Table 1. Dependency and care costs on admission and discharge.

Outcome	Admission median (IQR)	Discharge median (IQR)	Z-score *p*-value
NPDS	7 (2–14)	1 (0–5)	−6.842 <0.001
Cost of care (£ per week)	234 (168–564)	102 (18–168)	−6.851 <0.001

NPDS = Northwick Park Dependency Score.

The interim analyses are presented in Table 1 and demonstrate both substantial improvements in independence, and reductions in care costs. We would strongly encourage other rehabilitation teams to collect and collate data for commissioners to demonstrate the effectiveness of multidisciplinary rehabilitation programmes.

RORY O'CONNOR
Senior lecturer and honorary consultant physician in rehabilitation medicine
Academic Department of Rehabilitation Medicine

CLARISSA MARTYN-HEMPHILL
Year 5 medical student

CATRIONA MCNICOL
Year 5 medical student

RORY MORRISON
Year 5 medical student
University of Leeds

Reference

1 Turner-Stokes L, Tonge P, Nyein K *et al.* The Northwick Park Dependency Score (NPDS): a measure of nursing dependency in rehabilitation. *Clin Rehabil* 1998;12:304–18.

Diagnosis and management of urinary infections in older people

Congratulations to Drs Woodford and George for a well researched article on urinary infections in older people (*Clin Med* Feb 2011 pp 80–3), a common diagnosis encountered during most medical takes. As their article states, urine samples may be hard to obtain in older patients due to incontinence or cognitive impairment, but misdiagnosis of urinary tract infections may result in inappropriate exposure to antibiotics and delay in establishing the correct diagnosis, and urine culture 'if possible' is advised in the appropriate clinical context.

It would have been of interest to review any evidence base, techniques or recommendations for obtaining the urine culture in this commonly encountered subset of patients. Much is written in the paediatric literature about collection of urine by collection bags, supra-pubic aspiration, or 'in-out' catheterisation in young children who are not able to provide a sample easily, and it would be useful to know if these techniques may also have benefit in the adult population.

GUY HAGAN
Specialist registrar in respiratory/general medicine
West Midlands

Clinical and scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

The need for dedicated dermatology beds

Increasing pressure on inpatient beds has no doubt contributed to the ongoing reduction in designated dermatology beds within acute hospital trusts. Studies in Scotland[1] and Manchester[2] have highlighted an 82% and 57% reduction respectively in dedicated dermatology beds in recent years. This loss of acute beds for the treatment of patients with severe skin disease has led to a shift away from patient admission towards management in the community with expensive immunosuppressant therapies associated with potentially serious side effects.

We report a study from a designated 12-bedded dermatology ward at Amersham General Hospital in Buckinghamshire, which investigated the impact of admission on the Dermatology Life Quality Index (DLQI)[3] of patients with skin disease.

In total, 107 patients were admitted to the ward over a six-month period. Fifty-four per cent (58/107) were female and 46% (49/107) male. The average age was 53.8 years (range 16–94 years). The mean length of stay was 13.9 days (range 2–57 days). Fifty-two per cent of admissions to the ward were planned (eg photoinvestigations, eczema clearance and education) and 48% were emergency admissions (eg acute flares of eczema, psoriasis or cellulitis). The average DLQI score at time of admission was 12 (range 0–30). Three months post-discharge, the average DLQI was 6.5 with an individual average 5.8 point reduction in DLQI score (paired t test, $p=0.0001$).

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