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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Incontinence

SIR,—Your leading article on incontinence by Dr T B Hargreave and Dr N T M Galloway (8 October, p 1002) is further welcome evidence of the increasing interest in this long neglected topic. One dilemma inherent in the high prevalence figures is that of creating demand before doctors in general are well enough informed to respond appropriately. Dr Hargreave and Dr Galloway spell out the differential diagnosis and host of specific treatments for incontinence. This knowledge now needs to be widely taught.

A recent report, *Action on Incontinence*,[1] considers in detail the teaching of this subject provided at undergraduate and trainee general practitioner levels and its treatment in surgical and medical textbooks. Such teaching is limited in availability. It occurs mainly in the geriatric medicine attachment—and this itself is patchy throughout many medical schools.[2]

Action on Incontinence makes several recommendations in addition to emphasising a need for wider teaching. It suggests that each hospital district should set up a working party on incontinence including appropriate specialists and nurses (hospital and community) together with a supplies officer, and that this group should consider the need for an incontinence clinic as well as for a continence nurse adviser to the district. An important role would be the evaluation of current and future products in the management of incontinence and the uniform supply (in both hospital and community) of those approved. A further recommendation is the need for further public education.

One of the working party's proposals has already come about. The Joint Board of Clinical Nursing Studies has developed a post basic course on "The maintenance of continence and the management of incontinence." There is now the need for medical school deans to consider the demand for this important subject in their curriculums.

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[1] King's Fund. *Action on incontinence.* (King's Fund Project Paper No 43) 1983. London: King's Fund Centre.
[2] Smith RG, Williams BO. A survey of undergraduate teaching of geriatric medicine in the British medical schools. *Age and Ageing* 1983;**12**, suppl:2-6.

SIR,—In the timely leading article on incontinence (8 October, p 1002), the impression is given, perhaps inadvertently, that the management of incontinence should pass straight from the nurse incontinence adviser to a regional specialist referral centre. There is, however, a considerable area in which intervention by general practitioners, backed up when necessary by district general hospital consultants with extra expertise, can be helpful.

For the past three years this district general hospital has had a continence clinic run by a consultant physician in geriatric medicine, a gynaecology registrar, and a nurse, more recently appointed as a nurse continence adviser. It has easy, same day access to a general surgical clinic when necessary, offering a reciprocal service to it. The hospital has no urologist. Experience has shown that in many patients continence can be restored, often after years of neglected incontinence and even in the very old, by relatively simple means—for example, pelvic floor exercises in mild stress incontinence, a short course of oestrogens for senile atrophic vaginitis, and appropriate drug treatment in those who clinically appear to have an unstable bladder if bladder drill with charting has failed; the last two require a doctor's intervention.

The relief of severe constipation in itself suffices to restore urinary continence in some elderly patients. Relatively few patients require urodynamic studies, which are reserved for patients in whom the clinical picture is not