stay geriatric patients. They last as long as more expensive silicone coated or pure silicone catheters, are more comfortable because they are softer, and are contraindicated only in patients allergic to latex. This view was also shared by Dr Belfield himself a couple of years ago,¹ and supports the view that a catheter is changed according to patients' needs and not by manufacturer's specification.

Other workers have confirmed that there is no difference in the time between catheter changes with different types despite the apparently smoother surface of the Silastic catheters supposedly minimising encrustation.^{2,3} Indeed, scanning electronmicroscopy of the surface structure of different catheter materials has shown that the surface of unused siliconised latex is rough.⁴ Some patients are probably "encrustation formers" whatever catheter material is chosen. Alternative methods, such as high fluid intake and acidifying the urine with high dose ascorbic acid, are more effective at reducing blockage.

Our second comment concerns the treatment of "infection." We certainly agree that the addition of antibacterial substances into drainage bags is ineffective in preventing bacteriuria. There are, however, good studies reporting that bladder washouts are also ineffective and probably harmful by further disrupting the already damaged bladder epithelium, thus predisposing the patient to further infection.^{5,6}

Finally, we think that there should have been some comment about local care and about the effect on sex lives. A twice daily local soapy wash to the area, including the first six inches of catheter, and counselling on methods of sexual intercourse are minimum requirements for all patients.

C M CASTLEDEN
P EKELEND
H M DUFFIN

Department of Geriatric Medicine,
Leicester General Hospital,
Leicester LE5 4PW

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Sexual dysfunction among middle aged women

SIR,—Dr Madeline Osborn and others (2 April, p 959) highlight the disparity between women with operationally defined sexual dysfunction and those who identified themselves as having a problem. In the first group only 23% thought they had a problem, while 24% of those with a self identified problem would have been missed if operationally defined sexual dysfunction had been used alone.

While agreeing that general practitioners should be alert to sexual problems, I wonder how useful the concept of sexual dysfunction is in their day to day work. Surely it is how people feel that matters? A previous study concluded that "it is not the quality of sexual performance but the affective tone of the marriage that determines how most couples perceive the quality of their sexual relations."¹

For people engaged in research a well defined tool is necessary, but for doctors in primary care

the concept of sexual distress would be more useful. The emphasis could then be on recognising such distress, often hidden behind other complaints, and on an attempt to understand the cause in each patient.

The general practitioner is ideally placed to have a psychosomatic approach. For example, in this study vaginal dryness is an operationally defined sexual dysfunction and it is not stated whether any patient is receiving hormone replacement. It is possible that some patients could have accepted help in the form of oestrogen cream, although they could not immediately ask for help with a sexual problem. Such an approach would provide other opportunities for sexual discussion and, hopefully, would reach more women than the small number (4%) in this study who were able to ask for help directly.

RUTH SKRINE

Department of Obstetrics and Gynaecology,
Bristol Maternity Hospital,
Bristol BS2 8EG

- 1 Frank E, Anderson C, Rubenstein D. Frequency of sexual dysfunction in "normal" couples. *N Engl J Med* 1978;299:111-5.

SIR,—Dr Madeline Osborn and others (2 April, p 959) are right to draw attention to the incidence of sexual difficulty in middle aged women. However, their findings do not support their conclusions that general practitioners should be alert to detecting sexual dysfunction and that it could be treated by general practitioners or referred to specialists. Neither the study nor any of its references refers to straightforward and generally applicable treatments which are effective.

Since the study showed that only 4% of women both had a problem and wanted help for it the routine questioning of the other 96% would be a formidable task of doubtful general acceptability. A more appropriate conclusion might have been that women should feel free to approach their general practitioners for help about sexual dysfunction, and that general practitioners should try to maximise their sensitivity to the needs, ideas, and expectations of their patients of all ages and sexes.

BRIAN GOSS

Bungay,
Suffolk NR35 1BZ

Death despite malaria prophylaxis

SIR,—We have seen a case similar to that described by Dr C J Ellis (2 April, p 952).

A man returned from eight months in Zambia and developed a fever, chills and rigors, and severe diarrhoea. He was given a course of chloroquine by a general practitioner who thought of the diagnosis of malaria, and the patient started this immediately. He had not been taking his prophylaxis of chloroquine and proguanil regularly while abroad.

His symptoms improved during the first 24 hours, but he again became confused and febrile and developed severe diarrhoea on the second day. Another doctor who saw him thought that he might have a viral illness in addition to malaria. It took a retired nursing sister to advise the family to ask for immediate hospital admission, and fortunately this was done.

The patient was unconscious on arrival. Quinine was given intravenously and he made a remarkable recovery. A blood film confirmed 5% parasitaemia with *Plasmodium falciparum*.

Malaria should be diagnosed by demonstrating parasites in the peripheral blood film. General

practitioners in Britain should not attempt to treat malaria empirically without referring the patient to hospital as the treatment is different for *P vivax* and *P ovale* infections. We agree with Dr Ellis that quinine should be used to treat falciparum malaria and that chloroquine should be abandoned.

E L C ONG
E M DUNBAR

Regional Department of Infectious Diseases and
Tropical Medicine,
Monsall Hospital,
Newton Heath,
Manchester M10 8WR

Clinical carpal scaphoid injuries

SIR,—I am surprised that the scheme for managing clinical scaphoid injury advocated by Dr M R A Young and colleagues (19 March, p 825) makes no mention of radionuclide bone imaging. It is widely thought that focal increased uptake of bone agent reveals sites of bone injury not shown by conventional radiographs, provided the imaging is performed more than 24-48 hours after the injury. The particular application of bone imaging to scaphoid injury has been described from this department.¹

It is our practice to perform bone imaging early in the management of patients with scaphoid injury but no fracture apparent on radiographs. Normally the patients can be accepted straight from the accident and emergency department or fracture clinic and return to the clinic the same day with a report. In the past year (1987) 100 such patients were examined. In 57 cases the images were normal, but 35 showed abnormal focal uptake of bone agent. Twenty patients had focal uptake in the scaphoid and 12 in other bones of the carpus, suggesting bony injury at these sites. Three patients had focal uptake confined to areas of degenerative change in the radiographs, and five had diffuse uptake interpreted as soft tissue injury.

Patients with normal uptake may be mobilised and discharged early. The precise meaning of focal uptake in the absence of a fracture or degenerative change in the radiographs is debatable. Focal uptake indicates an area of local hyperaemia or osteoblastic response and may well indicate degrees of bony injury short of a complete fracture. Not all of these patients will be at risk of the complications of a scaphoid fracture, but they merit careful follow up and probably a period of immobilisation.

Bone imaging is a useful, safe, and inexpensive investigation in clinical scaphoid injury when the radiograph is normal and should be available in any hospital with nuclear medicine facilities.

J J LANGHAM-BROWN

Wessex Regional Department of
Nuclear Medicine,
Southampton General Hospital,
Southampton SO9 4XY

- 1 Rolfe EB, Garvie NW, Khan MA, Ackery DM. Isotope bone imaging in suspected scaphoid trauma. *Br J Radiol* 1981;54:762-7.

Wheelchairs

SIR,—Dr John B Young's article (27 February, p 625) contains some inaccuracies.

Firstly, the form AOF5G, recommending supply of a wheelchair, can be signed by a doctor, social worker, occupational therapist, or physiotherapist. Secondly, my copy of the handbook of wheelchairs (MHM408) does not describe 140 models of wheelchairs available from the DHSS: it describes only 66. Thirdly, the description of the model 9L