We appreciate the interest and critical evaluation by the authors of the recent letter by Xue and colleagues, titled “Assessing Opioid-Sparing Analgesic Efficacy of Continuous Bilateral Parasternal Plane Blocks After Cardiac Surgery Via Median Sternotomy,” regarding our study on the efficacy of continuous bilateral ultrasound-guided parasternal plane blocks (PSBS) in opioid-naïve patients undergoing cardiac surgery via median sternotomy. We welcome the opportunity to address their thoughtful comments and concerns.

The authors of the letter appropriately point out that the net between-group difference in maximum and mean numeric rating scale (NRS) score was less than the recommended minimal clinically important difference of 1.5 NRS score reduction. We acknowledge this observation and agree that assessing moderate-to-severe postoperative pain and patient satisfaction would provide a more comprehensive evaluation of the clinical significance of our findings. We intend to explore these aspects in future studies to better understand the impact of PSBP on postoperative pain control and patient-reported outcomes. The maximum and mean NRS scores on each postoperative day were notably reduced in patients who received PSBP compared with the control group in our study.

Regarding the oral morphine milligram equivalents of opioid consumption, the authors correctly note that the absolute reduction did not meet the recommended minimal clinically important difference of 10 mg of intravenous morphine in 24 hours. We acknowledge this limitation and recognize that the opioid-sparing effect of PSBP in our study may have been relatively modest. We appreciate the importance of assessing the cost–benefit ratio and clinical relevance of interventions and will consider these factors in future research endeavors. It is worth emphasizing that this small, yet significant, difference did translate into a number of patients who did not need opioids postoperatively in the block group.

Furthermore, the authors highlight the lack of significant difference in intensive care unit and hospital stays between our study groups. We acknowledge these findings and agree that the ultimate goal of enhanced recovery protocols is to facilitate rapid postoperative recovery. However, the study quoted in your response specifically focused on patients undergoing robotic-assisted mitral valve repair and, therefore, are not directly applicable to our study population. Our study focused on pain control and opioid consumption after median sternotomy, and future research should explore whether PSBP contributes to improved recovery endpoints.

In conclusion, we are grateful for the insightful comments and suggestions provided by the authors of the letter. Their feedback reinforces the importance of comprehensive research and thoughtful interpretation of results. We look forward to further investigating the role of PSBP in optimizing postoperative pain management and recovery in patients who undergo cardiac surgery and addressing the valid concerns raised in this letter.

Conflict of Interest Statement
T.K. is a speaker for Edwards Life Sciences, Medtronic, and Abbott. All other authors reported no conflicts of interest.

The Journal policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

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