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Fictitious parasitic infection

Sir,

A case is presented that may illustrate several important points of general medicine and specifically, of helminth epidemiology. In this case, failure of an internist to identify correctly an oligochaete caused misdiagnosis of the repeated spurious finding of this organism in the toilet. This resulted in inappropriate anti-helminth treatment and emotional distress for the patient.

An internist consulted one of the authors (K B) about an asymptomatic female patient who complained of finding small worms in the toilet on three occasions after bowel movements. The patient described the organisms but was not requested to bring a specimen for identification. The patient was treated for a roundworm infection with mebendazole. It was impossible to identify the parasite from the internist's description. Before treatment, three stool specimens examined for ova and parasites were negative. After the third negative test, the patient was given a glass container with formalin in order to collect the parasite if it reappeared in her stool.

Four weeks later, the patient called the consulting clinician (K B) about the rediscovery of the worms in her stool. A specimen was examined and identified as an oligochaete. Identification was confirmed by Professor Demaree at California State University. The patient was relieved to learn that she did not have this organism as a parasite.

An investigation of her house revealed the source of the oligochaete. The house was two storeys high and approximately 50 years old and had toilets on both floors. The patient most frequently used the toilet on the first floor. Apparently, some minute fractures in the water line enabled the oligochaete to enter the water source to the toilet on the ground floor. Upon examination, the organisms were seen in the toilet tank on the ground floor. After a certain density accumulated, they became visible to the patient.

Oligochaetes have been reported as being parasitic only on rare occasions.^{1,2} The significance of this case is that the patient was treated empirically without either clinical evidence of infection or positive identification of a parasite.

KENNETH A BORCHARDT
NINA MAIDA

Centre for Advanced Medical Technology
San Francisco State University
1600 Holloway Avenue
San Francisco CA 94132
United States of America

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Treating pre-tibial lacerations in elderly patients

Sir,

Pre-tibial lacerations in elderly patients heal poorly if sutured and the patient may be left with a chronic infected leg ulcer for many weeks.¹ This requires regular dressings by the district nurse. Work has been done in the past on the use of split skin grafts taken from the thigh to treat these chronic ulcers.¹

A new method of treating these lacerations has been tried among three elderly patients (aged between 50 and 70 years). All three were seen less than three hours after they had sustained the pre-tibial laceration; one was seen in the surgery and two were seen in the casualty department of the local hospital. Because they were seen within a short time of the injury it was possible to use the skin flap raised by the injury as a graft. The skin flap was cut off at its junction with undamaged skin and the dermal fat scraped off the back with a scalpel blade to produce a thin graft. This was carried out using local anaesthetic but this may be unnecessary as the skin flap is probably devoid of sensation. Using an aseptic technique the wound was cleaned with saline and any non-viable tissue removed. The skin flap was left in saline while this was done. The graft was then cut into small pieces, about 3-5 mm in diameter. The small pieces of skin graft were then laid on the wound bed, dermal side down. An open gauze mesh dressing impregnated with a soft paraffin base and generously pasted with petroleum jelly was placed over the wound site. The patient was then instructed to keep the leg elevated as much as possible. All three patients were pre-

scribed antibiotics.

The patient was seen in the surgery four days later. The wound was redressed with a fresh petroleum jelly dressing and the leg was kept elevated. The patient was then seen a week later and given a supply of dressings to use at night and instructed to wash the wound daily with saline, keeping it exposed to the air during the day. For all three patients, full healing occurred within five weeks and only two attendances at the surgery or casualty department were required.

Early treatment means that the patient is likely to recover more quickly and not need formal skin grafting in hospital. Leaving the dressing undisturbed for a week allows the graft time to take. Costs, in terms of district nursing time, dressings, and expensive wound healing agents, are reduced. Further work needs to be done to clarify whether or not this is a useful technique.

D A GRANT

10 Windsor Court
Victoria Terrace
Clifton
Bristol BS8 4LW

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Career patterns of men and women doctors

Sir,

Previous studies have suggested that the career patterns of men and women qualified in medicine develop in different ways.^{1,2} The disparities are most marked at senior grades, with fewer women at consultant grade in hospital practice or becoming principals in general practice.³ This is particularly important now that equal numbers of men and women enter medical school.⁴ In the west of Scotland we have been aware over the last few years of the increasing number of women doctors who are trainees in general practice or who are senior registrars in certain hospital specialties.

An audit of this was carried out in September 1992 in the region, and of 147 general practitioner trainees in the west of Scotland, 97 (66.0%) were women. In the largest health board area, which is in the centre of the region, 36 out of 52 trainees (69.2%) were women.

Of the 178 senior registrars in the region, 55 (30.9%) were women, with a predominance of men in the surgical specialties, in anaesthesia and in general