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 veins, the macaroni for smaller vessels (jugular) and the spaghetti for paediatric veins, the penne for small vessels (radial or temporal artery), the lasagne pasta for large peripheral veins (such as for central venous access), lasagne and spaghettis for deep veins (vena cava). The pasta is used primarily to demonstrate vein location and later allows for simulation of venous access by inserting a needle. However, the pasta cannot be used to serve as an actual needle. Instead, the ultrasound trainee will need to be able to assess the quality of access by palpation and observe where the needle has been inserted. This is done by returning the pasta to the boiling water and observing the position of the needle or line by direct visual control after scanning; the position of the needle or line can be confirmed by inserting a small amount of water into the pasta. The position of the needle or line is then assessed by ultrasound. The larger pasta tubes are suitable for simulation of large vessels (femoral vein), the macaroni for smaller vessels (jugular) and the spaghetti for paediatric veins, the penne for small vessels (radial or temporal artery), the lasagne pasta for large peripheral veins (such as for central venous access), lasagne and spaghettis for deep veins (vena cava). The pasta is used primarily to demonstrate vein location and later allows for simulation of venous access by inserting a needle. However, the pasta cannot be used to serve as an actual needle. Instead, the ultrasound trainee will need to be able to assess the quality of access by palpation and observe where the needle has been inserted. This is done by returning the pasta to the boiling water and observing the position of the needle or line by direct visual control after scanning; the position of the needle or line can be confirmed by inserting a small amount of water into the pasta. The position of the needle or line is then assessed by ultrasound.

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REFERENCES

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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 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 al2 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, athletes 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.

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REFERENCES

CORRECTION
The editor of the Best Evidence Topic reports in the December issue (Emerg Med J 2008;25:839) was Bernard A Foex, and not Kevin Mackay-Jones.
Ultrasound venous access simulation: the Italian job

A Rose and F Reynolds

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