ity is entered, the stoma can be mobilized quite rapidly. At this point, a Bookwalter retractor is inserted, and the procedure is continued in the usual fashion.

The total length of this incision is always less than the combined lengths of the traditional midline and stomal incisions. The abdomen is entered in a safer and more expedient manner. The stoma is mobilized more quickly, and visualization of the rectal stump is equivalent to use of a midline incision.

— Paul A. Brisson, M.D.
St. Clare's Hospital
Schenectady, New York

PANNING THE BEDPAN

A male urinal is preferable to a bedpan to obtain urine from female patients who have pelvic and/or femur fractures. The urinal is placed between the patient's legs, which are then closed around it to keep it in place. The angled neck of the urinal prevents dripping, and the pain caused by having to lift up the hips is avoided. Also, the skin of the buttocks does not stick to the urinal, a problem that frequently occurs with use of a bedpan.

— Jane Williams, M.D.
Berkeley, California

BEDSIDE HERNIA IDENTIFICATION TEST

Despite all the tests described for determining whether an inguinal hernia is direct or indirect, a mistake still can be made. A direct hernia comes out directly, while an indirect hernia has a palpable preface. The palpable lateral to medial movement of the hernia contents is unique to an indirect hernia. A bedside test can be performed to avoid the embarrassment of making the wrong diagnosis.

Reduce the hernia and keep the tips of your four fingers (left fingers for left hernia) on the inguinal canal so that the index finger is over the internal inguinal ring and the little finger is over the external ring. The middle and ring fingers rest over the canal. Ask the patient to cough. An indirect hernia gurgles down from the internal to external ring and is felt first by the index finger, progressing to the little finger. A direct hernia is only felt by the little and ring fingers as a direct anterior push.

— Jayant S. Vaidya, M.S., D.N.B.
Tata Memorial Hospital
Bombay, India

SUCTION TUBING COLOSTOMY ROD

Clear plastic argyle "bubble" suction tubing can be used to make a simple "rod" for a loop colostomy. Sterilize a 8"x12" length of tubing and package it. Cut the tubing to the desired length during the operative procedure and intussuscept the ends. Place a suture through the union and tie it to keep it from coming apart. The plastic is stiff enough to support the colostomy but flexible enough to be bent into the colostomy bag.

— J. D. Blackburn, M.D.
Marshall, Texas

HELPFUL ANATOMIC LANDMARK

The femoral artery is located below the inguinal ligament at the midpoint between the anterosuperior iliac spine and the pubic tubercle (useful in a "code" situation when the patient has no pulse). The femoral vein is medial to the artery. NAVEL is a helpful mnemonic for remembering these landmarks (from lateral to medial): Nerve, Artery, Vein, Empty Space, Lymphatics.

CENTRAL VENOUS CATHETER INSERTION

Some key points for those learning how to insert a central venous catheter (CVC):

1. Subclavian vein stenosis secondary to subclavian CVC placement may make the internal jugular (IJ) vein route more desirable in patients with end-stage renal disease (future ipsilateral AV fistula is less successful if there is stenosis).
2. Placement of a CVC can provide continuity between outside air and the central venous system. Once the needle is in the IJ or subclavian vein, taking care to ensure that the needle hub is not left open to air by quickly applying an air-occlusive dressing on the site will help to prevent an air embolism. This also is helpful in eliminating a potential tract for entry of air when removing the CVC or when the patient has pulled out the CVC.

— Terrence McKee, M.D.
Easton Hospital
Easton, Pennsylvania

PORT IDENTIFICATION

Subcutaneous placement of a port for an indwelling catheter is a common procedure. Following placement of the catheter in the operating room, identifying the location of the port decreases the risk of inadvertent injury to the patient or the port.

Multiple techniques have been described for marking the skin with ink, but we routinely use Steri-strips to mark this site. The strips are placed over the incision and parallel to it. Separate strips directed medially and laterally are placed from the corners of the incision to form a triangle, the center of which is the port.

BEDSIDE PERICARDIOCENTESIS

Tapping of pericardial effusions usually is done with electrocardiographic monitoring in a telemetry unit or