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Fascial blocks in the COVID-19 era: An alternative to consider[☆]

Bloqueos fasciales en la era COVID-19: una alternativa a considerar

To the Editor,

We read with interest the clinical case presented by Días et al.[1], in which the authors describe the use of a combination of fascial blocks in breast surgery: PEC II block, pecto-intercostal fascial block, and supraclavicular nerve branch block. Although they present this combination of blocks as a new technique in this type of surgery, they acknowledge that analgesia of the anterior chest wall, at the medial level, was insufficient.

In our experience, based on the innervation of the chest wall, performing a serratus intercostal block in the midaxillary line at the level of the fourth rib (BRILMA) is an opioid-saving technique that provides adequate analgesia for this type of surgery[2] and reduces the risk of chronic pain associated with this procedure[3]. We, therefore, believe that administering 2 effective blockades (PEC and BRILMA)[4] would overcome the analgesia deficit encountered with the authors' technique.

We agree that the risk of infection should be minimised in the COVID-19 era by avoiding airway manipulation, particularly in patients who have tested positive or have suspected COVID without a PCR confirmation test. Our obligation is to provide good quality care with minimal risks, and we therefore agree with Días et al., that in the COVID era and indeed at any other time, fascial blocks are a good analgesic option to consider not only at the level of the chest wall, where combined techniques have been proven effective, but also in surgery of the upper abdominal wall. The new fascial blocks have been presented as an effective option in these procedures[5], and can sometime replace general anaesthesia.

This is why we believe fascial blocks, which preclude the need for airway management in many different surgeries, should always be included in anaesthesia and analgesia strategies.

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