as a pragmatic means to assess alternative but related end points: laboratory diagnosis and clinical outcome.

Like others, we think empirical treatment on the basis of individual symptoms and signs exposes patients to unnecessary antibiotics. Attendant problems of medicalization, cost, contraceptive failure, side effects and antibiotic resistance are not trivial. There is good evidence that antibiotics are effective in reducing symptoms and duration of illness in women with UTI. Antibiotics should be prescribed to those patients with the highest probability of bacterial infection: clinical prediction rules incorporating symptoms, signs (if necessary) near patient dipstick test results are the most rational way of achieving this aim.

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References


Screening for alcohol misuse

Aira *et al.*’s constructive paper identifies seven categories influencing the physician-patient dialogue for alcohol consumption. We recently have completed a study of Senior House Officer (SHO) attitudes to screening for alcohol misuse in Accident and Emergency (A&E) (127 SHOs over 5 years). Briefly, we compare the experiences of GPs and A&E staff under the headings identified.

**Sensitive nature of alcohol drinking**

It is likely to be more problematic for GPs to broach the subject of alcohol as they are community rather than hospital based. A&E practitioners are less likely to meet their patients socially. Both types of doctor are equally likely to collude with the patient in terms of their own culturally engrained attitude to alcohol use/misuse—insight is the key.

**Reason for consultation**

Aira *et al.* comment “None of the physicians was ready to ask about alcohol consumption routinely in every consultation, but only when the reason is connected to alcohol.” We have identified a list of presenting complaints (‘the top 10’) which mandate the recording of an alcohol history using the Paddington Alcohol Test (PAT), which takes <1 min to administer. Over 60% of all A&E attendees have a presenting complaint from the ‘top 10’. We educate our practitioners to respond to the patient’s agenda first before introducing our own agenda of possible alcohol misuse. Further, in order to make it appear the natural course of the consultation, we teach our practitioners to introduce the subject non-judgementally by saying, ‘we routinely ask all patients who have had a fall (or whichever presenting complaint is relevant) do you drink alcohol?’ We emphasize the importance of detecting alcohol misuse at an early stage in a patient’s drinking history, when they may be more amenable to opportunistic intervention.

**Awareness of patient’s alcohol problem**

Prior knowledge concerning a patient’s alcohol problem is an advantage that primary care physicians have over A&E staff. We use the PAT routinely with repeat attenders, ‘repeat attendance’ being the 10th condition of the ‘top 10’.

**Patient factor**

GPs are inhibited from asking about alcohol consumption by value judgements concerning appearance, age, sex and profession. Alcohol is no respecter of such arbitrary divisions; doctors need education to gain insight.

**Availability of intervention tools**

Aira *et al.* describe the feelings of inadequacy that many GPs have with regard to managing early alcohol
problems, and counselling in particular. At St Mary’s A&E, the doctor’s role is limited to detection and referral to designated alcohol health workers. The appropriately trained professional undertakes the brief intervention, which is time and stress relieving for the referrer.

**Expectations of effectiveness of interventions**
Aira *et al.* describe the expectations of the effectiveness of counselling as being ‘very low’. However, brief interventions have been demonstrated to be effective, especially for the hazardous as opposed to the dependent drinker. In A&E, patients may present at a moment of heightened crisis, making the ‘teachable moment’ more vivid.

**Lack of time**
Time is frequently identified as a limiting factor by A&E and primary care staff alike. In A&E, we limit the doctor’s role to detection and referral. This also passes the decision to attend, or not, back to the patient—though the first step of the brief intervention has been taken by enquiring about alcohol consumption.

The major contrast between the two screening systems is that one is formalized with adequate support—a screening (PAT) and referral system with A&E designated alcohol health workers. We suggest that primary care should embrace a similar system, rather than the GP attempting to deal with a common and potentially time/effort-exhausting problem on an ad hoc basis, especially as new alcohol strategies place increased emphasis on brief interventions, largely through primary care.4

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**Feasibility of recruiting in a student bar for a trial of chlamydia screening in young women**

There has only been one trial of chlamydia screening to prevent pelvic inflammatory disease,1 and this has been widely criticized.2–4 Since the prevalence of chlamydial infection in women attending general practices tends to be low,5–7 and recruiting in primary care is often problematic, we decided to examine the feasibility of recruiting young women in a student bar.

With the agreement of the President of the Students’ Union, the Principal of the university and the college barman, we put up posters in the bar and gave out patient information sheets inviting women to take part in a feasibility study of chlamydia screening. Women considering taking part were asked to come to a table where the researchers answered any queries about the study. Those agreeing to participate signed a consent form giving their mobile number, address and e-mail, and the name of their GP. They then went into the lavatories to provide a self-administered vaginal swab. Finally they were asked to complete a confidential questionnaire on risk factors for chlamydial infection, i.e. age, ethnicity, number of sexual partners and smoking; and possible symptoms, i.e. intermenstrual bleeding, abnormal vaginal discharge or pelvic discomfort.

During the 90 min lunch period, 45 patient leaflets were given out and 25 female students were recruited. Of 16 who declined to take part, five had never been sexually active, seven were menstruating and four did not give a reason. Three further students offered to take part, but no more specimen packs were available. All the questionnaires were completed adequately. None of the swabs were positive for chlamydia by polymerase chain reaction assay.

The study showed that it is relatively simple to recruit in a student bar. However, those women recruited may have been at low risk of chlamydial infection since they were all involved in higher education which is known to be associated with later age of first sexual intercourse.8 Research in the real world is rarely easy!