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Community-acquired infections

Sir,

Prescribing in primary care is currently under pressure and antibiotic prescribing is one area in which concern has been expressed at the use of expensive newer agents.[1] Respiratory and urinary tract infections are the commonest reasons for prescribing antibiotics for the elderly population and also common causes of referral to hospital.[2] Most patients referred with an infection have previously been treated with antibiotics and reasons for referral are commonly the severity of illness or failure to improve on treatment, the latter raising concern about possible resistant bacterial infection.

On the basis that an appreciable level of resistant bacterial infection would be reflected in positive blood cultures on admission to hospital, a six month retrospective study was undertaken of patients with infection admitted to the geriatric unit of a district general hospital. Results of blood cultures were examined to ascertain the prevalence of positive blood cultures, and whether the organisms isolated and their sensitivities resulted in a change of antibiotic treatment from that instituted on admission.

Over the six month period between January and June in 1992 385 blood cultures were performed on 289 patients (approximately 25% of all admissions for any reason in that period). Blood cultures were performed where infection was suspected and where the patient was considered very unwell. Blood cultures were positive in 38 patients but only in seven were the results thought to be clinically significant by the reporting microbiologist, the rest either being thought contaminants or of uncertain significance. Organisms isolated in these seven patients were *Escherichia coli* (three), klebsiella (two), proteus (one), and *Staphylococcus aureus* (one). In three of the seven patients microbiology findings resulted in changes in therapy.

The prevalence of clinically significant blood cultures in patients admitted from the community was not high at 2.4%, but compares with that reported in other studies.[3,4] The low prevalence may well reflect previous antibacterial therapy received in the community; most of the 289 patients admitted had either received amoxycillin or trimethoprim. The organisms identified in positive blood cultures were in fact more typical of hospital acquired infections.[2]

It therefore seems that antibiotic treatment of community-acquired infections with standard regimens is appropriate for most chest and urinary infections, at least in this district. Reasons for admission of patients to hospital after being treated for infection appear to have been more related to associated clinical problems in elderly people, as evidenced from the patients' notes, such as dehydration, bronchospasm, hypoxia, heart failure, and difficulty in coping when unwell and living alone, than to resistance of infection to standard antibiotic regimens.[5] There does not, therefore, seem to be a major need for more powerful broad-spectrum antibiotics as first-line treatment of community-derived infections in primary care.

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Cervical screening

Sir,

It is mandatory in England for general practitioners to invite individuals for health screening.[1] It is therefore important that general practitioners should be aware of how their patients feel about the procedures involved, and that the clinics they hold should be organized to be as effective as possible in detecting risk factors and early manifestations of disease. As a gynaecologist I have a particular interest in community based gynaecological screening in terms of acceptability for the woman and the usefulness of the screening test.

It has been suggested that the majority of women feel some degree of embarrassment and discomfort when undergoing a gynaecological examination but the range of their feelings is considerable with extreme discomfort and hostility toward the medical personnel being reported.[2] A later study into patients' attitudes indicated that women saw the examination as a necessary and reassuring procedure and because of this learned to deal with their negative feelings well enough to allow proper gynaecological examination with a minimum of overall discomfort.[3] This apparent improvement in emotional response to a pelvic examination may reflect the greater emancipation and increasing recognition of female sexuality that occurred during the 10 year period between the two studies. It may also reflect changing attitudes of doctors towards their patients, or perhaps may indicate better patient education with its associated alleviation of fear.

The importance of cervical screening in the prevention of cervical carcinoma is indisputable and it is now becoming more common for the cervical smear to be taken by the practice nurse. One advantage of this is that it gives the woman a better opportunity of having a potentially threatening and embarrassing test performed by another woman. However, if the smear is taken by the nurse a bimanual pelvic examination is omitted. This does not matter provided that the frequency of asymptomatic, palpable pelvic pathology in this population group is rare.

In order to assess women's attitudes to a bimanual examination 168 women undergoing routine cervical screening in one general practice had pelvic ultrasonography performed, and completed an attitude questionnaire. Two cases of pelvic pathology were identified using ultrasound that would have been detected by a careful clinical examination. The first was