

submit amplicons to procedures that detect sequence polymorphism.^{2,3}

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Screening for urinary abnormalities

Sir—In his Jan 31 commentary, Billy Arant Jr¹ says that it's worth screening for urinary abnormalities and worth doing well. I agree: so much so, that it's even worth doing badly, if this can initiate a progressive audit cycle, and the alternative is not trying.

In the 1960s, a young man, aged 18 years, presented with end-stage renal failure, caused by a congenitally defective collecting system. When the district hospital laboratory made dipslide cultures available to general practitioners in 1968, we decided that such a disgrace would not be repeated. We started a programme of systematic case-finding, teaching mothers to use dipcultures in episodes of illness, which we reported as a 10-year first-stage audit in 1979.² We had already learned that so-called diagnostic symptoms were no better than non-specific illness as predictors of bacteriuria.

Since our audit used data from real life, it was full of gaps and errors, and so far as I know, no expert has ever cited it. But we made three great discoveries. We found two boys with seriously abnormal collecting systems, one of whom had successful major reconstructive surgery and the other had 5 years of medication with bacteriological control. Major renal impairments were eliminated from an entire cohort of Glynccorwg children born between 1968 and 1985, attaining our original objective and contributing to our wider programme

of preventive care for the whole population.³ Perhaps more importantly, an entire generation of mothers learned about the nature of diagnosis and disease, by taking dipcultures, observing the results ("Duw, you can see the germs!"), and resisting attempts by rota doctors to prescribe antibiotics for acute illness without evidence. Used with democratic imagination, dipslide cultures are a powerful educational tool. This lesson may be more obvious where we concentrate on doing a few things simply with all of the people, rather than everything perfectly for a few people.

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Treatment for obesity

Sir—William Jeffcoate (March 21, p 903)¹ believes that "The first fact to be grasped is that treatment of obesity does not work". I disagree: far too many doctors have grasped this "fact" and therefore do not try. He correctly identifies environmental factors which do much to explain the greatly increased prevalence of obesity, but is blind to (and contributes to) another powerful factor, which is the pathetic fatalism of doctors when confronted with an obese patient. It is true that only a small proportion of obese patients who consult doctors are permanently restored to normal body composition. Similarly, only a small proportion of schoolchildren in the UK who are taught French for 5 years emerge at all competent in that language (28% achieve GCSE at C grade or better). So, by Jeffcoate's reasoning, we should realise that French cannot be taught, and sack teachers of French, if only there were not a country across the Channel which achieves virtually 100% fluency.

Obesity is probably more effectively, safely, and inexpensively treated than any other cause of comparable chronic disability, but only by health-care professionals who have the skills and motivation to provide appropriate advice and support. Unfortunately, essays such as Jeffcoate's will further

decrease the supply of these valuable therapists, and so his prophecy of therapeutic failure will be increasingly fulfilled.

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Coma in children

Sir—Reinoud Gemke and Robert Tasker's March 28 commentary¹ on acute coma in children places little emphasis on the motor component of the Glasgow Coma Scale (GCS),² which is the most important variable in terms of prognosis in acute brain injury.

In 1983, Jagger and colleagues³ found that motor response alone was the best prognostic indicator, 1197 patients with head injuries, and its accuracy was not improved by addition of eye opening or verbal response. Beca and co-workers⁴ reinforced this finding in brain-injured children, when an absent motor response (flaccid) to painful stimuli on presentation gave a 100% positive predictive value for poor outcome.

We suggest that although modifications of paediatric coma scores⁵ may be useful in assessing changes in degrees of consciousness, more emphasis should be placed on the accurate measurement of the presenting motor score.

In many paediatric intensive-care units, most patients with acute brain injury are intubated before admission. It is, therefore, important that the physician or paramedic who has initial contact with the brain-injured child accurately records the motor component of the GCS before intubation. Clarity may be lost if the clinician is presented with various modifications of the GCS.

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