TURKISH JOURNAL OF EMERGENCY MEDICINE

Letter to Editor

Access this article online

Quick Response Code:

Website: https://journals.lww.com/TJEM

DOI: 10.4103/tjem.tjem_434_25

Correspondence: Comment on "Efficacy of erector spinae plane block versus intravenous tramadol for pain management in acute pancreatitis"

Swetha Ramesh*, V. T. Amrithanand

Department of Emergency Medicine, Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry, India
**Corresponding author*

We read with great interest the article by Priyanka *et al*., comparing the erector spinae plane block (ESPB) with intravenous tramadol for acute pancreatitis (AP) pain in the emergency department.[1] The authors are to be commended for exploring a significant and clinically relevant question in the acute care of AP, particularly the search for opioid-sparing analgesic strategies.

However, in the interest of methodological clarity and alignment with the CONSORT 2025 reporting standards, further details on a few aspects of trial conduct would benefit readers and enhance reproducibility.[2] It would be helpful if the authors specify the exact method of randomization (item 17b) used (e.g., simple, block, or stratified) and, if block randomization was applied, the block size and whether any stratification factors were incorporated. Clarification regarding allocation concealment (Item 18), such as the procedures used to ensure concealment (e.g., sequentially numbered opaque sealed envelopes, centralized assignment, or third-party allocation), would allow better assessment of selection bias control. It would be beneficial to elaborate on whether consecutive or convenience sampling was used, as well as who was responsible for screening and enrolling patients (treating clinicians, independent research personnel, or designated study staff). Providing these details in accordance with CONSORT 2025 would enhance transparency, improve interpretability, and facilitate the replication of this important work.

In the Methods section, the authors report a *post hoc* power analysis using G*Power, showing 98.7% power (Cohen's d = 0.847). While this appears impressive, *post hoc* power does not confirm that a study was adequately powered. Once results are known, the observed effect size and *P* value already convey the statistical strength, and recalculating power simply restates these findings. The CONSORT 2025 Explanation and Elaboration document advises that such *post hoc* calculations add no value and may mislead readers (Item 16a).[2] Proper sample size justification should instead be performed *a priori*, before recruitment, based on expected effect, variability, and desired power. Clarification on whether an *a priori* calculation was conducted would help assess the study's methodological rigor.

Although the authors report that rescue fentanyl (1 μg/kg) was administered for persistent Numerical Rating Scale (NRS) ≥4 after 1 h, further clarification regarding

How to cite this article: Ramesh S, Amrithanand VT. Correspondence: Comment on "Efficacy of erector spinae plane block versus intravenous tramadol for pain management in acute pancreatitis". Turk J Emerg Med 2026;26:156-7.

Submitted: 05-11-2025
Revised: 05-02-2026
Accepted: 07-02-2026
Published: 03-04-2026

ORCID:
SR: 0000-0001-8489-7473
VTA: 0000-0002-6410-2896

Address for correspondence:
Dr. Swetha Ramesh, Department of Emergency Medicine, Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry, India.
E-mail: swetharamesh710@gmail.com

the operational implementation of this protocol would enhance interpretability. Specifically, it would be helpful to clarify who assessed the NRS scores, how frequently pain assessments were performed, and whether the decision to administer rescue analgesia was standardized and protocol-driven across patients and study arms or left to individual clinician discretion.

The analysis reports the use of independent sample *t*-tests to compare pain scores between groups at multiple time points; however, since repeated measurements were obtained from the same patients, a repeated-measures ANOVA or mixed-effects model would have been more appropriate to account for within-subject correlations and temporal effects. Using multiple independent *t*-tests may inflate the risk of Type I error and could overstate statistical significance, potentially affecting the interpretation of changes in pain scores over time. Although pain scores at 12 and 16 h remained statistically lower in the ESP group, the corresponding confidence intervals (0.46–1.13 and 0.37–1.02, respectively) approach or cross commonly cited thresholds for clinical relevance, generally considered to be at least 1 point and conventionally taken as 2 points on the NRS.[3,4] As such, while these later differences are statistically significant, their clinical meaningfulness from the patient's perspective may be debatable.

However, it is also important to interpret these findings within the context of the overall analgesic profile observed in the study. The ESP group demonstrated pronounced and clinically meaningful reductions in pain scores during the first 8 h (at 1, 4, and 8 h), a period during which pain is typically most severe in AP and effective analgesia is particularly critical. These early benefits should not be disregarded. Given that pain intensity ratings represent a patient-reported outcome reflecting the patient's direct experience of treatment, clarification from the authors on how they balance early robust analgesic effects against later, potentially marginal clinical differences would help contextualize the clinical relevance of their findings beyond statistical significance alone.[5]

Finally, regarding the conclusion that the ESPB group was "hemodynamically stable," further clarification would be helpful. Although the ESPB group demonstrated lower heart rate and mean arterial pressure values in the 1st h after the intervention, there is no data indicating hemodynamic instability in the control group to justify a comparative claim of greater stability. Moreover, hemodynamic parameters were reported only for the 1st h, which may be insufficient to establish hemodynamic stability in patients with AP, where changes often evolve over several hours.

In this context, a more precise interpretation may be that ESPB did not adversely affect early hemodynamic parameters or that it was effective in preserving early hemodynamic status, rather than implying a broader or comparative hemodynamic stability. Such wording would more accurately reflect the presented data and avoid potential misinterpretation in the absence of predefined criteria for instability or longer-term hemodynamic assessment.

Author contributions statement

Dr. Swetha Ramesh: Conceptualization (lead); Writing – original draft (equal). Dr. Amritanand VT: Supervision (lead); Writing–review and editing (equal).

Conflicts of interest

None Declared.

Funding

None.

References

1. Priyanka VN, Joshi SR, Asif MS, Shincy S. Efficacy of erector spinae plane block versus intravenous tramadol for pain management in acute pancreatitis: A randomized controlled study. Turk J Emerg Med 2025;25:273-9.
2. Hopewell S, Chan A, Collins G S, Hróbjartsson A, Moher D, Schulz KF, *et al*. CONSORT 2025 explanation and elaboration: Updated guideline for reporting randomised trials. BMJ 2025;389:e081124. Available from: https://www.bmj.com/content/389/bmj-2024-081124. [Last accessed on 2025 Oct 27].
3. David SN, Murali V, Kattumala PD, Abhilash KP, Thomas A, Chowdury SD, *et al*. EASIER trial (Erector-spinAe analgeSia for hepatopancreaticobiliary pain In the Emergency Room): A single-centre open-label cohort-based randomised controlled trial analysing the efficacy of the ultrasound-guided erector-spinae plane block compared with intravenous morphine in the treatment of acute hepatopancreaticobiliary pain in the emergency department. Emerg Med J 2024;41:588-94.
4. Ramesh S, Ayyan SM, Rath DP, Sadanandan DM. Efficacy and safety of ultrasound-guided erector spinae plane block compared to sham procedure in adult patients with rib fractures presenting to the emergency department: A randomized controlled trial. Acad Emerg Med 2024;31:316-25.
5. Weldring T, Smith SM. Patient-reported outcomes (PROs) and patient-reported outcome measures (PROMs). Health Serv Insights 2013;6:61-8.