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CORRESPONDENCE

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Intensive care: a specialty or a branch of anaesthetics?

SIR,—Professor Hugh Dudley expressed the view that, while the present ad hoc arrangements for delivery of intensive care can be efficient, future demands are likely to necessitate the emergence of the "specialist intensivist" (21 February, p 459). He envisaged a core of such individuals in administrative charge of units with other consultants serving in a part time capacity. The original or parent discipline of either group of consultants might be anaesthesia, medicine, or surgery. In this regard Professor Dudley's comments are in line with the views of the interfaculty collegiate liaison group, although his advocacy of the devolutionary cause would not receive the group's support.

My own belief is that the controversial issue of independence need not stand in the way of present progress. What is important is to encourage without delay the development of the training programmes recommended by the liaison group. This would enable the specialties concerned to begin to work together and, in due course, help to ensure a more uniform distribution of adequate intensive care facilities throughout Britain. Much good will and cooperation will, of course, be required for the proposed training schemes to get off the ground.

The multidisciplinary approach to intensive care has much to recommend it in terms of both patient care and medical training. In this hospital such a system, involving both senior and junior staff, appears to have survived more or less successfully the rigours of some 20 years. Throughout this period we have encountered no significant administrative or professional problems, and two recent retirement vacancies from different specialties have been filled without conflict (one of the concerns raised by Stoddart).[1] More importantly, the unit's staff have benefited from the interdisciplinary exchange of clinical skill at the bedside, and the remainder of the hospital has benefited from the shared intensive care experience (thus allaying, to some extent at least, the concern expressed by Professor Dudley). Indeed, we like to think that this close collaboration with our ward medical colleagues extends beyond our own hospital through the medium of our regional mobile intensive care service.

In spite of Britain's proud record of research endeavour in anaesthesia, medicine, and surgery we do not share an equivalent international standing in intensive care (at least as judged by output of published papers). This regrettable fact is due, firstly, to the absence of a recognised training programme for those young people who would otherwise be willing, able, and enthusiastic contributors and, secondly, to a lack of academic commitment to what is undoubtedly one of the more exciting, rewarding, and worthwhile medical developments to emerge in recent years. The opportunity to make good both these deficiencies rests with the decision makers at departmental, collegiate, and university level and with those responsible for implementing recommended training guidelines locally. Although there may well be a "variety of good reasons"[1] why the rate of progress in the development of intensive care should not be unduly rapid, there are also a variety of good reasons why it should be more rapid than at present. Not the least important of these is that it is in the long term best interests of patient care.

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1 Stoddart JC. A career post—with intensive therapy? *Anaesthesia* 1986;41:1181-3.

Long term urethral catheterisation in the elderly

SIR,—Dr R B Kinder describes the high incidence of bacteriuria and its various complications in elderly patients with urethral catheters (28 March, p 792). We have shown that long term urinary catheterisation with concomitant chronic urinary tract infections may also result in damage to the bladder epithelium.[1-3] The urothelial damage may be extensive, affecting large areas of the bladder surface, particularly in patients who have had urinary tract infections for longer than four months. This damage may predispose the bladder to the recurrent infections that these patients develop.

Dr Kinder also considered the role of bladder lavage, suggesting that lavage is unsuccessful in the treatment of bacteriuria but that it may reduce the incidence and severity of catheter bypass by preventing accumulation of debris. More recently, we have confirmed the lack of efficacy of antiseptic bladder washouts for the treatment of bacteriuria and, in addition, found that bladder lavage further disrupted the already damaged urothelium in such patients (T S J Elliott *et al*, 10th international symposium on pyelonephritis). We used the number of urothelial cells exfoliated into the urine as a marker of bladder damage. Twelve patients with long term (longer than six months) indwelling catheters and recurrent urinary tract infections underwent bladder lavage with either noxythiolin or chlorhexidine solutions as part of their routine management. Immediately after lavage large numbers of urothelial cells, some in clusters, were found in the patients' urine. Three patients were monitored on consecutive days for up to three weeks, during which time they underwent several washouts. Increased urothelial cell exfoliation oc-