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# Clarifications on: Pectoralis Blocks Nomenclature and Clinical Applications of Regional Anesthesia Techniques for Breast and Thorax

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### To The Editor:

I read with great interest the recently published case series applying pectoralis blocks (Pecs blocks) for infective breast conditions.<sup>1</sup> I greatly commend Brewer et al for employing pecs blocks in the emergency department (ED) and hope many emergency physicians will adopt the interfascial plane blocks introduced in the last decade. I wish to provide a few clarifications regarding them.

Regarding nomenclature, the authors used the term “Pecs I and Pecs II”<sup>1</sup> and attributed it to a “lack of consensus” and cited our article to support that.<sup>2</sup> However, we categorically stated that it is incorrect to use that term (despite weak consensus); hence, I am surprised that Brewer et al used it throughout their article. I reiterate that stating “Pecs II block” (modified pecs block) itself is enough, as it is a combination of the Pecs I block (ie, interpectoral plane (IPP) block) and the pectoroserratus plane (PSP) block. To make it simple, we must use the term either pecs II or IPP+PSP blocks. Otherwise, it defeats the very purpose of the suggestion of nomenclatures by the experts.<sup>3</sup>

Regarding the choice of the block, we must pay careful attention to the sensory coverage of each block. For instance, in my view the IPP block is not required for drainage of breast abscess as it provides only relief from myofascial pain due to the disruption of pectoral muscles and does not block the thoracic nerves that are involved in the sensory innervation of the breast.<sup>4</sup> Also, there is a potential possibility of the presence of infection at the needle entry, precluding an IPP block in some cases. As infective conditions of the breast involve mainly the skin and subcutaneous tissues, either PSP block alone or its equivalent in sensory coverage, a serratus anterior plane (SAP) block, would be adequate. Of note, the SAP block is

technically easier to perform compared to the PSP block. Also, the site of needle entry would be farther away from the infected tissues. Alternatively, I suggest a modification of the pecs block (“Pecs Zero”) introduced by Tulgar et al wherein the needle entry would be above the clavicle.<sup>5</sup>

Recently, the erector spinae plane (ESP) block has gained popularity as a promising technique for pain relief in the ED setting for various conditions.<sup>6</sup> This block requires less expertise and time when compared to other fascial plane blocks. While Pecs blocks and the SAP block can be performed in the supine position, the ESP block requires a position other than supine such as sitting, lateral recumbent, or prone.

The authors attest that their institution requires neither Institutional Review Board approval, nor patient consent for publication of this letter to the editor. Documentation on file.

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