LETTER TO THE EDITOR

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Opioid-free versus opioid-sparing anaesthesia: is regional anaesthesia the variable that matters?

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Dear Editor,

Danel *et al*. [1] provide a valuable review of opioid-sparing anaesthesia (OSA) and opioid-free anaesthesia (OFA). Their conclusion stated that clinical outcomes depend more on the quality of the perioperative pathway than on whether opioids are simply reduced or avoided. We agree with this conclusion; however, we believe it points to a gap the review does not fully address. Specifically, what dictates the quality of a perioperative pathway, and how would one test this claim?

The paper itself notes that OFA is defined inconsistently across studies. Some studies exclude only systemic opioids, while others also exclude neuraxial opioids, and many „opioid-free" protocols still allow rescue opioids after surgery [1]. Trials comparing OFA and OSA therefore compare studies that do not share a common definition.

Mistry and Nair [2], in a methodological critique of pooled OFA data, argue that this inconsistency may create apparent differences, or apparent equivalence, that reflect definitional variation rather than true clinical effect.

In our view, this is the central issue of the current debate. Research keeps asking whether opioids should be present or absent, when a more useful question may be what else is present, in particular whether regional anaesthesia is used. A recently published network meta-analysis addresses this directly [3]. It found that regional anaesthesia, more than opioid avoidance, was the main determinant of better pain control. Intraoperative opioids added little extra benefit once regional blocks were adequate. It also concluded that without regional anaesthesia, neither strategy consistently outperformed the other.

We therefore propose that future trials move away from randomising patients by opioid presence or absence, and instead stratify by regional anaesthesia adequacy, treating opioid strategy as a secondary variable. This would test the pathway-quality hypothesis that Danel *et al*. [1] themselves propose, and would answer calls elsewhere for clearer, more consistent OFA terminology before further pooled analyses are attempted [4].

Until then, comparisons between OSA and OFA may answer the wrong question.

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