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*

lates to future ill health. Adults with chronic pyelonephritis have, as a rule, an excellent prognosis and we need to know why some scarred kidneys fail. Some women may need referral to an interested specialist because of atypical symptoms such as haematuria or frequently recurring and distressing attacks occurring every few weeks.[3] This is a major indication for referral but even then frequent attacks are usually best prevented by prophylactic antibiotics. Although excretion urography is a necessary investigation, the emphasis is on the lower urinary tract with cystourethroscopy, the assessment of bladder function and the investigation of urethral flow properties.

Perhaps we should all be emphasizing that frequent attacks, even of acute pyelonephritis, are not the same thing as chronic pyelonephritis and that in the past too many women have been subjected to upsetting and totally unnecessary investigation. It would be tragic if this otherwise excellent paper were to reawaken anxieties in this population of women or their doctors about a relationship between recurrent cystitis and renal tract disease.

D. BROOKS

133 Manchester Old Road
Middleton
Manchester M24 4DZ

References

1. Brooks D. *The Syndrome of dysuria and frequency in adults—a study from general practice.* University of Manchester: MD Thesis, 1971.
2. Manners BTB, Grob PR, Dulake C and Grieve NWT. The interrelationship of asymptomatic bacteriuria, acute bacterial pyelonephritis and bacterial cystitis in women: in Brumfitt W and Asscher AW (Eds) *Urinary Tract Infection.* London: Oxford University Press, 1973.
3. Brooks D and Mallick N. *Renal Medicine and Urology.* Edinburgh: Churchill Livingstone, 1982.

Hypertension Screening in General Practice

Sir,

I was interested in this paper by S. R. Mayhew (July *Journal* p. 434).

Although the method describes use of a random zero sphygmomanometer, the histogram of diastolic blood pressure distribution shows strong evidence of zero preference. The number of readings in the 65 band is fewer than that in both 60 and 70; the same effect is seen strikingly for 75 and is apparent for 95, 105 and 115. I find this zero preference difficult to reconcile with the use of a random zero sphygmomanometer.

JAMES S. MCCORMICK
Professor,
Department of Community Medicine

Trinity College Medical School
196 Pearse Street
Dublin 2.

The Assessment of Affective Learning

Sir,

In a letter (July *Journal,* p. 463) Dr Cyril Gill writes that as part of a thorough examination of the issue of psychiatry in general practice there should be an assessment of how trainees change when undergoing training for general practice both in half-day release case discussion groups and through the trainer-trainee relationship.

One means of assessing the change in trainees in a half-day release group is the degree to which affective learning, that is the emotional acceptance of new knowledge, occurs. Such learning involves the development of new attitudes towards the range of problems that are discussed in the group. It involves the relinquishing of former attitudes based on hospital medical education and the acquisition of a new knowledge base. This is essential if trainees are to acquire the necessary skills and attitudes to detect and deal with the various presentations of psychiatric problems in general practice.

In terms of assessing to what extent affective learning leads to change in trainees, a 'bereavement reaction' model can be utilized.[1] In relation to general practice this model attempts to trace four stages which focus on the feeling states that trainees may pass through after joining a half-day release group. The first stage suggests a period of confusion when beginning the group, followed by denial at the need to change; anger may then be expressed at the changes expected of them and finally a period of reintegration may follow in which new styles of working may be adopted to deal with the new situation.

The extent to which trainees pass through these stages may indicate the degree to which they can be assessed as having acquired the characteristics of the new professional role. Moreover, trainees' new awareness and insight into their own capacity for change should contribute to a more effective functioning in general practice and understanding of the problems presented.

RUTH SHAW
Sociologist

21 Hogarth Hill
London NW11

Reference

1. Kahn E, Lass S, Hartley R, Kornreich H. Affective learning in medical education. *Am J Med Educ* 1981; **56:** 646-652.

DATES FOR YOUR DIARY

North American Primary Care Research Group

The 12th Annual Meeting of the North American Primary Care Research Group will be held on 2–5 May 1984 and will be followed by the 17th Annual Spring Conference of the Society of Teachers of Family Medicine from 5–9 May 1984. Both meetings will be held in Orlando, Florida. The theme will be 'Research in a Brave New World: Community Oriented Primary Care'.

Further details for those who wish to attend or present papers can be obtained from: NAPCRG 1984, Department of Family Medicine, University of Miami, PO Box 016700, Miami, Florida 33104. (Tel: (305) 547-6681)

Study day on practice management

The Bedfordshire and Hertfordshire Faculty is organizing a study day on practice management to be held at the Luton and Dunstable Hospital Postgraduate Medical Centre on Saturday 10 December 1983.

Further details can be obtained from Dr R. D. Chapman, 59 Cotefield Drive, Leighton Buzzard, Bedfordshire.

All Pakistan Biennial Medical Conference

This Conference will be held on 23–27 November 1984 in Karachi. Those interested in attending should contact: Dr Mohammad Sarwar, Honorary Secretary General, Pakistan Medical Association (Centre), PO Box 7267, National Headquarters, PMA House, Garden Road, Karachi 3, Pakistan, for further details.