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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.

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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.

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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

medicine. In geriatrics, six of the seven senior registrars were women, and in psychiatry, 14 of the 21 were women. When United Kingdom figures for senior registrars are examined only child and adolescent psychiatry, microbiology and psychotherapy show a predominance of women.⁵ The current trends within the west of Scotland at senior registrar level could soon be mirrored throughout the UK when statistics become available.

The preponderance of women trainees has implications for the delivery of care and for the development of general practice in the future.⁴

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Intrauterine contraceptive devices

Sir,

I would like to congratulate Liora Dafni and colleagues (October *Journal*, p.423) for the sustained observations made on intrauterine contraceptive device users in their practice over a 22-year period. The discussion section of their paper, however, contains several inaccuracies and their conclusion, that inert devices should be reintroduced, is misguided.

While it is true that larger devices have lower pregnancy rates and expulsion rates than smaller devices, the advent of medicated devices has obviated the need for large devices, with their associated high incidence of pain and bleeding problems.¹ The first copper devices had an efficacy approximately equal to the inert devices, the newer copper devices have better efficacy and the levonorgestrel device (already marketed in some countries) has the lowest failure rate of any device so far produced, with an efficacy approaching that of the combined oral contraceptive pill.² Dafni and colleagues do not refer to relative failure rates, a serious omission.

Periodic reinsertions seem a small price to pay for a marked decrease in pain and bleeding, particularly among low parity women. Of the Israeli women 63% complained of pain, bleeding or discharge; of these, over half requested removal. This seems an unacceptably high event rate when there is better technology available.

Regarding the duration of clinical effectiveness of copper devices, lifespans of up to eight years are now being achieved with the newer copper-bearing devices with no loss of safety or efficacy.³ We need not wait another 20 years before deciding that inert devices have been superseded. Indefinite use of copper devices without reinsertion is not yet being advocated, except for devices inserted in those aged 40 years or over.⁴

The finding in the study by Dafni in 1983 that pelvic inflammatory disease is considerably less common in users of inert than copper devices is contrary to the findings in the literature. The literature shows no difference between devices. Two studies on infertility, rather than pelvic inflammatory disease, reported lower risks of tubal blockage with copper devices than with inert devices.⁵ Recent work on pelvic inflammatory disease has shown that infection is related to the insertion process and to background risk of sexually transmissible disease rather than to any inherent property of the device. Indeed the levonorgestrel device protects against pelvic infection.⁷ An editorial in the *Lancet* stated that with respect to pelvic inflammatory disease 'in all cases medicated devices releasing copper or levonorgestrel are preferable to the older non-medicated devices.'⁸

In my practice there are 2100 women aged 15-44 years; eight out of 98 current intrauterine contraceptive device users retain their inert devices. As long as they remain content and their haemoglobin levels do not fall, they may continue with their devices indefinitely. Any clinicians who still have supplies of inert devices, marketing of which has long since ceased, would be well advised to discard them and to use only medicated devices in future.

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Care of drug misusers

Sir,

Leaver and colleagues (November *Journal*, p.465) have produced an excellent analysis of their drug misusers' service workload and process, with important implications for future service delivery and funding. However, they do not address the issue of the relationship between doctor and patient that Robertson alludes to in his editorial (November *Journal*, p.451).

The relatively high temporary resident rate of 72% among drug misusers reported by Leaver and colleagues compares with a rate of 11% among my own patients (two out of 19 patients on a methadone programme, both awaiting residential rehabilitation). This suggests that Leaver and colleagues' patients attend for prescribing only and not for other aspects of care. However, the problems of drug abusers go beyond physical addiction and services for them must try to go beyond pharmacology.

A survey was conducted in my practice in October 1992 and consisted of a 30 minute semistructured interview with each of the nine patients then on a methadone programme. For five patients previous experiences of drug services revealed their unfulfilled desire to be treated as 'whole people', not just as 'drug problems', with an individualized non-judgemental approach.

My own approach, in close collaboration with the Newham drug advice project, is based on developing the doctor-patient relationship, the opportunity for which is underpinned by the prescribing programme. There is an initial stabilization phase encouraging mutual respect (to be respected is often a new experience for a drug misuser), in which the doctor is seen as a reliable and accessible source of help. There then follows a parenting-like process of gradual transfer of responsibility to the patient until he or she is able to