The skin surrounding a highly exuding wound may be further protected through the use of emollients (such as 50:50 mix of white soft paraffin and liquid paraffin) or the application of barrier films (such as Cavilon). Conversely, use of a highly absorptive dressing on a dry wound may lead to disruption of healthy tissue on the wound surface and cause pain when removed.

Allergic reactions are not uncommon: the dressing should be avoided, and the allergy may need to be treated with potent topical steroids. Tapes used to keep dressings in place are common causes of allergy. Many dressings require secondary dressings—for example, padding on highly exuding wounds—which may make them bulky. Secondary dressings should not be too tight, especially on patients with peripheral vascular disease.

Abdominoperineal resection wound treated with vacuum assisted closure. The skin edges are protected with a barrier cream to prevent maceration

Further reading

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Left: Allergy to dressing used to treat arterial leg ulceration. Note erythematous skin with sharply demarcated edges corresponding to the shape of the offending dressing. Right: Ulceration over the anterior aspect of the ankle caused by inappropriately tight bandage

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"Seeing" is believing

"Your next batch of students arrive tomorrow," the administrator told me, "and one of them has a visual impairment."

It turned out that 20 years previously he had had retinitis pigmentosa diagnosed, and by the time he joined medical school he was registered blind. My colleagues were sceptical about his choice of profession, and we pondered how best to deal with this situation and what impact his presence would have on the rest of the team and the patients.

I met him the next day. Tall and elegant, he radiated a calm confidence. Accompanying him every step of the way was his guide dog, and a fellow medical student relayed the case notes to him (forming "the trio," as I soon called them). His history taking skills turned out to be excellent, and he was able to extract important information that had been missed by earlier students. He picked up all the findings on palpation and auscultation. The hepatic bruit is a specific sign of alcoholic hepatitis but can be difficult to hear even for experienced hepatologists—but he never missed one. During ward rounds, I was impressed by how well he connected with his patients and how comfortable they seemed with him. It was soon apparent that his presence was having a

positive and inspirational impact on the team, and "the trio" became instantly recognisable in the hospital.

He relied on innovative ways to overcome his disability. For his medical boards (equivalent to MRCP), he used a reader and scribe. During the anatomy exam, his palpation skills helped him to identify various parts on the cadaver. Since he had become blind in adulthood, he did not read Braille and instead consulted audiobooks and e-text. The most amazing development has been JAWS, a computer program that allows him to "write" case notes, search the internet, and respond to emails.

I had great respect and admiration for this remarkable medical student and indicated that to him at our last meeting. To overcome such personal hardship and, against all odds, choose to study medicine required strength of character and conviction that many of us lack. He graduated recently and is now training to be a psychiatrist. Before I met him, if someone had asked my opinion about a blind student training to be a doctor, I would not have been optimistic. I guess "seeing" is believing.

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