

College of Physicians and the Royal College of General Practitioners automatically give their recognition.

In October 1987 the Royal College of Surgeons of England produced their guidelines for pre-fellowship surgical training posts in accident and emergency medicine.<sup>1</sup> Since the majority of accident and emergency posts have the same work practice and educational content, irrespective of the future career that the incumbent wishes to pursue, these guidelines are applicable to all accident and emergency posts.

Because of the changes now taking place in general practice, the surgical experience to be gained in accident and emergency medicine makes it even more relevant for vocational trainees than perhaps it was in the past.

It must be remembered that there will not be time for education if departments are inadequately staffed, and the guidelines of the Royal College of Surgeons<sup>1</sup> make it quite clear that 'there should be approximately one trainee for every five thousand new patients per annum'.

Finally, the guidelines emphasize that time must be set aside for didactic education, as opposed to 'learning on the job'.

In summary, the training to be had in accident and emergency medicine, where we are specialists in the immediacy of a work practice of managing acute problems is very relevant to general practice; great thought has also been given to the training of accident and emergency trainees.

In addition the academic committee of the British Association of Accident and Emergency Medicine is producing a paper entitled *Teaching standards in accident and emergency departments* which will further delineate standards that must be attained.

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### Testing asymptomatic patients for *Chlamydia trachomatis*

Sir,

We support the view that the consequences of the chlamydia epidemic can only be reduced by testing asymptomatic

women in general practice, coupled with changes in sexual behaviour. However, the analysis presented in a recent paper (*April Journal*, p.142) has two significant flaws.

The authors state that the chlamydia culture method used was assumed to have a sensitivity of 75% and a specificity of 100%. Many general practices will not have access to chlamydia culture, and will have to rely on enzyme-linked immunosorbent assay (ELISA) methods, which have less than 100% specificity. A specificity of 95% may sound reasonable, but the implications of such a test when applied to a population with a 5% prevalence of chlamydia are that 5% of samples will yield true positive results, and 5% will yield false positives. The significance of a positive result could be evaluated by the toss of a coin. This sort of consideration is important before widespread screening programmes are contemplated.

Furthermore, the partner was also treated, but no contact tracing was performed. This is inadequate. The epidemic of chlamydial infection exists because young people do not confine their sexual activity to long-term faithful sexual partners. Treating only the most obvious partner may not prevent reinfection of the index patient, and will certainly have no impact on the overall epidemic of chlamydia. The epidemiological model used in this paper is too simplistic.

Many doctors will recognize that the correct procedure to follow in patients suspected of having chlamydial infection is referral to a sexually transmitted disease clinic.<sup>1</sup>

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#### References

1. Coker DM, Timmins DJ, O'Mahoney C. Chlamydia: one step forward or two backwards? *Br Med J* 1989; **298**: 51.

Sir,

I write to express my concern at the prospect of widespread screening for endocervical *Chlamydia trachomatis* among asymptomatic sexually active young women. I accept that there is a case to be made for such a programme. *C trachomatis* is a major cause of pelvic inflammatory disease in the industrialized countries<sup>1</sup> and cheap effective interventional treatment is possible within a latent interval.<sup>2</sup> Professor Buhaug and his col-

leagues (*April Journal*, p. 142) conclude that such a programme in sexually active young women could be cost effective.

My concern arises from the fact that the psychological effects on women who have been screened have not been studied. It has been shown that healthy adults who have been screened for cardiovascular risk markers experience an increased incidence of psychological distress.<sup>3</sup> It is likely that screening for a sexually transmitted disease would have an even more distressing effect on the participants. Before we are tempted to embark on yet another screening programme I believe we should find out more about women's attitudes to being screened for sexually transmitted disease and about the effect such a programme might have on the mental welfare of its participants and their families.

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2. Rahm VA, Gnarpe H, Rosen G. Chlamydia vanligt hos tonarsflicker som soks for preventivmedelsradgivning. [Chlamydia common among teenage girls visiting for advice on contraception]. *J Swed Med Assoc* 1986; **83**: 615-616.
3. Stoaite HG. Can health screening damage your health? *J R Coll Gen Pract* 1990; **39**: 193-195.

### Detection and management of urinary tract infection

Sir,

I would like to comment on the articles on the detection and management of urinary tract infection in general practice (*October Journal*, p.399, 403, 406).

First, I found it surprising that neither of the two original papers made any reference to the paper by myself and colleagues<sup>1</sup> which looked at the use of screening tests for the detection of bacteriuria in elderly subjects and which gave results quite similar to those found by Hiscoke and colleagues.

Secondly, I am concerned that in both original papers the laboratory diagnosis of bacteriuria was based upon the results of a single voided urine sample. As alluded to by Dr Brooks, it has been found that greater than 10<sup>8</sup> organisms per litre in a sample of urine predicts the presence of significant bacteriuria with an accuracy of 80% while greater than 10<sup>8</sup> organisms per litre of the same organism in two voided urine samples increases the accuracy to 95%.<sup>2</sup> Therefore, as a minimum require-

ment for these types of study, two voided urine samples are necessary to establish the presence of significant bacteriuria.

Finally, I found it rather strange that despite the evidence from these two papers and my own paper<sup>1</sup> Dr Brooks could still state that 'bacteriuria can only be established with certainty if bacterial cultures are obtained' when these studies have all found that screening tests for bacteriuria can be accurately used to screen out negative urine samples.

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2. Asscher AW. *The challenge of urinary tract infections*. London: Grune and Stratton, 1980.

Sir,

I read Brooks' leading article (October *Journal*, p.399) with interest. I would like to offer one criticism of the otherwise balanced advice on the management of suspected urinary tract infection in general practice.

Nowhere does the author mention, let alone stress, the importance of inspecting the vulva and vagina of all women presenting with dysuria (and taking vulval, urethral and anal swabs if indicated). If inspection is not carried out, the common monilial vulvovaginitis will be missed and the recommendation to 'give a short course of antibiotics' will make matters much worse; even more important, evidence of gonorrhoea and syphilis will be missed.

Dr Brooks doubtless assumed that such a clinical examination should always be done, but I feel that it is important to stress this basic point in an influential leading article.

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Sir,

I would like to comment on the statement in Dr Brooks' editorial (October *Journal*, p.399) that men with urinary infection need referral for investigation because obstructive uropathy may result in kidney damage.

Urinary infection in men, although less common than in women, occurs much more frequently than textbooks suggest and is not limited to patients with structural abnormalities or enlargement of the prostate. Over a 10 week period in 1984<sup>1</sup> the Public Health Laboratory of Portsmouth received urine specimens from 585 men with urinary symptoms. Four hundred and ninety seven men (85%) had presented to their general practitioners and 182 (31%) were less than 45 years of age. One hundred and seventy nine specimens yielded aerobic pathogens and 140 yielded fastidious organisms. It is unlikely that such a large number of men have abnormalities of the urinary tract requiring investigation.

The fact that urinary infections in men do not usually respond to treatment with  $\beta$ -lactam antibiotics or nitrofurantoin, which do not achieve therapeutic concentrations in the prostate, suggests involvement of the prostate in many infections. In recent years the laboratory has appended a comment to all reports of positive urine cultures from men suggesting that treatment with an agent that penetrates the prostate should be given for 14 days. Suitable agents are cotrimoxazole, doxycycline and ciprofloxacin; erythromycin may also be used for treatment of infections caused by gram-positive organisms. It is important to recognize that treatment of infection involving tissue must be given for longer than that for uncomplicated urinary infection.

Follow-up specimens from men treated in this way are usually negative, and it is hoped that, by appropriate management of the acute episode, the unpleasant condition of chronic prostatitis may be prevented.

Rather than subjecting all men with urinary infection to urological investigation it seems reasonable to treat appropriately as described above, and to reserve investigation for those who fail to respond.

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#### Reference

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Sir,

Neither of the papers looking at the rapid diagnosis of urinary tract infection in general practice (October *Journal*, p.403, 406) mentioned the shake test which has been used as a rapid diagnosis of pus cells in urine for many years. In this test, a

solution of potassium hydroxide is added to an equal quantity of urine in a test tube. The resultant mixture is shaken and if the bubbles remain in the solution then the test is regarded as positive and indicates pus in the urine.

When I first came to the practice, I found this test very reliable for diagnosing infections. Sometimes it picked up pyuria when no organism was grown but very rarely did it miss a true infection. It is a very simple test that is easily done in the surgery. In this practice a positive shake test would be regarded as an indication to start antibiotic treatment.

I feel this is a test that deserves wider popularity.

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## Involvement of clergy in patient care

Sir,

Michael King and Peter Speck (Letters, September *Journal*, p.392) make some rather misleading assumptions and statements in responding to my paper on clergy involvement in patient care (July *Journal*, p.280).

My paper stated quite clearly that its intention was to seek doctors' views only in respect of involving christian clergy in patient care as the report of the Royal College of General Practitioners and the Churches' Council for Health and Healing<sup>1</sup> and the British Medical Association's approved statement<sup>2</sup> were concerned only with christian clergy. It may also be helpful to know that the contents of my paper form only one part of a much wider study of the christian church's contribution to health care.

The assumption that the survey was located 'mainly in the city of Bristol' is also incorrect. As indicated in the paper an area within the Avon health district was chosen for the survey, consisting mainly of greater Bristol.

The concern over 'lack of data on the beliefs of doctors' misses the whole point of the survey, which was to discover what a cross-section of doctors (of any religious persuasion or none) think about the idea of involving clergy in patient care. It was found that among both referring and non-referring doctors personal belief, or the lack of it, played some part in their attitude to referral to the clergy. This suggests a whole field for further study.

I agree with the point concerning the