The Prevalence of Dysuria in Women in London

Sir,

I am writing to welcome the survey of dysuria reported by Walker *et al.* (July *Journal,* p. 411). Such symptom surveys of whole populations are basic to getting the clinical challenge of general practice into perspective. I have re-examined the data we collected in a survey[1] of patients consulting the doctors in my practice for inflammatory disease of the urinary tract during the 12 month period from July 1963 to June 1964 and find that of 1,724 women aged between 20 and 54 years, 236 (13.7 per cent) consulted us for this condition. We admitted into the survey patients complaining of pain or frequency of micturition, or renal pain or tenderness other than renal colic. Table 1 shows the age distribution of our patients compared with that found by Walker *et al.*

The choice of the symptom 'dysuria' might be criticized on the grounds that it is a purely urethral symptom (urethralgia of micturition) and we felt it necessary in our practice survey to cast the net wider to include vesical and renal symptoms.

Many patients with inflammatory disease of the urinary tract do not have dysuria and this includes some of the more important cases with inflammation of the bladder and kidneys. In our series just over 50 per cent of patients, both male and female, with inflammatory disease of the urinary tract had renal pain or tenderness. Insofar as dysuria draws attention to these patients it is an important finding. Like Walker *et al.* we also noticed a decline in incidence with age. In our series, incidence fell up to the age of 65 years, but above this age it rose again.

Although pyelonephritis of pregnancy is an important condition, it is relatively uncommon. The most troublesome conditions related to inflammatory disease of the urinary tract in females are:

—Renal pain and tenderness, because they are accompanied by a large group of symptoms, often mistakenly labelled 'neurotic', together in some cases with idiopathic oedema. Renal pain and tenderness can become chronic, debilitating and resistant to treatment.

—Chronic urethral obstruction—characterized in women by poor stream, hesitancy of micturition, loss of bladder sensation, hypogastric ache and bad-smelling urine. It gives rise to chronic ill-health.

From the results of treatment of inflammatory disease of the urinary tract with various urinary antibacterials, it would seem that this condition is usually of bacterial origin, but proof of this is difficult to establish. Of 100 patients with symptoms of urinary tract inflammation seen by me in this practice, only 30 had significant bacteriuria before treatment as shown by bacteriological examination of a mid-stream specimen and by inspection of a dip-slide.

It is clear that there remain many challenging problems in this field.

N. B. EASTWOOD
82 Victoria Road
Oulton Broad
Lowestoft
Suffolk NR33 9LU.

Reference

1. Eastwood NB, Bruce RG and Wren WJ. Prevalence of inflammation of the urinary tract. *J Coll Gen Prac* 1965; **10:** 257.

Sir,

I read the paper by Walker, Heady and Shaper (July *Journal,* p. 411) with much interest. To my knowledge there has only been one previous study which has attempted to indicate just how common symptoms suggesting urinary tract infection are in the community.

I must confess to some surprise, however, when I came across the authors' recommendation that any woman who has had two or more episodes of dysuria within 12 months requires detailed investigation, as does any woman who has had dysuria in two or more successive pregnancies, in order to identify abnormal renal tract structure or function. Would the authors be prepared to re-examine or clarify this assertion?

Every practising clinician is aware (particularly if he starts asking routine questions as the authors recommend) that hordes of women would fall into this category. This would not matter if useful information resulted. Despite adequate therapy and a bacteriological cure as judged by post treatment urine investigation, nearly a third of women with symptoms and bacteriuria will develop bacteriuria again over a three month follow up—yet further investigation is a fruitless exercise.

I studied 137 women with dysuria and frequency syndrome and referred 57 of the worst afflicted with recurrent infection for further investigation which included cystoscopy and intravenous pyelography. Abnormalities were found in 10 per cent.[1] Manners and colleagues[2] reported a marked difference in pyelographic abnormalities between women with 'recurrent bacterial cystitis' at 4 per cent, women with 'asymptomatic bacteriuria' at 48 per cent and women with 'acute bacterial pyelonephritis' at 75 per cent. Reported abnormalities included scars, calculi, sponge kidneys and dilated and distensible calyces. Having found certain abnormalities, however, the authors still questioned the value of the exercise as most of the abnormalities (with the possible exception of calculi) are untreatable, have a questionable causal relationship with the dysuria and frequency syndrome and are of doubtful significance in terms of chronic ill health.

Dr Walker and her colleagues admit that modern opinion has it that urinary tract infection in adults is benign, even if distressing, and that progression of untreated or inadequately treated urinary tract infection does not lead to renal disease, renal failure or hypertension. The advantages of treating bacteriuria in pregnancy are generally accepted in order to prevent the later development of distressing acute pyelonephritis. With this proviso it is difficult to find any authority in the UK who would advocate any form of screening even in children, let alone adult women with dysuria.

Before we can recommend screening outside pregnancy we need to know whether renal scars are produced by vesico-ureteric reflux alone or by a combination of reflux and infection. We need to know whether treatment prevents further episodes of symptoms and scarring, and most important of all we need to know how the radiological diagnosis of chronic pyelonephritis re-

Table 1. Age distribution of women consulting their doctors for inflammatory disease of the urinary tract.

Age in years	Number on medical list	Number attending	*Per cent* (Dr Eastwood's practice)	*Per cent* (Dr Walker's findings)
20–29	493	95	*19*	*25*
30–39	486	80	*16*	*21*
40–49	465	38	*8*	*17*
50–54	280	23	*8*	*13*
Total	1,724	236	*13.7*	*20*