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).

Our practices 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 have had an information campaign 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.

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References


Cerazette for premenstrual tension

It was interesting to read Mr Ali Kabba’s letter published in the October 2004 issue of your Journal on the above subject.1

1. I have prescribed Cerazette® for a small cohort of patients (eight patients) and have found the medium in clinic, patients 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 psychological symptoms and since went on fluorescent 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.

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Reference


Spinal fracture in a young Depo-Provera user

Following the latest alarm1 on the risks of osteoporosis in Depo-Provera® users, a 22-year-old patient 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 premenstrual symptoms within 3 months of starting the treatment. 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 premenstrual symptoms within 3 months of starting the treatment.

She first attended our clinic at ages 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 had not combined pill until changing to Depo-Provera at age 19 years. She now weights 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 cracked the top of the bone scan waiting list and her bone mineral density (BMD) was reported as: *Hip BMD = 1.054 g/cm², % expected for age: 112%. Lunar spine BMD = 0.960, % expected for age: 95%. The result is normal*.

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

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Reference