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Nitrite test for bacteriuria detection

Sir,
We were interested to read the letter by Cooper and colleagues (August *Journal,* p.346) which stated that use of nitrite strip testing in general practice detected urinary tract infection with a sensitivity of 33%. In a study involving elderly hospital inpatients and day hospital outpatients, sensitivities of 83% and 90%, respectively, were obtained.[1] A sensitivity of 95% was reported for hospital patients by Flanagan and colleagues,[2] where the nitrite test was used combined with the leucocyte esterase reagent strip test. Three possible explanations may account for the differences in sensitivities.

The timing of obtaining a urine sample can influence the result, as the chance of there being a positive nitrite test in the presence of a urinary tract infection depends in part on the length of time organisms incubate within the bladder. Assessment of urine which has been in the bladder for at least four hours, or ideally early morning specimens, is likely to increase the sensitivity of the test, but this may not be practicable within a general practice setting.[3] A number of the patients described by Cooper and colleagues may have recently passed urine before providing the sample for testing at the surgery, thus decreasing the test's sensitivity.

Secondly, sensitivities may be affected by the type of organism grown. Most pathogens convert urinary nitrate into nitrite. Any study which by chance includes a high prevalence of non-converting pathogens would result in a reduced sensitivity for nitrite testing. Unfortunately, the authors did not comment on the timing of the urine samples or the organisms grown.

Thirdly, the colour change of nitrite strips in response to a urinary tract infection may affect results. In our experience the colour changes may be subtle when there is a low concentration of urinary nitrite. A positive reaction may therefore be missed unless particular care is taken when interpreting results.

When interpreting the result of nitrite testing, it is important to be aware of the limitations, since we believe the test is likely to be of more use than would be suggested by the results of the report by Cooper and colleagues.

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Mental health care

Sir,
I was encouraged to see that Chris Dowrick's review article emphasized the pivotal position of general practice in the care of people with mental health problems (September *Journal,* p.382). However, in emphasizing the potential for development of services in the future, we should not lose sight of the fact that general practice already provides most of the professional mental care available to patients.[1] Furthermore, it has the advantages of being both accessible, and free of much of the stigma that can be associated with psychiatric services.

Counselling in general practice remains something of a 'trendy panacea'.[2] Formal counselling, as opposed to the use of counselling skills, remains to be properly evaluated in the context of primary care. For general practitioners to offer formal counselling is not without considerable problems.[3] We should extend the Balint idea[4] of the doctor acting as a drug to counsellors too, and therefore we need to ask what are the potential side effects and dangers associated with the drug's use?

In the Edinburgh primary care depression study, the differences between psychiatrists, clinical psychologists, social workers and general practitioners were minimal in terms of short term outcome for people with depression, but general practitioners were the cheapest option, and also managed to achieve their results in considerably less time than it took the other professions.[5]

The principal initiative, in both research and service development, should be the maximizing of the potential of ordinary general practitioner care for people with mental health problems. This allows readily accessible care for most people and is available long term. For the many people whose mental health problems are ill defined and inseparable from their physical health and the context of their families, general practitioner care will remain the best option.

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Sir,
In Chris Dowrick's review article (September *Journal,* p.382) it was disappointing to see that the role of the patient with psychosis or schizophrenia in his or her own care was omitted. Patient held records are of considerable value in long term care.[1] They are acceptable to patients with severe mental illnesses, they increase patient autonomy, and improve communication and effectiveness of shared care. Compliance is good, but patient held records seem more acceptable to patients than to psychiatrists.[1] It is important to work with patients, and the pa-

tient held record is a step in the right direction.

Another area which was not mentioned in the review is the delay between patient discharge and the immediate discharge summary being sent from the hospital to the general practitioner. In a survey of discharge practice in the south east Thames region it was found that of 72 psychiatrists who responded, 22% did not send any early discharge summary. Sixteen per cent of psychiatrists gave seven days supply of medication on discharge and 78% gave enough medication for between seven and 14 days, yet they all estimated that it would take four to eight weeks for the final report to reach the general practitioner.[2]

There is an urgent need for general practitioners and psychiatrists to reach agreement on the need for early discharge summaries and to decide on what information should be provided. Until such basic communication problems have been tackled, there is little hope for improving the immediate follow-up care for this vulnerable group of patients.

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Continuing medical education

Sir,
Dr Harding and colleagues from the Cardiff Postgraduate Medical Centre congratulate colleagues from the west of Scotland in attracting general practitioners to courses, but comment that their successes have not been experienced in other parts of the United Kingdom (letters, October *Journal,* p.443).

The Wessex GP Education Trust is now in its third year. It has a membership of nearly 1300, representing 70% of general practitioners in Wessex (excluding Bath, which has a different organization). The majority of postgraduate education within Wessex is covered financially, directly or indirectly, by the trust on behalf of its members. Members can attend an unlimited number of courses across the region without extra charge.

Income is generated from subscriptions, interest on investments and fees from non-members attending trust events. The subscription needed for the trust to break even is £150 per annum, but as a consequence of a surplus of funds, the subscription for existing members is at present £50 per annum. Members who wish to attend external courses can have a proportion of the course fee reimbursed up to £168.

As well as funding activity within postgraduate centres some of the trust's money is being utilized to develop innovative educational projects, such as focused small group learning, the development of higher professional education and courses that require a specific tutor or facilitator on a longer term basis than the usual study days or refresher courses.

The Wessex GP Education Trust is a registered charity and has an independent executive board to which the regional adviser is automatically co-opted. It has a small office in the headquarters of the regional health authority, and a part-time administrator and part-time secretary. The advantage of the trust is that it has a region-wide base and its size allows for administrative savings, together with the ability to invest surplus income. The trust would be delighted to develop reciprocal arrangements with other similar schemes where they exist.

The Wessex and west of Scotland regions have shown the way forward, and if similar regional schemes could be developed throughout the UK, they might address the fears for the long term future of postgraduate education.

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Cervical cytology

Sir,
We read with interest the comprehensive review relating to cervical cytology by Clare Wilkinson (August *Journal,* p.336).

In the guidelines published by the national coordinating network[1] it is recognized that in some women a minor cervical smear change may represent the only evidence of sexually transmitted disease and referral to a genitourinary medicine clinic should therefore be considered. The possibility that attending for routine cervical cytology may lead to information suggesting a transmissible condition caused concern both within the profession and among women receiving results relating to abnormal smears.

It therefore seems important to consider women with inflammatory smear results as potentially at risk of ascending infection which may lead to fallopian tube occlusion and infertility. The borderline cervical smear result is particularly challenging as the differential diagnosis would include all grades of cervical intraepithelial neoplasia, severe inflammatory changes, and changes owing to papillomavirus. *Chlamydia trachomatis* is considered to be the most important microorganism associated with ascending genital tract infection in women.[2] In women under the age of 25 years, the opportunity to use a minor cervical cytology abnormality to protect future reproductive function may be critical.

The department of genitourinary medicine at Doncaster Royal Infirmary has a commitment to training future general practitioners and has also offered an open access chlamydia culture service since 1980. Table 1 suggests that the peak recovery of *C trachomatis* in the mid-1980s included samples sent from primary care. These data provide an indication that early diagnosis and control may be achieved. These data may also demonstrate greater awareness of the risk of acute chlamydial infection in women compared with men outwith genitourinary medicine departments. However, it would be anticipated that a related increased incidence of tubal occlusion infertility and ectopic gestation might occur five to 10 years later.[3] Examination of the diagnosis at discharge from two adjacent south Yorkshire health districts showed the number of ectopic pregnancies in 1988–89 to be 81, in 1989–1990 to be 73 and in 1990–91 to be 102. Initial evidence does indeed suggest that a rise in ectopic pregnancy may be happening.

The relationship between minor smear abnormality and the presence of chlamydial disease is well recognized. Hicks and colleagues investigated women with inflammatory cervical cytology with detailed microbiology and found at least one sexually acquired infection in 74.9% of 215 patients.[4] This was in fact of greater statistical significance than in other women attending a department of genitourinary medicine where sexually transmitted disease was identified in 64.5% of patients.

It has been argued that genitourinary medicine populations may have epidemiological differences from other groups of young women seeking reproductive health care. This has not been our clinical experience. In 1982 Haworth and colleagues identified the possibility of diagnosing chlamydia within the general practice.[5]

Wilson and colleagues[6] assessed premenopausal women with inflammatory changes on cervical cytology for genital infections and cervical abnormalities and