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Author Reply to "Regarding 'Preoperative Quadratus Lumborum Block Reduces Opioid Requirements in the Immediate Postoperative Period Following Hip Arthroscopy: A Randomized, Blinded Clinical Trial'"

We thank Dr. Li et al. for their letter[1] regarding our publication.[2] During the design of a randomized clinical trial, defining what constitutes a minimal clinically importance difference (MCID) for opioid reduction is not always straightforward as opioid consumption may be influenced by gender, body mass index, preoperative pain, genetics, and metabolism.[3] Although there is very little data to determine the MCID for many outcomes,[4] including opioid consumption,[3] 28% recurs frequently. As an example, a recent publication that aimed to determine the MCID for morphine milligram equivalents (MMEs) in patients with failed back surgery syndrome concluded the MCID was 28.2% for MMEs.[5] Similarly, in a widely respected and frequently cited investigation, Farrar et al. concluded that a decrease in pain greater than or equal to 28% was clinically significant.[6] Thus, we chose to power for a 30% opioid reduction based on a quality review of the perioperative care for 10 hip arthroscopy patients. Notably, postoperative opioid consumption was reduced 28.3% in the block group in our study.[2] Additionally, while an absolute decrease of 10 mg intravenous morphine over 24 hours (~2.4 mg/hour) was recently proposed as a clinician-perceived MCID estimate for lower extremity arthroplasty,[7] our data and postoperative opioid consumption were only collected over approximately 1.5 hours (~2.1 mg/hour). Last, Dr. Li et al. suggest that our patients may have had inadequate pain relief as their VAS scores were greater than 30 on discharge. All patients were provided opioids in recovery until they determined that their pain control was adequate for home discharge; only then did they make their final pain rating. Although we excluded patients taking opioids for more than 3 months preoperatively, most of our patients had preoperative pain, were already taking multimodal analgesics, including opioids, and reported pain scores exceeding 30 in the preoperative holding area prior to surgery. Therefore, after an extensive operative procedure and repair, it is not unreasonable to expect their pain to be greater at discharge than on arrival.

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Note: Full ICMJE author disclosure forms are available for this article online, as supplementary material.

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