

LETTERS

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Night visits

Sir,

Department of Health financial data on general practitioner claims for night visits have been analysed and the findings reveal that utilization of general practitioner services at night by patients in London appears to be low. The total number of night visits per 10 000 of the resident population is nearly double the London figure both nationally and in a group of comparable areas with a similar sociodemographic profile to authorities in London (Table 1). This holds true where the patients are visited by their own general practitioner (or another general practitioner in a non-commercial rota), or to a lesser extent, by a commercial deputizing service even though consents to use deputizing services are high in London (the proportion of general practitioners in London as a whole with consent to use a deputizing service in 1989–90 was 91%).¹

Table 1. Night visits per 10 000 of the resident population in 1990–91.

Area	Total ^a	Higher rate claims	Lower rate claims
London	14.6	9.2	5.4
Non-London comparable areas	25.6	17.5	8.0
England	25.0	18.0	7.0

^aClaims at the higher rate indicate a visit by the patient's general practitioner or a colleague, while claims at the lower rate indicate use of a deputizing service. The sum of the two figures gives overall use of general practitioner services at night.

It seems unlikely that this pattern reflects actual levels of need for primary care at night. One possibility is that patients in London seek care elsewhere, probably from accident and emergency departments. Utilization of accident and emergency services per head of resident population — which, without a variable 'primary care' component, might be ex-

pected to be a simple function of resident population — is indeed high in London (the number of attendances at accident and emergency departments in 1990–91 per 1000 of the resident population was 337 in London overall compared with 284 in England as a whole).¹ Few firm conclusions can be drawn from this since London's large day-time population confounds the picture. Surprisingly, some of the non-London comparable areas have simultaneously high rates of accident and emergency services utilization (362 per 1000 of the resident population in 1990–91) and general practitioner night visits.

We are continuing our research on this issue as part of a broader analysis of primary health care in London. We would, however, be interested to hear readers' views on the inferences which can be drawn from the existing data.

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References

- Boyle S, Smaje C. *After Acheson: a comparative analysis of primary health care services*. London: King's Fund Institute, 1992.

Unrecognized ovarian failure after hysterectomy

Sir,

It is traditionally believed that hysterectomy has no adverse effects on the function of conserved ovaries.¹ However, a retrospective study of patients attending a menopause clinic suggested that after hysterectomy the menopause was significantly advanced.² The issue is important because women who have undergone a hysterectomy may fail to recognize an early menopause, an event associated with increased risk of later osteoporosis and myocardial infarction.^{3,4} Such women are eligible for hormone replacement therapy to reduce these

risks.^{5,6} It was therefore decided to measure the prevalence in one practice of unrecognized early menopause in women aged 43 years or less who had undergone hysterectomy with ovarian conservation.

The practice of 5650 patients is based in a small industrial town. The study was carried out in November and December 1991. Twenty four women aged 43 years and under who had undergone abdominal or vaginal hysterectomy with ovarian conservation were identified. The age range of these patients was 32–43 years, age at hysterectomy 27–39 years and time since hysterectomy between one and 16 years. None of the patients was known to be menopausal at the time of hysterectomy. Five patients had received hormone replacement therapy at some time since hysterectomy but none within one year of the study. All 24 patients accepted an invitation to take part in the study. Blood was taken for follicle stimulating hormone and luteinizing hormone assays. The assay technique was a microparticle enzyme immunoassay using an Abbot IMX[®] analyser with a working range of one to 100 mIU ml⁻¹ for both hormones.

Postmenopausal levels of these hormones are difficult to define precisely but four patients (16.7%) were regarded as unequivocally postmenopausal with follicle stimulating hormone levels over 70 mIU ml⁻¹ and luteinizing hormone levels over 30 mIU ml⁻¹. Two of the four women were aged 42 years and both had had their hysterectomy when aged 39 years, one because of dysmenorrhoea and the other as a result of vaginal prolapse. One woman had both ovaries conserved and the other had one removed. Their follicle stimulating hormone levels were 86.7 mIU ml⁻¹ and 98.3 mIU ml⁻¹ respectively, and their luteinizing hormone levels 30.9 mIU ml⁻¹ and 76.0 mIU ml⁻¹, respectively. The other two women were aged 43 years. One had had her hysterectomy when aged 39 years as a result of heavy and irregular bleeding and the other at 35 years, for the same reason; both women had both ovaries conserved.