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 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 request 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 women. We felt it was important to discuss the screening during the pilot study described in my paper.

In the first instance. The idea was to demonstrate to GPs the potential for chlamydia testing. 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 we chose not to involve our reception staff directly in the offer of screening.

With regard to the economic evaluation, as 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.

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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.

I have prescribed Cerazette® for a small cohort of patients (eight patients) (right patients) (until) 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 Miranda, FRCGC, FFPH
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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. Information leaflets 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 we chose not to involve our reception staff directly in the offer of screening.

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 for screening. We felt it was important to discuss the pros and cons of 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.

I agree with regard to the economic evaluation, as 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.

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Reference

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 is as 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 possible relevant point in her medical history was her mother’s muscle wasting disease on the left side of her back. She was a non-smoker, and 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 the results to 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%. Lumbar spine = 0.96, % expected for age: 95%. The result is normal’.

The hospital immediately took her off Depo-Provera due to 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