

from the area. Moreover, data from Soviet studies based on much larger samples⁴ or the total population⁵ seem to have been arbitrarily dismissed. One of the most perturbing aspects of the published summary is the elimination of the estimates of increased incidences of cancer and leukaemia found in the original technical report. As the incidence of leukaemia is increasing rapidly and has now reached west European levels this omission raises some serious questions as to why this action was taken.

Clearly, future studies should contain sufficient numbers; be conducted prospectively over at least 20 years with reports at regular intervals; follow accepted standards of epidemiological investigation; and publicise the results in full for evaluation by the scientific community throughout the world. Future work should be undertaken by an independent body.

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- 1 International Advisory Committee. *International Chernobyl project. An overview*. Vienna: International Atomic Energy Authority, 1991.
- 2 Darby SC, Reeves GK. Lessons of Chernobyl. *BMJ* 1991;303:1347-8. (30 November.)
- 3 Mikhailenko YT, Matsidonskaya GF, Peterburgskaya VF. Content of thyroid hormones and placental lactogen in the blood of pregnant women suffering from hypertrophy of the thyroid gland. *Public Health in Byelorussia* 1990; June: 48-51.
- 4 Lazjuk GI, Nokolaev DL, Ilyina EG. Hereditary malformations in children born in the south of Gomel and Mogilyev regions. *Public Health in Byelorussia* 1990; June: 56-8.
- 5 Brennan M. *The effects of the Chernobyl disaster*. Birmingham: Chernobyl Disaster Fund for Health Care and Ecological Research in Byelorussia, 1991.

Urinary incontinence

SIR,—James O'Brien and colleagues found in a survey that 30% of patients with regular urinary incontinence who have discussed this problem with their general practitioner report having never received any form of assessment.¹ The authors express concern that, if their findings are representative of the situation in other health districts, a large burden of treatable unmet need exists.

Because of concern that some community services were being underused we undertook an anonymous postal survey of general practitioners in our district in June 1989. We received replies from 101 practitioners, of whom 42 reported never having used the continence advisory service for any of their elderly (aged >65) patients. Given the prevalence of urinary incontinence in the population aged 65 and over reported by O'Brien and colleagues (16.0% in women and 13.3% in men), it seems unlikely that a lack of any suitable patients would account for this. Our findings suggest, furthermore, that difficulty in obtaining the service is unlikely to be a major explanation for never referring patients: two general practitioners reported usually or always having difficulty in referring to the service, 21 reported occasionally having difficulty, and 36 never had difficulty.

This non-referral to the continence advisory service is surprising, given that the service, led by a trained nurse continence adviser, has been well established and widely advertised for several years and is directly accessible to general practitioner referrals. O'Brien and colleagues quote previous concern that there is a widely held belief among the medical and nursing professions that incontinence is more of a nuisance than a real problem,² and this may partly explain our results.

Our findings, based on a survey of general practitioners, and O'Brien and colleagues' findings, based on a survey of patients, lead to the same conclusion that a large burden of need is not being

met, even when services are available. The reasons for this are not clear, and the issue merits further attention.

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- 1 O'Brien J, Austin M, Sethi P, O'Boyle P. Urinary incontinence: prevalence, need for treatment, and effectiveness of intervention by nurse. *BMJ* 1991;303:1308-12. (23 November.)
- 2 King's Fund. *Action on incontinence*. London: King's Fund, 1983. (Project paper No 43.)

Urinary incontinence in women

SIR,—Linda Cardozo suggests that urinary diversion should be considered earlier rather than later for young disabled women with urinary incontinence.¹ Severe disability is not, however, necessarily a bar to learning how to perform self catheterisation as patients often show great ingenuity in their determination to gain control of their bladders.^{2,3}

We studied 112 women aged 16-85 who attempted to use intermittent catheterisation. Eighty eight women had a neuropathic bladder, mainly due to spinal dysraphism, multiple sclerosis, intervertebral disc lesions, spinal tumour, or spinal injury. Twenty four women had a non-neuropathic bladder, of whom a third had an atonic bladder associated with gynaecological problems. Although some women had no disability apart from incontinence, others were severely disabled and relied on wheelchairs. Many of these women, however, mastered the technique despite paraplegia, an anaesthetic perineum, intention tremor, severe spinal deformity, learning disability, old age, and even blindness. Their remarkable determination arose from the handicap imposed by incontinence, severe urinary infections, or episodes of acute retention.⁴

Cardozo recommends clean intermittent self catheterisation for patients with chronic urinary retention and overflow incontinence as it may enable them to become dry and safeguards the kidneys from the effects of back pressure and infection.⁵ As the technique is simple and safe and can be abandoned if unsuccessful with no long term side effects,⁶ it is always worth trying as an alternative to, or while a woman is awaiting, an operation.⁶ Some women have been so pleased with its results that they have continued with it in preference to surgery.

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- 1 Cardozo L. Urinary incontinence in women: have we anything new to offer? *BMJ* 1991;303:1453-7. (7 December.)
- 2 Hunt GM. Recent advances in intermittent catheterisation. *Z Kinderchir* 1989;44(S):50.
- 3 Hunt GM, Whitaker RH. A new device for self catheterisation in wheelchair bound women. *Br J Urol* 1990;66:162-3.
- 4 Hunt GM, Whitaker RH, Doyle PT. Intermittent self catheterisation in adults. *BMJ* 1984;289:467-8.
- 5 Underused: intermittent self catheterisation. *Drug Ther Bull* 1991;29:37-8.
- 6 Clean intermittent catheterisation. *Lancet* 1979;ii:981-3.

Understanding Marfan's syndrome

SIR,—Ian Young's editorial on Marfan's syndrome raises the problem of distinguishing patients with the syndrome from patients with similar conditions within a range of connective tissue disorders.¹ The consequences of providing a diagnostic label may not be trivial for the patient.^{2,3}

The Berlin nosology attempted to establish strict criteria for diagnosing Marfan's syndrome.⁴ As Young comments, skeletal characteristics may be striking. We have studied families with no such skeletal features but with aortic dilatation and ectopia lentis and no relation fulfilling the criteria of the Berlin nosology. Another large family exhibits obvious skeletal features and several members of the family have aortic dissection but none show any eye signs. This large family did, however, show linkage to the fibrillin gene on chromosome 15 in the consortium study.⁵ In contrast to the above cases, one patient fulfils the criteria for Marfan's syndrome but does not have any evidence of aortic disease. How are we best to classify and, more importantly, counsel such patients? Will the first two families, which fail to qualify for the diagnosis of Marfan's syndrome, have a less serious prognosis than those that fulfil the criteria?

The perception of the term Marfan's syndrome, particularly among patients, is initially determined by family experiences. Families in which aortic dissection has resulted in death will regard it as a lethal condition, whereas those without such experience will not until advised that it is a risk of the condition. Raising such fears and the consequent need for regular monitoring is justified only if the risk is real. If patients labelled as having Marfan's syndrome do in fact have a heterogeneous collection of connective tissue disorders we can recognise disorders outside the strict criteria and should label them as "marfanoid" until we can determine with greater precision the risks concerned.

We hope that the progress in mapping the gene segregating with Marfan's syndrome and the finding of a decreased level of fibrillin in many patients with the syndrome⁶ will help to clarify these issues.

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- 1 Young I. Understanding Marfan's syndrome. *BMJ* 1991;303:1414-5. (7 December.)
- 2 Glesby MJ, Pyeritz RE. Association of mitral valve prolapse and systemic abnormalities of connective tissue. *JAMA* 1989;262:523-8.
- 3 Bridges AB, Faed M, Boxer M, Gray JR, Bundy C, Murray A. Marfan syndrome in a large family: response of family members to a screening programme. *J Med Genet* (in press).
- 4 Beighton P, de Paep A, Danks D, Finidori G, Gedde-Dahl T, Goodman R, et al. International nosology of heritable disorders of connective tissue, Berlin, 1986. *Am J Med Genet* 1988;29:581-94.
- 5 Tsipouras P, Sarfarazi M, Devi A, Weiffenbach B, Boxer B. Marfan syndrome is closely linked to a marker on chromosome 15q1.5->q2.1. *Proc Natl Acad Sci USA* 1991;88:4486-8.
- 6 Godfrey M, Menashe V, Welebers RG, Koler RD, Bigley RH, Lovrien E, et al. Cosegregation of elastin-associated microfibrillar abnormalities with the Marfan phenotype in families. *Am J Hum Genet* 1990;46:652-60.

Health of the nation: personality disorder

SIR,—Mental illness in relation to *The Health of the Nation* was addressed by Graham Thornicroft and Geraldine Strathdee in the *BMJ*'s series of articles responding to the green paper,¹ yet I believe that it is pertinent to highlight personality disorder, a subcategory of mental illness that often passes undiagnosed. Its prevalence is roughly 10% in the total population, rising to 20-30% in those attending general practices.² When present with other diagnoses it worsens the prognosis, resulting in longer and more expensive treatment. Personality disorder is associated with target areas that have already been identified—namely, abnormal eating habits, alcohol and drug misuse, smoking, prevention of accidents, HIV and AIDS, and other mental illness itself.