

terms of staff time saved are unquantifiable, as are longer-term savings made to the NHS from prompt diagnosis of urinary tract infection. Subsequent published papers have also shown that there is no significant difference in urine collected by clean catch versus UCP.^{8,9}

The cost of obtaining a urine sample in babies can be considerable, not only in monetary terms, but also in time, quality of sample, delay in making a diagnosis, and discomfort for the child and family.^{5,6,8} Clean catch samples of urine require significant input, both in time and persistence from parents and staff, and contamination is not uncommon.⁸ Pads, however, can be appropriately sited, checked every 10 to 20 minutes, are comfortable for the baby, and parent compliance is improved.

Urinary collection pads are now widely used in the United Kingdom and will soon be available in procedure packs, comprising two pads, syringe, universal container, and instruction sheet. They are suitable for use in collecting urine from severely handicapped children, and may also be used to collect urine from elderly and confused incontinent patients.⁷

In conclusion, pads are a simple and accurate way of collecting urine in babies.

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Community hospitals

Sir,

The editorial by Ritchie and Robinson (*March Journal*)¹ highlights the pivotal role of community hospitals in providing care throughout the UK.

These hospitals provide a high quality of care, and are usually situated near patients' homes. The use of community hospital beds appears to be increasing, with several hospitals setting up their own palliative care suite or room.

An evaluation of 72 consecutive patients cared for in one such palliative care unit² revealed that the majority were admitted for terminal care, with only a small number ($n = 6$) admitted for procedures; e.g. treatment of hypercalcaemia. The majority of admissions were short term (85%) and were for less than 21 days.

Nearing the time of death, 68% of patients were commenced on a syringe driver containing diamorphine, and, in 85% of cases, one other drug was used; these were mostly antiemetics. Very few drugs were written up on the 'as required' chart, and, in the last 12 hours of life, 23 patients required medication (mostly analgesics and sedatives). As there was no doctor on sight, there was considerable delay at times in obtaining permission for medication to be given.

Possibly the use of drug charts with pre-written 'as required' drugs that the admitting doctor could complete with an appropriate dose range, may be a solution. This system is used in many hospices where there are no resident medical staff.

The principles of palliative care are applicable to all patients with end-stage disease, and the use of community hospital beds in this way may further enhance palliative care services and make such care accessible to more patients.

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Telling the truth

Sir,

Vassilas and Donaldson (*March Journal*)¹ highlight the dilemma that doctors face in deciding whether to disclose the diagnosis of Alzheimer's disease, and dementia in general, to patients. They found that GPs were reluctant to tell patients that they had a dementia, and that the most important factors influencing their decision were the degree of certainty of diagnosis, the patient's wish to be told, and the patient's emotional stability. In contrast, they found that the large majority of GPs would tell patients of a diagnosis of terminal cancer.

In the early 1960s, doctors were also reluctant to disclose the diagnosis of cancer to patients, and the reasons for this practice mirror many of the reasons currently given for not telling the patient with dementia his or her diagnosis — the lack of effective treatment for many cancers at the time, and a fear of the patient becoming depressed. By the late 1970s, doctors' practices with cancer patients had changed dramatically,² partly due to improved treatments and also a growing belief that the patient had the right to know.

However, we feel that Vassilas and Donaldson omitted to discuss what is possibly the greatest barrier to disclosure of diagnosis to the patient with dementia — the resistance of family members. In 1996, from a memory clinic in Dublin, we published a study of family members' attitudes toward telling patients with Alzheimer's disease their diagnosis.³ In 83 out of 100 cases the family member said that their relative should not be told the diagnosis. The main reason given was a fear that the disclosure of the diagnosis would upset or depress the patient. In contrast, 71 of the 100 relatives wished to be told the diagnosis should they themselves develop Alzheimer's disease, emphasizing their 'right to know'. This dramatic inconsistency may be puzzling, but is probably partly explicable in terms of a paternalistic desire to protect the (usually) older relative from distress, which, to an extent, reflects ageist attitudes ('I would be able to deal with the diagnosis, but my mother wouldn't').

The recent advent of potential treatments for Alzheimer's disease (cholinesterase inhibitors, such as donepezil) and the increasing public awareness of the disease and other dementias, may help to overcome some of the fears of both families and doctors, and herald a move towards informing the patient with dementia of the diagnosis, as happened for cancer patients 20 years ago.

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Practice nurse telephone triage

Sir,

The paper by Gallagher *et al* (April *Journal*)¹ on telephone triage of acute illnesses by a practice nurse is a useful contribution to the means of managing this aspect of primary care workload. It is one that we are contemplating in our own, equally busy, practice. However, I am astonished about the statement in the discussion that 'a large proportion of patients seeing the nurse require prescriptions'.

General experience and workload reports from out-of-hours cooperatives suggest that the majority of 'acute' illnesses, for which urgent advice is sought, include coughs, colds, 'flu-like illnesses, earaches, vomiting, diarrhoea, and minor allergic conditions. Very few of these are likely to be helped significantly by medical actions, and symptomatic remedies are easily available from pharmacy outlets.

I would be concerned that a high rate of prescribing will compound surgery attendance for these conditions, and that opportunities to inform and educate patients towards a greater degree of self-reliance is being lost.

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Prevalence and treatment of dizziness

Sir,

The editorial studying the prevalence and treatment of dizziness (April *Journal*)¹ was a fascinating read. It certainly is the case that 'undifferentiated illness' such as dizziness forms a substantial part of our workload in general practice. How disappointing then, that the aetiology of dizziness described in standard textbooks is written by ENT specialists rather than general practitioners.

Yardley *et al* state that the aetiology might be vestibular, cardiovascular, iatrogenic, psychiatric, neurological, or 'multi-sensory' in origin. Another possible source of dizziness, not mentioned in standard textbooks, is the neck. Proprioceptors in the neck enable us to sense the position of our head in relation to the rest of our body. Might such disturbed proprioception be an important cause of dizziness? In my experience, assessing and treating patients' necks with osteopathic methods within my own general practice, I have been struck by the number of patients who complain of dizziness along with their neck pain. Sometimes this dizziness improves dramatically with osteopathic manipulation.

I hasten to add that I am not advocating neck manipulation for all dizzy patients, but that osteopathy provides new insights into possible alternative aetiologies. Interestingly, Yardley *et al* state that chronic dizziness is associated with neck pain, but claim that this is a secondary phenomenon consequent to adopting a rigid head position. Perhaps the neck symptoms are the primary problem and the dizziness is a secondary phenomenon?

The description of 'vestibular rehabilitation'² includes a programme of graded exercises consisting of eye, head, and body movements that are designed to stimulate the vestibular system. Surely they will also stimulate proprioceptors in the musculo-skeletal system? Normal balance involves a complex interplay between numerous interacting systems, vestibular, neurological, proprioceptive, and visual. Dizziness results when this fails.

Professor Bain³ asks how 'vestibular rehabilitation' can be provided within general practice. This question also applies to the provision of other physical therapies including spinal manipulation. Providing such assessment and treatment within general practice not only broadens our therapeutic choice away from the narrow, unsatisfying, and unproven confines of pharmacology, but also provides us with insight into alternative aetiologies for

these common but neglected disorders.

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Group D streptococcal throat infection

Sir,

The brief report by Sanders (February *Journal*)¹ suggests an unusually high incidence of isolation of Lancefield group D β -haemolytic streptococci in patients with pharyngitis or tonsillitis in a London general practice. Moreover, he attributes this organism as the likely source of infection. We feel that this is giving a false impression of the pathogenicity of group D streptococci, and goes contrary to the current and long-standing opinion that groups A, C, and G are responsible for throat infections.²

Lancefield group D streptococci are almost all enterococci (the majority being *E. Faecalis*), which are normal gastrointestinal commensals. They may be a cause of urinary tract infections, post-operative sepsis, septicaemia, and endocarditis. They are generally less sensitive to penicillin than the other haemolytic streptococci.

Dr Sanders quite rightly diagnoses the infection on clinical grounds, but wrongly attributes isolated bacteria, not recognized pathogens in that site, as being the causal organism. He makes no mention of whether the patients had been previously treated with an antibiotic. Antibiotic therapy would select out resistant organisms, such as enterococci, and give the impression of a higher than usual carriage rate. We suspect, however, that most of these infections are viral. Dr Sanders makes no reference to any attempt to investigate a viral cause for these infections.

We also wish to make the point that he uses 'near patient testing' in the wrong context. Near patient testing is widely