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Referral for 'prostatism': developing a 'performance indicator' for the threshold between primary and secondary care?

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Objective. We aimed to define a performance indicator at the gateway between primary and secondary care.

Method. We carried out an analysis of referral letters sent to an urological department within the catchment area of a teaching hospital in Cardiff, Wales. The subjects were 221 sequential referral letters from 221 GPs. The main outcome measures were the information content of referral letters analysed. Letters were stratified into referral threshold groups by the presence of history, examination, routine investigations and specialized investigations.

Results. Three distinct categories of referral practice were identified: referrals which contained history alone; those providing history examination and a selection of routine investigations; and those providing history, examination data and the results of routine and specialized investigations. The study demonstrated that more than a third of GPs do not report the results of digital rectal examination in their referrals and only 4% record urinary flow rates and post-micturition residual urine volume.

Conclusions. The majority (60%) of generalist referrals to an urology department for prostatism provide enough information for specialists to be able to prioritize appointments, but more than a third (36%) of the referrals contain inadequate information. The method has the potential of being developed into a gateway performance indicator in clinical practice.

Keywords. Performance indicator, prostatism.

Introduction

The recently published NHS Executive 'performance indicators' for primary care have been widely debated and tensions have arisen between managerial and clinical viewpoints.[1] It has proven particularly difficult to establish how the 'gateway' between primary and secondary care should be monitored. This pilot study outlines a possible approach in an important and common clinical presentation—prostatism. Studies of referral practice[2] have repeatedly revealed the variation in 'rates'[3,4] and of 'letter quality', but have not been able to establish a 'performance or quality indicator'. 'Appropriacy' is a difficult measure to apply:[5,6] firstly, the question arises of 'appropriate' from whose perspective: specialist, generalist, patient or purchaser? Secondly, it can be argued that 'appropriacy' can only definitively be measured in terms of 'outcomes'.[7,8]

Differing 'thresholds' for referral have been described,[9] but the area is not comprehensively researched. This study evaluates to what extent referral letters state the amount of investigation and management that occurs before a referral decision is made. Although many guidelines exist,[10,11] referral practice in this area varies immensely. There are no studies that analyse the quality of referrals and the effect this has on the ability of specialists to prioritize out-patient appointments.

The development of medical therapies for benign prostatic hypertrophy (BPH) and the availability, for some practitioners, of post-micturition bladder residual volume and urinary flow-rate estimations make it possible to advise patients that 'watchful waiting' is a realistic option, thereby avoiding a referral.[12] Pilot studies

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TABLE 1 *Content evaluation of 221 referral letters for prostatic symptomatology*

Criteria measured	No.	%
Dominant symptom:		
Obstructive symptoms	112	51
Irritative symptoms	128	58
Background information:		
Relevant past medical history	110	50
Medication	82	37
Objective findings:		
Palpable bladder	41	19
Rectal examination result	133	60
PSA result	122	55
Investigations:		
MSU result	48	22
Renal function result	52	24
USS of bladder residual volume	8	4
Urinary peak flow result	8	4

using interactive videotapes have already demonstrated the feasibility of this approach.[13,14] Is there any evidence that practitioners are making use of the management options open to them? In short, can we determine what is the appropriate referral behaviour for prostate disease so that specialists can prioritize their out-patient workload?

Methods

The collaborating urology department receives approximately 40 referrals per month relating to problems of the lower urinary tract in men suggestive of benign prostatic hypertrophy, the large majority from GPs in the county of South Glamorgan. Two 3-month time-frames were chosen for an analysis of letters: June–August 1995 and February–April 1996. The 221 referrals collected consecutively in these time-frames were photocopied, anonymized and analysed. The content evaluation criteria were agreed by a group composed of four GPs, an urologist and a researcher, and are listed in Table 1.

Results

The results of the referral letter analysis are summarized in Table 1. The most striking feature is the paucity of important information in the referral letters. The findings of physical examination (including the results of a digital rectal examination) were not included in over a third (36%) of referral letters. Helpful information about simple investigations (MSU and renal function) was absent from over two-thirds (77%) of referral letters. Conversely, the PSA test was reported in 60% of referrals despite debate about its usefulness as a screening procedure for prostatic carcinoma. The results of more sophisticated investigations (post-micturition ultrasound scan and urinary flow rates) were included in 4% of referrals. The study reveals a wide variation of referral practice, suggesting that practitioners have very different thresholds for requesting the opinion and intervention of a specialist. Letters are divided into those which contain history alone (36%), history, examination (including rectal examination) plus results of routine tests (60%) and only 4% with history, examination plus the results of more specialized investigations (Table 2).

Discussion

There was a striking absence of information about physical examination, including the results of a digital rectal examination, which is a recognized discriminating criterion for the identification of prostatic carcinoma[15] in over a third of letters. The results of simple tests were absent in over two-thirds of the referrals. Urologists

TABLE 2 *Three referral thresholds*

Letter category (n = 221)	Content	No.	%
Symptom referral	History but no other details	81	36
Symptoms and objective findings	History, examination (including rectal examination) Results of routine investigations (MSU, renal function)	133	60
Symptoms, objective findings and specialized tests	History, examination (including rectal examination) Results of routine investigations Residual bladder volume scans Peak urinary flow rates	8	4

receiving such limited information are placed in the difficult position of being unable to prioritize patients for out-patient visits. This is not so much a question of referral 'appropriateness' or clinical competence but one of clinical performance that may compromise future management.

Only 4% of referral letters included the results of the more sophisticated tests. The limited availability and relative novelty of the ultrasound service may have contributed to the willingness of some generalists to extend their BPH management but it is clear that shifting investigations from the secondary to the primary physician[16] is going to be a slow process without active change agents in all partnerships.

We are tempted to conclude that many general practice partnerships may benefit their patients and their local urologists by undertaking an in-house audit of referral letters in relation to prostatism after setting an appropriate local standard. Clinical guidelines may assist this process but they will need to be continually reviewed to take account of the recent debate about the PSA test.[11,17–20] The concept of 'substitution'[16] describes how new skills and technologies may allow the transfer of health care to community-based locations. The feasibility of managing problems, such as prostatic hyperplasia, more extensively in primary care will be of interest to the emerging visions of managed care.[21] Debate may rage about the core content of general practice,[22] but there is no debate about the need to convey appropriate information to specialist colleagues at the time of referral to aid clinical prioritization in an overstretched service. Although it lacks a psychosocial perspective (description of patients' preference and 'bother levels'), this study begins to identify minimal normative criteria for BPH referral practice.[23] It could be the forerunner of a 'performance indicator' at the gateway between primary and secondary care for an important condition in our ageing society.

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