Is the cane being used correctly? A cane is generally advanced in unison with and on the side opposite the weak or painful leg. Studies have shown that use in this way reduces force on the leg opposite the cane by almost two-thirds.[4] Canes can easily support up to 15% to 20% of a patient's body weight.[5] Watch out for patients using their standard cane grip backward, as this might signal unsafe and excessive weight bearing.

A quick test you can do in the office would involve walking with the patient while holding their hand. If a single assisting hand helps them walk, then logically a cane might be of potential benefit. If, however, you need to hold both their hands to steady their gait, a walker might be a better choice.

These questions will help organize your approach when determining whether patients have the right canes and whether they are using them properly. Choosing the correct ambulatory device, however, involves considering many factors, including the patient's cognitive function, coordination, upper-body and grip strength, physical endurance, and walking environment. Ultimately, a patient's performance and personal preference will dictate the correct aid. A large walker is more stable but is also heavier, more bulky, and cannot be used by a patient who lives in a small apartment, especially if there are stairs to negotiate. Further, unattractive 4-legged canes might spend more time in the closet if not endorsed by patients and their lifestyles. If problems do arise, consider referring your patient to a physiotherapist for a complete mobility assessment. A physiotherapist can make further recommendations about appropriate gait aids to maximize function.

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Competing interests

None declared

References

1. Sudarsky L. Geriatrics: gait disorders in the elderly. *N Engl J Med* 1990;322(20):1441-6.
2. Van Hook FW, Demonbreun D, Weiss BD. Ambulatory devices for chronic gait disorders in the elderly. *Am Fam Physician* 2003;67(8):1717-24.
3. O'Sullivan SB, Schmitz TJ. Assistive devices and gait patterns. In: Schnee M, editor. *Physical rehabilitation: assessment and treatment*. 4th ed. Philadelphia, PA: FA Davis Company; 2001. p.425-34.
4. Joyce BM, Kirby RL. Canes, crutches and walkers. *Am Fam Physician* 1991;43(2):535-42.
5. Studenski SA, Brown CJ, Duncan PW. Mobility aids. In: American Geriatrics Society. *Review syllabus: a core curriculum in geriatric medicine*. 6th ed. New York, NY: American Geriatrics Society; 2006. p.117-8.

We encourage readers to share some of their practice experience: the neat little tricks that solve difficult clinical situations. Practice Tips can be submitted on-line at **http://mc.manuscriptcentral.com/cfp** or through the *CFP* website **www.cfp.ca** under "Authors."

Kinder immunizations for babies

Michelle Greiver MD CCFP

We give many "shots" to babies. In Ontario, infants usually get 2 needles at 2, 4, 6, 12, 15, and 18 months of age. I routinely ask parents to give their baby some acetaminophen before the visits and have recently implemented several other changes to decrease the discomfort associated with vaccinations.

A study published in the *British Medical Journal* found that babies vaccinated with longer needles (25 mm) had fewer local reactions than those vaccinated with shorter needles (16 mm).[1] I now use 25-gauge, 1-inch needles. At the end of the well-baby examination, I load both vaccines in my laboratory area, away from the examination room, and fill the immunization card ahead of time. When I return, I ask mom or dad to hold baby securely in their arms, I put half of each band-aid on, and I get my alcohol wipes ready. I let the baby's mother know that she can breastfeed afterward if she wishes and then quickly give both vaccines. I try to have all my counseling finished before giving the needles so that parents can concentrate on soothing their baby. I just remind parents to make the next appointment and let them know that they can take their time getting their child settled and ready to go. I then leave the examination room.

Babies seem to cry and fuss less with this process; I think the calmer approach is helpful to parents as well. These changes have not added any time to the visits; I think they could easily be implemented by any health professional offering vaccines to infants.

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Competing interests

None declared

Reference

1. Diggle L, Deeks JJ, Pollard AJ. Effect of needle size on immunogenicity and reactogenicity of vaccines in infants: randomised controlled trial. *BMJ* 2006;333(7568):571.