ASH SPLIT VENOUS PORT,PROCEDURE DETAILS: ,The patient was taken to the operating room and placed in supine position and monitored anesthesia care provided by the anesthetist. The right anterior chest and supraclavicular fossa area, neck, and left side of chest were prepped with Betadine and draped in a sterile fashion. Xylocaine 1% was infiltrated in the supraclavicular area and anterior chest along the planned course of the catheter. The patient was placed into Trendelenburg position.,The right internal jugular vein was accessed by a supraclavicular 19-gauge, thin-walled needle as demonstrated by easy withdrawal of venous blood on the first pass of the needle. Under fluoroscopic control, a J-wire was advanced into the right atrium. The needle was removed and the skin puncture site enlarged to about 8 mm with the scalpel. A second incision was made 5 cm inferior to the right midclavicular line, through which an Ash split catheter was advanced, using the tunneling rod, in a gently curving pass to exit the skin of the neck incision. The tunneling needle was removed and the catheter split up to the marker as indicated in the recommended use of the catheter.,Sequential dilators were advanced over the J-wire under fluoroscopic control to dilate the subcutaneous tunnel followed by advancement of a dilator and sheath into the right superior vena cava under fluoroscopic control. The dilator and wire were removed, leaving the sheath in position, through which a double-lumen catheter was advanced into the central venous system. The sheath was peeled away, leaving the catheter into position. Each port of the catheter was flushed with dilute heparinized

saline.,The patient was returned to the flat position. The catheter was secured to the skin of the anterior chest using 2-0 Ethilon suture placed through the suture ""wings."",The neck incision was closed with 3-0 Vicryl subcuticular closure and pressure dressing applied. Fluoroscopic examination of the chest revealed no evidence of pneumothorax upon completion of the procedure and the catheter was in excellent position.,The patient was returned to the recovery room for postoperative care.