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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- 1 Harris A. Health checks for people over 75. *BMJ* 1992;305:599-60. (12 September.)
- 2 Barker A, Betmouni S, Harrison M, Jones R. Health checks for people over 75. *BMJ* 1992;305:1098-9. (31 October.)
- 3 Canadian Task Force on Periodic Health Evaluation. Periodic health examination, 1991 update. 1. Screening for cognitive impairment in the elderly. *Can Med Assoc J* 1991;144:425-31.
- 4 O'Connor DW, Pollitt PA, Hyde JB, Fellows JL, Miller ND, Brook CPB, et al. The reliability and validity of the mini-mental state in a British community survey. *J Psychiatr Res* 1989;23:87-96.
- 5 O'Neill D, Surmon DJ, Wilcock GK. Longitudinal assessment of memory disorders. *Age Ageing* (in press.)
- 6 Blessed G, Black SE, Butler T, Kay DWK. The diagnosis of dementia in the elderly. *Br J Psychiatry* 1991;159:193-8.

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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- 1 Dyer C. Rheumatologist convicted of attempted murder. *BMJ* 1992;305:731. (26 September.)
- 2 Correspondence. Euthanasia. *BMJ* 1992;305:951-2, 1224-5. (17 October, 14 November.)

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

the risk of an early menopause and to offer measurement of gonadotrophin concentrations with a view to their starting hormone replacement therapy if appropriate. From October 1991 to March 1992 I studied the general practice population of Oxford Terrace Surgery, Gateshead, a city practice with a list of 10 500.

The notes of all the women aged 50 and under who had had a hysterectomy with conservation of ovaries were extracted. A letter was sent to all those who were not already taking hormone replacement therapy explaining the aims of the study and offering advice and measurement of gonadotrophins. Those women who replied had a serum sample taken by the practice nurse for measurement of the gonadotrophin concentration and were offered a discussion with the doctor of the results, the pros and cons of hormone replacement therapy, and any concerns they had. After consultation all the women with a follicle stimulating hormone concentration >20 U/l were offered unopposed oestrogen therapy.

There were 97 women in the targeted group. Of these, 36 were already taking hormone replacement therapy and four others were excluded from further study (two left the practice during the study, one had Turner's syndrome, and one had adenocarcinoma of the uterus). In the 57 remaining women hysterectomy had been performed for various benign conditions, mostly pelvic inflammatory disease and menorrhagia. Thirty five women (61% of those invited) had their follicle stimulating hormone concentration measured. Eleven of these had concentrations in the menopausal range, of whom seven started oestrogen therapy. A further three women, whose follicle stimulating hormone concentration was not measured, started hormone replacement therapy during the study because of symptoms; this was a result of the interest generated in the practice. Therefore, of the 57 women contacted, 11 (19%) were found to be menopausal and 10 (18%) started hormone replacement therapy as a result of the study.

Both studies show a high level of interest from the women concerned. These women are often discharged from follow up by gynaecologists. Without the vigilance of general practitioners such women may fail to receive treatment that may have an important impact on their future health.

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1 Seeley T. Oestrogen replacement therapy after hysterectomy. *BMJ* 1992;305:811-2. (3 October.)

Avoiding injuries in theatre

EDITOR,—We welcome T H Taylor's editorial on injuries in theatre.¹ We would like the concept of teamwork and collective responsibility to be implemented. Patients treated in theatre are at the mercy of a complex extended team: ward staff, porters, theatre and recovery room nurses, operating department assistants, anaesthetists, surgeons, sterile supply and laundry staff, blood transfusion staff, engineers, and cleaners; yet the spotlight is traditionally only on doctors. When complications occur the entire theatre team should be reviewed. The failings of one group may lead another group to cause injury to the patient. Surgeons and anaesthetists may fail because of substandard instruments or unpredictable assistants or blood banks. Recovery room nurses will not pick up danger signs early if they are handling more patients than they should. Well integrated, coordinated, and audited service from all groups will raise overall standards and reduce complications.

We are worried by the growing pressure to do

much more with much less in terms of resources. There is a minimum staffing structure below which the safety of patients and staff is compromised. We hope that theatre directors will monitor developments. Dedicated night staff increase safety. No theatre (anaesthesia) team must ever be made up of people who are all on call for 24 hours or longer. A plastic surgery theatre team worked all night to save a limb, having worked on routine cases during the day. High theatre temperatures were required, and the anaesthetist struggled to stay awake. He repeatedly had to leave the theatre to cool down and wake up, knowing that safety is normally jeopardised when the anaesthetist leaves a patient.² Much more alarming was the finding after an anaesthetist fell asleep that nobody had been watching the patient. Two theatre nurses had also succumbed to sleep. The surgeon and his assistant were busy looking down the microscope.

If staff have to be on call then at least one team member must not be on duty for more than 12 hours to be fresh enough to deal energetically with all emergencies, including waking up dozing staff. No amount of monitoring and skill and no safety record can save a patient from injury if the anaesthetist is absent (asleep).

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2 Association of Anaesthetists of Great Britain and Ireland. *Recommendations for standards of monitoring during anaesthesia and recovery*. London: Association of Anaesthetists, 1988.

Urodynamic investigation in elderly women

EDITOR,—Declan P Keane and colleagues' observation that few elderly women are referred for urodynamic investigation does not surprise us.¹ Many geriatricians and continence advisers dealing with incontinent elderly women do not request these investigations routinely even when they are readily available; we do not believe that they appreciably alter our management of these patients.

Urinary incontinence in elderly people is usually multifactorial, and the management protocol for each patient needs to be planned after a careful history has been taken from the patient, the carer, and other witnesses, supplemented by a physical examination and information from a frequency-volume chart. This approach is time consuming but less invasive and time consuming than routine urodynamic investigation. We are not aware of any study that has shown elderly incontinent women who have had a routine urodynamic investigation to be any more likely to regain continence than elderly incontinent women assessed by an interested clinician (nurse or doctor) without urodynamic investigation.

We suggest that urodynamic investigation in elderly women (aged over 75) should be reserved for those who have had an adequate trial of conservative management and are being considered for surgical management. In our clinic conservative management includes advice on the most appropriate toileting regimen, pelvic floor exercises, review of current drug treatment, and, often, a trial of oxybutynin. We normally expect at least three quarters of our patients to be continent again within three months of conservative management; the main role of the continence service during this period is to educate the patient in managing her continence problems.

From our experience over the past eight years we

expect to perform urodynamic investigations on only one or two incontinent elderly women each year in our district. Such investigations tend mainly to be done to assess patients being included in research protocols.

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1 Keane DP, Eckford SD, Shepherd AM, Abrams P. Referral patterns and diagnoses in women attending a urodynamic unit. *BMJ* 1992;305:808-9. (3 October.)

Boxing injuries

EDITOR,—So the BMA wants evidence of boxing injuries.¹ Medical school boxing clubs were just petering out when I started my training and Dr Edith Summerskill was leading the antiboxing brigade. A small but vocal lobby, with some neurologists strongly represented, has continued the campaign ever since.

Silver has reported 63 cases of severe paralysis resulting from rugby football between 1952 and 1982 in one series.² If neurologists believe that a sport should be banned if it causes serious injuries are these not serious enough? Glasgow neurosurgery unit reported 14 depressed skull fractures, several in children, caused by golf balls or clubs over five years'; has the BMA a group seeking to ban golf?

The many racing drivers, mountaineers, skiers, yachters, hang gliders, etc who die presumably cause concern to neurologists too as they are brain stem dead. But no, it is always boxing. Why? I have heard people say that it is because the injuries are deliberate. It is surely disgraceful to suggest that a boxer is trying to inflict a permanent injury on his opponent any more than the rugby player who collapses a scrum, the ice hockey player who "takes out" an opponent, or those who hurl a rock hard ball at 90 miles an hour at a tail end batsman and call it a bouncer. But if this is the reason the issue is a moral one, not a medical one; surely doctors do not set themselves up as experts on morals.

The BMA's comments will not affect professional boxing, but for three decades I have admired the work of countless ordinary men and women in equipping, training, transporting, feeding, matching, and judging young amateur boxers, who nowadays wear headguards. By teaching often disadvantaged young people fitness and self control and giving them a sense of achievement, supported by doctors at all levels, they earn gratitude from social workers and the police and brickbats from the BMA. Many sporting activities include an element of danger: caving and climbing risk the lives of rescuers as well.

Is it not time that these gifted and important doctors turned their energies to more important and relevant matters? How about fishing, now that a fisherman has died of Weil's disease?

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1 Beecham L. BMA wants evidence of boxing injuries. *BMJ* 1992;305:895. (10 October.)

2 Silver JR. Injuries of the spine sustained in rugby. *BMJ* 1984;288:37-43.

3 Lindsay KW, McLatchie G, Jennett B. Serious head injury in sport. *BMJ* 1980;281:789-91.