, etc. It should be based on the two important factors, namely the type and extent of the surgical incision, sensory coverage of the blocks. Hence, we should consider breast surgeries as “multidimensional entity” and choose the available interfascial plane blocks accordingly, rather than having an impulse to approach it in only two ways, i.e., to block or not to block?<sup>4</sup>

## Conflicts of interest

The author declares no conflicts of interest.

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