

**Table 1.** Analysis of information included on the 243 personal medical attendant reports.

Question	% of forms indicating an answer			
	Full answer	No answer	Not known	Answer refused
Patient general practice details	98.8	1.2	—	—
Smoking habit	72.0	—	27.6	0.4
Alcohol intake	60.5	—	39.0	0.4
Illnesses/accidents	100	—	—	—
Treatment	89.3	10.7	—	—
Time off work	24.7	75.3	—	—
Sequelae	93.4	6.6	—	—
Current treatment	93.0	7.0	—	—
Investigations	94.7	5.3	—	—
Blood pressure recording	71.2	28.8	—	—
Additional information	6.6	93.4	—	—

ations by proposers have been identified on personal medical attendant reports since the access to medical reports act came into force on 1 January 1989 and only one person has refused to allow the form to be submitted, from the approximately 50 000 reports received. Fewer than 10% of proposers require to see the form (Flanagan MJ, Medial Sickness Group, personal communication). This suggests that the ethical dilemma may be more of a problem for general practitioners than their patients, although some proposers may be worried by the delay of up to 21 days that a request for access may cause.

The insurance company asks general practitioners for information about smoking habits, alcohol intake and blood pressure measurement, although the first two are also requested on the proposal form. Completion in this regard was significantly higher (chi square test,  $P < 0.01$ ) in those who had been registered with their general practitioner for less than one year. This may well be a result of the registration check, brought in as part of the new contract for general practitioners, in which all new patients are offered simple screening procedures, which include urinalysis and blood pressure measurement.

Legibility was acceptable, given that Mansfield found 14% of general practitioner records contained illegible entries.<sup>6</sup>

Completing insurance forms appears to be more a problem of data retrieval than an ethical problem.

WILLIAM HAMILTON

Pynes Hill House  
Pynes Hill  
Rydon Lane  
Exeter EX2 5SP

#### References

- Noakes J. Double agent [editorial]. *Br J Gen Pract* 1990; **40**: 92-93.
- Toon P. Insurance forms. *Practitioner* 1991; **235**: 308-310.

- Beale JD. Difficulties raised by insurance medical reports [editorial]. *BMJ* 1989; **298**: 1469-2470.
- Anonymous. AIDS and life insurance [editorial]. *Lancet* 1989; **1**: 627.
- Lorge RE. How informed is patients' consent to release of medical information to insurance companies? *BMJ* 1989; **298**: 1495-1496.
- Mansfield BG. How bad are medical records? A review of the notes received by a practice. *J R Coll Gen Pract* 1986; **36**: 405-406.

### Minocycline induced skin pigmentation

Sir,

Skin pigmentation as a complication of minocycline therapy is familiar to dermatologists but is less well recognized in general practice where the treatment is widely prescribed. Although the *British national formulary* states that high doses of minocycline are associated with hyperpigmentation of acne lesions,<sup>1</sup> this specific side effect is not included in the minocycline data sheet or the *Monthly index of medical specialities (MIMS)*.<sup>2</sup> In a six month period two patients have been referred to our department of dermatology for assessment of facial pigmentation. Both patients told their general practitioners that they felt the minocycline had caused the pigmentation but this was refuted.

In case A, a 58 year old woman developed perioral pigmentation after four years' treatment with minocycline 50 mg twice daily for a perimenopausal acneiform eruption. The patient had been taking conjugated oestrogens 0.625 mg and norgestrel 0.15 mg as hormone replacement therapy for a similar period of time. On examination there was perioral grey pigmentation and grey pigmentation of the conjunctiva and nails. These appearances have remained unchanged despite discontinuing therapy 12 months ago.

In case B, a 15 year old Asian patient was prescribed minocycline 50 mg twice

daily for acne vulgaris. After six months' therapy she noted pigmentation of the face. Examination showed grey pigmentation which was confined to acne scars of the forehead, pigmentation of the tongue and grey discoloration of the nails. Six months after discontinuing therapy these changes are resolving.

Three types of minocycline pigmentation are known to occur.<sup>3</sup> The most common type is well-demarcated blue-black macules at sites of previous inflammation and the patient in case B showed this pattern of pigmentation. Circumscribed macules distant from the site being treated (usually the legs) may also occur. The staining characteristics of the pigment in these two types are those of iron and the pigmentation tends to resolve within about 12 months of stopping treatment. The third type of pigmentation is known as the 'muddy skin' syndrome and describes a diffuse brown-grey discoloration, worse in sun exposed areas. Here the pigment stains as melanin. In these patients the pigmentation is often irreversible and case A fits this pattern.

Minocycline pigmentation is not uncommon; in a prospective study of 300 patients, the incidence was shown to be 3.7%<sup>4</sup> and there was no statistically significant difference between dosages of 100 mg and 200 mg daily. The average time to onset was five months. Previous reports have suggested that concurrent therapy with ethinyloestradiol and cyproterone acetate or phenothiazines may potentiate minocycline pigmentation<sup>5,6</sup> and the role of hormone replacement therapy in case A should be considered.

Minocycline is a convenient, effective treatment for acne vulgaris and with the introduction of the new once daily preparation its use as first line therapy is likely to increase. Included in the list of side effects of minocycline therapy in the *Data sheet compendium* is pigmentation of the thyroid gland and it is stated that dermatological reactions are rare, but no specific mention of skin pigmentation is made.<sup>7</sup> It is particularly important that general practitioners recognize this adverse effect early as in a small number of cases the change is irreversible.

JULIA K SCHOFIELD  
F M TATNALL

Department of Dermatology  
Watford General hospital  
Watford WD1 8HB

#### References

- British Medical Association and The Pharmaceutical Press. *British national formulary*. Number 23. London: BMA and The Pharmaceutical Press, 1992.
- Monthly index of medical specialities*. London: Haymarket, February, 1993.

3. Ridgway HA, Sonnex TS, Kennedy CTC, *et al.* Hyperpigmentation associated with minocycline. *Br J Dermatol* 1982; **107**: 97-102.
4. Layton AM, Cunliffe WJ. Minocycline induced skin pigmentation in the treatment of acne — a review and personal observations. *J Dermatol Treatment* 1989; **1**: 9-12.
5. Basler RSW, Lynch PJ. Black galactorrhea as a complication of minocycline and phenothiazine therapy. *Arch Dermatol* 1985; **121**: 417-418.
6. Eedy DJ, Durrows D. Minocycline induced pigmentation occurring in two sisters. *Clin Exp Dermatol* 1991; **16**: 55-57.
7. The Association of the British Pharmaceutical Industry. *Data sheet compendium 1993-1994*. London: Datapharm, 1993.

## 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.<sup>1,2</sup> 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

## References

1. Crew W, Chubb JC. An oligochaete as a 'spurious parasite' of man. *Trans R Soc Trop Med Hyg* 1979; **73**: 324.
2. Dar FK, Kidwai SA, Munir R. Intestinal infection by terrestrial isopoda (oniscus spp) and oligochaeta (lumbicus spp). *Trans R Soc Trop Med Hyg* 1984; **78**: 703-704.

## 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.<sup>1</sup> 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.<sup>1</sup>

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

## Reference

1. Shankar S, Koo CT. Lower limb skin loss; simple outpatient management with meshed skin grafts with immediate mobilisation. *Arch Emerg Med* 1987; **4**: 187-192.

## 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.<sup>1,2</sup> The disparities are most marked at senior grades, with fewer women at consultant grade in hospital practice or becoming principals in general practice.<sup>3</sup> This is particularly important now that equal numbers of men and women enter medical school.<sup>4</sup> 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