In the pilot screening programmes, reception staff recruited most of the screening subjects in general practice and family planning clinics. Making use of other members of the primary health care team would significantly reduce the burden on clinical staff and therefore the cost of a population-wide screening programme.

Finally, the author attempted to calculate the cost per case detected and treated. A formal economic evaluation, which includes administrative and clinical time, would be more helpful, but is beyond the scope of his paper. Some of these issues are already addressed in the economic evaluation arm of Chlamydia Screening Studies (CLaSS).[3]

Our practice started testing for chlamydia and other sexually transmitted infections (STIs) in the risk groups since June 2004 as part of National Enhanced Service (NES) for More Specialised Sexual Health Services. We put up posters and information in the waiting room to encourage testing; this enabled patients to feel empowered to initiate STI screening. Clinicians also felt less embarrassed about bringing up the subject of screening because patients understood this is what we offer routinely. We have identified and treated 14 cases of chlamydia to date, in both men and women.

Apart from making use of non-clinical staff, we need information campaigns to raise awareness and normalise the screening process. Opportunistic strategies will only work if individuals feel empowered to request screening; an information campaign should therefore not only focus on health professionals but on patients too.

Richard Ma, MRCGP, DFFP
General Practitioner and Staff Grade in Contraceptive Services, The Village Practice, 115 Isledon Road, Islington, London N7 7JJ, UK

References
1 http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SexualHealth/SexualHealthGeneralInformation/SexualHealthGeneralArticle/fs/en?CONTENT_ID=4084098&chk=CSLxsK [Accessed 24 April 2005].
2 Harris D. Implementation of chlamydia screening in a general practice setting: a 6-month pilot study. *J Fam Plann Reprod Health Care* 2005; **31**: 109–112.
3 http://www.chlamydia.ac.uk [Accessed 24 April 2005].

Reply

I would like to thank Dr Ma for his helpful comments.

The study was undertaken in late 2003 when cervical cytology screening offered an ideal opportunity for us to contact women in our cohort. We do not rely on any single method of contracting patients in the at risk group.

Screening for chlamydia is not denied to any of our patients. Posters about chlamydia screening are displayed in patient waiting areas and toilets. The posters have been modified to hold an information leaflet on chlamydia and a request slip to take to the reception area to ask for a urine pot for chlamydia testing.

In an ideal world with unlimited consultation time it would be great to offer everybody screening for everything. However, as I pointed out in my article, I recognised that GPs are under increasing pressure to offer yet more health promotion advice in a routine consultation; it was for this reason that screening was restricted in the first instance. The idea was to demonstrate to GPs that they could offer screening during a normal consultation rather have to set up a new service to do this.

Practice nurses, health care assistants and GPs were involved in offering opportunistic screening during the pilot study described in my article. Information leaflets and request slips for a chlamydial urine test are freely available in the practice and these can be taken to reception staff who are happy to provide a urine test pot for screening. We felt it was important to discuss the pros and cons for screening and what the patient might do if the result was positive. And it was for this reason we chose not to involve our reception staff directly in the offer of screening.

With regard to the economic evaluation, as I clearly stated in my article this did not include administrative or clinical time, which I agree would have been more helpful; however, this was beyond the scope of the article.

Like Dr Ma we have empowered our patients to make decisions about their screening needs. I wish Dr Ma every success with the article he has submitted to the Journal on chlamydia screening in general practice.

David I Harris, MRGCP, DFFP
Principal in General Practice, Killamarsh Medical Practice, 209 Sheffield Road, Sheffield S21 1DX, UK. E-mail: david.harris@nhs.net

Cerazette for premenstrual tension

It was interesting to read Mr Ali Kubba's letter published in the October 2004 issue of your Journal on the above subject.[1]

I have prescribed Cerazette® for a small cohort of patients (eight patients) in my PMS/Menopause Clinic, who presented with both psychological and physical symptoms within the last year. In 6/8 patients there was a marked improvement in the psychological symptoms and moderate improvement was seen in physical symptoms within 3 months of starting the treatment.

One patient did not show any improvement in her physical or psychological symptoms and since went on fluoxetine with marked improvement of her symptoms, and one patient's psychological symptoms got worse to the extent of personality changes and suicidal tendencies and these symptoms completely disappeared on stopping Cerazette.

All these patients were sexually active young women with an age range of 25–45 years. Of the six women who showed an improvement in their symptoms, only three women became amenorrhoeic with this treatment; the other patients, despite an improvement in their symptoms, had irregular cycles.

Sam Mirando, FRCOG, MFFP
Consultant Community Gynaecologist, Prince Charles Hospital, Merthyr Tydfil CF47 9DT, UK. E-mail: Sam.Mirando@nglam-tr.wales.nhs.uk

Reference
1 Kubba A. Cerazette for premenstrual tension (Letter). *J Fam Plann Reprod Health Care* 2004; **30**: 277.

Spinal fracture in a young Depo-Provera user

Following the latest alarm[1] on the risks of osteoporosis in Depo-Provera® users, a 22-year-old patient of ours was admitted in January 2005 with a fractured vertebra following low-impact trauma. She had been on Depo-Provera for almost 3 years. She had had irregular menstrual spotting only with no actual bleeding as is common with long-term injectables.

She first attended our clinics at age 15 years with heavy regular cycles, weighing 8 stone and smoking 10 cigarettes per day. The only other possibly relevant point in her medical history was her mother's muscle wasting disease on the left side of her back. She chose the combined pill until changing to Depo-Provera at age 19 years. She now weighs 10 stone 13 pounds, her height is 5'1" and she has a body mass index of 29. She stopped smoking 2 months ago.

The vertebral fracture occurred at home when she was putting on her shoes, lost her balance and fell backwards onto the floor. She is on no medication, has never taken corticosteroids, has had no symptoms of oestrogen lack, and goes to the gym three times weekly.

Eventually she came to the top of the bone scan waiting list and her bone mineral density (BMD) was reported as: "Hip BMD = 1.054 g/cm^2. % expected for age: 112%. Lumbar spine BMD = 0.980. % expected for age: 95%. The result is normal".

The hospital immediately took her off Depo-Provera when the fracture occurred. Does this case illustrate that an association does not equate with causation, at least for this individual?

E Stephen Searle, MFPH, FFFP
Clinical Director and Consultant in Contraception and Sexual Health, Contraception and Sexual Health Service, Saltergate Health Centre, Saltergate, Chesterfield, Derbyshire S40 1SX, UK. E-mail: stephen.searle@highpeakanddalespct.nhs.uk

Reference
1 http://www.mhra.gov.uk [following Lara-Torre E, Edwards CP, Perlman S, Hertweck SP, Bone mineral density in adolescent females using depot medroxyprogesterone acetate, *J Pediatr Adolesc Gynecol* 2004; **17**: 17–21].

Stop 'QOFing' and moaning; start lobbying!

Following on from my last rant,[1] I feel compelled to write again to represent another view from primary care. Dr Bugerem dismisses the incentive scheme operating in general practice under the new contract that is the Quality and Outcomes Framework (QOF), and notes many of these incentives relate to chronic disease management but not sexual health.[2] I do not subscribe to the comparison of QOF to 'loyalty points'. For a start, you *earn* money with QoF, whereas you have to *spend* money to get the latter!

The strength of the QOF is it rewards practices for achieving prescribed outcomes such as target blood pressures and cholesterol levels, not merely the process of intervention such as measuring blood pressure or cholesterol. The fact that many GPs are exceeding their aspirations on QOF targets is a victory for public health and chronic diseases management.

One thing I do agree with Dr Bugerem is the lack of incentives for provision of sexual health care; this is an issue that the Royal College of General Practitioner's Sex, Drugs and HIV Task Group have been working hard to raise with the GP contract negotiators. Separating sexual health from the core contract to an enhanced service only discourages GPs to offer even the most basic of sexual health care and promotion such as contraception. Merely having policies on preconceptual advice and emergency contraception is not adequate to achieve sexual health outcomes aspired to in the National Strategy for Sexual Health and HIV.[3] Under the old contract, any contraception activity enabled us to claim the contraception fee, which was worth about £17 per patient per year; QOF points relating to contraception are only worth £240 for an average practice of 5000 patients in the 2005/2006 financial year.

Sexual health promotion such as contraception advice, screening for sexually transmitted infections and use of long-acting reversible contraceptives are effective in reducing sexual ill health and unwanted pregnancies. GPs with an interest in sexual health should be joining forces to lobby the GP contract negotiators; sexual health work should be recognised in the core contract and QOF.

We should all stop moaning and start lobbying!

Jenny Talia, MSc, MRCGP
GP, Pastures Green, UK

References
1 Talia, J. Sexual health delivery in general practice (Letter). *J Fam Plann Reprod Health Care* 2005; **31**: 82.
2 Bugerem, G. View from primary care: what a load of 'QoF'. *J Fam Plann Reprod Health Care* 2005; **31**: 160.
3 Department of Health. *National Strategy for Sexual Health and HIV*. London, UK: Department of Health, July 2002. http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SexualHealth/SexualHealthGeneralInformation/SexualHealthGeneralArticle/fs/en?CONTENT_ID=4002168&chk=pmmyeN [Accessed 24 April 2005].