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LETTERS

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ALL ABOUT POLYCLINICS

What is and what is not a polyclinic

I was shocked to see the polyclinic in Hove hailed as an example of one of the only polyclinics in the country.¹ I strongly supported the principle in the early 1990s, obtaining funding from the then regional health authority to build it, but it developed as far from the polyclinic concept as you will find.

The original concept was a new large general practice in Hove incorporating additional space for such luxuries as a hydrotherapy pool, physiotherapy, and outpatient and minor surgery facilities. Local general practitioners were antagonistic because their autonomy was being removed, the concept being sold to them as, "Would you like your patients to be seen at Dr Higson's surgery for their outpatient appointment?" Local health service managers lacked enthusiasm for a building with only one room for a manager. I therefore declined the funding and passed the monies to the local community trust.

The development that resulted was a building of useless spaces, with a whole floor devoted to management and support services and a small outpatient physiotherapy department, x ray department, and health visitor clinics. Some rooms were built for consultant outpatients but none to incorporate primary care. On subsequently applying to open a general practice in the polyclinic, I was refused access on various nebulous grounds.

The current arguments about the development of a polyclinic culture reek of a surgeon believing that general practitioners can work together and share ethic—this is rarely possible. The advantages of a polyclinic do not need all general practices to relocate to provide the same benefit.

I proposed the concept of a "virtual polyclinic" to all general practitioners in Hove in the late '80s, and it is still appropriate today.

This is the development of a central administrative centre that can provide services such as diagnostics, physiotherapy, outpatient services, and minor surgery facilities, together with responsibility for running the local computer database and centralised trend analysis to aid planning. Electronic data linkages will be made to local general practices serving a local population and need. Hence local practices can still exist but perhaps with fewer staffing overheads as appointment systems and data services are provided by the polyclinic. This maintains local provision of service while reducing the massive costs of an excessively large new-build and maintains "ownership" by the general practitioners both of their premises and of cooperative working without the need to work together. As practices evolve with time, some may elect to move to the same site as the centralised unit while others may determine their affection is elsewhere.

There is no one solution, but the enforced move of the majority of practices to polyclinic sites without the ownership and enthusiasm of those practices will be detrimental to the quality and quantity of health care provided by medical practitioners.

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Competing interests: None declared.

1 Finch R. When is a polyclinic not a polyclinic? *BMJ* 2008;336:916-8. (26 April.)

Community hospitals are polyclinics by another name

When I read the article by Finch,¹ I realised that our trust, and many other rural trusts, has been running polyclinics for decades—except we call them community hospitals. We run 11 of these in small Dorset market towns. They are usually within a few hundred metres of the local general practice, and the general practitioners are variously involved from managing beds, doing minor operations lists, gastroscopy sessions, etc. Consultants from all the local hospitals run clinics in the community hospitals, and surgeons perform a sizeable number of operations there. Several of the hospitals have small mental health inpatient units with community mental health units based

there. The hospitals provide physiotherapy, occupational therapy, and a range of diagnostic services. Many elderly patients can be investigated or, if necessary, admitted which prevents admissions to acute hospitals and the small size allows innovative joint working between old age medicine and psychiatry.

Perhaps the most important thing is they are hugely popular with staff and patients alike, and hospital friends' groups have raised sums in excess of a million pounds to invest in a local hospital for which they feel a real sense of ownership. If polyclinics are to become a successful development, perhaps the key is to create them only when there can be clear benefits for patients, primary care, and secondary care, and for all three groups to participate in the planning and design from the outset.

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1 Finch R. When is a polyclinic not a polyclinic? *BMJ* 2008;336:916-8. (26 April.)

Where is the money for Darzi centres coming from?

Whether the money allocated to Darzi centres will be totally new money or come out of existing primary care funding remains unclear.¹ In my locality, general practitioners have been told that there is no new money for this purpose. Therefore the Darzi centre will directly compete with existing practices for patients, and some practices will inevitably be forced to close.

Who will staff the Darzi centres is also unclear. The centres will be put out to tender, and if the tenders are awarded to private firms, completely different models of health care could be imposed that need not involve general practitioners or even doctors at any time.

Much depends on the contractual agreements with individual primary care trusts, and whether authority trusts will have to ensure that the services are maintained to the standards expected of existing practices, or even whether trusts would deem current clinical governance procedures relevant or applicable to a centre operating under a different model of healthcare provision.

Furthermore, private organisations must operate at a profit and are under no obligation

to recognise any trade unions or offer the usual NHS rates of pay.

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- 1 Eaton L. Polyclinics could close 1700 general practices, Conservatives claim. *BMJ* 2008;336:907-a. (26 April.)

Should “policlinics” replace “polyclinics”?

The spellcheckers of my English and French computers accept both polyclinic and policlinic. Etymology suggests that the focus of polyclinic is the multiple competences of the health professionals while that of policlinic (Greek: polis, the town) is proximity. Might spelling influence the current discussions?¹

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- 1 Finch R. When is a polyclinic not a polyclinic? *BMJ* 2008;336:916-8. (26 April.)

HUMAN PAPILLOMAVIRUS VACCINE

Effect of ethnic group should be clarified

One of the most striking findings in the study of Brabin et al on the uptake of human papillomavirus (HPV) vaccine by schoolgirls was the apparent effect of ethnic group on compliance with vaccination.¹ The accompanying editorial also highlighted the possible effect of religion on uptake, two schools having declined to participate in the study on religious grounds.² It would have been interesting to know their religious affiliation.

The apparent effect of ethnic group on vaccine uptake is not clear cut. One can only infer from the article that schoolgirls from “ethnic minority groups” have a lower vaccine uptake.

The effects of ethnic group and possibly religion on vaccine uptake are potentially important findings. They suggest that the successful implementation of the national HPV vaccine programme may vary across the United Kingdom according to local variation in demography. That the authors did not provide a more detailed exposition of their findings was therefore disappointing. The collective term “ethnic minority” lacks precision. The latest UK population census contained no less than 16 ethnic groupings.³

Whether the research questionnaire gathered data on ethnicity on an individual basis is also not clear. These data would be helpful to the authorities that are to introduce the vaccine, especially in cities such as London, where in 2003 about 40% of the population was not classified as “white British.”⁴

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- 1 Brabin L, Roberts SA, Stretch R, Baxter D, Chambers G, Kitchener H, et al. Uptake of first two doses of human papillomavirus vaccine by adolescent schoolgirls in Manchester: prospective cohort study. *BMJ* 2008;336:1056-8. (10 May.)
- 2 Waller J, Wardle J. HPV vaccination in the UK. *BMJ* 2008;336:1028-9.
- 3 Bosveld K, Connolly H, Rendall MS. *A guide to comparing 1991 and 2001 census ethnic group data*. London: Office for National Statistics 2006. www.statistics.gov.uk/CCI/article.asp?ID=1471&Pos=2&ColRank=1&Rank=224
- 4 Large P, Ghosh K. Estimates of the population by ethnic group for the areas within England. *Population Trends* 2006;124:8-17.

Some issues around consent remain unresolved

Brabin et al’s success in achieving an uptake of 70% of two doses of human papillomavirus vaccine among adolescent schoolgirls is extremely encouraging.¹ However, this pilot study has raised important issues that will need to be addressed before the vaccination programme is rolled out nationally.

Guidance is currently ambiguous in situations where there is a disagreement between a parent and child’s decision about vaccination. Parental opinion is divided as to whether a girl should be able to seek the vaccine without parental knowledge.² The principle of “Gillick competence” might apply if a girl sufficiently understands the concepts involved and wishes to make the decision for herself.³ However, given that the long term effects of this vaccine are not known, is it safe for children to be vaccinated without those with parental responsibility knowing? Furthermore, would it be ethical to apply Gillick competence in such a setting?

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- 1 Brabin L, Roberts SA, Stretch R, Baxter D, Chambers G, Kitchener H, et al. Uptake of first two doses of human papillomavirus vaccine by adolescent schoolgirls in Manchester: prospective cohort study. *BMJ* 2008;336:1056-8. (10 May.)
- 2 Brabin L, Roberts SA, Kitchener HC. A semi-qualitative study of attitudes to vaccinating adolescents against human papillomavirus without parental consent. *BMC Public Health* 2007;7:20.
- 3 Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security¹⁹⁸³ 3 WLR (QB).

EVERYONE’S A RADIOLOGIST NOW

Shift training from NHS trusts to skills laboratories . . .

Wise’s article is timely.¹ All ultrasound trainees currently require a clinical placement that is supported by specialist trainers and these are typically situated in NHS trusts. Where these placements already exist, there is already

“competition” for machine time for training by sonographers and specialist trainees in radiology. Access to ultrasound systems for training is also becoming increasingly difficult in the target driven NHS, and no workforce planning for sonographers has been done, with a resultant national shortage. Non-radiology medics with an interest in ultrasound are therefore finding it difficult to obtain clinical training.

The approach to early clinical training needs to shift away from the NHS trusts. This is achievable if a skills laboratory is used. This allows trainees to acquire basic ultrasound scanning and interpretive skills under the guidance of expert trainers in a relaxed environment outwith busy NHS trusts, using human models who have given informed consent for scanning. They can then move into clinical practice in the hospital setting with a degree of proficiency to obtain true clinical experience of cases under supervision until signed off as competent. This model is being used to good effect in this university for training of sonographers, radiologists, urologists, nephrologists, and physiotherapists. A national strategy is required to support the development of these skills laboratories to ensure that the ever increasing demand for ultrasound training can be met.

Ultrasound scanning requires good manual dexterity and spatial awareness. In conventional ultrasound scanning, the operator has to obtain scan planes and must reconstruct a three-dimensional reconstruction of the body structures in their mind. Some people are not able to develop these skills and are therefore never able to practise ultrasound competently. It is essential that anyone who picks up a probe is properly trained and assessed to ensure patient safety. **Julie Michelle Walton**, senior lecturer, head of ultrasound training, School of Health Sciences, Faculty of Medicine, University of Liverpool, Liverpool L69 3GB
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Competing interests: None declared.

- 1 Wise J. Everyone’s a radiologist now. *BMJ* 2008;336:1041-3. (10 May.)

. . . and maintain competency

Given the effectiveness of ultrasound scanning as a clinical tool it is perhaps inevitable in the long term that market forces will drive the increasingly compact ultrasound devices into wards and surgeries to be used routinely by physicians and general practitioners. However, Wise does not mention that ultrasound scanning is a modality where the accurate reporting of an abnormal finding depends on the confidence of the operator.^{1 2} This in turn is reliant on maintaining skills by using ultrasound regularly as part of daily clinical practice. An ad hoc approach to maintain the necessary required standard would not suffice and, on the contrary, would generate

unnecessary further imaging.

Furthermore, radiologists' ultrasound skills are continuously honed in the department by correlating ultrasound findings with computed tomography and magnetic resonance imaging, as well as case discussions in multidisciplinary team meetings, where both positive and negative feedback is of educational merit. The main concern with the explosion of ultrasound as a diagnostic tool is not if non-radiologists are adequately trained, but whether the necessary competency can be maintained.

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- Competing interests: None declared.
- 1 Wise J. Everyone's a radiologist now. *BMJ* 2008;336:1041-3. (10 May.)
 - 2 Jang T, Naunheim R, Sineff S, Aubin C. Operator confidence correlates with more accurate abdominal ultrasounds by emergency medicine residents. *J Emerg Med* 2007;33:175-9.

ELECTRONIC HEALTH RECORDS

Massive change is driven by generations X and Y

Microsoft's HealthVault and Google Health are on the cusp, but more and massive changes may be expected in the future. It is not just health records that consumers are wanting access to. They want to know about similar patients and more information on their drug combinations. Patients like me (www.patientslikeme.com/), DoubleCheckMD (www.doublecheckmd.com/), PharmaSurveyor (www.pharmasurveyor.com), and Drug Interaction Database Online (<https://druginteractions.epnet.com/>) allow individuals (and doctors) to mine huge amounts of information to assess their own drug combinations.

I disagree with Kidd in that I do not think the NHS's Connecting for Health initiatives, the summary care record and HealthSpace, are too little too late.¹ This space is fluid and fast moving and, currently, personally controlled health records and consumer empowerment will continue to grow exponentially.^{2 3}

I agree with Kidd, however, that with increased use of technology and the internet in the community, the power has shifted to the consumer. The new technologies with the new applications will push the uptake of information and communication technology in the health sector. Generation Y, for example, is immersed in this technology, readily using Web 2.0 and mobile technologies. The convergence of technology is moving so fast and the benefits for the doctor and patient are immense. Twitter (<http://twitter.com>, a social networking tool) is an example of increased technology and increased sophistication of use of the internet

in the community. It is a micro blogging tool that could solve much inefficiency for free. For years, hospitals have been weighing up technologies to get point of care details into a live database. Now, by using a mobile phone (no wireless network needed), health professionals can push short messages to a micro blog site for many different users to see and analyse the information. I won't even mention the impact of the iPhone. . .

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Competing interests: None declared.

- 1 Kidd MR. Personal electronic health records: MySpace or HealthSpace? *BMJ* 2008;336:1029-30. (10 May.)
- 2 Mandl KD, Kohane IS. Tectonic shifts in the health information economy. *N Engl J Med* 2008;358:1732-7.
- 3 Steinbrook R. Personally controlled online health data—the next big thing in medical care? *N Engl J Med* 2008;358:1653-6.

Access to your own GP record is available now

It is disappointing that technical difficulties contributed to poor uptake.¹ The pilots corroborate experience in Scotland and elsewhere that most people are happy to have their records shared, particularly those with certain conditions—they immediately see the benefits. Currently, both Microsoft and Google are offering the same facility as HealthSpace: patients can upload information that they currently hold about their health to secure vaults and share that with whomever they wish. In this study, few people wanted to do that. However, we do know, as Kidd points out, that patients are keen to have access to their full record, in order to see results, letters and consultation records.

This facility has been available to patients in all EMIS practices for a year or so.² Patients individually authenticate themselves and, on a web browser anywhere in the world, can see their full GP record reformatted so that it is easier to navigate around. In addition, the data are automatically linked with health information so that readers can understand better what they read. It may soon be possible to add Web 2.0 options.

Forty practices have registered to offer this free service. Initial (as yet unpublished) research commissioned by NHS Connecting for Health shows that patients are enthusiastic and using it in ways that we had not anticipated.

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Competing interests: BHF is co-director of PAERS Limited, which enables patients to see their full GP record online. He is also funded by EMIS as record access collaborative lead, bringing people together around the world who are interested in patient record access.

- 1 Kidd MR. Personal electronic health records: MySpace or HealthSpace? *BMJ* 2008;336:1029-30. (10 May.)
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RICHARD J GREENS PCL

BLOODY DIARRHOEA

Test early for verotoxin producing *Escherichia coli*

Murphy's article on the management of bloody diarrhoea in children in primary care (and indeed his interests, judging from his reference 1) seems to be orientated towards the early diagnosis and treatment of inflammatory bowel disease.¹ Some of his recommendations, however, particularly figure 1, should therefore be expanded so as not to be problematic for the management of infection, in general, and verotoxin producing *Escherichia coli* O157, in particular.

Surveillance based on a GP sentinel scheme in Wales showed an incidence of bloody diarrhoea of 30/100 000 in under 15 year olds, 80% of which was caused by either salmonella or campylobacter infection,² in line with Murphy's estimates. Recognised infection with verotoxin producing *E coli* O157 is rare (1-2/100 000 per year in Wales), but early diagnosis—which, contrary to table 2, can usually be achieved by stool culture—is important:

- Spread occurs readily in household³ and similar settings (such as children's nurseries⁴) and affects primarily young children who are at high risk of developing life threatening haemolytic uraemic syndrome (HUS).⁵
- Diagnosis is a contraindication for antibiotic therapy and antimotility therapy
- Outbreak detection is facilitated and thereby, hopefully, further cases are prevented.

The risk of household spread of verotoxin producing *E coli* O157 and its serious complications may be sufficient in certain circumstances (such as a young child in nappies with a similarly young sibling) to merit promptly admitting a child to hospital (or in some other way separating them from their siblings⁵) even if they are passing less than six bloody stools a day. Suspicion of the diagnosis, on clinical grounds such as severe abdominal pain or epidemiological grounds such as a history of contact with farm animals, even with no bloody stools (which may occur

in less than 50% of cases), should lead to urgent steps to establish the diagnosis and communication with public health services, to ensure that urgent action is taken to prevent further cases.

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Competing interests: None declared.

- 1 Murphy MS. Management of bloody diarrhoea in children in primary care. *BMJ* 2008;336:1010-5. (3 May.)
- 2 Chalmers RM, Salmon RL. Primary care surveillance for acute bloody diarrhea, Wales. *Emerg Inf Dis* 2000;6:412-4.
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COMPRESSION STOCKINGS

We need to look critically at evidence for universal use

The article by Phillips et al is yet another so called evidence based report that fails to appreciate the clinical aspect of thromboembolism.¹ The report mentions only the incidence of the surrogate outcome measure of asymptomatic venous thromboembolism. Clinical outcomes of clinical deep vein thrombosis, pulmonary embolism, and mortality are not mentioned.

The authors have not used clinically relevant outcomes. They are incorrect to state without reference that asymptomatic venous thrombosis often gives rise to long term morbidity. This is contrary to published evidence in orthopaedics, according to which such asymptomatic thrombi resolve without any associated morbidity.²

In orthopaedics there is lamentable evidence about the efficacy of graduated compression stockings. The four studies on orthopaedic patients in the Cochrane review entailed a total of only 316 participants.³ A reduction in asymptomatic thrombosis was noted but no clinical benefits recorded. A later, more detailed study of 795 participants found no benefit for compression stockings.⁴

Phillips et al recommend the universal use of compression stockings and the incorporation of measures of their use into hospital quality assessment measures.¹ This conclusion is seriously flawed. The widespread use of such measures would cost the health service millions



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of pounds to supply the stockings and provide assistance in applying such stockings. Good quality large and independently conducted randomised trials are urgently needed to evaluate the effectiveness of such measures before we make dramatic and unsupported statements about their use.

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Competing interests: None declared.

- 1 Phillips SM, Gallagher M, Buchan H. Use graduated compression stockings postoperatively to prevent deep vein thrombosis. *BMJ* 2008;336:943-4. (26 April.)
- 2 Kim YH, Oh SH, Kim JS. Incidence and natural history of deep-vein thrombosis after hip arthroplasty. *J Bone Joint Surg Br* 2003;85-B:661-5.
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- 4 Cohen AT, Skinner JA, Warwick D, Brenkel I. The use of graduated compression stockings in association with fondaparinux in surgery of the hip. *J Bone Joint Surg Br* 2007;89-B:887-92.

REPRODUCTIVE LIBERTY AND DEAFNESS

Outlawing selection is move against discrimination

As someone who has been deaf since birth and experienced many problems stemming from his hearing loss, including a threatened attempt by his local authority to take him into care after his parents refused to teach him to sign, I believe Emery et al are completely misguided in calling for deaf people to be allowed to select deaf embryos.¹

From my experience, being deaf automatically condemns you to life as a second class citizen, whether from inability to access facilities on the same level as everyone else (depressingly few trains have visual substitutes for verbal announcements, for example) or from casual derogation by other people (as a child, I vividly remember being taunted about having AIDS—hearing aids). The anti-discrimination policies adopted by the current government have made large strides in reversing some of these inequalities and helping deaf people establish equal opportunities and equal access. However, there is only so much

anti-discrimination legislation can achieve.

If deaf parents are allowed to actively condemn their children to deafness then we are allowing this difficult state of life to be perpetuated. By preventing deaf embryos from being selected, we are reducing the number of people who are deaf and therefore reducing the number of people who experience discrimination. The low numbers of people actively wanting deaf children that Emery et al cite is, to my mind, evidence that deaf people do not want their children to have the same negative experiences as they have had.

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Competing interests: SS has been profoundly deaf since birth.

- 1 Emery S, Blankmeyer Burke T, Middleton A, Belk R, Turner G. Clause 14(4)(9) of embryo bill should be amended or deleted. *BMJ* 2008;336:976. (3 May.)

PREMATURE MENOPAUSE

Hormone replacement therapy is indeed indicated

I strongly disagree with Lewars's conclusion about the use of hormone replacement therapy (HRT) in women with a premature menopause.¹ He is quoting the Women's Health Initiative, which was undertaken in women older than 50 and does not pertain to women in their 30s or even younger with early ovarian failure.

Women with untreated premature menopause are at increased risk of developing osteoporosis, cardiovascular disease, cognitive decline, dementia, and parkinsonism.²⁻³ Therefore, a need for oestrogen replacement exists until the average age of the natural menopause, which is about 52 in the United Kingdom. This does not increase the risk of breast cancer.⁴ The recommendation for HRT use by Jones et al is in accordance with national guidelines.⁵

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Competing interests: None declared.

- 1 Lewars MD. Article's recommendation of HRT is highly questionable. *BMJ* 2008;336:1033-4. (10 May.)
- 2 Rocca WA, Bower JH, Maraganore DM, et al. Increased risk of cognitive impairment or dementia in women who underwent oophorectomy before menopause. *Neurology* 2007;69:1074-83.
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- 5 British Menopause Society Council Consensus Statement. *Premature menopause*. www.thebms.org.uk/statementcontent.php?id=3