Intravenous urography is now superseded for reflux

EDITOR,—I agree with Eira Stokland and colleagues that renal ultrasonography alone cannot be recommended for the detection of reflux nephropathy.¹ It is, however, still useful, not only because it can detect major malformations and dilatation of the urinary tract but because renal length and therefore growth may be measured accurately.^{2,3} I hope that the authors' use of intravenous urography as the gold standard will not increase the number of requests for this investigation. Studies have shown that scintigraphy with dimercaptosuccinic acid labelled with technetium-99m, to which the authors make only passing reference, is more sensitive than intravenous urography in detecting renal cortical scarring.^{4,5} In addition, they have also shown a positive correlation between the cortical abnormalities detected by scintigraphy with dimercaptosuccinic acid and the degree of reflux. Therefore scintigraphy with dimercaptosuccinic acid should be adopted as the gold standard.

The dose of ionising radiation from scintigraphy with dimercaptosuccinic acid is considerably less than that from intravenous urography, and the procedure avoids the use of intravenous contrast. This further increases its desirability. At Guy's Hospital children with suspected reflux nephropathy are investigated by ultrasonography combined with scintigraphy with dimercaptosuccinic acid. This generally avoids the need for intravenous urography.

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Community hospitals in the new NHS

Need to change role

EDITOR,—I fear that R W Liddell¹ has misunderstood the main thrust of my editorial on community hospitals.² There is no doubt that community hospitals have made a considerable contribution to total health care and are therefore supported by professionals and public alike. I suggested, however, that these hospitals may have to change their role to adapt to the expectations of the new NHS so that they continue to have an effective role. Liddell's suggestion that many community hospitals deal primarily with acute care is interesting, although he does not say how this will continue in the internal market, where there can be competition from other providers. It is also worth bearing in mind that the secretary of state for health in England has recently stated that there will be a 40% reduction in inpatient provision over the next few years.

Secondly, there was no confusion on my part relating to general practitioner fundholders and their relationship with community hospitals. Increasingly, many fundholders will probably be

responsible for purchasing total health care for their practice population, and my comments related to this. If fundholding is about increasing the choices for general practitioners and patients, can the current loyalty to community hospitals be expected to continue? These are relevant issues, which I believe need to be discussed in relation to the future of community hospitals; my editorial was an attempt to start the debate.

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- 2 Ramaiah RS. Community hospitals in the new NHS. *BMJ* 1994;308:487-8. (19 February.)

Private nursing care is not a threat

EDITOR,—Community, or general practitioner, hospitals have recently become the subject of considerable controversy. The NHS reforms have raised questions about the relevance of these hospitals to modern health care. In an editorial Sam Ramaiah feared that community hospitals would lose out at the expense of competition from long term care provided in the private sector.¹ We have evidence, which is remarkably consistent with R W Liddell's,² to suggest that Ramaiah's fears regarding the demise of community hospitals may be largely unfounded.

In a retrospective survey of the workload of two of the four remaining community hospitals in Northern Ireland in 1990-1 we found that, of the 509 predominantly elderly inpatients (mean age 69) at both hospitals, 316 (62%) had been admitted primarily for "the management and/or diagnosis of a medical and/or surgical problem," 48 (9%) for convalescence, 41 (8%) for investigation, 31 (6%) for respite care or holiday relief, and 22 (4%) for terminal care.³ Thus both hospitals were providing mainly acute medical care to patients with a wide range of diagnoses comparable to those reported in other studies with similar sized samples,^{4,5} with comparatively little emphasis on long term or terminal care.

Both the mean length of stay (20.5 days) and the occupancy rate (80%) compared favourably with those of the two local district general hospitals for patients of the same age, indicating that inpatient beds were used reasonably effectively. In all, 412 of the patients were discharged within four weeks, and there was no evidence of bed blocking. Moreover, when asked to assume that beds in a community hospital were not available the general practitioners estimated that more than three quarters (391/509) of their patients would have been admitted to one of the local district general hospitals rather than nursing or residential care. These findings, like those reported by Liddell, strongly suggest that private nursing care and residential care are unsuitable alternatives for most people admitted to community hospitals and therefore constitute little real threat to the future of these hospitals.

Nonetheless, despite the difficulties of conducting empirical research on the unusually diverse nature of care provided by community hospitals, we need to look more closely at both the benefits and costs of community hospitals versus alternative forms of care. Only in this way can the issue of their continuing role in the new NHS be fully resolved.

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- 1 Ramaiah S. Community hospitals in the new NHS. *BMJ* 1994;308:487-8. (19 February.)

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Breast feeding and multiple sclerosis

Research could have been reviewed

EDITOR,—The contents of a recent paper on breast feeding and multiple sclerosis seem to have escaped a referee (incidentally, it would be a good idea if referees appended their names to articles which are accepted).¹ Specifically: in any environmental study on multiple sclerosis, "selected...patients attending a neurological outpatient department" are not entirely satisfactory for cases and controls. Also, patients who "declined" or could not provide "reliable information" were "excluded." Did this bias apply equally to the patients with multiple sclerosis and the controls?

Furthermore, patients were contacted by two interviewers who were blind to the objectives of the study, but there is no information on the questionnaire which was used.

Finally, one wonders how many patients or their mothers can accurately remember whether breast feeding lasted for 0-6 months or 7 months or more. This questions the validity of the conclusion "that patients with multiple sclerosis were less likely than controls to have been breast fed for a prolonged period."

It is a pity that Piscane *et al* and the referee (if there was one) failed to notice a paper by Spencely and me; we did a carefully controlled study which failed to show any association between breast feeding and multiple sclerosis.²

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Authors' reply

EDITOR,—We have read with interest the comments about our paper on breast feeding and multiple sclerosis.¹ Studies about breast feeding and disease are difficult, and conflicting data are sometimes published. Adequate sample size, clear definition of exposure and outcome, avoidance of bias in the design, and correction for potential confounders are among the factors that can improve the quality of these studies.² The paper quoted by Dick represents an example of the potential biases of these studies (actually, no clear criteria for definition of multiple sclerosis were provided, information was collected for 83% of cases and 45.9% of controls, and potential confounders were not investigated).³

We think that to enrol all the patients attending an outpatient department is correct in an hospital based case-control study. Ten cases and nine controls could not provide any information about their feeding during infancy, and four controls declined the interview: the cases were excluded and the controls were replaced by the first patients meeting the matching criteria. The background characteristics of these patients were not different from those of the study groups.

The questionnaires that we used for the patients