intestinal tract are common in the community. Symptoms compatible with the diagnosis of irritable bowel syndrome, for example, are experienced by at least one fifth of the general population.[1,2] Not surprisingly, gastrointestinal complaints are common reasons for consultation with general practitioners and the difficulties of making clinical diagnoses in upper and lower abdominal disorders are well documented.[3] The diagnostic delay reported in this study is hardly surprising, particularly in view of the rarity of Crohn's disease. Although the authors comment on the changing pattern of this disease, three quarters of the patients, as expected, had colicky abdominal pain or a change in bowel pattern, although it is interesting to note that only about 40% had rectal bleeding. Before suggesting that diagnostic delay could be reduced it would be necessary to know something about the frequency and severity of symptoms during the period between symptom onset and final diagnosis. It may be, for example, that those patients in whom diagnostic delay appears excessive had relatively mild and infrequent symptoms during this period. It is perhaps also worth pointing out that a small proportion of patients confidently diagnosed as having irritable bowel syndrome after exclusion of organic disease by extensive investigation subsequently turn out to have inflammatory bowel disease.[4]

For these clinical observations to be of value in making a diagnosis, some measure of the predictive value of symptoms, either in isolation or in combination, needs to be determined. Otherwise, one logical conclusion which could be drawn from the study is that more investigations should be performed at an earlier stage in more patients, leading to unnecessary use of investigations and to wasted resources.

Perhaps most importantly, we need more information about how far general practitioners are able to investigate patients with persistent lower bowel symptoms in the surgery. Access to radiological and pathological tests is now fairly widespread, but only a minority of general practitioners have the expertise and facilities to perform sigmoidoscopies, for example, in their surgeries. Given that two thirds of the patients in this study had large bowel involvement with Crohn's disease, the use of sigmoidoscopy is of particular diagnostic relevance.

What would be of great interest would be a review of the general practice records of these patients. It might then be possible to describe thresholds of symptom frequency or severity leading to investigation or to determine the diagnostic weight of individual symptoms or symptom complexes.

ROGER JONES

Primary Medical Care
University of Southampton
Aldermoor Health Centre
Southampton SO1 6ST

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Chronic pelvic pain

Sir,

Dr Guirgis reports a personal study of 200 women years of pelvic pain (December *Journal,* p.567). In no less than three teaching hospitals gynaecological assessment failed to reach a diagnosis in the majority despite laparoscopy in 174 cases and only 26 improved with gynaecological treatment. As a result of this study he suggests that 'chronic pelvic pain has a psychological rather than an organic basis in the vast majority of cases'. He then makes a series of recommendations to general practitioners.

His suggestions and recommendations reflect the confidence of the well trained. The less well trained could be forgiven for having doubts about their validity. Doubts about the infallability of collecting evidence and about its interpretation, both so dependent on personal experience, learning and preconceptions. Doubts too about the completeness of our present taxonomy of diseases.

While certainty dispenses with questions, doubts should generate questions and these may lead to the discovery of new symptom complexes, unrecorded physical signs or even a revision of the current conceptual models used in diagnosis.

Dr Guirgis offers the standard dualism of psyche and soma for the origin of pain. The one accessible to exploration, experiment and laboratory testing, the other far less so. Little account has apparently been taken of the processes going on in that almost totally inaccessible area that links the two together — the spinal cord.

Research into the mechanisms of pain

transmission has been undertaken for many decades. Fifty years ago Lewis and Keilgren demonstrated that pain associated with autonomic and muscular effects could be created at a distance from nociceptor stimulation in paravertebral tissues.[1] To most clinicians referred pain still equals 'nerve root pressure'. Other work shows the fundamental role of a complex interactive signalling system in the cord in the creation of pain. Of basic importance is proof that pain may arise from a change in balances of signals within that system which is unrelated to stimulation of nociceptors. As long as clinicians continue to ignore this scientific evidence we shall continue to be unhelpful to women with chronic pelvic pain.

Using this available knowledge transforms a frustrating unproductive consultation into an intellectual challenge requiring a truly whole body approach by the clinician. Something from which, by his very calling, the specialist is exempt.

B.J. BROOKS

The Coach House
Scholards Lane
Ramsbury
Wiltshire SN8 2PL

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Caring for the mentally handicapped in the community

Sir,

Dr Payne's timely editorial on the future of community and residential care (December *Journal,* p.536) alongside Dr Andrew's study of a general practitioner's work in a private nursing home for the elderly (December *Journal,* p.546) draws attention to a problem of concern to most general practitioners. The burden of chronic care is exacerbated further by the consequences of the policy of caring for the mentally handicapped in the community.[1]

I practice on the doorstep of two of the country's largest mental institutes and I have just received a report based on a two week visit by the National Development Team for People with a Mental Handicap to the Ribble valley in June 1987.[2] The report correctly highlights the importance of general health care for mentally handicapped patients relocated in the community and recommends that 'health authorities develop ways of monitoring and improving the quality of health care to people with a mental handicap'. In spite of a policy of resettling patients in their original health authorities where possible, general practitioners in the Ribble valley have found themselves looking after many resettled patients. Primary health care needs appear to have a low priority, and registration with a general practitioner is an afterthought.

A representative of the Lancashire family practitioner committee met a member of the visiting team to give evidence but neither the local medical committee nor the local general practitioners were aware of the visit. National hospital advisory teams visiting our district have invited, received, and appreciated a general practitioner input.

There are two types of resettlement: in homes organized, staffed and resourced by hospitals, and in private residential homes with apparently little supervision or control.

I have carried out a brief audit of the effect of one home of the first type, with six young patients and residential staff. The effect on the workload of a group practice in Clitheroe is shown in Table 1.

Table 1. Effect of a residential home on practice workload.

	Mentally handicapped patients ($n = 6$)		All practice patients ($n = 7585$)	
	1986	1987	1986	1987
Number of doctor–patient contacts[a] per patient per year	5.5	4.8	3.6	3.6
Number of visits per patient	0.5	1.3	0.6	0.6
Number of other contacts[b] per patient	18.3	18.2	N/A	
Number of letters written per patient	4.0	4.2	0.2	0.2

[a] Appointments and visits. [b] Telephone communications and new prescriptions. N/A = not applicable.

The reasons for this higher workload from mentally handicapped patients include the associated physical handicaps, for example spina bifida with suprapubic catheter and epilepsy, and the high expectations of the staff who were used to