

## Prevention of complaints is better than cure

**Sir,**

Pyrah and colleagues (vol 69(6), 2008, p. 312) argue the need to find a way to learn from complaints by responding to them respectfully and humbly. Criticisms need not become complaints if they are taken as constructive.

Who would disagree with their argument? But there is an equally strong need to try to prevent complaints by good communication with individuals and their families, by asking them what they think, by listening to what they say, and by endeavouring to address their concerns at all stages of our contact with them (General Medical Council, 2006). This is easy to say but not always easy to do with the competing demands of modern health and social care.

Misunderstandings grow when they are not brought into the open and talked through – on both sides. Yet sometimes we avoid talking with people who have

strong views instead of engaging them in dialogue. How often do we hear comments such as ‘she’s a difficult relative’? Usually this describes someone who has had a long and difficult struggle with illness and services. All too often we don’t care enough for the carer: their care is an intrinsic part of caring for their relative.

We all want to do a good job and a few compliments would not come amiss, but I doubt that compliments are a force for change (Choudhari, 2001). A complaint about the custard doesn’t mean the nursing care was no good, but it might mean that the carer needs help and we’re not providing them with what they need.

**Susan Mary Benbow**

*Professor of Mental Health and Ageing  
Centre for Ageing and Mental Health  
Staffordshire University  
Stafford ST18 0AD*

Choudhari Y (2001) A memorable patient: Compliments. *BMJ* 323: 803

General Medical Council (2006) *Good Medical Practice*. General Medical Council, London ([www.gmc-uk.org/guidance/good\\_medical\\_practice/](http://www.gmc-uk.org/guidance/good_medical_practice/) accessed 14 May 2008)

but there have been cases occurring as quickly as 20 months (Enoch et al, 2004). In this case because of the past medical history the ulcer was thought to have been ischaemic, but given a normal vasculature with no obvious embolic source it is more likely that it was a de novo occurrence.

Treatment of squamous cell carcinoma detected early is simple excision (Enoch et al, 2004). However, its ability for local destruction and potential for metastasis means that delay in diagnosis may necessitate a more radical approach (Enoch et al, 2004). The overall rate of metastases from squamous cell carcinoma is low (1–2%), but Marjolin’s ulcers have a much higher rate, averaging 30% (Bernstein et al, 1996).

When dealing with ulcers it will sometimes be impossible to determine whether squamous cell carcinoma is de novo or Marjolin’s ulcer. It is essential to ensure early diagnosis for a better prognosis. The authors suggest a low threshold for biopsy in unusual non-healing ulcers occurring anywhere on the body, even those not manifesting any obvious evidence of malignant change.

**U Minhas**

*Clinical Fellow in General Surgery  
Royal Gwent Hospital  
Newport NP20 2UB*

**MD Rocker**

*Consultant General and Vascular Surgeon  
Royal Glamorgan Hospital  
Llantrisant*

Bernstein SC, Lim KK, Brodland DG, Heidelberg KA (1996) The many faces of squamous cell carcinoma. *Dermatol Surg* 22: 243–54

Enoch S, Miller DR, Price PE, Harding KG (2004) Early diagnosis is vital in the management of squamous cell carcinomas associated with chronic non healing ulcers: a case series and review of the literature. *Int Wound J* 1: 165–75

Fitzpatrick TB, Johnson RA, Wolff K (2005) *Colour Atlas and Synopsis of Clinical Dermatology*. 5th edn. McGraw Hill, New York

## Unusual presentation of squamous cell carcinoma as a gangrenous toe

**Sir,**

A rare case of squamous cell carcinoma presenting as a gangrenous fifth toe is discussed, highlighting the importance of early tissue diagnosis of non-healing wounds to ensure prompt diagnosis, correct treatment and improve prognosis. This presentation is rare but important to vascular surgeons who frequently deal with gangrenous digits.

A 58-year-old man with type 2 diabetes mellitus, a history of smoking and a previous abdominal aortic aneurysm repair presented with a 2-year history of a worsening gangrenous ulcer involving his right fifth toe. On examination all limb pulses were present. Arterial duplex confirmed no significant stenoses. The toe appeared infected and was treated with antibiotics with little response. Plain radiographs confirmed osteomyelitis. The toe was amputated and sent for histology because it had an unusual texture. This confirmed a squamous cell carcinoma invading bone with

incomplete excision. The patient underwent further excision with histology confirming clear margins.

Squamous cell carcinoma is the second commonest form of skin cancer with a rising incidence worldwide (Fitzpatrick et al, 2005). Diagnosing squamous cell carcinoma can be challenging even for the experienced clinician because it can be found anywhere on the body and has a varied clinical presentation (Enoch et al, 2004).

Squamous cell carcinoma most commonly arises de novo but its association with chronic ulcers is well established, a condition known as Marjolin’s ulcer (Enoch et al, 2004). Marjolin’s ulcer typically occurs after a latent period of 20–30 years

## Correspondence

**If you would like to comment on any of the articles in *British Journal of Hospital Medicine*, or any issues which are relevant to our readers, please write in no more than 250 words to:**

Dr Jack Tinker  
Editor-in-Chief, BJHM  
c/o Rebecca Linssen, MA Healthcare  
St Jude’s Church  
Dulwich Road  
London SE24 0PB  
email: [bjhm@markallengroup.com](mailto:bjhm@markallengroup.com) fax: 020 7978 8316