usual cut off of $\leq 23/30$. Nearly one eighth of those scoring $\leq 23/30$ were suffering from functional illnesses.¹

The lack of national guidance on this matter is probably due to an understanding that the methodology of cognitive screening in the community is neither sufficiently sophisticated nor proved to be effective, as well as of the difficulties of diagnosing early dementia.⁵ The abbreviated mental test score proposed by the Alzheimer's Disease Society works well in hospital settings. Two problems detract from its use in community screening. One is that all short tests (about 10 questions) suffer from a more pronounced "ceiling effect" than longer scores (such as the mini-mental state examination), whereby many patients with mild cognitive impairment may score no errors.⁶ The second problem is that the abbreviated mental test asks the patient to recognise two people—a question of limited utility in the homes of the many older people living alone. The recognition of organic brain disease in elderly patients by general practitioners virtually quadrupled from 15% in 1964 to 58% in 1988.⁵ This occurred in the absence of community screening. It is worth waiting for more research on the topic before recommending any particular mental test score for community screening for cognitive impairment.

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EDITOR,—Simon Winner and Simon Plint emphasise the importance of coordinating medical and social services assessments in the light of the NHS and Community Care Act.¹ We agree with this in principle, but not all general practitioners share this view.

General practitioners' terms of service require them to determine whether a client needs to be offered general medical services. Some general practitioners hold the view (expressed by the General Medical Services Committee in its recent discussions with the Department of Health) that extra work undertaken in helping clients to get community care needs to be separately identified and costed. It is against this background that we are developing our approach to the health check for those over 75.

Locally we are working to ensure sharing of intelligence and compatibility between the assessment of those over 75 and community care assessments by making representations to the multi-disciplinary groups developing referral and assessment instruments. Both we and our local authority colleagues are aware of the need for cross matching to avoid duplications.

In our experience the assessment of those over 75 rarely provides the first indication that community care services might be required. In view of this we have asked social services to provide clear information on pathways to services for use in everyday practice rather than concentrating solely on following up on the health check. Like Winner and Plint, we have been impressed by the OxCASSE health check schedule, but we believe that a less cumbersome and more sensitive tool may be more appropriate locally.

We have a strong commitment to an oppor-

tunistic approach and interest in improving uptake of services in areas of unmet need, such as dental, audiological, psychological, and continence services. Socioeconomic deprivation is considerable in the boroughs we serve. This leads many clients to have a low expectation of services, which in turn leads to underexpressed need: contacts with social services in particular tend to be limited to crisis intervention.

To break this cycle we need to adopt a surveillance schedule that will show unexpressed need and indicate where minor interventions will lead to substantial improvement. The latter kind of intelligence will not be generated on, for example, mobility by applying the Barthel scale. Another deficiency lies in the possible iatrogenic effects of using an abbreviated mental test score.

For these reasons we are looking at a range of assessment tools that combine sensitivity and acceptability to practices and elderly people. We want to discover whether the patient is a carer, whether there are needs specific to ethnic minorities, and whether we can prevent accidents by identifying environmental risks at home. We believe that the OxCASSE check is too complex and insufficiently focused on the needs of an inner city population.

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Mild cervical cytological abnormalities

EDITOR,—Mahmood I Shafi and colleagues' editorial on mild cervical cytological abnormalities attempts to reassure clinicians that cytological surveillance is adequate management.¹ Indeed, this seems a definitive statement. We agree with it in so far as it applies to cooperative patients in the general population, with a fail safe system of follow up. In the high risk group who attend genitourinary clinics with genital warts, however, this philosophy may not be adequate.

We offer colposcopic assessment of the cervix to patients seen in our department with genital warts. Altogether 428 patients (mean age 22) with negative results of cervical smear tests had colposcopy and punch biopsy. One hundred and forty six had cervical intraepithelial neoplasia, of whom 72 had grade I disease, 62 grade II, and 12 grade III or worse. Five patients had invasive carcinoma of the cervix. Three of them had a normal looking cervix on routine examination and would have been missed in the early stage if colposcopy had not been done. A further 56 patients with mild cytological abnormality had colposcopy; 17 had grade I cervical intraepithelial neoplasia, 18 grade II, and nine grade III or microinvasive carcinoma; 12 showed no cervical intraepithelial neoplasia.

If we had relied on cervical smear testing alone we would have missed a third of the cases of cervical intraepithelial neoplasia in our group. In fact, 74 of these patients had grade II or worse disease. It is well recognised that asymptomatic disease is more likely to be small volume. Thus the morbidity and mortality will be much lower. In patients with mild cytological abnormality almost half had grade II or worse disease. As we do not yet know the natural progression of the disease, colposcopic assessment in this group is more pressing.

We believe that the high risk, highly mobile patients mainly below the age of 25 with mild cytological abnormalities merit colposcopic examination of the cervix. We also believe that

patients with genital warts should be offered colposcopy. As most genitourinary departments now have the facility and skill for this investigation this group should not be a drain on the available resources.

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Euthanasia

EDITOR,—We have followed with interest the case of Dr Nigel Cox and the subsequent debate and correspondence on euthanasia in the lay and medical press.^{1,2} Physicians, anaesthetists, general practitioners, and many others have felt moved to comment, but psychological and psychiatric perspectives seem to have been neglected. Many patients with chronic pain also become concurrently depressed, and severe depression may intensify the experience of pain, making life not worth living.

Evidence of psychiatric assessment was not provided in this case. As Eric Wilkes points out (17 October), there are many complex reasons for requesting euthanasia. Nevertheless, without adequate psychiatric assessment or consultation with other experts in disciplines such as palliative care and anaesthetics (and appropriate intervention within these areas), we believe it hard to defend the actions of a doctor from only one discipline making a euthanasia decision. Euthanasia may appear the only humane option to a family faced with the apparent hopelessness of the patient's position and unaware that other forms of care, support, and treatment might be of considerable benefit.

The Mental Health Act was in part devised to protect the rights of patients in a suicidal state. The act requires that assessments of the patient are made by two doctors and a social worker, to protect the patient against the potentially unrepresentative views of some doctors and also distraught relatives. Here the purpose is to save life against the wishes of the patient. An act should be even more rigorous if life is to be terminated.

Although this is an oversimplified view of the multidisciplinary requirements of the Mental Health Act, our point is that other independent professionals should be involved in the consideration of euthanasia (which, unlike sectioning is irreversible). If the moral argument for euthanasia is won and the law is changed, the opinion of just one doctor and the relatives could potentially be inappropriate.

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Oestrogen replacement therapy after hysterectomy

EDITOR,—Tony Seeley reports a study to identify women who might benefit from oestrogen replacement after hysterectomy.¹ I have conducted a similar study, whose results reinforce his findings.

I aimed to inform women who had undergone hysterectomy with preservation of the ovaries of