

External oblique intercostal plain block - A single injection solution to anterolateral upper abdominal wall analgesia

Dear Sir,

We would like to share our perspective on the article entitled "External oblique muscle plane blocks in combination with modified thoracoabdominal nerves block through perichondrial approach for analgesia in abdominal surgery: A case report."

We read with great interest the zeal Dr. Yuchi Ohgoshi *et al.* showed for covering analgesia of abdominal wall postcholecystectomy and post-laparoscopic surgeries in two of his patients.^[1] We congratulate you, sir, for opening a new channel for postoperative analgesia through your article.

Postoperative pain management due to thoracoabdominal surgeries has always posed a challenge, and every day, a new block is being introduced into the field. Unmanaged pain may lead to respiratory compromise and increased hospital days. The case reports are published and are followed, but patient safety should always be a priority, as very clearly and loudly concluded by Dr. Yuchi Ohgoshi.

We would like to point out that giving 100 ml of 0.2% Ropivacaine at five different sites seems to be too much of a task and time consumption, especially in an era of USG-guided, highly reliable, and safe regional anesthesia. Added to this, keeping track of the drug dose as such would become very difficult, and the pinnacle has already been achieved with 60 ml of 0.375% ropivacaine in 72 kg or 100 ml of 0.2% in 42 kg patients. The door at which LAST (local anesthetic-induced systemic toxicity) begins is very near, and it is surprising if the patients above did not show any tingling, nervous, or cardiac symptoms already. If we are more practical, the dose in the first case comes out to be 222 mg that has been given to the patient; the upper limit is 216 mg, considering 3 mg per kg to be a safe upper limit dose.^[2] In the second patient, the dose given is 200 mg, whereas the upper safe limit is 126 mg. Well, that sounds scary!

In spite of the fact that these are interfascial plain blocks and we have a much safer limit, vascular absorption is always there, and the chances of LAST cannot be ruled out, especially at such enormous doses. The approach and the dose do

not seem to be pragmatic. We have an external oblique intercostal plain block now introduced by Dr. Elsharkawy that covers anterior as well as lateral cutaneous branches of T6 to T12 dermatomes with a single injection site.^[3] The drug is deposited deep into the external oblique intercostal muscle and, thus, an extensive local anesthetic spread along the fascial plane. For laparoscopic surgeries bilateral blocks can be given. We at our institute have been practicing this for quite some time, and patients have shown numeric rating scale score of less than 2 for 24 hours postoperatively with the dose used 140 mg in an average 70 kg patients. Moreover, the patient mentioned in the first case is diabetic and has alcoholic liver disease, doses should further be reduced as per the protocols.

To conclude we have safer USG-guided interfascial plane blocks that are a good armamentarium in our regional anesthesia practice. The local anesthetics dose must always be calculated before giving to any patient and upper safe limit should not be crossed in any case considering the best for the patient safety.

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Conflicts of interest

There are no conflicts of interest.

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