ders that may occur coincidentally. For example, a woman with dysuria and suprapubic discomfort in association with haematuria may be diagnosed with cystitis; or acute prostatitis may present in men with low back pain and fever. In the absence of an obvious unrelated cause, symptoms are often assumed to be due to the chronic disorder. Serious coincident diagnoses may be overlooked, which would lead to a delay in treatment. We have described two patients with polycystic kidney disease and bladder carcinoma. The clinical presentation of renal tract cancer is similar to the other, more common complications of polycystic kidney disease,[5] and the incidence of these malignancies matches that of the general population.[6] With these points in mind, how should one effectively screen this group of patients who develop haematuria for underlying urothelial malignancy?

In the general population, standard investigations for haematuria include urinary microscopy, cytology testing, intravenous urography, and ultrasound scanning. These identify an upper renal tract malignancy in less than 1% of screened patients. Cystoscopy detects bladder carcinoma in 12%.[7] Detection rates of malignancy in polycystic kidney disease are likely to be lower as the incidence of benign pathology is much higher. Macroscopic haematuria is frequently recurrent,[3] which could result in repeated investigation. Both our cases of bladder carcinoma were diagnosed after transabdominal ultrasound scanning. This is a useful detection method for larger bladder tumours, but the yield is proportional to tumour size.[8] Urine cytology may be a useful adjunct for high grade bladder cancer, but sensitivity is poor in detecting low grade malignancy.[9 10] For upper renal tract cancers ultrasound scanning and intravenous urography are difficult to interpret in adult polycystic kidney disease, and enhanced computed tomography scanning of the abdomen is the radiological investigation of choice.[11]

We have reported two cases of bladder carcinoma manifesting as macroscopic haematuria in adult polycystic kidney disease. These cancers can also be associated only with microscopic haematuria, and this further emphasises the need for continued vigilance. Underlying malignancy should be considered in patients with associated abdominal pain, weight loss, or constitutional symptoms,[5] irrespective of age. Indeed, the second case provides further evidence that bladder carcinoma is not exclusively a disease of those aged more than 40 years,[7] so screening protocols should include younger patients.

Routine screening for underlying urothelial tumours among all patients with adult polycystic kidney disease who also have episodes of haematuria is probably untenable. Simple non-invasive investigations such as transabdominal scanning and urine cytology may be viable, and these could easily be requested before referral to the appropriate specialty. Further studies are needed to assess whether such a routine screening protocol would be cost effective and whether there is a cohort of high risk patients who would benefit from more intensive investigation.

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Department of Renal Medicine, Hull and East Yorkshire Hospitals NHS Trust, Hull Royal Infirmary, Hull HU3 2JZ
Sunil Bhandari *consultant nephrologist*
Correspondence to: R Dedi
rdedi@doctors.org.uk

Correction

ABC of AIDS: Development of the epidemic

An administrative error in the processing of this article by Michael W Adler (19 May, pp 1226-9) led to data for 1999 being reported instead of data for 2000. The first paragraph in the subsection "Worldwide" (p 1227) should have reported that by the end of 2000 there were 36.1 million people (34.7 million adults and 1.4 million children aged <15 years) living with HIV/AIDS and that during 2000 there were 5.3 million new infections (16 000 a day). In the next subsection ("USA, UK, and Europe," p 1228) the second paragraph should have reported that there were 236 406 adult cases in Europe by June 2000 and 17 151 in the United Kingdom by December 2000. In the table showing adult patient groups (p 1228) the numbers of patients in the United Kingdom should read (downwards): 11 345, 1095, 307, 828, 3391, 185 (with the row titled "Mother to infant" completely deleted); the total should therefore be 17 151, and the percentage in the fifth row should be 20 [not 18]. The total number of males and females given in the figure on p 1229 should be 35 626 and 8106 respectively, and the caption should state that these are data to December 2000.

In addition, in the last box on p 1226 "Mycobacterial tuberculosis should be qualified by "at any site," and the final sentence of the article should talk about developing a control strategy [not a strategy or control].

Endpiece

Best when old

Physicians, like beer, are best when they are old.

Thomas Fuller (1608-61) in *The Holy State and the Profane State* (1642). Fuller was one of the most popular preachers and authors of his day, and was appointed chaplain in extraordinary to King Charles II after the Restoration.

Submitted by Fred Charatan,
retired geriatric physician, Florida