Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Erector Spinae Plane and Transgluteal Sciatic Nerve Blocks for Low Back Pain and Sciatica in the Emergency Department

Peter Alsharif

peter.alsharif@gmail.com

Denver Health Medical Center

Alessandra Santiago

University of Colorado Anschutz Medical Campus

Spencer Seballos

Denver Health Medical Center

Meredith Meadows

University of Colorado Anschutz Medical Campus

Frederick Milgrim

Denver Health Medical Center

Nhu Nguyen Le

Denver Health Medical Center

Matthew Riscinti

Denver Health Medical Center

Joseph Brown

University of Colorado Anschutz Medical Campus

Research Article

Keywords:

Posted Date: June 5th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9794547/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Additional Declarations: No competing interests reported.

Abstract

Objectives:

Providing effective analgesia for patients with low back pain and sciatica in the emergency department (ED) is challenging, and existing medical therapies often provide incomplete relief. Ultrasound-guided regional analgesia techniques, including the erector spinae plane block (ESPB) and transgluteal sciatic nerve block (TGSNB), have emerged as potential treatments, though comparative data in the ED setting remain limited. This study aimed to evaluate the analgesic efficacy of ESPB in patients with and without sciatica, and to compare ESPB with TGSNB among patients presenting with back pain complicated by sciatica.

Methods:

In this retrospective cohort study we reviewed all ultrasound-guided nerve blocks (UGNBs) performed for back pain at two academic EDs in Denver from March 2022 to March 2025. Pain reduction at 30–60 minutes following the procedure was abstracted from standardized nerve block procedure notes and nursing documentation, recorded on a quartile scale. The primary outcome was the proportion of patients achieving ≥50% pain reduction. Comparisons were made between ESPB with versus without sciatica, and between ESPB and TGSNB among patients with sciatica, using chi-square testing.

Results:

Among 232 UGNBs performed for back pain, 139 were indicated for sciatica. In patients without sciatica, ESPB resulted in ≥50% pain reduction in 72% of cases. Among patients with sciatica, ESPB and TGSNB demonstrated similar rates of ≥50% pain reduction (68% vs 69%, respectively; p=0.57). No cases of local anesthetic systemic toxicity or clinically apparent peripheral nerve injury were identified.

Conclusion:

In this multicenter retrospective study, ultrasound-guided ESPB and TGSNB were both associated with substantial short-term pain reduction in ED patients with low-back pain and sciatica. For sciatica, ESPB and TGSNB demonstrated similar efficacy. These findings support the role of regional analgesia as a potential adjunctive strategy for managing back pain in the ED, while highlighting the need for prospective comparative trials.

Introduction

Low back pain (LBP) is a common complaint in the Emergency Department (ED) with an annual prevalence varying between 0.9%-17.1% among all ED visit reasons.[1] Sciatica is a form of lumbosacral radicular pain that may result when LBP is accompanied by pain radiating down the leg along the course of the sciatic nerve due to ectopic activation of the spinal nerve or its roots.[2] Annual incidence of sciatica ranges from 1–5% with an overall lifetime incidence of 13–40%.[3]

In the ED setting, the current treatment of acute sciatica includes a multimodal approach of non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, opioids, topical analgesics, muscle relaxants, benzodiazepines and systemic steroids.[4–6] The short-term efficacy of NSAIDs in reducing pain and disability among acute cases of LBP has been found to have a small statistical improvement over placebo, though NSAIDs and other existing therapies often fail to provide complete relief during acute episodes.[7–9] Additionally, among patients with non-operative management of acute LBP, leg pain and LBP recurred at a rate of 25% and 43% respectively within 1 year.[10,11]

The erector spinae plane block (ESPB) and transgluteal sciatic nerve block (TGSNB) have emerged as novel techniques for managing pain among patients with acute LBP and sciatica. Efficacy of the ESPB and TGSNB in post-operative sciatic pain settings has been documented, though evidence supporting efficacy in the ED is limited.[12–14] The purpose of this retrospective cohort study was to assess the degree of analgesia associated with the ESPB and TGSNB for patients presenting with LBP complicated by sciatica to the ED. We hypothesized that TGSNB would provide greater analgesia than ESPB in patients with sciatica, while ESPB efficacy would not differ based on the presence of sciatica.

Methods

Study Design

We conducted a retrospective review of ESPB and TGSNB ultrasound-guided nerve blocks performed for low back pain at the University of Colorado Anschutz Campus (CU) and Denver Health and Hospital Authority (DH) between April 2022 and March 2025. This time period was chosen to correspond with a new nerve block procedure note template that was generated in order to collect more granular data regarding patients undergoing ultrasound guided regional analgesia as part of the national registry of ultrasound guided nerve blocks (NURVE registry).[15,16] We sought to compare ESBP in patients with sciatica to those without sciatica in order to ascertain if sciatica influences the outcomes of this procedure. Among patients with sciatica we compared the efficacy of the ESPB and the TGSNB, in an attempt to identify which block may be more associated with greater pain reduction.

Inclusion and Exclusion Criteria, Subject Selection

All ESPBs and TGSNBsduring the time period were queried from the electronic health record (Epic Systems Corporation), with appropriate institutional review board oversight (IRB approval # 22–0048).[17] These cases were then manually reviewed by three research staff members. Any cases where the listed indication for the procedure was rib fracture were excluded from the analysis, and cases where low back pain was listed as an indication were subsequently included. Procedures with other listed indications (for example: knee pain) were excluded from analysis. Cases were dichotomized as back pain with sciatica or back pain without sciatica. Both adult and pediatric cases were included.

Primary Outcome

As part of the nerve block procedure note, clinicians documented the degree of pain reduction that patients experienced on a quartile scale (0 to 25%, 26 to 50%, 51 to 75%, or 76 to 100%) at 30 to 60 minutes after the procedure. This standard reassessment was made possible due to standard operating procedures at both institutions mandating cardiac monitoring and reevaluation for thirty minutes after large volume, fascial plane UGNBs. The primary outcome for this study was the percentage of patients who experienced a greater than 50% reduction in pain at 30–60 minutes after the procedure, according to the nerve block procedure note. This was chosen as it was thought to represent a clinically meaningful pain reduction. Quartile pain reduction scoring was done in line with standardized practice established by the NURVE block registry study team.[16] The comparisons performed were between patients who received the ESPB for back pain with sciatica to those without sciatica, as well as those who received the ESPB for back pain with sciatica to those who received the TGSNB for back pain with sciatica.

Secondary Outcomes

Beyond documentation in the nerve block procedure note, research staff members reviewed the electronic health record to identify potential complications of UGNBs in the selected cases, including local anesthetic toxicity, peripheral nerve injury, worsening pain scores, or allergic reaction. Aside from these a priori complications, research staff attempted to identify other possible complications not considered by our team before the outset of this study by qualitative semantic review of the medical records.

Other secondary outcomes evaluated included the dispositions (admission/transfer, observation, or discharge), ED length of stay (LOS) and overall hospital LOS. These times were calculated by review of the subject's hospital course timeline.

Covariate data including race, ethnicity, age, weight, and height (used to calculate BMI) were manually extracted from the subject's face sheet and vital sign flowsheets from the ED encounter.

Power Calculation

For this study, we analyzed a complete sample of cases during the time period and did not perform sample size calculations a priori. We did however consider a clinically important minimum detectable effect in the primary outcome between groups of 20%. Using an alpha value of 5%, a predicted 1:2 sampling ratio, and a projected sample size of about 200 cases. This would correspond to a power (beta) of 88%.

Statistical Analysis

All statistical analysis was performed by the primary researcher in IBM SPSS (Version 31), with figures generated in Microsoft Excel (Version 2510).[18,19] For the primary outcome, the degree of pain reduction was considered in a binary fashion of > 50% or </= 50% pain reduction. Chi-squared analysis was used to compare between groups (ESPB with vs without sciatica, and ESPB with sciatica vs TGSNB with sciatica), with a plan to use Fisher's exact test in the case of any individual group containing less than 5 subjects. Ultimately, all groups were larger than 5 subjects. A similar analysis was used to compare the dispositions between the two UGNBs. For other secondary outcomes of ED and hospital length of stay, we performed a natural log transformation of times a priori (in the units of minutes from ED triage) in order to adjust for naturally occurring rightward skew. This transformation was done in order to make the distribution of times normally distributed and acceptable for parametric testing.[20] We used independent T tests to compare these lengths of stay.

Finally, in order to identify putative covariant factors for differences in the primary outcome of pain reduction, we used multivariable logistic regression, using the variables of nerve block performed (ESPB or TGSNB), presence or absence of sciatica, institution (CU or DH), sex, race/ethnicity, age, and weight. We planned to combine categories with less than 5 subjects a-priori, in order to reduce degrees of freedom in the model and to address data singularities.

Results

Patients Included

During the study time period, providers performed 1003 UGNBs, with 360 at CU and 643 at DH. See Fig. 1. Erector spinae plane blocks represented 277 of these, with 190 performed for the indication of back pain (n = 93 without sciatica, n = 97 with sciatica). All 42 transgluteal sciatic nerve blocks were performed for the management of back pain with sciatica. Descriptive features of the included cases are summarized in Table 1. In patients with sciatica, we noted that the TGSNB was more commonly performed at CU, and the ESPB was more commonly performed at DH ($p < 0.001$). Otherwise, the baseline characteristics of included patients were similar.

Efficacy of Regional Analgesia in Sciatica

For cases where the UGNB was performed for back pain with sciatica, there was no significant difference in the proportion of patients reaching 50% pain reduction after ESPB (n = 66/97, 68%, 95CI: 58 to 77%) compared to TGSNB (n = 29/42, 69%, 95CI: 54 to 81%, p = 0.57). See Fig. 2.

Association of Sciatica with ESPB Efficacy

We calculated the percentage of patients reaching a 50% reduction in pain after the ESPB for back pain without concomitant sciatica. The degree of pain reduction in these patients (n = 67/93, 72%, 95CI 62 to 80%) was similar to that of patients who received the ESPB for back pain with sciatica (p = 0.41). See Fig. 2.

Disposition

Figure 3 summarizes the dispositions of patients who received the TGSNB or ESPB for back pain with, or without, sciatica. Patients without sciatica who received the ESPB were discharged in 83% of cases (n=77, 95CI: 74 to 89%). While those who received the ESPB for back pain with sciatica were discharged in 91% of cases (n=88, 95CI: 84 to 95%). There was no significant association between the presence of sciatica on distribution of patients that were admitted, observed, or discharged after ESPB (p=0.25). Patients who were treated for back pain with sciatica using the TGSNB were discharged in 81% of cases (n=34, 95CI: 67 to 91%). There was again no significant association between the procedure performed for sciatic back pain and the patient's disposition (p=0.27).

Length of Stay

We compared the length of stay in the emergency department as well as overall hospital length of stay in Fig. 4. Natural log transformation of these lengths of stay led to reduced and acceptable levels of skew for parametric testing (Table 2). For patients who received the ESPB, there was no association between the absence (mean: 308 min, 95CI: 270 to 351 min, IQR: 198 to 448 minutes), or presence of sciatica (mean: 344 min, 95CI: IQR: 298 to 398 min) on ED LOS (p = 0.26). However, the TGSNB was associated with a significantly shorter ED LOS when performed for sciatica (mean: 259 min, 95CI: 259 min, 95CI: 222 to 301 min, IQR: 198 to 310 min) when compared to patients who received the ESPB for sciatica (p < 0.01).

In terms of overall hospital length of stay, there was no significant difference between patients who received the ESPB for back pain with, or without, sciatica (with:without sciatica mean ratio = 1.0, 95CI: 0.8 to 1.3, p = 0.84) or in comparing patients who received the ESPB to the TGSNB for sciatica (ESPB:TGSNB mean ratio = 1.1, 95CI 0.7 to 1.1 p = 0.56).

Identification of Confounders

To identify confounding factors influencing the efficacy of UGNBs, we performed multivariable logistic regression along putative factors of patient age, gender, race, ethnicity and weight, as well as the institution where the procedure was performed. Post-hoc, race and ethnicity categories were consolidated due to data singularities. Patient height was not included due to a large proportion of cases missing this information from the data set. The overall fit of the model was poor, with pseudo R^2 values between 0.03 and 0.06.[21,22] Results of this analysis are summarized in Table 3. There was no statistically significant association of any of the parameters on the likelihood of 50% pain reduction.

Complications

By qualitative review of all included charts, two cases of potential complications were identified. In one patient who received an ESPB for back pain with sciatica, the procedure needed to be terminated early due to patient discomfort during the procedure. The patient was subsequently discharged 2 hours into his ED stay at his own request, with no change in his pain following the block. In another case, a patient

transiently experienced worsening pain during an ESPB for back pain without sciatica. A CT of the abdomen and pelvis showed fluid and air within the erector spinae muscles likely secondary to intramuscular injection during the procedure. This patient was admitted to the hospital for pain control and later discharged at 23 hours after initial presentation with improved pain after multimodal pain therapies. No cases of local anesthetic toxicity or peripheral nerve injury were identified.

Discussion & Limitations

Discussion

Our findings add to a limited but growing body of literature supporting ultrasound-guided regional analgesia for low back pain and sciatica in the emergency department

Prior studies of ESPB in the ED for lower back pain involved case series with three and six patients, respectively, as well as a randomized control trial with 19 patients randomized to ESPB.[5,23,24] Prior studies evaluating TGSNB in sciatica included a case series with four patients, and an observational study with 63 patients.[12,25] In our observational study, 277 patients received ESPB blocks for low back pain, the largest study of this modality for treatment of low back pain in the ED. Furthermore, this study involved 139 patients with sciatica, the largest study evaluating use of regional analgesia for sciatica in the ED setting, with 97 patients receiving ESPB and 42 undergoing TGSNB. Prior studies have identified a 1–7% risk of transient foot drop in TGSNB.[12,26] While this study did not identify any cases of clinically apparent peripheral nerve injury or LAST following either type of nerve block, suggesting the safety of these when performed by emergency clinicians, this study may have been underpowered to detect such complications.

Limitations

While our study was larger than prior studies evaluating UGNBs for back pain and sciatica, there are several limitations. First, while multi-center, these two centers are both within the same urban metropolitan area and resident physicians from the same emergency medicine program rotate at both sites. Second, this study was an observational study, and different distribution of blocks performed between sites may reflect individual physician faculty experience and comfort with certain types of nerve block. The institutions involved in this study have faculty involved with standardized education for regional analgesia in the ED setting, limiting generalizability of this study to other centers with less ultrasound-guided nerve block experience. Future multi-center studies with EDs in various practice settings could further evaluate how regional analgesia could be integrated into the treatment of low back pain given variations in ED workflows and provider experience with these ultrasound-guided nerve blocks.

A considerable limitation that was discovered in our research methodology was identified in performing initial data analyses of pain reduction after UGNB with the pain reporting tool in our block note. Our group had initially identified 50% as a clinically important pain reduction threshold, and thus built our

block note for providers to assess pain reduction in quartiles for the sake of simplicity. However, when conducting data analysis, we realized that it became impossible to analyze pre- and post-block pain scores, as well as absolute reduction in pain. We consider this a limitation, and have already changed our pain reporting tool to improve future data abstraction and analysis for nerve block research.

Furthermore, the absence of a control group for patients with similar symptoms who received customary pain regimens without regional analgesia limits the evaluation of the absolute effect of these nerve blocks. Factors influencing the effectiveness of either block compared to the other may exist that our team did not consider or evaluate. However, given the reduction of pain in both groups of patients presenting to the ED with sciatica, future research directions could involve a head-to-head, prospective randomized trial comparing ESPB vs.TGSNB in this population.

Conclusions

In this retrospective research study, approximately two-thirds of patients experienced ≥ 50% pain reduction within 60 minutes of receiving either ESPB or TGSNB.Patients undergoing the erector spinae plane block had similar levels of analgesic relief whether or not there was concomitant sciatica. For patients presenting with back pain complicated by sciatica, the ESPB and TGSNB performed similarly. Future research by our team will evaluate if these blocks are associated with rebound pain, changes in emergency department utilization, and/or delayed diagnosis of actionable or surgical conditions.

Declarations

- Ethics approval and consent to participate: This project was reviewed and approved by COMIRB (the University of Colorado institutional review board) with IRB Approval # 22-0048). The ethical standard for COMIRB and this research project are grounded in the principles of respect for persons, beneficence, and justice as articulated in the Ethical Principles and Guidelines for the Protection of Human Subjects of Research (often referred to as the Belmont Report). This project is in compliance with the Department of Health and Human Services (HHS) regulations at 45 CFR 46 (also known as the “Common Rule”) and the Food and Drug Administration (FDA) regulations at 21 CFR 50 and 21 CFR 56.
- Consent for publication: This publication does not include any individual’s protected health information or identifying information.
- Availability of data and materials: Deidentified data will be available through a dropbox link if accepted for publication.
- Competing interests: The authors declare that they have no competing interests.
- Funding: This project was not funded.
- Authors' contributions: Conception and Study design (PA, FM, NL, JB, MRi), Literature Review (PA, AS, SS, MM, BO, MRo, MRi), Data acquisition (PA, AS, SS, MM, JB, MRi), Data Analysis and

Interpretation (PA, BO, MRo, JB, MRi), Drafting of the manuscript (PA, AS, SS, MM, FM, NN, JB, MRi), Critical revision (PA, FM, NN, BO, MRo, JB, MRi). All authors read and approved the final manuscript

- Acknowledgements: We would like to acknowledge Jessica Rast PhD, Stacy Trent MD, and Jason Haukoos MD for their crucial review and support by reviewing the statistical analysis for this project.

References

1. Edwards J, Hayden J, Asbridge M, Gregoire B, Magee K. Prevalence of low back pain in emergency settings: a systematic review and meta-analysis. BMC Musculoskelet Disord 2017;18:143.
2. Stafford MA, Peng P, Hill DA. Sciatica: a review of history, epidemiology, pathogenesis, and the role of epidural steroid injection in management. Br J Anaesth 2007;99(4):461-473.
3. Fairag M, Kurdi R, Alkathiry A, et al. Risk factors, prevention, and primary and secondary management of sciatica: an updated overview. Cureus 2022;14(11):e31405.
4. Maslak JP, Jenkins TJ, Weiner JA, et al. Burden of sciatica on US Medicare recipients. J Am Acad Orthop Surg 2020;28(10):e433-e439.
5. Silver D, Anderson K, Esener D, Rose G. Ultrasound guided lumbar erector spinae block: a case series on a novel technique for the treatment of acute low back pain. Am J Emerg Med 2023;72:e1-223.
6. Walkerly A, Neugebauer RE, Misko B, et al. Prevalence, predictors and trends of opioid prescribing for lower back pain in United States emergency departments. J Clin Pharm Ther 2021;46:698–704.
7. Werthman AM, Jolley BD, Rivera A, Rusli MA. Emergency Department management of low back pain: a comparative review of guidelines and practices. Cureus 2024;16(2):e53712.
8. van der Gaag WH, Roelofs PDDM, Enthoven WTM, van Tulder MW, Koes BW. Non-steroidal anti-inflammatory drugs for acute low back pain. Cochrane Database of Syst Rev 2020;4:CD013581.
9. Qaseem A, Wilt TJ, McLean RM, et al. Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline from the American College of Physicians. Ann Intern Med 2017;166(7):514-530.
10. Suri P, Rainville J, Hunter DJ, Li L, Katz JN. Recurrence of radicular pain or back pain after nonsurgical treatment of symptomatic lumbar disk herniation. Arch Phys Med Rehabil 2012;93(4):690–5.
11. Suri P, Pearson AM, Scherer EA, et al. Recurrence of pain after usual nonoperative care for symptomatic lumbar disk herniation: analysis of data from the Spine Patient Outcomes Research Trial. PM R 2016;8(5):405-14.
12. Goldsmith AJ, Merz-Herrala J, Gullikson J, et al. The efficacy of ultrasound-guided transgluteal sciatic nerve blocks for sciatic radiculopathy pain in the emergency department: a multicenter prospective study. J Am Coll Emerg Physicians Open 2025;6(3):100137.
13. Gonzalez-Cobos CA, Rosa Carrasquillo MJ, Agrait Gonzalez MF. Ultrasound-guided erector spinae plane block in the emergency department: a treatment for intractable sciatica. Cureus 2024;16(12):e75932.

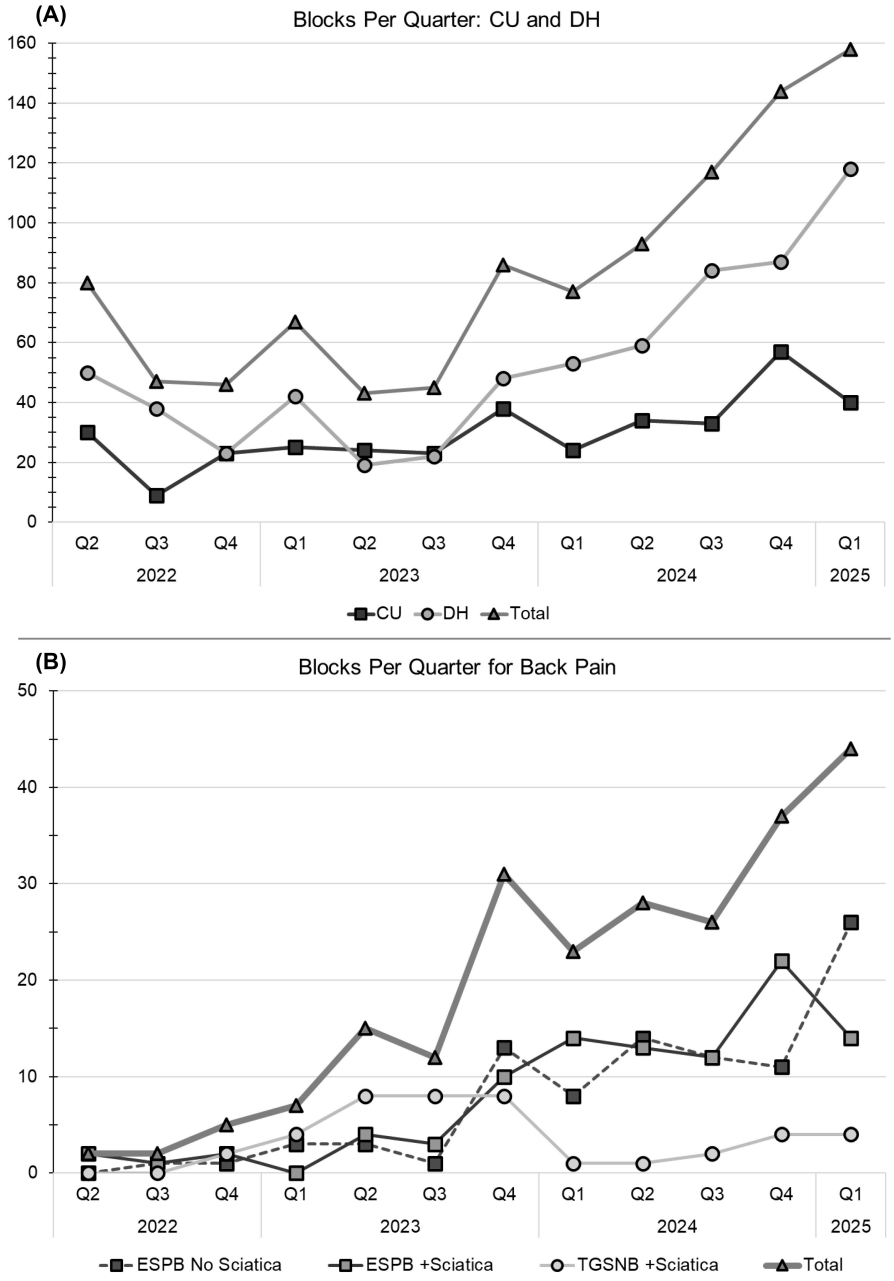
14. Hasoon J, Mahmood S, Nguyen A, Orhurhu V. Erector spinae plane block for chronic lumbosacral pain: a case report. Orthop Rev 2024;16:124769.
15. Goldsmith A, Driver L, Duggan NM, et al. Complication Rates After Ultrasonography-Guided Nerve Blocks Performed in the Emergency Department. JAMA Netw Open 2024;7:11:e2444742.
16. Brown J, Milgrim F, Driver L, et al. Efficacy and Safety of Adjunct Medications in ED Ultrasound-Guided Nerve Blocks: A National Ultrasound-Guided NeRVE (NURVE) Block Registry Study. Acad Emerg Med. 2025;32(12):1299-1308.
17. Epic. Epic Systems Corporation. https://www.epic.com/. Accessed November 3, 2025.
18. IBM Corp. IBM SPSS Statistics for Windows (Version 31). Armonk, NY: IBM Corp., 2025.
19. Microsoft Corporation. Microsoft Excel. 2018. https://office.microsoft.com/excel. Accessed November 3, 2025.
20. Curran-Everett D. Explorations in statistics: the log transformation. Adv Physiol Educ. 2018 Jun 1;42(2):343-347
21. McFadden, D. Conditional Logit Analysis of Qualitative Choice Behavior. Berkeley, CA: UC Berkeley Institute of Urban and Regional Development; 1972
22. Nagelkerke, NJ. A note on a general definition of the coefficient of determination. Biometrika. 1991 Sep;78(3):691-692
23. Anshus AJ, Oswald J. Erector spinae plane block: a new option for managing acute axial low back pain in the emergency department. Pain Manag 2021;11(6):631-637.
24. Ho B, Fyfe-Brown R, Chopra S, McMeel K. The erector spinae plane block vs. usual care for treatment of mechanical back pain in the emergency department: a pilot study. CJEM 2024;26(8):543-548.
25. Silver D, Esener D, Rose G. Ultrasound guided transgluteal sciatic nerve hydrodissection for the treatment of acute sciatica in the emergency department. Am J Emerg Med 2023;69:219.e3-219.e6.
26. Kale A, Usta T, Basol G, Cam I, Yavuz M, Aytuluk HG. Comparison of ultrasound-guided transgluteal and finger-guided transvaginal pudendal nerve block techniques: which one is more effective? Int Neurourol J. 2019;23(4):310–320. doi: 10.5213/inj.1938112.056.

Tables

Tables 1, 2 & 3 are available in the Supplementary Files section.

Figures

Figure 1: Regional Analgesia Procedures Per Quarter by Hospital and Technique



Caption:

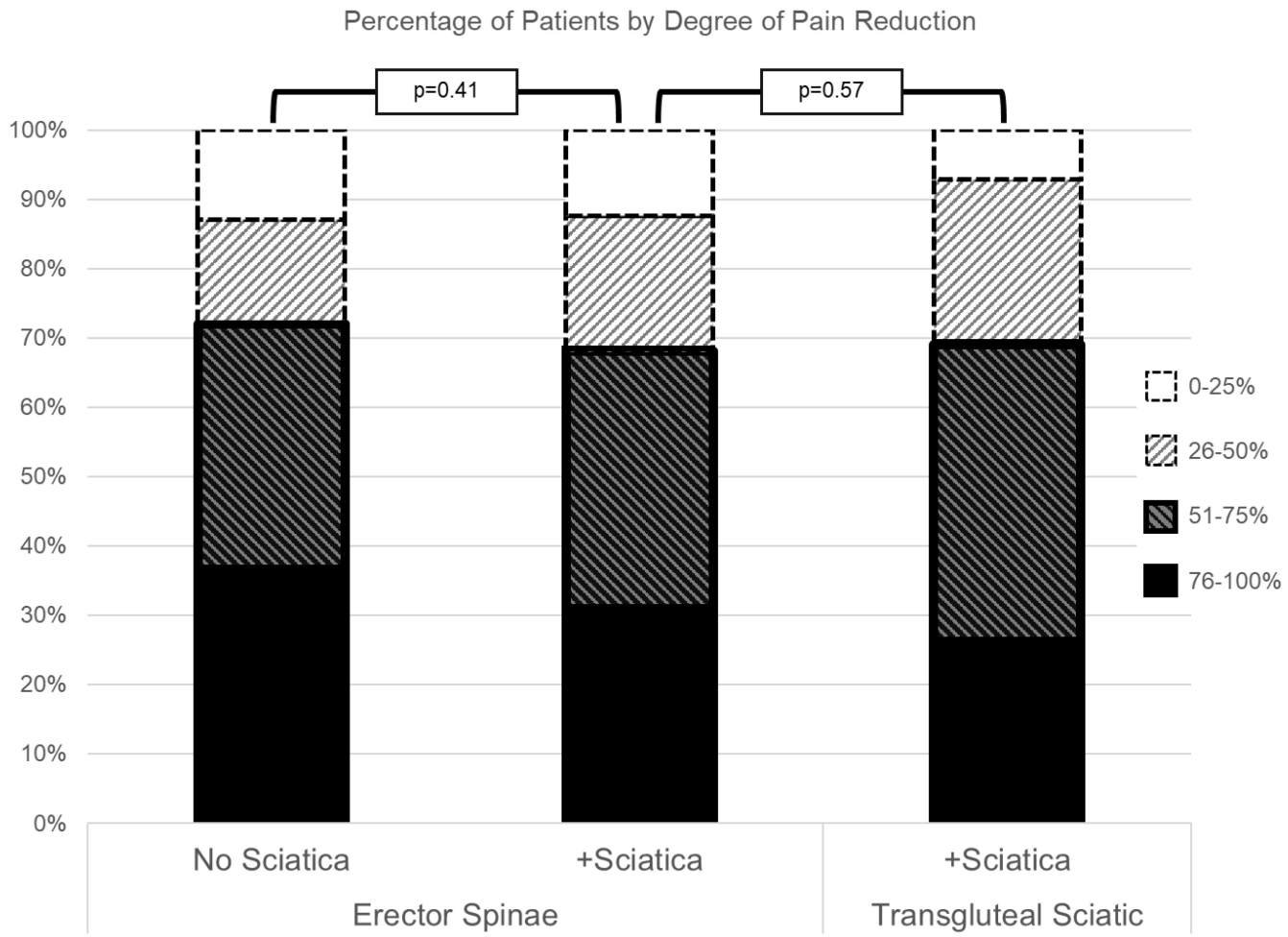
A. Number of blocks (of all types) performed per quarter at University of Colorado Hospital and Denver Health. **B.** Number of erector spinae plane and transgluteal sciatic nerve blocks performed per quarter for the indication of low back pain.

CU: University of Colorado Anschutz, DH: Denver Health and Hospital Authority, ESPB: Erector Spinae Plane Block, TGSNB: Trans-gluteal Sciatic Nerve Block

Figure 1

See image above for figure legend.

Figure 2: ESPB and TGSNB Efficacy



Caption:

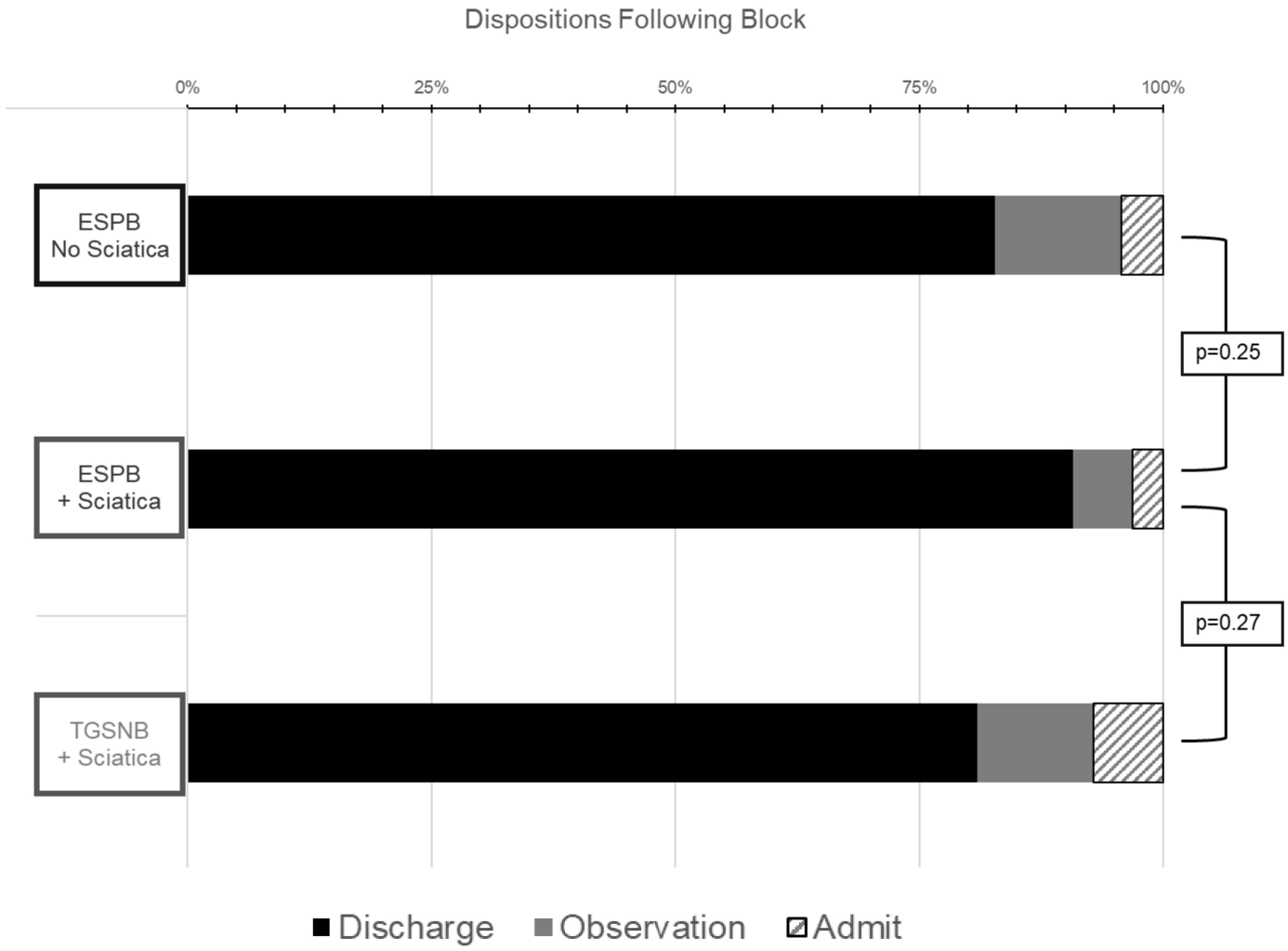
Bar graph depicting the efficacy of ESPB and TGSNB, measured by percent pain reduction based on provider–recorded pain scores. For cases where the regional analgesia procedure was performed for back pain with sciatica, there was no significant difference in the proportion of patients reaching 50% pain reduction after ESPB compared to TGSNB (p=0.57).

ESBP: erector spinae plane block, TGSNB: transgluteal sciatic nerve block

Figure 2

See image above for figure legend.

Figure 3: Disposition



Caption:

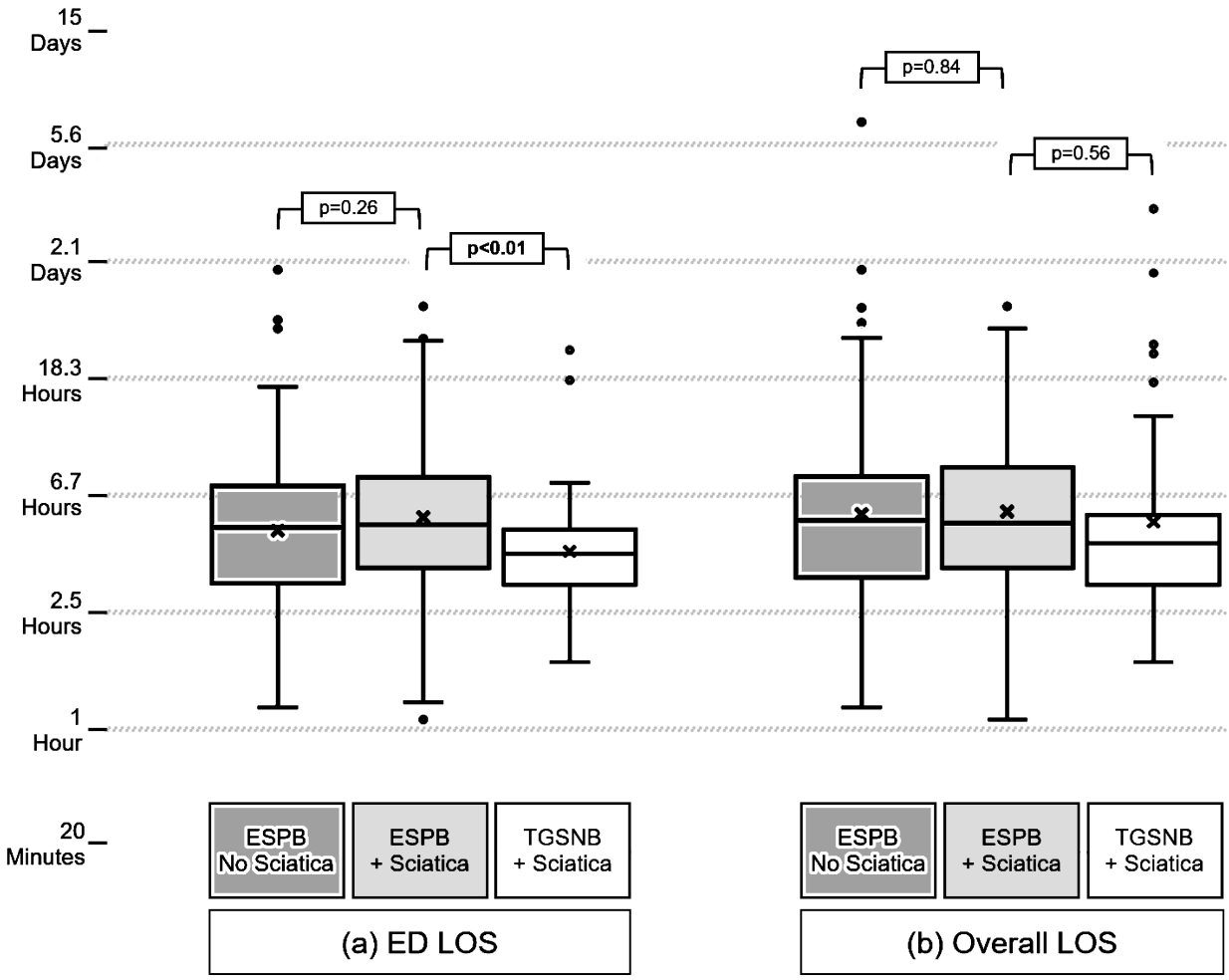
Bar graph comparing patient dispositions following ESPB or TGSNB for back pain with, or without, sciatica. There was no significant association between the presence of sciatica on patient disposition after ESPB (p=0.25). There was again no significant association between the procedure performed for sciatic back pain and the patient's disposition (p=0.27).

ESBP: erector spinae plane block, TGSNB: transgluteal sciatic nerve block

Figure 3

See image above for figure legend.

Figure 4: ED and Overall Length of Stay



Caption:

Comparison of **(a)** emergency department and **(b)** overall hospital length of stay (natural log adjusted) by block type and presence of sciatica. For ESPB, there was no significant difference in ED length of stay between patients with and without sciatica ($p = 0.26$). In contrast, TGSNB performed for sciatica was associated with a significantly shorter ED length of stay compared to ESPB for sciatica ($p < 0.01$).

ESBP: erector spinae plane block, TGSNB: transgluteal sciatic nerve block, ED: Emergency Department, LOS: Length of Stay

Figure 4

See image above for figure legend.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- ESPBvsTGSNBTable1v522261.jpg
- ESPBvsTGSNBTable2v522261.jpg
- ESPBvsTGSNBTable3v522261.jpg