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.

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(*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.

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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.

They therefore attend the surgery complaining of any of a number of symptoms remote from the urinary tract and their urinary tract symptoms and signs are discovered only on enquiry.

Urinary Tract Symptoms

Frequency of micturition	35
Renal tenderness to percussion	26
Pain (scalding) on micturition	14
Hypogastric ache	14
Renal ache or pain	12
Urgency	9
Hypogastric tenderness	7
Infrequent micturition	5
Foul urine	5
Stress incontinence	4
Difficulty of micturition	3

Also complained of were lack of desire to micturate and haematuria.

Non-urinary tract symptoms

Frontal headache	20
Abdominal bloating (The patient complains that the abdomen is distended and that she feels about six months pregnant. This distension is apparent to the observer).	18
Unilateral or bilateral sacroiliac pain	15
Tiredness	12
Pallor	9
Depression	6
Irritability	6
Insomnia	4

Also complained of were loss of libido, dyspareunia, nausea and epigastric pain and slight general oedema in the absence of albuminuria.

The foregoing non-urinary tract symptoms are so frequently noticed as presenting symptoms of urinary inflammation that in this practice it is customary to look for urinary tract inflammation in all patients presenting in this way.

It is apparent that frontal headache, abdominal bloating, sacro-iliac low backache and depressive and psychological symptoms such as tiredness and irritability are particularly important. I would also draw attention to the importance of light percussion with the closed hand over the renal angle[2] in bringing to light urinary tract inflammation.

I should like to express my thanks to the East Anglian Regional Hospital Board for a grant towards clinical investigation of urinary tract inflammation.

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1 Kass, E. H. (1956). *Transactions of the Association of American Physicians*, **69**, 56.

2 Eastwood, N. B., Bruce, R. G. & Wren, W. J. (1965). *Journal of the College of General Practitioners*, **10**, 257.

DIAGNOSIS AND NAMING

Sir,

Dr Howie's paper on diagnosis (May *Journal*) is a neat exposition of the theme that, in general practice, naming is a less reliable predictor of action than is information-clustering. He goes on to suggest that difficulties ensue in establishing a common clinical language between hospital and community practice as a result.

However, such difficulties only arise if 'diagnosis' and 'naming' are regarded as synonymous, i.e. if 'diagnosis' is given the restricted connotation of 'naming'. This synonymity is implied by Dr Howie throughout his paper; and does less than justice to the hospital clinician.

No matter where the physician happens to practise—in hospital or outside it—every consultation confronts him with four questions: 'What is wrong?', 'Why has it happened?', 'What is going to happen?', 'What should be done?' The basis of his answers to all four questions is probabilistic; and their relevance purely predictive. Both hospital and community practice share this probabilistic basis of activity; and any divergence between them is more apparent than real.

Diagnosis is more than naming—and to use (or imply) the terms as coextensive is to perpetuate a clinical attitude which inevitably confuses both the student and the physician.

Naming is a necessary human activity:

1. Attempting to reduce 'content information' to 'sign information'.
2. Satisfying (at least partially) the human need (of the physician) to reduce uncertainty.
3. and, in some degree, essential to experiential learning.

In the process of problem solving the physician's mind constantly switches between the particular and the general; and any formulation of the general requires naming and classification. These are useful tools; but not to be confused with diagnosis.

Only when the distinction between naming and diagnosis is clearly kept can clinical method shed the restrictions produced by servitude to traditional nosology: and the physician think more freely about the diagnostic process.

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REFERENCE

Howie, J. G. R. (1972). *Journal of the Royal College of General Practitioners*, **22**, 310–15.

MICHAEL BALINT

Sir,

While staying with a friend I saw the March *Journal* with the editorial on Michael Balint.