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CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must 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.

Management of chronic urinary retention

SIR,—Professor J P Mitchell in his regular review on chronic urinary retention pointed out the difficulties which may be encountered in establishing the diagnosis of low pressure chronic retention clinically (1 September, p 515). He recommended the use of intravenous urography—provided that the blood urea concentration is below 30 mmol/l (180 mg/100 ml)—to show the state of the upper urinary tract and confirm the distension of the bladder. The role of ultrasound scanning was not mentioned. It is an accurate, quick, safe, and cheap technique to demonstrate a distended urinary bladder and assess any dilatation of the upper urinary tract. The technique is available in most hospitals. I hope that Professor Mitchell would agree that ultrasound scanning should be the initial investigation in this condition in preference to intravenous urography, which may have certain complications.

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SIR,—I agree with Professor J P Mitchell's statements on the management of both acute and acute on chronic retention of urine. I do not, however, agree with him on the inevitability of haematuria. Most patients who attend with acute on chronic retention have been restricting their fluid intake to avoid distending the bladder further, and this restriction has often taken place over days, if not weeks, resulting in a considerable amount of dehydration. They often arrive late in the day and the relief of the catheter is such that they probably sleep well for the first time in weeks, thus compounding their dehydration and low urinary output. Over the past two years it has been my practice to set up an intravenous drip before inserting the catheter, thus ensuring a fluid load and therefore a good diuresis at the time that the bladder is decompressed. This expedient has reduced our incidence of haematuria considerably and has also increased the rate at which the blood urea reverts to normal levels.

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"I have a bone stuck in my throat"

SIR,—It is sad that foreign bodies impacted in the pharynx are still being diagnosed only after a fatal outcome despite patients presenting early for medical advice (18 August, p 424). We think that several comments must be made if the correct lessons are to be drawn from the events described by Drs N Kirkham and Ruth English in their lesson of the week. People who think that they have an impacted foreign body in their throat may present to many different departments including general practice, accident and emergency, surgical, paediatric, thoracic, medical, and otolaryngology. Both these patients were seen and treated by the staff of the accident and emergency department only, but despite the history, excessive reliance was placed on radiography.

Chevalier Jackson has summarised the chief factors in overlooking the diagnosis of foreign body ingested or aspirated.[1] These are: failure to consider the possibility; failure to elicit the history; absence of the history; scepticism of the possibility of a foreign body; apathetic attitude of the practitioner; symptomless interval; multiplicity of foreign bodies; awaiting spontaneous expulsion; symptoms explained by other medical condition; lack of emphasis (medical teaching); and character of the foreign body.

Unfortunately, there is no absolute diagnostic sign of a foreign body in the oesophagus/pharynx. Nevertheless, certain symptoms call for diagnostic rigid endoscopy to be performed —odynophagia, feeling of something in the throat, and drooling. Even with good radiology and indirect laryngoscopy it may not be possible to exclude an impacted foreign body. The only sure test is endoscopy, and thus competent medical advice should always be obtained when a patient presents with the symptom of "something in the throat." The patient's symptoms and the skill of the otolaryngologists should not be ignored.

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1 Jackson C, Jackson CL. *Diseases of the air and food passages of foreign body origin.* London: W B Saunders, 1936.

SIR,—Drs N Kirkham and Ruth English correctly emphasise the importance of a good