penicillin and flucloxacillin. Results of blood cultures were negative, but the skin swabs grew *Staphylococcus aureus* that was sensitive to flucloxacillin and erythromycin. Routine blood tests were normal. Doppler ultrasonography showed no evidence of deep vein thrombosis. After three days' treatment with intravenous antibiotics his leg had not improved, so he was seen by the dermatologist.

The patient had crusting, scaling, exudative and erythematous patches on the left leg, and a few similar patches on his arms and paraumbilical area. He also had varicose veins. A diagnosis of varicose eczema with secondary dissemination to the arms and abdomen was made. The antibiotics were stopped. Twice daily his leg was cleansed with a 1:10 000 potassium permanganate solution, and a potent topical steroid was applied. His legs were raised when he was sitting and while in bed. The rash resolved in a week. He was discharged home and told to use the topical steroid if the problem recurred.

Discussion

Although the exact aetiology of varicose eczema is unknown, the disorder is related to varicose veins and a previous history of deep vein thrombosis. It is one of the endogenous eczemas—that is, atopic, discoid, seborrhoeic, affecting the hands and feet, and asteatotic. Cellulitis is infection and inflammation of the skin and subcutaneous layers that is commonly caused by *S aureus* and *S pyogenes*. What causes the confusion is the erythematous inflammation that is found in both conditions. However, there are other clinical features which differentiate the two conditions (table). Crusting or scaling is the most important sign in eczema and this is not seen in cellulitis, where the skin is smooth and shiny. Small blisters (vesicles) are common in eczema. These break down and the serous fluid released dries to form crusts which coalesce (figure). Although blister formation is uncommon in cellulitis, if blisters do develop they are large and herald the onset of skin necrosis.

Comparison of clinical features of varicose eczema and cellulitis of the leg

	Eczema	Cellulitis
Symptoms	No fever	May have fever
	Itching	Painful
	History of varicose veins or deep vein thrombosis	No relevant history
Signs	Normal temperature	Feverish
	Erythematous, inflamed	Erythematous, inflamed
	No tenderness	Tenderness
	Vesicles	One, or a few, bullae
	Crusting	No crusting
	Lesions on other parts of the body, particularly other leg and arms	No lesions elsewhere
Portal of entry	Not applicable	Usually unknown, but break in skin, ulcers, trauma, athlete's foot implicated[1 2]
Investigations	White cell count normal	White cell count high
	Blood culture negative	Blood culture usually negative[3]
	Skin swabs—*Staphylococcus aureus* common	Usually negative, except for necrotic tissue[3]

Varicose eczema should always be considered in the differential diagnosis of cellulitis of the leg. Where the diagnosis is uncertain, the patient should be referred immediately to a dermatologist to avoid the unnecessary use of intravenous antibiotics. If a delay in seeing a dermatologist is likely, however, intravenous antibiotics should be started, because cellulitis is a potentially serious problem.

Contributors: CMQ-P is the sole contributor.

1 Aly AA, Roberts NM, Seipol KS, MacLellan DG. Case survey of management of cellulitis in a tertiary teaching hospital. *Med J Aust* 1996; 165:553-6.
2 Wang JH, Liu YC, Cheng DL, Yen MY, Chen YS, Wang JH, et al. Role of benzathine penicillin G in prophylaxis for recurrent streptococcal cellulitis of the lower legs. *Clin Infect Dis* 1997;25:685-9.
3 Semel JD, Golding H. Association of athlete's foot with cellulitis of the lower extremities: diagnostic value of bacterial culture of ipsilateral digital space samples. *Clin Infect Dis* 1996;23:1162-4.

(Accepted 24 November 1998)

Corrections and clarifications

ABC of labour care: Physiology and management of normal labour
This article by Philip Steer and Caroline Flint (20 March, pp 793-6) shows photographs of delivery positions (p 796) in which the birthing attendants' personal protective equipment is limited to gloves. However, the Department of Health's guidelines and royal colleges' recommendations make it clear that personal protection for the attendant's exposed areas (such as face, eyes, and forearms) should always be adopted, not just on a selective basis.

Fertility patterns after appendicectomy: historical cohort study
The two graphs in this paper by Roland Andersson and colleagues (10 April, pp 963-7) were misplaced. Thus, the Kaplan-Meier plot referred to in the caption for fig 1 wrongly lies over the caption for fig 2, and the graph of rates of first birth referred to in the caption for fig 2 wrongly lies over the caption for fig 1.

Recent advances in haematology
In this article by Drew Provan and Denise F O'Shaughnessy (10 April, pp 991-4) the second bullet point in the second box on p 993 should have read: "Umbilical cord transplants, including transplantation from unrelated donors."

More on the Bristol affair: What went wrong and how can we move forward?
This letter by Maria Shortis and Elisabeth Winkler (10 April, p 1011) refers to a website on which are published the results of operations performed in Bristol Royal Infirmary's cardiac unit. The address for this site should have read www.ubht.org.uk (not www.bht.org.uk).

Evidence based case report: Use of prostaglandins to induce labour in women with a caesarean section scar
This article by Sarah Vause and Mary Macintosh (17 April, pp 1056-8) should have also have been credited to a third author—M R Glass, a consultant obstetrician at Leeds General Infirmary—whose name was omitted because of an editorial error.

Victorian medicine: Our grandfather's patient
In this article by Geoffrey Russell Steele Grogono and Basil John Steele Grogono (24 April, p 1117) the second sentence of the second paragraph should have read: "He was brought to me soon afterwards, when I cauterised the wounds freely with lunar [not linear] caustic."

Influence of hospital and clinician workload on survival from colorectal cancer: cohort study
Two errors occurred in this paper by F Kee and colleagues (22 May, pp 1381-6). On p 1383 the y axis for the upper figure should have ranged from 0 to 3 (not 0 to 30), and age in table 3 should have read "per decade" (not per year).