CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *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.*

Cannulas and junior doctors

SIR,—Not only is the number of patients being treated in hospital increasing but it is thought that treatment is becoming more intensive. It has been my impression that this is throwing a considerable burden on junior staff.

I have obtained data on the number of intravenous cannulas supplied annually over the past eight years to the two adjacent health districts of Dudley and Sandwell, serving a population totalling 500 000 (table).

Number of cannulas, discharges and deaths, and doctors in two health authorities in the west midlands

	1981-2	1985-6	1988-9
Cannulas	34 200	68 000	84 500
Discharges and deaths	51 400	63 800	71 200
Junior doctors	167	173	181
Consultants	94	125	129

Over the period inpatient throughput has increased by 40% and the use of cannulas by 150%; the number of junior staff has gone up by only 8% and that of consultants by 37%. Except in the specialty of anaesthetics the vast majority of cannulas are inserted by junior staff.

Whereas some of this dramatic increase in use of cannulas may reflect unnecessarily aggressive management, the figures are of such magnitude as to suggest that an increasing proportion of patients is very ill and that advances in management demand more intravenous medication and transfusions. Whatever the explanation it is clear that the workload of junior doctors has substantially increased over the years in terms of both patient load and work per patient.

Achieving a Balance will reduce the ratio of junior to consultant staff. It is unlikely that consultants will greatly increase their own "menial work" by clerking and performing simple practical procedures for inpatients. In that case the burden will fall on an even smaller pool of juniors. They will probably spend less time in outpatient clinics, that work becoming more consultant led. Thus, the educational component of juniors' work will be eroded while tedious (albeit important) work will increase. Such a process cannot add to the future attractiveness of hospital practice, already menaced by the white paper.

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Sex and the elderly

SIR,—The recent article by Dr John M Kellett underlines the lack of awareness in the medical profession regarding sexuality in the elderly.[1] With the aging of our society elderly patients will form an increasing proportion of the workload of clinicians. This will be particularly true for gynaecologists as the mean female lifespan is 78 years and, on average, a 75 year old woman can expect to live another 10 years.[2]

Younger patients may be offered some sort of preoperative counselling regarding potential sexual problems associated with surgery, but this is probably not the case with older women. Such counselling is even more important for women with gynaecological cancer as not only surgery but radiation and chemotherapy may influence future sexuality. In the 26 month period from December 1986, 380 women with invasive gynaecological cancer were referred to our institution. Of these, 72 were over 70 years old, of whom only seven were medically unsuitable for radical pelvic surgery. A quarter of the elderly women with vulvar cancer, nearly a third of those with ovarian and endometrial cancer, and almost half of those with cervical cancer were still sexually active. In total, 22 of the 65 patients who had radical surgery still had occasional sexual intercourse. The mean age of these 22 patients was 75·9 years.

Preoperative counselling for women with gynaecological cancer should include the effect of the proposed treatment on sexuality as well as the possible structural changes to the genital tract, vaginal dryness and discomfort, proctitis, malaise, and alopecia. In addition, an idea of when sexual activity might restart and an outline of the range of sexual behaviour after treatment should be given. This information is no less important for elderly women.

About half of gynaecological cancers occur in women over 65 years old. Much morbidity will be avoided in this population when the medical profession realises that at least a third of it is still sexually active.

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1 Kellett JM. Sex and the elderly. *Br Med J* 1989;**299**:934. (14 October.)
2 Parker RT, Piscitelli JP. Gynecologic surgery in the elderly patient. *Clin Obstet Gynecol* 1986;**29**:453-61.

SIR,—The presence of sexually transmitted disease in the elderly offers further evidence to support Dr John M Kellett's reminder that sexual expression is important in this growing sector of the population and should be considered when managing patients.[1]

Seventy three patients (58 men, 15 women) of 60 years or more (range 60-82 years) attended our genitourinary department in 1988 for investigation of genital tract symptoms or exclusion of sexually acquired infection. Three men were homosexual. Of the 73 patients, 53 (73%) were sexually active, including two of the three men over 80. Forty four men were sexually active and 19 had multiple regular sexual partners or were in casual sexual relationships, some with prostitutes. The number of sexual partners in the six months preceding attendance ranged up to 30. Sexually transmitted infections were identified in 22 patients and included cervical gonorrhoea (one), non-gonococcal urethritis (six), genital warts (five), and genital herpes simplex infection (three), and five patients were positive for treponemal antibodies. Ten patients attended for HIV antibody testing, and anxiety relating to this infection was considerable. Only two non-sexually active patients admitted impotence, and in one of these antihypertensive treatment was implicated. Nineteen of our elderly patients were receiving regular prescriptions for chronic medical conditions, suggesting that they were not a peculiarly healthy subpopulation of the elderly.

Sexual activity in the elderly is common[2] and may result in the acquisition of sexually transmitted disease. The possibility of such infection should not be discounted on grounds of age, particularly when patients present with genital tract symptoms. The incidence of sexually related infection in the elderly remains undefined. In addition, the pattern of sexual activity in some of our elderly patients puts them at risk of acquiring HIV infection, and anxiety concerning this infection was evident.

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1 Kellett JM. Sex and the elderly. *Br Med J* 1989;**299**:934. (14 October.)
2 George LK, Weiler SJ. Sexuality in the middle and late life. *Arch Gen Psychiatry* 1981;**38**:920-3.

Oestrogen deficiency and oestradiol implants

SIR,—Though we agree with many of the points raised by the correspondents to our paper,[1] we disagree with others.

We stated that to our knowledge supraphysiological concentrations of oestradiol do no harm; by implication we have been called "sanguine" by Mr G I M Swyer.[2] We are not, and believe that our original statement is factually accurate. Sustained high oestrogen concentrations occur during pregnancy, yet we know of no direct adverse consequence. We are concerned, however, by the supraphysiological oestradiol concentrations