confirmed cases closely follows the writer's recommendations later in his letter. Many of those concerned for the welfare of presenile dementia sufferers and their families in Scotland believe that the provision of a reasonable number of hospital beds within the mental illness services for the investigation, respite care, and terminal care of this sometimes neglected group of patients is an essential factor in maintaining minimum standards of care. It is unhelpful to interpret our professional commitment to the well supported option of inpatient care for presenile demential patients as a "sad reflection on health care in Scotland."

It is difficult for us to comment informatively on the likely source of differences between our study and the unpublished work of Newens and his colleagues. While they have much information about methods used in both studies we can know only our own. We did not, as they assert, state the findings of Treves *et al* to be consistent with our finding of a sex effect. We examined exhaustively all patterns of investigation and care available to presenile dementia sufferers in Scotland and concluded that admission to psychiatric hospital had identified the considerable majority. It is misleading for Newens *et al* to infer that their data on initial point of specialist referral within a complex pattern of care are inconsistent with our observations on psychiatric admissions at any time after presentation. There is too little information to support that inference. They state that "women with dementia are more likely than men to be admitted to psychiatric hospital for long term care because [of] the higher rate of widowhood among elderly women in general" but this is true for senile dementia, not presenile disease, where most couples are middle aged and not yet widowed. A difference in survival between the sexes would anyway make no difference in a study of incidence. But our findings of a reversed sex ratio in multi-infact dementia indicate that this was not the cause. We look forward to reading Newens *et al*'s study when it is published and suggested that if our methods are comparable the differences between studies may contribute to a better understanding of risk factors for Alzheimer's disease.

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# Urinary incontinence

## Social and financial costs high

EDITOR,—Urinary incontinence is a commonly encountered condition regularly seen by a wide variety of doctors. One of the heartening findings in J C Brocklehurst's paper was the observation that a larger number of men and women were today prepared to seek medical help for their problem than was reported previously.[2]

Our group has quantified the influence of urinary incontinence on the quality of life of elderly women by using the Nottingham health profile questionnaire.[3] Women suffering from urinary incontinence obtained higher scores in the domains of emotional disturbances and social isolation than continent women from a control group matched for age. This was particularly the case for women suffering from urge incontinence, who also reported more disturbance of sleep. The uncontrollable loss of urine as seen in women with urinary incontinence clearly had a detrimental effect on their daily lives and caused them to avoid social contacts.

Urinary incontinence not only causes considerable personal suffering for the individual afflicted but is also of immense economic importance for the health service. In a recent study we estimated that the annual cost of urinary incontinence in Sweden in 1990 accounted for 2% of the total health care costs (unpublished data). A large proportion of the incurred costs related to the care of elderly people in whom incontinence is extremely prevalent. During the past few decades Sweden has had among the highest proportion of elderly people surviving to very old age in the world. This would imply that the occurrence of age related disorders like urinary incontinence in the Swedish population may predict the future situation in countries with an ongoing increase in survival rates. Costs for the investigation, treatment, and care of incontinent people are thus expected to increase gradually during the next few years, but improved knowledge and more cost efficient treatment could change this development.

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## GPs lack confidence

EDITOR,—J C Brocklehurst reported that action taken by general practitioners when consulted about incontinence consisted principally of taking a urine sample, referral to a specialist, and prescribing medication. Less than a quarter of those who consulted for incontinence were given a full examination.[1] G J Jarvis concluded that incontinent adults seem to have limited confidence in the medical and allied professions.[2]

We studied the current provision of continence promotion in primary care and the training requirements of general practitioners and practice nurses. A postal questionnaire was sent to a 1:20 stratified random sample of general practitioners in the United Kingdom. Questions asked related to knowledge of, skills in, and attitudes to continence promotion in relation to the doctors' medical training and the demography of their practices. Of the 1861 questionnaires circulated, 1284 were returned completed (69% response rate). Respondents were representative of practitioners in the United Kingdom with respect to length of time in general practice and size of practice. Of the respondents, 1117 (87%) were trained in Britain and 385 (30%) were female.

In all, 1223 (95%) respondents believed that both general practitioners and practice nurses have a role in identifying and assessing new patients and managing the condition. A total of 1142 (89%) routinely inquired after incontinence in people over 75 and 847 (66%) in postnatal patients. Few inquired of children and "well" adults.

Although 1194 (93%) practices employed practice nurses, only 64 (5%) held continence clinics. In 1117 (87%) practices it was community nurses who provided continence services; general practitioners offered continence care to individual patients in 835 (65%) practices.

Knowledge of incontinence was poor, 974 (76%) having "no idea of its prevalence." Only 385 (30%) general practitioners felt "very confident" to diagnose and manage incontinence, with 205 (16%) expressing confidence to diagnose and manage urge incontinence and 244 (19%) incontinence in children. There were no significant differences in reported confidence to diagnose and manage incontinence between the 937 general practitioners with more than five years in practice, 859 (92%) of whom had received no training in continence promotion, and the 347 with less than five years' experience, of whom 170 (49%) had had no such training. General practitioners with less than five years' service were significantly more likely to have received training as an undergraduate than were practitioners who had been longer in general practice ($\chi^2$ test, $p<0{\cdot}001$). Of 177 (51%) with less than five years' practice experience who had received undergraduate training in continence promotion ($\chi^2$ test, $<5$ years $v>5$ years, 117 (66%) had only one to four hours' instruction. Of general practitioners with less than five years in practice, 271 (78%) had received some training at postgraduate level, predominantly one to four hours. A total of 1027 (80%) respondents thought that their training in continence promotion was totally inadequate; 1093 (85%) believed that continence promotion should be included in undergraduate medical education and 1183 (92%) at postgraduate level. A total of 1027 (80%) considered that specialist continence advisers could provide continence promotion training to doctors and practice nurses.

The study revealed a perceived lack of medical training in continence care at undergraduate and postgraduate levels. Demand exists for specific postgraduate education in this discipline for general practitioners and practice nurses.

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# Hypercalcaemia with topical calcipotriol

EDITOR,—K A Hardman and colleagues described hypercalcaemia in two patients with chronic plaque psoriasis who were treated with topical calcipotriol ointment (50 μg/g).[1] It is surprising that patients using less than 100 g of calcipotriol a week (mean 83 g/week and 70 g/week) should develop hypercalcaemia, particularly after prolonged uncomplicated treatment periods. Several large multicentre trials of calcipotriol detected no change in mean serum calcium concentration.[2-4] Admittedly, the mean weekly dose was only about 40 g. Smaller comprehensive studies, monitoring more sensitive markers of calcium homoeostasis including urinary calcium excretion and using larger doses of calcipotriol (mean 80 g/week and 100 g/week), also detected no effect on calcium metabolism (R Wehr *et al*, American Academy of Dermatology, San Francisco, 1992; D Gumowski-Sunek *et al*, Swiss congress of dermatology, Berne, 1992). We studied 10 patients with extensive disease who used 100 g a week for four weeks. Mean urinary calcium concentration rose slightly but significantly from 4·75 mmol/24 h to 5·89 mmol/24 h ($p<0{\cdot}05$; normal values 2·5-7·5 mmol/24 h). Mean serum calcium concentration remained unchanged.

We know of only three case reports of hypercalcaemia in patients with chronic plaque psoriasis, all resulting from amounts exceeding the licensed dose ($\leq$ 100 g/week) of calcipotriol (mean 210 g/week, 280 g/week, 490 g/week; personal communication, Leo Laboratories). We investigated 10