

reference	participants' characteristics	intervention group/ control group	outcomes	critical appraisal/ conclusion																
<p><a href="#">Hotta et al. 2011</a> Comparison of the analgesic effects of continuous extrapleural block and continuous epidural block after video-assisted thoracoscopic surgery. J Cardiothorac Vasc Anesth. 2011;25(6):1009-13.</p>	<p><b>inclusion criteria</b> - age 20–85 yrs - ASA physical status I–II</p> <p><b>exclusion criteria</b> - coagulopathies - contraindication for morphine, NSAIDs, and local anaesthetics</p> <p><b>demographic data:</b> group EX group EP age (yrs) 64 (40–80) 69 (42–84) sex (m/f) 10/10 10/10 height (cm) 160 (146–178) 156 (145–169) weight (kg) 54 (45–79) 54 (42–80)</p> <p><b>patient flow and follow up:</b> <u>total patient number included:</u> 48 <u>randomised in:</u> group EX: 24 group EP: 24 <u>excluded:</u> group EX: 4 group EP: 4 <u>analysed:</u> group EX: 20 group EP: 20 <u>follow-up:</u> 4, 12, 24, 36, 48 h postop</p>	<p><b>mode of anaesthesia</b> - remifentanyl</p> <p><b>surgical approach</b> - VATS</p> <p><b>at the end of surgery</b> <u>- group EX:</u> - bolus 5 mL of 0.75% ropivacaine on placement of catheter - bolus 5 mL of 0.75% ropivacaine at the end of surgery - continuous infusion of 0.2% ropivacaine at 4 mL/h for 60 h <u>- group EP:</u> - bolus 5 mL of 0.75% ropivacaine through the epidural catheter - bolus 5 mL of 0.75% ropivacaine at the end of surgery - continuous infusion of 0.2% ropivacaine at 4 mL/h started at the end of surgery for 60 h</p> <p><b>supplemental analgesia</b> - IV 0.1 mg/kg morphine + 50 mg flurbiprofen at chest closure - IV flurbiprofen or oral loxoprofen given on demand 8 hly</p> <p><b>postoperative analgesia</b> - IV-PCA with bolus 1 mg morphine, 10 min lo</p>	<p><b>postoperative pain [VAS]:</b> - there were no significant differences in VAS pain score, both at rest and on movement, between the 2 groups</p> <p><b>dosage of morphine [mg]: mean±SD</b></p> <table border="1"> <thead> <tr> <th></th> <th>group EX</th> <th>group EP</th> <th>p</th> </tr> </thead> <tbody> <tr> <td>0-24 h</td> <td>9.4±8.2</td> <td>8.0±5.8</td> <td>0.68</td> </tr> <tr> <td>24-48 h</td> <td>3.9±5.7</td> <td>2.2±3.0</td> <td>0.81</td> </tr> <tr> <td>Total</td> <td>12.9±11.3</td> <td>10.2±6.9</td> <td>0.82</td> </tr> </tbody> </table> <p><b>additional outcomes</b> NSAIDs (n) 3 (1.25–3.00) 2 (1.00–3.75) 0.73 ambulation on POD 1 (n) 18 19 1.00 ambulation on POD 2 (n) 20 20 1.00 hospital stay after surgery (d) 12.7±6.3 12.6±4.7 0.66</p> <p><b>adverse effects/ events (n)</b> nausea 12 11 p=1.0 vomiting 5 7 p=0.73</p>		group EX	group EP	p	0-24 h	9.4±8.2	8.0±5.8	0.68	24-48 h	3.9±5.7	2.2±3.0	0.81	Total	12.9±11.3	10.2±6.9	0.82	<p><b>methodological shortcomings</b> - the study did not include a placebo control group - the authors only studied the effect of local anaesthetic infusion in the epidural group - the investigators in the study were not blinded to the procedure used - not reported how the allocation sequence was generated, who implemented it, enrolled participants, and assigned the participants to their groups - dates defining the period of recruitment and follow-up not reported</p> <p><b>level of evidence: 1</b> <b>authors' conclusion</b> "this study did not show the superiority of continuous extrapleural block relative to continuous epidural block in VATS patients"</p>
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<p><a href="#">Kanazi et al. 2012</a> Subpleural block is less effective than thoracic epidural</p>	<p><b>inclusion criteria</b> - posterolateral thoracotomy for lung cancer</p> <p><b>exclusion criteria</b></p>	<p><b>intervention prior to anaesthesia</b> - midazolam 2 mg + glycopyrronium 0.2 mg</p>	<p><b>postoperative pain [VAS]:</b> - group SP had higher VAS at rest and on coughing than group TEA at all time points</p> <p><b>hypotension in first 6 h(n)</b></p>	<p><b>methodological shortcomings</b> - not reported who generated and implemented the random allocation sequence, who enrolled participants,</p>																

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<p>analgesia for post-thoracotomy pain: a randomised controlled study</p> <p>Eur J Anaesthesiol. 2012 Apr;29(4):186-91.</p>	<p>- ASA physical status <math>\geq</math>IV  - previous history of thoracotomy  - taking chronic pain medication  - a contraindication to receiving local anaesthetics or thoracic epidural block</p> <p><b>demographic data:</b>  group SP group TEA  age (yrs)  60 (12) 58 (18)  sex (m/f)  15/6 14/7  weight (kg)  85 (18) 80 (19)  height (cm)  172 (7) 169 (9)</p> <p><b>patient flow and follow up:</b>  <u>total patient number included:</u>  42  <u>randomised in:</u>  group SP: 21  group TEA: 21  <u>excluded:</u>  0  <u>analysed:</u>  group SP: 21  group TEA: 21  <u>follow-up:</u>  - every 15 min for the first 2 h and then every 6 h for the next 24 h.</p>	<p><b>mode of anaesthesia</b>  - fentanyl</p> <p><b>surgical approach</b>  - posterolateral thoracotomy for lung cancer</p> <p><b>at the end of surgery</b>  - group SP: 0.125% bupivacaine + 5 mg/mL adrenaline via subpleural catheter  - group TEA: 10 mL of 0.125% bupivacaine + 5 mg/mL adrenaline via epidural catheter</p> <p><b>supplemental analgesia</b>  - IV 1 g paracetamol/6 h</p> <p><b>postoperative analgesia</b>  - continuous infusion of 0.125% bupivacaine at 8 mL/h for 24 h postop through either catheter</p>	<p>- group SP: 0  - group TEA: 5  - p=0.047</p> <p><b>adverse effects/ events: n (%)</b>  - sedation, nausea and vomiting scores were similar in both groups</p>	<p>and who assigned the participants to their groups</p> <p>- not reported whether the sequence was adequately concealed until interventions were assigned</p> <p><b>level of evidence: 1</b></p> <p><b>authors' conclusion</b>  "TEA is better than subpleural analgesia in providing pain relief at rest and during coughing for control of post-thoracotomy pain"</p>