Figure 1 The proposed technique of securing protruding K-wire ends

3/0 nylon suture. A less bulky dressing can then also be used on top of the protector. This technique prevents accidental injuries from sharp wire ends, and limits wire migration.

Needle locking tip that reduces needle stick injuries

LAYTH GURGIA, LOUIS DE WEERD
Department of Plastic and Hand Surgery, University Hospital
North Norway, Tromsø, Norway

CORRESPONDENCE TO

Layth Gurgia, Department of Plastic and Hand Surgery,
University Hospital North Norway, Tromsø, Norway
E: gurgia@hotmail.com

After having finished suturing, and while the needle is still mounted on the needle holder (Fig. 1), use your forceps and just rotate the needle so that the needle's axis is in line with the axis of the needle holder (Fig. 2). The needle's sharp tip is now locked (Fig. 3). The risk of a stick injury to yourself or to your assistants

Figure 1 In the position shown, the needle's sharp tip is exposed. It may also penetrate the sterile dressing causing it to lose its sterility.

Figure 2 Rotate the needle with the forceps to lock its sharp tip.

Figure 3 Illustrating how the needle tip is locked.

is minimised. If the needle is placed on a sterile table with its sharp end down there is a risk for penetrating the sterile dressing. This technical tip reduces such a risk as well. It may also contribute to reducing the risk of postoperative infection.

A simple way to aid accurate guide-wire placement in dynamic screw fixation of femoral neck fractures

C THAKAR, A DATTA, G ABBAS, J McMASTER
Trauma Unit, John Radcliffe Hospital, Oxford, UK

CORRESPONDENCE TO

Chrisan Thakar, Trauma Unit, John Radcliffe Hospital,
Headley Way, Headington, Oxford OX3 9DU, UK
E: chris49@hotmail.com

The use of the dynamic hip screw is common practice for fixation of intertrochanteric fractures of the femoral neck. Success of this procedure requires accurate guide-wire placement. This can prove difficult at times and can result in repeated attempts leading to longer operating time, multiple tracks and, more importantly, greater radiation exposure to both patient and operating staff.

Figure 1 Rotation of the intensifier image so that the guide wire is vertical.

Coren *et al.*¹ argue that human vision favours horizontal or vertical lines rather than oblique lines. Thus, rather than use the standard anterior-posterior projected image of the hip, we routinely rotate the intensifier image so that the guide wire appears to be passing in a vertical direction. By rotating the image (Fig. 1) in this way, it becomes significantly easier to visualise the projected direction of the guide wire and, in doing so, ensure its accurate final placement thereby minimising possible complications.

Reference

1. Coren S, Ward LM, Enns JT. *Sensation and Perception*, 4th edn. Fort Worth, TX: Harcourt Brace, 1994.

A simple method to improve sterility of joint injections

SE COLE, MJ WILSON

Royal Devon and Exeter Hospital, Exeter, Devon, UK

CORRESPONDENCE TO

Matthew J Wilson, Royal Devon and Exeter Hospital, Barrack Road, Exeter EX2 5DW, UK, E: mattwilson@doctors.org.uk

The aspiration and injection of joints is a valuable diagnostic and therapeutic procedure. The palpation of anatomical landmarks immediately prior to injection can desterilise the field. We present a simple method for improving 'no-touch' technique, although we acknowledge that this technique is not original. The injection site is palpated before preparing a sterile field. The tip of the ensheathed needle is gently pressed into the planned injection site and held for several seconds. On removal, the tip of the sheath leaves a 'bull's eye' impression in the skin, which remains visible for several minutes (Fig. 1). Skin preparation and joint injection can then proceed without the need for further palpation.

Figure 1 Generation of a 'bull's eye' impression.

A novel head drape technique

ANDREW N MORRITT, DAVID GK LAM

Department of Plastic Surgery, City Hospital, Nottingham, UK

CORRESPONDENCE TO

Andrew N. Morritt, Department of Plastic Surgery, City Hospital, Nottingham, NG5 1PB, UK
E: andymorritt128@hotmail.com

As with many hospitals, we recently moved to self-adhesive operative drapes. We find the plastic towel clips for these drapes ineffective and describe a head drape technique which avoids their use. Two drapes are placed under the head with the upper drape positioned upside down and the adhesive strip (arrow) away from the head (Fig 1a). The skin is prepared and the head wrapped with the upper drape (Fig 1b). The adhesive strip (*) is exposed, fixed onto the patients forehead over the edges of the head drape (Fig 1c), and laterally onto the body drape (Fig 1d).

Figure 1 The head drape technique.

Prevention of contamination from cement fragments during revision hip and knee arthroplasty

RAJESH RACHHA, MANOJ SOOD

Department of Orthopaedics, Bedford Hospital, Bedford, UK

CORRESPONDENCE TO

Rajesh Rachha, Senior Clinical Fellow, Department of Orthopaedics, Bedford Hospital, Bedford MK42 9DJ, UK
E: drrajeshracha@yahoo.com

Intra-operative scattering of cement fragments during cement removal with osteotomes in revision arthroplasty is common and potentially harmful. Fragments are propelled out of the surgical