Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Personal letter and use of hormone replacement therapy

Sir,

Hormone replacement therapy can successfully treat menopausal symptoms and prevent both coronary heart disease and osteoporosis.[1,2] However, few women take it, even when at risk of premature menopause, for example after ovarian or uterine surgery.[3]

A study was undertaken between August 1993 and July 1994 in an urban, computerized, non-fundholding practice of 10 500 patients to improve the uptake of hormone replacement therapy in women under the age of 50 years who had had a hysterectomy. Women who had had ovarian surgery and those who had not were included. Women who had had a hysterectomy were targeted because they were an easily identifiable group in the practice because of a computerized cervical smear recall system. In addition it was felt that these women would find hormone replacement therapy acceptable because of absence of withdrawal bleed.[4]

All 131 women were identified from a computer search. A personal letter containing an information leaflet about hormone replacement therapy was sent to these women regardless of their current use of hormone replacement therapy. Six women with important contraindications to hormone replacement therapy were not sent the letter: this group had breast cancer (two women), ovarian cancer (one), pulmonary embolus (one), deep vein thrombosis (one) and severe angina (one). Therefore, a total of 125 women were sent the letter. Those who had ovarian surgery including cystectomy were identified as a separate group because of their increased risk of a premature menopause.

At three months 35 women (28.0%) had attended the surgery to discuss the letter and 22 new prescriptions had been issued, thus the number of women using hormone replacement therapy increased fom 46 before the letter was sent to 68 three months after the letter had been sent (Table 1). A greater proportion of women who had had ovarian surgery were using hormone replacement therapy after the letter than were women who had had a hysterectomy only. This would be expected as the incidence of menopausal symptoms would be higher in the group who had had ovarian surgery. This is a relatively short follow-up period and more consultations may well occur. It is proposed to look again at the use of hormone replacement therapy in the group at 12 months.

These provisional results suggest that a personalized letter may be a simple way of improving uptake of hormone replacement therapy. Similar letters have been shown to improve patients' use of other prescribed treatments.[5] The effect of such letters on long term use still needs to be established.

SUSAN D SALT

31 Southfield
Heptonstall
Hebden Bridge
West Yorkshire HX7 7LS

References

1. Stampfer MJ, Willet WC, Cobelitz JA. Menopause and the risk of coronary heart disease in women. *N Engl J Med* 1987; **316:** 1105-1110.
2. Stevenson JC. Pathogenesis, prevention and treatment of osteoporosis. *Br J Obstet Gynaecol* 1990; **75:** 365-415.
3. Sidell N, Sarrell P, Whitehead MI. The effect of hysterectomy on age of ovarian failure. Identification of a subgroup of women with premature loss of ovarian function and literature review. *Fertil Steril* 1987; **47:** 94-100.
4. Sinclair HK, Bond C, Taylor R. Hormone replacement therapy: a study of women's knowledge and attitudes. *Br J Gen Pract* 1993; **43:** 365-370.
5. Cormack MA, Sweeney KG Hughes-Jones H, Foot GA. Evaluation of an easy, cost-effective strategy for cutting benzodiazepine use in general practice. *Br J Gen Pract* 1994; **44:** 5-9.

Table 1. Influence of personal letter on use of hormone replacement therapy (HRT).

	% of women using HRT	
	Before letter	**After letter**
Who had had ovarian surgery (*n* = 51)	*47.1*	*64.7*
Who had had hysterectomy only (*n* = 74)	*29.7*	*47.3*
Total (*n* = 125)	*36.8*	*54.4*

n = number of women in group.

Skin biopsies in general practice

Sir,

Arguments for and against the performance of minor surgery by general practitioners vary. Points in favour include shorter waiting times, increased convenience to the patient and lower cost to the National Health Service.[1] Against this background, doubts have been expressed concerning an increased burden on laboratory services and uncertainty about the competence of general practitioners to perform minor surgery.[2,3] In order to clarify the position, the referral practices of general practitioners were studied with regard to skin biopsies in an inner city area of London, together with their diagnostic accuracy.

All skin biopsies (722 from 704 patients) submitted directly by local general practitioners to the department of histopathology at King's College Hospital, over the period April 1991 to June 1993, were reviewed and clinical versus histological diagnoses compared. There were 143 general practitioners in the South East Thames locality who referred cytology or histology specimens to King's College Hospital during this time. Of these, fifty eight (40.6%) referred skin biopsy cases for histological interpretation during the study period and only 10 performed more than 20 biopsies each. There was a fourfold increase in the total number of skin biopsies submitted by general practitioners following the introduction of the 1990 contract (approximately 100 biopsies per year before, and 400 biopsies per year after), but this was a small increase in the overall workload of the histopathology laboratory which manages over 1300 specimens per year.

The accuracy of the clinical diagnosis was assessed by comparison with the histological diagnosis (Table 2). Encouragingly the general practitioners made important errors (malignancy unsuspected or misdiagnosed prior to histology) in only 13 of the 722 cases (1.8%), and exci-

sion was incomplete in only four of these. Only one general practitioner attempted to excise what he believed to be a malignant melanoma (shown subsequently to be a squamous cell carcinoma) which is perhaps a testimony to the ease of access to a pigmented lesion clinic in the locality. Incorrect clinical diagnoses were made in 40.9% of all referrals but most of these were minor diagnostic errors involving usage of terminology. Interestingly, the general practitioners' use of the term papilloma accurately reflected the histopathological use of the term papilloma (squamous or basal cell) in only 28.7% of the 94 cases. Most of these incorrect diagnoses were naevi, benign soft tissue tumours or fibroepithelial polyps which clinically should often be clearly distinguishable from papillomas.

Fears that large numbers of malignant lesions are inappropriately excised by general practitioners appear to be unfounded and advice given by dermatologists to avoid carrying out a biopsy of malignant or inflammatory lesions has in most cases been heeded, at least in so far as specimens to the study laboratory are concerned. It is our belief that skin biopsies can be competently performed by general practitioners.

MARK DEVERELL

The Quarterjack Surgery
Wimborne
Dorset BH21 1AP

ELIZABETH BEST
JONATHAN SALISBURY

Department of Histopathology
King's College School of Medicine
and Dentistry
Bessemer Road
London SE5 8RS

References

1. Williams RB, Burdge AH, Jones SL, Skin biopsy in general practice [letter]. *BMJ* 1991; **303:** 1179-1180.
2. Hunt AC, Sherwood A. Competence for GP surgery [letter]. *BMJ* 1990; **301:** 495.
3. Pitcher R, Gould DJ, Bowers DW. An analysis of the effects of general practice minor surgery clinics on the workload of a district general hospital pathology and dermatology department. *Br J Dermatol* 1991; **125** (suppl 38): 93.

Lofexidine based regimen for opiate addicts

Sir,

Detoxification of opiate dependent patients is a common clinical problem. Several outpatient detoxification regimens are available but most have some disadvantages, for example, abuse potential, inadequate relief of withdrawal symptoms or potential to cause hypotension. Lofexidine hydrochloride is an alpha-2 adrenergic agonist, similar to clonidine, which has been shown to reduce opiate withdrawal symptoms in methadone dependent subjects without the hypotension that may occur with clonidine.[1-3]

A pilot study was undertaken in a specialist substance misuse unit between September 1993 and March 1994 to evaluate the effectiveness of a lofexidine based regimen in outpatient detoxification of opiate addicts typical of those seen in the community, namely those dependent on a variety of opiates and, in some cases, other drugs of abuse such as temazepam. In this regimen, participants received lofexidine 0.2 mg twice daily, increasing by 0.2 mg twice daily until control of the withdrawal symptoms was achieved or the maximum recommended dose of 1.2 mg twice daily was reached. Having found that subjects frequently experienced abstinence-threatening anxiety and insomnia, those complaining of marked anxiety symptoms received chlordiazepoxide (up to 25 mg six hourly) and of insomnia, chloral hydrate (up to 2 g at night), both being reduced over the first week. When the subject had felt comfortable for five days, the lofexidine was reduced by 0.4 mg per day, or more rapidly if requested.

Opiate addicts requesting detoxification were offered the then standard detoxification regimen of chlordiazepoxide and co-phenotrope or the lofexidine based regimen. Sixteen out of 30 opiate dependent subjects chose lofexidine. Of this group three failed to complete the detoxification for reasons unrelated to opiate withdrawal. Of the remaining 13, the main drug of abuse was methadone in five cases, heroin in four (three were injecting it and also taking temazepam) and dihydrocodeine in four cases. Ten subjects required additional treatment with chlordiazepoxide and four with chloral hydrate. Symptoms of postural hypotension were not evident. Seven subjects (54%) successfully completed the detoxification, that is, achieved a drug-free state at the end of the detoxification. Of this group of seven, three had been dependent on methadone, two on heroin (both had been intravenous users and had also abused temazepam) and two had been on dihydrocodeine.

Repeated opiate abuse (on more than one occasion) during the detoxification period was a strong predictor of ultimate failure of the regimen (chi square fisher exact test, $P<0.001$).

The notes of 24 opiate dependent subjects who had undergone outpatient detoxification with the established regimen employed in the specialist unit were then studied retrospectively. In this two-week, reducing regimen subjects received chlordiazepoxide (initially 25 mg six hourly) and co-phenotrope (diphenoxylate hydrochloride 2.5 mg and atropine sulphate 25 µg, one tablet three times daily). The reported preferred opiate of dependence was heroin in 18 cases (intravenously in 15 cases), dihydrocodeine in five cases and methadone in one. Five of the heroin-dependent subjects also took dihydrocodeine, three took methadone and six also took temazepam. Of the 24 subjects only four (17%) successfully completed the detoxification.

Significantly more of the subjects on the lofexidine based regimen achieved a drug-free state than those on the chlordiazepoxide and co-phenotrope regimen (7/13 versus 4/24, χ^2, $P<0.05$).

Our general impression was that better control of withdrawal symptoms could potentially be achieved by commencing treatment at a higher lofexidine dosage and/or increasing the dose more rapidly. This warrants further study.

While this pilot study was undertaken in a specialist substance misuse unit in close

Table 2. General practitioners' diagnoses and percentage found to be correct histologically, together with number of important errors[a] and number of these incompletely excised.[b]

GP diagnosis	Percentage correct	Number of important errors[a] (number incompletely excised[b])
Cyst (*n* = 136)	*80.9*	2 (0)
Wart/keratosis/horn (*n* = 122)	*81.1*	1 (1)
Naevus (*n* = 116)	*67.2*	1 (0)
Papilloma (*n* = 94)	*28.7*	0 (0)
Skin tag/polyp (*n* = 82)	*61.0*	0 (0)
No diagnosis given (*n* = 74)	–	7 (2)
Benign connective tissue tumour (*n* = 68)	*66.2*	1 (1)
Basal cell carcinoma (*n* = 12)	*75.0*	0 (0)
Inflammatory, eg psoriasis (*n* = 8)	*75.0*	0 (0)
Squamous cell carcinoma (*n* = 5)	*40.0*	0 (0)
Miscellaneous (*n* = 4)	*25.0*	0 (0)
Malignant melanoma (*n* = 1)	*0*	1 (0)
Total (*n* = 722)	*59.1*	13 (4)

n = number of biopsies given diagnosis by GPs. [a]Malignancy unsuspected or misdiagnosed prior to histology. [b]Important errors incompletely excised.