

recommend, as S Field and colleagues do in their editorial,² that two views should be taken instead of one and that the screening interval should be reduced from three to two years, without even considering the possible adverse effects of repeated exposure to low doses of ionising radiation,³ strikes me as foolhardy.

ROBERT BLOMFIELD
General practitioner

Hebden Bridge,
West Yorkshire

- 1 Woodman CBJ, Threlfall AG, Baggis CRM, Prior P. Is the three year breast screening interval too long? Occurrence of interval cancers in NHS breast screening programme's north western region. *BMJ* 1995;310:224-6. (28 January.)
- 2 Field S, Michell MJ, Wallis MGW, Wilson ARM. What should be done about interval breast cancers? *BMJ* 1995;310:203-4. (28 January.)

Has increased the workload for primary care teams

EDITOR,—In his editorial on breast screening Paul A Creighton highlights the tendency of the government to raise patients' expectations but to expect those delivering care to absorb any extra work without complaint or extra resources.¹ The Cumbria Practice Research Group sought to document the extra workload for primary care teams that resulted from the national breast screening programme in the first few months after its introduction. Practice receptionists, nurses, and general practitioners completed time sheets.

The data collected showed that up to five hours of work in total was generated per 1000 patients on a general practitioner's list. Most of the time was spent on administrative tasks such as checking the prior notification list and filing results, but general practitioners reported extra consultations for counselling patients and inquiries related to different aspects of the screening process. These figures were almost certainly underestimates as the long period of the survey resulted in staff forgetting to record data.

We believe that if we are to provide new services to our patients the extra work entailed must be taken into account and costed appropriately. In this particular instance, as Creighton suggests, extra reimbursement for appropriately trained administrative staff and practice nurses should be made available.

ELERI M RODERICK
General practitioner
JIM COX
General practitioner

Caldbeck Surgery,
Caldbeck,
Wigton,
Cumbria CA7 8DS

- 1 Creighton PA. What general practitioners should do about breast screening. *BMJ* 1995;310:204-5. (28 January.)

Uptake of breast screening

Accurate addresses will improve uptake rates

EDITOR,—R Rudiman and colleagues report no significant correlation between uptakes of breast screening and cervical screening in Grampian, which is an area with less deprivation than other Scottish health boards and high uptakes of screening.¹ We have compared uptakes of breast screening and cervical screening in 156 practices in east London, a highly deprived inner city area, in contract with City and East London Family Health Services Authority. The tables shows the data. Like Rudiman and colleagues, we found that the uptake of breast screening was consistently lower than the uptake of cervical screening. Unlike them, however, we did find a significant positive correlation between the two rates ($r=0.51$ (95% confidence interval 0.38 to 0.62), $P<0.01$).

Comparison of uptake of breast screening in prevalence round completed in 1992 and uptake of cervical screening in the 5.5 years before 30 June 1993 in 156 practices in east London. Figures are percentages

	Breast screening	Cervical screening
Mean (SD) uptake	44.1 (9.66)	63.0 (20.73)
Interquartile range	37.9-51.7	46.2-82.2
Minimum-maximum	7.1-64.0	2.2-98.8

East London is an area of high mobility. Practices with high rates of cervical screening have probably achieved these in part by more thorough completion of prior notification lists, correcting wrong addresses known to the practice and deleting patients no longer attending the practice. If the accuracy of the addresses are improved the uptakes of both cervical and breast screening will be improved. Practices in east London also have much greater variations in their uptakes of cervical screening (SD 20.73% compared with 4.20% in Grampian). These differences between Grampian and east London may explain why a correlation between uptakes of cervical and breast screening was found in east London but not in Grampian.

The more centralised delivery of mammography compared with cervical cytology screening argues against the introduction of target payments to general practitioners for breast screening. Extra payments for thorough completion of prior notification lists should, however, be evaluated in inner city areas with high mobility among patients.

KAMBIZ BOOMLA
General practitioner

Chrisp Street Health Centre,
London E14 6PG

KATH MOSER
Research officer

JEANNETTE NAIISH
Senior lecturer

Department of General Practice and Primary Care,
Medical Colleges of St Bartholomew's
and the Royal London Hospitals,
Queen Mary Westfield College,
London E1 4NS

- 1 Rudiman R, Gilbert FJ, Ritchie LD. Comparison of uptake of breast screening, cervical screening, and childhood immunisation. *BMJ* 1995;310:229. (28 January.)

May be influenced by practice specific factors

EDITOR,—R Rudiman and colleagues suggest that a financial incentive may be required to increase the participation of primary care staff in the management of breast screening.¹ Data from a study undertaken in 1990-1 of part of the prevalence round of breast screening in a health district in the then Northern region support this.

Almost 3500 women aged 50-64 who were registered with six general practices were invited

for breast screening between 1 October 1990 and 31 January 1991. The overall uptake among these women was 75.8%. Decreasing age and increasing affluence, as determined by the Townsend score for ward of residence, were significantly associated with increasing uptake of the invitation ($P<0.001$, $\chi^2=19.7$, $df=2$ and $P<0.001$, $\chi^2=46.8$, $df=3$, respectively).² Uptake varied significantly among the practices, ranging from 65.3% to 81.0% ($P<0.001$, $\chi^2=22.78$, $df=5$). The distribution of age and ward of residence of the women, however, only partly explained the differences (table).

The uptakes of cervical cytology screening during the year ending 31 March 1991 among women aged 50-64 registered with the six practices were almost consistently higher than the uptakes of breast screening and ranged from 72.6% to 90.3%. The rank orders for the uptakes of cervical cytology and breast screening were similar from the six practices (table).

These data suggest that factors specific to the practices, such as willingness or ability to participate in population screening programmes without appropriate financial reward, in addition to population factors may have accounted for the differences in the uptake of breast screening among the practices.

VIVIEN HOLLYOAK

Consultant in communicable disease control
County Durham Health Commission,
Durham DH1 5XZ

- 1 Rudiman R, Gilbert FJ, Ritchie LD. Comparison of breast screening, cervical screening, and childhood immunisation. *BMJ* 1995;310:229. (28 January.)
- 2 Townsend P, Phillimore P, Beattie A. *Inequalities in health in the Northern region: an interim report*. Newcastle upon Tyne and Bristol: Northern Regional Health Authority and University of Bristol, 1986.

Non-responders can be encouraged to attend

EDITOR,—As a general practitioner, I was particularly interested in R Rudiman and colleagues' comparison of uptake of breast screening, cervical screening, and immunisation in the Grampian region.¹ I have studied the uptake of breast screening in my practice (11 000 patients), where the response rate is 78% overall and 92% at my branch surgery. These rates exceed the target of 70% set in the Forrest report.

We are notified of women who do not respond, whose notes are then flagged so that the subject can be raised at subsequent consultations. Fears can be aired and education and reassurance given. Our nurses and attached staff are involved as well, and we have periodic poster campaigns. In this way we have encouraged about a third of women who did not respond initially to attend; these are in addition to the percentages given above.

In a study of women who did not respond I

Factors affecting uptake of breast screening and of cervical cytology screening by general practice in an English district, 1990-1. Figures are numbers (percentages) except where stated otherwise

	General practice					
	1	2	3	4	5	6
	<i>Breast screening</i>					
No of women	182	823	617	807	118	715
Distribution of age of target population:						
50-54	69 (37.9)	285 (34.6)	216 (35.0)	269 (33.3)	48 (40.7)	240 (33.6)
55-59	62 (34.1)	263 (32.0)	199 (32.3)	263 (32.6)	32 (27.1)	216 (30.2)
60-64	51 (28.0)	275 (33.4)	202 (32.7)	275 (34.1)	38 (32.2)	259 (36.2)
Distribution of ward of residence of target population:						
Group A	20 (11.0)	105 (12.8)	81 (13.1)	118 (14.6)	27 (22.9)	436 (61.0)
Group B	48 (26.4)	192 (23.3)	168 (27.2)	288 (35.7)	22 (18.6)	88 (12.3)
Group C	57 (31.3)	278 (33.8)	140 (22.7)	212 (26.3)	38 (32.2)	84 (11.7)
Group D	57 (31.3)	246 (29.9)	228 (37.0)	188 (23.3)	31 (26.3)	105 (14.7)
Uptake	138 (75.8)	596 (72.4)	470 (76.2)	612 (75.8)	77 (65.3)	579 (81.0)
Rank order of uptake	2	5	4	2	6	1
	<i>Cervical cytology screening</i>					
Uptake (%)	90.3	79	83.5	72.6	74.3	86.8
Rank order of uptake	1	4	3	6	5	2

Group A=most affluent wards.