important, as I thought, that I refused to endanger it by going for more. Peripheral information not adequate in quantity and quality would be useless; and it would never be secured without a loyal and integrated staff meeting regularly in committee.

No chance missed

Wilson told me often of various adventures that he had experienced in his efforts to extend the PHLS beyond the wishes of those who opposed the growth of joint hospital-PHLS microbiology laboratories. One account he gave me is worth recording as an illustration. He knew that a certain hospital laboratory had got itself into serious trouble as a result of grossly inadequate microbiology. He knew that proposals for a joint hospital-PHLS laboratory in that place would be resisted both by the senior administrative officer (SAMO) of the relevant regional hospital board (RHB) and by the local hospital pathologist. So—one Friday—he arrived by bicycle at the office of the SAMO and suggested a joint PHLS-hospital laboratory to avert any further substandard microbiology. The SAMO, relying on the known vigorous objections of the local hospital pathologist, was discouraging; but was incautious enough to agree that there *could* be a joint laboratory but for the objections of the local pathologist. If these could be overcome the regional hospital board of course would not oppose the idea.

This was enough for Wilson. He was at once “on his bike” and off to the local pathologist. To him Wilson conveyed cordial greetings,

sympathy over the recent misfortunes, and a proposal for a joint hospital-PHLS microbiology laboratory. The local pathologist, relying on the SAMO of the regional hospital board, said that the RHB would not bless the idea. But Wilson truthfully assured him that he had just checked with the SAMO of the RHB that there would be no objection on his part if the local pathologist did not dissent.

The local pathologist's nerve gave way. So the principle was agreed—details to be worked out after the PHLS representative had arrived to take his part. When would that be? Answer: “Monday morning.” And so it happened—fruitfully and in the end happily for all concerned. That was Wilson all over. No dishonesty—but no chance missed for extending the service—all in the public good. He was an incredible man. He was a perfectionist, scrupulously honest, but ruthless in the promotion of the PHLS. He worked all hours for his service. He spared no effort on its behalf—even if he did not realise that the change from the Medical Research Council's administration called for a new approach.

He worshipped Topley's memory, and in his editorship of Topley and Wilson's seventh edition of their famous textbook he has provided a double memorial for Topley and himself. He was a meticulously correct writer and an obstinately persistent editor. He was not an easy man to know—some would say impossible. He loved fine wine and good food. He was a very good gardener and a loyal and devoted member of the Church of England; and in all respects a truly English gentleman of unusual character and complete integrity.

Lesson of the Week

Osteolytic lesions in an elderly diabetic woman

ALEXANDER FOSS, HUGH MARKUS

Haematogenous osteomyelitis is classically a disease of children but is being increasingly recognised in the elderly. Its incidence is bimodal, with the second peak occurring in the sixth decade.¹ In this older age group it usually affects the vertebral column: this accounted for over half of the cases in one series. The diagnosis is often missed in the elderly, osteolytic lesions being most often mistaken for malignant secondary lesions. Recognised risk factors include intravenous drug abuse,² diabetes mellitus,^{3,4} and urinary tract infection or instrumentation. The difficulty in diagnosis is emphasised in reports about the condition.^{2,3,5} It is an important diagnosis to miss, as it carries the risk of serious complications—for example, septicaemia, and paraplegia in spinal osteomyelitis.⁶

All patients with isolated osteolytic lesions whose cause is not known should have a biopsy

Case report

A 78 year old woman with a 12 year history of diabetes mellitus that was well controlled with insulin, who had been fit and active until seven months before referral, simultaneously developed pain in her left buttock and a urinary tract infection. *Escherichia coli* was cultured from the urine, and the infection was treated successfully with trimethoprim, but the pain in her buttock persisted and she was referred to hospital as an outpatient. Radiography of the pelvis showed an osteolytic lesion of the left inferior pubic ramus with a breach of the periosteum and associated specks of soft tissue calcification (fig 1). A bone scan showed a corresponding “hot spot” but no other abnormalities. The findings were interpreted as consistent with a neoplasm, most probably a secondary lesion, and the patient was advised to have a biopsy. She was initially unwilling, despite the diagnostic problem being explained, but agreed after about three months. While the biopsy was being arranged she was admitted as an emergency with septicaemia due to *Staphylococcus aureus*. She responded well to flucloxacillin and sodium fusidate, to which the organism was sensitive. Radiography of the pelvis showed new bone associated with the lesion, and this was considered so characteristic of osteomyelitis that biopsy was deferred.

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FIG 1—Osteolytic lesion of left inferior pubic ramus with breach of periosteum and soft tissue calcification.

She was discharged after four weeks still taking oral flucloxacillin and sodium fusidate but was readmitted with pain in the left buttock that prevented her from walking. Radiography showed a second lesion destroying the pubic symphysis, despite her compliance with antibiotic treatment (fig 2). Biopsy of the bone showed chronic osteomyelitis. The symptoms improved with intravenous flucloxacillin and gentamicin, and she was discharged taking flucloxacillin and sodium fusidate at an increased dose; antibiotic concentrations in the blood were assayed to ensure that bactericidal concentrations were achieved. She subsequently recovered and was able to walk again.

FIG 2—Periosteal reaction to first lesion, suggesting partial healing, but new lesion visible around pubic symphysis.

Discussion

Osteomyelitis is rare in the United Kingdom, and Young claimed that "osteomyelitis of the pubis and ischium is so rare it is hardly necessary to give it consideration."⁷ Pelvic osteomyelitis has accounted for only 2-11% of series, and infection of the pubic bone is the rarest type of all.^{8,9} Osteomyelitis may result from local infection or haematogenous spread; local infection is more common and is well recognised after gynaecological or urological procedures. The infective nature of "osteitis pubis" has been in doubt, owing to the low rate of isolation of organisms and the fact that experimental

attempts to infect the pubis in rabbits by mimicking the surgical procedure (by exposing the joint and irrigating it with infected urine) have usually been unsuccessful. More recently anaerobic bacteria and *Pseudomonas aeruginosa* have been identified as the organisms usually infecting this site.¹⁰ Haematogenous infection of this site is exceptionally rare. Heldrich and Harris found only 49 cases reported between 1883 and 1978, which were almost invariably in children and in which the commonest organism was *S aureus*¹¹; abusers of intravenous drugs are also at risk.¹²

An interesting feature of our case was the apparent development of a separate focus of infection despite treatment with antibiotics. A possible explanation may be drawn from a case report of multifocal pelvic osteomyelitis in which the satellite lesions were thought originally to have been continuous through serpiginous tracts, possibly following the course of venous sinuses.⁵

Although osteomyelitis is a rare cause of an isolated osteolytic lesion, its diagnosis should not be overlooked as the consequences may be serious. If the results of other investigations, including blood cultures, are negative a biopsy is essential.

We thank Professor J Grimley Evans for his encouragement to report a patient under his care.

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ANY QUESTIONS

In what parts of Spain does leishmaniasis, which is spread by sandflies, occur? What causes the disease and what treatment is advised?

Both visceral and cutaneous leishmaniasis occur in Spain. The former is caused by the protozoan parasite *Leishmania donovani*, which is widespread among dogs in Spain, constituting the important reservoir of infection. Transmission to humans is by the bite of sandflies, especially *Phlebotomus ariasi* and *P perniciosus*. Most human visceral leishmaniasis is reported from the east coast provinces of Alicante and Murcia, but it is possible to acquire visceral leishmaniasis in many parts of Spain. Only small numbers of cases have been reported in recent years. In the Mediterranean region visceral leishmaniasis is traditionally a disease of infants but cases are sometimes reported in adults, who may also have serological evidence of asymptomatic infection. An increase in adult cases may occur if more immunosuppressed people are exposed to infection. Cutaneous leishmaniasis is also seen in eastern coastal areas of Spain. A few isolates from people with cutaneous leishmaniasis have been typed and shown to be *L donovani*, but *L tropica* also occurs in other Mediterranean countries.

Treatment of visceral leishmaniasis is with pentavalent antimony preparations such as sodium stibogluconate (Pentostam) and good results are obtained by experienced physicians. Cutaneous leishmaniasis may also be treated with antimony or by surgical excision but as lesions usually heal with time therapeutic enthusiasm must be tempered.—G B WYATT, senior lecturer in tropical medicine, Liverpool.

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