discovered by health unit epidemiologists working with information supplied by the Public Health Branch of the Ontario Ministry of Health. In these records the place of residence of the mother was coded inaccurately or inconsistently, making it impossible to obtain correct counts of live births by geographic area.

To illustrate the error, we compared 2 sources of information for 1994 births, both obtained through the Ontario Ministry of Health: vital statistics birth data for which place of residence was given as within the metropolitan Toronto area and hospital discharge data from the Canadian Institute for Health Information (CIHI) for live births to women residing in Metropolitan Toronto (Table 1).

Although the total number of Metro Toronto births is similar for the 2 sources, the differences among the 6 municipalities are substantial. Similar differences have been found in some rural areas of Central East Ontario. Which figures are correct? And which should be used to support local planning?

In a letter entitled "Error corrected, conclusions the same" (*CMAJ* 1997;157[6]:646-7), Indira Singh of the Ontario Ministry of Consumer and Commercial Relations and Janet Hagey of Statistics Canada acknowledge the birth weight errors in Ontario vital statistics data. They replicate Joseph and Kramer's analysis with corrected data and conclude that there has been a statistically significant increase in low-birth-weight births in Ontario in recent years.

Although this may be true at the provincial level, the apparent errors in geographic coding make it impossible for local health authorities to identify the specific areas where low birth weight is a problem and to take the appropriate remedial action.

Because this information is extremely valuable to health researchers and planners, efforts should be made to set national standards for the collection, management and reporting of these data, so that trends in reproductive health outcomes can be followed at the national, provincial and local levels. Without good local data, the integrity of health planning and program evaluation is jeopardized.

It appears that the time has also come to consider whether the collection and management of such data should be transferred from the provincial Ministry of Consumer and Commercial Relations to the Ministry of Health.

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Received by email

Table 1: Place of residence of mothers for births in the metropolitan Toronto area in 1994, according to data from Ontario vital statistics and Canadian Institute for Health Information (CIHI)*

	Data source; no. of births		
Recorded place of residence	Vital statistics	CIHI	Difference†
City of Toronto	13 400	8 925	4 475
City of East York	503	1 683	1 180
City of Scarborough	8 257	8 518	261
City of York	1 167	2 514	1 347
City of Etobicoke	4 306	4 814	508
City of North York	6 676	8 498	1 822
Total	34 309	34 952	643

*CIHI data has been selected for the calendar year 1994.
†Absolute value.

Debating the management of osteoporosis risk

My experience as a participant in the BC Study of Osteoporosis Risk has been enlightening.

Until slow progressive multiple sclerosis developed 16 years ago, I was physically active and sports oriented. Even when my physical activities became severely limited, I maintained daily yoga exercises. Eventually, even that became impossible, and for the past 6 years I have had quadriplegia. During the time that I have had slow progressive multiple sclerosis, my general practitioner, my neurologist, the research team at the University of British Columbia and even my husband, who is a physician, never broached the possibility of osteoporosis. However, from the ultrasound test I underwent as part of the study, I learned that my bone density is seriously deficient. I reported this information to my doctor immediately and began a program that we hope will impede further deterioration.

In my view, osteoporosis risk assessment is a worthwhile exercise, and I hope its use will be expanded. In a letter returned to the organizers of the BC study along with my participant questionnaire, I suggested that they consider a targeted program for both women and men with impaired mobility, especially those in wheelchairs, since osteoporosis might be a factor in their disability.

Agnes Sovereign
Vernon, BC

[Dr. David Kendler, BC Study of Osteoporosis Risk, responds:]

This letter is typical of many received after the BC Study of Osteoporosis Risk suspended recruitment in January 1997. The study, cosponsored by the Osteoporosis Society of British Columbia, the British Columbia's Women's Hospital, the

BC Hydro Foundation and industry, was designed to investigate the short-term effects of osteoporosis risk assessment on patient behaviour. Over the long term, the study was intended to relate any fractures that occurred to the results of the initial calcaneal ultrasonography and historical risk factors. The trial was considered particularly relevant in BC, where the provincial government has restricted the number of densitometry-testing sites to the 7 that existed in 1994.

The study sought to recruit 10 000 volunteers. Participants were to undergo osteoporosis risk assessment and receive advice on diet and lifestyle modification to reduce their risk of fracture. The risk assessment involved a questionnaire, and participants were informed of historical risk factors along with the results of calcaneal ultrasonography. No drugs or other diagnostic tests were discussed or recommended, and follow-up was by mailed questionnaire. In 10 months 6500 participants were recruited, and the response was universally positive.

In November 1996 a provincial agency, the BC Office of Health Technology Assessment, held a closed meeting to discuss its review of bone densitometry, a report that has never been made public. The office did not request any representation from or information about the BC study. In discussing the study, the office argued that bone densitometry (by dual-energy x-ray absorptiometry [DXA] or ultrasonography) was not a valid tool for risk assessment. In December 1996 and January 1997 a series of newspaper articles stated that fractures are a normal consequence of aging and that risk assessment is therefore unnecessary. Fearful of controversy, hospital administrators decided not to support further recruitment to the trial, although follow-up would be continued. BC residents have since expressed disappointment that their needs for information are not being met.

Over the past year many study participants have asked why people took issue with researching the outcome of osteoporosis risk assessment that promoted good diet, exercise and better lifestyle habits. They have asked whether the calcaneal ultrasound technology was inappropriate. With the passage of a year, we have seen European, US and Canadian osteoporosis societies endorse multifactorial risk assessment, including bone mass measurement (which can be done by calcaneal ultrasonography) — exactly the same process that was done in the BC study. The Food and Drug Administration has now approved the first calcaneal ultrasound instrument for use in the US. At a recent consensus meeting, the Osteoporosis Society of Canada endorsed the use of this instrument in settings such as those arranged for the BC Study of Osteoporosis Risk. Time has answered a lot of the questions raised by opponents of osteoporosis risk assessment.

What we now need are data from studies such as this one to guide us in implementing multifactorial osteoporosis risk assessment for improving patients' behaviour. Only through pioneering initiatives such as this one will we be able to stand up for our patients' right to acquire the personal health information they need to make important decisions about their future.

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Follow-up after endometrial cancer

As radiation oncologists at the BC Cancer Agency, we frequently see patients with endometrial cancer — 221 in 1996 alone. As such, we eagerly read the article "Costs and benefits of routine follow-up after curative treatment for endometrial cancer" (*CMAJ* 1997;157[7]:879-86), by Dr. Olu O. Agboola and colleagues.

We congratulate the authors on a clearly written paper, but we also have a few concerns that were not addressed there.

When considering follow-up, physicians should give thought to the goals of such follow-up and the selection of an appropriate population. The risk of recurrence and the chance of potential curative treatment depend on the tumour and individual patient factors. Treatment recommendations are therefore based on these factors. For example, grade and stage are significant prognostic factors in endometrial cancer and can be used to predict recurrence. The risk of pelvic recurrence is affected by whether or not the patient has received adjuvant treatment. Karnofsky performance status is also a factor in patients with recurrent disease.

If treatment recommendations depend on these factors, then it seems reasonable that follow-up should also, to some extent, be based on the same factors, as well as those related to fiscal responsibility.

In the cohort of patients described by Agboola and colleagues, 62% of recurrent lesions were at distant sites. Such lesions are conventionally thought to be incurable, so their early detection has little effect on overall survival. In contrast, isolated local recurrence is thought to be treatable, and in the *CMAJ* study most local recurrent cases were picked up during routine follow-up. From this perspective, routine follow-up with pelvic examination was important.

Follow-up is also important for assessing the toxic effects of treatment. Many times we are not only assessing disease status but also the morbidity associated with radiation therapy, surgery or chemotherapy. Knowledge of toxic effects and survival is important for critical assessment of current treatment policies and consideration of newer treatment regimens.