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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

[a]Claims 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 expected 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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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 simulating 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.

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 onwards[8] 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