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LETTER TO THE EDITOR

Chronic low back pain: should we be adopting novel analgesic techniques?

Lombalgia crônica: devemos adotar as novas técnicas de analgesia?

Dear Editor,

We read with interest the recently published study by Sakae et al.[1] comparing the postoperative analgesic efficacy between Erector Spinae Plane Block (ESPB) and epidural block in patients submitted to open cholecystectomies. Our colleagues[1] found poorest pain relief both 2 and 24 hours after the surgery in the group where the ESPB was performed, with statistical significance, which they mainly correlate with the volume and anatomical spread of the local anesthetic injected in their ESPB technique.

As anesthesiologists currently managing patients with chronic Low Back Pain (LBP), we have been facing this same doubt and curiosity: should we prefer the novel ESPB or the well-established lumbar epidural analgesia?

The ESPB was originally described by Forero M. et al.[2] as a simple and safe interfascial plane technique that led to neuropathic thoracic chronic pain relief. Since then, it has increasingly been used in lumbar spinae surgeries,[3] as well as in chronic conditions of various origins.[4]

Since chronic LBP if often multidimensional and rarely exclusively myofascial, and agreeing with Galacho J. et al.[5] when affirming that ESPB does not only block somatic fibers but also the sympathetic chain, we have been using the ultrasound-guided ESPB more often in our ambulatory patients with fairly good results. In a recent and not yet submitted to publication in BJAN case series (10 patients) of our Pain Clinic, we found a mean of 20.8 days of pain relief after L1-L2 bilateral injection of 20 mL ropivacaine 0.2% and dexamethasone (4 mg), with no need for systemic pharmacological therapy escalations or rescue analgesia.

As most of the chronic pain management tools, ESPB could be part of a multimodal and multidisciplinary approach. It shows preliminary advantages as an alternative to epidural blocks in these patients since it is easily performed with a lower complication risk; allows immediate discharge home with the absence of motor block; it seems easier to be consented by the patient; and it can produce a good ''therapeutic window'' time span: time for patients' physical rehabilitation and exercise with tolerable levels of pain (interruption of pain cycle).

Conflicts of interest

The authors declare no conflicts of interest.

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Inês Gonçalves Morais *, Ana Martins

Centro Hospitalar Vila Nova de Gaia, Departamento de Anestesiologia, Espinho, Portugal

* Corresponding author.
E-mail: inesmorais2011@gmail.com (I.G. Morais).

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