17. KEABLE-ELLIOTT, R. A. (1972). The use of electrocardiography in general practice. *Medical Digest*, **17**, No. 5, 19–28.
18. KIDD, D. W. & McLellan, D. L. (1972). Self-poisoning with tetrabenazine. *British Journal of Clinical Practice*, **26**, 179–180.
19. MACLEAN, D. W. (1972). An appointments system in trouble. *Update*, **4**, 1021–1024.
20. MANNERS, B. T. B., Dulake, C., GROB, P. R. & GRIEVE, N. W. T. (1972). Urinary tract infection in general practice, *Update*, **4**, 965–969.
21. PICKWORTH, K. H. & MELROSE, W. M. (1972). Repeat prescriptions: safety and control. *Update*, **4**, 961–962.
22. PINSENT, R. J. F. H. (1972). The diagnostic index. *Update*, **4**, 1157–1159.
23. PINSENT, R. J. F. H. (1972). Records in general practice. Correspondence. *Update*, **4**, 839–841.
24. RANKIN, E. (1972). The problem of birth control. *Royal Society of Health Journal*, **92**, 81–84.
25. ROWE, I. L. & LAMONT, J. (1972). A clinical trial of benzydamine hydrochloride ('Tantum') in simple trauma. *Australian Family Physician*, **1**, 49–53. (Feb.)
26. SCOTT, J. R. (1972). Myopia and hayfever. *Practitioner*, **208**, 685–686.
27. TAYLOR, C. (1972). Annual reports from General Practice, 1970. Liverpool. *Update*, **4**, 1127–1136.
28. THOMPSON, M. K. (1972). The examination of the elderly patient. *Update*, **4**, 1005–1012.
29. WALLACE, D. R. (1972). Annual reports from General Practice, 1970. The Isle of Arran. *Update*, **4**, 875–888.
30. WHEATLEY, D. (1972). Drowsiness and antidepressant drugs in mild depressive illness. *British Journal of Psychiatry*, **120**, 517–519.
31. WHITAKER, A. J. (1972). The general practitioner's approach to pain. *Update*, **4**, 931–936.
32. WILLIAMS, E. I., BENNETT, F. M., NIXON, J. V., NICHOLSON, M. R. & GABERT, J. (1972). Sociomedical study of patients over 75 in general practice. *British Medical Journal*, **2**, 445–448.

BATTERED BABIES

The Battered Child Research Department is offering intensive case work support to families living within the boroughs of Westminster, Kensington, Chelsea or Camden.

Enquiries are welcomed at the Battered Child Research Department, Denver House, 316 Ladbroke Grove, London W10 5LR. Telephone 01 969 1212 day and night.

SCOTTISH HOSPITAL MORBIDITY DATA

The Scottish Home and Health Department Health Service Studies No. 20 published in May 1972 on Scottish Hospital Morbidity Data 1961–68. This work was undertaken by Dr Eric Lockwood, who is a lecturer in the Department of General Practice, University of Edinburgh.

Correspondence

FOUNDATION COUNCIL AWARD, 1972

Sir,

Through the *Journal* I would like to thank the members of the Foundation Council and of our College for bestowing this great honour upon me.

When the President presented the Award to me on the occasion of the Spring Meeting in Liverpool he reminded me of the calibre of previous recipients, and referred to the object itself as "this gem". This description is significant in its connotations; and the craftsmanship displayed in this miniature silver replica of the Chairman's gavel is superb.

I shall endeavour to maintain the trust that has been placed in me, and the standards required of all members and associates of our fraternity.

A man can receive no greater honour than that accorded by his own colleagues who share his way of life, and who know his failings as well as his attributes. I am able to accept this honour as a tribute and encouragement to all those doctors who are involving themselves in the immediate care of the seriously injured, in the spirit of the Good Samaritan.

Like him they may not be the best qualified to render assistance but they offer what they can and do not 'turn aside'.

In Great Britain they now number over 700. I am grateful for the kind way in which they have listened to me at their meetings, and the welcome I have been given in so many homes over the past five years.

No man is an island. The gratifying achievements of these years could not have been attained but for the loyal help of members of our own pilot scheme, and especially of my two partners who share the trials and pleasures of practice with me, and who joined me in the full knowledge that attendance at road accidents was an accepted commitment.

My deepest gratitude however is to my wife Janet who has been involved in this work since we came to Catterick in 1949. Her help and support has been unselfish and constant throughout this time. It was a delight that she was invited to Liverpool for this memorable occasion. Through her may I thank the wives of all of us with similar sentiment.

I had intended to say something of this in the form of 'a gracious reply' after the presentation, but the Chairman of Council warned me that after he had read his most perceptive citation I would be in no fit state to speak. In this he was quite correct.

KENNETH EASTON

Stepping Stones,
32 Low Green,
Catterick Village,
Richmond,
Yorkshire.
(*See* May *Journal*).

NATURAL HISTORY OF ACUTE APPENDICITIS

Sir,

May I be permitted to comment on some of the points raised by Dr Howie (April *Journal*) on this subject and concerning the article we published in the January *Journal*.

In my epidemiological study there is a possibility of bias, but we believe that this was reduced to a minimum in the reported series. Most of the cases admitted to the study were reported within the first six months of the recording period and with a condition like acute appendicitis it is very likely that many doctors did not have a second case to report within this period. This explains why the full quota was not achieved.

We cannot agree that hospital cases should be used as the index. Admission to hospital is a problem of primary medical care and on discharge the patient returns to primary medical care. Hospital admission is only an incident in a continuing process and to disregard this is to create an unrealistic situation.

We agree that the significant events in follow-up are re-admission and death. Since death from acute appendicitis is infrequent, as Dr Howie shows, one accepts that our follow-up sample is too small to evaluate this risk, but re-admission is a different matter.

Our sample is big enough to detect a re-admission rate of anything greater than ten per cent in a five year follow-up and since we are interested in orders of magnitude and not absolute figures, at this stage of our studies, this is adequate.

The figures detailed by Dr Howie are important and worth serious consideration but I suggest, with respect, that they narrow the problem unnecessarily.

In conclusion we thank Dr Howie for his interest and shall certainly bear his remarks in mind when we come to the second stage of the analysis. We also look forward to seeing the results of any further studies which he himself might initiate.

A. JACOB
Secretary
Research Committee

10 William Street,
Dundee,
DD1 2NL.

CASE FINDING IN URINARY TRACT INFLAMMATION

Sir,

Kass's[1] original discovery that urines can be bacteriologically divided into two classes on the basis of urinary bacterial counts has provided a tremendous impetus to the bacteriological investigation. It has concentrated effort on the study of those patients with more than 10^5 bacteria per ml of urine, and this is an important and necessary development.

However, the urinary tract problem as it presents itself to the general practitioner is not clearly defined in bacteriological terms. He is equally responsible to his patients with urinary tract symptoms, whether or not they have a particular level of bacteriuria. If a practitioner is to investigate his patients with clinical features of urinary tract inflammation, he has first to identify them, and this is not such an easy task as might at first appear. This letter indicates some symptoms with which patients commonly present, which should alert the practitioner to the possible need for further investigation of the urinary tract. Some of the patients in this series have been fully investigated in hospital and others have not. Some have significant bacteriuria and others, equally ill, have not.

Urinary tract inflammation is characterised by symptoms referable to the urinary tract and also by symtoms remote from it.

For the purpose of this study the symptoms of 50 consecutive female patients aged 15 and over and seen by me in this practice were recorded. Patients were admitted to the series if they possessed any of the following characteristics: (1) Frequency of micturition. (2) Pain on micturition. (3) Renal angle tenderness to light percussion with the closed hand or (4) Grossly infected urine. Women in this group often do not complain of even quite severe frequency of micturition and are usually unaware of the presence of a tender kidney.