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

Figure 1 Using the cement extraction osteotome through the pulsed lavage shield.

field and can become contaminated on visors, masks or any other unsterile surface before falling back and causing contamination. To prevent this, we insert the long cement extraction osteotomes through the hole in a pulsed lavage shield (Fig. 1). This method does not hinder the dexterity of the surgeon, and does not obstruct vision as the shield is transparent. The shield is inexpensive, readily available, and prevents contamination by blocking any propelled fragments.

A simple technique to prevent aspiration of speaking valves following laryngectomy

MATTHEW WARD¹, CALLUM FARIS¹, CAROLINE HAMPTON²

¹Department of ENT, Southampton General Hospital, Southampton, UK

²ENT Outpatient Department, Royal South Hants Hospital, Southampton, UK

CORRESPONDENCE TO

Caroline Hampton, Macmillan Clinical Nurse Specialist Head and Neck, c/o ENT Outpatient Department, Royal South Hants Hospital, Brintons Terrace, Southampton SO14 0YG, UK
E: caroline.hampton@suht.swest.nhs.uk

Surgical voice restoration following laryngectomy is commonly performed and often utilises a speaking valve through which air may be shunted to allow speech. It is possible for these valves to become dislodged and aspirated.¹ We describe a cheap and effective method to prevent this. A short length of shearing elastic is threaded through the mounting hole on the side arm of the valve prior to insertion. Once successful valve placement is confirmed, the elastic is threaded around the patient's neck and loosely tied (Fig. 1). Should the valve then become displaced, it is highly unlikely that aspiration can occur.

Figure 1 Demonstration of speaking valve *in situ* with elastic attached.

Reference

1. Ten Hallers EJ, Marres HA, Rakhorst G, Hagen R, Staffieri A, Van Der Laan BF *et al.* Difficulties in the fixation of prostheses for voice rehabilitation after laryngectomy. *Acta Otolaryngol* 2005; **125**: 804–13.