The use of different language would not change the poor sensibility and specificity. The choice of using a composite accuracy score rather than the actual individual variables, for the analysis of the resident accuracy in determining the airway difficulty, was discussed with our statistician, and, in our opinion, is more effective and comprehensible to the reader. Since we did not follow a per-patient randomization protocol, traditional figures would not have been appropriate. We regret any confusion that may have resulted.

We performed the largest prospective study to determine whether or not a well-known airway assessment tool really serves the purpose of difficult airway recognition in a clinical and practical setting, and when performed systematically and correctly. The only other large-scale study that can be considered similar to ours is the one from Catalona, Spain, but it has unfortunately only been presented as a meeting abstract. 4

In summary, our study was a composite design of education and airway assessment making a single analysis modality difficult. The study presented some limitations and study design challenges that were addressed in the best way possible. Owing to such limitations, we recommended that the study be considered for the clinical and practical standpoint, rather than simply the statistical value.

**Declaration of interest**
None declared.

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**Psoas compartment block for surgical repair of inguinal hernias**

Editor—We read with considerable interest the letter by Mokini and colleagues 1 about the psoas compartment block (PCB) as a sole anaesthetic technique for surgical repair of inguinal hernias. Although we encourage the use of this technique for less obvious surgeries and therefore congratulate the authors on this publication, we still have some remarks and concerns related to the use of this technique for lower abdominal wall surgery.

The L2–3 approach of a PCB presented by the authors was first described by Hanna and colleagues 2 in 1993; therefore,
the technique described by Mokini and colleagues actually is a well-known approach of the PCB rather than a modification of a PCB as suggested by the authors. However, as rightly recognized by the authors, the use of this technique has some restriction which should be known to physicians before considering this technique for inguinal surgery. In contrast with lower lumbar dermatomes, the higher lumbar dermatomes are unreliably blocked by a PCB, regardless of which approach has been used. A possible explanation for this is the anatomic location of the lumbosacral plexus. Kirchmair and colleagues reported that in the majority of cases, the lumbosacral plexus lies within the psoas major muscle, and not inside a sheath between the muscles. We wonder if the reproducibility of this technique was also tested in a hernia repair patients group.

Furthermore, the authors rightly pointed out some serious complications of a PCB such as hypotension, epidural- or subarachnoid spread, systemic toxicity, renal puncture, and retroperitoneal haematoma. A more cephalad approach of the PCB like the L2–3 approach suggested by the authors could be more prone to an unattended puncture of the kidney. The most frequently occurring undesirable side-effect of a PCB is a bilateral spread of the injected local anaesthetics, resulting in epidural anaesthesia. It was previously thought that the occurrence of bilateral spread depended on the approach taken for a PCB. However, Gadsden and colleagues concluded that injection of a local anaesthetic with high injection pressure (≥20 psi) during lumbar plexus block commonly results in an unwanted bilateral block and is associated with high risk of neuraxial block. Mokini and colleagues did not describe any injection pressure or assessment of bilateral local anaesthetic spread resulting in an epidural anaesthesia in their patient(s).

Finally, in a time of increased emphasis on patient safety, information with regard to success rate or complication rate of this technique for inguinal surgery is needed. In that sense, some data with regard to the number of patients anaesthetized with this technique and the reliability of the result thereof would have been helpful. Until then, in our opinion, the lack of reliability regarding blocking dermatome L1, together with the fact that this technique probably does not anaesthetize manipulations of the spermatic cord and the peritoneum sac (also described by Mokini and colleagues), makes this technique unsuitable for most patients undergoing inguinal hernia surgery.

**Declaration of interest**

None declared.

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**L1–2 roots block with psoas compartment block?**

**Reply from the authors**

Editor—we thank Drs de Leeuw and Perez for their interest in our letter and we would like to make a few comments.

Our modification of the psoas compartment block (PCB) technique is that we aim at eliciting the twitch of the lower anterior abdominal wall (i.e. L1–2 root stimulation), instead of searching for the quadriceps twitch (i.e. L3–4 root stimulation), in order to increase the chance for a successful block and avoid femoral and obturator block, see Figure 1 and accompanying video.

In selected inguinal hernia patients where local anaesthetic infiltration was not possible and general or neuraxial anaesthesia was at high risk or impossible to perform, we found reasonable to propose PCB at L2–3 level for three main reasons. First, there is a higher probability to find L1–2 roots block with psoas compartment block?