

PRACTICE OBSERVED

Simple scale for assessing level of dependency of patients in general practice

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Abstract

A rating scale has been designed for assessing the degree of dependency of patients in general practice. An analysis of the elderly and disabled patients in a two doctor practice is given as an example of its use and simplicity.

Introduction

Many scales for the assessment of disability and social functioning have been described. Powell Lawton and Brody commented on the many existing incompatible scales, while describing two new scales of their own.

The scale

The scale table consists of a series of dependency attributes which are grouped under nine headings: General, Social, Accommodation, Housing, Conditions, Mobility, Mental state, Sensory, Continence, and General ability to cope.

intended to be a catch-all to reflect the doctor's general assessment of the patient. Details of the patient's medical condition are excluded, the scale concentrates on social functioning.

Dependency score

The various dependency factors obviously mean greater or lesser degrees of difficulty for the patient concerned. I have attempted to reflect the degree of adversity of the different attributes by attaching what may be appropriate weighting scores.

Discussion

Despite the many functional rating scales that have been described, none has come into widespread use in general practice. This may be because they are complex, and any benefits resulting from their use have not justified the effort in applying them.

Contribution of Gardnerella vaginalis to vaginitis in a general practice

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In a study of 154 adult women who presented to their general practitioner with vaginal symptoms 30 (20%) had Gardnerella vaginalis on its own and 51 (33%) had G vaginalis in combination with anaerobes or known pathogens.

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The assessment scale showing the dependency scores for each attribute and an analysis of the 259 patients currently included in the dependent patient review index.

Table with 4 columns: Attribute, Score, No., %

*Scores are added to obtain each patient's total dependency score.

continuing controversy about its importance as a pathogen and its ability to cause vaginitis. There have been no reports of its prevalence in a general practice population.

The aims of this study were: (i) to identify the prevalence of Gardnerella vaginalis among women who presented with vaginal symptoms in general practice; (ii) to identify the prevalence of the organism among asymptomatic women controls; (iii) to test the hypotheses that a G vaginalis on its own is a vaginal pathogen and (iv) if present with other known pathogens (yeasts, Trichomonas, anaerobes, Escherichia coli, Chlamydia, herpes) makes vaginal symptoms worse.

Method

The study was carried out in the department of general practice, which serves a population mainly belonging to social classes III to V according to the Registrar General's classification. There were 2609 women over 16 years of age registered with the practice in 1983.

Results

During the 12 month study period 210 women presented with vaginal symptoms, and 154 were included in the study. Six were excluded because eight had proved urinary infection to account for their symptoms.

Table I lists the organisms that were isolated from patients. G vaginalis was isolated in 81.5% patients, alone in 30.3% with anaerobes in 26.1% and with other organisms in 25.16%.

Figure 1 shows the relations between the three common presenting

symptoms (soreness, irritation, and discharge) and results of the laboratory investigations. Patients who were culture negative reported the fewest symptoms.

Patients with G vaginalis alone or G vaginalis plus anaerobes reported more symptoms than patients with anaerobes only were included in this group because separate analysis showed that they had a similar pattern of symptoms and those with G vaginalis plus known pathogens reported the most.

Table 1—Organisms isolated from 154 patients with vaginitis and 138 asymptomatic control patients (as presented to the doctor)

Table with 3 columns: Organism, No. of patients, % of control patients

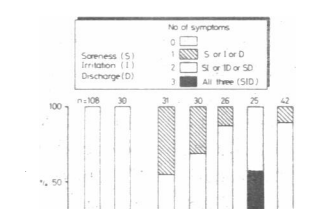


FIG 1—Number of vaginal symptoms in 154 patients and 138 control patients who presented to the general practitioner.

Table 2—Symptoms on vaginal examination in 154 patients presenting to the general practitioner with vaginal symptoms (percentages in parentheses)

Table with 5 columns: Symptom on examination, Culture negative, G vaginalis alone, G vaginalis + anaerobes, G vaginalis + known pathogens, Known pathogens

*P < 0.001

Table II compares soreness on vaginal examination with laboratory findings. The culture negative group had the least degree of soreness, those with G vaginalis alone after 48 hours' incubation, and those with G vaginalis plus anaerobes had significantly more soreness than those with known pathogens alone or those with G vaginalis alone.

Table III compares discomfort related to intercourse with laboratory findings. It follows a similar pattern to soreness on vaginal examination with the culture negative group having the least discomfort and those with G vaginalis plus anaerobes having more discomfort than those with G vaginalis alone.

Figure 2 shows the amount of discharge for the control patients and patients. Even among the control patients some who were G vaginalis positive showed a discharge, whereas over half of those with G vaginalis alone produced a discharge, and over three quarters of those with G vaginalis plus anaerobes produced a discharge.

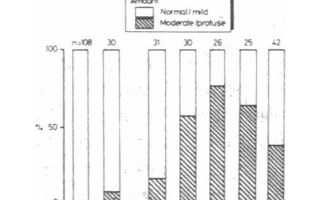


FIG 2—Amount of discharge in 154 patients with vaginitis and 138 control patients who presented to the general practitioner.

Table 3—Discomfort related to intercourse among 142 sexually active patients presenting to their general practitioner with vaginal symptoms (percentages in parentheses)

Table with 5 columns: Discomfort on intercourse, Culture negative, G vaginalis alone, G vaginalis + anaerobes, G vaginalis + known pathogens

Discussion

The prevalence of G vaginalis in this study in both patients and control patients was unusually high. The organism has not been studied in general practice populations and has been reported only on selected populations.

Much interobserver variability has been shown between two doctors reviewing the same amount of discharge. Taylor et al found a good correlation between doctor and patient on amount of

discharge. In our study, with a single observer, G vaginalis alone or with other organisms was a powerful producer of discharge. The pattern of discharge observed (fig 2) is different from the patterns of symptoms reported (fig 1) or those with G vaginalis plus anaerobes produced the most discharge but G vaginalis plus known pathogens caused the most symptoms and signs of vaginitis.

It is generally accepted that G vaginalis plus anaerobes cause a vaginitis; yet in our study the pattern of presenting symptoms in the group with G vaginalis alone was similar to that in the group with G vaginalis plus anaerobes.

When the two groups, known pathogens and known pathogens plus G vaginalis, are compared the frequency and severity of reported symptoms is significantly greater in the latter group. These findings are at variance with the notion that G vaginalis on its own causes a vaginitis (discharge but no vaginitis) and support our hypotheses that G vaginalis on its own may cause a vaginitis and when present with known pathogens contributes to the degree of vaginitis.

It is difficult to decide on appearance whether a vaginal mucosa is inflamed or not. We relied on a single observer throughout our study, and the report of discomfort related to intercourse and of tenderness on vaginal examination are objective evidence of vaginal inflammation.

Furthermore, the symptom (discomfort on intercourse, table II) and the sign (tenderness on vaginal examination, table III) both follow a similar pattern to the presenting symptoms of soreness, irritation, and discharge and thereby provide internal validation.

There is a spectrum of vaginal symptoms and signs ranging from clinically mild to severe. It seems that G vaginalis may be present at any point within that spectrum (either alone or in combination with other pathogens), but at whatever point it occurs in that spectrum it adds to the symptoms. If G vaginalis contributes as much to vaginitis in patients in other practices as it does in ours then doctors will have to broaden their diagnosis and management in dealing with this common condition.

Our findings suggest that it is not enough to assume that vaginal symptoms fall into the broad categories of "another attack of thrush" or "non-specific vaginitis."

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