placed between these two landmarks. This projects a true horizontal reference line. The image viewed on the screen can then be rotated until the line produced by this radio-opaque marker is indeed horizontal (Fig. 1). This technique allows accurate orientation of the weight-bearing surface of the acetabulum and avoids miscalculation of the amount of coverage of the femoral head.

Safety first in the use of 'K'-wires

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Kirshner ('K') wires are a useful tool in trauma and orthopaedics. The sharp cut end, however, risks intra-operative glove puncture and needle-stick injury to surgeon and assistant. This is a heightened problem where there is a high HIV seroprevalence. In Kwa-Zulu Natal, South Africa, we have instituted a policy to 'clip, cut, then condomise' (Fig. 1) the sharp cut wire end with a section of infant feeding catheter (IFC) appropriate to the

diameter of the 'K'-wire. We have found the following sizes to fit best: 1.2 mm 'K'-wire, CH 4/5 IFC; 1.4–1.8 mm 'K'-wire, CH 8 IFC; and 2 mm 'K'-wire, CH 10 IFC.

A simple manoeuvre that avoids kinking of chest tubes

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A chest tube kinked within the pleural space can cause poor drainage, discomfort and trauma on removal, and may require repositioning. With declining usage of trocars for chest tube placement, kinking may occur more frequently. Rotation of the tube around its long axis during insertion ensures that any tendency of the tip to deviate will be annulled by its spiralling forward progression in the direction of advancement. After placement, a straight or gently curved tube can be rotated freely. An angulated tube resists rotation and will twist back when released unless, in the process, it straightens out.

Figure 1 Sections of 8CH feeding tube fit and protect the sharp cut ends of two 1.8 mm 'K'-wires during articular reconstruction.

The use of cough to sample detrusor muscle during flexible cystoscopic biopsy

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During flexible cystoscopy, a biopsy may be required. Whilst it is useful to sample detrusor, controlling biopsy depth is frustrating and samples will frequently not yield muscle. We describe a simple technique that will ensure detrusor muscle sampling. During cystoscopy, the biopsy area is located and flexible forceps are introduced into the bladder. With the forceps open, push against the target region such that the bladder wall is slightly indented. The patient is asked to cough and, whilst simultaneously maintaining constant pressure against the wall, close the forceps. With the instrument's mouth closed, again ask the patient to cough and swiftly withdraw the forceps. This successful method is very easy to use and conjures no additional cost. Furthermore, we have observed that patients' subjective perception of pain is lowered.