

understood through the conceptual framework of complexity science³ which tells us that what is crucial is the coherence of the community of stakeholders in terms of these high-order values as 'rules' for action. That is where our efforts should be focused.

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A new approach to patients with lower urinary tract symptoms

In their otherwise excellent editorial on lower urinary tract symptoms (LUTS), Blanker *et al* made two surprising assertions.¹ They recommend rectal examination, especially when patients fear prostate cancer, but state that its objective value is limited. I presume they mean by this that rectal examination is poor at discriminating between benign and malignant prostatic disease. I agree.

Therefore, to follow this by saying rectal examination will often meet the expectation of the patients, and (if negative) patients can be reassured that prostate cancer is not the cause of their symptoms, but one cannot state categorically that such patients do not have cancer. This sounds rather doubtful medicine; reassuring patients on an imperfect test, when there is a superior one: the prostate specific antigen (PSA).

Blanker *et al* reject the use of PSA in patients with LUTS by equating it with screening. This is an error; screening is systematic investigation of asymptomatic individuals, not investigation of symptomatic

patients. The difference between these populations is twofold.

First, the prevalence of disease is almost certainly higher in the symptomatic population than the asymptomatic one. Most LUTS have positive predictive values for prostate cancer of around 3%, whereas the yield of cancers in asymptomatic screening is lower.² Second, if treatment is being considered, it is likely to be different for a malignant as opposed to a benign prostate.

I wholly agree with the authors that we must inform patients about the pros and cons of PSA testing when they present with LUTS, but we must be careful to use the right information in doing so. I have no desire to have my PSA done while I'm asymptomatic, but may well ask for it once symptoms are bad enough to see my doctor about them.

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Telling the truth: why disclosure matters in chronic kidney disease

Abdi *et al's* editorial¹ raises some important issues. Many patients with chronic kidney disease (CKD) are asymptomatic, but this differs from say, hypertension, in that end-organ damage has already occurred. Once disclosure has been made to a patient, as it should be, most would need to be guided through a risk assessment by their GP. The apposite appearance, in the same issue, of a paper on communicating risk to patients² highlights the potential difficulties of this. It is problematic with the familiar, such as cardiovascular disease (CVD), and I suspect many GPs would find the process even more complex with CKD. The highlighted

statement caught my eye, that 'Patients should be educated on preventative strategies, including ... temporary cessation of medications such as renin-angiotensin blocking agents during periods of acute illness'.¹ I was reminded of an incident with a patient of mine, many years ago, when angiotensin converting enzyme (ACE) inhibitors were in their infancy in general practice. He had been prescribed an ACE inhibitor for congestive cardiac failure by his cardiologist. His renal picture fulfilled the criteria for referral to a nephrologist, confirmed at a lecture that I had recently attended. On my recommendation, my patient agreed to the referral. He was shortly after admitted to hospital with acute congestive cardiac failure, following the summary cessation of his ACE inhibitor by the nephrologist. His ACE inhibitor was restarted to beneficial effect, but he never quite regained his previous level of wellbeing. I was copied in to the subsequent animated correspondence between hospital specialists. It was my introduction to clinical compartmentalisation.

Given that CKD is a known risk factor for CVD, each GP is likely to have a number of patients who would be within the remit of this recommendation. Clearly, my anecdote does not give an evidential basis to a contrary argument, but does raise a clinical concern. I was surprised, therefore, to find that the recommendation was not supported by references. I would need more than just an authoritative statement to change my clinical practice. Is this merely an accidental error of omission, or is it a case of Dawkins' triad and we are in at the beginning of a new tradition?³

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