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 clinicial 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 referrals 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 vesicouretaric relux (VUR) with renal scars in the girls.

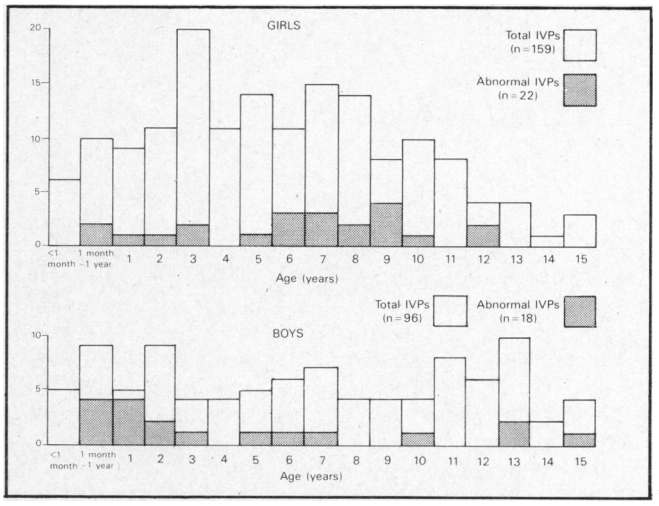

Figure 1. *Number of normal and abnormal intravenous pyelograms (IVP) for 255 children with urinary tract infection, by age and sex; All Saints Hospital, Chatham 1980–83*

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 date 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

puzzled that it should have been thought worthwhile to set up a trial for yet another benzodiazepine, and then compare it with the popular diazepam.

We feel that the comparison is deeply flawed in that the response of patients with anxiety to simply attending sympathetic (and perhaps prolonged) consultation without any therapy at all is frequently very good. The efforts by general practitioners to reduce the amount of benzodiazepines prescribed and the conscious attempt to wean the too many addicted patients off it, may well have been helped if Dr Kay's trial had included a group of patients who received no other treatment than the therapeutic support of seeing the doctor and psychologist or counsellor. Frankly, does it matter very much whether one benzodiazepine is more or less potent than another?

It is difficult to avoid a feeling that the manufacturers were anxious and willing to promote this research for a 'new drug' whose patent may not yet have expired. We wonder whether time and effort should be spent on trials of this sort, particularly when there is bound to be a very considerable interest in the outcome by the Head of Medical Affairs, Roche Products Limited.

The trial was only for two weeks and there must be many general practitioners who would not be inclined to place patients with acute or moderate anxiety of short duration on any medication at all. In fact many of them might regard it as bad practice to do so.

A dose of 15mg a day would seem to us a large dose for mild anxiety and perhaps the withdrawal of five patients for adverse reactions on this dose would not be surprising.

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The College and the pharmaceutical industry

Sir,

Over the last three years, I have been fortunate to have the opportunity to start a new general practice from scratch. I came to this challenge from full-time employment with a research based British multinational pharmaceutical company. My list size has now grown to over 1,600 patients and I continue to work as a consultant to that pharmaceutical company. I feel that this experience puts me in a special position to comment upon the editorial 'Preventing promotion' (September *Journal,* p.473).

My own feeling is that the issues of the relationship between the *Journal* and the pharmaceutical industry are wider than this simple matter of advertising space. In particular I am interested in drug trials carried out by general practitioners and the subsequent publication of the results of this work. I believe that we should all like to see the *Journal* publish quality work carried out by general practitioners to evaluate drugs.

Unfortunately, it is my general experience that many general practitioners are not interested in undertaking this sort of work. It is very exacting work and requires skill and diligence. It is unfortunately true that general practitioners are also suspicious of covert drug promotion dressed up as clinical research. Sometimes this is a genuine fear, but also sometimes simply an excuse. Fortunately, it is possible to carry out good quality drug evaluation in this country in general practice. The information derived is of great value both to the pharmaceutical industry and to prescribing doctors.

What is the relationship of the *Journal* of the College to all this? Surely the College and the *Journal* have a responsibility to take an active interest in this area of general practice. Unfortunately a journal made up of even the highest quality drug trials would make fairly dry reading. I would therefore propose that this *Journal* seriously considers setting up a supplement to publish this work. Such a supplement need not be circulated to all College members, but would form a body of data available to doctors and may be reported in the *Journal.* This would fulfil the obligation which I believe rests with the College to be seen to be actively involved in this area of research.

I would ask my clinicians frustrated in trying to have their work published, or any member of the pharmaceutical industry interested in supporting this idea to write to me and I will pass on these letters to the College.

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Fifth disease

Sir,

I was interested to read the short report about fifth disease in Brechin (October *Journal,* p.573). Our rural area based on Stalham, Norfolk, had a similar outbreak of fifth disease which started in November 1983 and was centred on the local middle school. No records are available but between 30–60 children were probably affected.

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Premenstrual syndrome

Sir,

The recent editorial about the premenstrual syndrome (October *Journal,* p.533) serves only to confuse general practitioners further in the diagnosis and treatment of what is in effect a straightforward progesterone deficiency disease. Straightforward, that is, if one keeps to the correct definition of the syndrome which is: 'the recurrence of symptoms in the pre-menstruum with the absence of symptoms in the post-menstruum.' (Dalton K.) The diagnosis is made very simply by recording the timing of symptoms in relation to menstruation. This is far easier and more accurate than a diary recording day-to-day experiences over a period of a few months.

If the symptoms are only present in the luteal phase then they will be relieved by progesterone supplements. By using this definition and simple charts it offers general practitioners the opportunity of relieving very real, distressing cyclical symptoms that affect not only the patient but her family. It may or may not be that 95 per cent of women experience premenstrual symptoms, but it does not take much discrimination on the part of the patient and her doctor to decide whether an individual needs treating. What is more worrying is that about 95 per cent of general practitioners appear to have little knowledge of this essentially general practice illness and this includes women doctors. 'Pull yourself together woman!' still seems to be the rather depressing advice that continues to be given. General practitioners can easily opt out of their responsibilities and refer such patients to a wide variety of specialists, including psychiatrists, according to the presenting symptoms.