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Editor's choice

A GP's notes

A letter to GPs ...

I recently had reason to ask my local doctors' practice if I could see my notes — not just the electronic version, but the handwritten too. When I received them, I sat down with my little brown packages and studied them for an hour or two.

Although I was looking for some specific facts, what my general practice notes taught me most is that a detached, respectful response to patients is just what is needed. I confess I expected to find some judgment, criticism, or callousness among the many notes and letters over my 64 years. There was no mention of my broken back being due to horse-riding-while-drunk, or my one foray into illicit drug taking ending up disastrously. Instead I found a comprehensive summary of ailments and breakages, with not a single subjective remark among them. I felt enormously relieved and grateful to a profession that can be detached enough to care just for the body at times, regardless of how much its owner has contributed to its distress, and I felt I wanted to thank you all.

There was one exception to the rule, a long time ago — a verbal telling off by a GP, not something written in the notes. However understandable and human, the power of those comments remained for a long time. Presumably nowadays doctors may take those feelings to clinical supervision or a Balint group? But that was all, in 64 years of medical attention, a pretty good record.

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DOI: 10.3399/bjgp12X654849

A new approach to patients with lower urinary tract symptoms (LUTS)

Blanker and colleagues from the Dutch College of General Practitioners Working committee on LUTS write eloquently on

the multifactorial nature of lower urinary tract symptoms in patients presenting in primary care.¹ However, as members of the Guideline Development Group (GDG) for the NICE LUTS in men clinical guideline,² published in 2010, we are perplexed at the criticisms made within this editorial.

The authors selectively quote our guideline and conclude that we 'chose to act as lemmings heading for only one direction: the prostate'. The sentence quoted in the editorial 'In men, the most common cause is benign prostate enlargement ... which obstructs the bladder outlet' is taken wholly out of context. In the guideline document it sits within a paragraph that clearly describes the multiple possible causes of LUTS.

Interestingly, NICE initially commissioned two guidelines, one for benign prostatic hyperplasia and a second for LUTS. At a very early stage however, they recognised that a single LUTS guideline was more appropriate. This reflected a desire to move away from the concept of 'prostatism' towards an open-minded and holistic approach to the possible causes of symptoms in any given patient, ranging from factors such as excessive fluid intake, through heart failure and diabetes, to overactive bladder, and benign prostatic enlargement. The paper quoted in the editorial³ describing the conclusions of an expert panel, which the authors of the editorial felt ran contrary to our approach, had as first author Professor Chris Chapple, the chairman of our GDG, and was published in 2008, during the NICE guideline's consultation period.

The authors' suggestions of a scheme for managing LUTS in general practice is difficult to disagree with: a holistic history including patient's concerns, a physical examination including a digital rectal examination, completion by the patient of a frequency volume chart, followed by medical treatment if required, and consideration of surgery if unsuccessful. However, this is the exact pathway suggested by our guideline. The use of the frequency volume chart, a useful and underused diagnostic tool, was preferred to the International Prostate Symptom Score again to move away from the assumption of benign prostatic enlargement as the cause of all LUTS.

We would agree with much of the sentiment expressed in this editorial, but would wish to defend the NICE guideline as really being little different in its message

to primary care. The causes of LUTS are many and varied, with the general practice perfectly placed to make a holistic assessment and initiate initial management, whether through lifestyle measures or medical therapy.

It would be a great pity if doctors chose to ignore the NICE guideline as a result of a false impression given by this editorial and we hope that this letter clarifies the position of the GDG and the intention of the guideline to improve the management of men with LUTS, whatever the cause of their condition.

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DOI: 10.3399/bjgp12X656694

Integration of care

My brief experience as a GP clinical commissioner, tells me that we have no choice but to develop closer integration across primary care, secondary care, and social care.¹ The dichotomy between primary care and secondary care has become unhealthy, and most consultants I come across are only too happy to work at joined-up solutions; the nonsensical attempts to push care costs between cash-strapped primary care commissioners and even more cash-