
ABSTRACTS

Why do general practitioners recognise major depression in one woman patient yet miss it in another?

A T Tylee, P Freeling, S Kerry

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The aim of this study was to establish whether psychiatric patient characteristics and the presence of physical illness affected general practitioners' recognition of major depressive illness in women patients. The 30 item general health questionnaire was used as a first stage screening instrument for psychiatric morbidity and each patient selected was interviewed, usually within three days of consulting their general practitioner, using the combined clinical interview. A sample of 72 women with major depressive disorder was obtained from patients consulting 36 general practitioners mainly from the south west Thames region of England, each general practitioner providing one patient he

or she had correctly recognised as being depressed and one patient whose depression had not been recognised. Few differences were found between the groups with recognised and unrecognised depression in their psychiatric or physical features. More patients with unrecognised depression experienced physical illness and were tired. Patients with serious physical disease were five times more likely not to be recognised as depressed than those without physical disease. Patients with recognised depression described a more distinct quality to their depressed mood. Women with unrecognised major depression are similar to those women whose major depression is recognised by their general practitioner. These findings require further elaboration by process and content analysis of the women's consultations.

Access to general practice and general practitioners by telephone: the patient's view

Lesley Hallam

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Postal surveys were conducted among samples of patients in four practices to determine accessibility of surgeries and general practitioners by telephone. Over half of the respondents reported being unable to get through to the surgery on their first attempt. Significant differences between practices were related to the number of patients served by each incoming line. Although all of the general practitioners involved were accessible to patients by telephone, only half of the respondents knew this. Significant differences in awareness levels between practices were related to policies and methods of disseminating this information. Satisfaction with the help received from doctors by telephone was uniformly high, but patients were less satisfied with the process of contacting a doctor, particularly where receptionists questioned callers about their problem. It is suggested that practices review the adequacy of their telephone system against a recommended standard of one incoming line per 2500 patients and consider how information about their telephone policies and services can be effectively communicated to patients. Reception staff may need additional guidance on managing telephone contact with patients.

Partners or partisans? Patient participation at Marylebone health centre

Patrick Peitroni, H Derek Chase

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This paper outlines some of the issues which arose for patients and professionals involved in patient participation projects at the Marylebone health centre in London. It describes the project undertaken and focuses on the practical implications of working with rather than for patients. Dilemmas surrounding patient participation are discussed, including the ways volunteers are rewarded, how doctors and patients can share knowledge,

how participation is affected by professional boundaries, and why a regular group meeting may not necessarily be the best way to involve patients in decision making. The successes of patient participation are also highlighted.

ABSTRACTS

Impact of previously unrecognised benign prostatic hyperplasia on the daily activities of middle-aged and elderly men

W M Garraway, G B McKelvie
E B A W Russell, M Hehir
R J Lee, A C N Rogers
G N Collins, R J Simpson

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To assess the importance of benign prostatic hyperplasia on activities of daily living, a cross-sectional survey of 1627 men aged 40-79 years (representing a 65% response rate) registered with two health centres in central Scotland was carried out, using a urinary symptom questionnaire and uroflowmetry to identify men more likely to have benign prostatic hyperplasia. The condition was defined as a prostate gland of more than 20g in the

presence of symptoms of urinary dysfunction and/or a peak flow rate of less than 15ml s⁻¹, without evidence of malignancy. Transrectal ultrasonography was used to measure the volume (and by inference weight) of prostate glands. A total of 410 men satisfied the criteria for benign prostatic hyperplasia. Overall, 51% of men with benign prostatic hyperplasia reported interference with at least one of a number of selected activities of daily living as a result of urinary dysfunction, compared with 28% of men who did not have this condition. In 17% of men of working age (40-64 years) with benign prostatic hyperplasia, this interference occurred most or all of the time for at least one activity of

daily living compared with only 3% of men in the same age group who did not have this condition.

If the criteria of unmet need for treatment of benign prostatic hyperplasia constitutes interference by urinary dysfunction most or all of the time in at least one activity of daily living, then the findings of this survey suggest that a substantial number of middle aged and elderly men living in the United Kingdom may be in need of assessment and treatment for this condition.

Table 2. Percentage of men finding symptoms bothersome in past month by whether or not they had benign prostatic hyperplasia (BPH); mean rating of bothersomeness on scale of zero to six.

Symptom	BPH present		BPH absent	
	% of men finding symptom bothersome (n)	Mean rating of bothersomeness * (SD)	% of men finding symptom bothersome (n)	Mean rating of bothersomeness * (SD)
Nocturia twice or more	36.8 (356)	2.2 (1.4)	12.6 (988)	1.7 (1.1)
Hesitancy	31.7 (356)	1.8 (1.0)	10.6 (978)	1.4 (0.9)
Urgency	42.5 (353)	2.4 (1.5)	23.1 (973)	1.7 (1.2)
Straining	26.6 (353)	1.9 (0.9)	7.8 (987)	1.4 (0.9)
Intermittency	40.5 (358)	2.0 (1.2)	13.2 (987)	1.3 (0.7)
Dribbling	46.4 (358)	2.2 (1.4)	25.0 (980)	1.6 (1.1)
Incomplete bladder emptying	31.7 (356)	2.1 (1.3)	11.1 (981)	1.5 (1.1)
Weak stream force	40.2 (348)	1.7 (1.1)	12.3 (985)	1.4 (0.9)

n = total number answering question. SD - standard deviation. * Range = 1-6.