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 the 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 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 also postion 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.

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Reference

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.

I have prescribed Cerazette® for a small cohort of patients (eight patients) in my PMX/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.

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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 of ours was admitted in January 2005 with a fractured vertebra following low-impact trauma. She had been taking Depo-Provera for almost 3 years. She had had irregular menstrual spotting only with no actual bleeding as is common with this treatment; the other patients, despite an improvement in their symptoms, had irregular cycles.

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Stop ‘QOFin’ 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 Bugerum 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 does not comment on the QOF’s targets.¹ I do not agree with 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 practitioners 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 disease management.

One thing I do agree with Dr Bugerum 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 preconception advice and emergency contraception is not adequate to achieve sexual health outcomes aspired to in the National Strategy for Sexual Health and HIV.² 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 is effective in reducing sexual all 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, MBChBP
GP, Pastures Green, UK

References

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Following the latest alarm¹ 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 taking Depo-Provera for almost 3 years. She had had irregular menstrual spotting only with no actual bleeding as is common with this treatment; the other patients, despite an improvement in their symptoms, had irregular cycles.

She first attended our clinics at age 15 years and she has a body mass index of 29. She stopped 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/cm², % expected for age: 112%. Lumbar spine BMD = 0.980 g/cm², % 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?

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