Dangers of long waiting times for outpatient appointments at a urology clinic

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Great pressure has recently been put on clinicians by hospital managers and politicians to reduce waiting times. Unfortunately, the emphasis of current initiatives on waiting lists tends to be on reducing the wait for surgery rather than the waiting time for an appointment at an outpatient clinic. We report the potential dangers of long waiting times for a routine outpatient appointment at a urology clinic.

Patients, methods, and results

Over the past three years 55 patients with symptoms of bladder outflow obstruction were recruited for two clinical trials. These patients were recruited from the waiting list of new patients which comprised patients who had been classified as having routine conditions by the consultant on the basis of the information in the referral letter. Recruitment into the trials depended on patients satisfying the entry criteria and giving their informed consent. The protocols for the trials were approved by the ethical committee. The average wait for these patients who were seen outside the normal times of outpatient clinics, was 13 (range 3-104) weeks. All patients gave a full medical history and had a full examination, and routine investigations for bladder outflow obstruction were performed. One trial (25 patients) also required transrectal ultrasonography of the prostate and a serological test for prostate specific antigen whereas the other (30 patients) required further investigation only if malignancy was suspected clinically.

During our investigation of these patients, we diagnosed seven new cases of cancer of the prostate. These were detected by rectal examination (five), a raised concentration of prostate specific antigen (one), and transrectal ultrasonography (one). Four of these cancers were well or moderately well differentiated, and five of the six bone scans obtained yielded negative results. A superficial cancer of the bladder was detected during transrectal ultrasonography of the prostate and a caecal cancer was found on barium enema examination in a patient with iron deficiency anaemia. In four patients a history of haematuria was elicited for the first time and was investigated. Ultrasonography also detected one case of chronic retention of urine with overflow.

Comment

This study highlights the prevalence of associated disease in patients who were classed as having routine bladder outflow obstruction. The average wait for a routine appointment at our department's outpatient clinic was eight months, with a further wait of two years for a prostatectomy. A random poll of 16 departments of urology was conducted by means of a telephone conversation with each consultant's secretary or the clerk responsible for admissions. The average waiting time for a routine appointment in a urological outpatient clinic was 7·4 (range 3-36) months and for a non-urgent prostatectomy 21 (9-36) months, and the situation in Wales was slightly worse than in the United Kingdom as a whole.

Opinion is divided about the value of screening for prostatic cancer and about the management of localised disease. Since 84% of apparently localised cancers of the prostate progress if left untreated[1] some centres advocate radical prostatectomy for early cancer.[2,3] If long term follow up shows improved survival in patients treated by radical surgery then early detection of the tumour by screening would be desirable, and the most useful method of detection is rectal examination by a trained urologist.[4] Since most of the prostatic cancers detected in this study had not metastasised to bone and were well or moderately well differentiated these patients might have suffered if detection had been delayed.

A long wait for a patient with bladder outflow obstruction for a specialist opinion is both undesirable and unacceptable. The high prevalence of associated disease in these patients should encourage and justify efforts to reduce waiting times for appointments at outpatient clinics.

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Effect of long term tamoxifen treatment on bone turnover in women with breast cancer

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The non-steroidal antioestrogen tamoxifen is widely used to treat breast cancer, predominantly in postmenopausal women. It exhibits oestrogenic and antioestrogenic properties, depending on the species and tissue. In the human breast it acts as an antioestrogen whereas oestrogenic effects have been reported on human vaginal epithelium and endometrium.[1] If tamoxifen exerts antioestrogenic effects on bone women receiving long term treatment may be at greater risk of osteoporotic fracture. Densitometry has generally shown no adverse effect of tamoxifen on bone mass in postmenopausal women,[2] although one study reported loss of bone in premenopausal women.[3] Our study provides the first histological data on bone turnover in women receiving long term tamoxifen treatment.

Patients, methods, and results

Forty one postmenopausal women aged 40-70 with stage I or II breast cancer were recruited into the study on the basis of their willingness to undergo bone biopsy; 22 had received tamoxifen for at least 15 (range 15-54) months, and the remainder had not received tamoxifen. Women with a history of bone disease and those taking drugs or with conditions known to affect bone metabolism were excluded from the study.

Full thickness biopsy specimens of the iliac crest were obtained under local anaesthesia after the women