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Abnormal menstrual bleeding in perimenopausal women

Sir,

Irregular menstrual bleeding and menorrhagia occur frequently among perimenopausal women¹ and are common reasons for consultation with a general practitioner.² Recommendations from specialists are that any woman over the age of 40 years with menorrhagia or other forms of increased vaginal bleeding should undergo endometrial biopsy in order to detect atypical endometrial hyperplasia and endometrial carcinoma.³ The incidence of malignant neoplasms of the uterus increases rapidly in women over the age of 40 years.⁴ A study was undertaken to investigate the frequency with which general practitioners refer women over this age who present with a new episode of abnormal menstrual bleeding.

The study involved 11 general practitioners in four surgeries. All the practices were fully computerized and contributed research data to one of two bodies (VAMP research or the Royal College of General Practitioners weekly returns unit). Women aged over 40 years who had consulted a general practitioner with abnormal menstrual bleeding were identified by a computer search of their records. Computer records and written records were then analysed.

The study was designed to observe the management of new episodes. Women who had consulted before full computerization of the practices and/or who had first consulted when aged 40 years or less were excluded. In addition, women who had had a hysterectomy, were postmenopausal, had consulted only with postoperative bleeding or pregnancy-related bleeding and those that had undergone endometrial biopsy within the previous three years were also excluded. In order to ensure adequate follow up, women with a new episode within nine months of the search were excluded and therefore so were women referred more than nine months after the onset of the new episode.

The diagnosis classification system used by the computer contains 28 terms which may involve increased menstrual bleeding. Some of these terms are specific, reflecting excess menstrual loss (for example, menorrhagia) and others are non-specific (for example, dysfunctional uterine bleeding). The diagnoses were divided into four groups. Of 110 women with excess menstrual loss, 38 (34.5%) were referred to a consultant gynaecologist; of 28 women with irregular menstrual loss, six (21.4%) were referred; of 15 women with intermenstrual loss, 10 (66.7%) were referred; and of 41 women with non-specific loss, 12 were referred (29.3%).

The rationale for endometrial biopsy in menopausal women who complain of abnormal menstrual loss is to detect endometrial abnormality yet only 34.0% (confidence interval 27.3%–40.7%) of such women were referred by their general practitioners.

If endometrial carcinoma is to be detected earlier then it would appear that either general practitioners need to refer more often and quickly or there needs to be more specific criteria for referral which reflect the issues within primary care. The new devices for endometrial sampling⁵ may provide a means of performing endometrial biopsy in general practice according to current specialist recommendations.⁶ The cost effectiveness of each approach needs to be evaluated.

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Non-attenders for cervical screening

Sir,

Although the achievement of cervical smear targets has been part of general practitioners' workload for some years, it is useful to examine the reasons why some women do not attend for screening.

Immediately prior to recent media scares concerning the taking of cervical smears,¹ a survey of call and recall non-attenders was carried out in a semi-rural practice with two men general practitioners. Although the practice achieves the higher uptake target (80%), it has a considerable group of non-respondents to requests to attend screening sessions.

An anonymous, postal questionnaire, sent to patients' homes with a stamped, addressed reply envelope, was used so that patients responding to the questionnaire could not be followed up. More than half of the 77 patients surveyed (53%) replied. In common with previous studies² reasons for non-attendance included a stated preference for the smear to be taken by a woman (24 respondents), and fear generated by the perceived lengthy waiting period for results (mentioned by six women). However, there were two other important findings.

Seven of the women reported feeling pressurized to attend for cervical screening in some instances to a degree where they were actively avoiding their doctor. Although the group considered themselves to be well informed on the importance of the smear test, three quarters (31 women) responded positively to a question offering their removal from the recall register until they themselves requested to be reinstated.

The study involved a small number of women. However, more than half of the group not responding to cervical screening requests were prepared to complete the questionnaire and return it to the practice and their replies to the questionnaire raise important issues. Where does health promotion end and undue pressure begin? Does the fact that doctors receive cervical screening target payments lead to the pressurization of patients? How would allowing a group of non-respondent to opt out of the programme affect such target payments? As there is a direct relationship between a regular cervical smear programme and reduced mortality from invasive cervical neoplasia,^{3,4} what are the ethical considerations in allowing vulnerable women to opt out?

It would be valuable to learn whether these feelings are present in non-attenders at cervical smear programmes in other practices and whether or not the more