**Study Design:**

The study will be designed as a prospective, randomized, controlled, single blind in an academic university hospital. The study will be carried out in accordance with the principles set out in the Helsinki Declaration. Written informed consent forms will be taken from all patients who agree to participate in the study.

**Inclusion Criteria:**

The study will include patients between the ages of 18-65, who have a physical status I-III of the American Society of Anesthesiologists (ASA), will undergo elective hepatectomy surgery, a bilateral subcostal incision as a surgical incision, and a self-retaining retractor will be used in surgery.

**Exclusion Criteria:**

Obese (body mass index> 30 kg / m2), local skin infection in the area where the needle will be inserted, known allergy to any of the drugs to be used in the study, coagulopathy, chronic opioid consumption, disability to use patient controlled analgesia (PCA) device, patients with advanced hepatic insufficiency or renal insufficiency and refusal to participate in the study will be excluded.

**Patient Groups and Randomization:**

Patients will be randomized by lot using the closed opaque technique and their groups will be determined. This process will be carried out by a researcher who is not involved in the study. There will be two groups in the study. Patients who will not block and use only PCA device for postoperative analgesia will form the Control Group (Group C). Preoperative bilateral erector spina plane (ESP) block will be made and patients who will use the postoperative PCA device will form the ESP Group (Group ESP).

**Anesthesia Application:**

The same general anesthesia method will be applied to all patients and hepatectomy operation will be performed by the same surgical team. The anesthesia method to be applied and all of the monitorizations are the routine methods and no specific application will be made for the study. Before the operation, all patients will be told about the 11-point numerical rating scale (NRS, 0: no pain 10: the most severe pain imaginable) and how to use the PCA device.The demographic data of the patients, gender, age, height, weight, body mass index (BMI), ASA scores will be recorded. Patients will be monitored in the operating room with electrocardiogram, peripheral oxygen saturation, non-invasive blood pressure measurement and neuromuscular transducer (NMT) and muscle relaxant monitoring. Crystalloid infusion at a dose of 15 ml / kg / h will be started by providing intravenous (iv) route with 22 gauge intracet. Bilateral ESP block will be performed in patients who are sedated with 0.03 mg / kg midazolam, and those in Group ESP, before anesthesia induction accompanied by ultrasonography. Anesthesia induction of patients will be done with 40 mg lidocaine, 2 mg / kg propofol, 1 μg / kg remifentanil and 0.6 mg / kg rocuronium.When the train of four (TOF) is 0%, the patients who will be intubated will have an anesthetic maintenance of SpO2 of 96-98%, FiO2 is set to 30-50% and 0.5-1 MAC desflurane inhalation and 0.1-0.25 μg / kg / min. remifentanil infusion. Right internal jugular vein catheterization will be performed by using ultrasonography and invasive artery monitoring will be performed using non-dominant radial artery. During the surgery, the analgesic need of patients will be monitored with the surgical plethysmographic index (SPI), and the remifentanil infusion dose will be adjusted to be below SPI 50, and total intraoperative remifentanil consumption will be recorded. Intravenous fluid application will be performed so that central venous pressure (CVP) is <5 cm H2O to prevent congestion until liver dissection is completed, and CVP 10 cm H2O after dissection to ensure the ovolemic condition. Surgery will be performed by making a bilateral subcostal incision and using a self-retaining retractor. The duration of the surgery and the surgery performed (right hepatectomy, left hepatectomy) will be recorded. 0.1 mg / kg morphine iv will be administered as a slow bolus for postoperative analgesia 30 minutes before the end of the operation.Patients will be administered antiemetic iv 0.1 mg / kg ondansetron. Patients whose muscle relaxation will be rejected with sugammadex will be extubated when TOF values ​​are 90% and taken to the post-anesthesia care unit (PACU). Here, iv PCA device will be used for postoperative analgesia. PCA will be programmed with 1 mg / ml dose of morphine without basal infusion dose, 1 ml per bolus and lock-out time of 6 minutes. Patients will remain in the PACU until the Modified Aldrete Score reaches 9 and will then be transferred to the intensive care unit of the relevant clinic.

**ESP Block Application:**

All blocks will be performed approximately 30 minutes before anesthesia induction. The block will be made at the level of the T8 vertebra. The T7 vertebra that corresponds to the level of the lower ends of the scapula will be identified and the T8 vertebra below one level will be detected by palpation. Patients will be laid in prone position and skin preparation will be done with 10% povidone iodine. Skin-subcutaneous anesthesia will be provided with 3 ml 2% lidocaine at the target injection site. T8 spinous process in the midline and horizontal plane will be displayed first by using a linear probe coated with a sterile drape at 8 mHz frequency accompanied by ultrasonography. The probe is then turned to the longitudinal plane, approximately 3 cm from the midline, the transverse process on the left lateral and the erector spina muscle will be displayed on it. The 22-gauge, 80-mm block needle will be advanced cranio-caudal as in-plane and the transverse process will be touched. Then, after the needle is minimally retracted, 20 ml 0.375% bupivacaine hydrochloride + 4 mg dexamethasone will be injected, and simultaneous local anesthetic emission will be monitored by ultrasonography. By applying the same procedure to the right side, bilateral ESP block will be performed. Loss of sensation of warm-cold sensation below and above the bilateral T8 dermatome level 20 minutes after the block is made will be considered as block success. Patients who fail the block will be excluded. The number of blocked dermatome will also be noted.

**Pain Assessment and Analgesia Protocol:**

Postoperative patients' pain scores and analgesic needs will be evaluated by a blind research assistant in PACU and surgical service groups. NRS will be used to evaluate the severity of pain. The severity of pain will be assessed both at rest and when coughing. NRS at the time of cough will be considered dynamic NRS and will be defined as dynamic pain if there is a difference of 2 points or more with NRS at rest. The resting NRS and dynamic NRS values ​​of the patients in the postoperative 10th minute, 1st hour, 6th hour, 12th hour and 24th hour and morphine consumption of the 1st hour, 6th hour, 12th hour and 24th hour will be recorded. Rescue analgesia will be performed according to patients' resting NRS values. NRS> 4 will be considered as insufficient analgesia and 0.5 mg / kg meperidine will be administered to the patient iv. After 30 minutes, the patient will be reassessed and if still NRS> 4, 0.5 mg / kg of iv meperidine will be administered. The need for total rescue analgesics in the first 24 hours postoperatively will also be noted. The same protocol will be applied for postoperative analgesia in both groups. It will also be recorded whether there is nausea and vomiting during the postoperative 24-hour period. Nausea severity will be assessed by patients on a 4-point scale (0: absent, 1: mild, 2: moderate, 3: severe). In the presence of moderate and very severe nausea-vomiting, patients will be administered additional ondansetron iv at a dose of 0.1 mg / kg. In addition, coagulation parameters, which are routinely monitored in the preoperative and postoperative period; international normalized ratio (INR), activated partial thromboplastin time (aPTT) values ​​will also be recorded. For these values, routine practice will not be excluded and extra blood will not be drawn from patients.

**Primary and Secondary Outcomes:**

The primary outcome measure of the study will be total morphine consumption in the first 24 hours postoperatively. Secondary outcome measures; Resting and dynamic NRS scores at 5 different time points (postoperative 10th minute, 1st hour, 6th hour, 12th hour and 24th hour), intraoperative remifentanil consumption and total recovery analgesic requirement in the first 24 hours postoperatively. In addition to these measurements, the presence of dynamic pain, postoperative nausea-vomiting, preoperative and postoperative coagulation parameters, and the number of dermatomes held in patients with blockade, duration of surgery and surgery performed (right hepatectomy, left hepatectomy) will also be evaluated.

**Sample Size Calculation and Statistical Analysis:**

According to the control group, the sample size required to detect a 30% difference in morphine consumption in the first 24 hours postoperatively in the ESP group was calculated as 21 patients for both groups with 90% power and 0.01 error margin. Considering the possible losses, a total of 50 patients are planned, including 25 patients for both groups. The data obtained as a result of the research will be analyzed through appropriate statistical package programs. Parametric or nonparametric tests will be used according to the measurement levels and normality analyzes of the variables. While determining whether there is a difference between the groups in terms of variables; Independent Samples T test in two group comparisons or Mann-Whitney U test, One Way Anova or Kruskall-Wallis H test in three or more group comparisons. Paired Samples T test or Wilcoxon Signed Rank test will be used for intra-group time-based comparisons.