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References

1. Gregg I. Differences between peak flow meters on prescription. *BMJ* 1991; **302**: 600-601.
2. Bland JM, Altman DG. Statistical methods for assessing agreement between two methods of clinical measurement. *Lancet* 1986; **1**: 307-310.
3. De Hamel FA. The Miniwright peak flow meter as a lung function measuring device. *N Z Med J* 1982; **95**: 666-669.
4. Vathesen AS, Cooke NJ. Home peak flow meters. *BMJ* 1991; **302**: 738.
5. Beasley R, Cushley M, Holgate ST. A self management plan in the treatment of adult asthma. *Thorax* 1989; **44**: 200-204.
6. Hayward SA, Levy M. Patient self management of asthma [letter]. *Br J Gen Pract* 1990; **40**: 166.
7. Charlton I, Charlton G. New perspective in asthma self-management. *Practitioner* 1990; **234**: 30-32.

Nitrite test for bacteriuria detection

Sir,

We were interested to read the letter by Cooper and colleagues (August *Journal*, p.346) which stated that use of nitrite strip testing in general practice detected urinary tract infection with a sensitivity of 33%. In a study involving elderly hospital inpatients and day hospital outpatients, sensitivities of 83% and 90%, respectively, were obtained.[1] A sensitivity of 95% was reported for hospital patients by Flanagan and colleagues,[2] where the nitrite test was used combined with the leucocyte esterase reagent strip test. Three possible explanations may account for the differences in sensitivities.

The timing of obtaining a urine sample can influence the result, as the chance of there being a positive nitrite test in the presence of a urinary tract infection depends in part on the length of time organisms incubate within the bladder. Assessment of urine which has been in the bladder for at least four hours, or ideally early morning specimens, is likely to increase the sensitivity of the test, but this may not be practicable within a general practice setting.[3] A number of the patients described by Cooper and colleagues may have recently passed urine before providing the sample for testing at the surgery, thus decreasing the test's sensitivity.

Secondly, sensitivities may be affected by the type of organism grown. Most pathogens convert urinary nitrate into nitrite. Any study which by chance includes a high prevalence of non-converting pathogens would result in a reduced sensitivity for nitrite testing. Unfortunately, the authors did not comment on the timing of the urine samples or the organisms grown.

Thirdly, the colour change of nitrite strips in response to a urinary tract infection may affect results. In our experience the colour changes may be subtle when there is a low concentration of urinary nitrite. A positive reaction may therefore be missed unless particular care is taken when interpreting results.

When interpreting the result of nitrite testing, it is important to be aware of the limitations, since we believe the test is likely to be of more use than would be suggested by the results of the report by Cooper and colleagues.

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References

1. Evans PJ, Leaker BR, McNabb WW, Lewis RR. Accuracy of reagent strip testing for urinary tract infection in the elderly. *J R Soc Med* 1991; **84**: 588-589.
2. Flanagan PG, Rooney PG, Davies EA, Stout RW. Evaluation of four screening tests for bacteriuria in elderly people. *Lancet* 1989; **1**: 1117-1119.
3. Czerwinski AW, Wilerson RG, Merrill JA, *et al.* Further evaluation of the Greiss test to detect significant bacteriuria. *Am J Obstet Gynecol* 1971; **110**: 677-681.

Mental health care

Sir,

I was encouraged to see that Chris Dowrick's review article emphasized the pivotal position of general practice in the care of people with mental health problems (September *Journal*, p.382). However, in emphasizing the potential for development of services in the future, we should not lose sight of the fact that general practice already provides most of the professional mental care available to patients.[1] Furthermore, it has the advantages of being both accessible, and free of much of the stigma that can be associated with psychiatric services.

Counselling in general practice remains something of a 'trendy panacea'.[2] Formal counselling, as opposed to the use of counselling skills, remains to be properly evaluated in the context of primary care. For general practitioners to offer formal counselling is not without considerable problems.[3] We should extend the Balint idea[4] of the doctor acting as a drug to counsellors too, and therefore we need to ask what are the potential side effects and dangers associated with the drug's use?

In the Edinburgh primary care depression study, the differences between psychiatrists, clinical psychologists, social workers and general practitioners were minimal in terms of short term outcome for people with depression, but general practitioners were the cheapest option, and also managed to achieve their results in considerably less time than it took the other professions.[5]

The principal initiative, in both research and service development, should be the maximizing of the potential of ordinary general practitioner care for people with mental health problems. This allows readily accessible care for most people and is available long term. For the many people whose mental health problems are ill defined and inseparable from their physical health and the context of their families, general practitioner care will remain the best option.

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References

1. Wilkinson G. I don't want you to see a psychiatrist. *BMJ* 1988; **297**: 1144-1145.
2. Rowland N. Can general practitioners counsel? [letter]. *J R Coll Gen Pract* 1989; **39**: 435.
3. Cocksedge SH. GPs should not counsel long-term [letter]. *J R Coll Gen Pract* 1989; **39**: 347.
4. Balint M. *The doctor, his patient and the illness.* Edinburgh: Churchill Livingstone, 1964.
5. Scott AI, Freeman CP. Edinburgh primary care depression study. *BMJ* 1992; **304**: 883-887.

Sir,

In Chris Dowrick's review article (September *Journal*, p.382) it was disappointing to see that the role of the patient with psychosis or schizophrenia in his or her own care was omitted. Patient held records are of considerable value in long term care.[1] They are acceptable to patients with severe mental illnesses, they increase patient autonomy, and improve communication and effectiveness of shared care. Compliance is good, but patient held records seem more acceptable to patients than to psychiatrists.[1] It is important to work with patients, and the pa-