

# Ultrasound-guided Erector Spinae Plane Block for postoperative analgesia: A Meta-Analysis of Randomized Controlled Trials

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## Research article

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# Abstract

**Background** Ultrasound-guided Erector Spinae Plane Block (ESPB) has been increasingly applied in patients for postoperative analgesia. Its safety and effectiveness remain uncertain. This meta-analysis aimed to determine the clinical safety and efficacy of ultrasound-guided ESPB in adults undergoing general anesthesia (GA) surgeries.

**Methods** A systematic databases search was conducted in PubMed, Embase, and the Cochrane Library for randomized controlled trials (RCTs) comparing ESPB with control or placebo. Primary outcome was iv. opioid consumption 24 h after surgery. Standardized mean differences (SMDs) or risk ratios (RRs) with 95% confidence intervals (CIs) were calculated with a random-effects model.

**Results** A total of 11 RCTs consisting of 540 patients were included. Ultrasound -guided ESPB showed a reduction of iv. opioid consumption 24 h after surgery (SMD=-2.15; 95% confidence interval (CI) -2.76 to -1.5,  $p < 0.00001$ ), pain scores at 1st hour (SMD=-0.97; 95% CI -1.84 to -0.1,  $p = 0.03$ ) and pain scores at 6th hour (SMD=-0.64, 95% CI -1.05 to -0.23,  $p = 0.002$ ). Also, it lessened the number of patients who required postoperative analgesia (RR=0.41, 95% CI 0.25 to 0.66,  $p = 0.0002$ ) and time to first rescue analgesia (SMD=4.56, 95% CI 1.89 to 7.22,  $p = 0.0008$ ). Differences were not significant with the pain score at 12th hour, 24th hour and postoperative nausea and vomiting (PONV).

**Conclusions** Ultrasound-guided ESPB provides postoperative analgesic efficacy in adults undergoing GA surgeries with no increase in PONV.

## Background

Ultrasound-guided Erector Spinae Plane Block (ESPB) is a novel regional anesthesia technique that local anesthetic (LA) injection is performed into the fascial plane situated between the transverse process of the vertebra and the erector spinae muscles it is considered a relatively safe simple technique to perform.[1, 2] Followed by first description by Forero et al.[1] in 2016, it has been demonstrated successfully to provide analgesia in thoracic and thoracoabdominal surgeries[3, 4] However, the use of ultrasound-guided ESPB remained controversial. Recently, several randomized controlled trials (RCTs)[5-7] on this topic have been published, but the determine conclusions cannot be established owing to the modest sample size of these RCTs. We therefore conducted a meta-analysis to examine the efficacy of ultrasound-guided ESPB among adults undergoing general anesthesia (GA) surgery. Our primary outcome was intravenous opioid consumption 24 h after surgery. Secondly outcomes included pain scores, number of patients who need rescue analgesia, time to first rescue analgesic and postoperative nausea or vomiting (PONV).

## Methods

### Literature search and selection Criteria

This systematic review and meta-analysis of RCTs was reported abiding by the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) statement[8] and it was conducted base on the statement of the Cochrane Handbook for Systematic Reviews of Interventions[9]. No formal protocol was registered for this meta-analysis.

PubMed, EMBASE, and the Cochrane Library were searched from inception to August 2019 with no language restriction. The search terms used were:('erector spinae plan block' OR 'erector spinae block' OR 'erector spinae plan blocks' OR 'erector spinae blocks'). The bibliographies of included trials were also manually searched for any eligible trials missed by the electronic search. This process was conducted iteratively until no extra reference could be verified.

Two of us independently performed the preliminary data search, after removing duplicate references, the titles and abstracts were screening for the eligible trials. We included all RCTs in adults who were undergoing GA surgery with the intervention of ultrasound-guided ESPB Trials were excluded for the following criteria: animal or cadaveric studies; reviews; did not report opioid consumption or pain scores as an outcome; Any discrepancies were resolved by discussion with coauthors.

### **Data extraction and quality assessment**

Data collection was performed by two authors (JH and JCL). The following information was collected from each eligible trial: first author, publication year, patient number, patient characteristics, American Society of Anesthesiologists (ASA) physical status, surgical procedure, ESPB group (position, dosage and concentration), control group (placebo or no invention). Extracted data were entered into a predefined standardized Excel (Microsoft 6 Corporation, USA) file.. For continuous data, we calculated mean and SD, if not provided, median and interquartile range were seen as means and standard deviation(SD) approximately as follows: the median was considered equal to the mean, and the SD was calculated as the interquartile range divided by 1.35[10]. Any uncertainty arose were figured out though a consensus achieved.

Two authors (JH and JCL) evaluated the methodological quality of the trials according to the Cochrane risk-of-bias tool[11]. Each item was categorized as having a 'low', 'unclear', or 'high' risk of bias. Any uncertainty arose were resolve by discussion between two researches until a consensus was achieved.

### **Statistical Analysis**

The relative risks (RRs) and standardized mean differences (SMDs) with 95% confidence intervals (CIs) were calculated. A random effects model was selected to acquire the most conservative effects estimate. An  $I^2$  statistic of 25%-50% were defined as low heterogeneity, an  $I^2$  statistic of 50%-75% were described as moderate heterogeneity, and those with an  $I^2$  statistic of  $> 75\%$  were considered as high heterogeneity[12], The heterogeneity was substantial when an  $I^2$  value was over 50%. Subgroup analysis was conducted based on additional analgesia (patient-controlled analgesia device (PCA) versus not PCA) . Publication bias was evaluated using funnel plots. Statistical analyses were calculated using the Review Manager Version 5.3 (Nordic Cochrane Centre, Cochrane Collaboration)

# Results

## Study identification and characteristics

A total of 675 studies were obtained by the literature search. One further citations were found by hand searching. 212 records were excluded for duplicate studies and a further 448 records removed by screening titles and abstracts. 16 full text publications remained were scrutinized for conclusive identified. 4 of them were excluded because 2 did not report data of interest[13, 14], one was currently ongoing study[15],one was review article[16].Finally,12 RCT[5-7, 17-25] satisfied our inclusion criteria. A flowchart of the literature search is shown in Fig. 1.

All RCTs included in this meta-analysis were published between 2018 and 2019, with a total of 490. The main characteristics of the 12 RCTs included are presented in Table 1.

## Primary outcomes

All RCTs[5-7,17-25] reported data on intravenous opioid consumption 24 h after surgery . Pooled analysis showed that ultrasound-guided ESPB was associated with a reduction of opioid 24h after surgery (-2.18, 95% CI -2.76 to -1.61;  $P < .00001$ ; Fig2). Substantial heterogeneity was observed among these studies ( $P$  for heterogeneity  $< .00001$ ;  $I^2 = 87\%$ ). The finding was consistent in subgroup analysis. (Fig.3)

## Secondary outcomes

Ultrasound-guided ESPB significantly decrease pain scores at the 1 h(-0.80, 95% CI -1.54 to -0.06;) and 6 h[-0.64, 95% CI -0.99 to -0.30;].Furthermore, No. need rescue analgesia (0.41, 95% CI 0.25 to 0.66;  $P = .0002$ ,  $I^2 = 67\%$ ) was lower in the ESPB group and time to first rescue analgesic (4.56, 95% CI 1.89 to 7.22 ) was longer in the ESPB group .Pain scores at 12 h,24 h after surgery and PONV did not achieve statistical significant significance. All outcomes of the identified trials are reported in Table 2.

## Quality assessment and publication bias

Four trials at a low risk of bias, and 8 trials at an unclear risk of bias. The randomisation procedure was adequately generated in 11 trials [5-7, 17-20,22-25]. Since we subjectively judge the outcome measurement was little prone to be changed by lacking of blinding, all RCTs included were classified as low risk of bias at blinding of outcome assessments. Assessment of risk-of-bias summary of all RCTs are presented in (Fig.4). There was no evidence of publication bias by inspection of the funnel plot(Fig.5)

# Discussion

## Main finding

The main finding of this meta-analysis is that ultrasound-guided ESPB significantly reduced opioid consumption 24 hours after surgery. It further reduced pain scores and patients who need rescue

analgesia, besides, it prolonged the time to first request of rescue analgesia. Despite of the high heterogeneity, the main finding was consistent in subgroup analyses.

### **Possible mechanisms for findings**

Ultrasound-guided ESPB is a peri-paravertebral regional anesthesia technique which is supposed to block the dorsal and ventral rami of the thoracic and abdominal spinal nerves [1], and thereby to block the anterior, posterior, and lateral thoracic and abdominal walls. However, the mechanisms of action and spread of LA are not fully elucidated. Several potential mechanisms have been posited. one of the suggested mechanisms of ultrasound-guided ESPB is paravertebral spread of LA, LA infiltration was observed from injection site to three vertebral levels cranially and four levels caudally [26]. Based on this mechanism, Coşarcan SK et al.[27] reported a modification ESPB and got good pain relief in various surgeries. However, the mechanism of paravertebral spread of LA remained debated in several cadaveric studies[28-30]. Another potential mechanism is epidural spread of LA. Schwartzmann A et al [31], Tulgar S, et al[32] and Altıparmak B, et al[33]found unilateral erector spinae plane block result in bilateral sensory blockade in some patients, epidural spread of the LA during ESPB may explain this result. Moreover, some evidence indicated that penetration of LA acted on dorsal and ventral rami through the connective tissues and branch communication led to visceral analgesia [34, 35]

### **Implications for clinical researches**

Our findings demonstrated that ultrasound-guided ESPB was associated with a reduction of opioid consumption, which further proved the effectiveness of ESPB. However, ultrasound-guided ESPB has only been utilized in clinical setting for about three years, several important issues have not been resolved yet. First, the optimal concentration, volume and type of LA in ESPB is not well established. Although 20 and 30ml of 0.25% bupivacaine or 0.5% ropivacaine were recommended[36], concentrations of 0.25-0.5% bupivacaine 10-20ml were used in ultrasound-guided ESPB among all 12 RCTs included in this meta-analysis. Is bupivacaine more preferred than ropivacaine? why? We tried to make a judgment but stop by the insufficient evidence. More researches of ultrasound-guided ESPB on concentration, volume, type of LA are necessary. Next, although no complications of ultrasound-guided ESPB have been reported in all included RCTs, risks such as LA toxicity, vascular puncture and pneumothorax still need our attention. Two studies have reported pneumothorax associated with ESPB [37, 38], and Selvi O et al. [39] reported unintended motor block linked to ESPB. More complications may appear as the increased use of ultrasound-guided ESPB in population. Last, compared to other regional block techniques such as transversus abdominis plane block (TAPB), serratus plane block (SPB), and Quadratus Lumborum Block (QLB), is the erector spine block more effective in some operations where the block areas overlap? Several RCTs on these topics published recently but far from achieving convincing conclusions[40-42]

## Strengths and limitations

Our meta-analysis has several strengths. As far as we know, this is the first meta-analysis to evaluate the efficacy of ultrasound-guided ESPB in adults undergoing GA surgery. Besides, we performed this meta-analysis in compliance with the Cochrane Handbook and the PRISMA statement. Several notable limitations should be considered when interpreting the results. Firstly, the trials included have a modest sample size which could magnify the treatment effect. Secondly, the substantial heterogeneity was observed, one major factor result in heterogeneity is the diversity of surgery types (breast, lumbar spine, hip, abdominal etc). Parietal pain is more prominent in breast and lumbar spine, while visceral pain is the main component of postoperative pain following abdominal surgeries. The use of different types of opioid and supplementary analgesics such as paracetamol [23,24] may also add an extra heterogeneity. Furthermore, owing to all patients were under GA surgeries, sensory blocking could not be evaluated adequately to exclude potential block failures of ESPB. Last, although we conducted a comprehensive literature search, it is hard to rule out the possibility of missing studies.

## Conclusion

In summary, ESPB block provides an effective analgesic in adults. However, the results should be interpreted cautiously since insufficient evidence, although accumulating. Further large-scale RCTs are required to support our results.

## Abbreviations

ESPB: erector Spinae Plane Block; GA: general anesthesia; LA: local anesthetic;

RCTs: randomized controlled trials; PRISMA: Preferred Reporting Items for Systematic Reviews and Meta Analyses; RCTs: American Society of Anesthesiologists;

PONV: postoperative nausea or vomiting RRs: relative risks; SD: standard deviation;

SMDs: confidence intervals (CIs) standardized mean differences; PCA: patient-controlled analgesia device

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## Declarations

**Ethics approval and consent to participate:** Not applicable

**Consent for publication:** Not applicable

**Availability of data and materials:** Not applicable

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## Tables

**Table 1.** Characteristics of included studies.

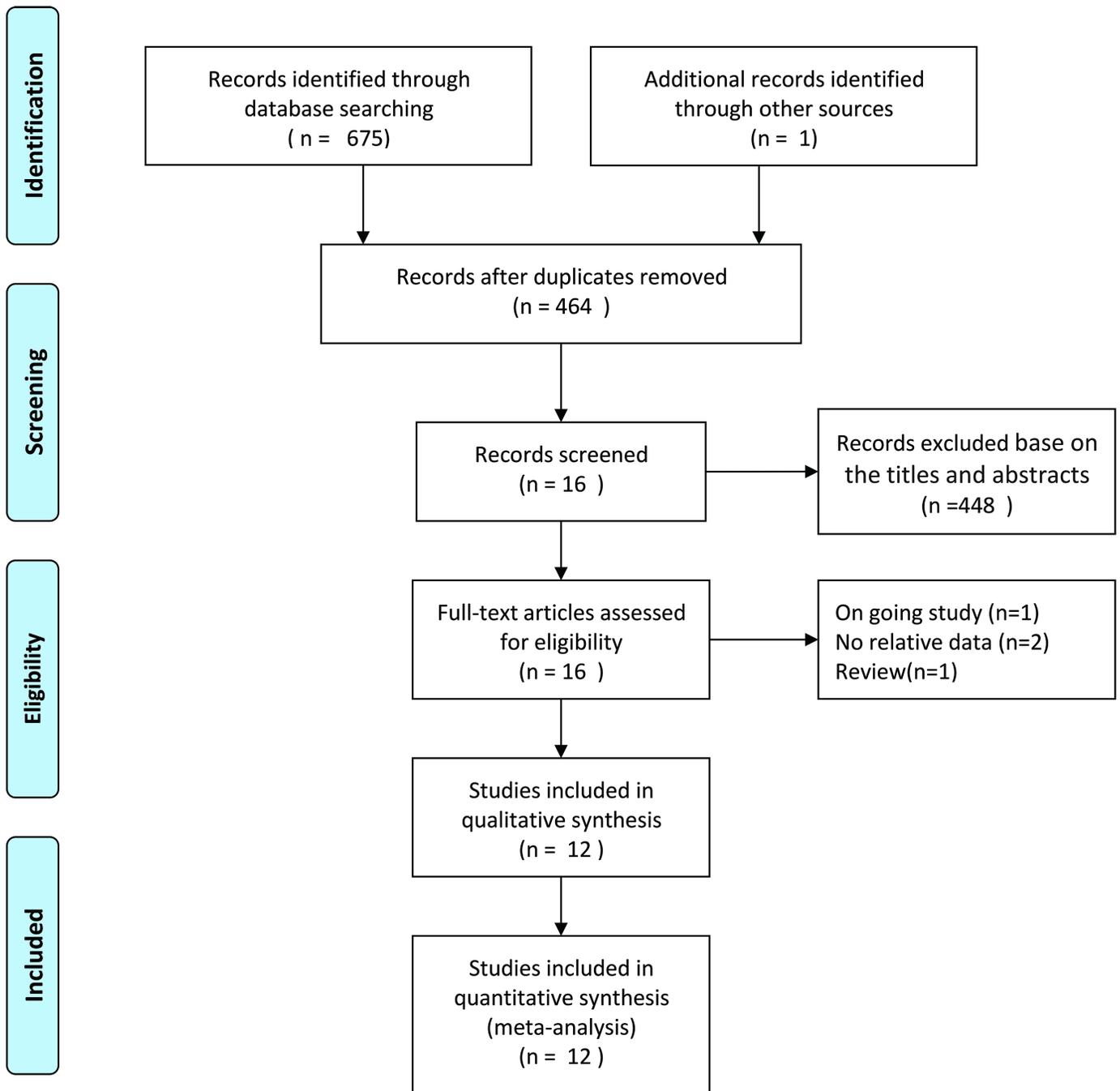
No. Of patients	Surgical procedure	ASA	Patient Characteristics	ESPB group	Control group	GA induction
Tulgar 30(15/15) 2018 (1)	Laparoscopic cholecystectomy	II-II	18-65 years of age	Bilateral ultrasound-guided ESPB at the level of T9 transverse process using 10 mL of bupivacaine 0.375% on each side	Received no intervention	Propofol 2-3mg/kg-1, fentanyl 100µg and rocuronium bromide 0.6mg kg-1
Gürkan 50(25/25) 2018	Elective breast cancer surgery	II-II	Aged 20-65 years	Ultrasound (US)-guided ESPB with 20 ml 0.25% bupivacaine at the T4 vertebral level	Received no intervention	Propofol(2-3 mg kg-1) and fentanyl(2 mg kg-1) iv, rocuronium 0.6mg kg-1
Tulgar 40(20/20) 2018 (2)	Hip and proximal femur surgery	II-II	Aged 18-65 years	Ultrasound-guided ESPB at T9 vertebrae level with 20 ml bupivacaine 0.5%, 10 ml lidocaine 2%,	Underwent the same procedure but had no block	Propofol 2-3mg/kg, fentanyl 100 µg and rocuronium bromide 0.6 mg/kg.
Singh 40(20/20) 2019 (1)	Elective lumbar spine surgery	II-II	18-65 years of age	Ultrasound (US)-guided ESPB with total 20 ml 0.5% bupivacaine at the T10 vertebral level	Received no intervention	Propofol 2 to 3 mg/kg, morphine 0.1 mg/kg and vecuronium 0.1 mg/kg
Gürkan 50(25/25) 2019	Elective unilateral breast surgery	II-II	Aged 18-65 years	Ultrasound (US) guided ESP block with 20 ml 0.25% bupivacaine at the T4 vertebral level	Received no intervention	Propofol (2-3 mg kg-1 ) and fentanyl (2 µg kg-1 ) iv and rocuronium 0.6 mg kg-1
Singh 40(20/20) 2019 (2)	Modified radical mastectomy	II-II	Female patients between 20-55 years	Ultrasound (US)-guided ESP block with total 20 ml 0.5% bupivacaine at the T5 vertebral level	Received no intervention	Propofol 2-3 mg kg-1 , morphine 0.1 mg kg-1 and vecuronium 0.1 mg kg-1
Aksu 46(23/23) 2019 (1)	Laparoscopic Cholecystectomy	II-II	20-75 years of age	Ultrasound (US) guided ESP block with 20 ml	Received no intervention	Propofol (2-3 mg kg-1) and fentanyl (2 mg kg-1) iv

					0.25% bupivacaine at the T5-6 vertebral level		and Rocuronium (0.6 mg kg-1)IV
Ciftci 2019	60(30/30)	Video-Assisted Thoracic surgery	□-□	18-65 years of age	Ultrasound guided Bilateral ESP block with 20ml of 0.375% bupivacaine at the T5 vertebral level	Received no intervention	Propofol (2-2.5 mg/kg) and fentanyl (1-1.5 mg/kg) and rocuronium bromide (0.6mg/kg)
Ciftci 2019	60(30/30)	Video-Assisted Thoracic surgery	□-□	18-65 years of age	Ultrasound guided Bilateral ESP block with 20ml of 0.375% bupivacaine at the T5 vertebral level	Received no intervention	Propofol (2-2.5 mg/kg) and fentanyl (1-1.5 mg/kg) and rocuronium bromide (0.6mg/kg)
Yayik 2019	60(30/30)	Lumbar Spinal Decompression Surgery	□-□	18-65 years of age	Ultrasound guided Bilateral ESP block with 0.25% bupivacaine 20 mL at the L3 vertebral level	No intervention was performed	2 mg/kg IV propofol 0.6 mg/kg IV rocuronium and 2 mcg/kg IV fentanyl
Hamed 2019	60(30/30)	Abdominal hysterectomy	□-□	Women aged 40-70 years old and weighed 50-90 kg	Ultrasound-guided ESPB at T9 vertebrae level with 20 ml bupivacaine 0.5%.	Underwent the same procedure but had a sham injection (20 ml of saline)	Fentanyl 2 mcg.kg-1 and propofol 2 mg.kg1, followed by atracurium 0.5 mg.kg-1
AKSU 2019 (2)	50(25/25)	elective breast surgery	□-□	Aged between 25 and 70 years	Ultrasound-guided ESPB between T2 and T4 with 10 ml of 0.25% bupivacaine	No intervention was performed	Propofol (2-3 mg/kg) and fentanyl (2 mg/kg) iv and Rocuronium 0.6 mg/kg was administered iv

**Table2:** Outcome data of RCTs included in the meta-analysis.

Outcome	Studies include	RR or Std.mean [95%CI]	P-value for statistical significance	P-value for heterogeneity	I <sup>2</sup> test for heterogeneity
Opioid consumption in the first 24 hour(mg)	12	-2.18[-2.76,-1.61]	<0.00001	<0.00001	87%
VAS/NRS scores at the 1st hour	6	-0.80[-1.54,-0.06]	0.03	<0.00001	88%
VAS/NRS scores at the 6th hour	8	-0.64[-0.99,-0.30]	0.0003	0.03	58%
VAS/NRS scores at the 12th hour	6	-0.16[-0.66,0.33]	0.51	0.0008	76%
VAS/NRS scores at the 24th hour	8	-0.83[-1.78,0.12]	0.09	0.00001	94%
Rescue analgesia requirement(n)	7	0.41[0.25,0.66]	0.0002	0.006	67%
Time to first rescue analgesic(min)	3	4.56[1.89,7.22]	0.0008	0.00001	95%
POVN( postoperative nausea and vomiting )	9	0.45[0.20,1.00]	0.05	<0.00001	84%

## Figures



**Figure 1**

PRISMA flow diagram showing literature search results.

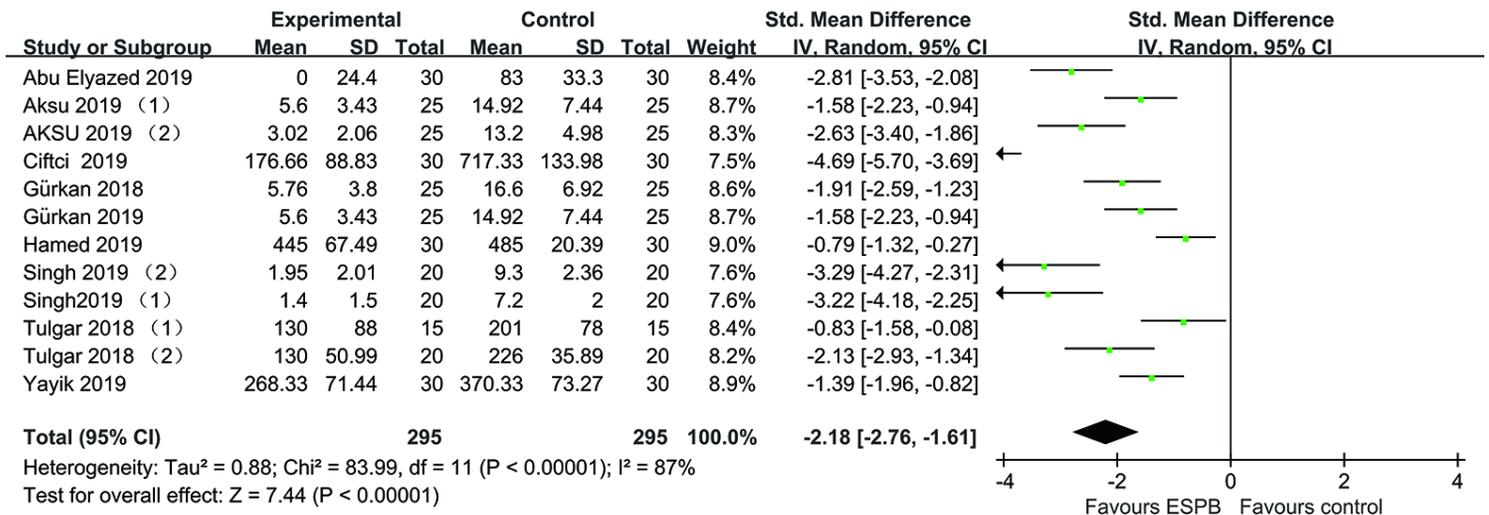


Figure 2

Forest plots of morphine consumption 24 hour after surgery.

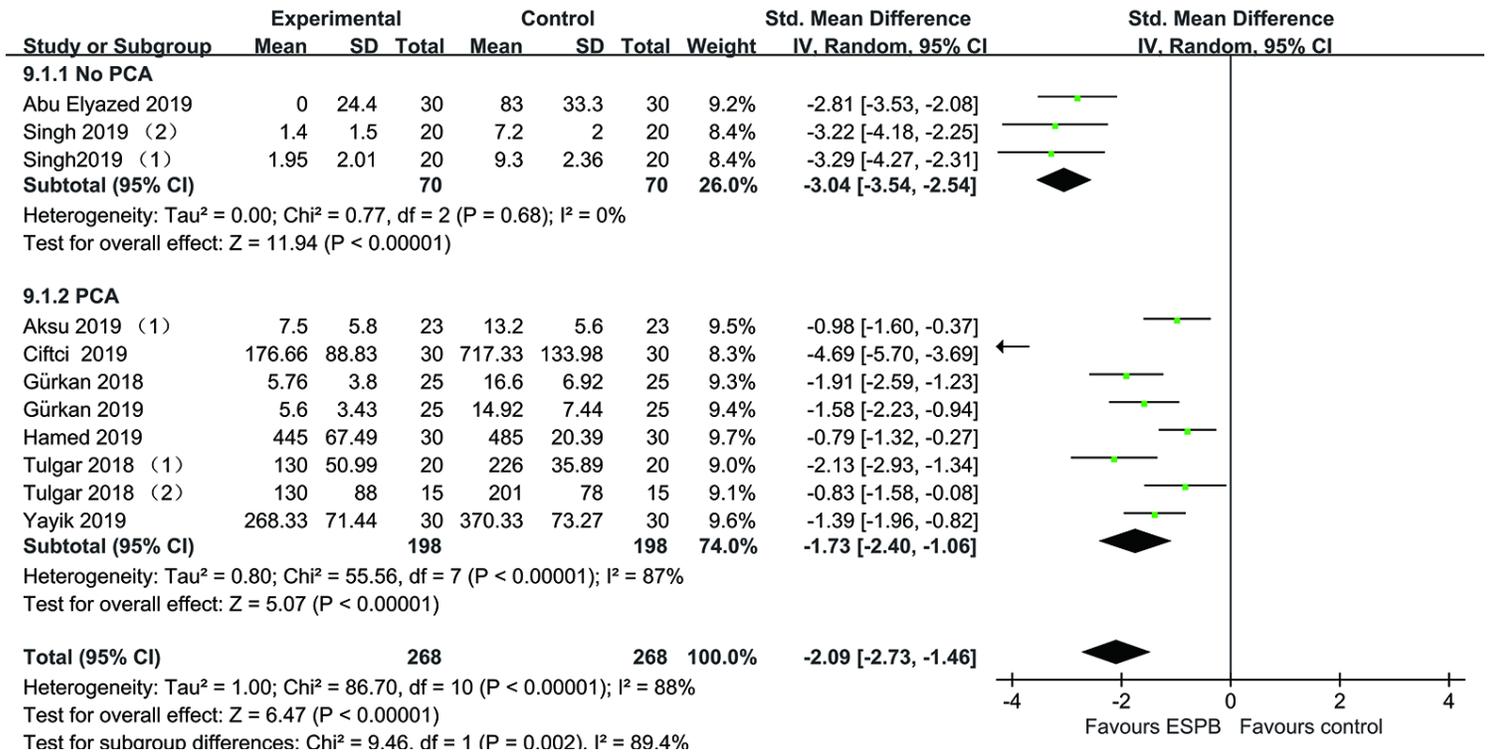


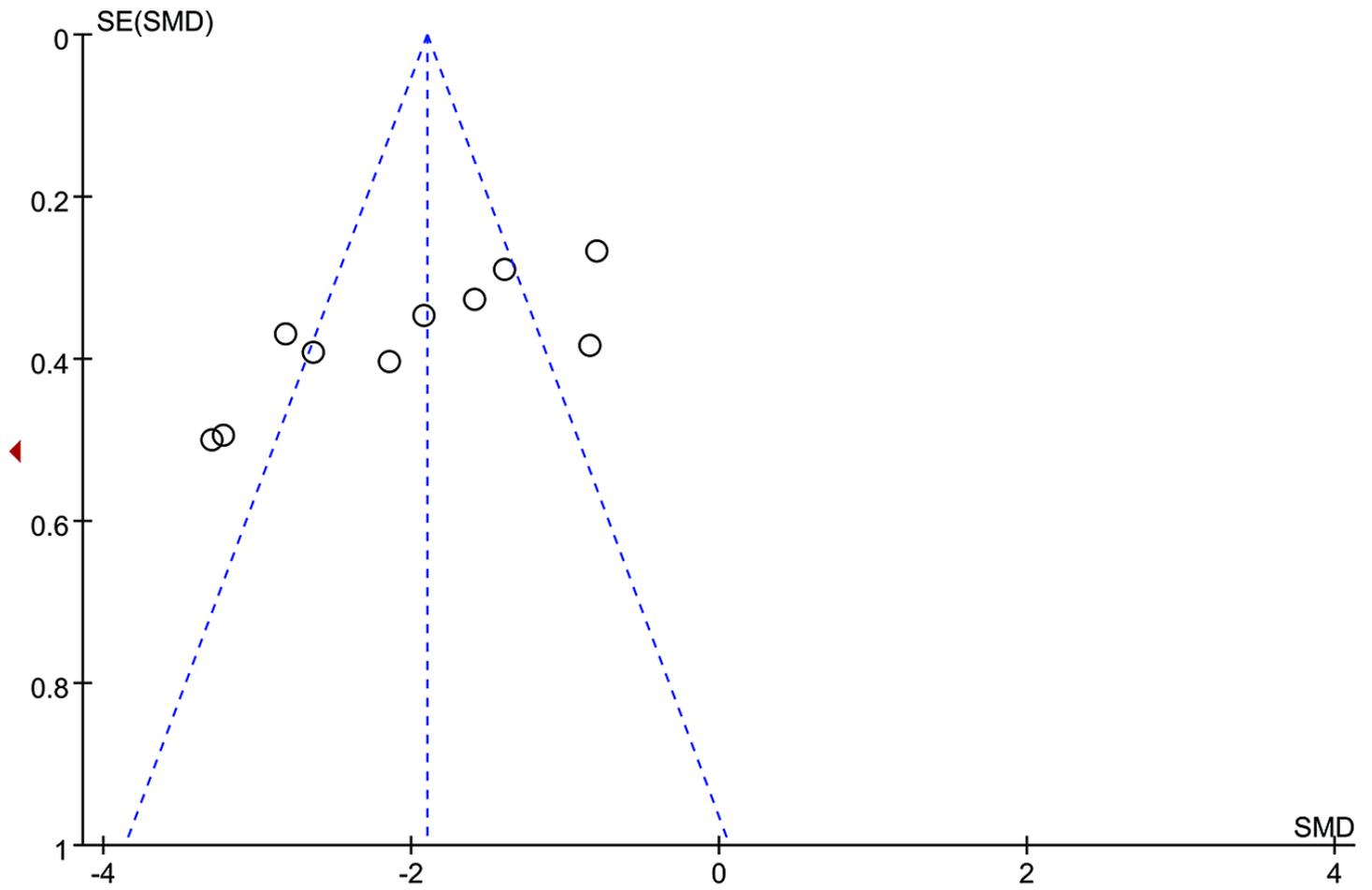
Figure 3

Forest plots of subgroup analysis.

	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Other bias
Abu Elyazed 2019	+	+	+	+	?	+	+
Aksu 2019 (1)	+	+	?	+	+	+	+
AKSU 2019 (2)	+	?	?	+	+	+	+
Ciftci 2019	+	?	+	+	+	+	+
Gürkan 2018	+	?	?	+	+	+	+
Gürkan 2019	+	+	+	+	+	+	+
Hamed 2019	+	+	+	+	+	+	+
Singh2019 (1)	+	?	+	+	+	+	+
Singh 2019 (2)	+	?	+	+	+	+	+
Tulgar 2018 (1)	+	+	+	+	+	+	+
Tulgar 2018 (2)	+	+	+	+	+	+	+
Yayik 2019	?	?	?	+	+	+	+

Figure 4

Risk of bias.



**Figure 5**

Funnel plot evaluating publication bias.

## Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [PRISMAchecklist.doc](#)