The part of the lower urinary tract in the female that does relate to vaginal development is the distal urethra. Both these structures derive a common origin from the Müllerian tubercle and this is reflected in their structure, and in particular the stratified squamous epithelium that covers both organs. It is the stratified squamous epithelium of the urethra that is the oestrogen-sensitive component of the urinary tract. The trigone develops quite independently from the vagina. With age there is increasing spread of squamous epithelium along the urethra and this may extend up on to the trigone in certain patients. However, the precise relationship of this squamous spread to urinary tract symptoms is not completely understood. Certainly it is optimistic in the extreme to claim that urinary stress incontinence can be cured by oestrogen alone. Oestrogen will undoubtedly help those patients with atrophic urethritis and a urethral syndrome, particularly when the latter is associated with urge incontinence. Similarly the oestrogens will help in the preoperative preparation for patients undergoing vaginal surgery.

Finally, I think it should be said that a prostatectomy can cure the overflow incontinence associated with chronic retention. The improvement in catheter materials has certainly made catheter drainage more acceptable and there will always remain patients who are not suitable for any form of treatment by surgery. However, as you make clear, long-term catheter drainage is the final degradation for the urinary tract. An aggressive approach to the understanding and management of urinary incontinence remains a priority for surgical development in Britain.

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Uncovering physical illness in elderly patients with dementia

SIR,—We were interested to read your recent leading article (10 December, p 1499) on this subject, as we recently undertook physical examinations and selected laboratory investigations on patients in a long-stay psycho-geriatric ward in what you so quaintly refer to as a "residential psychiatric unit."

Twenty-one patients who had been admitted more than 12 months (mostly 1-15 years) previously were examined. They were aged between 65 and 86; one was male. The most striking finding was that so few patients were without any abnormality. Indeed, there were only two patients without a significant anomaly and one of these refused venepuncture.

Physical examination revealed only a small number of abnormalities, though constipation was common. On the other hand laboratory investigation, following a standard protocol with additional tests when indicated, yielded a mass of abnormal results. Serum folate levels were commonly in the low or low normal range and this was associated with mild macrocytic anaemia in six patients; the explanation for this folate deficiency was not clear but may have been dietary. Two patients had mild iron deficiency anaemia with occult blood in the stools. Three patients had a raised serum alkaline phosphatase value; two of these had a raised erythrocyte sedimentation rate (ESR) and one had known pelvic masses.

There were, perhaps surprisingly, no abnormalities of thyroid function or of plasma calcium or electrolyte levels. The blood urea concentration was raised in one patient. Urinary infection occurred, asymptotically apart from the almost invariable urinary incontinence, in six patients.

Your leading article argues for a rational approach to ensuring the physical wellbeing of the elderly demented patient. Our experience suggests that the traditional "annual physical" is not rational but, rather, time-consuming and ineffective. On the other hand a combination of careful examination when the clinical state changes and, say, biennial laboratory screening using some modification of the above protocol might be more helpful to the patient. Such problems as folate deficiency and constipation are surely preventable and should be prevented. A difficulty arises with the interpretation and investigation of such "abnormalities" as a raised ESR¹ or mild degrees of iron deficiency; we feel that over-zealous investigation may not be acceptable for many of these patients, but of course a balance must, as always, be drawn between the discomfort of investigation and the distress of occult disease rendered still more occult by the patients' mental clouding.

We should like to thank the nursing staff of Ward 24, Friern Hospital, for their unstinting assistance in this project, and the laboratory staff of Friern and the Royal Free hospitals who carried out the investigations.

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¹ Boyd, R V, and Hoffbrand, B I, *British Medical Journal*, 1966, 1, 901.

Boston Collaborative Drug Surveillance Program

SIR,—In the book review by Professor C T Dollery (17 December, p 1592) he reported that the Boston Collaborative Drug Surveillance Program is "now discontinued." We have no idea where Professor Dollery got this impression, but we wish to correct the error. We have continued to carry out intensive in-hospital monitoring, currently in five countries. In addition, we have expanded the monitoring programme to include surgical patients. Last year we published 18 original papers and currently have some 12 in press. We look forward to an interesting and productive future.

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The NHS 5-ml spoon

SIR,—A J Cronin's Drs Finlay and Cameron investigated the quantities of medicine administered when ordinary teaspoons and tablespoons were used. It seems that there has been very little improvement since their day.

A little investigation, asking patients to help, indicates that the 5-ml NHS issue measuring spoon (BS 3221/4) delivers between 2.5 ml and 4 ml when used in the home. The most likely quantity is 3 ml. At 4 ml the spillage between bottle and mouth is much and messy. Under laboratory conditions the

5-ml spoon does indeed measure 5 ml if the meniscus is observed correctly. However, in this state it is nearly impossible to hold it in the hand without spillage. Careful ordinary mortals align the edges of the spoon with the highest part of the convex meniscus, so have a volume of about 4 ml.

The NHS spoon offends against most rules governing accurate measurement. It is shallow, with a very wide "neck" (meniscus surface). I suggest that its use be discontinued and that a new 5-ml measure with suitable handle should replace it. The new measure should have a flat bottom, vertical sides, and a depth equal to the radius of the bottom. This shape should give a reasonably convenient and acceptable measure for ordinary use. It need not cost more or involve more manufacturing problems than the present inadequate spoon.

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Confidentiality and life insurance

SIR,—The letter from Dr T M Pickard (10 December, p 1544) and the comment from Mr V M Kendall (14 January, p 109) raise wider issues concerning the information contained in the NHS medical record envelope. On the one hand we must maintain accurate records containing those personal details about patients which are essential for good general practice care. On the other hand we must encourage our patients to talk to us about deeply personal issues and be able to assure them that whatever they say is truly in confidence and will not be passed on to any third party.

Mr Kendall points out that loose terminology may cause confusion in assessing reports from doctors. It may also cause confusion among doctors sharing the patients' care if imprecise diagnostic labelling is used in records. Thus the unhappy patient should be described as unhappy and not depressed; a single marginally elevated blood pressure reading should not be labelled as hypertension.

There appears to be an increasing tendency for patients to be asked to give permission for their medical histories to be supplied not only to life insurance offices but also to other third parties. One would accept Mr Kendall's comment that life offices are providing a service in the interests of the patient, but many employers are now also asking prospective employees to sign a declaration permitting the general practitioner to release his or her medical history to the company. It is made clear to the person that he or she will not be employed unless this is done. Many members of the public realise that this practice is growing. A most undesirable trend is that the patient may now refrain from discussing with his or her GP those confidential and personal issues which are so important in the management of patients in general practice, knowing that information about these problems may subsequently be extracted from the medical record and passed to a prospective employer. For example, in this practice a patient with a sexual deviation who clearly needed help procrastinated for several years before finally asking if he could discuss the problem without the details being recorded in the medical record envelope.

Dr Pickard suggests that we tell our patients that anything they say to us may be taken down and used in evidence against them when