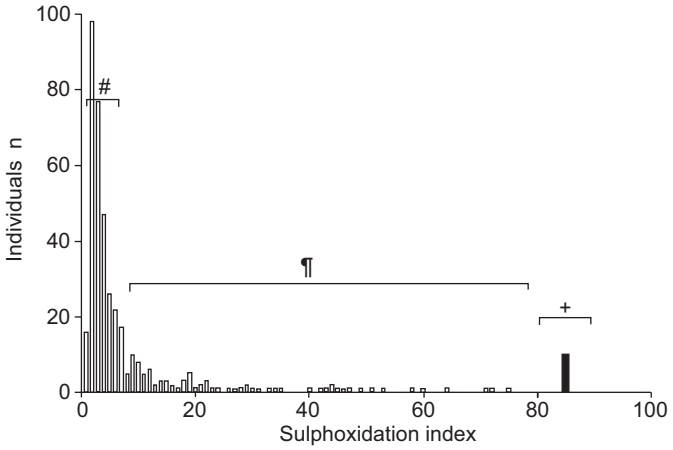

FIGURE 1. Distribution of *S*-carboxymethyl-L-cysteine sulphoxidation capacities for 401 subjects (*S*-carboxymethyl-L-cysteine was dosed *p.o.* at 09:00 h and urine was colleted from 09:00–17:00 h) expressed as a sulphoxidation index (SI; ratio sulphides/sulphoxides). The population can be divided into three sub-groups as follows. #: extensive metaboliser phenotype, 65.8% population (SI<6); ¶: intermediate metaboliser phenotype, 31.7% (SI 6–80); +: poor metaboliser phenotype, 2.5% (SI>80).

patient population for whom benefit may be gained. Some form of practical screening prior to mucolytic therapy would permit the correct dosage to be assigned.

We would welcome correspondence concerning the efficacy, or otherwise, of *S*-carboxymethyl-L-cysteine in the treatment of chronic obstructive pulmonary disease.

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Urinary incontinence in patients with bronchiectasis

To the Editors:

The psychosocial impact of bronchiectasis is frequently underestimated as chronic productive cough is often embarrassing for the patient. In addition, in many females, cough may precipitate an episode of urinary incontinence. We have found that patients with bronchiectasis are often reticent to discuss their incontinence issues with any healthcare professionals and, as such, go untreated. We conducted an audit of the female attendees of a mixed severe asthma/bronchiectasis clinic to determine whether there were any unmet healthcare needs.

Female patients attending the Manchester Severe Asthma Service (Manchester, UK), a tertiary referral clinic for the diagnosis and management of severe asthma and bronchiectasis, were approached to participate. Data were collected on age, menopausal status and parity (vaginal or caesarean). Prevalence of incontinence and its impact on quality of life was assessed using the Incontinence Quality of Life questionnaire (I-QoL) [1]. Severity of incontinence was measured by assessing frequency of incontinence (regardless of severity) and worst degree of urinary leak on any occasion. Patients were clinically classified as having asthma, bronchiectasis, chronic cough, or any combination of these three. Previous access to gynaecological services and requests for referral was audited.

In total, 80 consecutive patients completed the audit questionnaire, of which 75 were suitable for analysis (mean (range) age, 47 (18–73) yrs). Of the 75 patients, 43 (57%) had bronchiectasis (with or without asthma).

The overall prevalence of urinary incontinence (at least 1 episode·week^{-1}, regardless of severity) in females attending the

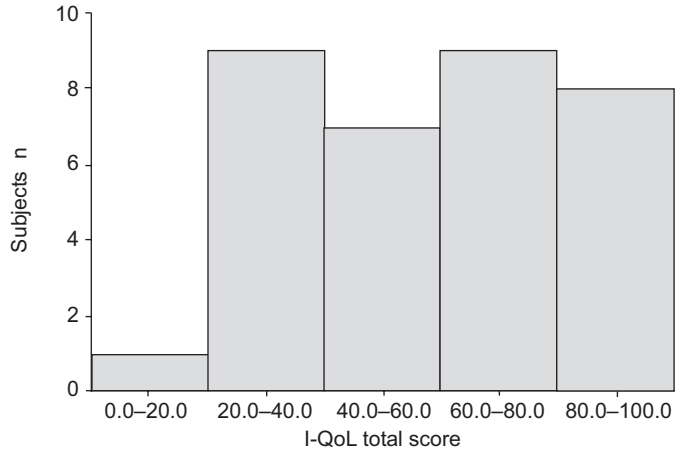

FIGURE 1. Frequency distribution of Incontinence Quality of Life questionnaire (I-QoL) scores in patients with at least weekly urinary incontinence. Range is from 0 (maximal impairment of quality of life) to 100 (no impairment of quality of life).

clinic was 34 out of 75 (45.3%). The prevalence was similar in patients with bronchiectasis, 20 out of 43 (46.5%), to those without bronchiectasis, 14 out of 32 (43.7%). Prevalence peaked in the 50–64-yr age range at 64.3%. The prevalence of urinary incontinence in women between 35–64 yrs in our cohort (52.7%) was significantly higher than that reported for the general population (10.2–11.9%) [2]. Our definition of incontinence (at least once per week) is stricter than that of THOMAS *et al*. [2] who used a definition of 2 episodes·month^{-1}. A similar prevalence has been reported in cystic fibrosis (37.9–68%) [3, 4] using the same definition as THOMAS *et al*. [2].

I-QoL scores, frequency of incontinence and severity were significantly associated with menopausal status and previous vaginal delivery. I-QoL scores, frequency of incontinence and severity were similar in the bronchiectasis and chronic cough groups, compared with those with other respiratory diagnoses. Direct comparisons of severity with the general population are difficult to make; however, the distribution of I-QoL scores shown in figure 1 demonstrates that as many females have significant impairment of quality of life (scores 20–40) as those who have minimal impairment (scores 80–100), suggesting that severe incontinence is over-represented in this population.

Of the 34 patients who had at least weekly incontinence, only nine (27%) had either sought or been offered treatment. We identified 14 out of 75 (18.6%) patients who had at least daily symptoms that could be severe enough to leak through to the outside clothes. Of these, 11 had neither requested nor been offered treatment and only eight patients required referral when this was offered as a result of the audit.

In conclusion, there appears to be a high prevalence of incontinence across respiratory populations, not necessarily associated with cough. This raises the possibility of a modifying co-factor (such as corticosteroid use) that has not been measured in our audit. Many patients are reluctant to seek help for incontinence despite wishing assistance. We recommend that specific questioning on incontinence issues should form part of a respiratory assessment as it is a treatable source of significant morbidity.

ACKNOWLEDGEMENTS

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Metalloptysis

To the Editors:

Here, we report the case of an interesting and unusual post-operative complication, involving the asymptomatic expectoration of 17 surgical staples over a 2-yr period following thoracic surgery for a pulmonary aspergilloma.

A 55-yr-old female had a resection of her left upper lobe and part of the apical segment of the left lower lobe to treat massive haemorrhage from a pulmonary aspergilloma. Eleven months later, she coughed up an open surgical staple. Over the next 3.5 yrs, she coughed up a further 12 single staples at regular intervals (fig. 1a). Recently, she expelled four linked, closed staples (fig. 1b).

Throughout this time, she has remained clinically well and there has been no change in her chest radiographs other than a reduction in the number of staples. In previous cases, this