

Comments on “Postoperative Analgesic Efficacy of Modified-Thoracoabdominal Nerves Block Through Perichondrial Approach and Transversus Abdominis Plane Block in Patients Undergoing Open Hysterectomy with Bilateral Salpingo-Oophorectomy”

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Dear Editor,

I read with great interest the recent article by Balcı et al. (1), published in the *Van Medical Journal*, which compared the postoperative analgesic efficacy of the modified thoracoabdominal nerves block through perichondrial approach (M-TAPA) and the transversus abdominis plane (TAP) block in patients undergoing open hysterectomy with bilateral salpingo-oophorectomy. The study adds valuable data to the still-limited literature comparing these two regional techniques. However, several methodological issues merit further consideration. First, the study was conducted with an open-label design. Both patients and clinicians were aware of the assigned interventions, which introduces the potential for measurement bias in patient-reported outcomes such as numerical rating scale (NRS) pain scores. Expectancy and psychological influences are known to affect subjective pain ratings, especially when participants know which technique they received (2). In a study relying heavily on subjective assessments, even minimal bias may alter the results. Future investigations would benefit from a single- or double-blinded design, where the assessor and ideally the patient remain unaware of the allocated intervention. Second, the sample size was relatively small, including only 15 patients per group. Although the authors conducted a power analysis, the assumed effect size ($d = 1.34$) appears unusually high for clinical pain studies (3). Such an optimistic estimate increases the risk that the study is potentially underpowered, leading to a Type II error by failing to detect a true difference between the two blocks if the actual effect

size is more modest. Third, all participants received a strong multimodal analgesic regimen consisting of paracetamol, dexketoprofen, and ibuprofen, in addition to intraoperative opioids. While this is clinically appropriate, it may have created a “ceiling effect” that masked potential distinctions between M-TAPA and TAP (4). When systemic analgesia is already optimal, additional regional techniques may appear equivalent simply because there is little room for further improvement in pain scores. Studies designed with standardized but less potent background analgesia could better reveal the real contribution of each block. Finally, the authors used the Kruskal–Wallis test to compare outcomes. Since the original study included three groups—M-TAPA, TAP, and a control group—post-hoc pairwise analyses are necessary to determine exactly which groups differ (5). Without these follow-up comparisons, it remains unclear between which specific groups the statistically significant results occurred. In summary, this work contributes important preliminary data on the comparative analgesic effects of M-TAPA and TAP blocks in open gynecologic surgery. Future randomized trials with blinded assessments, more conservative power calculations, less potent background analgesic regimens, and complete statistical reporting would provide more definitive conclusions.

Sincerely,

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