supplementary oxygen who are monitored by routine oximetry and given conventional sedation. Until this information is available, routine use of a β blocker for patients undergoing endoscopic cholangiopancreatography seems premature because the risk of hypotension induced by β blockade may be an additional hazard.

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Danish data confirm low prevalence of HRT among women prescribed oral corticosteroids

EDITOR,—L J Walsh and colleagues report the use of oral corticosteroids in a population of 65 786 in Nottinghamshire.[1] They had found few epidemiological data on the use of corticosteroids in community populations, which is surprising, since the potential side effects of corticosteroids—for example, osteoporosis, hypertension, and diabetes—are important.

We report here supplementary data on the use of oral corticosteroids and hormone replacement therapy obtained from a population based prescription registry for the county of North Jutland in Denmark. The region has 330 general practitioners and 487 000 inhabitants. For each prescription for drugs for which the costs are reimbursed the pharmacies collect the name and amount of the drug, the defined daily dose, the personal registration number of the patient, the date that the drug is dispensed, and several other variables.

The population consisted of 242 614 men and 244 379 women. In the database we identified 3023 men (1.2%) and 4133 women (1.7%) who had received at least one prescription for oral corticosteroids in 1993. Walsh and colleagues found that 0.5% of their population had been "continuously" treated with oral corticosteroids. The difference is probably due to the different inclusion criteria, as Walsh and colleagues included only patients treated with oral corticosteroids for at least three months. Among the 4133 women who had received corticosteroids in North Jutland we identified 567 (13.7%) who had received hormone replacement therapy. In their study Walsh and colleagues found that 14% of the women treated with corticosteroids had received hormone replacement therapy.

The incidence of the most common conditions requiring continuous treatment with oral steroid increases with age. Correspondingly, we found that the proportion of the population treated with steroids increased with age (table 1).

Steroid treatment increases the risk of osteoporosis and fractures,[3-5] and prophylactic treatment for osteoporosis should certainly be considered when steroids are prescribed. We do not know the proportion of patients who had received advice on diet, exercise, or over the counter drugs to help prevent osteoporosis, but we find the proportion of women who received hormone replacement therapy surprisingly low, given the strategies recommended for preventing fractures caused by steroid induced osteoporosis.[2]

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Investigation is needed into why some patients are not offered cardiac rehabilitation

EDITOR,—Jill Pell and colleagues report the influence of social deprivation on the uptake of cardiac rehabilitation.[1] Through their study the authors have identified an important area of research that could eventually lead to improvements in rehabilitation for deprived patients. In 1995 we reported that economically disadvantaged patients showed poorer survival than others after myocardial infarction,[2] and Pell and colleagues' study suggests a possible mechanism for this: that fewer deprived patients take up and complete rehabilitation programmes.

We note that the type of consultant and the hospital attended were also associated with uptake of rehabilitation. Just as striking is that the invitation to take up rehabilitation also depended on the consultant and hospital attended. In addition to carrying out research into why deprived patients are less likely to complete rehabilitation we clearly need to ask ourselves why some patients are not invited in the first place. The sizes of the effects suggest that the potential for improvement lies as much with the medical community as with the patients.

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Table 1—*One year prevalence of treatment with oral corticosteroids in North Jutland, Denmark, by age*

Age (years)	No (%) who had received corticosteroids		No (%) of women who had received HRT*
	Men	Women	
0–29	172/99 417 (0.2)	224/93 087 (0.2)	37 (16.5)
30–39	212/35 204 (0.6)	268/33 710 (0.8)	43 (16.0)
40–49	337/36 613 (0.9)	462/34 918 (1.3)	68 (14.7)
50–59	380/26 405 (1.4)	567/26 567 (2.1)	78 (13.8)
60–69	646/21 835 (3.0)	858/23 964 (3.6)	99 (11.5)
70–79	845/16 282 (5.2)	1071/20 130 (5.3)	143 (13.4)
80–89	396/6162 (6.4)	594/9090 (6.5)	85 (14.3)
≥90	35/694 (5.0)	89/1573 (5.7)	14 (15.7)
Total	3023/242 614 (1.2)	4133/24 4379 (1.7)	567 (13.7)

HRT = Hormone replacement therapy.
*Women who had received at least one prescription for corticosteroids.

People will be able to surf across languages for health data on the Internet

EDITOR,—Health research data and other health data are increasingly stored in electronic format on networks, which enables faster and more flexible access to the literature. One of the most widely used on line databases in the health field is Medline, which contains more than 7.5 million citations from over 4000 biomedical journals and is international in scope. Increased access to the Internet will further facilitate worldwide distribution of health information. The Internet currently reaches an estimated 40 million people in 90 countries, and the number of its host computers is expected to exceed 100 million before the year 2000.

Language barriers serve to block the globalisation of health information resources. Although English is widely used in science, not everyone can communicate well in English. Much useful information in web sites on the Internet is in languages other than English. Only a few home pages that are in languages other than English provide abstracts in English. This restricts the sharing of information worldwide.

To help globalise health information further we are setting up a multilingual home page for the global health network (http://www.pitt.edu/HOME/GHNet/GHNet.html) on the Internet.[1 2] The first step is to translate the English version into other languages so that more researchers and practitioners can use the home page in their mother tongue (a Japanese version is at http://www.pitt.edu/HOME/GHNet/GHNet-j.html). The second step is to build a home page dealing with health information available from countries where the home page is not in English. The third step will be to put a short description about the site, in English, into each foreign language site along with the email address of a person in charge of the site who can communicate in English. That person will serve as a contact when English speaking people access the site. Finally, we will either include computer assisted translation software among our site services or link our site to others providing such services. Such software now can provide a rough but usable translation, and its quality will improve in the coming years.