had not. One patient had been shot and one had suffered attempted strangulation. In three patients, we recorded severe psychological symptoms; panic disorder, a depressive reaction and 'shock'. Only 12 victims of assault had informed the police, and only six were aware of the victim support scheme.

It is interesting to note that so many of the patients who were injured in assaults did not contact the police, even if they had received a fracture, and that there was widespread lack of knowledge about the victim support scheme or the Criminal Injuries Compensation Board scheme, which makes *ex gratia* payments to victims of crimes of violence. There is clearly an unmet need in this practice for information among the victims of violence. By using an agreed health promotion clinic format, we were able to identify those at special risk and educate patients about their rights to compensation and support. This work could only have been carried out opportunistically and would be impossible in a formal clinic session.

STEFAN CEMBROWICZ

Montpelier Health Centre
Bath Buildings, Montpelier
Bristol BS6 5PT

Useful Address

The Criminal Injuries Compensation Board, Whittington House, 19 Alfred Place, London WC1E 7LG (telephone 071-636 9501).

Home remedy for dysuria

Sir,

Each year 20% of women experience an acute episode of dysuria often accompanied by frequency and urgency; most of those who seek medical attention are found to have a urinary tract infection.[1] In addition to an appropriate antibiotic, urinary analgesics such as potassium citrate are often given to alleviate these distressing symptoms. These medications, however, can themselves cause adverse reactions.[2,3] We have conducted a study of a home remedy claimed to relieve these symptoms. The remedy consists of 70 g white granulated sugar to which tap water is added and thoroughly mixed, to make one cup of solution.

The study group was composed of nine afebrile non-diabetic women, aged between 20 and 54 years. All were staff at a hospital in New York City who presented consecutively to the emergency room with acute dysuria (burning or pain on or between urination), frequency and urgency. A baseline urinalysis from all nine patients was positive for pyuria, bacteriuria, haematuria, or a combination of these. Initial urine specimens from eight patients were cultured; all grew *Escherichia coli* (greater than 10^5 organisms ml^{-1}). After rapidly swallowing the cup of liquid, all the participants answered a questionnaire over the following 60 minutes.

All the women reported some relief from dysuria, frequency and urgency after 15–20 minutes. Two claimed complete relief of symptoms at this time, while another two reported complete relief by 30 minutes. The level of relief remained constant for the remainder of the one hour period. Although unpleasantly sweet, the sugar water caused no nausea or other adverse symptoms. The repeat urinalyses carried out 45–60 minutes after drinking the sugar water remained negative for glucose, while specific gravity and pH were unchanged or varied only slightly. At the end of the study all the patients were given an appropriate antibiotic with instructions for follow up.

Three of the study patients have since developed recurrent urinary tract infections and have again used the sugar water remedy with success. They report that symptoms may return after several hours and a second dose is then effective. The women have not found it necessary to take more than three doses of sugar water after beginning a course of antibiotics during any dysuric episode.

We do not know how the sugar water works nor the origins of this home remedy and we cannot now assess the extent of any placebo effect. Nevertheless, our preliminary findings of the use of the therapy have been interesting and it is our hope that this correspondence will stimulate further investigation into what may prove to be a safe and useful adjunct in the treatment of acutely dysuric women.

STEVEN PELTZ
SHEREEN HASHMI

Department of Dermatology
Level 4, Lauriston Building
The Royal Infirmary
Edinburgh EH3 9YW

References

1. Sanford JP. Urinary tract symptoms and infections. *Annu Rev Med* 1975; **26**: 485-498.
2. Browning JJ, Channer KS. Hyperkalaemia caused by potassium citrate mixture. *Br Med J* 1981; **283**: 1366.
3. *Physicians' desk reference.* 44th edition. Oradell, New Jersey: Medical Economics Company, 1990: 1655.

Can infertility treatment cause infertility?

Sir,

The phenomenon of conception occurring after many years of unexplained infertility is well recognized by general practitioners and obstetricians. I report a case of a woman who conceived normally after 10 years of infertility and four attempts at assisted conception.

The woman, a 23 year old clerk, first sought advice after three years of involuntary infertility in 1982. She had never had amenorrhoea or galactorrhoea. Standard investigations, including a laparoscopy, revealed patent tubes and secretory endometrium. Thyroid function tests and an x-ray of the sella turcica were normal. However a raised prolactin level (1200–1400 mU l^{-1}) was detected on three occasions; serum progesterone levels on day 20 suggested ovulation on two occasions, but levels were low on two others. Her partner's sperm count was normal.

She was treated first with bromocriptine, then with clomiphene and bromocriptine, but by 1986 had still failed to conceive and was referred for assisted conception. Over the ensuing three years she had two attempts at *in vitro* fertilization and two attempts at gamate intrafallopian tube transfer. Each attempt involved several round trips of 180 miles between her home and the treatment centre. All were unsuccessful, and in March 1989 a decision was made to undergo no further attempts.

Following a menstrual period on 20 April 1989 she became pregnant and went on to deliver a healthy female baby on 5 February 1990. She declined contraception after delivery and, while still breast feeding, became pregnant again nine months after giving birth. Her raised prolactin levels have not been investigated further as she has either been pregnant or breast-feeding since stopping attempts at assisted conception.

Infertility is poorly understood. Women with tubal blockage will not have successful pregnancies without assisted conception; women with unexplained infertility or intermittent problems with ovulation, like this patient, may become pregnant spontaneously. It can be postulated, but not proven, that this woman had intermittent hyperprolactinaemia related to the stress of infertility and the investigations and treatment which she subsequently underwent. Both *in vitro* fertilization and gamete intra-fallopian tube transfer have, in even the best centres, a low 'baby yield' and it is possible that spontaneous conception was delayed in this case by attempts at assisted conception. This raises the question of whether treatment centres should adopt different policies for different categories of infertility. I feel that the subject deserves further debate.

JOHN GILLIES

Four Winds, Main Street,
Glenluce, Wigtownshire DG8 0PU