

pressure placed upon services for drug users by the human immunodeficiency virus. Although the debate about substitute prescribing is something which needs to be increased rather than swept under the carpet where it has been for 20 years, we cannot ignore the threat of the acquired immune deficiency syndrome. The first priority now for many doctors is to keep drug users uninfected for long enough to allow recovery or progress to controlled use.

J. ROY ROBERTSON

Edinburgh Drug Addiction Study
1 Muirhouse Avenue
Edinburgh EH4 4PL

Dr Robertson makes an important point. It was my decision to omit any consideration of AIDS in the editorial by Dr Chang because we intend to publish a further editorial on this subject in the near future. Ed.

Sir,

Dr Chang is right to highlight the plight of families of opiate addicts and to suggest that their suffering is under-recognized. However, she goes beyond the available evidence when she states that 'getting involved with the family is of far greater benefit than counselling the addict or prescribing or indeed any other form of therapy'. Her explanation for this statement is the fact that families 'enable' their addicted relative to escape the consequences of their addiction.

Having experience of the management of opiate addiction in both general practice and as a member of a specialist drug dependency clinic I consider that such 'enabling' plays a very small part in the perpetuation of addiction. The most impressive thing about established opiate dependency is the sheer resistance to change in most cases despite disintegration of marriages and families, debt, imprisonment, disease, and indeed despite all interventions be they medical, penal or social. This, sadly, is the realistic starting point for planning management for many addicts.

Dr Chang does not mention referral to specialist drug dependency services. There is a good case for referring 'hard-core' addicts as such individuals are usually time consuming to deal with and may be awkward and aggressive. With their multidisciplinary input, specialist clinics can offer inpatient detoxification, counselling about pregnancy and about human immunodeficiency virus infection and can monitor their patients more closely with urinalysis. I think there is a place for maintenance prescribing in such clinics to try to keep confirmed addicts stable until they enter that mysterious process of

maturation out of their addiction. The existence of specialist services leaves no excuse for those general practitioners who refuse to accept suspected or known addicts onto their list.

G. WOOD

Whiston Hospital
Prescot, Merseyside L35 5DR

Managing the difficult patient

Sir,

Towards the end of an excellent article on 'Managing the difficult patient' (*August Journal*, p.349), I encountered a paragraph beginning 'Sharing the burden...' I thought this would be an elegant summary of the role of the doctor with these difficult patients, in helping them focus on and discuss their various social problems, along the lines of a problem shared being a problem halved.

Sadly, the paragraph actually suggested sharing the care of difficult patients with one's partners, which, while undoubtedly superficially attractive, really amounts to running away from the problem and seems contrary to the tone of the rest of the article. In fact, in an earlier paragraph a similar ploy of referral to specialists 'primarily to allow the doctor to escape from contact with the patient' was described as unnecessary.

GRAHAM M. BROWN

129a Victoria Road
Kirkcaldy KY1 1DZ

Pathogenesis of urethral syndrome

Sir,

The author of a book is entitled to expect that a reviewer for a serious journal should give potential readers an idea of the book's purpose and content.

In the *August Journal* six of the seven book reviews published did just that. The seventh, that of my book *Urinary tract infection in clinical and laboratory practice*, made no such attempt. The reviewer chose rather to highlight two small and one rather larger aspect with which he apparently disagrees, and to dismiss the whole book in somewhat personal terms.

In my view, the argument over the pathogenesis of urethral syndrome is a scientific one which must be resolved on the basis of scientific evidence. Unlike the microbiologists at the Royal Free Hospital I have never wished to conduct the debate in a personal way and I am content for my case to rest on the evidence.¹ The decisive rebuttal by careful research mentioned by your reviewer consists of one paper.² Patients with symptoms were in-

vestigated on one occasion only; the isolation rate of lactobacilli and the presence of pyuria were similar to the figures obtained in our laboratory. The authors' dismissal of the significance of these organisms rested upon their observation that lactobacilli were also isolated from controls. Their controls, however, were either pregnant women (from whom there is a large body of published evidence that fastidious organisms are frequently isolated) or women who were subject to urinary tract infection and had been treated for it. If my hypothesis is correct, that the cause of urethral syndrome is an imbalance of urethral commensal flora, analogous to *Candida vaginitis*, patients who have recently received antibiotics are also inappropriate as controls. It is well documented that many women who suffer from bacterial cystitis are also subject to urethral syndrome.³ I have suggested that the latter is fuelled by antibacterial treatment given for the former. In our two-year prospective study⁴ — the only one in which patients have been investigated on more than one occasion — the controls were selected appropriately as having had no urinary symptoms for one year and no antibiotics in the previous three months. The isolation rate of lactobacilli differed significantly between patients and controls. This finding was confirmed more recently by other authors who also used appropriately selected controls.⁵

We continue to amass further scientific data on the role of fastidious organisms in the urinary tract of the very large number of patients (including those with interstitial cystitis, prostatitis, and irritable bladder) who complain of urinary symptoms for which conventional microbiology finds no explanation. I am averse, as your reviewer says, to attributing psychological causes to conditions for which there is objective evidence (clinical, microscopic, histological and occasionally radiological) of disease. Despite your reviewer's view that I am 'out of touch with the clinical world' — unlikely when one is married to a general practitioner — I continue to look after a large number of such patients in a urinary infection clinic. Many of them have not been helped by the conventional management that they have received from their general practitioners or from various specialists. I have no doubt, from the clinical and microbiological evidence, that the great majority suffer from organic conditions.

ROSALIND MASKELL

Public Health Laboratory
St Mary's General Hospital
East Wing, Milton Road
Portsmouth PO3 6AQ