

There is an indication that staff embarrassment must be overcome. Apart from during family planning consultations, staff found it easiest to raise the subject of condoms during travel clinics. However, anecdotal evidence from the nurses at the practices indicates that some found it difficult to initiate discussions about condoms unless the patient had done so. Further, in spite of being trained to do so, health professionals reported giving only 12% of patients a condom application demonstration.

Most evaluations of condom distribution through general practice have recommended that the projects should continue. There seems little reason for restricting the availability of the full range of contraceptive methods from general practice (still less if the availability of the condom as protection against sexually transmitted diseases is also considered). Taking into account the economic considerations, it may be necessary to limit the numbers distributed and to target potentially or newly sexually active and high-risk patients.

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Management of hypertension

Sir,
In the article by Fahey and Peters on inter-practice variation in control of hypertension,¹ they mention that unknown confounding factors may be responsible for the correlation they observed, indicating that practices who controlled blood pressure well did so whatever guideline was used as a standard.

We agree with Smith and Clayton,² and

Table 1. Proportion of people diagnosed hypertensive after one or two readings (%).

Practices	1	2	3	4	5
1995	12/18 (66)	8/12 (66)	13/41 (32)	2/9 (22)	9/25 (32)
1996	6/11 (55)	8/13 (62)	7/22 (32)	7/12 (58)	12/30 (40)

suggest that an important factor may be the number of blood pressure recordings taken before hypertension is diagnosed and, consequently, whether true hypertension exists. All five guidelines quoted by Fahey and Peters recommend that more than two readings should be taken before diagnosis.

In an audit of hypertension management in five inner-city practices, a significant proportion of those recorded as having hypertension and receiving medication had been diagnosed after only one or two blood pressure readings had been taken. Of 105 patients diagnosed with hypertension in 1995, 44 (42%) were diagnosed after only one or two readings. These findings were repeated for the audit period of 1996, with 40/88 (45%) having two or fewer recorded blood pressure readings. This mean figure disguises significant inter-practice variation (Table 1).

Consequently, blood pressure control may be excellent, but there may be some patients who do not necessarily have hypertension in the first instance.

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Primary care services for problem drug users

Sir,
Ann Deehan *et al* (November *Journal*) suggest that GPs are only minimally involved in the care of problem drug users, and that extra training would not even encourage them to increase this involvement.¹

This conclusion seems to be supported by their data, derived from a questionnaire

survey to which 52% of the 157 GPs in one London area responded. Geographically, service provision for problem drug users varies considerably throughout the UK. The same is true in London. In many areas, the level of GP involvement is considerably higher than Deehan *et al*'s data suggest.²

A recent London survey of over 200 female drug injectors, of whom 82% were recruited in the community rather than in treatment settings, showed three interesting things (Hunter GM, Judd A. Women injecting drug users in London: the extent and nature of their contact with drug and health services. Submitted to *Drug and Alcohol Review*, 1997). First, the majority of participants were in contact with services in relation to their drug use; secondly, among those who were not, lack of perceived need for services rather than a perception of service inaccessibility was cited as the principal reason; and thirdly, the main service used was general practice.

Outside London, the evidence suggests that GPs are the principal service providers in contact with problem drug users either through 'shared care' arrangements with specialist services or exclusively in primary care where these services don't exist.^{3,4} A survey of 341 GPs in Manchester achieved a 79% response.⁵ It showed a much higher level of contact between GPs and drug users than in Deehan *et al*'s study. Sixty-five per cent of GPs who responded stated a desire for extra training in this area.

Several things are clear. The first is that being prepared to work with problem drug users varies among GPs for a variety of reasons. Despite this, general practice is currently the mainstay of the service response to problem drug use throughout the UK and, because of the numbers involved, is likely to remain so. Apart from a perceived lack of specialist knowledge, a barrier to further GP involvement is probably scepticism as to the effectiveness of the interventions involved. Such evidence that exists derives almost exclusively from non-UK, non-primary care settings.⁶ Clearly, this is a deficiency and points to an area where further work is needed.

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General practitioner teaching in the community

Sir,

As new GP tutors teaching undergraduate students formally for the first time this year, we were very interested to read Gray and Fine's paper (October *Journal*)¹ on general practitioners' (GPs') views of some of the rewards and problems of undergraduate teaching. It is clear from their paper that the majority of GPs surveyed had some teaching experience, but it was not clear what level of training or support, if any, they had received with this.

We were intrigued about some of the views of the GPs on the need for training and support for undergraduate GP tutors. What surprised us was that, when asked what support they would like from medical schools, such a small proportion wanted membership of a tutors' group (48/301 or 15.9%). In our experience, participation in an undergraduate GP tutors' group run by the medical school has been one of the most rewarding and helpful parts of out professional development as new teachers.

It is inevitable that tutors will encounter difficult problems at some point when teaching groups of medical students who, for example, may feel 'entitled' to do the minimum work necessary to pass their

exams. This could contribute to low morale and the perceived lack of self-confidence that has been noted among GP tutors.² In our view, the ability to share these problems, constructively create solutions with our colleagues, and benefit from their experiences in a safe, supportive environment has been vital.

The tutors' group has also made us more aware of different teaching styles and how educational theory can work in practice. We feel that these factors have helped to increase our confidence and develop our teaching skills. In addition, GP tutors' groups can provide an opportunity to assist in developing the curriculum by providing feedback of their own impressions as well as the student evaluations.

It is also interesting that, in Gray and Fine's paper, as much as 56% of GPs with no undergraduate teaching experience were unaware of the support available from medical schools. We feel that ongoing support is critical for current and potential undergraduate GP tutors. Medical schools should ensure that tutors have both an awareness of and access to this support.

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Prostate specific antigen in urinary tract infection

Sir,

Prostate specific antigen (PSA) has a reported sensitivity for prostatic adenocarcinoma of up to 80%.¹ However, it lacks specificity. The reported positive predicted value of an elevated PSA (Hybritech Tandem-R PSA radioimmunoassay >4 ng/ml) for prostatic carcinoma in screening studies is only 28-33%.^{1,2,3} This is largely because 21-53% of men with benign prostatic enlargement (BPE) will have an elevated PSA above 4 ng/ml.^{4,5} Prostatitis, including subclinical histologically proven

inflammation, may lead to an elevated PSA.^{6,7} The physiological variation in serum PSA levels can be up to 30%.⁸ Nevertheless, serum PSA is a useful tool in the detection and staging of organ-confined prostate cancer^{1,2} and the monitoring of disease progression and response to hormonal manipulation.

We present a series of 31 men (mean age = 67 years; range = 48-82 years) who were referred to the urology unit over a 17-month period with a raised PSA, BPE on digital rectal examination, and a documented urinary tract infection (UTI). Five men were asymptomatic. The mean PSA (Hybritech Tandem-R PSA radioimmunoassay) at presentation was 24 ng/ml, with a range of 5.4-100 ng/ml (normal range = 0-4 ng/ml).

A clinically significant UTI (>10⁵ organisms per ml) was documented in all 31 patients. Following eradication of the UTI, the PSA returned to normal (mean = 2.7 ng/ml; range = 0.3-3.9 ng/ml) in 81% of cases (25) within 17 weeks. In the remaining six cases, the PSA fell after treatment but remained persistently elevated above the normal range (9.7 ng/ml; range = 4-14.9 ng/ml). Eleven of the symptomatic cases became asymptomatic after treatment.

The failure of the PSA to return to normal in six cases may be due to bulky benign prostate hyperplasia⁹ or an age-related variation in PSA.¹⁰ However, this group requires careful urological follow-up.

An uncomplicated UTI in men with BPE appears to be the cause of an elevated PSA. Following eradication of the UTI, the PSA normalizes in the majority of cases. The half-life of PSA is between 2.2 and 3.15 days. Estimation of the serum PSA in men with BPE on digital rectal examination with a suspected or documented UTI is therefore not recommended for a period of at least six weeks after successful antibiotic treatment. This will reduce the number of patients undergoing negative prostatic biopsies — a procedure not without an associated morbidity.¹²

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