College of Physicians and the Royal College of General Practitioners automatically give their recognition.

In October 1987 the Royal College of Surgeons of England produced their guidelines for pre-fellowship surgical training posts in accident and emergency medicine.[1] Since the majority of accident and emergency posts have the same work practice and educational content, irrespective of the future career that the incumbent wishes to pursue, these guidelines are applicable to all accident and emergency posts.

Because of the changes now taking place in general practice, the surgical experience to be gained in accident and emergency medicine makes it even more relevant for vocational trainees than perhaps it was in the past.

It must be remembered that there will not be time for education if departments are inadequately staffed, and the guidelines of the Royal College of Surgeons[1] make it quite clear that 'there should be approximately one trainee for every five thousand new patients per annum'.

Finally, the guidelines emphasize that time must be set aside for didactic education, as opposed to 'learning on the job'.

In summary, the training to be had in accident and emergency medicine, where we are specialists in the immediacy of a work practice of managing acute problems is very relevant to general practice; great thought has also been given to the training of accident and emergency trainees.

In addition the academic committee of the British Association of Accident and Emergency Medicine is producing a paper entitled *Teaching standards in accident and emergency departments* which will further delineate standards that must be attained.

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Reference

1. Royal College of Surgeons of England. *Guidelines for pre-fellowship surgical training posts in accident and emergency.* London: RCS: 1987.

Testing asymptomatic patients for *Chlamydia trachomatis*

Sir,

We support the view that the consequences of the chlamydia epidemic can only be reduced by testing asymptomatic women in general practice, coupled with changes in sexual behaviour. However, the analysis presented in a recent paper (April *Journal,* p.142) has two significant flaws.

The authors state that the chlamydia culture method used was assumed to have a sensitivity of 75% and a specificity of 100%. Many general practices will not have access to chlamydia culture, and will have to rely on enzyme-linked immunosorbent assay (ELISA) methods, which have less than 100% specificity. A specificity of 95% may sound reasonable, but the implications of such a test when applied to a population with a 5% prevalence of chlamydia are that 5% of samples will yield true positive results, and 5% will yield false positives. The significance of a positive result could be evaluated by the toss of a coin. This sort of consideration is important before widespread screening programmes are contemplated.

Furthermore, the partner was also treated, but no contact tracing was performed. This is inadequate. The epidemic of chlamydial infection exists because young people do not confine their sexual activity to long-term faithful sexual partners. Treating only the most obvious partner may not prevent reinfection of the index patient, and will certainly have no impact on the overall epidemic of chlamydia. The epidemiological model used in this paper is too simplistic.

Many doctors will recognize that the correct procedure to follow in patients suspected of having chlamydial infection is referral to a sexually transmitted disease clinic.[1]

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References

1. Coker DM, Timmins DJ, O'Mahoney C. Chlamydia: one step forward or two backwards? *Br Med J* 1989; **298:** 51.

Sir,

I write to express my concern at the prospect of widespread screening for endocervical *Chlamydia trachomatis* among asymptomatic sexually active young women. I accept that there is a case to be made for such a programme. *C trachomatis* is a major cause of pelvic inflammatory disease in the industrialized countries[1] and cheap effective interventional treatment is possible within a latent interval.[2] Professor Buhaug and his colleagues (April *Journal,* p. 142) conclude that such a programme in sexually active young women could be cost effective.

My concern arises from the fact that the psychological effects on women who have been screened have not been studied. It has been shown that healthy adults who have been screened for cardiovascular risk markers experience an increased incidence of psychological distress.[3] It is likely that screening for a sexually transmitted disease would have an even more distressing effect on the participants. Before we are tempted to embark on yet another screening programme I believe we should find out more about women's attitudes to being screened for sexually transmitted disease and about the effect such a programme might have on the mental welfare of its participants and their families.

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References

1. Westrom L, Mardh P-A. Salpingitis. In: Holmes KK, Mardh P-A, Sparling PF, *et al (eds). Sexually transmitted diseases.* New York: McGraw, 1989.
2. Rahm VA, Gnarpe H, Rosen G. Chlamydi vanligt hos tonarsflicker som soks for preventivemedelsradgivning. [Chlamydia common among teenage girls visiting for advice on contraception]. *J Swed Med Assoc* 1986; **83:** 615-616.
3. Stoate HG. Can health screening damage your health? *J R Coll Gen Pract* 1990; **39:** 193-195.

Detection and management of urinary tract infection

Sir,

I would like to comment on the articles on the detection and management of urinary tract infection in general practice (October *Journal,* p.399, 403, 406).

First, I found it surprising that neither of the two original papers made any reference to the paper by myself and colleagues[1] which looked at the use of screening tests for the detection of bacteriuria in elderly subjects and which gave results quite similar to those found by Hiscoke and colleagues.

Secondly, I am concerned that in both original papers the laboratory diagnosis of bacteriuria was based upon the results of a single voided urine sample. As alluded to by Dr Brooks, it has been found that greater than 10^8 organisms per litre in a sample of urine predicts the presence of significant bacteriuria with an accuracy of 80% while greater than 10^8 organisms per litre of the same organism in two voided urine samples increases the accurary to 95%.[2] Therefore, as a minimum require-