

# Letter to the Editor: “Which is the Best Timing for Ultrasound-Guided Transversus Abdominis Plane Block During Laparoscopic Cholecystectomy: Preoperative or Postoperative?”

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## Dear Editor,

I have read with great interest the article titled “Which is the Best Timing for Ultrasound-Guided Transversus Abdominis Plane Block During Laparoscopic Cholecystectomy: Preoperative or Postoperative?” (1). While the study addresses a relevant clinical question, I note certain methodological limitations, particularly its retrospective nature.

First, standardization of the transversus abdominis plane (TAP) block technique is critical. The literature suggests varying success rates for subcostal, lateral, and posterior approaches in controlling somatic pain after laparoscopic cholecystectomy. For upper abdominal procedures, the subcostal approach is often superior due to higher dermatomal coverage (2). In a retrospective dataset, ensuring that blocks in both groups were performed using identical techniques or anatomical levels is difficult (3). Since technical inconsistencies—rather than timing—could drive the outcomes, the authors should clarify how they standardized these variations and accounted for the performing clinicians’ experience levels.

Secondly, the reliability of retrospective visual analog scale (VAS) scores and analgesic consumption data is often compromised. In the postoperative group, performing the block at the end of surgery influences initial post-anesthesia care unit scores. However, the “pre-emptive analgesia” potential of a preoperative block—its ability to prevent central sensitization—should be evaluated through total 24-hour opioid consumption and the incidence of chronic pain rather than static, early-phase VAS scores (4). The absence of long-term cumulative data weakens the conclusion regarding optimal timing.

If the observed analgesic benefit is confined to the first postoperative hour, the clinical significance of this finding remains debatable. This transient effect may reflect the pharmacokinetic profile of the local anesthetic or the surgery’s duration rather than a sustainable clinical advantage. Furthermore, the authors reported significantly lower intraoperative

remifentanil consumption in the preoperative group. While this finding suggests a potential blunting of the surgical stress response, it remains unclear how intraoperative analgesia was titrated. Were objective measures, such as the Bispectral index or other nociception monitoring tools, utilized to standardize remifentanil administration? Clarifying whether this reduction was a direct result of the block’s efficacy or was influenced by the clinician’s subjective assessment of anesthetic depth would enhance the clinical relevance of these findings.

The observation that the statistically significant difference in pain scores was confined to the first postoperative hour significantly challenges the clinical relevance of the findings. Rather than demonstrating true superiority of preoperative timing, this transient effect may simply reflect the pharmacokinetic profile of the local anesthetic or the total duration of surgery. If the surgery outlasts the peak effect of a preoperative block, the perceived advantage in the immediate recovery phase becomes a matter of timing rather than a sustainable “pre-emptive” benefit. It is essential to question whether such a short-lived difference translates into meaningful clinical outcomes, such as reduced total 24-hour opioid consumption or accelerated functional recovery.

While this study offers a perspective on the timing of TAP blocks in clinical practice, its retrospective nature necessitates support from prospective, randomized controlled trials. I believe that it would be prudent for readers to consider these limitations when integrating these data into their clinical protocols. The insights from the authors and the editorial board on these matters would be valuable to clinicians aiming to optimize patient recovery.

## Footnotes

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