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

before the smear is repeated.[2] This course of action although perhaps unwittingly dealing with the identifiable pathogens already mentioned, does not provide the opportunity to isolate, treat and contact trace chlamydial and/or gonococcal infection.

Another approach would be to follow the advice of Wilson's team and consider risk factors in deciding in whom to suspect an associated sexually transmitted disease: those aged under 25 years or those with a recent change in sexual partner.[1] Robinson and colleagues suggest this approach would be a suitable compromise in general practice as routine swabbing of women with inflammatory smears may not be cost effective.[3] It is also suggested that consideration should be given to a more aggressive policy for referring young women with a mildly abnormal smear to a genitourinary clinic for screening for sexually transmitted diseases.

Thus, although Wilkinson (review, August *Journal*, p.336) suggests high vaginal swabs for the follow up of persistent inflammatory smears, we urge the use of an additional investigation — endocervical swabbing.

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Sir,

Dr Clare Wilkinson must be congratulated on her review article (August *Journal*, p.336), and her extensive perusal of the literature. I certainly agree with her advice to repeat smears at three yearly intervals, and to take at least one smear from women aged over 65 years.

I would add two further recommendations. After the first smear, a second smear should be taken one year later, and three-yearly surveillance should then be started. Smears should be taken as soon as patients are known to be sexually active, even before the age of 20 years. In my practice of 2200 patients abnormal smears needing treatment were detected in three patients under 20 years of age over a five year period.

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Emergency contraception

Sir,

With reference to Dr Fluxman's letter on postcoital contraception (September *Journal*, p.394), I am writing to correct the point made about the Family Planning Association's leaflets on contraception. All the current Family Planning Association leaflets on contraceptive methods contain information about emergency contraception. The newest leaflet on male and female condoms contains a specific boxed section on emergency contraception, and this clearer presentation will be available in all future revisions.

The Family Planning Association is aware through its nationwide enquiry service (approximately 200 000 enquiries each year), that there is considerable confusion and misinformation among both consumers and professionals about emergency contraception. The Family Planning Association is currently working on a number of new initiatives to address this.

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Contraception clinic

Sir,

A child was waiting to cross the road, but kept standing without crossing. Somebody asked what she was waiting for and she replied 'My mummy told me to let a car pass by and then cross, looking right and left all the time. I have not seen any car pass by so how can I cross the road?'

A similar example of the literal interpretation of language occurred with a patient attending a special contraception clinic for young people asking for termination of a pregnancy, which had resulted from a burst condom. I asked if she knew about postcoital contraception. She replied that she had heard about it but did not know how to go about obtaining it. On asking if she had consulted her own general practitioner she replied that she could not as he knew her family well. I then asked whether she had considered attending a family planning clinic. She replied 'A family planning clinic is for married people to plan a family. I am not married and I have nothing to plan yet. I will not have a family and my boyfriend also feels this way. There are too many people on this earth so it is silly to go on producing more children. I feel very angry that it is not clear that one can go to a family planning clinic for contraception when one does not need to plan a family.'

Family planning clinics should therefore be renamed contraception clinics so that it is quite clear what they provide.

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Telephone consultations

Sir,

The practice of telephoning patients on the evening prior to their appointment, as advocated by Stainer (letter, August *Journal*, p.348), is unacceptable owing to the resulting breach of confidentiality.

A patient has the right to confidential treatment, and this applies to the fact that a consultation takes place as well as to the contents of that consultation. Once a telephone call has been made to the patient's home, that confidentiality is broken, as there is no control over who answers the telephone. Domestic telephones are often placed in living rooms or halls, and privacy is unlikely. Even if the patient declines to talk for fear of being overheard, there is no way this can be explained without in itself causing the patient to be compromised.

The timing and unexpectedness of the calls places the patient at a disadvantage. The early evening is a time of maximum chaos in most family homes, and the patient is also denied the time to mentally rehearse the presentation of his or her problem that the journey to the surgery or wait once there usually provides.

Even if none of these considerations applies, patients may well be left with the impression that their family doctor dislikes seeing them so much that he or she would rather spend the evening on the telephone trying to dissuade patients from coming, rather than spending the day actually attending them.

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