

TIPS FROM PRACTICE

Eye Patches

The efficacy of eye patches in the symptomatic care of corneal abrasions is being questioned by some recent studies; however, many physicians still use them regularly. I was taught to fold one eye pad in half, place it on the closed lids, cover it with a second eye pad and then use four or five 1-in. paper tape strips across the side of the face and forehead to keep the pad in place.

The alternative, a device with a plastic shield and sponge eye pad on an elastic band, has several drawbacks, including cost, comfort, appearance, and compliance.

Recently my son was diagnosed with amblyopia. He had to wear a patch for several months. We tried a number of different brands and styles. The most comfortable to wear and remove was the Opticlude Orthoptic Eye Patch by 3M. Based on our experiences with his daily patch wear, I have changed my technique on patching.

When I have decided a patch is warranted, I place a 1-cm strip of tincture of benzoin around the orbit, fold an eye pad in half and place it on the closed lids, place a large Opticlude patch over this, and press firmly with the palm of my hand, holding it there briefly to ensure good adhesion. The patch feels better, looks better, and is much easier and faster to apply than the two-pad-and-tape method. It is also much easier and far more comfortable to remove.

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Alternative Buddy-Taping for a Broken Toe

Standard management for on displaced lower extremity proximal phalanx fractures (usually occurring in the 5th digit) is buddy-taping—binding the injured toe to the adjacent non-injured toe. The goals of this management strategy include stabilization of the fracture to promote rapid healing, pain relief from stabilizing the fragments, and prevention of reinjury by keeping the 5th toe from deviating laterally and risking a second trauma.

Traditional buddy-taping is accomplished by wrapping tape circumferentially around the two digits, usually with a small absorbent pad or bit of cot-

ton between the digits to prevent maceration of tissues. Because the ends of the 4th and 5th metatarsals occur at different levels, buddy-taping in this manner can result in equivalent or greater amounts of pain due to fracture fragment movement because of the biomechanics of walking.

For individuals experiencing equal or greater pain with walking after buddy-taping, an alternative buddy-taping strategy may be used. Try using a single piece of tape approximately 4 in. long applied from the medial aspect of the base of the 4th toe, traveling distally along the medial aspect of the toe, wrapping around over the end of the 4th and 5th toes, extending proximally along the lateral aspect of the 5th toe, ending approximately at the distal end of the 5th metatarsal.

There are several inherent advantages to this alternative taping method. It is faster and less painful to apply and remove, uses less tape, requires less manipulation of the fracture area, is simple and faster to teach the patient, and allows visibility of the involved toe.

This technique appears to serve the same function as the more traditional buddy-taping method, and may be more comfortable for many patients.

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Pneumatic Otoscopy

Tympanic membrane mobility should be checked when examining ears, but keeping up with insufflator bulbs is a constant problem. Regardless of how many are purchased, they seem to disappear or always be in another exam room. Even when present, they are difficult to use while pulling the pinna up and back with one hand and holding the scope with the other.

I keep a 6-in. piece of intravenous tubing in my pocket. The plastic connector fits into the otoscope head perfectly. A gentle puff into the other end is sufficient to determine tympanic membrane movement, and both hands are free for the exam.

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