given general practitioners ownership of patients. The next step in this debate is to ask the patients what they want.

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GP's participation in decisions about non-urgent tertiary referral is appropriate

EDITOR,—S Bridger and S R Cairns's study of general practitioners' views of consultants' non-urgent referral of outpatients to other consultants highlights one of the multitude of changes in clinical, managerial, and educational aspirations and requirements currently facing hospital doctors.¹ It is entirely appropriate for general practitioners to participate in decisions about non-urgent tertiary referral of their patients.

Most general practitioners have one or two preferred consultants in each specialty to whom they regularly refer most of their patients. Each consultant team, however, may see patients from 200 or 300 general practitioners. Furthermore, the current balance of medical staffing results in many consultations being conducted by non-consultant medical staff, who are unlikely to have knowledge of local general practitioners' preferences.

From a practical point of view, hospital doctors need to know the degree of involvement that general practitioners would like to maintain with their patient's current problem. If general practitioners wish to be involved in tertiary consultations then they might indicate this in the referral letter. It would also be helpful if general practitioners advised hospital doctors at the time of referral that they would like to be involved early in monitoring treatment once diagnostic procedures have been carried out and treatment has been planned.

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Urological emergencies in general practice

Simple test diagnoses or excludes epididymo-orchitis

EDITOR,—Chris Dawson and Hugh Whitfield state that the differential diagnosis of torsion of the testis includes epididymo-orchitis.¹ A simple clinical test will diagnose or exclude epididymo-orchitis; most cases occurring between the ages of 20 and 40 are secondary to sexually acquired urethritis.

The patient should be instructed to perform a two glass test. The first 40-50 ml of urine to be voided should be caught in the first container, and the residue should be caught in the second container. If the patient has urethritis the first voided urine will be turbid and cloudy, whereas the residual urine will be clear. If this is the case the patient should be referred to the local department of genitourinary medicine for testing

for *Neisseria gonorrhoea* and *Chlamydia trachomatis*. Gonorrhoea may be detected shortly after a two glass test,² but non-specific urethritis may be missed unless time is allowed to elapse between urination and urethral evaluation (DM, international conjoint sexually transmitted diseases meeting, Montreal, 17-21 Jun 1984).³ This simple test, and advice to the patient, can prevent unnecessary surgery.

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Herpes simplex not mentioned as cause of acute urinary retention

EDITOR,—Chris Dawson and Hugh Whitfield include neurological disorders and urinary tract infection in the list of causes of acute urinary retention.¹ Herpes simplex is worth specific mention as it is believed to be the most common cause of acute urinary retention in younger sexually active people, especially women.²

Urinary retention associated with herpes simplex is often accompanied by systemic symptoms, constipation, inguinal lymphadenopathy, and local neurological disturbance, sometimes in the absence of clinically obvious herpetic lesions, which have been described as occurring up to eight days after and three weeks before urinary retention occurred.^{3,4} Cervical or urethral herpetic lesions may be missed unless careful clinical examination is carried out.

For some patients it is sufficient to advise them to urinate in a warm bath; catheterisation will be needed in less than a quarter of cases.² In cases in which anogenital herpes is possible we advise that swabs should be taken and cultured for herpesvirus. After a clinical diagnosis, antiviral treatment should be started.

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Symptoms and diagnoses should have been distinguished

EDITOR,—I was disappointed to see Chris Dawson and Hugh Whitfield perpetuating the error of using the terms stress incontinence and urge incontinence as if they are diagnoses when they are in fact symptoms.¹ It must be over 25 years ago that it was realised that the symptom stress incontinence is not pathognomonic of the condition of genuine stress incontinence and the symptom urge incontinence is not pathogno-

monic of an unstable bladder. While it is true that most patients with the symptom stress incontinence have genuine stress incontinence and most of those with the symptom urge incontinence have an unstable bladder, several authors, including myself, have shown that about a quarter of women with an unstable bladder complain of the symptom stress incontinence even though they do not have genuine stress incontinence and over 35% of patients with genuine stress incontinence and a stable bladder complain of the symptom urge incontinence.²

The need to distinguish between symptoms and signs and the accepted terminology have been defined by the International Continence Society in its classification of lower urinary tract dysfunction, published in the *British Journal of Urology* in 1976 and in the *British Journal of Obstetrics and Gynaecology* in 1990.^{3,4}

Distinguishing between the symptoms and the diagnosis is not pedantry. If the diagnosis is confused with symptoms then between 25% and 37% of patients will be offered the wrong treatment.

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Authors' reply

EDITOR,—Dermot Murray's suggestion that a two glass test will differentiate between epididymo-orchitis and testicular torsion is interesting. Although this may be true in subjects who are sexually active, epididymo-orchitis is also seen in a younger age group who are not sexually active. In younger patients, in whom testicular torsion is more common but blood-borne testicular infection also occurs, the two glass test will not be diagnostically helpful.

A Stirland and colleagues state that herpes simplex causes acute urinary retention. As we mentioned in our article, acute retention of urine in women is rare; acute primary herpes simplex infection may occasionally be the cause in both men and women. We acknowledge the need for prompt antiviral treatment of the acute genital lesion based on a clinical diagnosis before the results of culture of swabs for herpesvirus are known, but in practice the immediate clinical management in both sexes will be urethral catheterisation. The value of antiviral treatment in hastening the resumption of normal micturition is only speculative.

G J Jarvis's comments about terminology are correct. Urologists and gynaecologists should not use anything other than the terminology set out by the International Continence Society. The ABC of Urology, however, is directed not at specialists in urodynamics but at generalists. As Jarvis points out, if patients are to be offered correct treatment an accurate diagnosis is a prerequisite, which is why we recommended that all patients with urinary incontinence should undergo videourodynamic tests, particularly before any surgical procedure is performed. Our intention was to heighten non-specialists' awareness of the two distinct causes of the two most common clinical presentations in urinary leakage. We hope that we have encouraged primary care physicians to expect that their patients