that is, good work is squeezed out. This undermines Dame Black's central tenet. If getting clients back to work is to succeed the work has to be good or else it results in further dysfunction and ill health. The challenge of her work requires a revolution of workplace culture to humanise the workplace without compromising its viability.

This editorial reinforces my experience in general practice that change will not be achieved by indoctrinating/forcing GPs to fill in a different form (Med3) in the hope that employers will do what is right and good for the client.

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## REFERENCES

1. Buijs P, Gunnyeon B, van Weel C. Primary health care: what role for occupational health? *Br J Gen Pract* 2012; **62(605):** 623–624.
2. Handy C. *Gods of management: the changing work of organisations.* London: Arrow Books, 2007.

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# Audit awareness among practices

Ken McLean states that a 'basic lack of awareness of basic audit Methodology' is 'especially concerning as the ability to carry out a full audit once every 5 years is a requirement for revalidation'.[1]

As part of the Appraisal Team in Kent and Medway, closely involved in the preparation of GPs for revalidation, I would like to draw attention to the GMC Guidelines for supporting information for appraisal and revalidation. It uses a clinical audit as one of five examples of supporting information that can be used in the section 'Quality Improvement Activity'. It may well be that certain members feel that a full audit cycle is the only way to demonstrate quality improvement but the requirements for revalidation can include various other methods of reviewing and assessing one's practice and how one is improving year on year.

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## REFERENCE

1. McLean K. Audit awareness among practices. *Br J Gen Pract* 2012; **62(605):** 629.

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# ME/CFS and *Blastocystis spp* or *Dientamoeba fragilis*, an in-house comparison

In their Global Health editorial *BJGP* (October) on exotic infections, Behrens and Coltart did not mention the more mundane high prevalence of protozoal infections in warmer climates.[1] We caught the anaerobic protozoa *Blastocystis spp* and *Dientamoeba fragilis* in Burma, however they are already common in UK, but little known to practitioners.

*Blastocystis* was the most common enteric parasite (6.9%) found in routine stool samples in a study in Wales[2] and *D. fragilis* was found in up to 16.9% of samples submitted to alternative practitioners.[3] However, the detection of both parasites is difficult and requires specialist laboratories; even then they may not be found. Faeco-oral seems their likely mode of transmission.

The pathogenic nature of *D. fragilis* is now more accepted,[4] but two forms are known;[5] while nine different subtypes of *Blastocystis* have been reported, observed disorders appear to be subtype dependent.[6] Both protozoa have been linked to IBS.[7,8]

Treatment of *Blastocystis* is varied and metronidazole has shown resistance.[9] For *D. fragilis*, only secnidazole[10] and paromomycin[11] gave very low treatment failure rates. Although both medicines are old, and both are registered and used within the EU, neither is registered for any use in UK.

My wife and I presented common severely debilitating symptoms of chronic fatigue and inability to concentrate for extended periods. I initially had severe diarrhoea, followed by soreness in the lower bowel, while my wife showed almost no intestinal disturbance or discomfort, however when we both had the same diet, the symptoms were the same. Later, headaches became more prevalent. The addition of milk (2% fat) plus cereals, particularly wheat based, increased the bowel disturbance. We had many blood and stool tests, with essentially no adverse findings. After many months and over 10 stool samples from each, I was diagnosed with *D. fragilis* and my wife with *Blastocystis*. Both had been found by microscopic examination of preserved stained specimens.

The parasites were treated: *D. fragilis* with paromomycin (750 mg tid) for 10 days (28 mg/kg) and *Blastocystis* with nitazoxanide (500 mg bid) for 3 days. Bowel disturbance continued for several weeks in both patients.

Our experiences, although limited, do offer direct comparisons between the parasites and support the conclusion that both can be pathogenic and the effects of both organisms can be similar, giving the ME (myalgic encephalopathy) symptoms of chronic physical and mental fatigue, with bowel disturbances related to cereal/milk diet. However, for patients and practitioners, the biggest problem is lack of efficacious approved drugs in UK.

I wish to thank the laboratory staff in the Department of Medical Parasitology at the London School of Hygiene and Tropical Medicine for making the diagnoses.

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## REFERENCES

1. Coltart CE, Behrens RH. The new health threats of exotic and global travel. *Br J Gen Pract* 2012; **62(603):** 512–513.
2. Windsor JJ, Macfarlane L, Hughes-Thapa G, *et al.* Incidence of *Blastocytis hominis* in faecal samples submitted for routine microbiological analysis. *Br J Biomed Sci* 2002; **59(3):** 154–157.
3. Schuster H, Jackson RS. Prevalence of *Dientamoeba fragilis* among patients consulting complementary medicine practitioners in the British Isles. *J Clin Pathol* 2009; **62(2):** 182–184.
4. Barratt JL, Harkness J, Marriott D, *et al.* A review of *Dientamoeba fragilis* carriage in humans: several reasons why this organism should be considered in the diagnosis of gastrointestinal illness. *Gut Microbes* 2011; **2(1):** 3–12.
5. Johnson JA, Clark CG. Cryptic genetic diversity in *Dientamoeba fragilis. J Clin Microbiol* 2000; **38(12):** 4653–4654.
6. Tan KSW, Mirza H, Teo JDW, *et al.* Current views on the clinical relevance of *Blastocystis spp. Curr Infect Dis Rep* 2010; **12(1):** 28–35.
7. Borody T, Warren E, Wettstein A, *et al.* Eradication of *Dientamoeba fragilis* can resolve IBS-like symptoms. *J Gastroenterol Hepatol* 2002; **17(Suppl):** A103.
8. Jimenez-Gonzalez DE, Martinez-Flores WA, Reyes-Gordillo J, *et al.* Blastocystis infection is associated with irritable bowel syndrome in a Mexican patient population. *Parasitol Res* 2012; **110(3):** 1269–1275.
9. Haresh K, Suresh K, Khairul Anus A, Saminathan S. Isolate resistance of *Blastocystis hominis* to metronidazole. *Trop Med Int Health* 1999; **4(4):** 274–277.
10. Girginkardeşler N, Coşkun S, Cüneyt Balcioğlu I,

*et al. Dientamoeba fragilis*, a neglected cause of diarrhea, successfully treated with secnidazole. *Clin Microbiol Infect* 2003; **9(2):** 110–113.

11. van Hellemond JJ. Superior efficacy of paromomycin for eradication of *Dientamoeba fragilis* in adults. Abstract 335. 22nd European Congress of Clinical Microbiology and Infectious Diseases, 31 March – 3 April 2012, London.

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# The importance of considering sebaceous gland carcinoma in presumed chalazia in South Asian patients?

A 51-year-old Malaysian female was referred with a left lower eyelid lesion noticed 4 years ago. She consulted her GP a year ago and was diagnosed to have a chalazion. Her GP requested funding for treatment. The primary care trust (PCT) considered this a low-priority procedure and declined funding. One year later she approached her GP again and was referred to a hospital for management of this eyelid lesion (Figure 1). She underwent a biopsy and the histology was suspicious of a squamous cell carcinoma. She was referred to our unit. On examination, she had a left lower eyelid, firm 4mm nodule with thickening and distortion of tarsal conjunctiva. With a clinical suspicion of sebaceous gland carcinoma (SGC), a wedge excision of the lesion was performed. Paraffin section histology confirmed complete excision of SGC. Delayed repair required a Tenzel flap. She remains asymptomatic at 5-month follow-up.

## Discussion

Eyelid SGC is known to masquerade as chalazion.[1] Patients with longer duration of symptoms have been reported to have more advanced disease and higher rates of recurrence or metastasis. Delay in diagnosis and treatment of SGC by more than 6 months has been reported to be associated with increased incidence of recurrence.[2] In this case of SGC the treatment was denied by a PCT, after mis-diagnosis as a chalazion, considering it as a low priority procedure.

Although criteria may vary, PCTs only fund excision of chalazion when the following criteria are met: the chalazion has been present for more than 6 months, it is situated on the upper eyelid, and it is causing blurring of vision.

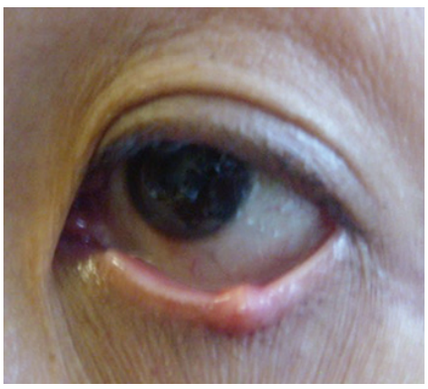

***Figure 1. Lower eyelid lesion.***

SGC is more common in the upper eyelid than lower, with ratios varying from 1.3 to 3. The above PCT criteria could lead to a delay in diagnosis of a SGC masquerading as chalazion in the lower eyelids. SGC is rare in the white population, accounting for 1–5.5% of all eyelid malignancies.[3,4] However, SGC appears to be much more common in the Asian population (South Asian and Indian), accounting for 27–40% of all eyelid malignancies.[3,4] Hence, the possibility of SGC should be considered in Asian individuals presenting with persistent chalazion. Persistent or recurrent chalazion and increase in size of lesion particularly in individuals of Asian origin should justify early referral to the ophthalmologist.

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## REFERENCES

1. Ozdal PC, Codère F, Callejo S, *et al.* Accuracy of the clinical diagnosis of chalazion. *Eye* 2004; **18(2):** 135–138.
2. Song A, Carter KD, Syed NA, *et al.* Sebaceous cell carcinoma of the ocular adnexa: clinical presentations, histopathology, and outcomes. *Ophthal Plast Reconstr Surg* 2008; **24(3):** 194–200.
3. Takamura H, Yamashita H. Clinicopathological analysis of malignant eyelid tumor cases at Yamagata university hospital: statistical comparison of tumor incidence in Japan and in other countries. *Jpn J Opthalmol* 2005; **49(5):** 349–354.
4. Wang JK, Liao SL, Jou JR, *et al.* Malignant eyelid tumours in Taiwan. *Eye (Lond)* 2003; **17(2):** 216–220.

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