ably requested surgery appointments and home visits, the picture is of the telephone service being used largely as an alternative access point to the doctor.

The findings of this study would suggest that general practitioners should not be apprehensive about the possible increase in workload generated by introducing telephone consultations, for example in phone-in clinics. Patients approve of telephone consultations,[5,6] and general practitioners can be reassured that telephone accessibility does not lead to an additional but to an alternative workload. Telephone consultations should therefore be seen as a valuable part of access to primary health care.

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Oral contraceptives and cervical neoplasia

TRYING to disentangle the relationship, if any, between the use of oral contraceptives and the development of cervical neoplasia presents a classic epidemiological dilemma. Cigarette smoking increases the risk of cervical neoplasia and users of oral contraceptives smoke more than non-users. Users of oral contraceptives are more likely to have cervical smears taken and at more frequent intervals than non-users; the more frequently that smears are taken the more likely it is that cervical dysplasia is detected. On the other hand, the more that dysplasias are detected and treated the less likely it is that they progress to carcinoma *in situ* and to invasive cervical cancer. Further confusion can occur when comparing users with non-users of oral contraceptives; many of the latter may use barrier methods of contraception, which protect against cervical neoplasia.

It is possible to obtain reasonably accurate data on these variables and adjust the calculations of risk so that like is compared with like. The most frustrating problem, however, is to obtain reliable data on the sexual behaviour of users and non-users of oral contraceptives and also of their male partners. Yet sexual habits are strongly associated with cervical neoplasia: the risk increases with the frequency of coitus of the woman, and with multiple sexual partners, and if her regular male partners have multiple sexual partners.

These comments are prompted by a report from a hospital-based case-control study carried out in Thailand, Mexico and Chile under the supervision of the World Health Organization. The cases were patients admitted for the treatment of cervical carcinoma *in situ*; the controls were patients admitted who did not have carcinoma *in situ*. Hospital controls are less likely to be representative of the general population of women than controls selected from the community. The history of past use of oral contraceptives was obtained from cases and controls. The relative risk was derived by comparing the relative proportions of women in the two groups who had formerly used oral contraceptives. Analyses of the data were adjusted for each of the likely confounding variables discussed previously, although the quality of data relating to sexual habits, as in all studies, remains dubious.

The results showed a significantly increased overall relative risk of cervical neoplasia from any use of oral contraceptives of 1.34; this rose to 2.04 after five years of use, and declined to essentially normal levels four to five years after stopping use. These results are in general agreement with studies which have been reviewed by Brinton (*Contraception* 1991; **43:** 581-595).

In a study by Beral and colleagues, with a cohort design, it was shown that, although carcinoma *in situ* (and invasive cervical cancer) rates were increased in users of oral contraceptives, the risks of endometrial and ovarian cancers were reduced, so that overall there was no increase in mortality from genital tract cancers (*Lancet* 1988; **2:** 1331-1335). Interestingly, there were data presented which suggested that cervical smears might be less effective in detecting cervical neoplasia in oral contraceptives users than in non-users.

The association of oral contraceptive use and cervical neoplasia can be explained by three possible mechanisms: oral contraceptives may cause some cases of cervical neoplasia; women whose lifestyle puts them at greater risk of cervical neoplasia may choose to use oral contraceptives; or women who choose to use them may adopt a more risky lifestyle.

For clinical purposes the reality is that users of oral contraceptives are at higher risk of cervical neoplasia than non-users. Is there justification for more intense screening of these higher risk women? The answer can only be determined through research aimed specifically at resolving this issue; the cost-effectiveness of more intensive screening will have to be evaluated. My view is that, in the meantime, users of oral contraceptives should be carefully monitored to ensure that they do not miss having a cervical smear at the recommended intervals.

CLIFFORD R KAY
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Source: Ye Z, Thomas DB, Ray RM and the WHO collaborative study of neoplasia and steroid contraceptives. Combined oral contraceptives and risk of cervical carcinoma *in situ*. *Int J Epidemiol* 1995; **24:** 19-26.

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Food for thought...

'Direction and hope are not solely the needs of deprived areas — they are the needs of all people. You can test this yourself by reflecting on your own life: when you know what you stand for, with whom you identify and where you fit into the whole, you feel competent for the journey ahead. When you feel good about all these things you feel hopeful. When you feel hopeful, getting out of bed in the morning is not such a bad thing.'

Thomas P. There is hope yet for the development of primary health care in deprived areas [editorial]. November *Journal,* p.572.