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Ultrasound-guided bilateral lumbar erector spinae plane block for postoperative analgesia after myomectomy with Pfannenstiel incision

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To the Editor;

Pfannenstiel incision is a horizontal skin incision between the umbilicus and symphysis pubis that is preferred by obstetricians for cesarean section and by gynecologists for gynecological surgeries. Intense postoperative analgesic management is required after open technique myomectomy for enhanced recovery after surgery.

The ESPB was first described by Forero et al. [1] for the treatment of neuropathic pain. Since then, the ESPB has become a prosperous plane block to provide postoperative analgesia after several surgical settings [2–5]. We want to present our results with ultrasound-guided bilateral lumbar ESPB for postoperative analgesia in a patient scheduled for myomectomy with Pfannenstiel incision.

The patient was a 57 years old female admitted to obstetrics and gynecology policlinics with the complaints of menometrorrhagia. Her ultrasound examination revealed a 45 × 65 mm solid mass in the corpus of the uterus, and her hematocrit level was 21%. She was scheduled for myomectomy under spinal anesthesia. Written informed consent was obtained from the patient for the spinal anesthesia, ESPB, myomectomy, and for the use and publishing of the data.

On arrival to the operation room, she was monitored, and an intravenous line was secured. After sedation with 2 mg midazolam and sterile draping in the prone position, L1 vertebra was navigated with the 2–5 MHz convex probe of ultrasound (Esaote MyLab30, Florence, Italy) in sagittal axis and the transverse process was identified 4 cm lateral to the midline. Block needle (Temena GmbH, Felsberg, Germany) was inserted in cranio-caudal direction with in-plane technique. Contact of the needle with the transverse process was visualized. After confirmation of erector spinae plane with 2 ml of saline, 10 ml 0.25% bupivacaine and 10 ml 1% prilocaine were injected on both sides. The patient was turned to the left lateral position, and spinal anesthesia was performed at L4–5 interspace with 17.5 mg hyperbaric bupivacaine.

The operation lasted for 45 min. The patient was followed-up at recovery room for 2 h. With the regression of motor block, the sensory block was assessed and determined between T4 – L4 dermatomes. Diclofenac 75 mg intravenous was ordered if her numeric rating scale (NRS) was > 2, and Meperidine 50 mg intramuscular was prescribed as rescue analgesic if NRS > 4. She did not ask for any analgesic in the ward, and she did not have nausea or vomiting. No complication was reported related to surgery, anesthesia, and ESPB. At postoperative 6th hour, she was mobilized, and her NRS score was 3 with mobilization and the sensory block was between T10–L1 dermatomes. She was discharged on the postoperative 24th hour free of pain and complications.

We performed the ultrasound-guided bilateral lumbar ESPB before the start of surgery which was suggested in a recent study [2] to provide a clear surgical field, effective postoperative analgesia, and a stable hemodynamic course throughout the surgery. We suggest that ultrasound-guided lumbar ESPB is an effective postoperative analgesia modality after myomectomy. However, our results should be validated with randomized controlled trials.

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Declaration of Competing Interest

None.

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