ment for these types of study, two voided urine samples are necessary to establish the presence of significant bacteriuria.

Finally, I found it rather strange that despite the evidence from these two papers and my own paper[1] Dr Brooks could still state that 'bacteriuria can only be estabished with certainty if bacterial cultures are obtained' when these studies have all found that screening tests for bacteriuria can be accurately used to screen out negative urine samples.

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Sir,
I read Brooks' leading article (October *Journal,* p.399) with interest. I would like to offer one criticism of the otherwise balanced advice on the management of suspected urinary tract infection in general practice.

Nowhere does the author mention, let alone stress, the importance of inspecting the vulva and vagina of all women presenting with dysuria (and taking vulval, urethral and anal swabs if indicated). If inspection is not carried out, the common monilial vulvovaginitis will be missed and the recommendation to 'give a short course of antibiotics' will make matters much worse; even more important, evidence of gonorrhoea and syphilis will be missed.

Dr Brooks doubtless assumed that such a clinical examination should always be done, but I feel that it is important to stress this basic point in an influential leading article.

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Sir,
I would like to comment on the statement in Dr Brooks' editorial (October *Journal,* p.399) that men with urinary infection need referral for investigation because obstructive uropathy may result in kidney damage.

Urinary infection in men, although less common than in women, occurs much more frequently than textbooks suggest and is not limited to patients with structural abnormalities or enlargement of the prostate. Over a 10 week period in 1984[1] the Public Health Laboratory of Portsmouth received urine specimens from 585 men with urinary symptoms. Four hundred and ninety seven men (85%) had presented to their general practitioners and 182 (31%) were less than 45 years of age. One hundred and seventy nine specimens yielded aerobic pathogens and 140 yielded fastidious organisms. It is unlikely that such a large number of men have abnormalities of the urinary tract requiring investigation.

The fact that urinary infections in men do not usually respond to treatment with β-lactam antibiotics or nitrofurantoin, which do not achieve therapeutic concentrations in the prostate, suggests involvement of the prostate in many infections. In recent years the laboratory has appended a comment to all reports of positive urine cultures from men suggesting that treatment with an agent that penetrates the prostate should be given for 14 days. Suitable agents are cotrimoxazole, doxycycline and ciprofloxacin; erythromycin may also be used for treatment of infections caused by gram-positive organisms. It is important to recognize that treatment of infection involving tissue must be given for longer than that for uncomplicated urinary infection.

Follow-up specimens from men treated in this way are usually negative, and it is hoped that, by appropriate management of the acute episode, the unpleasant condition of chronic prostatitis may be prevented.

Rather than subjecting all men with urinary infection to urological investigation it seems reasonable to treat appropriately as described above, and to reserve investigation for those who fail to respond.

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Reference

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Sir,
Neither of the papers looking at the rapid diagnosis of urinary tract infection in general practice (October *Journal,* p.403, 406) mentioned the shake test which has been used as a rapid diagnosis of pus cells in urine for many years. In this test, a solution of potassium hydroxide is added to an equal quantity of urine in a test tube. The resultant mixture is shaken and if the bubbles remain in the solution then the test is regarded as positive and indicates pus in the urine.

When I first came to the practice, I found this test very reliable for diagnosing infections. Sometimes it picked up pyuria when no organism was grown but very rarely did it miss a true infection. It is a very simple test that is easily done in the surgery. In this practice a positive shake test would be regarded as an indication to start antibiotic treatment.

I feel this is a test that deserves wider popularity.

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Involvement of clergy in patient care

Sir,
Michael King and Peter Speck (Letters, September *Journal,* p.392) make some rather misleading assumptions and statements in responding to my paper on clergy involvement in patient care (July *Journal,* p.280).

My paper stated quite clearly that its intention was to seek doctors' views only in respect of involving christian clergy in patient care as the report of the Royal College of General Practitioners and the Churches' Council for Health and Healing[1] and the British Medical Association's approved statement[2] were concerned only with christian clergy. It may also be helpful to know that the contents of my paper form only one part of a much wider study of the christian church's contribution to health care.

The assumption that the survey was located 'mainly in the city of Bristol' is also incorrect. As indicated in the paper an area within the Avon health district was chosen for the survey, consisting mainly of greater Bristol.

The concern over 'lack of data on the beliefs of doctors' misses the whole point of the survey, which was to discover what a cross-section of doctors (of any religious persuasion or none) think about the idea of involving clergy in patient care. It was found that among both referring and non-referring doctors personal belief, or the lack of it, played some part in their attitude to referral to the clergy. This suggests a whole field for further study.

I agree with the point concerning the

distinction between religious practice and spiritual belief, about which Speck has written at length.[3] What my survey revealed, is that too many doctors seem to fail to make any such distinction. My purpose in writing of 'some people who claim to be not religious', was to point out that those patients who do not obviously practise religion may still have spiritual or religious needs which need to be met. These are the people whom King and Speck refer to as possessing spiritual belief while not necessarily involving themselves in religious practice. They are also the people who may not be receiving care, because too many doctors are unaware of their real need and therefore to whom they might best be referred.

What makes this situation of concern is the recognition that the proportion of the population with religious or spiritual problems is probably a large one (although it must be acknowledged that many would not articulate their problems in this way)[4,5] and that research in the USA has revealed that patients often go to a doctor with trivial symptoms when really looking for reassurance, guidance, or even confession.[6] The question then arises as to the doctor's ability to respond to these religious problems. Shriver has pointed out that many doctors are 'making life and death decisions from the religious stance of a 14 year old', that being the age at which formal religious education ceases for most people, whereas education in other areas, particularly science, continues through at least another decade.[7] This is disconcerting given the priestly role which many patients are evidently according their doctor these days.[8]

My hope is that the debate over meeting spiritual needs will achieve a higher profile in both the education of medical practitioners and the provision of medical care. While this fails to be the case, it will be to the detriment of good patient care.

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Psychiatrists in primary care

Sir,

In their interesting paper on psychiatrists in primary care (September *Journal,* p.369) Brown and Tower describe patterns of existing links between psychiatrists and general practitioners in primary care settings. We would like to report a particular form of linkage which we have found to be of value over the last 15 years. Once a month the partners as a group meet over lunch with a consultant psychiatrist to discuss the nature and management of patients who are giving rise to concern. Some patients are the difficult, demanding and dependent patients we all know so well, but others are of clinical interest, or have raised particular questions of management for the practice.

The focus of discussion is as much on the interaction between the general practitioner and patients, or between the general practitioner and the specialist to whom the patient has been referred, as on the presenting pathology. The value of this regular linkage is not just the development of a relationship between the consultant psychiatrist and individual partners and trainees, but between the psychiatrist and the partnership as a whole, and between all the partners. The discussions have allowed the emergence of a group consensus both on what is possible and what is desirable within the practice. Trust has grown up over the years, and partners are able to speak openly of their anxieties, doubts, and uncertainty over how best to respond to these patients.

Although the discussion often focuses on patients with manifest psychiatric, or at least psychological/emotional content in their presentation, the reason for discussion of a particular patient is as often the internal conflict or difficulty the patient causes the general practitioner, as the nature of the presenting pathology. As a result, the benefits of this linkage have extended beyond the management of a set group of patients, to all troubled and troubling patients who call on the general practitioners for help.

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Fatal methaemoglobinaemia in a dental nurse

Sir,

I read this case report (November *Journal,* p.470) with sadness. As Dr Gowans points out, nitrites are substances of abuse that can result in severe poisoning and death. They are also standard antidotes for cyanide poisoning and are, therefore, commonly found in university and commercial chemistry departments. Since 1 October 1989 it has been required by law that before any process involving a hazardous material is undertaken an employer must assess the process with the aim of reducing the risk to employees. Part of the assessment is the correct storage of materials and how to clear up spillages. In addition, the employer must provide information, instruction and training to staff about hazardous materials. These regulations are known as the control of substances hazardous to health (COSHH) regulations and they specifically mention that all substances marked with the skull and crossbones and other hazard labels should be assessed. Every dental surgery in the country using sodium nitrite tablets should be aware of their toxicity and should be able to show the factory inspectorate that they have informed and trained their staff appropriately. Likewise all general practitioners should have looked at their activities in a similar way.

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Hazards of chlorine to asthmatic patients

Sir,

The discussion of the aetiology and management of asthma is a regular feature in the *Journal.* Contrary to the prevalent assumption that swimming is beneficial, a review of my asthmatic patients who swim suggests that in certain individuals, exposure to the irritant fumes of chlorine in the swimming pool contributes to their bronchospasm. This association would be logical in view of the recent developments elucidating the inflammatory pathology of asthma and wartime experience of the toxic effects of chlorine on airway endothelium. Regarding the continuity of the respiratory tract, how many of our chronic wheezy, catarrhal and deaf patients could be exacerbating their condition with a weekly swim in increasingly undiluted bleach?

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