

LETTERS

Ultrasound venous access simulation: the Italian job

Brown *et al*¹ suggest the use of water-filled latex glove fingers embedded in chicken breast for simulation of ultrasound-guided access. In our hospital we have had very good experience with the following simple recipe.

Pasta in jelly (Italian style)

Suitable for one ultrasound instructor and four trainees.

- ▶ Boil a handful of penne, macaroni and spaghetti al dente.
- ▶ Take a large flat ceramic dish (eg, a lasagne dish).
- ▶ Place the pasta in the dish, distribute evenly, and let it cool down.
- ▶ Prepare 500 ml of double strength jelly. Use half the amount of water suggested on the packet.
- ▶ Pour the hot jelly over the pasta.
- ▶ Place in the fridge overnight.

Orange jelly gives the best ultrasound resolution. The larger pasta tubes are suitable for simulation of large vessels (femoral vein), the macaroni for smaller vessels (jugular) and the spaghetti for paediatric vein or arterial line simulation. Use a piece of cardboard or a cloth to obstruct the view of the dish while scanning. Any cannula, needle and syringe or even central line can be used to insert into the pasta. The position of the needle or line can be confirmed by direct visual control after scanning; the trainee thus gets instant feedback.

Enjoy!

A Rose,¹ F Reynolds²

¹Emergency Department, Birmingham Children's Hospital, Birmingham, UK; ²PICU, Birmingham Children's Hospital, Birmingham, UK

Correspondence to: Dr A Rose, Emergency Department, Birmingham Children's Hospital, Birmingham, UK; ameroose@doctors.org.uk

Competing interests: None.

Accepted 8 May 2008

Emerg Med J 2009;**26**:76. doi:10.1136/emj.2008.061796

REFERENCE

1. Brown C, McNicholl B, Wright R. Ultrasound simulator for venous access. *Emerg Med J* 2008;**25**:122.

Status epilepticus after topical application of a solution containing camphor

We read with interest the report by Guibert *et al*¹ on a case of status epilepticus after topical application of a solution containing camphor. For this case of suspected camphor poisoning by transcutaneous absorption, we

would like to suggest a few points for discussion.

First of all, the patient developed seizures 72 h after abdominal massage of a solution containing camphor. It is well known that camphor is rapidly absorbed transcutaneously and causes rapid onset of seizures, usually within the first few hours. Unless there was a reasonable explanation for delayed or continuous absorption, the seizure occurred 72 h after the exposure, which was incompatible with the diagnosis of camphor poisoning.

Besides, a detectable blood camphor level will be very helpful in establishing the causal relationship. Less ideally, the detection of camphor metabolites in urine can be used as an alternative.

Moreover, it would be helpful to know the percentage of camphor in the solution. A single topical use of camphorated solution of low concentration makes camphor poisoning very unlikely.

With respect to the widespread availability of camphor-containing products for topical use and few reports of camphor poisoning through the transcutaneous route,² we believe that camphor poisoning is an unlikely event after the normal topical use of a camphor-containing product.

C K Chan, Y C Chan, F L Lau

Hong Kong Poison Information Centre

Correspondence to: Dr C K Chan, Hong Kong Poison Information Centre, K2A, United Christian Hospital, 130 Hip Wo Street, Hong Kong; ck7477@yahoo.com

Competing interests: None.

Accepted 3 June 2008

Emerg Med J 2009;**26**:76. doi:10.1136/emj.2008.063198

REFERENCES

1. Guibert J, Flamant C, Hallalel F, *et al*. Anti-flatulence treatment and status epilepticus: a case of camphor intoxication. *Emerg Med J* 2007;**24**:859–60.
2. Manoguerra AS, Erdman AR, Wax PM, *et al*. Camphor poisoning: an evidence-based practice guideline for out-of-hospital management. *Clin Toxicol (Phil)* 2006;**44**:357–70.

Ice/cryotherapy and management of soft tissue injuries

I read with interest the review article by Collins regarding the use of ice in the management of acute soft tissue injuries (STI) and the conclusion that there is insufficient evidence to suggest the use of ice/cryotherapy improves clinical outcome.¹ Collins highlights one of the main problems within sports injury/STI management—that many of the accepted clinical practices used have little solid evidence base behind their rationale.

There are many problems in conducting a randomised controlled trial regarding the use

of ice in an acute STI: (1) the time from injury to presentation is variable and patients may be included up to 72 h post-injury when swelling may have an effect on clinical outcome; (2) patients may also have applied ice to their injury in the prehospital setting, thus excluding themselves from any possible randomisation; (3) any icing protocol will rely heavily on the patient's rigid compliance; (4) blinding of patients to the use of ice is not possible and preconceived ideas about the benefits of ice may influence the results, especially when subjective outcome measures are used; (5) outcome measures are difficult to quantify and are often subjective in nature (eg, ankle function scales, pain scoring scales); (6) how to differentiate the effect of ice alone or in combination with other elements of RICE, mainly compression and elevation.

A recent study by Bleakley *et al*² compared two icing protocols in the management of acute ankle sprains. The results highlighted only a small difference in ankle pain on activity after 1 week when ice was applied intermittently. Although they did not find any difference in many other outcomes analysed, the study was underpowered and it is possible that further studies may demonstrate a difference.

Until definitive evidence is present in the literature, the use of ice in the management of acute STI will continue. Many sports physicians will give anecdotal testament to the benefits of cryotherapy and use ice in the immediate management of STI. I would even suspect that, if cryotherapy was proved to be of no benefit in the future, sportsmen would still want to use ice for their injuries, sports physicians would be reluctant not to use ice, and many years would pass before this practice changed.

S H Boyce

Correspondence to: Dr S H Boyce, Department of Emergency Medicine, Wishaw General Hospital, Wishaw, Lanarkshire, UK; steveboyce_scotland@yahoo.com

Competing interests: None.

Accepted 3 June 2008

Emerg Med J 2009;**26**:76. doi:10.1136/emj.2008.063180

REFERENCES

1. Collins NC. Is ice right? Does cryotherapy improve outcome for soft tissue injury? *Emerg Med J* 2008;**25**:65–8.
2. Bleakley CM, McDonough SM, MacAuley DC. Cryotherapy for acute ankle sprains: a randomised controlled study of two different icing protocols. *Br J Sports Med* 2006;**40**:700–5.

CORRECTION

The editor of the Best Evidence Topic reports in the December issue (*Emerg Med J* 2008;**25**:839) was Bernard A Foëx, and not Kevin Mackway-Jones.