To our knowledge, no other long term follow up study exists of infants with bacteriuria on screening, and comparisons can thus be made only with studies of symptomatic urinary tract infection. The rates of recurrence of bacteriuria seemed to be lower than in infants with symptomatic urinary tract infection¹⁹ and the rate of radiological abnormalities was also low.²⁰⁻²² The small number of infants with bacteriuria in our study, however, makes such comparisons uncertain.

The purpose of this study was to clarify whether screening for bacteriuria in the infant period might identify individual children at risk of developing renal damage. Among the 14 girls and the 36 boys found to have bacteriuria only two girls and one boy experienced attacks of pyelonephritis, with risk of subsequent renal scarring.^{13 23 24} These children might have been detected outside the screening programme because of their symptoms. A urethral valve was found on radiological examination in the boy with pyelonephritis. Although the urethral obstruction was minimal, the finding may itself be regarded as a risk factor. In addition, one girl had obstructive nephropathy (stenosis of the pelviureteral junction) at initial urography without progression at follow up. She was free of symptoms and would probably have been undetected outside the screening programme. The remaining 11 girls and 35 boys had episodes of asymptomatic bacteriuria, which cleared either spontaneously or when antibiotics were given for reasons other than the bacteriuria; they did not show recurrences of a serious nature. Neither measurements of the renal concentrating capacity nor detailed analyses of the radiological follow up indicated a risk of renal damage in infants with bacteriuria on screening.

Previously, screening at school entry disclosed bacteriuria in about 1% of girls.^{1 25-27} In our group of girls with bacteriuria on screening in infancy no recurrence of infection was observed after the age of 5 years. Therefore, they probably constitute a different population from those detected with bacteriuria at school entry.

Mass screening for bacteriuria in infancy seems to result primarily in the detection of infants with innocent bacteriuric episodes and is not therefore recommended.

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Where and when to detoxify single homeless drinkers

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Oxford has a large population of homeless people, many of whom are alcohol dependent. Acute detoxification is offered by two facilities, a regional alcohol unit based at this hospital under the supervision of a consultant psychiatrist and Simon House, a hostel run by a charitable foundation. We compared the service offered by the two facilities.

The regional alcohol unit offers medical detoxification to inpatients, who are treated by doctors, trained nurses, and others; subsequent treatment may be offered after the patients have been discharged. Treatment as an inpatient cost over £100 a day at the time of the study. The hostel detoxifies new residents, giving drug treatment under the supervision of a general practitioner; there are no trained staff, and the emphasis is on the community and on peer support.

Once a patient has been detoxified moving on is seen as a medium term goal, although abstinence and reasonable behaviour are the only conditions of indefinite residence. The cost was roughly £25 a day at the time of the study.

Patients, methods, and results

Over 20 weeks all homeless people requesting alcohol detoxification at any of the agencies to which they would normally present—a night shelter, a general practitioner's surgery for the homeless, the probation service, and the two units being compared—were assessed for the study. They were then randomly allocated to either the regional alcohol unit or the hostel provided that (a) immediate admission to a psychiatric or general hospital was not needed, (b) they had not been abstinent for more than 24 hours, (c) they had not previously been in the study, and (d) their consent was obtained. After allocation the normal arrangements for admission to the facilities operated. In addition to the subjects' routine care the daily withdrawal symptom score was recorded¹ and the total dose of chlorthalidone

	Hostel	Regional alcohol unit	Total
Mean (range) age (years)	42.9 (18-56)	41.5 (29-68)	42.2 (18-68)
Sex	25 M	23 M, 2 F	48 M, 2 F
No whose abode was:			
Sleeping rough	8	5	13
Night shelter	15	16	31
Hostel	2	4	6
Dependence score*	41	45	43
No with anxiety [†]	19	19	38
No with depression [†]	13	10	23
No with γ -glutamyltransferase activity >40 IU/l [†]	12	8	20
No with mean cell volume >95 fl [†]	23	13	36
No who attended for assessment	17/25	14/25	31/50
No accepted for detoxification	14/17	11/14	25/31
Mean chlorthalidone dose (mg)	369	290	336
Total 5 day symptom score [†]	74	57	66
No who completed detoxification	11/22	8/22	19/44
No abstinent for one month	7/21 [†]	3/21 [†]	10/42
Time between referral and assessment (No of patients):			
<12 Hours	16	6	22
12-24 Hours	8	13	21
>24 Hours	1	6	7

*As assessed by severity of alcohol dependence questionnaire.

[†]One patient could not be traced.

poxide calculated. Detoxification was regarded as successful if the subject was abstinent one day after drug treatment was stopped and symptoms had subsided; the information for follow up at one month was obtained from contacts in the network of agencies concerned.

Altogether 95 subjects presented for detoxification during the time that the study was running. Thirty one of these were ineligible: 14 had been in the study previously; 12 excluded themselves by expressing a preference for where they were treated (one for the regional alcohol unit and 11 for the hostel); three had been abstinent for more than 24 hours; and two had been banned from the hostel. Fourteen others were not referred to the study. The remaining 50 subjects were randomised to either the regional alcohol unit or the hostel (25 to each). All of the 50 patients were heavily dependent on alcohol,² and a considerable proportion were clinically anxious or depressed.³ More than half had macrocytosis; less than half had biochemical evidence of liver dysfunction⁴ (table). There was no difference between the two groups in these measures.

The table shows the proportions of patients in the two groups who attended for assessment, completed detoxification, and were sober for one month. The apparent advantage in the group who attended the hostel was not significant. In both groups three subjects were not admitted: the hostel refused to admit one patient who was too young (age 18) and two others because it was full; the regional alcohol unit did not

admit three patients who were judged to be suffering insufficient withdrawal symptoms to warrant care as an inpatient. Three patients in each group failed to complete detoxification. Although both the mean total dose of chlorthalidone and the score for withdrawal symptoms were greater in the group treated in the hostel, the difference was not significant.

Significantly more patients had to wait over 12 hours for assessment at the regional alcohol unit than at the hostel (χ^2 with Yates's correction=6.57, $p<0.02$) (table). There was no significant difference in the number who waited over 24 hours. When both groups were aggregated waiting over 12 hours did not have a significant effect on the likelihood of attendance or the subsequent completion of detoxification. Waiting over 24 hours before the appointment had a highly significant effect on attendance and detoxification: 31 out of 43 attended when the appointment was within 24 hours but none of seven when the appointment was later (χ^2 Yates's correction=10.40, $p<0.01$). Nineteen of the 37 patients whose referral was appropriate and who were seen within 24 hours completed detoxification (χ^2 Yates's correction=4.41, $p<0.05$).

Overall, 19 out of 44 patients completed detoxification and 10 out of the 42 who were traced remained abstinent for a month.

Comment

This small study indicates that severely dependent drinkers can be detoxified as effectively in a hostel for the homeless as in a hospital; the hostel is generally preferred by this population and is cheaper. We found no indication that it is less safe. Patients are more likely to attend for and successfully complete detoxification if given an appointment for assessment within 24 hours of presenting. Giving appointments within 12 hours is not necessary.

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clinics and the limited resources of agencies such as Victim Support. We studied a series of patients who sustained injuries in assaults and accidents.

Patients, methods, and results

Psychometric questionnaires were completed by 122 consecutive patients who were treated for jaw fractures at the Bristol Royal Infirmary and Dental Hospital during October 1987 to September 1988. The questionnaires assessed anxiety, depression, psychiatric symptoms, and personality trait (hospital anxiety and depression scale, Beck depression inventory, general health questionnaire, and Eysenck personality questionnaire) and were completed at outpatient appointments one week (within 24 hours) and three months (within two days) after injury. Seven patients were in hospital at one week and completed the questionnaires in their wards. Seventy patients had been assaulted (mean age 26; 52 men) and 52 had had

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Psychological distress after assaults and accidents

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Victims of trauma often have psychological problems as well as physical injuries.¹⁻³ The psychological sequelae may persist long after physical injuries have healed and can develop into psychiatric illness. Although fairly minor injury may produce serious psychological consequences⁴ and uninjured witnesses of traumatic incidents may suffer psychological distress,⁵ few studies have been attempted to identify which types of trauma cause the most serious sequelae. Such information is particularly important because of the limited time for counselling in general practice, accident and emergency departments, and orthopaedic