kinked during insertion. We elected to reinsert the PLMA, but we allowed the aspiration catheter to protrude 4 to 5 cm at the end of the drainage tube during insertion (Figure). The aspiration catheter acted as a guide, directing itself and the tip of the mask towards the upper esophageal sphincter. The catheter was easily advanced in the stomach where gastric fluid was aspirated. Subsequently, the catheter was removed and reinserted successfully, demonstrating that the PLMA and its drainage tube were correctly positioned, without obstruction.

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Prediction of difficult intubation: are we talking about the same thing?

To the Editor:

Preoperative screening to identify those patients in whom tracheal intubation could be difficult or impos-

sible may save lives.^{1–4} The existing bedside measurements of: thyromental distance, forward protrusion of the mandible, interincisor gap, atlanto-occipital extension, and the Mallampati test,² have been shown, when taken separately, to be neither sensitive nor specific for routine use. Combinations of various measurements in a multivariate model are being used in the hope of improving the ability to predict (sensitivity and specificity) difficult intubation.⁵ Despite the abundance of literature in this area (more than 1700 manuscripts referenced in the *National Library of Medicine*), the tools used to measure the relevant criteria are often not described.⁶ How are these measurements taken? Are any investigator-dependent -variables taken into consideration that could influence the validity of these results?⁷

To obviate these difficulties, we use a ruler (Figure) known in France (French patent no. 9103007) as “RAPIDE”, an acronym that stands for Règlette d’Anesthésie Prédictive d’une Intubation Difficile (which could be translated as Ruler for Anesthesiologists to Predict Intubation Difficulties - RAPID). Notched callipers are used to measure the interincisor gap; while pointed callipers are used to measure the thyromental distance and protrusion of the mandible. A half-protractor assists in the measurement of angulations (e.g., atlanto-occipital extension). The Mallampati views are shown for direct comparison. The mean normal values for each sex are presented on the ruler.

In view of limiting inter-investigator variability when measuring the variables used to predict difficulties with intubation, I suggest my colleagues should either obtain the ruler or have one made up. Used in conjunction with precise definitions of the variables to be measured, the “RAPID” ruler will help provide more uniform and reproducible measurements for clinical, teaching and research purposes.

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FIGURE Ruler for anesthesiologists to predict intubation difficulties - RAPID.

FIGURE Saline-filled LMA revealing two holes made during the stellate ganglion block (photographed by Mario Martin, Centre Universitaire de Santé de l'Estrie).

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Puncture of the laryngeal mask airway during stellate ganglion block

To the Editor:

Performing a stellate ganglion block (SGB) while a laryngeal mask airway (LMA) is in place may be hazardous. The tip of the LMA cuff lies within the esophagus, just above the cricoid cartilage.¹ During SGB, the needle is inserted just below the cricoid cartilage, beside the esophagus.^{2,3}

A 39-yr-old man came to the operating room for a change of dressing over his right hand. A SGB was required to relieve pain and help healing of the hand. Under general anesthesia, a #5 LMA was inserted easily. A right SGB was then performed using a #21 needle. The right carotid was retracted laterally, and the neck extended. While slowly advancing the needle perpendicularly at the medial edge of the sternocleidomastoid muscle, just below the lower edge of the cricoid cartilage, continuous aspiration through the syringe was applied. The syringe became filled with a few millilitres

of air. The needle was advanced a little further and contacted Chassaignac's tubercle. The needle was withdrawn approximately 2 mm. Aspiration for blood or cerebrospinal fluid was negative while 10 mL of local anesthetic was injected gradually. Throughout the surgical procedure, the patient's ventilation was easy and no air leak was audible. At the post-anesthesia care unit, the patient was calm, had right ptosis and a sensation of warmth in his right upper extremity. After removal, the LMA was filled with saline, revealing two holes at its tip (Figure). No postoperative infectious morbidity resulted from this accidental puncture of the LMA.

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