I have some questions concerning the recommendations on follow-up surveillance. The incidence of endometrial cancer is not increased if a progestin is used in addition to the estrogen, yet the incidence of postmenopausal bleeding would be considerably higher. The authors recommend vaginal ultrasonography, then uterine sampling if needed. Hospital-based dilatation and curettage is expensive and involves the use of general anesthetic. Office sampling is not yet common in family practices. Is the sensitivity and safety of this procedure great enough to justify its wider use in primary care?

The Ontario Breast Screening Program offers women screening mammography every 2 years from the age of 50. Surveillance recommendations are for a mammogram every 1 to 2 years, yet breast-cancer rates are not increased during the first 5 years of estrogen therapy.[1] Should a woman 45 years of age be counselled to undergo mammography when hormone therapy is initiated, or would it be reasonable to wait until she is 50?

The author recommends that annual pelvic examinations be arranged. The recent guidelines for Papanicolaou smears in Ontario recommend that samples be taken yearly for 3 years, then every 2 years if results are normal until age 69.[2] If there is no history of fibroids or endometriosis, could the same guidelines be used for Papanicolaou smears and pelvic examinations once hormone therapy is initiated? There would be no increased risk of cervical cancer, and rapid growth of fibroids could be detected at the 1-year follow-up. The pelvic examination would be done sooner if there was any abnormal bleeding. Perhaps the reminders for Papanicoloau smears could be included in the letters sent by the Breast Screening Program, since the target populations dovetail.

With the increasing use of hormone therapy, follow-up surveillance and its associated costs are likely to become more important. I would like to be reassured that the guidelines are based on sound evidence.

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The consensus statements from the Scientific Advisory Board of the Canadian Osteoporosis Society are, in general, a welcome update for the primary care physician. However, the rather sparse comments on the management of steroid-induced osteoporosis were rather disappointing. In "The use of bone density measurement in the diagnosis and management of osteoporosis" (*Can Med Assoc J* 1996;155[suppl]:924-9), Dr. William Sturtridge and colleagues recommend that "if significant bone loss has occurred, a bone density measurement may aid in the decision to intervene with calcium and vitamin D supplementation." Several studies have now shown that significant bone loss (in the order of 10% to 20%) occurs within 6 to 12 months of starting treatment with supraphysiologic doses of glucocorticoids (greater than 10 mg) in approximately 60% of patients,[1] and a portion of this loss is irreversible. Therefore, it is appropriate to recommend a bone density assessment at baseline and appropriate intervention if there is evidence of osteopenia. Furthermore, there is little evidence that either calcium or vitamin D supplementation constitutes effective prophylaxis against steroid-induced osteoporosis.[2] Although recommending supplementation is standard practice among many physicians when steroid therapy is initiated, it is arguably more cost-effective to initiate bisphosphonate therapy in all patients receiving supraphysiologic doses of steroids.[3]

A separate consensus statement on steroid-induced osteoporosis would have been more appropriate than this article's unnecessarily conservative statements, which do not reflect currently available evidence or modern standards of practice.

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Keeping kids away from guns

I applaud Drs. Antoine Chapdelaine and Pierre Maurice's excellent article "Firearms injury prevention and gun control in Canada" (*Can Med Assoc J* 1996;155:1285-9). It is particularly timely because, in late November 1996, federal Justice Minister Allan Rock tabled proposed regulations that will define important areas of the law, such as the screening of applicants for firearm ownership and the requirements for locking and storing firearms.[1]

Reducing access to firearms is particularly relevant to preventing injuries to children and adolescents. Developmental characteristics of children and adolescents make them particularly vulnerable to the risks of an improperly stored firearm. Young children may have a poor under-

standing of the severity and permanence of injuries caused by firearms, or may be so lost in fantasy play that they forget any previous instruction about the dangers of firearms. Adolescents may be impulsive and have feelings of invulnerability. They are subject to peer pressure and may experiment with drugs and alcohol.

Chapdelaine and Maurice make an elegant argument for the effectiveness of the licensure, registration and safe-storage provisions of the new law in reducing unauthorized or inappropriate use of firearms. This decreased availability and accessibility of firearms is likely to reduce related mortality, particularly in younger people, who are greatly affected by measures that reduce the availability of firearms.[2,3]

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Psychotherapy and chronic illness

I was moved by Dr. R. Peter Uhlmann's story, "Learning to let go: one physician's experience with cancer" (*Can Med Assoc J* 1997;156: 1029-31). He reminded us of "a real deficiency of Western medicine: it can treat my *cancer*, but it can't heal *me*." What is missing?

It is now well established that psychologic therapy can alleviate distress and improve quality of life in patients with cancer and heart disease. Such treatment even appears to prolong survival.[1–3] Despite this, less than 10% of patients receive such therapy. It seems that professionals may endorse such treatment but seldom recommend it.[4] Only 1 of the patients I have seen for chronic illness was referred by a physician!

Perhaps such "low-tech," medication-free treatment is simply too unglamorous; to what extent do physicians fulfil themselves by offering tangibles such as tests? There is also an information gap. Most colleagues incorrectly believe that psychotherapy consists mainly of listening and offering advice, and there also seems to be a widely held notion that the depression and anxiety experienced by some patients with chronic physical illness are as refractory to treatment as the precipitating disease. I find the opposite to be true: these symptoms often lift much more quickly in ill patients. There is every reason to believe that patients with any chronic illness would similarly benefit.

In light of the efficacy and safety of such treatment, it has been suggested that we deem it "adjuvant therapy"[4] and consider it routinely. It is time to advocate this as vigorously as we do cholesterol management.

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