done but that learning has taken place which can be linked to external standards of practice. Pressures from patients and purchasers and the need for public confidence in the effectiveness of continuing medical education may call for an assurance of competence linked eventually to a system of reaccreditation. A crucial element of the self-directed learning of individual general practitioners must surely be audit, to identify under-performance or to reinforce appropriate practice. Further efforts will be required to engage more general practitioners in audit as a personal activity and to combat negative attitudes. If portfolio-based learning succeeds, more general practitioners will be writing about and discussing their work with colleagues. Surely this must be good for doctors and for patient care.

ALASTAIR F WRIGHT
Editor of the Journal

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Address for correspondence

Dr A F Wright, British Journal of General Practice, Royal College of General Practitioners, 12 Queen Street, Edinburgh EH2 1JE.

Urinary incontinence in women — a conundrum

UP to 10 million people in the United Kingdom suffer from urinary incontinence.[1] It is a condition which adversely affects quality of life for many patients and causes 'social death' for some chronic sufferers.[2] It mostly affects women and up to one third worry about their incontinence.[3] However, fewer than one third of all regularly incontinent women discuss the problem with a general practitioner or nurse.[4] Indeed 20% of women referred to a urodynamic clinic had delayed seeking their general practitioner's advice for more than five years after the symptoms had become troublesome.[5] Most of these women are likely to be well used to consulting doctors about other matters, including those of a gynaecological nature.

Urinary incontinence is an imprecise medical term and not a diagnosis; 85% of patients have stress urinary incontinence and 10% have detrusor instability, although both can coexist.[6] In stress urinary incontinence the patient complains of urine leakage on coughing and on exercise and this can be replicated in the clinical examination. Specific clinical signs are absent in detrusor instability although psychological factors are more evident than in stress incontinence. Distinguishing stress incontinence from detrusor instability is important because the management strategies are different. Bladder pressure studies are now a minor inconvenience as the benefits from diagnosis and appropriate treatment are worthwhile.

There are now a variety of management strategies available to incontinent women and their medical and nursing advisers.[7] These include pelvic floor exercises, appliances, drugs and surgery. Many of these methods have been studied in controlled trials and have been shown to be safe and effective. The less invasive techniques such as pelvic floor exercises require commitment from the patient after initial instruction.

In this issue of the *Journal*, Harrison and Memel describe the use of a health promotion clinic in the management of urinary incontinence.[8] Despite attempts at generating interest among their patients and the user friendliness of their clinic only 8% of their incontinent patients attended. A leaflet was, however, sent to incontinent patients and may have made a clinic visit unnecessary. Practices thinking of using a clinic format for their incontinent patients will find the authors' experiences helpful, if disheartening.

There is little doubt that for the majority of women incontinence is a minor inconvenience. Modern pads, pants and washing facilities allow most to cope without medical or nursing assistance. Many women accept it as a consequence of childbirth yet many nulliparous women also suffer.[9] Others see it as part of ageing yet many young women are regularly incontinent of urine.[10] There is, however, a strong association between neurotic personality traits and anxiety and both detrusor instability and stress urinary incontinence.[11] It is likely that such patients may have a lower consulting threshold for their urinary symptoms than those who are less neurotic or anxious.

Women with longstanding urinary incontinence and those with neuropathic bladders are deserving of specialized support and treatment. Where appropriate continued management will inevitably involve the primary carers, whether in the patient's own home or a nursing home. Treatment of recurrent urinary infections will make the patients more comfortable, while thought about the timing of, or indeed need for, diuretics may improve quality of life. Intermittent self catheterization has been shown to be safe, simple and possible in the home.[12] Such catheterization may free some selected patients from an indwelling catheter and these patients should be considered for referral for a trial of self catheterization.

Despite the array of skills and medications available, patients are slow in coming forward. In other areas of medicine doctors feel overwhelmed by demand, much of it inappropriate. Old attitudes in medicine may have conveyed uninterest or helplessness to the incontinent patient. Urinary incontinence is now seen as a team effort involving the patient herself and her medical and nursing advisers. If we are to meet her needs we need to understand why the most important member of the team is reluctant to take part.

T C O'DOWD
Professor, Department of Community Health and General Practice, University of Dublin

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Address for correspondence
Professor T C O'Dowd, Department of Community Health and General Practice, University of Dublin, Trinity College, Dublin 2, Ireland.

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