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- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Screening and the 1990 contract

SIR,—Implementation of the new contractual arrangements for general practitioners will have numerous knock on effects on various hospital services. Dr Simon Jenkins¹ and Dr John W Chisholm,² in common with the government, have failed to foresee the serious situation that is about to emerge. I refer specifically to workload implications for hospital cervical cytology and histopathology services.

Currently there are considerable variations in the percentage uptake of cervical screening. In many districts, however, this is often 10-30% below the new 80% uptake target. These substantial increases in cytology workload could have been predicted, adequately funded, and planned for in advance. Smear samples taken before 1 April will count towards target payments, and the potential enormity of the problem is already beginning to emerge. For example, the numbers of smear samples taken in Rotherham district by general practitioners in January, February, and March 1990 were respectively 49%, 29%, and 54% higher than in 1989. As a consequence our critically staffed department is now unable to cope, and a progressive increase over the mandatory four weeks' reporting time (health circular 88/1) is beginning to occur. Informal discussions with consultant colleagues elsewhere in the country indicate similar experiences. It is difficult to generalise, but the cytology staffing implications of the new contract could be one cytoscreener and two consultant cytopathologist sessions per district. Furthermore, delays in reporting the results of smear tests will gradually sabotage the payment system.

The effects of minor surgery should also cause concern as many specimens will be submitted for pathological examination. To receive a fee at least five surgical procedures must be undertaken and sessions can be repeated monthly. In Rotherham district over 70 practitioners have expressed an interest in minor surgery, giving a theoretical yearly projection of over 4000 specimens. This workload equates with an additional two medical laboratory scientific officers and seven consultant histopathologist sessions. How histopathology departments will accommodate this possible acute increase in work remains unclear.

It is widely acknowledged that laboratory funding for both the national cervical and breast screening programmes continues to be inadequate. These continuing problems in hospital laboratories are, however, about to be severely compounded by the 1990 contract. Laboratory chaos is, I suspect, about to ensue.

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- 1 Jenkins S. Screening and the 1990 contract. *Br Med J* 1990;300:825-6. (31 March.)
- 2 Chisholm JW. The 1990 contract: its history and its content. *Br Med J* 1990;300:853-6. (31 March.)

Screening elderly patients

SIR,—Professor W J Maclennan's editorial highlights the uncertainty of both the scientific case for screening the elderly and the details of what to screen for and how.¹ Assessment of screening is controversial primarily because of the lack of randomised controlled trials of sufficient power. It is unfortunate that mandatory screening of the over 75s in the general practitioner contract has removed the possibility of determining the overall benefit of a health check. Different methods for carrying out the loosely defined assessments must, however, be properly evaluated.

Screening may produce benefits in terms of mortality, quality of life, and use of resources that are far from "modest," as suggested in the editorial. In a randomised controlled trial in Copenhagen regular assessment over three years was associated with a reduction in the intervention group of 15% in mortality, 25% in hospital bed days, and 19% in hospital admissions.² This resulted in a net saving, over 10 years ago, of £1200 per patient—a not inconsequential amount. It is not clear whether similar benefits would be found in the United Kingdom. Vetter *et al* found a considerable reduction in mortality in one screened area (41%) but not the other (<1%), and a non-significant trend of improvement in quality of life.³ The United Kingdom has one of the lowest life expectancies in the elderly in the European Community, and any potential for improvements should not be ignored.

Professor Maclennan believes that there is little place for screening for asymptomatic disease in the elderly with the possible exception of hypertension. Lack of evidence of benefit should not, however, be confused with evidence that screening is of no benefit. Asymptomatic haematuria, raised intra-ocular pressure, and depression are just three examples in which targeted screening packages may be appropriate and need further evaluation. Moreover, a considerable burden of disease in the elderly is due to common cancers such as breast and colorectal cancers. Trials have shown benefits of screening for breast cancer in the elderly. In the Swedish two counties study there was a significant reduction of 40% in mortality from breast cancer in the 50-74 age group,⁴ and in the Malmo study a reduction of 20% in the 55-79 age group, though this was not significant.⁵ Trials are also in progress for assessing screening for colorectal cancer by using tests for faecal occult blood in subjects up to the age of 74.⁶ There may also be benefits of screening elderly women for cancer of the cervix.⁷

Reducing mortality in the elderly is important,

not only in its own right but also as improvements in survival are often accompanied by a gain in the quality of life owing to a reduction in morbid events and symptoms. We need to reach a consensus on the goals of health care for elderly people and base our judgment of appropriate intervention on scientific evidence.

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- 1 Maclennan WJ. Screening elderly patients. *Br Med J* 1990;300:694-5. (17 March.)
- 2 Hendriksen C, Lund E, Stromgard E. Consequences of assessment and intervention among elderly people: a three year randomised controlled trial. *Br Med J* 1984;289:1522-4.
- 3 Vetter NJ, Jones DA, Victor CR. Effect of health visitors working with elderly patients in general practice: a randomised controlled trial. *Br Med J* 1984;288:369-72.
- 4 Tabar L, Fagerberg G, Duffy S, Day N. The Swedish two county trial of mammographic screening for breast cancer: recent results and calculation of benefit. *J Epidemiol Community Health* 1989;43:107-14.
- 5 Andersson I, Aspegren K, Janron L, *et al*. Mammographic screening and mortality from breast cancer: the Malmo mammographic screening trial. *Br Med J* 1988;297:943-8.
- 6 Hardcastle J, Thomas W, Chamberlain J, *et al*. Randomised, controlled trial of faecal occult blood screening for colorectal cancer. Results for first 107 349 subjects. *Lancet* 1989;i:1160-4.
- 7 Fletcher A. Screening for cancer of the cervix in elderly women. *Lancet* 1990;ii:97-9.

Thyroxine replacement treatment and osteoporosis

SIR,—Dr J A Franklyn and Professor M C Sheppard in their editorial on thyroxine replacement therapy and osteoporosis¹ refer twice to their paper, which ends "the difference in cholesterol values in those treated with suppressive doses of thyroxine and with lesser doses suggests that higher doses have a beneficial effect on hypercholesterolaemia and may favourably influence cardiovascular morbidity."² After years of crying in the wilderness that impaired thyroid function is a risk factor for coronary artery disease in women^{3,4} this paper seemed to signify a conversion among academic thyroidologists the like of which has not been seen since the incident involving St Paul at Damascus. It is therefore surprising that a few months later Dr Franklyn and Professor Sheppard suggest that the risk of causing osteoporosis by treating hypothyroid women with a dose of thyroxine that reduces the thyroid stimulating hormone concentration below the normal range is greater than the benefit of the larger dose on the serum lipid concentrations.

The authors mention the discussion at the 1989 meeting of the American Thyroid Association on this subject but ignore the 1989 meeting of the European Thyroid Association, where Harvey and