OPEN PEER REVIEW

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As a new feature for progressing towards transparency, we decided to open a new window for all of our editors as well as authors titled "**Peer Review**". We hope by this new facility, our reviewers will be more motivated and authors will be more satisfied with the review process. We believe that publishing our peer review reports could make a transparent and clear environment for all our efforts within a journal, but not all reviewers tend to publish their comments.

What is "Open Peer Review" process?

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Advantages of "Open Peer Review" process

- More transparency, constructiveness and tactful comments of the peer review process: leads to an increase in the quality of reviews
- More motivations for all involved roles in the review process
- Authors' satisfactions from the review process: Increases honesty between authors and reviewers
- Education of both authors and new students
- Prevents reviewers from following their individual agendas and leading to the detection of reviewers' conflicts of interests

You can find out more at:

Peer Review

Anesthesiology and Pain Medicine
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Peer Review Report for "Ilioinguinal and Iliohypogastric Nerve Block for Acute and Chronic Pain Relief After Caesarean Section: A Randomized Controlled Trial"

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Review Timeline:

Submit Date:	12 Dec 2021
Revised Date:	12 Feb 2022
Accepted Date:	13 Feb 2022

Revision (0)

Here, you can see the **Reviewers**, **Associate Editors** and **EICs'** comments from the beginning to the end of the revision process.

REFEREE : EIC

7 Jan 2022

Major Revision

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Revision (1)

Reply to Reviewers

Ideally, the reviewing process can significantly improve the submitted manuscripts by allowing the authors to take into account the advice of reviewers. Author(s) must reply to all reviewers' comments in a separate Word file, point by point. A "**Reply to Reviewers**" document is submitted along with revised manuscript during submission of revised files, summarizing the changes that the authors made in response to the reviewers' comments. The responses to reviewers' comments specifies how the authors addressed each comment the reviewers made.

You can read the authors' responses to the reviewers' comments in the next page.

- Q1: [1. The title is not appropriate and needs to be corrected]
- R: [Role of Ilioinguinal and Iliohypogastric Nerve Block in Acute and Chronic Pain Relief after Caesarean Section: A Randomized Controlled Trial] Page 1, Line 1,2.
- Q2: [Key words need to be corrected]
- R: [Acute Pain, Chronic Pain, Ilioinguinal, Iliohypogastric, Caesarean Section] Page 1, Line 24.
- Q3: [How is the severity of chronic pain measured]
- R: [chronic postoperative pain, which was defined as persistent continuously or intermittently for more than 3 months after surgery, as reported by the International Association for the Study of Pain (IASP)] Page 4, Line110-112.
- Q4: [What test is used to determine the normality of quantitative data scattering?]
- R: [Shapiro-Wilks test and histograms were used to evaluate the normality of the distribution of data. Quantitative parametric data were presented as mean and standard deviation (SD) and were analyzed by unpaired student t-test. Quantitative non-parametric data were presented as median and interquartile range (IQR) and were analyzed by Mann Whitney-test.] Page 5, Line 132-136.
- Q4: [5. In the results section, write the exact mean with standard deviation in the text.]
- R: [On assessing postoperative complications, the incidence of nausea and pruritis was significantly more encountered in controls ($p < 0.005$). However, there was no significant difference between the two groups regarding the incidence of vomiting, bradycardia, and hypotension ($p > 0.05$). The incidence of chronic postoperative pain showed a significant decrease in the block group at the two scheduled follow-up visits. This complication was reported by 10% and 33.3% of ladies at the three-month visit ($p = 0.028$), while it was reported by 3.3% and 20% of them at the six-month visit ($p = 0.044$)] Page 6, Line161-167.
- Q5: [Graph the pain changes for each of these]
- R: [Figure 2 and 3].
- Q6: [Calculate the severity of chronic pain at follow-up]
- R: [The pain severity was significantly lower in group B than group C after 3 and 6 months ($P = 0.001$ and 0.014 respectively). [Table 4]] Page 6, Line 168-169.
- Q7: [Requires English text corrections]
- R: [English correction was done]
- Q8: [Cesarean section (CS) should be mentioned as a complete form for the first time and abbreviated form for the next time. Because this phrase has been repeated many times in the text.]
- R: [Done].
- Q9: [In the introduction section, the available pharmacological and non-pharmacological treatments should be mentioned and why this intervention was chosen in this study]
- R: [Several analgesic modalities - pharmacological and non-pharmacological- may be used during the cesarean section postoperative period. Pharmacological as neuraxial opioids such as fentanyl and morphine, neuraxial administration of non-opioid analgesics, systemic opioid and other systemic analgesics as NSAIDs] Page 2, Line 34-37.

- Q10: [Please note the ethical code and registration clinical trial code]
- R: [The study was performed after being approved by Institutional Ethical committee (code: 33905/6/20) and was registered at Clinicaltrials.gov (registration code NCT04526015)] Page 3, Line 61-62.
- Q11: [Which adverse effects related to the intervention were expected? And how many patients were affected?]
- R: [Other postoperative complications, including nausea, vomiting, sedation, and pruritis, were documented.] Page 4, Line 108-109.
- Q12: [What was the novelty of this paper?]
- R: [To our knowledge, this is the first study to show the role of ilioinguinal and iliohypogastric nerve block in acute and chronic pain relief after caesarean section.] Page 2, Line 56-57.
- Q13: [In the method section inclusion and exclusion criteria should be noted clearly with the title.]
- R: [Inclusion criteria included pregnant full-term females prepared for elective lower segment CS under spinal anesthesia.
- Also, exclusion criteria included emergent cases, opioid-dependent cases, multiple pregnancies, obesity (BMI > 30 kg/m2), previous CS, allergy to one of the study medications, coagulopathy, uncontrolled systemic comorbidities, or having an American Society of Anesthesiology class more than II.] Page 3, Line 63-68.
- Q14: [The method of randomization and blinding should be noted. Who documented the data? Who performed random allocation?]
- R: [Through sealed opaque envelopes, patients were randomly allocated into two groups: a total of 64 cases were included, and they were randomly divided using computer randomization into two equal groups.] Page 3, Line 75-77.
- Q15: [The characteristics of the hospital should be noted completely. General or specific to gynecological and obstetrics operations?]
- R: [Obstetrics and Gynecology Department, Tanta University hospitals] Page 2, Line 59-60.
- Q16: [Who was blinded to the study groups?]
- R: [Of note, outcome parameters were assessed by another anesthesiologist who was blind to the groups of assignment. Patients were also blinded too.] Page 4, Line 115-116.
- Q17: [The method of the intervention should be discussed completely with details the exact method step by step and the dosage of the drugs and drugs manufacture]
- R: [After the surgical procedure had been performed, the ultrasound-guided ilioinguinal and iliohypogastric block was performed. The abdomen was scanned through the anterior superior iliac spine line, where both ilioinguinal and iliohypogastric nerves were identified within 1 – 3 cm from it, within the neurovascular plane between the internal oblique and transversus abdominis muscles. After negative aspiration (to exclude intravascular injection), 10 ml of bupivacaine (0.25%) was injected. The same technique was performed on the other side.] Page 4, Line 93-99.
- Q18: []
- R: [] Page, Line.
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13 Feb 2022

Accept