

Their follicle stimulating hormone levels were 75.9 mIU ml⁻¹ and 73.5 mIU ml⁻¹ respectively and their luteinizing hormone levels 55.7 mIU ml⁻¹ and 43.3 mIU ml⁻¹, respectively. Only one of the four women had presented to her general practitioner with hot flushes since her hysterectomy.

The menstrual histories of 24 control patients matched for age and parity were obtained. As judged by the last menstrual period within six weeks or recent pregnancy, none of these control patients was postmenopausal. The four hysterectomy patients judged to be postmenopausal were informed of their hormone profile. The woman who had experienced hot flushes had suspected her postmenopausal status. All four patients chose to commence hormone replacement therapy.

In the United Kingdom the median age of the onset of menopause is 50 years.⁷ The occurrence of the menopause at the age of 43 years or less is uncommon and it was therefore surprising to find four of the 24 study patients with evidence of postmenopausal status. This small survey lacks statistical power but the findings are consistent with the hypothesis that there is an association between hysterectomy and ovarian failure. The cause of such an alleged association is unclear. Operative disruption of ovarian blood supply or failure of a utero-ovarian hormone mechanism have been suggested.² Clarification of the prevalence and mechanism of ovarian failure after hysterectomy requires larger prospective studies. Meanwhile clinicians and patients should be aware that ovarian failure may not be uncommon after hysterectomy. Regular clinical and hormonal review of these patients would seem worthwhile. Given the high prevalence of hysterectomy from the age of 35 years onwards⁸ there may be many women who have undergone a hysterectomy in the UK who have unrecognized early menopause.

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Nurses and cervical cytology

Sir,

The differences in health provision between affluent and deprived areas of Glasgow is well described by Wyke and colleagues (July *Journal*, p.271) and it is reassuring to know there is some evidence that resources are shifting to where they are most needed.

However, I disagree with the assertion in the article that a woman doctor is necessary for a high uptake of cervical cytology. We need to move away from the notion that doctors are either necessary or desirable for the screening of women. In our two man training practice, 90% cervical cytology rates are achieved; the service has been thought out and planned over the years by the doctors, but the key member of the team is the practice nurse who, having been properly trained, runs the well woman service. I agree that sex is important, but in a service which is always short of funds, and where more and more is being asked of general practitioners, increasing use needs to be made of, and responsibility given to, our nursing colleagues.

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Abnormal cervical cytology

Sir,

In her review of the management of abnormal cervical cytology (August *Journal*, p.336) Clare Wilkinson fails to mention two important aspects of screening and gives potentially misleading information on the management of inflammatory smears.

It is important that general practitioners

and practice nurses are aware that the false negative rate for cervical cytology is as high as 15%,¹ the main reason being operator error as a result of faulty technique. Either the transformation zone is not sampled or lower lip lesions are missed as the spatula pulls away during sampling. The latter can be minimized by maintaining pressure throughout the rotation. Proper supervised training of staff is therefore essential.

One of the most important aspects of any screening process is the adequacy of follow up of abnormal results. A diagnostic cytology laboratory reported that adequate follow up was achieved for only 59% of women in the district following a first report of abnormal cytology.² Although there were many reasons given for this, by far the commonest were failure on the part of the general practitioner to act on an abnormal result and failure by reception staff to bring the abnormal result to the attention of the doctor.

Dr Wilkinson's suggestion that women with persistent inflammatory smears should have a high vaginal swab taken is unjustified. This will fail to detect those infections which commonly cause such abnormalities, namely gonorrhoea and chlamydia.³ Endocervical sampling in appropriate media for these organisms is an essential step in managing such patients.

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Sir,

Wilson and colleagues, who detected chlamydia infection in one in six of study subjects, state this organism has no specific cytological features other than inflammatory changes, and may coexist with identifiable infections such as *Gardnerella vaginalis*, *Candida albicans* or trichomonas.¹

Kelly and Black suggest that patients whose cervical smear result reports severe inflammation should be treated with metronidazole and antifungal pessaries