have worn off. It is certainly remarkable that, given the relatively stable populations in primary care, two-, three-, or even five-year follow-up cannot be achieved.

However, would longer follow-up yield results more 'favourable' to counselling? With current measuring tools, I doubt it; what we know of psychodynamics would suggest that effective counselling is likely to shift the baseline from which patients perceive their satisfaction or dissatisfaction with themselves upwards. Counselled patients rarely lie down quietly and stay counselled, they frequently come back for more at a deeper level, and would be scoring poorly on measuring instruments yet again because of higher expectations. It is rather like operating on a patient's leg arteries and improving their walking so that they then become disabled by angina. We need more sensitive measuring tools that allow for a baseline shift.

Counsellors feel that their presence in a practice contributes to the overall functioning of the practice, for example, by taking some patients away from the doctors they enable the latter to be less stressed and perhaps more productive for the patients they do see.

We should think very carefully before we dispense with counsellors in our practices.

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Hormone replacement therapy

Sir,
As Joy Townsend points out in her recent paper (January *Journal*),[1] there are few direct survey data on the prevalence of use of hormone replacement therapy (HRT). Using prescription cost data, Townsend has estimated that use of HRT in England in women aged 40 to 64 years has risen from 2% in 1987 to 22% in 1994. This compares with the current levels of HRT use by 24% of postmenopausal women in the USA and 47% of postmenopausal women doctors in the USA.[2] Townsend suggests that, in England, HRT use will increase further to 25% by the year 2000.

However, the prevalence of HRT may be different in an inner-city, multi-ethnic population. I recently carried out a pilot study in an inner-city London general practice using a computer search of prescriptions for HRT preparations. I found 844 women in the practice, aged 40 to 65 years inclusive, of whom 114 (13%) were current users of HRT and 58 (6.8%) were ex-users. This number did not include patients who have had HRT prescribed by a previous GP or by a hospital (e.g. for implants) and who may only be picked up by a direct survey. This lower prevalence in the inner city may reflect the difference in doctors' prescribing habits or the individual preferences of the patients.

As Philip Hannaford highlights in his editorial,[3] most women currently use HRT for short durations only, and therefore may be missing out on some of the longer-term benefits, such as protection against heart disease and osteoporosis.

I intend to conduct a questionnaire survey on all current users of HRT and a similar sized random sample of non-users in an inner London general practice. The aim is to examine HRT use related to ethnicity and educational level, and to discover some of the reasons for women stopping HRT and the beliefs about HRT use that deter or encourage women to use it in my inner-city population. This may shed light on the obstacles concerning the use of a potentially useful preventive treatment.

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STD and HIV screening in general practice

Sir,
Harper *et al* (March *Journal*) found that GPs in the South Thames region did not routinely screen women, prior to termination of pregnancy (TOP), for STDs.[1] We would like to debate the issue of whether GPs should in fact be routinely screening for STDs in women prior to TOP.

Current recommendations are that the management of women undergoing TOP should include a strategy for minimizing the risk of post-abortion pelvic inflammatory disease (PID). This can be achieved either by the use of antibiotic cover (universal prophylaxis) at the time of the TOP or by testing for STDs with treatment and follow-up of positive cases.[2] In Leicestershire, both approaches are used: one provider unit screens all women undergoing TOP for STDs, the other provider unit uses antibiotic cover at the time of the TOP. Both strategies are supported by evidence from randomized controlled trials.[2,3,4] Although one might expect screening before TOP to be more effective as it allows for contact tracing and treatment of partners of positive cases, there is no published research that shows that screening is more effective than universal prophylaxis for prevention of post-abortion PID. Screening before TOP cannot therefore be recommended as the preferred strategy for minimizing the risk of post-abortion PID.

If one pursues a policy of screening women for STDs prior to TOP, it is by no means certain that this screening should be performed by GPs. GPs may feel it more important to spend their time counselling a woman about having a TOP rather than routinely performing a pelvic examination and taking swabs for chlamydia and other STDs. It was the opinion of the multidisciplinary Leicestershire genital chlamydia guidelines group that it was inappropriate for general practitioners to routinely test women for chlamydia prior to TOP, and that testing should be performed by the gynaecologist at the assessment clinic. The group also felt that the operation letter should state the result of the test and, if positive, whether or not the woman had been referred to a genitourinary medicine clinic for contact tracing.[5]

We conclude that it is important that the management of women undergoing TOP should include a strategy for minimizing the risk of post-abortion PID. We suggest that this can be best achieved by ensuring that there is a district-wide strategy to make sure that all providers of termination services follow current recommendations[2] and offer either screening for STDs or universal prophylaxis.

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Watchful waiting in glue ear

Sir,
The brief report entitled 'Do GPs have the techniques for "watchful waiting" in glue ear?' by Dr Mark Huggard and his team at the MRC Institute of Hearing Research (March *Journal*), highlights a serious shortcoming in British general practice: a postal survey of 900 practices (711 respondents) revealed that an audiometer was used in only 43.3%.

Deafness is the second most common handicap (after mobility problems) and afflicts millions of our patients. We cannot begin to help them if we have no instrument to measure hearing loss, any more than we can manage blood pressure without a sphygmomanometer.

In January 1990, the council of the Royal College of General Practitioners approved a paper calling for the audiometer to be looked upon as a standard piece of equipment in every GPs' practice. The reasons why more than half of our practices still lack one probably includes cost, a deficiency of training, procrastination consequent on the hurly-burly of the day's work, and perhaps a degree of misplaced humility over the contribution general practice can make towards the problem of deafness. Suitable audiometers, however, cost in the region of one-third of the price of electrocardiograph (ECG) machines. Learning to record audiograms is no more challenging than learning to record ECGs, and the recordings take no more time. As well as being needed in the management of glue ear, audiograms are required to identify the growing problem of presbyacusis (more than one-third of patients over the age of 70 years are deaf enough to need a hearing aid), and in the counselling of patients with tinnitus.

Dr Haggard *et al* have provided us with a timely audit, let us hope we will come out better if and when the audit is repeated.

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Counselling

Sir,
I was interested to read the two papers on counselling in the *Journal* this month (March *Journal*).

Counselling is usually offered to patients in emotional states or with relationship problems that often resolve with time. Therefore, any assessment of treatment effect needs to be in the form of a comparative randomized controlled trial. Unfortunately, Baker *et al*[1] were merely recording the natural resolution of these emotional states, and it is impossible to relate this to any treatment effect of the counselling service they provided.

Harvey *et al*[2] present the results of a randomized controlled trial, which appears to show that GPs are as good as trained counsellors in their communication skills. Outcome was measured at baseline and after four months. This appears a relatively long time for the majority of minor emotional crises that present to GPs. By four months they have often been resolved.

Counselling may be more effective than 'placebo', but the difference is likely to be greater soon after the emotional crisis. With time, the differences would expect to diminish. Could not the outcome in future trials be measured at intervals over time rather than a single long-term outcome?

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Evidence-based consultation

Sir,
Toby Lipman's article on evidence-based consultation (February *Journal*: Back Pages) illustrates that using scientific evidence in medical care is a prerequisite to, and not a substitute for, the art of medical care. I have a few quibbles however. First, the New Zealand risk tables for heart disease are to be found at www.nzgg.org. and not at the address given in the article. Secondly, it is not accurate to say that '80% of children with earache settle without antibiotics in 2 to 7 days'. It is correct to say that, by 2 to 7 days after presentation, 80% will have no pain. This is not the same however, since many patients recover much more quickly: by 24 hours after presentation 60% of children will have no pain.

For those who are interested, an evidence-based patient information leaflet on throat infection is available on the Internet at www.nhantphd.demon.co.uk/tonsil.htm and I am developing a similar leaflet for acute otitis media.

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