accordingly. The advent of HIV infection has obviously forced a reappraisal of this, but as yet we see no reason to alter a system that is working very well. In our experience, people who inject opiates can, and do, change their behaviour for the better, and our philosophy is to enhance and encourage this process; prescribing street drugs inhibits it and hinders the formation of useful therapeutic relationships. Prescribing also creates a situation in which it becomes very difficult or impossible to distinguish between reported and actual behavioural change.

It is completely misleading and unjustified, therefore, to infer that, simply because a medical practitioner does not unquestioningly embark on Dr Greenwood's commonsense approach of prescribing maintenance drugs, there is no medical intervention or that no useful therapeutic work is being done. Quite the opposite, in fact.

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Perimenopausal women's views on hormone replacement therapy

SIR,—In their article Drs Juliet Draper and Martin Roland report the results of their survey in an urban practice of 102 perimenopausal women's views on hormone replacement therapy.¹ I would like to add my experience of a similar postal survey performed in 1989 in a rural practice in Hampshire.

All of the 635 women aged 44-64 (mean age 53 years) were asked their views on hormone replacement therapy; 539 completed this questionnaire—a response rate of 85%. A greater proportion of these women (483, 90%) than of those in the study of Drs Draper and Roland had heard (principally through the media) of hormone replacement therapy to help with the menopause. As in their study this knowledge was associated with being in a higher social class ($\chi^2=29.5$; $p<0.001$). Similarly, the majority of women (356, 66%) perceived the treatment as helping to prevent osteoporosis, and over half (308, 57%) expressed anxiety about possible side effects, the dominant one being an association between hormone replacement therapy and cancer. Unlike in the Cambridge study, however, an interest in receiving treatment was strongly associated with women considering themselves to be in "the change of life" ($\chi^2=64.1$; $p=0.01$) and suffering from important related symptoms ($\chi^2=39.5$; $p<0.001$)—findings similar to those in an American community study.² Also, of the 420 women who had not had a hysterectomy, 169 (40%) said that they were deterred from using hormone replacement therapy by the thought of prolongation of periods after the menopause, with 48 saying that they would consider a hysterectomy as an alternative, whereas less than a fifth of respondents in the study by Drs Draper and Roland regarded continued menstruation as a major drawback.

Past or present use of hormone replacement therapy was not related to social class but was significantly associated with being symptomatic ($\chi^2=46.3$; $p<0.001$), having had a hysterectomy ($\chi^2=13.3$; $p<0.001$), believing that hormone replacement therapy helped to prevent osteoporosis ($\chi^2=4.3$; $p=0.04$), and whether the doctor had been an important source of information about the treatment ($\chi^2=169$; $p<0.001$) but, interestingly, was not associated with a close family history of fracture that suggested osteoporotic risk.

I agree that there seems to be considerable

awareness and interest among perimenopausal women about hormone replacement therapy. However, various problems remain (for example, anxieties regarding cancer and continued menstruation), that need to be carefully addressed in the provision of this service in primary care, and it is not clear whether those at highest risk (for example, those with a family history of fractures) are the ones approaching their general practitioners for this treatment.³

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Use of skin thermometer to diagnose acute appendicitis

SIR,—In his short report Mr J E Hambridge quite rightly states that a substantial percentage of appendicectomies are unnecessary and that tests that increase the accuracy of preoperative diagnosis would help to reduce this risk.¹ We disagree, however, with his concluding comment that his results for skin thermography showed the technique to be of value.

Firstly, we are concerned that he considers a positive result to be a temperature difference of 1°C measured with a thermometer that was accurate only to the nearest degree Celsius. Our main reservations, however, relate to the small size of the groups of patients that were analysed. The difference between the two groups of patients was not significant (using either a χ^2 or even the Fisher exact test), and in addition we think that it is misleading to utilise percentage values with such low patient numbers.

In particular, Mr Hambridge assessed only three patients who had a negative result on appendicectomy. This is surely the precise group of patients on which his paper should have focused, and the fact that all three had negative skin test results is hardly a basis for any useful conclusion. In fact, using the author's own stated figures (eight out of 11 patients with a negative result had appendicitis) a patient with suspected appendicitis and a negative skin test result was probably more likely than not to require surgery. Furthermore, the extremely low negative predictive value of the test (27%) is increased to a more respectable level (78%) only by including results from the control group of 25 orthopaedic patients. This naturally has the effect of reducing the worrying impact of the eight false negative results by attaching a totally separate and different group of patients in whom there is no suspicion of appendicitis whatsoever. We believe that this manoeuvre to increase predictive values and accuracy is methodologically unsound unless, of course, Mr Hambridge is seriously contemplating removing the appendix of those 25 unfortunate patients.

Finally, we are not necessarily discounting the possible value of the skin thermography test in diagnosing appendicitis but merely suggest that larger numbers of patients should be analysed before meaningful conclusions can be drawn.

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General practitioner budget holding

SIR,—I am a partner in a five partner rural practice. We recently expressed an interest in becoming a budget holding practice. Most of the partners did not like the idea, but we decided that we should keep our options open. Hospitals and district health authorities are doing the same thing, and Mr Clarke is grateful for the publicity he can give these expressions of interest. Ballots of hospital workers, however, do not support advancing beyond this stage.

The General Medical Services Committee, commenting on budget holding, makes no mention of the effect this will have on the relationship between general practitioners and consultants. If the consultant's role is going to entail anything more than giving a rubber stamp to a general practitioner's decision that, for example, a hysterectomy is necessary, then the following will occur.

A patient has menorrhagia. The general practitioner will need to telephone various hospitals (although it is possible that hundreds of hospitals will be sending price lists and waiting times every month to all budget holding practices) for prices of outpatient referrals for opinion and tests only. At the same time he or she will ask for prices of referral for opinion and any necessary treatment. A third possibility is opinion and tests in one hospital and treatments in another (for example, another hospital may be offering laser resection of the endometrium). How will consultant A feel about treatment being performed by consultant B? Will consultant B accept consultant A's opinion and tests? All these permutations will need time scales attached to them, and then the general practitioner will need to discuss them with the patient.

The fundamental flaw in the whole market theory is that there are no figures on outcome (success and complication rates). How can I advise patients about the above options without this information? The patient might also want to know how long she is likely to be in hospital and even what the food is like. The general practitioner's only considerations will be price, waiting time, and the distance the patient (and relations) will have to travel.

Further difficulties will occur when a consultant decides that the patient should be seen by another consultant. The first consultant will decide initially to whom that referral should be, but the general practitioner (who will be paying for it) will want to know the cost and perhaps will want to price alternatives and again discuss these options with the patient.

After an inpatient treatment that is chargeable to the budget will the practitioner have any say in follow up outpatient attendances, which will also be charged to the budget? Will a consultant want to check a patient after an operation to repair a hernia? How much say will a general practitioner have in determining whether a patient attends the diabetic clinic for prolonged follow up? Will patients of non-budget holding practices through block contracts from the district health authority have to wait longer than patients of budget holding practices? I can foresee only a chaotic situation. I do not disagree with providing more information about the nuts and bolts of the NHS (for example, referral rates); until basic information is available planning will be unreliable and will lead to the enormous gamble being taken with *Working for Patients*.

There is no evidence to date that patients will benefit from general practitioners holding budgets, and we should therefore, as a group, support hospital workers and refrain from any further discussion about practice budgets. Indeed, district health authorities are relying on data being provided by practices (which apply to hold a budget) during 1990 to help formulate contracts for general