Low blood pressure is unlikely to be complication of dementia process

EDITOR,—Zhenchao Guo and colleagues report an association between low blood pressure and different types of dementia, including Alzheimer's disease.¹ Adults with Down's syndrome have a high prevalence of Alzheimer's disease²; they also have significantly lower diastolic and systolic blood pressures than the general population.³ We reviewed data from a five year prospective longitudinal study investigating aging in a cohort of adults with Down's syndrome to explore a possible association between low blood pressure and Alzheimer's disease.

Measurements of blood pressure and evidence used in making a diagnosis of Alzheimer's disease according to criteria in the *International Classification of Diseases* (10th revision)⁴ were available for 80 subjects aged over 45. Twenty one subjects fulfilled the criteria for Alzheimer's disease. The mean age of the group without dementia was 52.6 years and that of the group with dementia was 55.0 years ($t=0.32$, $P=0.75$). The mean systolic blood pressure was 109.5 mm Hg and 114.7 mm Hg respectively ($t=1.6$, $P=0.25$), and the mean diastolic blood pressure was 76.6 mm Hg and 75.9 mm Hg respectively ($t=0.32$, $P=0.75$). Thus there was no significant difference in either blood pressure between the two groups.

Incessant hypoperfusion due to persistent low blood pressure in adults with Down's syndrome may predispose to the development of neuro-pathological changes of Alzheimer's disease. We found no evidence, however, that low blood pressure is a complication of the clinical dementia process in people with Down's syndrome.

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Providing intensive care

Criticisms of situation in Birmingham are unsubstantiated

EDITOR,—D F Bowden and D P Burke make inaccurate and unsubstantiated allegations about the organisation of intensive care beds in University Hospital Birmingham NHS Trust.¹ We are disappointed that they did not have the courtesy to check their facts before criticising a third party.

University Hospital Birmingham NHS Trust comprises two hospitals (Queen Elizabeth Hospital and Selly Oak Hospital) some 2.4 km apart. Across the trust there are 46 critical care beds: Queen Elizabeth Hospital has 34 (general intensive therapy unit, 10; liver intensive therapy unit, 6; cardiac intensive therapy unit, 6; and neurocritical care, 6 intensive therapy unit beds and 6 high dependency unit beds) and Selly Oak Hospital has 12 (general intensive therapy unit, 7; and trauma intensive therapy unit, 5). These beds are largely run by a trustwide anaesthetics

and intensive care directorate, although the specialist units relate to their specific directorates. We pride ourselves on the collaboration between our departments, which allows maximum flexible use of critical care beds by patients who require them. We need to support patients whose specific treatment requires back up from an intensive therapy unit, such as those having cardiac surgery, liver and cardiac transplantation, or vascular surgery and neurosurgery, in addition to patients who require intensive care, including those with burns, major trauma, and severe medical illness. There is no professional or managerial block to flexible use of these beds.

Bowden and Burke are wrong in almost all of their comments. We have a major investment in critical care facilities, and these facilities are used flexibly and fully. Like other large acute trusts we sometimes face pressure on intensive therapy unit beds, which prevents us from accepting all patients who would benefit from critical care. We are concentrating on the development of high dependency beds to complement our existing pool of intensive care beds. An increase in critical care beds may require additional resources as well as the optimum use of existing facilities.

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Authors misinterpreted results of study that they cited

EDITOR,—D F Bowden and D P Burke's suggestion that the major injuries unit in Birmingham contributes to the current lack of provision of intensive care services in the city is based on incorrect facts and lack of understanding of the situation.¹ This is partly due to a misreading or a misinterpretation of a thesis that does not support their assertions.²

The number of patients admitted to the five bedded major injuries unit for intensive care over the past five years has been 305, 303, 277, 383, and 407. The unit not only admits patients with major trauma but also provides intensive care for patients admitted to the regional burns unit; other patients are admitted when need coincides with empty beds.

Over the past six months 146 patients have been admitted to the unit; the average bed occupancy has been 90% (range 81-101%). Eighty of these patients had major injuries, 31 had burns, and the remaining 35 needed general intensive care; in terms of bed days, trauma accounted for 61%, burns for 27%, and other cases for 12%. Some patients from other hospitals were included in this last figure when empty beds were available.

The authors quote Janjua's study as showing that there is no difference in outcome between patients admitted to an accident and emergency department and those admitted to a dedicated major injuries unit.² They do not mention that the aim of the study was to compare the outcome of two routes of admission that had occurred unintentionally. Except for one case, all patients in both series were finally treated in the major injuries unit. Analysis by trauma and injury severity score showed more unexpected deaths in the patients admitted through the accident and emergency department. These were investigated further, and it was shown that unnecessary

delays occurred. The recommendation that naturally arose was that patients are best treated by one team from admission onwards, so that delays and misunderstandings can be reduced to a minimum. No judgment regarding the number of intensive care trauma beds arises: the argument concerns only their most effective use.

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GPs' views of consultants' non-urgent referral of patients to other consultants

Time is wasted if GPs make the second referral

EDITOR,—S Bridger and S R Cairns present data on the different attitudes of fundholding and non-fundholding general practitioners to non-urgent referral of patients by one consultant to another.¹ One can speculate on the reasons for the difference between these results and those of a survey carried out in 1991, before the introduction of fundholding.² More important than the opinions of the general practitioners are the opinions of the patients, for whose benefit these referrals are made.

The consultant should make the referral only after discussion with, and with the consent of, the patient. For the general practitioner to interfere with that referral is for him or her not to respect the patient's autonomy. Referring the patient back to the general practitioner to decide on the appropriateness of the referral means that there could be a delay in the referral process; the letter from the consultant to the general practitioner or from the general practitioner to the second consultant could be lost; or the general practitioner might decide against the referral. Whatever decision the general practitioner makes, he or she will have to contact the patient by letter or telephone or see the patient to say whether the referral has been made and if it has not been, why not; otherwise the patient is uninformed and uncertain about his or her care. Either case entails extra work for the general practitioner and possibly an extra visit for the patient, and any referral is delayed.

Bridger and Cairns give two hypothetical scenarios, but this exaggerated process of referral and rereferral already happens sometimes, with potentially serious consequences for the patient. A diabetic retinopathy screening programme was set up, in which colour slide photographs were taken of the retinas of diabetic patients. The photographs were reviewed by a consultant ophthalmologist, and patients with an abnormality were referred to their general practitioner for referral to a consultant ophthalmologist.³ A letter lost in the post on either leg of the referral process or a decision by the general practitioner not to make the referral would be detrimental to the patient. In any event, there would be a delay until the patient received treatment.

General practitioners are the lynchpin of primary care and should be kept fully informed of what is happening not to their patients but to patients in their practice. Fundholding has not

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