Local warming of the hand and lower arm improved successful peripheral venous cannulation and reduced insertion time


**QUESTION:** Does local warming of the hand and lower arm facilitate insertion of peripheral venous cannulas?

**Design**
Randomised (allocation concealed), blinded (clinicians and outcome assessors) controlled trial and randomised (allocation concealed), blinded (clinicians and outcome assessors) crossover trial.

**Setting**
Neurosurgical unit and haematology ward of a university hospital in Vienna, Austria.

**Active warming v passive warming before insertion of peripheral venous cannulas**

(-neurosurgical patients only)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Active warming</th>
<th>Passive warming</th>
<th>RBI (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful insertions on first attempts</td>
<td>94%</td>
<td>72%</td>
<td>31% (10 to 62)</td>
<td>5 (3 to 13)</td>
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</tbody>
</table>

*Abbreviations defined in glossary; RBI, NNT, and CI calculated from data in article.*

**COMMENTARY**

Venous cannulation is a common procedure with a relatively high first time failure rate—one that would be unacceptable in other invasive procedures. Most practitioners could relate at least a few “horror” stories of patients with difficult access, and no doubt, more than a few patients view cannulation with some trepidation. When troubleshooting difficult peripheral intravenous access, the use of warmth in various forms is frequently recommended. Lenhardt et al, in 2 studies, offer the first evidence of the superiority of this practice over standard insertion.

The designs of the studies were good. Randomisation was secure with an audit confirming the integrity of the allocation sequence. Loss to follow up was minimal. Efforts were made to blind the nurse anaesthetist and residents to group assignment; however, complete blinding was impossible due to the obvious change in hand temperature. Although some subjectivity exists in the method used to determine vein scores, outcomes such as time to insertion, number of failed first attempts, and skin temperature provide quantitative evidence of benefit.

It is clear that use of the Thermamed mitt increases skin temperature and reduces cannulation failure. With an NNT of 5 (95% CI 3 to 13) to obtain first attempt cannulation, the mitt could benefit many patients with little risk of adverse events. Although the device is electrically heated, insulation makes the likelihood of burns low if patients are more than a few patients view cannulation with some trepidation. When troubleshooting difficult peripheral intravenous access, the use of warmth in various forms is frequently recommended. Lenhardt et al, in 2 studies, offer the first evidence of the superiority of this practice over standard insertion.

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**Intervention**
Neurosurgical patients were allocated to active warming with a carbon fibre warming mitt (Thermamed, Bad Oeynhausen, Germany) warmed to 52°C and placed over the left hand and forearm in the preoperative area (n=50) or to passive warming (mitt not heated) (n=50).

**Patients**
100 neurosurgical patients (mean age 53 y, 53% women) who had a physical status score of 1 or 2 (healthy or mild and well controlled systemic disease, American Society of Anesthesiologists) were included in the randomised trial, and 42 patients (mean age 63 y, 52% women) with leukaemia who were scheduled for ≥2 sessions of chemotherapy at least 1 week apart were included in the randomised crossover trial. All neurosurgical patients and 95% of patients with leukaemia were included in the analysis.

**Main outcome measures**
Insertion success rates, time from the start of searching for an appropriate vein (after tourniquet application) to successful insertion of the cannula (confirmed by administration of a crystalloid solution without signs of infiltration), skin irritation, and patient discomfort.

**Main results**
In neurosurgical patients, the insertion success rate was higher in the active warming group than in the passive warming group (table), and insertion time was 26 seconds shorter (56 ± 62 s, p=0.002). In patients with leukaemia, insertion success rates were higher in the active warming group than in the passive warming group (95% v 73%, p < 0.001), and insertion time was 20 seconds shorter (95% CI 8 to 32). No skin irritation was observed, and no patients reported discomfort.

**Conclusion**
Local warming of the hand and lower arm increased the rate of successful insertion of peripheral venous cannulas and reduced insertion time in neurosurgical patients and patients with leukaemia.