

the psychologist as a resource of information and ideas, broadened the range of interventions that the doctor in the practice could make. In this way, referrals to the psychologist became fewer and more specific to the particular skills which the psychologist could offer.

Other ways of using the resource of a clinical psychologist include involvement in general practitioner training courses, both in teaching trainees about common psychological disturbances encountered in general practice, and also in giving instruction on interviewing skills in the consultation. In Mersey region, the latter has been done with trainers using video feedback to train them in ways of enhancing the consultation skills of their trainees.

Often doctors are unclear about the nature of the work of a clinical psychologist and do not refer to a hospital-based service, nor think of providing a specialist session in the practice, because they are not sure of what constitutes an appropriate referral. Two practices in Liverpool who used clinical psychologists, combined to provide an evening to share experiences with a number of other general practitioners. Discussion and comment from the general practitioners and psychologists helped to further ideas about the potential joint work that could be undertaken. Clinical psychology has also been represented at the annual meeting of the branch of the Royal College of General Practitioners through invitations to present papers on benzodiazepine dependence in general practice and on the work of the clinical psychologist in primary care.

Given the scarce resource of the clinical psychologist, developments must be made in a direction away from mere specialist clinics towards joint venture and co-operation in patient care.

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#### Reference

1. Cormack MA, Sinott A. Psychological alternatives to long-term benzodiazepine use. *J R Coll Gen Pract* 1983; 33: 279-281.

## Urinary tract infection in children

Sir,  
Houston's letter (September *Journal*, p.494) questions the validity in our study (May *Journal*, p.324) of extrapolating findings in Smellie's highly selected group of children to the general population. We share these doubts.

Far from seeking to promulgate this view our study was designed to test the opinions of general practitioners and non-specialist paediatric consultants in our area to the view that all children under five years who have a urinary tract infection require both an intravenous pyelogram (IVP) and micturating cystogram (MC). It demonstrated quite clearly that paediatricians in south-east Thames consider IVP only as the first line investigation in first time childhood urinary tract infection (UTI). Seven of the 20 paediatricians who took part in the survey would consider MC as well for a two-and-a-half-year-old boy, but none would do so in an eight-year-old girl. Interestingly about 50 per cent of general practitioners expected this boy to get both IVP and MC. Quite clearly the role of MC as part of radiographic investigation is contentious.

In Medway Health District during the years 1980-83, 107 boys and 169 girls were referred to the paediatric department for investigation of urinary infection. One hospital provides the sole paediatric department for the district and does not receive refer-

als from elsewhere. Eighty per cent of children were referred after what was presumed to be their first infection. All had IVP and the results of those whose records could be traced are shown in Figure 1. Interestingly 33 per cent of the children with abnormal IVPs had no urinary symptoms at first presentation. The commonest abnormalities were pelviureteric junction obstruction and bifid drainage systems in boys and vesicoureteric reflux (VUR) with renal scars in the girls.

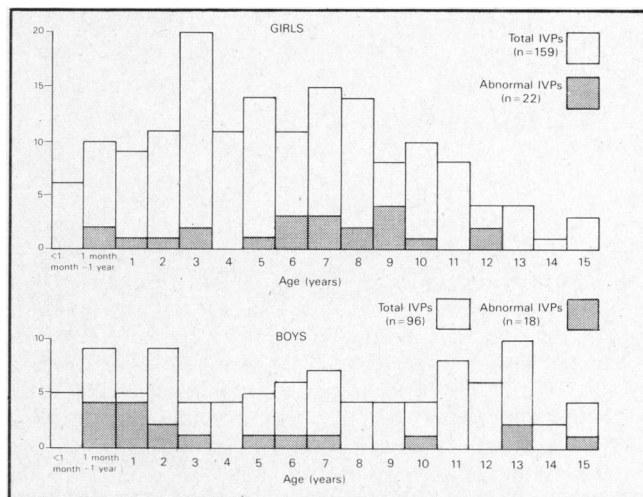


Figure 1. Number of normal and abnormal intravenous pyelograms (IVP) for 255 children with urinary tract infection, by age and sex; All Saints Hospital, Chatham 1980-83

The proportion of children with urinary tract abnormality is, as we expect, lower than in surveys from specialized centres, but is still so great that an IVP must be done for every child with a proven UTI — to do otherwise might possibly be construed as inexcusable.

The data in Figure 1 illustrates precisely the point made in the concluding paragraph of our study, namely that in any health district general practitioners and consultants should together be able to implement a practical management policy for childhood UTI based upon local data, and hence relevant to that population.

In the absence of other widely available techniques for identifying children at risk after UTI, it is difficult to imagine how a prospective longitudinal study from general practice of childhood UTI is going to shed light on 'best current management' without recourse to radiographic investigation even if this is to include only an IVP.

Using our incidence rate, we would expect about 50 boys and 90 girls aged between one and twelve years to be referred to the Medway Health District in any one year. Over the past four years the actual numbers are about half of that. What would be a fruitful exercise is to study prospectively the characteristics and investigation results of those not being referred.

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## Medicines Surveillance Organisation

Sir,  
Work coming from the Medicines Surveillance Organisation, directed by Clifford Kay, naturally attracts serious consideration (September *Journal*, p.509). We are therefore all the more