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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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