

The hairdryer: a useful adjunct to achieving peripheral venous access

Sir,

Obtaining peripheral venous access for cannula insertion or venepuncture in a patient with poorly identifiable veins is a problem for junior medical doctors and nursing staff on hospital wards. A number of adjuncts may be of benefit in these situations, including ultrasound-guided devices, transillumination devices and topical vasodilators (Mbamalu and Banerjee, 1999). Although these adjuncts have been reported to bring some benefit, they are often unavailable on hospital wards.

Another adjunct, warm compressors, may be more available on the wards and improve visibility of vessels by warming the limb and causing greater vasodilatation (Roberge, 2004). However, the authors have found that the heat can dissipate quickly upon placing on a limb, which limits its benefit.

In the joint haematology and oncology ward at The Royal Berkshire Hospital the authors have used a hairdryer to help obtain peripheral venous access in patients with poorly identifiable veins. Sometimes placing a

tourniquet and using other common methods of enhancing venous visibility, e.g. fist clenching, 'tapping' and 'milking' veins, fails to produce a usable vein. The authors have found that, in addition to these methods, using a hairdryer for 2–3 minutes on a designated area, holding it around 20–30 cm away from the skin, allows greater visualization of veins than the use of warm compressors, perhaps because hairdryers can provide a constant level of heat. Unlike the other adjuncts, hairdryers are consistently available on the wards.

As most wards have a communal hairdryer for patient use, the authors would encourage ward staff to use it to facilitate easier venous access in patients with poorly identifiable veins. The exact setting to use is dependent on the hairdryer and the patient, but the authors advocate using the warmest temperature which the patient can tolerate. If the warm air causes significant discomfort to the patient, placing paper towels over the site while using the hairdryer produces the same effect and makes the process more tolerable.

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Short QT syndrome and ventricular tachycardia

Sir,

Among the causes of ventricular tachycardia mentioned by Nijjer et al (vol 78(1), 2017, p. C2), the short QT interval syndrome should also be mentioned. In one case a 28-year-old man presented with palpitations and an electrocardiogram which showed a wide QRS tachycardia with right bundle-branch morphology and superior axis. A previous electrocardiogram showed sinus rhythm with a corrected QT interval of 300 msec. Risk factors for short QT interval were absent, e.g. hypercalcaemia, hyperkalaemia, hyperthermia, acidosis, alterations in autonomic tone and relevant drug history (Sadeghian et al, 2014). Wide complex tachycardia was subsequently induced with programmed stimulation, and the ventricular tachycardia was successfully ablated (Sadeghian et al, 2014).

Portugal et al (2014) reported a 52-year-old man who had recurrent episodes of ventricular tachycardia requiring external electrical cardioversion. During sinus rhythm a 12-lead electrocardiogram showed a short QT interval (corrected QT interval 327 msec), with frequent R on T extrasystoles triggering sustained polymorphic ventricular tachycardia.

Criteria for short QT interval include a corrected QT interval of <330 msec and a family history of sudden death (Gollob et al, 2011). Atrial fibrillation is one of the complications (Lu et al, 2006), justifying a heightened index of suspicion for ventricular tachycardia in otherwise healthy patients who have syncopal episodes in the context of previous documentation of atrial fibrillation. Other electrocardiogram stigmata of short QT syndrome include a short or even absent ST segment, and narrow T waves (Lu et al, 2006).

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