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morbidity  
registration  
sentinel stations  
the netherlands

**1985**

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## FOREWORD

On 1 January 1985 the sixteenth year of functioning of the Continuous Morbidity Registration Sentinel Stations the Netherlands began. In addition to morbidity in general practice, from the very beginning of the project "actions performed" have been registered: sterilization of the man of the woman, cervical smear taken and the prescription of a number of categories of medicines.

In 1984 a form of referral by the general practitioner was included in the registration for the first time: referral to medical specialists. Referral for physiotherapeutic treatment follows in 1985. The registration of these referrals forms part of an extensive and systematic investigation of the place of physiotherapy in Dutch health care.

In 1985 a number of topics were registered for the last time: Parkinson's disease, malignancies, depression (treated for) and myocardial infarction (suspicion of). Further research has been performed into each of these subjects, which will be reported on elsewhere.

This phenomenon of "the further investigation" that is performed with reference to a subject appearing on the weekly return has grown in extent in recent years. The fact that this has proved possible within the spotter stations may be described as a most pleasing development.

In the present report a start is made with the listing of the publications that are based on these supplementary data supplied by the sentinel stations.

Eye-catching from the 1985 data is the fact that while the number of sterilizations performed on men is more or less the same as that in previous years, clearly fewer sterilizations have been performed on woman (30% less than in the three previous years).

The figures on malignancies show what is not complete in the cancer-registration based only on histopathological confirmation: in 1984 8% and in 1985 7% under-reporting. This under-registration seems to be founded on selectivity by age, state of health, localization of the tumour and anticipated course of the illness. It is the question whether official statistics of malignancies are complete without supplementary information from general practice.

In this way registration in the sentinel stations makes a contribution, with a simple but effective method, to insight into the morbidity presented to the general practitioner and the functioning of health care.

Mrs J.M. Bensing, director of the Netherlands Institute of Primary Health Care,  
Chairman of the Sentinel Stations Counselling Committee.

## INTRODUCTION

Continuous Morbidity Registration is a method of registration based on general practice. A national network of general practices, the sentinel stations, covers 1% of the Dutch population. In the composition of this network allowance has been made for a geographical spread over regions with a varying degree of urbanization (see p 6-8). The participating general practitioners, the spotter physicians, submit a form every week on which certain illnesses, occurrences and actions are reported, the weekly return. This weekly return comprises a distribution by age and where necessary a distribution by sex (see p. 99).

Every two years a census takes place of the practice populations concerned. In this way the population to which the collected data must be related is known.

On the whole frequencies are calculated according to age group per 10 000 men or women (see p. 17).

Every year the topics which are to be placed on the weekly return are selected by the Counselling Committee. Requests or suggestions from others are also taken into consideration. In order that an illness or occurrence may be placed on the weekly return, three conditions must be met:

1. a description of the importance of the subject is obligatory;
2. it must be possible to formulate strict and clear criteria with respect to the disease or occurrence;
3. application of these criteria may not be too time-consuming and it has to suit the practice of the general practitioner.

When a topic is included for the first time in the weekly return, some background information is given; for the 'old subjects' it is necessary to consult one of the previous reports.

When considering the subjects which have been included during the years on the weekly return (see p.15-16 and 100-102) the conclusion is reached that the name of the project, Continuous Morbidity Registration not diseases which are registered but actions or occurrences. The name sentinel stations is better: a watch is kept, sometimes for one year, sometimes longer or even continuously. That is why the name "Continuous Morbidity Registration, Sentinel Stations the Netherlands" is used.

In addition to the submission of weekly returns, a start was made in 1976 with incidental investigations. This entails the physicians

being asked non-recurrent questions about diseases or occurrences which do not happen frequently.

The report gives neither an exhaustive (statistical) analysis of the collected material nor an extensive study; the aim of the project is to collect basic details on certain subjects and to pass them on.

In 1985 contacts were maintained with comparable systems of "sentinel stations" in other countries. In the future projects for cooperation with these other sentinel station systems may perhaps be set up.



## COUNSELLING COMMITTEE

The subsidy arrangement with the Ministry of Welfare, Public Health and Culture lays down that the Counselling Committee for the implementation of the registration system consists in principle of:

1. two representatives of the Ministry of Welfare, Public Health and Culture
2. the Director of the Netherlands Institute of Primary Health Care (Chairman),
3. one representative of the Netherlands Institute of Primary Health Care
4. two representatives of the Chief Medical Office of Health
5. two representative of the spotter physicians
6. one representative of the joint Institutes for General Practice of Dutch Universities
7. two members on the basis of specific expertise.

In 1985 the committee functioned in the following composition:

	Mrs. J.M. Bensing, <sup>2)</sup>
	Dr H. Bijkerk, M.D. <sup>4)</sup>
	W.M.J. van Duyne, M.D. <sup>7)</sup>
	F.K.A. Fokkema, M.D. <sup>5)</sup>
	H.J. van der Leen, M.D. <sup>5)</sup>
	A. Schaap <sup>1)</sup> (to 21-10-'85)
	H.O. Sigling, M.D. <sup>6)</sup>
	W.A. van Veen, M.D. <sup>1)</sup>
	A. Vrij, M.D. <sup>4)</sup>
	J.J. Zandvliet <sup>1)</sup> (from 21-10-'85)
	Dr J. van der Zee Ph.D. <sup>3)</sup>
Project leader:	Dr Bertine H.J.A. Collette, M.D. (to 1-3-'85)
	A.I.M. Bartelds M.D. (from 1-3-'85)
Secretary:	Mrs. F.G. Hoeben-Schaafsma
	Mrs. M. van Valen

This committee met three times in 1985. It had one vacancy in that year.

## MEETING OF SPOTTER CO-WORKERS

On 9 Februari the annual meeting for the co-workers of the project was held in Utrecht. The number present at this meeting was 46, of whom 26 from the sentinel station practices.

This meeting is held at the beginning of the calendar year, so that any problems concerning the new items on the weekly return can be discussed in good time. It is endeavoured to invite as speakers experts on the subjects to be registered.

Mr. E.H.G. Kenters, general practitioner, discussed the subject "Reliability in the registration of euthanasia".

A number of factors have a negative effect on the reliability of registration of both request for and performance of euthanasia. The absence of an unequivocal definition of euthanasia comes to mind immediately. The physician's attitude to the patient seems to be of no less influence. Physicians who are opposed to euthanasia and operate in the "paternalistic model" argue that they never receive requests for application of euthanasia<sup>1</sup>. Fear of legal consequences, social control and the physician's idea of acting unnaturally interfere with the relation between patient and doctor and influence the latter's readiness to cooperate in registration.

The speaker then exchanged ideas with the spotter physicians present on the way in which this subject was registered within the sentinel stations project and the significance of this registration. Despite the problems mentioned by the speaker in registration of request for euthanasia, the spotter co-workers are of the opinion that, in view of the ongoing social discussion on euthanasia, it is a good idea to gain an impression of the frequency with which this request is made of the general practitioner. The sentinel stations are the only place in health care where an - albeit limited - quantitative registration takes place<sup>2,3</sup>.

Dr. P.P. Groenewegen, sociologist and staff-member of the Netherlands Institute of Primary Health Care, explained the new topic "referral to physiotherapy". Referral by general practitioners to physiotherapists, in contrast to referral to medical specialists, is a little-trodden field of research. The research performed so far is not very systematic. Insofar as it makes anything clear, this is the considerable variation in the extent to which general

practitioners refer patients to physiotherapistis. However, this variation is not the same for all age groups of patients, which may be bound up with views of general practitioners on the complaints for which good results can be attained with physiotherapy. Linked to the registration of referral to physiotherapist by the sentinel stations is a futher investigation which endeavours to answer a number of further questions:

1. Which patients are referred by general practitioners with which kind of complaints or diagnoses, and what does the physiotherapist do with these patients?
2. What influences the height of the referral figure by general practitioners to physiotherapists, and how can the great differences between general practitioners in this field be explained?
3. What are the relations between general practitioners and the physiotherapists to whom they refer patients?

This supplementary investigation relates to the general practitioner who does the referral and the physiotherapist to whom referral is made, so that one and the same patient is followed.

Performed in this way, this futher investigation, in combination with registration by the spotter physicians, will be able to draw a more complete picture of the referral process from general practitioner to physiotherapist and offer a number of points of departure for an explanation of the difference in referral figures between general practitioners.

Then, under the chairmanship of the project leader, a number of questions on supplementary investigations from 1983 and 1984 were discussed, some new subjects on the 1985 weekly return were explained and a list was made of ideas for 1986 and following years on the part of those present.

At the end of the meeting Mrs. J. Bensing, director of the Netherlands Institute of Primary Health Care, bade farewell to Mrs. H.J.A. Collette, who was to leave the project with effect from 1 March 1985. Mrs. Collette's considerable services to the project were recalled. On behalf of all project co-workers, in the practices and at the Institute, and on behalf of the members of the Counselling Committee, she was presented with flowers and a gift.

In her turn Mrs. Collette thanked all for their years of cooperations and effort and for the gift. In conclusion she expressed her confidence in the new project leader and wished the whole project fruitful years for the future.

DISTRIBUTION OF THE SPOTTER PHYSICIANS OVER THE NETHERLANDS  
(Fig. 1, page 143)

The number of sentinel stations fell by one in 1985 (45).  
The number of general practitioners taking part is now 59.

In the processing and discussion the following abbreviations or codes are used:

- A for the Groningen, Friesland and Drenthe (northern provinces) province group;
- B for the Overijssel, Gelderland and Southern IJsselmeer Polders (eastern provinces) province group;
- C for Utrecht, North Holland and South Holland (western and central provinces) province group;
- D for the Zeeland, North Brabant and Limburg (southern provinces) province group;
- 1 for the A<sub>1</sub>-A<sub>4</sub> urbanization group (rural municipalities)<sup>4\*</sup>
- 2 for the B<sub>1</sub>-B<sub>3</sub>, C<sub>1</sub>-C<sub>4</sub> urbanization group (urbanized rural municipalities together with (municipalities with urban characteristics)
- 3 for the C<sub>5</sub> urbanization group (municipalities with a population of 100 000 or more).

Appendix 1 (page 97-98) gives a survey of the general practitioners who took part in the sentinel station project during 1985. In 12 sentinel stations there is cooperation between two or more general practitioners, viz 11 times 2 and once between 4 practitioners. In January 1985 the percentage of general practitioners cooperating throughout the Netherlands was 39, and among the spotter physicians 51 (30 out of the 59). There are 11 dispensing spotter physicians, 6 in urbanization group 1 and 5 in urbanization group 2, that is 19%. For the whole of the Netherlands this percentage is 15<sup>5</sup>.

Tables 1 and 2 give a distribution of the number of spotter physicians and sentinel stations per province and urbanization group in the years 1970-1985. Adjustment to the standards applicable to the classification by degree of urbanization takes place where and when necessary.

\* Footnotes, not pertaining to the tables, are placed at the end of this report.

Comparison with the number of general practitioners in the Netherlands in the various subgroups shows that the spotter physicians form a proportional representation (see 1981 report, p. 13).

Table 1: distribution of the spotter physicians and sentinel stations per province group in the years 1970-1985<sup>6</sup>

provin- ce- group	A		B		C		D	
	Groningen, Friesland and Drenthe		Overijssel, Gelderland and the Southern IJsselmeer polders		Utrecht, North and South Holland		Zeeland, North Brabant and Limburg	
	number of GPs sentinel stations		number of GPs sentinel stations		number of GPs sentinel stations		number of GPs sentinel stations	
1970	7	6	10	9	22	22	14	14
1971	7	6	10	9	23	22	13	13
1972	7	6	9	8	23	22	12	12
1973	8	6	10	9	25	22	13	12
1974	8	6	10	9	27	21	13	12
1975	8	6	9	8	28	21	14	12
1976	8	6	9	7	29	21	14	11
1977	8	6	10	7	28	20	13	11
1978	9	6	12	9	27	21	13	11
1979	10	6	12	9	27	21	12	10
1980	10	6	13	9	27	21	12	10
1981	10	6	11	9	27	21	13	10
1982	10	6	11	9	27	21	13	10
1983	10	6	11	9	27	21	14	10
1984	10	6	11	9	27	21	14	10
1985	10	6	10	8	25	21	14	10

Table 2: distribution of the spotter physicians and sentinel stations per urbanization group in the years 1970-1985

urbanization	1		2		3		Netherlands	
	rural municipalities		urbanized rural municipalities together with municipalities with urban characteristics		municipalities with a population of 100 000 or more			
	number of GPs sentinel stations		number of GPs sentinel stations		number of GPs sentinel stations		number of GPs sentinel stations	
1970	10	9	28	27	15	15	53	51
1971	12	11	26	24	15	15	53	50
1972	11	10	25	23	15	15	51	48
1973	12	11	28	23	16	15	56	49
1974	12	11	30	23	16	14	58	48
1975	13	11	30	22	16	14	59	47
1976	14	11	30	20	16	14	60	45
1977	13	11	29	19	17	14	59	44
1978	10	8	35	25	16	14	61	47
1979	11	8	35	25	15	13	61	46
1980	11	8	36	25	15	13	62	46
1981	11	8	36	25	14	13	61	46
1982	11	8	36	25	14	13	61	46
1983	11	8	37	25	14	13	62	46
1984	11	8	37	25	14	13	62	46
1985	10	7	35	25	14	13	59	45

## THE PRACTICE POPULATIONS

A complete census of the practice populations again took place in 1983; these details are used for processing with effect from 1-1-1984. In 1985 a new census is to be held. When the project was set up the aim was to take a sample of about 1% of the Dutch population. A geographical distribution (the above-mentioned province groups) was taken into account, as also a distribution of regions with various degrees of urbanization (urbanization groups). An enquiry was made to whether this aim is still being met. This proved broadly to be so, as the following surveys demonstrate.

In 1985 3 general practitioners ended their activities as spotter physicians. The population of the sentinel station practices fell by nearly 11 000 patients. The Dutch population increased by over 59 000 inhabitants.

Table 3: comparison of the population of the practices of the spotter physicians with the total population of the Netherlands may be seen in the following survey

		number of inhabitants of the Netherlands <sup>1)</sup> (with percentages)	number of patients of sentinel stations <sup>2)</sup>
province group	A	1 588 230	21 998 (1.4%)
	B	2 911 360	25 290 (0.9%)
	C	6 398 989	69 360 (1.1%)
	D	3 554 040	35 133 (1.0%)
urbanization group	1	1 667 636	23 470 (1.4%)
	2	9 275 051	91 428 (1.0%)
	3	3 509 932	36 883 (1.1%)
sex Men		7 150 394	73 980 (1.0%)
Women		7 304 653	77 801 (1.1%)
total		14 455 047	151 781 (1.1%)

<sup>1)</sup> 1-1-1984, Central Bureau for Statistics. Persons on the Central Register of Persons (CPR) are excluded.

<sup>2)</sup> Practice census 1983.

Province group A (the northern provinces) and urbanization group 1 (rural municipalities) are relatively somewhat overrepresented. However, this is favourable, since these are precisely the smallest groups for the Netherlands as a whole (This explains the small difference between the percentage distribution of the physicians (1981 report, p. 13).

The percentages of the men and women of the population of the Netherlands coming under the sentinel stations, per age group, province group and urbanization, are as follows.

age years	province group								urbanization group						Nether- lands	
	A		B		C		D		1		2		3		M	F
	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
0- 4	1.3	1.3	0.7	0.7	0.9	0.9	0.8	0.9	1.2	1.3	0.8	0.8	1.1	1.0	0.9	0.9
5- 9	1.4	1.4	0.7	0.7	1.0	1.1	0.9	1.0	1.3	1.4	0.9	0.9	1.1	1.1	1.0	1.0
10-14	1.4	1.5	0.8	0.9	1.1	1.1	1.1	1.1	1.5	1.5	1.0	1.0	1.0	1.1	1.1	1.1
15-19	1.4	1.4	0.9	0.9	1.0	1.1	1.0	1.0	1.4	1.5	1.0	1.0	1.0	1.0	1.0	1.0
20-24	1.3	1.5	0.9	1.0	1.1	1.3	1.0	1.0	1.3	1.7	1.0	1.1	1.0	1.2	1.0	1.2
25-34	1.4	1.6	0.8	0.8	1.1	1.1	1.0	1.0	1.3	1.4	1.0	1.0	1.2	1.3	1.1	1.1
35-44	1.3	1.4	0.8	0.8	1.0	1.1	0.9	1.0	1.3	1.4	0.9	1.0	1.0	1.1	0.9	1.0
45-54	1.3	1.3	0.9	1.0	1.0	1.1	1.0	1.0	1.4	1.5	1.0	1.0	1.0	1.0	1.0	1.1
55-64	1.3	1.3	0.9	0.9	1.1	1.1	0.9	0.9	1.5	1.5	1.0	1.0	1.0	1.0	1.1	1.0
≥ 65	1.3	1.3	1.0	0.9	1.0	1.0	0.9	1.0	1.5	1.4	1.0	1.0	1.0	0.9	1.0	1.0
total	1.3	1.4	0.8	0.9	1.0	1.1	1.0	1.0	1.4	1.4	1.0	1.0	1.0	1.0	1.0	1.0

With regard to the age groups a minor shift has occurred: in the youngest age groups, in comparison with the previous census, there are more subgroups with a percentage less than one; in the oldest age groups, on the other hand, such subgroups are fewer. This points to a low degree of aging of the sentinel station population; the population as it were grows along with the spotter physicians who are faithful to the project. However, care should be taken that this does not lead to distortion.



## SCOPE AND CONTINUITY OF THE REPORTING

Since 1975 the number of days reported annually per sentinel station and the number of all days per week of all sentinel stations together have been examined and processed. In this an effort was made to follow the scope and continuity of the reporting. In general the spotter physicians state - or have someone state - whenever they cannot report (vacation, illness, personal circumstances). In the case of a weekly return not being submitted on time, telephone contact is made.

The maximum number of days which can be reported depends on the number of weeks in the year in question and the number of sentinel stations. In 1985 it was 11 700 (52 weeks x 5 days x 45 sentinel stations). Table 4 shows the absolute numbers and percentages.

Table 4: maximum and actual number of reporting days per year

year	maximum number of days which can be reported	actual number of reported days absolute	percentage
1975	11 960	9 505	79.5%
1976	11 925	10 095	84.7%
1977	11 440	10 163	88.8%
1978	12 090	10 592	87.6%
1979	11 960	10 518	87.9%
1980	12 190	10 618	87.1%
1981	11 960	10 520	88.0%
1982	11 960	10 627	88.8%
1983	11 960	10 515	87.9%
1984	11 960	10 546	88.2%
1985	11 700	10 340	88.4%

The percentage of reporting days is a little more than in 1984. A breakdown by province and urbanization group may be seen in the following table. No great differences prove to exist. The cities are lowest, 86.5%, the northern provinces highest, 91.7%.

Per province group		Per urbanization group	
A	91.7%	1	90.1%
B	89.3%	2	86.5%
C	86.6%	3	88.8%
D	89.7%		

In Fig. 2 the weekly reporting can be found. This figure clearly shows the influence of public holidays. The average number of nonreporting days per week is a little more than 27 (maximum 45 x 54= 225).

Table 5 presents the frequency distribution of the number of days not reported per sentinel station. The average number of non-reporting days per sentinel station is 30, the same as in the previous year.

A breakdown into single and group practices shows a clear difference here, viz 36 and 14 days respectively. This is in line with the frequent assertion that forms of cooperation of general practitioners increase the continuity of reporting.

Table 5: frequency distribution of the number of days not reported per sentinel station

number of days not reported on	number of sentinel stations									
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
0	0	0	1	1	2	2	1	2	2	1
1- 9	5	11	8	11	7	9	9	7	6	8
10-19	6	7	5	2	2	2	2	5	3	1
20-29	3	3	3	5	4	3	6	1	7	8
30-39	16	9	10	10	11	18	15	12	9	10
40-49	6	10	11	10	10	8	10	14	17	15
50-59	2	2	6 <sup>2</sup>	4	8	2	3	4	1	2
60-69	3	0	1	2	1	1	0	1	1	0
70-79	0	1	0	0	0	0	0	0	0	0
80-89	1	0	1	0	1	1	0	0	0	0
90-99	1	0	0	1	0	0	0	0	0	0
≥ 99	2	1	1 <sup>3</sup>	0	0	0	0	0	0	0
	45	44	47	46	46	46	46	46	46	45
average	41	29	32	31	34	31	29	31	31	30
mediaan	36	32.5	34	34.5	38	38	34.5	37	35	34

<sup>2</sup>)One sentinel station started in February 1978.

<sup>3</sup>)One sentinel station ended in August 1978.

Further study of this table shows a clear improvement in reporting over the years. A major failure to report, i.e. more than 50 days per sentinel station per year, hardly occurs any longer.

When the failure to report per week is considered, in 1985 there were 9 weeks with more than 50 days failure to report. This is more than in 1983 and in 1984 (7 and 6 weeks respectively).

The questions on the weekly return for 1985 were selected as follows by the Counselling Committee:

1. New cases of influenza (-like illness)
2. Cervical smear
3. Parkinson's disease
4. Sterilization of the man performed
5. Sterilization of the woman performed
6. Prescription of morning-after pill
7. Malignancies
8. Depression (treated for)
9. (Attempted) suicide
10. Myocardial infarction (suspicion of)
11. Ulcus pepticum
12. Referral to/authorization for physiotherapist

The basis in principle was weekly reporting, which means that patients 'seen' by the locum tenens during the weekend are reported as well (influenza excluded). Diagnoses made or advice given by telephone are not entered in the weekly return in principle; here too influenza is an exception.

A survey of the questions included on the weekly return in the years 1970-1984 is given below; the questions of the current year, 1985, are also given. The subjects in alphabetical order can be found in Appendix 3 (p. 100-102) together with the years of registration.

Subjects on the weekly returns 1970-1986

subject	'70	'71	'72	'73	'74	'75	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85	'86
influenza																	
(-like illness)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
exanthema e causa ignota	x																
acute diarrhoea e causa ignota	x																
consultations for family planning	x	x	x	x	x	x	x										
request for abortion (attempted)	x	x	x	x	x	x											
suicide	x	x	x								x	x	x	x	x	x	x
rubella (-like illness)		x															
otitis media acuta		x															x
abortus provocatus	x	x	x	x	x	x	x	x	x								
accidents	x																
tonsillectomy or adenotomy		x															
prescription of morning-after pill			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
sterilization of the man performed			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
prescription of tranquilizers		x	x	x													
consultation for drug-use (suspicion of)			x	x	x						x	x	x				
battered child syndrome				x	x												
sterilization of the woman performed					x	x	x	x	x	x	x	x	x	x	x	x	x
consultation with regard to addiction to smoking					x												
measles						x	x	x	x	x							
alcoholism						x											
ulcus ventriculi/duodeni						x											
skull traumas in traffic						x	x	x									
certificate for another dwelling issued						x											

Subjects on the weekly returns 1970-1986 (continuation)

subjects	'70	'71	'72	'73	'74	'75	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85	'86
psoriasis							x	x									
prescription of anti-hypertensive or diuretic							x										
cervical smear mononucleosis							x	x	x	x	x	x	x	x	x	x	x
infectiosa								x	x	x							
prescription of medicine for infection of the urinary tract								x									
hay fever									x	x	x	x	x				
myocardial infarction (suspicion of)									x					x	x	x	
traumas in sport										x	x	x	x	x			
diabetes mellitus											x	x	x	x			
Parkinson's disease											x	x	x	x	x	x	
accidents in the private sector												x	x	x			
spontaneous abortion or partus immaturus													x	x			
partus at gravidity $\geq 28$ weeks													x	x			
penicillin (prescription and side effects)													x	x			
depression (treated for)														x	x	x	
malignancies															x	x	
traumas of the musculo-skeletal system																x	
referrals																x	
ulcus pepticum (first time, relapse)																	x
referrals physiotherapy																	x
discharge of psychiatric patient																	x
bites by pets																	x
cerebrovasculair accident																	x
referral of psycho-social problems																	x

## PROCESSING OF THE DATA ON THE WEEKLY RETURN

This report contains the results of the weekly return for 1985. The data were processed by the Computer Centre of the Ministry of Welfare, Public Health and Culture as usual.

Three tables are produced on a routine basis:

- 1.The number of patients by sex and age group
- 2.The number of patients by sex and province group
- 3.The number of patients by sex and urbanization group.

Tables 1, 2 and 3 are produced per week on behalf of the surveillance and per quarter and per year on behalf of the reporting. Moreover, Table 1 is also produced every quarter per sentinel station for the convenience of the participating physicians.

With the exception of the information furnished per sentinel station, the data are expressed per 10 000 of the total practice population (relative frequencies). The frequencies are given in round figures. In the case of a frequency of under 0.5 per 10 000 inhabitants, the figure is rounded off to '0'. When no cases at all have been reported, this is indicated by '-'. A frequency that is based on fewer than 5 reports is put between brackets.

When the frequency of new cases of a disease in a given period is concerned, one also speaks of incidence; if, on the other hand, all existing cases of that disease in a given period or at a given moment in time are concerned, that is designated as prevalence. There is also a subdivision into absolute and relative incidence or prevalence.

In this report the relative incidence or prevalence is in all cases calculated per 10 000 inhabitants or men or women. So as to be able, if desired, to calculate absolute numbers for the Netherlands, in Appendix 4 (page 103) the age structure as on 1 January 1985 is given.

When a sentinel station does not report over the whole week, (sickness, vacation, etc.), this is mentioned. The data from the physicians who have reported on 0, 1 or 2 days of the week are not processed, while the populations of these practices are not included in the calculation of the frequencies. The data from the practices that

have reported on more than 2 days of the week are processed. Till 1978 a correction factor was applied to this. Consideration of the number of times that this was applied showed that the influence on the total was so small that this correction has been done away with effect from 1 January 1978. Moreover, enquiries among the spot-ter physicians revealed that in the case of 1 of 2 days' absence the work was simply moved to a later date.

The returns are built up from the weekly figures, the frequencies being calculated on the average population present in the quarter. This annual report will not attempt to give a complete analysis of the material, as already mentioned in the introduction.

The following quarterly and annual tables are included here (p. 105-142):

Tables 1a, 1b, 1c, 1d and 1e: the number of patients per 10 000 of the age group<sup>7</sup>).

Tables 2a, 2b, 2c, 2d and 2e: the number of patients per 10 000 of the province group.

Tables 3a, 3b, 3c, 3d and 3e: the number of patients per 10 000 of the urbanization group.

In 1982 it was decided to introduce age groups in 5-year classes. Unfortunately the computer program could not be modified in time, so that the reporting for 1985 still uses the old classification (see tables 1A-1E).



## INFLUENZA(-like illness)

Influenza<sup>8</sup> is the only subject to have appeared on the weekly return since the start of the sentinel station project. The data on this subject are regularly distributed and used at international level. As soon as an increase in the incidence is noted, the numbers are reported weekly to the WHO in Geneva, together with virological and serological results. In this way the Netherlands participates in an influenza surveillance that extends over a large number of countries inside and outside Europe.

### Influenza 1985/1986

Table 4a and fig. 3 (pages 140-142 and 145) give the number of new cases of influenza per 10 000 inhabitants per week, per province group and per urbanization group for 1985-1986<sup>9</sup>. Fig. 4 gives the trend in comparison with previous years. The progress of influenza at the first week of 1985 was already described in the 1984 report. For a number of seasons now, starting with the 1982/1983 season, the picture has been that during a certain period the weekly incidences of influenza-like illnesses are more than ten times as high outside the influenza season. The highest incidences in the 1984/1985 season were observed from week 8 to week 12 incl. of 1985, with 25, 54, 53, 36 and 23 cases per 10 000 inhabitants respectively. In the 1985/1986 season the peak of epidemic rise of the influenza-like illnesses lies from week 5 to week 12 of 1986 incl., with 28, 35, 50, 77, 76, 55, 37 and 21 cases respectively, an epidemic rise of greater size in 1986 than in 1985.

In the 1984/85 season the main emphasis of the moderate epidemic lay in the northern and southern provinces, with as highest incidences 79 and 88 cases per 10 000 inhabitants respectively. In the rural municipalities clearly less influenza was reported to the general practitioners than in the other urbanization groups: 30, 57 and 55 cases per 10 000 inhabitants respectively.

The more extensive epidemic of the 1985/1986 season was again more severe in the northern and southern provinces than in the centre and west of the country: 81 and 94 per 10 000 inhabitants and 74 and 75 per 10 000 inhabitants respectively. At the beginning the epidemic

was somewhat more severe in the rural municipalities; at its peak an influenza-like illness was most frequently diagnosed by the general practitioners in municipalities with a population of 10 000 or over: in weeks 8 and 9 of 1986 61 and 62 cases per 10 000 inhabitants in the rural municipalities as against 84 and 82 cases in the cities. In 1986 from the beginning of the epidemic both the influenza A (H3N2) virus and, though to a smaller extent, influenza B virus were isolated and identified. The occurrence of influenza caused by sub-type influenza A (H1N1) was serologically diagnosed on one occasion in the Netherlands in the 1985/1986 season.

Table 6: number of patients with influenza(-like illness), per 10 000 inhabitants, 1975-1986

year	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
total per calendar year	695	717	575	829	438	425	491	497	396	502	464	
total per 'season' <sup>1</sup> highest weekly inci- dence per 'season'	701	557	711	502	449	448	392	507	607	465		
	68	44	107	43	15	36	20	42	53	57	77	

<sup>1</sup>) For these totals the limit of 30 June - 1 July is adhered to, which gives a more realistic picture of the size of the epidemic than per calendar year.

If the annual figures for 1975 to 1985 inclusive (i.e. not just the figures during an epidemic) are compared, the year 1983, with 396 cases per 10 000 inhabitants, proves to give the smallest number since reporting started. This is a result of the fact that the peak of the "epidemic" in the 1982/1983 season was located largely in 1982, whereas the peak of this last epidemic lay in 1984. The seasonal peak in the last three years was always in the second and third months of the year.

#### Age and sex distribution

During the period of registration, no difference was ever found in the frequency of influenza between men and women, so that a division is not included in the weekly return for this category.

The age distribution (table 1a-1e) shows as in the preceding years the highest frequencies in the age group under 5 years and the lowest in the 10-14 age group. In the other groups the numbers are nearly identical.

This topic is to be maintained on the weekly return.

## CERVICAL SMEAR

Taking of a cervical smear was placed on the weekly return for the first time in 1976. The aim was to obtain insight into the extent of this work outside the mass screening for cervical cancer. However, it must be well realized that the spotter physicians are not a random group of general practitioners, which may be of influence here. However, a study in which the presence or otherwise of trends is examined is most definitely meaningful.

The question is subdivided into the indication for taking a cervical smear, i.e. following complaints and/or symptoms, on 'preventive' grounds at the initiative of the spotter physician or the woman, and a separate column in the case of a repeat smear, irrespective of the indication for taking the previous smear. To make comparability with the investigation subsidized by the Ministry as great as possible, 3 years has been adhered to as the period within which a second or following smear has to be reported as a repeat smear. For 1985 that therefore means that a smear is reported as a repeat smear when the spotter physician himself already has taken a smear from the woman in question after 1 January 1982. This period is identical with the interval between two mass screenings.

The results of this topic will acquire greater importance in the near future, since in March 1982 the then Minister of Public Health and Environment announced the intention to amend the policy regarding mass screening for cervical cancer<sup>10</sup>. It is being endeavoured to entrust the performance of this method of early detection to the general practitioner in 1987.

Table 7 (see next page) gives the total number of smears taken, with a subdivision for the indication for taking the smear, including the repeat smears.

Table 7: number of smears taken by spotter physicians, by indication for taking a smear, per 10 000 women, 1976-1985

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
complaints and/or symptoms 'preventive', general-practitioners initiative	87	86	80	80	62	57	57	65	57	62
'preventive', woman's initiative	282	268	218	198	168	184	171	174	204	197
repeat smear	103	112	105	124	93	110	126	120	132	127
	31	55	120	143	148	159	170	168	182	184
total	503	521	523	545	471	510	524	527	575	570

The total number of smears (570 per 10 000 women) is then practically the same as in 1984, the year in which up to now the largest number of smears was organized (575 per 10 000 women). When considering these tables, as has also been remarked in the preceding reports, allowance must be made for the fixed period of three years within which a smear counts as a repeat smear; the subdivisions are therefore comparable only for 1978 and following years. Moreover, it should be realized that the volume of the organized use of this method in the form of mass screening gradually increased after 1979, reached a climax in 1981 and 1982 and thereafter decreased. For the years 1976, 1977 and 1978 a subdivision was therefore made between sentinel stations where mass screening was organized in the area covered by the practice and where this was not the case. There then proved to be major differences that could be explained by this activity (see the 1978 report, p. 30-33). The spotter physicians were again asked whether mass screening was organized in the area covered by their practice. In 1982 and 1983 there were six physicians who had to reply in the negative; by 1984 this number had grown to 15.

In 1985 no further screening for cervical cancer took place in 28 out of the 45 spotter station populations. The switch in policy is now the practice.

Table 8 gives the comparison between the sentinel stations, where

mass creening is still organized and the Sentinel stations in regions where this is no longer the case.

Table 8: number of cervical smears by age group per 10 000 women in 1984 and 1985

	Age group					total
	20-24	25-34	35-44	45-54	55-64	
No mass screening:						
1984	584	1322	1431	1200	490	1005
1985	651	1307	1377	985	324	927
Mass screening:						
1984	584	1142	951	711	256	728
1985	494	1098	886	884	352	742

As in 1984, in the regions where no mass screening was held the numbers of smears taken in 1985 are higher than in the areas where mass screening was still organized. Only in the 55-64 age group, which is not covered by the mass screening, is the number of smear taken in the regions where mass screening was held higher.

The number of smears taken in the age groups that were not covered by the mass screening for cervical cancer and are still not covered even if such screening is organized may in any case be discribed as high. When we assume that age limits for mass screening for cervical cancer are based on those ages at which the chance of occurrence of this disease is extremely slight , it may cautiously be concluded that a large percentage of the smears taken by the general practitioner has not been indicated on medical grounds (see Table 9).

Table 9: smears taken per age group for the sentinel stations (in percentages)

age	total numbers of smear	"first" smear
<hr/>		
< 35 years		
1984	45.9	52.5
1985	42.2	48.7
35-54 years		
1984	46.8	40.7
1985	48.6	42.8
≥ 54 years		
1984	7.4	6.8
1985	9.2	8.5
<hr/>		

In 1984 we wrote that general practitioners are inclined to regard screening for cervical cancer as their task. We are now inclined to state that, though the general practitioners seemed to be prepared to do that, the performance of that screening has not always been equally effective.

The number of smears on account of complaints and/or symptoms displays a small increase in 1985 in respect of 1984: 62 and 57 per 10 000 women respectively. (See Table 10)

As regards this category, however, the arrangement to register every smear taken from one and the same woman within a certain period as a repeat smear should be borne in mind. The actual number of smear taken on medical indication will therefore be higher.

The total number of smear taken on preventive indication, i.e. on the initiative of both the general practitioner and the woman, is lower in 1985 than in 1984: 324 and per 10 000 woman respectively. The subcategory repeat smears remains the same: in 1984 and 1985 184 per 10 000 women. This subcategory makes it possible to calculate from the total numbers the number of women who are reached via this method by general practitioners. The number of woman who are reached in this way at least once every three years may be seen in the total of Table 10. This table contains only the numbers of first smears per 10 000 women, with a subdivision for the indication for taking

the smear and per province and urbanization group (see also Figs 5 and 6). The total number of first smears has fallen somewhat, notably in the categories "preventive", general practitioner's initiative and "preventive", woman's initiative.

This decline occurs above all in the north of the country; in the south there is some increase in this subgroup.

In the subgroups a number of differences may be observed. In the eastern provinces we see a - further - rise in the number of smears taken on the initiative of the general practitioner (206 per 10 000 woman in 1984 as against 232 per 10 000 women in 1985). In the western provinces a decline occurs in this subgroup: from 217 per 10 000 women in 1984 and 196 per 10 000 women in 1985.

In the category "preventive" woman's initiative the number of smears in the northern and eastern provinces falls from 123 and 128 per 10 000 women respectively in 1984 to 109 and 105 per 10 000 women in 1985.



Table 10: number of 'first' cervical smear taken per province group and urbanization group, by indication for taking a smear and for the total, per 10 000 women, 1976-1985

		province group				urbanization group			Nether lands
		A	B	C	D	1	2	3	
complaints and/or symptoms	1976	85	102	100	52	62	91	103	87
	1977	65	95	109	48	64	96	88	86
	1978	116	93	72	68	78	66	118	80
	1979	130	95	63	79	73	70	114	80
	1980	129	61	52	44	73	51	90	62
	1981	119	59	41	52	73	39	95	57
	1982	95	65	44	58	78	37	98	57
	1983	97	99	49	53	90	44	105	65
	1984	99	97	37	45	78	42	84	57
	1985	90	92	45	52	85	49	78	62
'preventive', general practitioner's initiative	1976	139	218	302	360	228	322	257	282
	1977	112	234	327	260	214	308	240	268
	1978	170	259	230	183	325	169	269	218
	1979	170	198	214	178	248	154	280	198
	1980	121	170	207	105	186	119	306	168
	1981	159	189	223	112	239	147	247	184
	1982	157	146	183	174	203	148	212	171
	1983	162	202	175	156	237	138	226	174
	1984	180	206	217	190	229	161	308	204
	1985	167	232	196	195	235	151	288	197
'preventive', woman's initiative	1976	112	95	114	79	66	134	79	103
	1977	88	79	151	68	80	146	77	112
	1978	110	85	130	64	94	115	89	105
	1979	141	112	142	82	119	125	126	124
	1980	110	83	104	66	67	92	120	93
	1981	104	112	125	80	107	113	104	110
	1982	84	129	149	98	115	117	157	126
	1983	100	130	137	88	131	111	136	120
	1984	123	128	145	113	142	124	147	132
	1985	109	105	147	116	121	116	157	127
total	1976	336	415	516	491	356	547	439	472
	1977	265	408	587	376	358	550	405	466
	1978	396	437	432	315	497	350	476	403
	1979	441	405	419	339	440	349	520	402
	1980	360	314	363	215	326	262	516	323
	1981	382	360	389	244	419	299	446	351
	1982	336	340	376	330	396	302	467	354
	1983	359	431	361	297	458	293	467	359
	1984	402	431	399	348	449	327	539	393
	1985	366	429	388	363	441	316	523	386

### Age distribution

Table 11 gives a survey of the number of 'first' smears by age group per 10 000 women (cf. fig. 7).

Table 11: number of 'first' smears taken by age group, per 10 000 women, 1976-1985

	age group							
	10-14	15-19	20-24	25-34	35-44	45-54	55-64	≥65
total 1976	(2)	41	288	962	1397	884	248	62
1977	-	50	347	974	1276	880	248	70
1978	-	43	334	835	1028	742	280	43
1979	-	85	520	883	914	634	233	48
1980	-	47	536	740	607	464	211	51
1981	(2)	72	548	879	602	473	225	47
1982	-	64	565	859	651	455	207	43
1983	-	63	543	797	724	515	233	42
1984	(2)	72	529	957	693	525	244	48
1985	(2)	86	446	908	724	543	212	38

There are some discrepancies with the figures from previous years; Clearly fewer smears are being taken from women in the age groups of 20-24 years and 25-34 years: for the 20-24 age group 529 smears per 10 000 women in 1984 as against 446 per 10 000 women in 1985, and for the 25-34 age group 957 per 10 000 woman in 1984 as against 908 per 10 000 women in 1985. In the 35-44 and 45-54 age groups, the groups for whom mass screening was organized, there is a slight increase in the number of smears taken. It will have to emerge in 1986 whether this increase in the taking of "first" smears from women in these age group continues.

Table 12 gives for 1978 and following years a breakdown by age group and by indication for taking a smear, including the repeat smear (see also fig. 8). This table gives more information.

The years 1976 and 1977 are not given here, as a result of the fact that the period that has been adhered to as the period within which a second smear from one and the same woman must be reported as a repeat smear had not yet elapsed then.

Table 12: number of smears taken by spotter physicians by age group and by indication for taking the smear, per 10 000 women, 1978-1985

		age group						
		15-19	20-24	25-34	35-44	45-54	55-64	≥65
complaints and/ or symptoms	1978	17	102	153	193	147	55	7
	1979	28	93	158	207	113	62	13
	1980	21	84	122	121	108	47	20
	1981	16	90	127	106	72	46	17
	1982	16	92	130	97	85	31	17
	1983	19	88	117	153	96	51	18
	1984	14	44	123	110	98	36	19
	1985	20	71	128	129	93	32	14
preventive, general prac- titioner's initiative	1978	20	162	467	542	401	151	29
	1979	49	265	442	412	345	94	21
	1980	18	379	389	274	206	95	26
	1981	47	339	460	291	253	94	13
	1982	38	318	422	292	214	79	16
	1983	29	357	410	288	230	85	14
	1984	50	400	533	287	222	97	20
	1985	53	374	506	297	238	87	7
preventive, woman's ini- tiative	1978	(6)	70	215	293	194	74	7
	1979	8	162	283	295	176	77	14
	1980	8	73	229	212	150	69	(5)
	1981	9	119	292	205	148	85	17
	1982	10	155	307	262	156	97	10
	1983	15	98	270	283	189	97	10
	1984	8	85	287	296	205	111	9
	1985	13	76	274	298	212	93	17
repeat smear	1978	(5)	50	199	367	293	70	8
	1979	(2)	63	225	470	324	99	12
	1980	6	55	224	416	385	149	17
	1981	(6)	68	279	454	385	119	14
	1982	(6)	89	304	468	387	135	8
	1983	(3)	60	255	539	397	132	8
	1984	5	65	318	446	444	136	15
	1985	7	82	296	457	461	146	19
total	1978	48	384	1034	1395	1035	350	51
	1979	87	583	1108	1384	958	332	60
	1980	53	591	964	1023	849	360	68
	1981	78	616	1158	1056	858	344	61
	1982	70	654	1163	1119	842	342	51
	1983	66	603	1052	1263	912	365	50
	1984	77	594	1275	1139	969	380	63
	1985	93	603	1204	1181	1004	358	57

There is a slight increase in the number of smears taken on the initiative of the spotter physician in the 35-54 age group. In the other age groups and categories there are some differences in respect of previous years, but these are not striking. In the repeat smears category we see somewhat varying figures for the various age groups.

There are not great changes in respect of 1984. As stated previously, it is still too early to be able to say that these figures are in fact a result of the changed policy regarding mass screening for cervical cancer.

As stated at the beginning of this chapter, the results of this topic will be of greater value when the government's plans proceed further.

This topic has been maintained on the weekly return for 1986.

## PARKINSON'S DISEASE

The Princess Beatrix Fund asked the sentinel stations to include Parkinson's disease as a topic in the weekly return. This started in 1980.

The definition used is as follows:

The genuine Parkinson's disease is a disorder of the central nervous system that begins unilaterally, usually with tremors in the hand. In the course of the years these gradually spread to the other extremities. Further typical characteristics are hypokinesia and extrapyramidal hypertonicity.

Only new cases of genuine Parkinson's disease are concerned. Disorders accompanying Parkinsonism are not registered.

Since the life expectancy of patients with Parkinson's disease is below the norm, a correction has to be made for age when it is desired to calculate the prevalence with the aid of these data<sup>11</sup>. The data collected up to now are, however, too few in number for this calculation to be made in a responsible fashion.

When the diagnosis is made both age and sex are stated.

The 'patient-control investigation' announced in the 1982 report started in mid 1983 retroactively. So far the results as regards the feasibility of such an investigation in the sentinel stations are satisfactory, from the side of both the general practitioner and the patients.

A provisional report was submitted to the Princess Beatrix Fund in 1985. The patient-control investigation was terminated on 31 December 1985. A final report of this investigation is being prepared.

Table 13 (see next page) states the incidence per 10 000 men and women per province and urbanization group.

Table 13: number of new cases of Parkinson's disease, per province group and urbanization group, per 10 000 inhabitants, 1980-1985

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
1980	12	11	4	(1)	12	5	3	6
1981	4	5	2	2	5	2	1	3
1982	3	6	1	2	5	2	(1)	2
1983	(1)	3	(1)	(1)	(2)	1	(1)	1
1984	(0)	(2)	(1)	(1)	(1)	(1)	(1)	1
1985	-	(1)	2	(1)	(1)	2	(1)	1

The absolute number of reports is higher in 1985 than in 1983 and 1984, viz 20 as against 14 and 16, but lower than in the years 1980-1982. In view of the small numbers, only slight value may be attached to frequencies displayed here. However, the thought occurs that overreporting took place in 1980 as the result of confusion with 'old patients'. Some of the prevalent cases are registered as incidental cases, a phenomenon that must be guarded against, especially in the case of chronic diseases declaring themselves slowly. Differences existing between 1983/1984 and 1981/1982 have probably also been caused by this phenomenon. The incidences found in 1983 and 1984 (1 out of 10 000 inhabitants) correspond to the extent of occurrence of this disorder elsewhere.

#### Age distribution

Table 14 gives the incidence per 10 000 men and women of Parkinson's disease.

Table 14: number of new cases of Parkinson's disease by age group, per 10 000 men and women, 1980-1985

		age group					
		25-34	35-44	45-54	55-64	≥ 65	total
men	1980	-	(1)	8	10	54	7
	1981	-	-	(4)	8	28	4
	1982	-	-	-	-	19	2
	1983	-	-	(1)	(2)	10	1
	1984	-	-	-	(0)	(3)	1
	1985	-	-	(1)	(6)	7	1
women	1980	(1)	(1)	(4)	9	29	5
	1981	-	-	-	4	10	2
	1982	-	-	-	4	17	2
	1983	-	-	-	-	7	1
	1984	-	-	-	(0)	8	1
	1985	-	-	(1)	-	9	1
total	1980	(0)	(1)	6	9	40	6
	1981	-	-	(2)	6	17	3
	1982	-	-	-	(2)	18	2
	1983	-	-	(1)	(1)	9	1
	1984	-	-	-	(2)	6	1
	1985	-	-	(1)	(3)	9	1

The literature<sup>12</sup> suggests that the incidence of Parkinson's disease is higher among men than among women. The data from this registration do not support this supposition.

For 1986 the topic has been removed from the weekly return.

## STERILIZATION OF THE MAN

Sterilization of the man has been a topic on the weekly return since 1972. The data obtained on this subject, together with those on the subjects sterilization of the woman and prescription of morning-after pill, are being used inter alia for the compilation of a Dutch contribution to the Council of Europe's report: 'Country Report of the Netherlands'<sup>13</sup> and for computing the trend of the population<sup>14</sup>.

The annually published data form a partial but as yet indispensable instrument for assessing developments in the field of birth control behaviour.

The number of sterilizations of men performed per 10 000 of all men and per province group and urbanization group is given in table 15 (cf. fig. 9).

Table 15: number of sterilization of men performed, per province group and urbanization group per 10 000 men, 1972-1985

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
1972	15	19	22	33	9	25	30	24
1973	11	26	41	61	22	38	59	40
1974	14	40	38	77	34	41	62	46
1975	18	38	44	69	58	44	37	46
1976	33	59	53	80	45	66	52	57
1977	50	50	48	65	43	59	50	53
1978	67	82	59	106	76	72	79	74
1979	86	101	85	139	97	106	82	99
1980	66	73	79	92	66	78	91	79
1981	51	60	58	67	52	58	67	59
1982	43	52	43	68	48	50	51	50
1983	40	60	37	58	68	41	43	46
1984	49	45	41	55	42	45	51	46
1985	45	57	35	50	68	39	39	44



The fall in the number of sterilizations that became clear in 1980 seems to be drawing to a close. In a number of subgroups the fall is still occurring; against this there is a rise, notably in the eastern provinces and in rural municipalities.

Extrapolation gives 31 500 for the total population of the Netherlands.

A breakdown per quarter offers an opportunity for investigating whether a change in frequency may be a reaction to some event by which the popularity of this method may be influenced (Table 16).

Table 16: number of sterilizations of men performed, per quarter, per 10 000 men, 1972-1985<sup>1</sup>

	1st quarter	2nd quarter	3rd quarter	4th quarter
1972	4	7	5	8
1973	9	10	9	12
1974	10	12	12	12
1975	12	12	10	12
1976	15	14	13	15
1977	14	13	11	14
1978	20	29	16	18
1979	22	22	22	33
1980	24	20	16	18
1981	18	16	12	13
1982	14	11	10	14
1983	13	10	12	12
1984	12	12	8	13
1985	12	10	10	12

<sup>1</sup>) As a result of rounding-off when calculating relative frequencies, small differences may have occurred in the totals.

The frequencies per quarter in 1985 correspond to those of 1983 and 1984.

As has been said in the previous reports, if no other factors play a role, one may in the course of time expect a stabilization as a result of the end of a 'historical catching-up effect' coming into sight. If in 1985 some 11 500 sterilizations of men had been performed (the 'replacement factor'), the percentage of men sterilized at some time would have remained the same as in 1984. Since in reality some 32 000 operations were performed, there is still a considerable

additional increase of some 20 000. The percentage of men in the Dutch population sterilized at some time who - statistically speaking<sup>15</sup> - form part of the fertile age group increases as a result from 11.5% in 1984 to 11.9% in 1985 (Dr E. Ketting, Netherlands Centre for Mental Health).

In fig. 11 the number of sterilizations per 10 000 of all subgroups together is compared with that of women. There proves to be close agreement.

#### Age distribution

The age-specific distribution of the number of sterilizations performed per 10 000 men is given in Table 17 (cf. Fig. 12).

Table 17: number of sterilizations of men performed, by age group, per 10 000 men, 1972-1985

	age group					
	15-19	20-24	25-34	35-44	45-54	55-64
1972	-	(3)	42	105	35	-
1973	-	16	79	179	40	(4)
1974	-	9	110	186	39	(4)
1975	-	(3)	95	196	53	(2)
1976	-	15	149	207	48	-
1977	-	10	117	208	52	(7)
1978	-	8	148	309	89	10
1979	-	13	225	404	91	8
1980	-	11	222	267	52	(6)
1981	-	7	175	197	24	8
1982	-	9	125	185	27	(3)
1983	-	(6)	119	159	33	(2)
1984	-	8	105	157	36	(3)
1985	-	-	110	151	25	(5)

For all years the highest frequency is to be seen in the 35-44 age group. The decline that started in 1980 seems to be coming to a halt in this group. In respect of 1979 a drop of 63% occurred in 1985 as against 54% in the 25-34 age group. In 1984 the fall in respect of

1979 in the 35-44 age group is 61% and in the 25-34 age group 54%. A cumulative calculation shows that in the Netherlands since 1971 at least 530 000 sterilizations of men have been performed, that is on 7.4% of the total male population.

For a further study see the next section, in which the topic 'sterilization of the woman' is dealt with.

The question is maintained on the 1986 weekly return.

## STERILIZATION OF THE WOMAN

Sterilization of the woman performed was placed on the weekly return in 1974 (of the man performed in 1972).

The number of sterilizations of women performed per 10 000 of all women and per province group and urbanization group is given in Table 18 (cf. Fig. 10).

Table 18: number of sterilizations of women performed, per province group and urbanization group, per 10 000 women, 1974-1985

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
1974	37	37	30	40	37	28	44	35
1975	58	50	41	53	55	47	39	46
1976	76	58	61	74	66	71	55	66
1977	61	54	67	68	52	68	67	64
1978	68	62	76	116	60	85	83	81
1979	80	74	88	118	89	97	74	90
1980	67	57	74	71	81	64	77	70
1981	37	49	44	55	40	47	48	46
1982	41	45	37	43	52	36	43	40
1983	45	38	37	42	42	35	51	39
1984	32	53	38	33	55	33	42	39
1985	24	29	24	28	33	23	28	26

The national frequency of the number of sterilizations of women performed, unlike what was observed with regard to men, clearly fell in 1985. In the case of women the decline is 33.3% (from 39 to 26 per 10 000 women); in the case of men it is only 4% (from 46 to 44 per 10 000 men). The decline is present in all subgroups. Strikingly strong is the decline in the eastern provinces and the rural municipalities (from 53 to 29 per 10 000 women and from 55 to 33 per 10 000 men). This decline in the number of sterilisations of women in those regions coincides with an increase in those subgroup where the number of sterilizations of men is concerned: from 45 to 57 per 10 000 men and from 42 to 68 per 10 000 men.

In Fig. 11 a comparison is given between the number of sterilizations of men and of women per year. The curves display a large measure of agreement up to 1985.

The remarks made on the trend in the preceding chapter are also applicable here. In 1985 the curves for men and women seem to diverge. It remains to be seen whether these differences will also occur in the years to come.

The number per 10 000 of all women per quarter is given in table 19. The quarterly figures of 1985 differ from those of 1984.

Table 19: number of sterilizations of women performed, per quarter and per 10 000 women, 1974-1985 <sup>1)</sup>

	1st quarter	2nd quarter	3rd quarter	4th quarter
1974	6	9	10	10
1975	9	12	11	14
1976	12	17	19	18
1977	14	14	15	21
1978	18	22	19	22
1979	20	19	24	28
1980	22	18	14	16
1981	11	14	10	11
1982	10	11	9	10
1983	11	10	9	9
1984	11	8	9	10
1985	7	8	5	6

<sup>1)</sup> As a result of rounding-off when calculating relative frequencies, small differences may have occurred in the totals.

#### Age distribution

The age-specific distribution of the number of sterilizations performed per 10 000 women is given in Table 20 (cf. Fig. 12).

Table 20: number of sterilizations of women performed, by age group per 10 000 women, 1974-1985

	age group					
	10-14	15-19	20-24	25-34	35-44	45-54
1974	-	(3)	8	92	147	7
1975	-	-	14	132	177	25
1976	-	(2)	13	160	293	37
1977	-	-	25	174	246	40
1978	-	(3)	13	204	339	52
1979	-	-	19	239	377	44
1980	-	-	13	191	283	32
1981	(2)	-	11	154	155	10
1982	-	-	22	117	140	14
1983	-	-	7	106	156	21
1984	-	-	10	127	115	14
1985	-	-	(3)	75	92	9

In the case of women of 35 years old and older there is a decrease in the frequency of sterilization. Below the age of 35 a decrease may be seen in 1985, in contrast to 1984, when there was a decrease. As in most of the other years the highest frequency is to be found in the 35-44 age group.

A cumulative calculation shows that in the Netherlands since 1973 sterilization has been performed in total on at least 452 000 women, i.e. 6% of the total female population. However, it is more realistic to relate the figures solely to women of fertile age (15-49 years) and at the same time to include the sterilization pattern of the man.

In that case it proves that in 1975 the woman or the man was sterilized in some 6% of (married) couples. This percentage has since risen via approx. 18.5 in 1980 approx. 21 in 1982 and approx. 22.4 in 1984 to 23.0% in 1985. Dr E. Ketting, who made these calculations, expects that in the Netherlands a situation will come about in which about 30% of all women who reach the age of 50 in a given year will have been sterilized at some time. In 1985 this is already 26%. The number of sterilizations which has then to be performed annually on the basis of this calculation to keep the total percentage stable would then be about 25 000 (men and women

together).

To keep the percentage of women sterilized at some time stable, only 16 000 sterilizations were required in 1985. The number of sterilizations performed (obtained by extrapolation) is, however, 19 000; there was thus a real surplus of 3 000. In 1984 and 1983 this surplus was still 15 000 and 17 000; this declining trend may be an indication that the "historical catching-up effect" is drawing to a close.

However, in making calculations on fertility in the Netherlands, the number of hysterectomies should also be taken into account.

This question has been maintained on the weekly return for 1986.

## PRESCRIPTION OF THE MORNING-AFTER PILL

In 1972 the spotter physicians were asked for the first time to report when they prescribed the morning-after pill.

Table 21 gives the frequency with regard to the prescription of the morning-after pill, per province and urbanization group (cf. Fig. 13).

Table 21: number of prescriptions of the morning-after pill, per province group and urbanization group per 10 000 women, 1972-1985

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
1972	34	42	55	68	45	41	81	53
1973	29	69	57	67	62	47	79	59
1974	59	86	55	85	76	51	94	68
1975	54	77	55	61	76	54	57	60
1976	88	64	54	52	56	61	61	60
1977	59	57	44	50	42	55	44	49
1978	76	59	45	39	45	51	49	50
1979	60	54	46	50	46	50	53	50
1980	78	47	42	52	43	49	57	50
1981	42	36	29	46	29	35	40	35
1982	31	39	35	37	26	32	51	35
1983	25	39	27	36	28	29	36	30
1984	45	43	35	37	41	35	47	38
1985	37	31	31	30	30	29	39	32

The year 1984 seems to be an anomaly: the frequency of prescription of the morning-after pill is back at the level of 1981-1983. The decline in prescription of the morning-after pill occurs in all province groups and all urbanization groups.

The quarterly figures differ little from each other table 22.



Table 22: number of times that the morning-after pill was prescribed, per quarter, per 10 000 women, 1978-1985<sup>1</sup>

	1st quarter	2nd quarter	3rd quarter	4th quarter
1978	11	15	10	13
1979	15	11	12	12
1980	13	11	14	12
1981	11	9	8	8
1982	9	10	8	8
1983	7	8	7	8
1984	7	9	12	9
1985	8	7	9	8

<sup>1</sup>) As a result of rounding-off when calculating relative frequencies, small differences may have occurred in the totals.

#### Age distribution

Table 23 gives the age distribution of the prescription of the morning-after pill (cf. Fig. 14).

Table 23: number of prescriptions of the morning-after pill, by age group, per 10 000 women, 1972-1985

	age group					
	10-14	15-19	20-24	25-34	35-44	45-54
1972	(2)	148	150	117	67	7
1973	7	190	196	94	66	18
1974	(2)	266	171	104	78	34
1975	(5)	194	176	105	62	24
1976	10	204	129	102	87	21
1977	(6)	147	140	87	54	22
1978	(6)	180	156	58	60	25
1979	(2)	142	171	85	51	16
1980	-	148	134	90	67	10
1981	(2)	101	112	58	44	9
1982	(5)	109	107	56	44	(5)
1983	(6)	99	85	47	36	9
1984	(5)	144	115	62	24	13
1985	9	125	82	54	21	9

The decline already mentioned for 1985 occurs in all age groups except that of women of 10-14 years. It is true that there is a decline in the 15-19 age group, but in this group the frequency of prescription of the morning-after pill is nevertheless the highest of all age groups.

Because a 5-year age group is too broad a classification for the younger age, it is requested that reports on those under the age of 20 state the exact age, and with effect from 1980 also for patients older than 50 years. Reports above 50 years occurred once. The absolute numbers under 20 years are given in Table 24.

Table 24: absolute numbers of prescription of the morning-after pill for women under 20 years, 1977-1985

	1977	1978	1979	1980	1981	1982	1983	1984	1985
11 jaar	-	-	-	-	-	-	1	-	-
12 jaar	-	-	-	-	-	-	-	-	-
13 jaar	1	-	-	-	1	1	1	1	1
14 jaar	4	4	2	-	-	1	2	2	4
15 jaar	12	11	12	8	13	12	5	7	3
16 jaar	18	20	18	20	9	14	16	21	18
17 jaar	23	36	19	32	14	17	23	21	32
18 jaar	17	21	29	23	17	16	15	28	15
19 jaar	19	26	14	17	16	16	7	12	6
totaal	94	118	94	100	70	78	70	92	79

The extrapolation of the frequencies found tot the Dutch population appears on p 85 From 1983 onwards, at the request of M.R. van Santen, gynaecologist in Utrecht, it was also requested that the kind of pill prescribed be noted. This was to investigate whether the "new morning-after pill" (200 mcg ethinylestradiol + 1 mg dl-normgestrel) has displaced the "old" one (5 mg ethinylestradiol for 5 days). This proves to be the case. In 1980 5 mg EE2 was still being used in practically 100% of the cases; now that is 21% according to this registration.

Some caution in interpretation is called for here.

The declining pattern of prescription need not indicate reduced use. On the contrary, there are indications that self-medication often occurs, since the pill tablets are easily obtainable. Incorrect use such as several times per cucle, after more than one unprotected coitus or use of the wrong pill tablets is conceivable. This registration records how often the general practitioner is asked to prescribe the morning-after pill.

The question has been maintained on the 1986 weekly return, with reporting of the product prescribed.

## MALIGNANCIES

In the Netherlands national cancer registration is being prepared. When setting it up an important question was which information sources should form the basis of this national system. The pathological-anatomical laboratories entered into consideration for this. However, the question was how many cases were not registered via these laboratories. The Sentinel Stations Project was approached by the Ministry of Welfare, Public Health and Culture with this question (A.A.M. Vloemans, M.D.).

It is a fact that various forms of cancer registration already existing in other countries have their own specific limitations and possibilities.

Thus most types of cancer registration are confronted with under-registration in the age group above 65 years. The system making use of the spotter physicians would have this possibility to a lesser extent because selection on the basis of no further referral or treatment is still within the general practitioner's field of vision.

Between suspicion of a tumour and the ultimate confirmation or amendment of a diagnose a varying time interval may exist, depending on the type of tumour, localization and age group. All systems based on reporting of incidental cases that close their registration per calendar year, such as this sentinel station registration too, are aware of this problem of fluctuating duration of follow-up, varying from one day to a year.

In 1982 and 1983 spotter physicians retrospectively counted at the end of the calendar year the number of patients with a suspected malignancy. This yielded a first indication of how often the general practitioner does not refer, or no longer refers, a patient with suspected tumour to the specialist, or of the cases in which the general practitioner and/or the specialist decide not to confirm the diagnosis of cancer by means of pathological-anatomical assessment of material collected *ad vitam*.

On the basis of the data from 1982-1983 that had been collected in collaboration with P.A.H. van Noord, M.D., an epidemiologist with the Epidemiology Department of the Institute for General Health Care and Epidemiology of Utrecht State University, it did not seem really feasible to distinguish prevalent cases and complications, or metastases, from incidental cases and any 'secondary-primaries' and double tumours.

In 1984 and 1985 a further prospective registration was performed with a grant from the Ministry in which, in addition to reporting via the weekly return, use was made of a more extensive questionnaire for all new, i.e. incidental, cases of cancer. The aim was to investigate whether and to what extent the conclusions from 1982-1983 ought to be adapted on the strength of this more detailed registration.

For 1983 a percentage of 9 was found for the suspicions of a malignancy not confirmed by pathological-anatomical examination.

A further objective was to obtain a clearer picture of which type of tumours may give an under-representation for which (age) groups in a cancer registration system based exclusively on histopathologically confirmed tumours. If under-registration by means of histopathology is a random event, it could suffice to find a fixed "correction" percentage by which the histopathological incidences could be raised to 100%.

In addition, at the beginning of 1984 it was retrospectively investigated for 1983 what the desirability would be of obtaining after death confirmation of the presence of a carcinoma in the as yet hypothetical case that the general practitioner were to have a simple possibility of having an autopsy performed himself.

The registered patients consist of two groups:

1. patients with regard to whom the spotter physician makes the diagnosis suspected malignancy, but for whom no further diagnosis has been performed for some reason or the other (before the end of the registration year). The moment when the spotter physician proceeds to act as if a patient with a carcinoma were concerned is the moment of registration.
2. Patients with regard to whom the diagnosis has been confirmed by the specialist in the year of registration. The moment of registration is the moment when the spotter physician is informed of this diagnosis.

## Results

### Representation within the Netherlands

As stated, in the course of the period 1982-1984 the method of registration was adapted, so that differences between the years may not be interpreted as differences in incidence but rather as a result of optimization of the registration.

Table 25 gives the numbers of new cancer patients per 10 000 men and 10 000 women by province group and urbanization group (cf. fig. 15).

Table 25.: numbers of new patients per province and urbanization group, per 10 000 men, per 10 000 women and per 10 000 inhabitants, 1984-1985

		province group				urbanization group			Netherlands
		A	B	C	D	1	2	3	
men	1984	39	31	38	40	29	37	46	37
	1985	36	31	43	29	31	37	39	37
women	1984	28	32	37	34	29	33	39	34
	1985	20	29	30	30	17	29	35	28
total	1982	21	23	27	20	19	22	30	24
	1983	27	23	36	25	22	27	44	30
	1984	34	32	38	36	29	35	43	36
	1985	28	30	36	30	24	33	37	32

The figures for 1984 and 1985 may be considered the most reliable and the most complete as regards the registration of new (i.e. incidental) cases of cancer.

In 1984-1985 most cancer patients (confirmed or suspected) are reported in the centre and west of the country (province group C) and the cities (urbanization group 3). This follows the pattern found for cancer mortality as stated in the Atlas for cancer mortality in the Netherlands (bases on cause-of-death statistics) of the Central Bureau of Statistics.

#### Age distribution

Table 26 shows how the reported cases of (suspected) cancer are distributed among the various age groups, per 10 000 men and per 10 000 women (cf. fig. 16).

Table 26: reported cases of (suspected) cancer, distributed among the various age groups, per 10 000 men and per 10 000 women

	age group						Total
	< 25	35-34	35-44	45-54	55-64	≥ 65	
men per							
10 000							
1982	(1)	(1)	6	25	68	157	25
1983	(2)	(1)	9	25	81	193	29
1984	(2)	(4)	13	37	99	210	37
1985	8	6	19	25	80	219	37
women per							
10 000							
1982	(1)	4	25	25	51	91	23
1983	(1)	6	20	47	87	114	31
1984	(1)	8	24	46	54	140	34
1985	(5)	9	20	36	49	113	28

The limitations as regards the interpretation of supposed differences between the registration years continue to apply here too.

Table 27: absolute numbers of (new) patients reported by the sentinel stations with (suspected) malignancy by localization retrospectively collected in 1982-1983, prospectively in 1984-1985, in order of the number of reports in 1985

Localization	ICD-code 9th revision	1982	1983	1984	1985
Skin + melanoma	172, 173	37	49	94	85
Lung	162	74	74	95	71
Colon + rectum	153, 154	50	52	53	58
Mamma	174	58	67	58	47
Male sexual organs	185, 186	18	18	15	31
Digestive tract, other	150-159 except 151, 153, 154	18	21	25	30
Female sexual organs	180, 182, 183	32	36	44	26
Urogenital tract, other	140-209	18	32	33	25
Stomach	151	20	29	33	22
Unclassifiable, incl. primary localization unknown		5	27	28	19
Other types of tumours	140-209	23	30	33	18
Lymphatic and hemato- poietic tissue	200-209	19	20	13	16
		372	455	524	448

In the case of double tumours the tumour of primary suspicion has been counted (Table 27). A presentation in percentages has been forgone, since this would be strongly influenced by the relatively strong increase in the number of reports of (non-melanoma) skin tumours, of which it has to be assumed that these were under-registered in 1982-1983.

The shifts in rankings per year may be regarded as a random phenomenon, given these small numbers, and partly as a registration phenomenon, viz an increase in the completeness of registration.

The decrease in absolute numbers of tumours between 1984 and 1985 is explained mainly by a smaller numbers of tumours found in women.

It would seem that with these sentinel station data some perception is being provided of the occurrence of skin tumours, notably the non-melanomas. Up to now these tumours have, worldwide too, mostly



remained outside the tumour registration systems based on mortality, hospital admission or confirmation by histopathological examination.

Table 28: absolute number of patients not referred for further diagnosis (i.e. no pathological-anatomical diagnoses) by age group, 1984-1985

	age group								Total
	<25	25-34	35-44	45-54	55-64	65-74	75-84	≥85	
1984	-	2	-	-	1	3	3	4	13
1985	-	-	-	-	1	-	6	4	11

Of the 11 patients in 1985, there were three cases with a process in the lung. Of the rest, referral was decided against, in connection with age.

(This table does not include the skin tumours removed by the general practitioner himself, but for which in all cases pathological-anatomical examination has been performed).

Table 29: absolute number of patients referred for whom no (further) pathological-anatomical examination was performed or the diagnosis was made differently, per age group, 1984-1985

	age group								total
	<25	25-34	35-44	45-54	55-64	65-74	74-85	≥85	
1984	2	-	-	2	5	7	9	5	30
1985	-	1	-	4	1	8	4	4	22

Although they were referred for further diagnosis, in the case of 15 patients from 1984 no pathological-anatomical diagnosis is known. For 1985 this number is 14. Ten patients of the 22 in 1985 without pathological-anatomical examination have meanwhile died. Six cases involved tumours in the "digestive tract, other" of which at least three with indications of a carcinoma of the pancreashead, that diagnosis being made on the basis of an echo or CAT-scan. In addition at least three lung processes, three kidney tumours and two

processes in cerebro were involved.

Proceeding from the totals of Table 29 and the non-referrals (Table 28), in 1984 as a minimum (30 + 13 = 43 of the 524) = in 8% and in 1985 (22 + 11 = 33 of the 448) = in 7% of the cases of suspicion no histopathological material was submitted.

From the additional questionnaire in 1985 it could be derived that in the case of a minimum 23 patients the specialist was the first to discover the malignancy as a "chance finding" in a patient who was already under supervision for another disorder. In this way the general practitioner received the report via the specialist.

In the case of seven of these 23 patients it was the specialist who made the diagnosis without pathological-anatomical examination and/or decided against further invasive diagnosis. The impression exists that these were in the majority older patients with an already deteriorated state of health, in view of the fact that patients were already under treatment or supervision of the specialist.

On the strength of the above we are inclined to assume that in the majority of the cases in which no pathological-anatomical examination was performed a malignancy is nevertheless involved; this is then assumed on the basis of other diagnosis and the rather high number of patients that die within the year (Schade<sup>16</sup> Nylenna<sup>17</sup>).

#### In conclusion

The detailed registration in 1984 and 1985 broadly confirm what had already been found in 1982 and 1983, namely that in cancer registration based on histopathological confirmation a not inconsiderable under-registration will take place:

- A. Quantitatively where a percentage of 8% or 7% under-registration is concerned;
- B. Quantitatively where this under-registration seems to be based on selectivity as regards age, state of health, localization and anticipated trend of the malignancy.

The type additional information that cancer registration by spotter physicians can provide seems characterized by this.

It has further emerged from this form of registration that for a number of tumour localizations under-registration can occur systematically because diagnosis is being performed by means of cytology (blood picture, bone marrow puncture), with an X-thorax and on the basis of an echo or CAT-scan. The last two techniques are

notably used with respect to tumours in cerebro, the kidney-cavity or the pancreashead.

Whether this is a trend in the general diagnosis of malignancies that will have to be anticipated by cancer registrations cannot be said on the strenght of the small number of cases found here. It does however, indicate that sentinel station cancer registration is capable of pointing to this kind of tendency.

The data on the four registration years will be the subject of a separate publication. For 1986 cancer registration has been removed from the weekly return.

## DEPRESSION (treated for)

Little is known about depression (depressive syndrome) as a medical problem for the general practitioner. For the psychiatrist it is one of the large groups of illnesses that form a major part of polyclinical and clinical morbidity.

On the other hand, a depressed state is often designated as a variation of mood forming part of a normal life and experienced from time to time by very many people. In such a mental state one is inclined to take a more sombre view of things, to interpret harmless physical defects more darkly and, possibly as a result of this, to visit the general practitioner sooner or later.

In many of those cases the physical problem and not the depressed state of mind will be to the fore. At that moment there is thus no question (as yet) of depression as a medical problem.

Few if any objective criteria are available for making a clear distinction between a depressed mood as a general human state of mind and a depressive syndrome as a problem calling for specific medical approach. In fact one cannot speak of depression as a medical problem until the general practitioner and patient (or the latter's family) call it a problem.

In the discussion whether or not to include depression on the weekly return, one was well aware of the probability of an 'interdoctor variation' with regard to using this diagnosis. It was therefore decided forthwith that an investigation would be made into this. Because action by the spotter physician could be influenced, it was agreed not to perform that investigation until the second year of registration. At present only the observed frequencies are being reported.

### Criteria:

By depressive syndrome is meant a syndrome recognized as such by the general practitioner in which the sombre negative state of mind occupies a central position.

Registration was not to take place until the seriousness of the depression led the physician to take some form of action, viz:

- antidepressive medication;
- treatment by discussion with the patient;
- follow-up contacts (i.e. repeat consultations or visits);

- referral for (co-)treatment (social worker, psychologist, psychiatrist and the like).

Only the first contact with a patient is reported. A breakdown in accordance with age and sex is made.

The criteria were drawn up by colleague H.O. Sigling, a former spotter physician who is at present a member of the medicine of general practice department of the Free University, Amsterdam. He will also perform the further investigation mentioned above.

Table 30 states the frequencies of the actions per provinces and urbanization group, subdivided by sex (see also Fig. 17).

Table 30: number of new patients "treated" for a depressive syndrome, by province and urbanization group, per 10 000 men and women, 1983-1985

		province group				urbanization group Netherlands			
		A	B	C	D	1	2	3	
Men	1983	75	57	40	75	56	46	81	55
	1984	58	57	32	61	53	35	74	46
	1985	36	30	44	24	16	31	61	36
Women	1983	148	74	87	138	75	84	182	104
	1984	106	116	77	105	103	72	147	94
	1985	74	78	61	63	64	63	106	73
Total	1983	112	65	64	107	65	65	133	80
	1984	83	87	55	71	78	55	112	71
	1985	55	55	61	44	40	47	84	55

For the whole of the Netherlands the total of the new patients "treated" for a depressive syndrome in 1985 fell further: from 80 (1983) via 71 (1984) to 55 per 10 000 inhabitants. The decline is visible in all subgroups, with one exception. Among the male inhabitants of the western provinces an increase has been established to above the 1983 level: in 1983 40, in 1984 32 and in 1985 44 new patents per 10 000 men.

In two subgroups the fall in the number of new patients is

strikingly large: among the men in the southern provinces (in 1984 still 61 and in 1985 24 per 10 000 men) and among the men in the rural municipalities (in 1984 still 53 and in 1985 only 16 per 10 000 men). In contrast with the years 1983 and 1984, more new patients were treated in 1985 in the western provinces than in one of the other provinces groups. Incidentally the years 1983 to 1985 incl. the differences in the frequencies are the least in the western provinces: 64, 55 and 61 per 10 000 inhabitants. In the northern provinces the frequencies of the new patients varied the most: for 1983 112, for 1984 83 and for 1985 55 per 10 000 inhabitants.

If we consider the differences between the province groups, they have been becoming steadily less from 1983 onwards: to put another way, the difference between the numbers of new patients treated per province group has become less and less.

The differences between the urbanization groups as established in 1983 and 1984 are also present in 1985. The highest frequencies are constantly found in the cities; even twice as high as in the rural municipalities, where the lowest frequencies were found (84 and 40 per 10 000 inhabitants respectively).

Between women and men an obvious difference was again found in 1985 for the whole of the Netherlands: in a ratio of 2 women to 1 man they were treated as new patients.

In the subgroups this ratio varies from 4.00 for the ratio between women and men in rural municipalities to 1.38 for the ratio between women and men in the western provinces.

#### Age distribution

Table 31 gives the frequencies per age group and per sex (see also Fig. 18).

Table 31: number of new patients 'treated' for a depressive syndrome by age group, per 10 000 inhabitants, 1983-1985

		age group								
		5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-65	≥ 65
men	1983	-	(2)	10	35	75	112	93	94	54
	1984	-	-	(6)	41	58	75	88	67	51
	1985	(-)	(2)	8	19	51	65	68	43	33
women	1983	-	(6)	67	103	140	173	182	129	99
	1984	(2)	9	47	85	132	149	132	115	104
	1985	-	(4)	38	63	119	104	132	77	66
total	1983	-	(4)	39	69	108	142	138	112	81
	1984	(1)	4	27	64	95	112	110	92	82
	1985	)1)	(3)	23	42	84	85	100	61	52

Below the age of 15 years the physician takes little action (see the criteria for registration) on account of a depressive syndrome; above that age this rises quickly, with a maximum of 100 times per 10 000 inhabitants of the 45-54 age group. Above that group a gradual decline occurs, ending with a frequency of 52 per 10 000 at an age greater than 64 years. The above-mentioned difference per sex is present in all age groups, with the proviso that the woman-man ration in the case of patients younger than 25 years is nearly 3.4:1; above that age it is nearly 2:1. As already stated, further analysis will take place against the background of a possible interdoctor variation.

This topic has been removed on from the weekly return for 1986.

## (ATTEMPTED) SUICIDE

In 1970-1972 attempted suicide, successful and unsuccessful, appeared on the weekly return. In consultation with the Chief Medical Office for Mental Health the Programme Committee decided to repeat this gauging in 1979.

In other fields too (hospitals), research into suicide is being performed at present. In this way it is being attempted to get an insight into the extent, the trend and other aspects of the problem. The name of the topic is the definition.

The Chief Office also requested that more data be collected on the cases reported. For this purpose a questionnaire has been compiled in cooperation with Professor R.F.W. Diekstra, clinical psychologist, Leiden. On this form the question whether the attempt was successful or not and how the attempt was made also appears. At the same time questions are asked about contacts with the medical sector prior to the (attempted) suicide.

However, the essential aspect here is not whether the attempt was successful; the primary concern is the patient's intention, with the possibility that suicide is a consequence of the action.

The absolute number of reports (which is not equal to the number of patients, since recidivists are not uncommon) was 106, 98, 95, 116, 148, 109 and 90 in 1979-1985.

The number of reports in 1983 proves to be the largest in comparison with those of the preceding years and of the period 1970-1972, when 109, 135 and 110 cases respectively were reported in a population of practically the same size. To what extent this is attributable to oscillations occurring, or whether the increase noted in the number of suicide attempts in data registered elsewhere is now also reflected in the sentinel station data, is for the time being not clear (see 1982 report, p. 50).

The number of attempts per province and urbanization group per 10 000 inhabitants may be found in Table 32. The breakdown into sub-groups is of limited value, because of the relatively small frequencies. As in 1984, most suicide attempts are reported in the western provinces and in the cities: 8 and 11 per 10 000 inhabitants respectively.



Table 32: number of reports of (attempted) suicide per province and urbanization group, per 10 000 inhabitants, 1979-1985

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
1979	8	6	8	5	5	7	9	7
1980	9	4	8	5	4	7	9	7
1981	6	4	7	7	3	7	7	6
1982	10	5	9	9	2	6	15	8
1983	16	5	11	8	4	8	16	10
1984	4	4	9	9	4	5	15	7
1985	6	3	8	5	2	6	11	6

### Age distribution

Table 33 gives the frequency of (attempted) suicide per 10 000 inhabitants per age group (see also Fig. 19).

Table 33: number of reports of (attempted) suicide by age group, per 10 000 inhabitants, 1979-1985

	age group							
	10-14	15-19	20-24	25-34	35-44	45-54	55-64	≥ 65
1979	(1)	5	7	12	11	11	9	7
1980	-	5	14	7	12	7	6	10
1981	(2)	4	12	11	8	6	5	6
1982	-	9	18	11	10	7	7	7
1983	-	8	15	15	16	12	9	8
1984	-	6	13	9	11	9	9	8
1985	(1)	3	10	11	8	11	4	6

With regard to age groups too the breakdown is of limited value on account of the small absolute numbers and the ease with which oscillations can occur.

In 1985 a decline occurs in most age group in the number of suicide attempts. The decline is a pronounced one in the 55-64 age group: in 1984 9 and in 1985 4 per 10 000 inhabitants. Compared with 1984 the 25-34 and 45-54 age groups display higher: for both age

groups in 1984 9 and in 1985 11 reports per 10 000 inhabitants.

#### Seasonal influences

In contrast to what is occasionally asserted, there proves to be no connection between the number of suicides or attempts and the seasons. This was likewise found by the Rotterdam Municipal Medical and Health Service in the period 1954-1981<sup>18</sup>.

This topic has been maintained on the weekly return for 1986.

## MYOCARDIAL INFARCTION (suspicion of)

Knowledge of the number of cases of myocardial infarction is important to adaptation of policy with to both health care and scientific research policy. For mortality the cause-of-death statistics of the Central Bureau of Statistics may be consulted. As regards morbidity, the Medical Registration Foundation can, of course, supply figures only on the basis of the discharge diagnosis from hospitals. So as to obtain a really complete insight into the incidence, a call was made in 1978 on the Continuous Morbidity Registration.

In the first instance there was a desire to gain insight in to the number of cases in which the physician acts as if an acute myocardial infarction is concerned. What is meant by this is that the diagnosis 'infarction' - both a primary and a recurrent infarction - is considered so probable that the usual measures for this are taken. This refers to the administration of antiarrhythmic agents and agents for combating pain and shock, possible resuscitation and reanimation, or (acute) admission to hospital.

Partly in connection with publications<sup>19</sup> pointing to favourable experience with home nursing, even compared with the coronary care units, there was increasing interest in the question how often suspicion of myocardial infarction led to hospitalisation. The question whether the diagnosis is verified or not is not important in the first instance. Such a verification can be obtained from other sources.

When recording the data for 1978 the desire was expressed to repeat the investigation five years later, with the idea of then doing further research into confirmation of the diagnosis made and the further course of the disease in the various subgroups. That was the reason why it was decided in 1983 to reintroduce this topic and to do so in unchanged form, for the sake of comparability with the 1978 data.

Two questions were formulated:

1. In how many cases did you take measures this week as if a myocardial infarction were concerned? (Both a primary and a recurrent infarction, even if a report on one and the same patient is concerned.)
2. How often did this lead to admission to hospital? (Within 48 hours.)

For both questions a breakdown by sex was made. Since this was a question about the physician's action, mors subita was kept outside the registration.

Dr F.H. Bonjer, secretary/coordinator of the former T.N.O. committee for the coordination of research into heart and vascular diseases, is acting as adviser for this topic.

Table 34 gives the frequencies of (suspicion of) myocardial infarction per province and urbanization group and for the Netherlands (see also Figs. 20 and 21).

Table 34: number of cases in which the spotter physician acts as if an acute myocardial infarction is concerned, per province and urbanization group, per 10 000 men or women, and by admission or non-admission to hospital within 48 hours, 1978 and 1983-1985

		province group				urbanization group			Netherlands	
		A	B	C	D	1	2	3		
clinical	M	1978	38	43	26	31	39	22	51	32
		1983	28	40	30	19	37	26	33	29
		1984	24	52	32	27	41	30	32	33
		1985	28	30	32	35	31	32	33	32
	F	1978	14	20	14	12	13	13	20	15
		1983	12	14	13	11	7	13	17	13
		1984	12	17	14	10	14	13	15	15
		1985	11	13	15	14	7	13	19	14
total	1978	26	31	20	22	26	17	35	23	
	1983	20	27	21	15	22	19	24	21	
	1984	18	34	18	18	28	21	25	23	
	1985	20	21	23	24	19	22	26	23	
non-clinical	M	1978	11	11	7	8	8	6	15	9
		1983	9	11	6	8	9	6	10	8
		1984	12	8	5	4	6	5	9	6
		1985	4	10	6	9	4	7	10	7
	F	1978	8	7	4	6	(3)	5	7	5
		1983	9	9	5	3	(2)	6	7	6
		1984	3	4	4	4	1	3	8	4
		1985	4	5	5	4	1	4	8	5
total	1978	9	9	6	7	6	6	11	7	
	1983	9	10	5	6	6	6	8	7	
	1984	7	6	4	4	3	4	8	5	
	1985	4	8	5	7	2	6	9	6	
clinical and non-clinical	M	1978	49	54	33	39	47	28	66	41
		1983	37	51	36	27	46	32	43	37
		1984	36	60	37	31	47	35	41	39
		1985	32	40	38	44	35	39	43	39
	F	1978	22	27	18	18	16	18	27	20
		1983	21	23	18	14	9	19	24	19
		1984	15	21	18	14	15	16	23	19
		1985	15	21	20	21	9	19	27	19
total	1978	35	40	26	29	32	23	46	30	
	1983	29	37	26	21	28	25	32	28	
	1984	25	40	27	22	31	25	33	28	
	1985	24	29	28	31	21	28	35	29	

If the figures for clinical and non-clinical patients for 1983, 1984 and 1985 are compared with those for the whole of the Netherlands, little or no difference is registered as regards (suspicion of) myocardial infarction in both men and women (37, 39 and 39 per 10 000 men and 19, 19 and 19 per 10 000 women respectively).

In the case of men admitted to hospital, after an increase in 1984, in 1985 in the eastern provinces a decrease occurs (52 per 10 000 men in 1984 and 30 per 10 000 men respectively). In the southern provinces the number of men admitted under suspicion of a myocardial infarction in 1985 continues to rise (27 in 1983, 35 in 1984 and 44 per 10 000 men in 1985 respectively). If we consider the breakdown by degree of urbanization of the men admitted, we see a decline in the number in rural municipalities (41 per 10 000 men in 1984 and 31 in 1985).

For women admitted with (suspicion of) myocardial infarction practically the same movements may be observed: a decrease in the eastern provinces from 17 to 13 per 10 000 women respectively, an increase in the southern province groups from 10 to 14 per 10 000 women and a decrease in the rural municipalities from 14 to 7 per 10 000 women.

In contrast to men in the cities, with regard to whom the figures for 1984 and 1985 were practically alike ( 32 and 33 per 10 000 men respectively), for women in the cities an increase occurs to 15 per 10 000 women in 1984 and 19 in 1985 respectively.

The difference for both sexes together and for both clinical and non-clinical patients between the province groups that were established in 1984 are less great in 1985.

More than in 1984 there are now differences between the urbanization groups: frequencies increasing from rural municipalities to the cities of 21, 28 and 35 inhabitants respectively.

### Age distribution

In table 35 the frequencies per age group are given (see also Figs 22 and 23).

The observation that for men myocardial infarction is clearly occurring at a younger age still applies. Here the fact that women in general become older should be taken into account, but, partly in view of the difference in relative frequencies, this cannot entirely explain the above-mentioned difference.

Table 35: number of cases in which the physician acts as if an acute myocardial infarction is concerned, per age group, per 10 000 men or women, and by admission or non-admission to hospital within 48 hours, 1978, 1983-1985

		age group						
		20-24	25-34	35-44	45-54	55-64	≥ 65	
clinical	M	1978	(2)	(3)	13	51	106	169
		1983	-	(2)	15	51	106	132
		1984	-	-	17	46	116	149
		1985	-	-	17	40	96	163
		1985	-	-	17	40	96	163
	F	1978	-	-	(4)	12	44	80
		1983	-	-	(4)	12	28	66
		1984	-	-	(2)	16	38	58
		1985	-	(1)	(3)	12	23	70
		1985	-	(1)	(3)	12	23	70
total	1978	(1)	(2)	9	31	74	118	
	1983	-	(1)	10	31	66	93	
	1984	-	-	9	32	75	95	
	1985	-	(0)	10	26	58	108	
	1985	-	(0)	10	26	58	108	
non-clinical	M	1978	-	-	(7)	12	40	33
		1983	-	-	2	6	26	48
		1984	-	-	(2)	6	12	40
		1985	-	(1)	3	7	22	39
		1985	-	(1)	3	7	22	39
	F	1978	-	-	(1)	(2)	(2)	44
		1983	-	(1)	-	(2)	(4)	39
		1984	-	-	-	(5)	7	20
		1985	-	-	-	4	7	26
		1985	-	-	-	4	7	26
total	1978	-	-	4	7	20	39	
	1983	-	(0)	(1)	4	15	43	
	1984	-	-	(1)	6	9	28	
	1985	-	(0)	(2)	5	14	31	
	1985	-	(0)	(2)	5	14	31	
clinical and non-clinical	M	1978	(2)	(3)	20	63	146	202
		1983	-	(1)	17	57	132	180
		1984	-	-	19	52	128	189
		1985	-	(1)	20	47	118	202
		1985	-	(1)	20	47	118	202
	F	1978	-	-	5	14	46	124
		1983	-	(1)	4	14	32	105
		1984	-	-	2	21	45	78
		1985	-	(0)	3	16	30	96
		1985	-	(0)	3	16	30	96
total	1978	(1)	(2)	13	38	94	157	
	1983	-	(1)	11	35	81	136	
	1984	-	-	10	38	84	133	
	1985	-	(0)	12	31	72	136	
	1985	-	(0)	12	31	72	136	

(N.B. In the collecting of the follow-up data per patient it proves that a number of spotter physicians have registered mors subita as 'non-clinical myocardial infarction'. To what extent this will affect the statements made here cannot yet be seen).

The percentage of patients with (suspicion of) myocardial infarction being nursed at home is Table 36.

Table 36: percentage of men and women with (suspicion) of myocardial infarction being nursed at home

	men, all ages	65 years	women, all ages	65 years
1983	22	27	35	37
1984	15.4	21	21.1	25
1985	17.9	19.3	26.3	27.1

The difference between men and women can be partly explained by the large percentage of women above 64 years being nursed at home: in 1985 27.1% women as against 19.3% men.

In 1984 these percentages differed less: for women 25% for men 21%. In 1983 the difference was greater: for women 37% and for men 27%. A further analysis may perhaps reveal the other factors that this decision. The Netherlands Heart Foundation has given a grant for this. At the same time will be endeavoured to gain insight into the severity of the disorder and the follow-up in the various groups of patients. This research will be performed by J. Fracheboud, general practitioner, under the supervision of Dr J. Berkel, internist, and Dr F.H. Bonjer, cardiologist. It is to be concluded in 1986.

For 1986 this subject has been removed from the weekly return.



## ULCUS PEPTICUM

In 1984 Hoogendoorn described in the *Nederlands Tijdschrift voor Geneeskunde* shifts in the epidemiological pattern of ulcus pepticum<sup>20</sup>. Over the period 1950-1981 he described the considerable changes that have occurred in the Netherlands with regard to ulcer sufferers. Among men the national mortality and the frequency of hospitalization on account of ulcus ventriculi and ulcus duodeni have fallen sharply. Among women there is any question of a decline; indeed, in various age groups opposite tendencies occur. In the case of young women there is a decrease in mortality and clinical morbidity; in the case of older women an increase occurs.

This study by Hoogendoorn was based on data from the medical Registration Foundation and the Central Bureau of Statistics, on the cause-of-death statistics and the data from hospital registration. The question arose whether in general practice too the above-mentioned developments could be established. It was decided to place the subject on the weekly return to supplement the above data. Since the subject also appeared on the weekly return for 1975, a comparison can be made with the data from that year. For this subject the advice was sought of Prof. Dr O.J. ten Thije, gastro-enterologist, Utrecht.

For the registration a distinction has been between suspicion of an ulcus pepticum and certain diagnosis.

Suspicion of an ulcus pepticum arises if a patient has stomach complaints for longer than one to two weeks: stomach ache, pain in the night relieved by food, milk or antacids, tendency to recur in the winter, stomach complaints for years already (periodical) and a painful area that can be indicated by one finger.

Gastroscopy, X-ray examination or the surgeon's eye can confirm suspicion of an ulcus pepticum. Spotter physicians have been asked to register the way in which certainty has been acquired with regard to the diagnosis.

A second distinction is that between new patients and patients with a recurrent ulcus pepticum. Recurrence occurs when a new episode of complaints puts in an appearance after a complaint-free period of three months. When the complaints manifested themselves for the first time in a person in 1985 and there was a recurrence in the

same person in 1985, the spotter physicians were requested not to register this recurrence. One may therefore speak of an underestimation of the number of recurrences. A distinction has been made with regard to the sex of the patient with an ulcer pepticum.

In Table 37 the numbers of patients with a suspected or certain first ulcer pepticum and with a suspected or certain recurrent ulcer pepticum are given per province and urbanization group per 10 000 men and women and for the Netherlands (see also Figs. 24-25).

Table 37: number of patients with a first ulcer pepticum, suspected or confirmed, and a recurrent ulcer pepticum, suspected or certain, per province and urbanization group, per 10 000 men and women for 1985

		province group				urbanization group Netherlands			
		A	B	C	D	1	2	3	
1st ulcer	M	13	15	15	11	10	16	9	14
	suspected F	14	4	14	10	7	13	10	11
1st ulcer	M	5	7	8	4	7	4	11	6
	certain F	2	3	4	11	4	4	9	5
1st ulcer	M	18	22	23	15	17	20	20	20
	total F	16	7	18	21	11	17	19	16
recurrence	M	16	12	24	17	10	15	36	19
	suspected F	4	6	10	7	4	7	12	8
recurrence	M	1	-	3	2	1	2	3	2
	certain F	-	-	3	1	-	1	5	2
recurrence	M	17	12	27	19	11	17	39	21
	total F	4	6	13	8	4	8	17	10
all ulcera	M	35	43	50	34	28	37	59	41
	total F	20	13	31	29	15	25	36	26

In 1985 men suffer more frequently from complaints whereby the general practitioner suspect an ulcer or can make a certain diagnosis than women.

For the whole country this is the case with 41 per 10 000 men and 26

per 10 000 women. With the odd exception, men suffer more than women from ulcera in all subgroups. The exception to this is formed by the southern provinces as regards the first ulcers diagnosed with certainty (4 per 10 000 men as against 11 per 10 000 women) and the cities for the recurrent ulcera diagnosed with certainty (3 per 10 000 men as against 5 per 10 000 women) and for the suspected first ulcera (9 per 10 000 men as against 10 per 10 000 women).

Exceptions are also the subgroups where the occurrence of *ulcus pepticum* and suspicion thereof is the same for men and women.

For the whole country this applies in the group of recurrent ulcera diagnosed with certainty (2 per 10 000 for both men and women) and, as regards the eastern and western provinces, likewise for the recurrent ulcera diagnosed with certainty. In the municipalities with urban characteristics together with urbanized rural municipalities (urbanization group 2) a first *ulcus pepticum* is diagnosed with certainty as frequently among women as among men (4 per 10 000 for both sexes). The *ulcus pepticum* occurs suspected and diagnosed with certainty both for the first time and as a recurrent disorder most frequently in the western provinces and in the cities: 81 and 95 per 10 000 inhabitants respectively.

Table 38 gives insight into the relation between suspected *ulcus pepticum* and the *ulcus* diagnosed by X-ray examination, gastroscopy or during an operation.

Table 38: numbers of patients with a suspected first and recurrent ulcer pepticum and with a first and recurrent ulcer pepticum diagnosed with certainty per province and urbanization group per 10 000 men and women for 1985

		province group				urbanization group Netherlands			
		A	B	C	D	1	2	3	
suspected ulcus (first and recurrent)	M	29	27	39	28	20	31	45	33
	F	18	10	24	17	11	20	22	19
total		47	37	63	45	31	51	77	52
certain ulcus (first and recurrent)	M	6	7	11	6	8	6	14	8
	F	2	3	7	12	4	5	14	7
total		8	10	18	18	12	11	28	15

These figures justify the pronouncement that in the event of a suspicion of an ulcer pepticum general practitioners need a further examination in order to underpin the diagnosis in only a minority of those cases.

#### Comparison with 1975

As stated above, ulcera also appeared on the weekly return in 1975, albeit in a somewhat different form, namely patients with regard to whom the diagnosis *ulcus ventriculi* or *ulcus duodeni* had been confirmed for the first time via X-ray examination or gastroscopy. It therefore related to those patients for whom the further diagnosis described was performed for the first time and the diagnosis *ulcus ventriculi/duodeni* was confirmed, whether a first ulcer or a recurrent one was concerned.

Some comparison is possible with the categories of confirmed first ulcer and confirmed recurrent ulcer used in 1985. A difference occurs where in 1985 further examination is made of the recurrent ulcer and it is not the first time that, by means of the

supplementary examination, the diagnosis *ulcus pepticum* is confirmed. The figures for 1985 can therefore be adjusted somewhat if they are to be properly comparable with those of 1975.

On the other hand it must be realized that, as a result of the instructions for registration, the figures for 1985 give an underestimate of the number of recurrence. It was agreed for 1985 that, if the complaints manifested themselves in 1985 for the first time in one person, this person would not be reported again in the case of a recurrence.

Table 39 gives the figures for the ulcers confirmed by means of further diagnosis for 1975 and 1985 per province and urbanization group per 10 000 men and 10 000 women.

Table 39: numbers of patients with an *ulcus pepticum* diagnosed by means of further examination per province and urbanization group per 10 000 men and 10 000 women for 1975 and 1985

		province group				urbanization group			Netherlands
		A	B	C	D	1	2	3	
1975	M	66	23	23	15	39	17	29	27
	F	3	14	11	8	9	8	14	11
1985	M	6	7	11	6	8	6	14	7
	F	2	3	7	12	4	5	14	7

With the reservation made above regarding the comparability of the figures for the two years, it may be said that notably the pronounced decline among men in the occurrence of an *ulcus pepticum* diagnosed with certainty, from 27 to 8 per 10 000 men in 1975 and 1985, stand out.

Among women the decline is less pronounced, from 11 to 7 per 10 000 women. In the case of women in the southern provinces something is going on. Among them the occurrence of *ulcus pepticum* confirmed by means of X-ray examination or gastroscopy, or during an operation, has even increased from 6 to 12 per 10 000 women in 1985. In the cities the frequency in 1975 and 1985 is the same, 14 per 10 000 women.

### Age distribution

Table 40 gives the frequencies of the ulcers per age group (see also Fig. 26).

Table 40: number of patients with a first ulcer pepticum, suspected or confirmed, and a recurrent ulcer pepticum, suspected or confirmed, by age group, per 10 000 men and per 10 000 women for 1985

		age group							
		10-14	15-19	20-24	25-34	35-44	45-54	55-64	≥65
first ulcer	M	(2)	(7)	22	24	20	12	22	(4)
suspected	F	-	-	9	18	18	20	19	9
first ulcer	M	-	(3)	(6)	4	5	9	17	13
certain	F	-	(2)	(1)	(3)	11	(3)	10	13
first ulcer	M	(2)	10	28	28	25	21	39	17
total	F	-	(2)	10	21	29	23	29	22
recurrent	M	-	-	8	25	31	39	34	19
suspected	F	-	(2)	-	10	11	16	12	11
recurrent	M	-	(2)	-	(2)	6	(1)	(5)	(3)
certain	F	-	-	-	-	-	(5)	(6)	(3)
recurrent	M	-	(2)	8	27	37	40	39	22
total	F	-	(2)	-	10	11	21	18	14
first + rec.	M + F	(1)	8	23	44	51	52	60	38

Ulcer pepticum proves already to occur at a relatively young age, in the 10-19 age group. It is then an exception, found more among boys than among girls. And even recurrence already exist. However, it is not until the age of 20 years onward that an obvious occurrence of this complaint is found. Up to the age of 65 years the frequency increases from 23 per 10 000 men and women in the 20-24 age group to 60 per 10 000 men and women in the 55-64 age group. Above the age of 65 the occurrence falls to 38 per 10 000 men and women.

Suspicion of a first or recurrent ulcer occurs as a rule more than the first or recurrent ulcer confirmed by further diagnosis. Only

the age group above 65 years forms an exception to this, and then only by the occurrence of the first ulcer.

In this age group there is clearly more need for diagnostic certainty when persistent stomach complaints occur for the first time. This is a tendency that incidentally already begins to be visible in the 45-54 age group as, in the first lengthier occurrence of stomach complaints, diagnosis is clearly performed more often than in the 35-44 age group. In the case of suspicion of a recurrent ulcer this need is less. (The ratio between suspected and confirmed ulcer is used as a criterion of the need for certainty on the part of the physician.)

What is striking in the 45-54 age group is the low frequency of suspicion of a first *ulcus pepticum* (12 per 10 000 men), whereas the frequency of suspicion of a recurrent ulcer in this group is the highest of all age groups (39 per 10 000 men).

However, a confirmed first ulcer clearly occurs more in this group than a confirmed recurrent one, respectively 9 per 10 000 men and (1) per 10 00 men.

#### Comparison with 1975

The figures found in 1985 for the confirmed first *ulcus pepticum* and the confirmed recurrence are compared in Table 41 with the registration data from 1975.

Table 41: numbers of patients with an *ulcus pepticum* diagnosed by means of further examination per age group per 10 000 men and 10 000 women for 1975 and 1985

		age group							
		10-14	15-19	20-24	25-34	35-44	45-54	55-64	≥ 65
1975	M	-	1	26	39	56	43	32	40
	F	-	1	7	12	19	17	13	17
1985	M	-	(5)	(6)	(6)	11	10	22	16
	F	-	(2)	(1)	(3)	11	8	16	16

In 1985 fewer confirmed ulcers are registered than in 1975. Exceptions are formed by the 15-19 age group, both boys and girls, and women above 65 years. In the younger age groups, however, very small

numbers are concerned in absolute terms, so that the figures for those groups must be used with caution. The main emphasis of further diagnosis in the case of suspicion of an ulcer pepticum, compared with 1975, has shifted to the older age groups. In 1985 an ulcer pepticum is also suspected at a younger age (see Table 41); the need for diagnostic certainty by means of the examinations mentioned above seems less great.

#### Seasonal influences

Seasonal influences have not been established in 1985 for the occurrence of an ulcer pepticum.

The subject has been maintained on the weekly return for 1986.



## REFERRAL TO (AUTHORIZATION FOR) THE PHYSIOTHERAPIST

To date there has been little investigation of the position and the functioning of the physiotherapist in Dutch health care. In the light of the considerable growth that this form of paramedical aid has undergone in recent decades, the amount of knowledge about these activities is limited and not very systematic. For about both the authorities and the organizations of physiotherapists this situation gave rise to consultation, in which the then Netherlands Institute for General Practice was involved as an expert body in the field of socio-scientific investigation of the structure and functioning of primary health care.

At the request of the Ministry of Welfare, Public Health and Culture, the Chief Medical Office of Health and professional organizations of physiotherapists, the then Netherlands Institute for General Practice formulated an investigation proposal. The aim of this investigation is the systematic collection of data on the characteristics of patients and physiotherapists, on the complaints of these patients and on the process of referral by general practitioner to physiotherapists.

To answer the question of how the process of referral from general practitioner to physiotherapists operates, the Counselling Committee of the Sentinel Stations Project was asked to place this subject on the weekly return. The Committee recognized the importance of properly charting this field of primary health care and decided to grant the request, despite some hesitation as to the additional burden that this project would impose on the spotter physicians.

It was decided to place referral to the physiotherapist on the weekly return. A distinction was made by sex and form of health insurance, and whether this was a new referral or continuation of an ongoing treatment. As a distinction between a new referral and a continuation of an ongoing treatment a complaint-free period was used as a criterion. For each new referral a supplementary questionnaire was completed. The further questions related to the nature of the complaints, the indication for the referral and the role played by psycho-social factors in the complaints. It was also asked who took the initiative for the referral and whether the physician had formulated a proposal for the treatment.

In this report we shall confine ourselves to stating the numbers of new referrals and authorizations issued for follow-up treatment for the various categories of patients. As indicated above, this registration by means of the weekly return is part of a wide-ranging investigation of the functioning of physiotherapy in primary health care. The other aspects of physiotherapeutic care mentioned earlier are being reported on elsewhere. The leader of this investigation and adviser for this subject is P.P. Groenewegen, a sociologist employed by the Netherlands Institute of Primary Health Care.

Table 42 states the frequencies of the referrals and the provision of authorizations for follow-up treatments per province and urbanization group, with a subdivision by sex and form of health insurance.

Table 42: numbers of new referrals and authorizations for follow-up treatment for physiotherapeutic aid per province and urbanization group per 10 000 men, insured by a health insurance fund or privately, and per 10 000 women, insured by a health insurance fund or privately, in 1985

		province group				urbanization group			Netherlands
		A	B	C	D	1	2	3	
new referral	M	519	493	622	483	418	552	634	549
health insurance fund	F	595	601	703	520	447	650	680	625
private	M	243	238	243	310	196	283	219	259
	F	255	236	318	352	163	338	299	307
follow-up treatment	M	329	680	428	295	577	392	397	426
health insurance fund	F	443	809	626	291	589	568	546	566
private	M	60	153	39	54	202	35	66	63
	F	30	140	54	77	138	50	91	70

As stated, the investigation into the referral to physiotherapy will be reported on in detail elsewhere. Only a few general findings will be given here. More women than men are referred to physiotherapeutic

treatment. Health insurance fund patients are clearly more by the general practitioner for a new treatment than those privately insured. These findings differ from the results of the health inquiry performed by the Central Bureau of Statistics. In this inquiry smaller differences are found between health insurance fund and private patients and between men and women. Most new referrals for physiotherapy are given in the western provinces and in the cities. The number of follow-up treatments authorized by the general practitioner are the greatest in the eastern provinces and in rural municipalities.

However, some caution is called for in interpretation of these data. Further investigation will have to yield insight into the significance of these differences.

Of the health insurance fund patients, more women and men are referred for new treatment by a physiotherapist, 625 per 10 000 women and 549 per 10 000 men. For women patients more authorizations for follow-up treatments were also issued than for the male health insurance fund patients, 307 per 10 000 women and 259 per 10 000 men.

The percentage of female health insurance fund patients given an authorization for a followup treatment is greater than the percentages of male health insurance fund patients 90.6 and 77.6 respectively (= number of follow-up treatments/number of new referrals for physiotherapy).

For the privately insured patients it is not the case in all subgroups that women are more frequently referred for physiotherapeutical treatment or a follow-up thereof than men.

In the northern and eastern provinces men and women are referred for a new treatment more or less with equal frequency. For a follow-up treatment in those province groups more men qualify than women. In the rural municipalities too men who are privately insured are referred more often than women to physiotherapeutic treatment or a follow-up of a commenced treatment. For the rest the percentage of privately patients that is prescribed or advised an extension of the treatment via the general practitioner is clearly lower than that health insurance fund patients. For the male privately insured patients it is 24.3, for the female 22.8. It is obvious that this will coincide with the fact that number of combined treatments for health insurance fund patients is limited.

## Age distribution

Table 43 gives the frequencies per age group and sex.

Table 43: numbers of new referrals and authorization for follow-up treatment of physiotherapeutic aid per age group and sex per 10 000 men, insured with a health insurance fund or privately, and per 10 000 women, insured with a health insurance fund or privately

		age group										
		≤1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	≥65
New re- ferrals	M	357	51	82	110	263	450	626	932	972	878	540
	F	291	54	77	186	317	418	614	916	1109	943	764
health insurance fund												
Private	M	(149)	(25)	48	68	173	146	248	385	385	413	315
	F	(149)	(18)	41	87	149	158	262	427	577	477	451
follow-up treatment												
health insurance fund	M	(153)	75	135	95	116	211	313	559	868	750	859
	F	-	39	61	135	190	204	388	715	835	852	1281
private	M	-	-	(6)	(17)	19	30	82	73	99	66	149
	F	-	(9)	-	(9)	(16)	(10)	57	92	112	109	189

From the youngest age group to the age of 45-54 years inclusive there is an increase in the number of new referrals for physiotherapeutic treatment. After the age of 55 years the number of new referrals falls. This applies both to health insurance fund patients and to privately insured patients.

In the case of follow-up treatment we see for men in the 55-64 age group a decline in the number but after the 64th year a rise again. For women we see a constant increase in the number of follow-up treatment from the youngest up to and including the oldest age group for both health insurance fund and private patients.

For 1986 this subject has been removed from the weekly return.

## EXTRAPOLATION OF FREQUENCIES FOUND TO THE DUTCH POPULATION

The following survey gives an approximate impression of the number of patients, consultations, actions and occurrence in the Netherlands, on the basis of the frequencies calculated from the results of the continuous morbidity registration by sentinel stations. As was remarked in the previous reports, it must be borne in mind, when studying the following table, that although the population of the sentinel stations is a reasonably good representation (see also p. 9-10) the spotter physicians are a selected group. Consequently it cannot be automatically established to what extent the results differ from the actual situation; the differences can vary depending on the nature of the question. Particular caution should be observed regarding those topics where there is intervention by a general practitioner. As an example one may think of the 'cervical smear' question; it is quite feasible that the spotter physicians differ from the typical general practitioner in this respect.

In the '(attempted) suicide' question proves to be a difference in respect of registrations from elsewhere, as a result of the fact that this event is presumably not always reported to the general practitioner. With regard, too, to the registration of diseases and occurrence in itself it may be stated almost with certainty that the spotter physicians act as a select group. However, this can only be to the benefit of the project. Nevertheless, the reader is advised not only to look at the extrapolated numbers but also to consult the relevant chapters.

For a correct interpretation of the extrapolated numbers first the total Dutch population per years is given, in thousands.

Dutch population by sex in thousands, 1970 - 1985 (Central Bureau of Statistics)<sup>1</sup>

year	men	women	total
1970	6 507	6 531	13 038
1971	6 587	6 607	13 194
1972	6 650	6 679	13 329
1973	6 699	6 740	13 439
1974	6 747	6 798	13 545
1975	6 804	6 862	13 666
1976	6 854	6 920	13 774
1977	6 889	6 967	13 856
1978	6 907	6 991	13 898
1979	6 945	7 040	13 985
1980	6 994	7 097	14 091
1981	7 048	7 159	14 207
1982	7 082	7 204	14 286
1983	7 103	7 237	14 340
1984	7 125	7 269	14 394
1985	7 150	7 305	14 455

1) Up to and including 1977 average numbers, thereafter the numbers as on 1 January in all cases of the year in question.

Extrapolation of frequencies found to the Dutch population

category	year	frequency <sup>1)</sup> *			Netherlands <sup>2)</sup> *		
		M	F	total	M	F	total <sup>3)</sup> *
influenza <sup>4)</sup>	1970			904			1 179 000
	1971			889			1 173 000
	1972			779			1 038 000
	1973			699			939 000
	1974			885			1 199 000
	1975			695			945 000
	1976			717			987 000
	1977			575			797 000
	1978			829			1 152 000
	1979			438			613 000
	1980			425			599 000
	1981			491			697 000
	1982			497			710 000
	1983			396			568 000
	1984			502			722 000
1985			464			671 000	
cervical smear							
-with complaints	1976		87			60 000	
and/or symptoms	1977		86			60 000	
	1978		80			56 000	
	1979		80			56 000	
	1980		62			44 000	
	1981		57			41 000	
	1982		57			41 000	
	1983		65			47 000	
	1984		57			41 000	
	1985		62			45 000	

\* for footnotes see page 86



Extrapolation of frequencies found to the Dutch population (continuation)

category	frequency <sup>1)</sup> *			Netherlands <sup>2)</sup> *			
	year	M	F	total	M	F	total <sup>3)</sup> *
-'preventive', general practitioner's initiative	1976		282		194	000	
	1977		268		186	000	
	1978		218		153	000	
	1979		198		140	000	
	1980		168		119	000	
	1981		184		132	000	
	1982		171		123	000	
	1983		174		126	000	
	1984		204		148	000	
	1985		197		144	000	
-'preventive', woman's initiative	1976		103		71	000	
	1977		112		78	000	
	1978		105		73	000	
	1979		124		87	000	
	1980		93		66	000	
	1981		110		79	000	
	1982		126		91	000	
	1983		120		87	000	
	1984		132		96	000	
	1985		127		93	000	
-repeat examination (within 3 years)	1976		31		21	000	
	1977		55		38	000	
	1978		120		84	000	
	1979		143		101	000	
	1980		148		105	000	
	1981		159		114	000	
	1982		170		122	000	
	1983		168		121	000	
	1984		182		132	000	
	1985		184		134	000	

\* for footnotes see page 86

Extrapolation of frequencies found tot he Dutch population (continuation)

category	frequency <sup>1)</sup> +			Netherlands <sup>2)</sup> *			
	year	M	F	total	M	F	total <sup>3)</sup> *
cervical smear total <sup>3)</sup>	1976		503				346 000
	1977		521				362 000
	1978		523				366 000
	1979		545				384 000
	1980		471				334 000
	1981		510				365 000
	1982		524				377 000
	1983		527				381 000
	1984		575				417 000
	1985		570				416 000
Parkinson's disease <sup>4)</sup>	1980	7	5	6			
	1981	4	2	3			
	1982			2			
	1983			1			
	1984			1			
	1985			1			
sterilization	1972	24			16 000		
	1973	40			7 000		
	1974	46	35		31 000	24 000	55 000
	1975	46	46		31 000	31 000	62 000
	1976	57	66		39 000	45 000	84 000
	1977	53	64		37 000	45 000	82 000
	1978	74	81		51 000	57 000	108 000
	1979	99	90		69 000	63 000	132 000
	1980	79	70		55 000	50 000	105 000
	1981	59	46		42 000	33 000	74 000
	1982	50	40		35 000	29 000	64 000
	1983	46	39		33 000	28 000	61 000
	1984	46	39		33 000	28 000	61 000
1985	44	26		32 000	19 000	51 000	

\* for footnotes see page 86

Extrapolation of frequencies found to the Dutch population (continuation)

category	frequency <sup>1)</sup> *				Netherlands <sup>2)</sup> *		
	year	M	F	total	M	F	total <sup>3)</sup> *
cumulative					531 000	451 000	
morning-after pill prescribed	1972		53			35 000	
	1973		59			40 000	
	1974		68			46 000	
	1975		60			41 000	
	1976		60			41 000	
	1977		49			34 000	
	1978		50			35 000	
	1979		50			35 000	
	1980		50			35 000	
	1981		35			25 000	
	1982		35			25 000	
	1983		30			22 000	
	1984		38			28 000	
	1985		32			23 000	
malignancies	1984	37	34	36	26 000	25 000	52 000
	1985	37	28	32	26 000	20 000	46 000
depression (treated for)	1983	55	104		39 000	75 000	114 000
	1984	46	94	71	33 000	68 000	102 000
	1985	36	73	55	26 000	53 000	80 000
(attempted) suicide <sup>5)</sup>	1979			7			
	1980			7			
	1981			6			
	1982			8			
	1983			10			
	1984			7			
	1985			6			

\* for footnotes see page 86

Extrapolation of frequency found to the Dutch population (continuation)

category	frequency <sup>1)</sup> *			Netherlands <sup>2)</sup> *			
	year	M	F	total	M	F	total <sup>3)</sup> *
myocardial	1978	32	15		22 000	10 000	32 000
infarction (suspicion of)	1983	29	13		21 000	9 000	30 000
- clinical	1984	33	15	23	24 000	11 000	33 000
	1985	32	14	23	23 000	10 000	33 000
- non-clinical	1978	9	5		6 000	3 500	9 500
	1983	8	6		6 000	4 000	10 000
	1984	6	4	5	4 000	3 000	7 000
	1985	7	5	6	5 000	4 000	9 000
1ste ulcer pepticum							
- suspected	1985	14	11	12	10 000	8 000	17.500
- certain	1985	6	5	6	45 000	3 500	8 500
recurrent ulcer pepticum							
- suspected	1985	19	8	13	13 000	6 000	19 000
- certain	1985	2	2	2	1 500	1 500	3 000

1) Number of patients, consultations etc. per 10 000 men and/or women (sentinel station data).

2) Extrapolation of the frequencies to the Dutch population (of the tear in question), in round thousands.

3) As a result of rounding-off, small differences may have occurred in the totals.

4) For influenza they are minimum numbers, since many influenza patients do not consult their family doctor.

5) In view of the very small numbers, extrapolation has been omitted here.

## INCIDENTAL INVESTIGATIONS

Since 1976 the 'incidental investigations' have existed as part of the Sentinel Station Project. These are investigations into relatively uncommon diseases or occurrences. For a list of the subjects thus treated see the second part of Appendix 3. Here the data accordingly collected for 1984 are reported. These data differ from the weekly return subjects in that they are asked for only once a year, right at the beginning of the following year. This makes it possible to collect retrospectively data on subjects for which registration is requested in the course of the year. However, one condition in that case is that it must be something that is firmly implanted in the physician's memory.

### Euthanasia (request for application)

In 1976 attention was devoted for the first time to requests made to the general practitioner for the application of euthanasia.

The form of the investigation is retrospective. A form is sent to all spotter physicians at the end of the year with the request that they report whether the question was asked of them in the past year by a patient himself or herself for the application of active euthanasia directly or indirectly<sup>21</sup> and if so, what the motive was for this. In addition, information is sought on the age, sex, current disease, place of care or nursing and the use or otherwise of an 'euthanasia declaration'.

The physicians are informed at the beginning of the year of the coming investigation.

The results per patient can be found at the end of this section. This table does not require much explanation.

The number of requests in 1985 was 39; nearly the same number as in 1984 and higher than in the years 1976 to 1983 incl. (see Table 44). As in previous years, the number of patients with a malignancy is, relatively speaking, again large: 74% of them have a mostly metastasized carcinoma. In the Netherlands mortality as a result of cancer is approximately 25% of total mortality

Of the 39 patients, 33 were living at home; five patients were in an old people's home and one patient requested euthanasia during a stay in hospital. The large majority related to requests for application of the direct form of euthanasia: 34 patients.

In the case of six requests use was made of a written declaration.

The distribution by province group and urbanization group is given in table 44.

Table 44: absolute number of requests to the general practitioner made by the patient himself or herself for the application of active euthanasia, per province and urbanization group, 1976-1985

abso- lute	province group						urbanization group Netherlands			
	M	F	A	B	C	D	1	2	3	
1976	5	10	1	2	11	1	4	7	4	15
1977	6	3	1	2	5	1	3	2	4	9
1978	6	4	3	2	4	1	2	8	-	10
1979	13	15	5	6	15	2	4	18	6	28
1980	10	12	2	3	16	1	3	12	7	22
1981	20	10	4	4	13	9	3	20	7	30
1982	17	9	2	6	17	1	3	7	16	26
1983	15	18	7	4	19	3	5	14	14	33
1984	24	16	5	2	25	8	3	24	13	40
1985	19	20	3	6	25	5	1	24	14	39
1976 - 1985										
total	116	97	30	31	125	27	30	112	71	213

#### Age distribution

The age distribution may be found in table 45.

Table 45: absolute number of patients who request the general practitioner to apply active euthanasia, by age group, 1976 - 1985

	55	55-64	65-74	75-84	≥85	total
1976	2	4	3	3	3	15
1977	2	3	2	2	-	9
1978	3	2	3	2	-	10
1979	3	7	12	2	4	28
1980	2	5	5	7	3	22
1981	8	4	5	10	3	30
1982	-	6	10	8	2	26
1983	3	10	9	9	2	33
1984	5	13	9	10	3	40
1985	8	8	9	11	3	39

It is not the aim of this project to make more pronouncements on this subject.

Extrapolation of these data to the Dutch population is possible, but it should be borne closely in mind that in that case the number is being related to the total population, while this should actually be done to the number of persons in circumstances in which the possibility of the question being asked is envisaged. The latter data (morbidity) are not available, however. Moreover, here distortion may occur through the spotter physicians not being a random group.

#### Requests by the patient for active euthanasia

age	sex	disease	motive for the request
87	f	myelodysplasia	fatigue
87	f	cardiac asthma; infarction	long duration
85	m	carcinoma of the lung	dyspnoea
84	m	carcinoma of the prostate with extensive metastases	pain, suffering, fear of being dependent
84	f	terminal emphysema	dyspnoea

## Request by the patient for active euthanasia (continuation)

age	sex	disease	motive for the request
84	f	chronic bronchitis on the basis of old tuberculosis	
82	f	metastasized mamma carcinoma	violent pain
78	m	carcinoma of the colon	can do nothing any more not even go to toilet
77	f	Hodgkin's disease, cerebrovasculair accident with thalamic syndrome	violent pain
76	m	circulatory cerebral insufficiency	neurological pain, dependence swallowing complaints
76	m	rheumatoid arthritis	pain, suffering without hope, depression at immobility
75	m	severe pulmonary emphysema	hopeless situation, dyspnoea
75	m	carcinoma of the larynx	no hope
75	f	metastasized mamma carcinoma	pain, dyspnoea
74	m	carcinoma of the stomach with metastases	pain
72	m	carcinoma of the larynx plus irradiation ulcer	pain, problems with acceptance situation
72	f	metastasized mamma carcinoma	pain
72	f	liver cell carcinoma	long illness, increasingly lacklustre, while admission to hospital is rejected
72	f	carcinoma of the gall	length of suffering, thirst, attacks of pain
71	m	terminal decompensatio cordis	dyspnoea, hopelessness
70	m	carcinoma of the lung	pain + fear of loss of dignity
70	m	metastasized carcinoma	strongly lacklustre through his illness, cannot take it any longer



Requests by the patient for active euthanasia (continuation)

age	sex	disease	motive for the request
65	f	state after poliomyelitis, many deformities	fear of futher helplessness
64	f	mediastinal tumour	extreme dyspnoea
63	f	bronchus carcinoma with metastases	
61	m	carcinoma of the pancreas	bellyful of tumour; increasing pain
60	m	metastasized carcinoma of the prostate	strongly lacklustre through decline
59	f	mamma carcinoma with bone mestatases	unbearable pain
57	m	metastasized carcinoma of the lung	pain, cachexia
57	f	ovary carcinoma with metastases, incl. cerebral	pain, epilepsy, cachexia
56	f	squamous-cell carcinoma of the bronchus	fear of suffocation
49	m	carcinoma of the pancreas with metastases	pain and general exhaustion
47	f	carcinoma of the lung or oesophagus	severe dyspnoea + serious problems with swallowing
46	f	liver metastases	pain
45	m	metastasized carcinoma in the abdomen	vomiting, dehydration as a result of passage disturbances high in the gastro-intenstinal tract
45	f	mamma carcinoma metastasized in cerebro	pain, cachexia
43	m	carcinoma of the stomach with metastases	pain
42	m	multiple sclerosis	fear of vegetating
36	m	pancreas fibrosis with bronchiectases	increasing dyspnoea

This investigation will be repeated for 1986.

## Anorexia nervosa and boulimia

Uncertainty about the degree of occurrence of "eating disorders", such as anorexia nervosa and boulimia, caused H.W. Hoek M.D., an epidemiologist with the Social Psychiatry Department of Groningen State University, to decide to direct a request to the Counselling Committee for permission to investigate the occurrence of these disorders in the spotter station practices. Anorexia is a serious disorder of which it is said that the incidence is on the increase. Others argue, however, that from the fact that anorexia nervosa is now diagnosed more frequently than before, and having regard to the lack of epidemiological data, it may be concluded that anorexia is increasing and also that this increase is only the result of greater familiarity with and better diagnosis of the syndrome<sup>22</sup>.

Since the general practitioner is envisaged as playing a crucial role in diagnosis of the eating disorders and since above all rearly diagnosing of these disorders is considered of importance tot he course and the treatment, the Counselling Committee decided to grant the request.

Registration takes place in the form of an incidental investigation.

Retrospectively the spotter physicians have been asked a number of questions per patient suffering from an eating disorder. Was this an eating disorder first diagnosed in 1985, and was the patient referred on account of the eating disorder to another source of assistance? A number of data concernng physical aspects of the illness were also tought.

72 patients were registered. Table 46 gives the distribution of these patients by age and sex.

Table 46: absolute number of patients with respect to whom the general practitioner has diagnosed an eating disorder, by age and sex in 1985

	<10	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	≥60
M	-	2	1	-	2	-	-	-	-	-	-	-
F	-	3	11	11	17	5	8	4	4	-	2	2

Eating disorders occur above all in the age of 15 to 40 years. In the case of 25 patients (35%) the eating disorder was diagnosed in 1985; in the case of 47 patients the disorder already existed before

1985. As regards a few patients the general practitioner reports that the problem has existed for years.

The distribution per province and urbanization group may be found in Table 47.

Table 47: absolute number of patients with respect to whom to the general practitioner has diagnosed an eating disorder, per province and urbanization group, in 1985 and per 10 000 inhabitants

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
absolute	8	15	33	16	9	36	27	72
per 10 000	4	5	4	5	4	4	7	4

On the basis of this registration the frequency of occurrence of eating disorders is clearly higher in the cities than in the other urbanization groups. Between the province groups there is little difference in the degree of occurrence of an eating disorder.

The investigation will be repeated for 1986.

## GENERAL REMARKS

1. The questions on the weekly return for 1986 have been compiled as follows by the Counselling Committee:
  - a. Influenza (-like illness)
  - b. Cervical smear
  - c. Discharged psychiatric patient
  - d. Sterilization of the man performed
  - e. Sterilization of the woman performed
  - f. Morning-after-pill prescribed
  - g. Bites by pets
  - h. (Attempted) suicide
  - i. Ulcus pepticum
  - j. Otitis media acuta
  - k. Cerebrovascular accident
  - l. Referrals for phycho-social problems
2. The incidental investigations for 1986 relate to the subject's euthanasia and anorexia nervosa and bulimia.
3. Suggestions relating to the questions on the weekly returns will be gladly received by the Counselling Committee.
4. Data from this report may be reproduced with acknowledgment of the source.

Aad I.M. Bartelds, General practioner/projectleader.

LIST OF PUBLICATIONS ON THE BASIS OR PARTLY ON THE BASIS OF THE  
DATA FROM CONTINUOUS MORBIDITY REGISTRATION SENTINEL STATIONS

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## Appendix 1

### Continuous Morbidity Registration, Sentinel Stations Participating General practitioners in 1985

Name:	Residence:	Province:
A.A.E.E. Brockmöller*)	't Zand	Groningen
J.Th. Ubbink	Groningen	Groningen
Y. Wapstra/K. Tanis (group practice)	Franeker	Friesland
S. Vriesinga*)	Oostermeer	Friesland
H.W. Reinking/F.M. van Soest/ R.F. Sparenburg/H.D.W.A. van Gysel (group practice)	Assen	Drenthe
H.E. Maillette de Buy Wenniger*)	Schoonoord	Drenthe
H. Nap*)	Gramsbergen	Overijssel
Th.J. van Dam/J.B.M. Stolte (group practice)	Swifterbant polders	Zuiderlijke IJsselmeer
E.J. van Apeldoorn	Heerde	Gelderland
Dr S. Rijpma*)	Laren	Gelderland
J.H. de Boer/Dr J. van Noort (group practice)*)	Zelhem	Gelderland
F.C.M Ummels	Velp	Gelderland
J.P. van Dam	Nijmegen	Gelderland
M.A.J. Janssen	Nijmegen	Gelderland
Mw. I.K.I. de Jongh-Kilian/ F.K.A. Fokkema (group practice)	Amersfoort	Utrecht
P.J. Kromeich/J.J. Dijkstra (group practice)	Utrecht	Utrecht
W.J. van Bodegom*)	Linschoten	Utrecht
M.M. Spoor	Alkmaar	Noord-Holland
C.W. Willeboordse	Heiloo	Noord-Holland
H.R. Neys*)	Broek in Waterland	Noord-Holland
D.E. Kuenen	Haarlem	Noord-Holland
Mw. A.M. Reijnierse(to 1-7-'85)		
Mw. Y.E.V. van Hazel(from 1-7-'85)	Amsterdam	Noord-Holland
Mw. A.J. Arbouw	Amstelveen	Noord-Holland
J.Th. Koop	Amstelveen	Noord-Holland
H.J. van der Leen	Hilversum	Noord-Holland
J. Hoornweg/E. Hoornweg-Sleeboom (group practice)	Voorhout	Zuid-Holland

Appendix 1 (continuation)

Participating General Practitioners in 1985

Name:	Residence:	Province:
Dr A.P. Oliemans	Den Haag	Zuid-Holland
Th.J. van Stockum jr.	Den Haag	Zuid-Holland
J.C.B.M. Rensing	Den Haag	Zuid-Holland
Dr B.J.M. Aulbers/J.E.G. Nieuwkamer (group practice)	Delft	Zuid-Holland
D. Pasman	Maassluis	Zuid-Holland
F.L. Reynders	Rotterdam	Zuid-Holland
G. Dorrenboom	Rotterdam	Zuid-Holland
G. van Gangelen	Sliedrecht	Zuid-Holland
A. Lagendijk	Dordrecht	Zuid-Holland
M. Reyerse	Middelburg	Zeeland
P.R.L. Vercauteren/H.J.W.A. Meijerink (group practice)	Terneuzen	Zeeland
R.J.F.M. Leijgraaf/A.F.A. van de Reepe (group practice)	Etten	Noord-Brabant
A.M.H.J.G. Sluijters/J.A.M. Keulers (group practice)*)	Ravenstein	Noord-Brabant
S.H.H.M. van der Meer	Rosmalen	Noord-Brabant
Dr J.P.C. Moors	Rosmalen	Noord-Brabant
Dr H.A.M. Hoevenaars/A. Hoevenaars (group practice)	Uden	Noord-Brabant
A.M.P. Linsen	Oirschot	Noord-Brabant
S.P.F. van Rijn	Eindhoven	Noord-Brabant
R.A.M. de Jong	Maastricht	Limburg

\*) With dispensary





## Appendix 3a

Subjects on the weekly returns in alphabetical order 1970-1986

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subject

---

abortion (spontaneous)	1982-1983
abortion (request)	1970-1975
abortus provocatus	1971-1979
accidents	1971
accidents in the private sector	1981-1983
alcoholism	1975
anti-hypertensivum or diuretic (prescription)	1976
battered child syndrome (suspicion of)	1973-1974
bites by pets	1986
cervical smear	1976-1986
cerebrovasculair accidents	1986
depression	1983-1985
diabetes mellitus	1980-1983
diarrhoea e causa ignota (acute)	1970
discharged psychiatric patient	1986
drug-use (consultation)	1972-1973 and 1979-1981
dwelling (certificate for another)	1975
exanthema e causa ignota	1970
family planning (consultations)	1970-1976
hay fever	1978-1982
influenza (-like illness)	1970-1986
malignancies	1984-1986
measles	1975-1979
mononucleosis infectiosa	1977-1979
morning-after-pill (prescription)	1972-1986
musculo-skeletal system (trauma of)	1984
myocardial infarction (suspicion of)	1978 and 1983-1985
otitis media acuta	1971 and 1986
Parkinson's disease	1980-1985
partus immaturus	1982-1983
partus at gravidity 28 weeks	1982-1983
penicillin (prescriptions and side effects)	1982-1983
psoriasis	1976-1977
referrals	1984
referrals for physiotherapy	1985
referrals for pshycho-social problems	1986
rubella (-like illness)	1971

Subjects on the weekly returns in alphabetical order 1970-1986 (continuation)

---

subject

---

skull traumas in traffic	1975-1977
smoking (consultation with regard to addiction)	1974
sport traumas	1979-1983
sterilization of the man performed	1972-1986
sterilization of the woman performed	1974-1986
suicide (attempted)	1970-1972 and 1979-1986
tonsillectomy or adenotomy	1971
tranquillizer (prescription)	1972-1974
ulcus ventriculi/duodeni	1975
ulcus pepticum	1986
urinary tract infection (prescription of medicine)	1977

---

Appendix 3b

Incidental investigations and other extra investigations, 1977-1986.  
(alphabetical)

---

subjects

---

alternative forms of treatment (registration)	1980
anorexia nervosa and bulimia	1985-1986
euthanasia (request for application)	1977-1986
malignancies	1982-1983
mastitis puerperalis	1982
multiple sclerose	1977-1982
serum collection	1980 and 1985
regretting sterilization	1980-1984

---

## Appendix 4

Age structure of the population of the Netherlands by sex, in thousands, 1 January 1985 (C.B.S.)

age	men	women	total <sup>1)</sup>
0- 4	447	428	875
5- 9	455	434	889
10-14	556	532	1 188
15-19	631	603	1 234
20-24	646	622	1 268
25-34	1 197	1 151	2 348
35-44	1 077	1 012	2 089
45-54	784	764	1 548
55-64	662	725	1 387
≥ 65	695	1 034	1 729
<b>totaal</b>	<b>7 150</b>	<b>7 305</b>	<b>14 455</b>

1) As a result of rounding-off, small differences may have occurred in the totals.



TABEL 1A

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

1E KWARTAAL 1985 PER 10.000

LEEFTIJD- GROEP	POPULATIE ----->			INFLU <--- CERVIKITSTRIJKJE --->			ZIEK <--- STERILISATIE --->			MORN- <--- MALIGNITEITEN --->				
	M	V	T	M+V	V	T	M+V	M	V	T	V	M	V	T
< 1 JR	374	427	801	612	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3429	3313	6742	433	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4329	4301	8630	357	-	-	-	-	-	-	-	2	2	2
10 - 14 JR	5731	5595	11326	244	-	-	-	-	-	-	-	5	-	-
15 - 19 JR	6288	6255	12543	242	6	18	5	-	-	-	-	29	2	1
20 - 24 JR	6532	7033	13565	184	21	88	16	20	-	-	-	23	2	1
25 - 34 JR	12440	12264	24704	232	32	122	64	55	-	35	24	30	9	1
35 - 44 JR	10003	9891	19894	291	30	65	65	84	-	35	15	25	9	4
45 - 54 JR	7803	7877	15680	315	19	61	46	94	-	8	5	6	1	4
55 - 64 JR	6770	7235	14005	290	7	17	25	26	-	1	-	1	-	24
> 64 JR	7030	10183	17214	297	4	1	4	3	1	-	-	-	-	54
TOTAAL	70728	74375	145103	278	15	47	29	35	0	12	7	9	8	9

TABEL 1A (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

1E KWARTAAL 1985 PER 10.000

LEEFTIJD- GROEP	----- POPULATIE ----->			<---- DEPRESSIE ---->			SUI CIDE POGING			----- KLINISCH -----			HARTINFARCT			NIET-KLINISCH		
	M	V	T	M	V	T	M+V	H	V	T	M	V	T	M	V	T		
< 1 JR	374	427	801	-	-	-	-	-	-	-	-	-	-	-	-	-		
1 - 4 JR	3429	3313	6742	-	-	-	-	-	-	-	-	-	-	-	-	-		
5 - 9 JR	4329	4301	8630	-	-	-	-	-	-	-	-	-	-	-	-	-		
10 - 14 JR	5731	5595	11326	-	2	1	1	-	-	-	-	-	-	-	-	-		
15 - 19 JR	6288	6255	12543	3	10	6	1	-	-	-	-	-	-	-	-	-		
20 - 24 JR	6532	7033	13565	3	13	8	3	-	-	-	-	-	-	-	-	-		
25 - 34 JR	12440	12264	24704	21	35	28	2	-	-	-	-	-	-	-	-	-		
35 - 44 JR	10003	9891	19894	17	29	23	3	4	-	2	-	-	-	-	-	-		
45 - 54 JR	7803	7877	15680	22	32	27	2	8	4	6	-	1	1	-	-	-		
55 - 64 JR	6770	7235	14005	9	18	14	1	16	7	11	4	4	4	4	4	4		
> 64 JR	7030	10183	17214	6	18	13	2	31	24	27	14	11	12	11	12	12		
TOTAAL	70728	74375	145103	10	19	15	2	6	4	5	2	2	2	2	2	2		



1E KWARTAAL 1985 PER 10.000

LEEFTIJD- GROEP	POPULATIE			ULCUS PEPTICUM														
	M	V	T	EERSTE MAAL				ZEKER				VERMOEDEN				RECIDIËF		
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
< 1 JR	374	427	801	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3429	3313	6742	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4329	4301	8630	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	5731	5595	11326	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
15 - 19 JR	6288	6255	12543	5	-	2	-	-	-	-	2	1	-	-	-	-	-	-
20 - 24 JR	6532	7033	13565	6	3	4	-	-	-	3	-	1	-	-	-	-	-	-
25 - 34 JR	12440	12264	24704	6	2	4	2	-	1	7	3	5	1	-	0	-	-	-
35 - 44 JR	10003	9891	19894	3	6	5	1	1	1	6	2	4	1	-	1	-	-	-
45 - 54 JR	7803	7877	15680	3	8	5	4	-	2	13	3	8	1	-	1	-	-	-
55 - 64 JR	6770	7235	14005	10	6	8	3	-	1	13	3	8	-	1	1	-	-	-
> 64 JR	7030	10183	17214	-	3	2	3	1	2	7	3	5	-	1	1	-	-	-
TOTAAL	70728	74375	145103	4	3	4	1	0	1	6	2	4	0	0	0	0	0	0

TABEL 2A

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

1E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE ----->			INFLU <--- CERVIJUITSTRIJKJE ---->			ZIEK <--- STERILISATIE --->			MORN- <- MALIGNITEITEN ---> AFTER -PILL				
	M	V	T	M+V	V	T	HERH /SYMPT	ONDZ	PARK	VERRICHT	V	T	V	T
GR+FR+DR	10667	11176	21843	356	26	45	30	21	-	14	5	10	10	8
OV+GLD+ZYP	11915	12345	24260	207	19	62	23	43	-	12	8	10	7	5
UTR+NH+ZH	31658	33808	65466	248	11	43	33	45	0	8	5	6	8	11
ZLD+NB+LIM	16488	17047	33535	340	13	44	24	19	-	19	10	15	6	10
TOTAAL	70728	74375	145103	278	15	47	29	35	0	12	7	9	8	9

TABEL 2A (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

1E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE ----->			DEPRESSIE ----->			SUI <----- CIDE POGING			KLINISCH			HARTINFARCT NIET-KLINISCH			
	M	V	T	M	V	T	M+V	M	V	T	M	V	T	M	V	T
GR+FR+DR	10667	11176	21843	12	19	16	0	6	6	6	-	2	1			
OV+GLD+ZYP	11915	12345	24260	8	21	15	1	3	2	2	2	2	2			
UTR+NH+ZH	31658	33808	65466	12	20	16	2	6	4	5	2	3	2			
ZLD+NB+LIM	16488	17047	33535	8	17	13	2	9	5	7	3	1	2			
TOTAAL	70728	74375	145103	10	19	15	2	6	4	5	2	2	2			

TABEL 2A (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 3

1E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE			EERSTE MAAL						ULCUS PEPTICUM					
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
GR+FR+DR	10667	11176	21843	3	4	3	1	-	0	6	-	3	-	-	-
OV+GLD+ZYP	11915	12345	24260	3	2	2	2	-	1	4	1	2	-	-	-
UTR+NH+ZH	31658	33808	65466	5	4	5	2	-	1	5	3	4	1	1	1
ZLD+NB+LIM	16488	17047	33535	2	2	2	-	1	1	8	1	4	-	-	-
TOTAAL	70728	74375	145103	4	3	4	1	0	1	6	2	4	0	0	0

TABEL 3A

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

1E KWARTAAL 1985 PER 10.000

URBANISATIE<----- POPULATIE ----->	INFLU <--- CERVIJUITSTRIJKJE --->			ZIEK <-- STERILISATIE --->			MO:IN- <- MALIGNITEITEN --->									
	M	V	T	M+V	V	T	M	V	T							
A1+A4	10869	11059	21928	179	20	59	21	24	-	16	7	11	8	6	5	5
B1-83+C1-C4	42754	44814	87567	275	13	31	26	35	0	12	6	9	8	9	7	8
C5	17106	18503	35608	348	18	78	41	42	-	10	7	8	7	11	10	11
TOTAAL	70728	74375	145103	278	15	47	29	35	0	12	7	9	8	9	7	8

ENZA KLACHT INIT VERZ HEPH  
/SYMPT ARTS VROUW ONDZ

VERRICHT  
PARK

AFTER  
-PILL

TABEL 3A (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

1E KWARTAAL 1985 PER 10.000

URBANISATIE<----- POPULATIE ----->	<---- DEPRESSIE ----->			SUI <----- HARTINFARCT ----->			NIET-KLINISCH									
	M	V	T	M	V	T	M	V	T							
A1+A4	10669	11059	21928	6	10	8	0	4	2	3	-	-	-	-	-	-
B1-83+C1-C4	42754	44814	87567	10	19	14	2	7	4	6	2	2	2	2	2	2
C5	17106	18503	35608	16	26	21	2	5	5	5	3	4	3	4	3	3
TOTAAL	70728	74375	145103	10	19	15	2	6	4	5	2	2	2	2	2	2

POGING

KLINISCH

NIET-KLINISCH

TABEL 3A (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 3

1E KWARTAAL 1985 PER 10.000

URBANISATIE- GROEP	POPULATIE			EERSTE MAAL						ULCUS PEPTICUM								
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
A1+A4	10869	11059	21928	3	1	2	3	-	1	4	-	2	-	-	-	-	-	-
E1-B3+C1-C4	42754	44814	87567	5	4	4	1	0	1	4	2	3	0	0	0	0	0	0
C5	17106	18503	35608	2	2	2	2	-	1	11	3	7	1	-	0	-	-	0
TOTAAL	70728	74375	145103	4	3	4	1	0	1	6	2	4	0	0	0	0	0	0

2E KWARTAAL 1985 PER 10.000

LEEFTIJDS- GROEP	----- POPULATIE ----->			INFLU <--- CERVIJKUITSTRIJKJE --->				ZIEK <--- STERILISATIE --->			MORN- <--- MALIGNITEITEN --->					
	M	V	T	M+V	V	V	VERZ	HEFH	M+V	M	V	T	V	M	V	T
				ENZA	KLACHT	INIT	ARTS	VERZ	ONDZ	PARK	VERRICHT	AFTEP	-PILL			
< 1 JR	364	414	778	129	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3375	3262	6637	93	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4289	4275	8563	60	-	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	5659	5533	11192	30	-	2	-	-	-	-	-	-	2	-	-	-
15 - 19 JR	6150	6122	12272	40	5	10	-	5	-	-	-	-	23	-	-	-
20 - 24 JR	6345	6815	13160	40	18	107	23	9	-	-	1	1	22	-	-	-
25 - 34 JR	12069	11956	24025	42	29	134	81	79	-	22	23	22	10	1	2	1
35 - 44 JR	9864	9742	19606	50	29	80	76	131	-	35	34	35	4	2	5	4
45 - 54 JR	7578	7654	15232	54	34	57	56	108	-	5	-	3	3	5	7	6
55 - 64 JR	6539	6979	13518	67	7	20	20	42	1	2	-	1	-	17	14	16
> 64 JR	6748	9743	16490	58	3	3	3	6	2	-	-	-	-	41	36	38
TOTAAL	68979	72495	141474	51	15	52	34	48	0	10	8	9	7	7	8	7

TABEL 1B (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

2E KWARTAAL 1985 PFR 10.000

BLAD 7

LEEFTIJD- GROEP	POPULATIE			DEPRESSIE			SUÏCIDE POGING			KLINISCH			HARTINFARCT NIET-KLINISCH		
	M	V	T	M	V	T	M+V	T	M	V	T	M	V	T	
< 1 JR	364	414	778	-	-	-	-	-	-	-	-	-	-	-	
1 - 4 JR	3375	3262	6637	-	-	-	-	-	-	-	-	-	-	-	
5 - 9 JR	4289	4275	8563	-	-	-	-	-	-	-	-	-	-	-	
10 - 14 JR	5659	5533	11192	-	-	-	-	-	-	-	-	-	-	-	
15 - 19 JR	6150	6122	12272	2	10	6	2	-	-	-	-	-	-	-	
20 - 24 JR	6345	6815	13160	2	16	9	3	-	-	-	-	-	-	-	
25 - 34 JR	12069	11956	24025	8	38	23	3	-	1	0	-	-	-	-	
35 - 44 JR	9864	9742	19606	16	26	21	3	5	-	3	-	-	-	-	
45 - 54 JR	7578	7654	15232	18	38	28	5	9	3	6	5	-	-	3	
55 - 64 JR	6539	6979	13518	17	20	18	1	28	6	16	5	-	-	2	
> 64 JR	6748	9743	16490	9	18	15	2	58	13	32	9	7	8	8	
TOTAAL	68979	72495	141474	9	20	15	2	10	3	6	2	1	1	1	

LEEFTIJD- GROEP	POPULATIE			ULCUS PEPTICUM															
	EERSTE MAAL			VERMOEDEN				ZEKER				VERMOEDEN				RECTDIEF			
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	
< 1 JR	364	414	778	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
1 - 4 JR	3375	3262	6637	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
5 - 9 JR	4289	4275	8563	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
10 - 14 JR	5659	5533	11192	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
15 - 19 JR	6150	6122	12272	2	-	1	-	-	-	-	-	-	-	-	-	-	-	-	
20 - 24 JR	6345	6815	13160	6	-	3	-	1	1	2	-	1	-	-	2	-	-	1	
25 - 34 JR	12069	11956	24025	3	7	5	2	2	2	2	7	3	5	1	-	-	-	0	
35 - 44 JR	9864	9742	19606	4	3	4	-	5	3	7	7	3	5	2	-	-	-	1	
45 - 54 JR	7578	7654	15232	4	5	5	1	3	2	9	9	9	-	-	-	-	-	-	
55 - 64 JR	6559	6979	13518	5	6	5	5	1	3	12	4	8	2	1	1	1	1	1	
> 64 JR	6748	9743	16490	1	1	1	1	-	1	1	1	3	2	1	1	-	-	1	
TOTAAL	68979	72495	141474	3	3	3	1	2	1	5	3	4	1	0	1	0	0	0	



TABEL 2B

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

2E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE		INFLU <--- CERVIKUITSTRIJKJE --->		ENZA KLACHT /SYMPT ARTS		HEB ONZ		ZIEK <--- STERILISATIE ---> PARK VERRICHT		MORN- <--- MALIGNITEITFN ---> AFTER -PILL						
	M	V	M+V	T	V	V	V	M+V	M	V	T	V	M	V	T		
GR+FR+DR	10324	10819	21144	21144	84	24	42	30	70	-	12	8	10	9	10	6	8
OV+GLD+ZYP	11100	11477	22577	22577	51	23	54	20	58	0	14	8	11	7	7	9	8
UTR+NH+ZH	31163	33259	64422	64422	43	11	51	40	63	0	7	10	8	7	7	9	8
ZLD+NB+LIM	16391	16940	33331	33331	47	14	60	35	24	0	12	6	9	4	4	6	5
TOTAAL	68979	72495	141474	141474	51	15	52	34	48	0	10	8	9	7	7	8	7

TABEL 2B (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

2E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE		SUI <--- DEPRESSIE --->		SUI <--- HARTINFARCT --->		NIET-KLINISCH		NIET-KLINISCH								
	M	V	M	T	M	T	KLINISCH	KLINISCH	KLINISCH	POGING							
GR+FR+DR	10324	10819	21144	21144	9	20	15	3	9	-	4	1	1	1	1	1	1
OV+GLD+ZYP	11100	11477	22577	22577	8	19	14	1	14	7	10	1	-	0	1	1	1
UTR+NH+ZH	31163	33259	64422	64422	11	22	17	3	8	3	5	2	1	1	1	1	1
ZLD+NB+LIM	16391	16940	33331	33331	4	18	11	1	13	2	7	4	2	2	2	2	2
TOTAAL	68979	72495	141474	141474	9	20	15	2	10	3	6	2	1	1	1	1	1

2E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE			ULCUS PEPTICUM														
	H	V	T	EERSTE MAAL			ZEKER			VERHOEDEN			RECTDIEF			ZEKER		
				M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
GR+FR+DR	10324	10819	21144	2	5	3	2	1	1	1	1	1	1	1	0	1	4	0
OV+GLD+ZYP	11100	11477	22577	4	-	2	1	1	1	3	3	3	-	-	-	-	-	-
UTR+NH+ZH	31163	33259	64422	3	3	3	1	1	1	7	3	5	1	0	1	1	0	1
ZLD+NB+LIM	16391	16940	33331	4	2	3	1	3	2	4	2	3	1	-	1	1	-	1
TOTAAL	68979	72495	141474	3	3	3	1	2	1	5	3	4	1	1	0	1	0	0

TABEL 3B

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

2E KWARTAAL 1985 PER 10.000

URBANISATIE<-----> GROEP	POPULATIE ----->			INFLU <--- CERVIJUITSTRIJKJE --->			ZIEK <--- STERILISATIE --->			MORN- <- HALIGNITEITFN --->									
	M	V	T	M+V	V	T	ENZA KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HEPM ONDZ	M+V	H	V	T	V	M	H	V	T
A1+A4	11018	11240	22258	31	20	62	26	19	0	15	10	13	6	5	4	4	4	4	4
B1-B3+C1-C4	42266	44237	86503	40	12	43	34	51	0	9	7	8	7	8	8	8	8	8	8
C5	15695	17018	32713	95	22	68	41	61	-	8	11	9	7	3	10	7	7	3	10
TOTAAL	68979	72495	141474	51	15	52	34	48	0	10	8	9	7	7	8	7	7	7	8

TABEL 3B (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

2E KWARTAAL 1985 PER 10.000

URBANISATIE<-----> GROEP	POPULATIE ----->			<--- DEPRESSIE --->			SUT <----->			HARTINFARCT			
	M	V	T	M	V	T	CLIDE	POGING	KLINISCH	NIET-KLINISCH	M	V	T
A1+A4	11018	11240	22258	4	18	11	0	9	4	6	-	-	-
B1-B3+C1-C4	42266	44237	86503	8	17	12	7	11	2	6	2	1	1
C5	15695	17018	32713	13	32	23	5	7	5	6	3	2	2
TOTAAL	68979	72495	141474	9	20	15	2	10	3	6	2	1	1

TABEL 38 (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEÏLSTATIONS  
2E KWARTAAL 1985 PER 10.000

BLAD 3

URGANISATIE<-----> GROEP	POPULATIE ----->			ULCUS PEPTICUM ----->														
	M	V	T	EERSTE HAAL				ZEKER				VERMOEDEN				RECIDIËF		
				M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
A1*44	11018	11240	22258	3	4	3	-	1	0	-	-	-	-	-	-	1	-	0
B1-B3*C1-C4	42266	44237	86503	4	2	3	1	1	1	3	2	3	0	-	0	-	-	0
C5	15695	17018	32713	1	3	2	2	2	2	13	5	9	2	1	1	1	1	1
TOTAAL	68979	72495	141474	3	3	3	1	2	1	5	3	4	1	0	0	0	0	0

TABEL IC

## CONTINUE MORBIDITEITSREGISTRATIE PFIJLSTATIONS

BLAD 1

3E KWARTAAL 1965 PER 10.000

LEEFTIJDS- GROEP	POPULATIE ----->				INFLU <--- CERVIKUITSTRIJKJE --->				ZIEK <--- SIFRILISATIE --->				MORN- <--- MALIGNITEITEN --->			
	H	V	T		M+V	V	V	M+V	M	V	T	T	V	M	V	T
					EN7A ALACHT /SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ	PARK	VERRICHT		AFTEP -PILL				
< 1 JR	229	377	705		227	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3062	2950	6012		110	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	3686	3860	7745		62	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	5158	5007	10165		29	-	-	-	-	-	-	-	-	-	-	-
15 - 19 JR	5656	5593	11229		31	5	18	4	-	-	-	-	-	-	-	-
20 - 24 JR	5789	6220	12006		52	21	117	23	29	-	-	-	-	-	-	-
25 - 24 JR	10940	10841	21781		45	39	141	76	80	-	27	7	17	18	4	4
35 - 44 JR	8948	8856	17804		50	37	86	71	121	-	30	24	27	6	7	1
45 - 54 JR	6950	7023	13973		37	17	75	56	137	1	3	1	2	4	7	7
55 - 64 JR	6001	6401	12401		43	8	22	30	37	2	2	-	1	-	10	11
> 64 JR	6226	6965	15191		40	3	-	6	6	3	-	-	-	-	55	20
TOTAAL	62924	66091	129015		47	17	57	34	51	1	10	5	7	9	9	5

TABEL 1C (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

3E KWARTAAL 1985 PER 10.000

LEEFTIJD- GROEP	POPULATIE		DEPRESSIE				SUI CIDE		KLTNISCH		HARTINFARCT		NIET-KLTNISCH	
	M	V	M	V	T	M+V	M	V	T	M	V	T	M	V
< 1 JR	329	377	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	2062	2950	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	3586	3860	3	-	1	-	-	-	-	-	-	-	-	-
10 - 14 JR	5158	5007	2	2	2	-	-	-	-	-	-	-	-	-
15 - 19 JR	5636	5593	2	13	7	1	-	-	-	-	-	-	-	-
20 - 24 JR	5789	6220	5	14	10	2	-	-	-	-	-	-	-	-
25 - 34 JR	10940	12641	15	24	19	2	-	-	-	-	-	-	-	-
35 - 44 JR	8946	8856	13	17	15	2	1	2	2	3	-	2	-	2
45 - 54 JR	6950	7023	14	28	21	1	10	1	9	-	-	3	1	1
55 - 64 JR	6001	6401	13	20	17	1	18	5	11	8	3	6	3	6
> 64 JR	6226	6965	8	21	16	2	43	12	25	8	3	5	8	5
TOTAAL	62924	66091	9	17	13	1	8	3	5	2	1	2	2	2

TABEL 1C (VERVOLGD)

CONTINUE MORBIDITEITSREGISTRATIE PULSTATIONS

BLAD 3

3E KWARTAAL 1995 PER 10.000

LEEFTIJD- GROEP	POPULATIE			ULCUS PEPTICUM																				
	H	V	T	EERSTE MAAL				ZEKER				VERMOEDEN				RECTDIEF								
	H	V	T	H	V	T	M	V	T	M	V	T	M	V	T	M	V	T	ZEKER	VERMOEDEN	RECTDIEF	ZEKER	VERMOEDEN	RECTDIEF
< 1 JR	324	377	729	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3062	2950	6012	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	3886	3860	7745	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	5156	5007	10155	2	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
15 - 19 JR	5636	5593	11229	-	-	-	2	2	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
20 - 24 JR	5789	6220	12006	2	5	3	2	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
25 - 34 JR	10940	10841	21751	5	6	6	1	-	0	7	3	5	-	-	-	-	-	-	-	-	-	-	-	-
35 - 44 JR	8948	8856	17804	8	6	7	2	3	3	10	5	7	2	-	1	-	-	-	-	-	-	-	-	-
45 - 54 JR	6950	7023	13973	3	1	2	4	-	2	6	4	5	-	4	2	-	-	-	-	-	-	-	-	-
55 - 64 JR	6001	6401	12401	3	3	3	3	5	4	5	3	4	2	3	2	-	-	-	-	-	-	-	-	-
> 64 JR	6226	8965	15151	-	1	1	3	6	6	5	1	3	2	2	2	-	-	-	-	-	-	-	-	-
TOTAAL	62924	66091	129015	3	3	3	2	2	2	4	2	3	1	1	1	-	-	-	-	-	-	-	-	-

TABEL 2C

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

3E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE		INFLU <--- CERVIKITSTRIJKJE --->		EHZA KLACHT / SYMPT		INIT VERZ ARTS		HERH ONDZ		ZIEK <--- STERILISATIE --->		VERRICHT		MORN- <--- MALIGNITEITEN --->		
	M	V	M+V	T	V	T	V	T	V	T	M+V	M	V	T	M	V	T
GR+FR+DR	9743	10178	19921	19921	89	26	39	25	28	-	9	1	5	9	4	5	5
OV+GLD+ZYP	11026	11392	22418	22418	51	25	57	29	51	-	13	7	10	6	9	6	8
UTR+NH+ZH	27344	29226	56570	56570	30	12	64	40	66	1	9	4	7	9	10	5	7
ZLO+HS+LIM	14811	15295	30106	30106	49	14	57	33	33	1	8	7	7	11	9	6	8
TOTAAL	62924	66091	129015	129015	47	17	57	34	51	1	10	5	7	9	9	5	7

TABEL 2C (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

3E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE		SUJ <--- DEPRESSIE --->		KLINISCH		HARTINFARCT		NIET-KLINISCH			
	M	V	M	T	M+V	M	V	T	M	V	T	
GR+FR+DR	9743	10178	9	17	13	1	8	3	6	1	1	1
OV+GLD+ZYP	11026	11392	10	18	14	0	8	2	5	4	1	2
UTR+NH+ZH	27344	29226	11	18	14	2	8	3	5	2	1	2
ZLO+HS+LIM	14811	15295	5	14	10	1	7	3	5	2	1	1
TOTAAL	62924	66091	9	17	13	1	8	3	5	2	1	2



TABEL 2C (VERVOLGD)

CONTINUÛ MORBIIDITEITSGEGISTRATE PEILSTATIONS

BLAD 3

3E KWARTAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE			ULCUS PEPTICUM																		
	M	V	T	EERSTE MAAL				ZEKER				RECIDIËF				ZEKER						
				VERMOEDEN	V	T	M	H	V	T	M	H	V	T	VERMOEDEN	V	T	M	H	V	T	
GR+FR+DP	9743	10178	19921		3	4	4	2	1	2	6	3	5	-								
OV+GLO+ZYP	11026	11392	22418		4	3	3	2	1	1	2	1	1	-								
UTR+NH+ZH	27344	29226	56570		3	3	3	2	2	2	5	3	4	2								
ZLD+NB+LIM	14611	15295	30106		3	2	3	1	3	2	4	1	2	1								
TOTAAL	67924	66591	129015		3	3	3	2	2	2	4	2	3	1								

TABEL 3C

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

3E KWARTAAL 1985 PER 10.000

URBANISATIE- GROEP	POPULATIE		INFLU <--- CERVIJUITSTRIJKJE --->				ZIEK <--- STERILISATIE --->		MORN- <--- MALIGNITEITEN --->						
	M	V	H+V	V	V	HEPH ONDZ	PARK VERRICHT	AFTEP -PILL	M	V					
A1+A4	10068	10256	17	21	59	39	28	-	18	10	14	7	9	5	7
B1-B3+C1-C4	38018	39819	37	15	46	29	49	1	7	3	5	7	8	6	7
C5	14838	16017	93	19	86	44	71	0	11	5	8	15	11	4	7
TOTAAL	62924	66091	47	17	57	34	51	1	10	5	7	9	9	5	7

TABEL 3C (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

3E KWARTAAL 1985 PER 10.000

URBANISATIE- GROEP	POPULATIE		<--- DEPRESSIE --->				SUI- CIDE POGING		HARTINFARCT NIET-KLINISCH		<--->	
	M	V	M	V	T	H+V	M	V	T	M	V	T
A1+A4	10068	10256	4	19	11	1	9	1	5	2	-	1
B1-B3+C1-C4	38018	39819	7	13	10	1	5	3	4	2	2	2
C5	14838	16017	17	24	21	2	14	3	6	2	-	1
TOTAAL	62924	66091	9	17	13	1	8	3	5	2	1	2

3C KWARTAAL 1985 PER 10.000

URBANISATIE- GROEP	FÖPULATIE			ULCUS PEPTICUM																	
	M	V	T	EERSTE MAAL				ZEKER				VERHOEDEN				RECTDIEF				ZEKER	
				M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
A1+A4	10068	10256	20323	2	2	2	3	1	2	4	3	3	-	-	-	-	-	-	-	-	-
B1-B3+C1-C4	38018	39819	77837	4	3	3	1	1	1	4	1	3	1	0	1	1	0	1	1	0	1
C5	14635	16017	30852	2	3	3	3	5	4	5	3	4	1	4	2	1	4	2	1	4	2
TOTAAL	62924	66091	129015	3	3	3	2	2	2	4	2	3	1	1	1	1	1	1	1	1	1



TABEL 10 (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PFILSTATIONS

BLAD 2

4E KWARTAAL 1985 PER 10.000

LEEFTIJDS- GROEP	POPULATIE			DEPRESSIE				SUI- CIDIF POGING			KLINISCH		HARTINFARCT		NIET-KLINISCH	
	M	V	T	M	V	T	H+V	M	V	T	M	V	M	V	T	
< 1 JR	364	414	778	-	-	-	-	-	-	-	-	-	-	-	-	
1 - 4 JR	3331	3218	6550	-	-	-	-	-	-	-	-	-	-	-	-	
5 - 9 JR	4214	4187	8401	-	-	-	-	-	-	-	-	-	-	-	-	
10 - 14 JR	5585	5453	11042	-	-	-	-	-	-	-	-	-	-	-	-	
15 - 19 JR	6126	6087	12213	2	7	4	-	-	-	-	-	-	-	-	-	
20 - 24 JR	6336	6807	13145	9	19	14	2	-	-	-	-	-	-	-	-	
25 - 34 JR	12001	11845	23846	7	21	14	7	-	-	-	-	-	-	-	0	
35 - 44 JR	9710	9598	19307	19	31	25	2	6	1	4	-	-	-	-	-	
45 - 54 JR	7590	7658	15248	13	34	24	3	8	4	6	1	-	-	1	-	
55 - 64 JR	6563	7018	13581	5	19	12	1	24	6	19	5	-	-	2	-	
> 64 JR	6824	9860	16683	10	9	10	1	31	20	25	7	4	5	1	-	
TOTAAL	68645	72149	140794	8	17	12	1	8	4	6	1	1	1	1	-	

4E KWARTAL 1985 PER 10.000

LELFTIJD- GROEP	POPULATIE			EERSTE MAAL						ULCUS PEPTICUM						
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	ZFKER
< 1 JR	364	414	778	-	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3331	3218	6550	-	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4214	4187	8401	-	-	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	5585	5458	11042	-	-	-	-	-	-	-	-	-	-	-	-	-
15 - 19 JR	6126	6087	12213	-	-	-	2	-	1	-	-	-	-	-	-	-
20 - 24 JR	6338	6807	13145	8	1	5	5	-	2	3	-	2	-	-	-	-
25 - 34 JR	12001	11845	23846	8	3	6	-	2	1	3	2	3	-	-	-	-
35 - 44 JR	9710	9598	19307	5	3	4	2	1	2	8	1	5	1	-	1	1
45 - 54 JR	7590	7658	15248	3	5	4	-	-	-	11	-	5	-	1	1	1
55 - 64 JR	6563	7018	13581	3	4	4	6	4	5	3	1	2	2	-	1	1
> 64 JR	6824	9860	16683	3	4	4	6	5	5	6	4	5	-	-	-	-
TOTAAL	68545	72149	140794	4	3	3	2	2	2	4	1	3	0	0	0	0

TABEL 2D

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

4E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE			INFLU <--- CERVIXUITSTRIJKJE --->			ZIEK <--- STERILISATIE --->			MOVN <--- MALIGNITEITEN --->			
	M	V	T	M+V	V	T	M+V	M	T	V	M	V	T
GR+FR+DR	10298	10769	21066	131	15	41	25	31	-	10	9	9	9
OV+GLD+ZYP	11968	12384	24352	105	26	59	33	57	1	19	6	13	11
UTR+NH+ZH	29786	31859	61645	66	11	39	34	63	0	11	5	8	7
ZLD+NB+LLIM	16593	17137	33731	75	12	36	25	34	0	11	5	8	9
TOTAAL	68645	72149	140794	84	14	42	30	50	0	12	6	9	8

TABEL 2D (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

4E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE			<--- DEPRESSIE --->			SUI <--- HARTINFARCT --->			NIET-KLINISCH			NIET-KLINISCH			
	M	V	T	M	V	T	M+V	M	V	T	M	V	T	M	V	T
GR+FR+DR	10298	10769	21066	6	18	12	7	6	2	4	2	-	1			
OV+GLD+ZYP	11968	12384	24352	4	20	12	0	6	2	4	4	2	3			
UTR+NH+ZH	29786	31859	61645	11	16	14	2	11	5	8	1	-	0			
ZLD+NB+LLIM	16593	17137	33731	6	14	10	1	6	5	5	1	1	1			
TOTAAL	68645	72149	140794	8	17	12	1	8	4	6	1	1	1			

4E KWARTAAL 1985 PER 10.000

PROVINCIE GROEP	POPULATIE			ULCUS PEPTICUM														
	M	V	T	EERSTE MAAL				ZEKER				VERMOEDEN				RFGT DIEF		
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
GR+FR+DR	10298	10769	21066	5	2	3	-	-	-	3	1	2	-	-	-	-	-	-
OV+GLD+ZYP	11966	12384	24352	4	-	2	3	1	2	3	1	2	-	-	-	-	-	-
UTR+NH+ZH	29786	31859	61645	4	3	4	3	1	2	6	1	3	C	0	0	0	0	0
ZLD+NB+LIM	16593	17137	33731	2	4	3	2	4	3	2	2	2	I	-	0	0	0	0
TOTAAL	68645	72149	140794	4	3	3	2	2	2	4	1	3	0	0	0	0	0	0



TABEL 3D

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

4E KWARTAAL 1985 PER 10.000

URBANISATIE<----- GROEP	POPULATIE ----->			INFLU <--- CERVIKITSTRIJKJF --->			ZIEK <--- STFRILISATIE --->			MORN- <--- MALIGNITEITEN --->						
	M	V	T	M+V	V	T	M+V	V	T	M	V	T				
A1+A4	11320	11535	22855	70	23	55	36	23	0	19	6	13	9	11	4	7
E1-B3+C1-C4	41220	43202	84422	65	10	32	23	49	0	11	6	9	7	12	8	10
C5	16105	17412	33517	144	19	57	32	71	1	10	6	8	10	13	11	12
TOTAAL	68645	72149	140794	84	14	42	30	50	0	12	6	9	8	12	8	10

ENZA KLACHT /SYMPT ARTS VROUW ONDZ  
 HEPH ONDZ  
 MORN- <--- MALIGNITEITEN --->  
 AFTEP -PILL

TABEL 3D (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

4E KWARTAAL 1985 PFR 10.000

URBANISATIE<----- GROEP	POPULATIE ----->			<--- DEPRESSIE --->			SUI <----->			HARTINFARCT ----->		
	M	V	T	M	V	T	CLINISCH	KLINISCH	NIET-KLINISCH	M	V	T
A1+A4	11320	11535	22855	3	17	10	0	10	1	5	2	1
E1-B3+C1-C4	41220	43202	84422	6	14	10	1	8	4	6	1	0
C5	16105	17412	33517	15	23	19	2	8	6	7	2	1
TOTAAL	68645	72149	140794	8	17	12	1	8	4	6	1	1

<--- DEPRESSIE --->  
 SUI <----->  
 CLINISCH  
 KLINISCH  
 NIET-KLINISCH

TABEL 3D (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 7

4E KWARTAAL 1985 PER 10.000

URBANISATIE- GROEP	POPULATIE			EERSTE MAAL						ULCUS PEPTICUM						RECIDIËF		
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
A1+A4	11320	11535	22855	3	1	2	2	2	2	3	1	2	-	-	-	-	-	-
B1-B3+C1-C4	41220	43202	84422	4	3	4	1	1	1	4	1	2	0	-	0	-	-	0
C5	16105	17412	33517	4	2	3	4	2	3	6	1	4	-	1	0	-	1	0
TOTAAL	68645	72149	140794	4	3	3	7	2	2	4	1	3	0	0	0	0	0	0

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

PLAD 1

1985 TOTAAL PFR 10.ROC

LEEFTIJD- GROEP	POPULATIE ----->			INFLU <--- CERVIKUITSTRIJKUF --->			ZIEK <--- STERILISATIE --->			MORBN- <--- MALIGNITEITFN --->					
	M	V	T	M+V	INIT ARTS	VERZ VROUW	HEBZ ONDZ	M+V	M	V	T	V	M	V	T
< 1 JP	358	403	765	1163	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JP	3300	3185	6485	6485	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JP	4179	4156	8335	8375	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JP	5533	5398	10932	360	-	-	-	-	-	-	-	-	-	-	-
15 - 19 JP	6050	6014	12064	380	20	53	17	7	-	-	-	-	-	-	-
20 - 24 JP	6251	6719	12970	363	71	374	76	R2	-	-	-	-	-	-	-
25 - 34 JP	11862	11727	23589	410	128	506	274	296	-	-	-	-	-	-	-
35 - 44 JP	9631	9522	19153	490	120	297	293	457	-	-	-	-	-	-	-
45 - 54 JP	7480	7553	15033	406	93	236	212	461	1	25	9	17	9	25	36
55 - 64 JP	6468	6908	13376	494	32	87	97	146	3	5	-	2	-	80	49
> 64 JP	6707	9688	16395	504	14	7	17	19	9	-	-	-	-	219	113
TOTAAL	67619	71277	139097	472	62	197	127	184	1	44	26	35	32	37	28

1985 TOTAAL PER 10.000

LEEFTIJD- GROEP	POPULATIE			DEPRESSIE			SUIKIDF POSSING			KLINISCH			HARTINFARCT			NIET-KLINISCH		
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
< 1 JR	356	408	765	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3300	3186	6485	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4179	4155	8335	2	-	1	-	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	5533	5798	10932	2	4	3	1	-	-	-	-	-	-	-	-	-	-	-
15 - 19 JR	6050	6014	12064	8	38	23	7	-	-	-	-	-	-	-	-	-	-	-
20 - 24 JR	6251	6719	12970	19	63	42	17	-	-	-	-	-	-	-	-	-	-	-
25 - 34 JR	11862	11727	23539	51	119	84	11	-	1	0	1	0	1	-	0	1	-	0
35 - 44 JR	9631	9522	19153	65	104	85	8	17	3	10	3	10	3	-	2	3	-	2
45 - 54 JR	7480	7533	15033	68	132	100	11	40	12	26	7	4	5	4	5	7	4	5
55 - 64 JR	6468	6908	13376	43	77	61	4	96	23	58	22	7	14	7	14	22	7	14
> 64 JR	6707	9688	16395	33	66	52	6	163	70	108	39	26	31	39	26	39	26	31
TOTAAL	67619	71277	139097	36	73	55	6	72	14	23	7	5	6	7	5	7	5	6

CONTINUE MORBIIDITEITSREGISTRATIE PFILSTATIONS

1985 TOTAAL PER 10.000

TABEL 1E (VERVOLG)

LEEFTIJD- GROEP	POPULATIE			ULCUS PEPTICUM																			
				EERSTE MAAL				ZEKER				VERMOEDEN				RECIDIËF				ZEKER			
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T		
< 1 JR	358	428	765	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
1 - 4 JP	3300	3186	6485	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
5 - 9 JP	4179	4156	8335	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
10 - 14 JR	5533	5398	10932	2	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
15 - 19 JR	6250	6214	12054	7	-	3	3	2	2	2	2	-	2	2	1	2	1	2	1	2	-	1	
20 - 24 JR	6251	6719	12970	22	9	15	6	1	4	4	8	-	-	-	4	-	-	-	-	-	-	-	
25 - 34 JR	11862	11727	23589	24	18	21	4	3	4	4	25	10	18	2	2	2	1	18	2	2	-	1	
35 - 44 JR	9631	9522	19153	20	18	19	5	11	8	8	31	11	21	6	6	6	11	21	6	6	-	3	
45 - 54 JR	7480	7553	15033	12	20	16	9	3	6	6	39	16	27	1	5	5	16	27	1	5	3	3	
55 - 64 JR	6463	6908	13376	22	19	20	17	10	13	13	34	12	22	5	6	6	12	22	5	6	5	5	
> 64 JR	6707	9688	16395	4	9	7	13	13	13	13	19	11	15	3	3	3	11	15	3	3	3	3	
TOTAAL	67819	71277	139037	14	11	12	6	5	6	6	19	8	13	2	2	2	19	13	2	2	2	2	

TABLE 2E

CONTINUE MORBIDITEITSREGISTRATIE PFIJLSTATIONS

BLAD 1

1985 TOTAAL PER 10.000

PROVINCIE GROEP	POPULATIE ----->			INFLU <--- CERVIKUITSTRIJKJF --->			ZIJK <--- STERILISATIE --->			MOON- <--- MALIGNITEITEN --->				
	M	V	T	M+V	V	T	M+V	M	V	T	V	M	V	T
GR+FR+DR	10258	10735	20993	671	90	167	109	109	45	24	34	36	20	28
OV+GLD+ZYP	11502	11899	23402	422	92	232	105	208	1	57	29	31	29	30
UTR+NH+ZH	29988	32038	62026	399	45	196	147	278	2	35	24	43	30	36
ZLU+NB+LIM	16071	16605	32676	519	52	195	116	109	1	50	28	29	30	30
TOTAAL	67819	71277	139097	472	62	197	127	184	1	44	26	37	28	32

ENZA KLACHT INIT VERZ HEPH  
/SYMPT ARTS VROUW ONDZ

VERRICHT  
PARK

AFTEP  
-PILL

TABLE 2E (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PFIJLSTATIONS

BLAD 2

1985 TOTAAL PER 10.000

PROVINCIE GROEP	POPULATIE ----->			SUI <----- HARTINFARCT ----->			NIET-KLINISCH						
	M	V	T	M	V	T	M	V	T				
GR+FR+DR	10258	10735	20993	76	74	55	6	26	11	20	4	4	4
OV+GLD+ZYP	11502	11899	23402	30	78	55	7	30	13	21	10	5	8
UTR+NH+ZH	29988	32038	62026	44	77	61	2	12	15	23	6	5	5
ZLU+NB+LIM	16071	16605	32676	24	63	44	5	15	14	24	9	4	7
TOTAAL	67819	71277	139097	36	73	55	6	32	14	23	7	5	6

CIDF  
POSTING

KLINISCH

NIET-KLINISCH

TAEL 2E (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 7

1955 TOTAAL PER 10.000

PROVINCIE URGEP	POPULATIE			EERSTE MAAL						ULCUS PEPTICUM					
	<----->			VERMOEDEN			ZEKER			VERMOEDEN			RFGDIEF		
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
LR+FR+JP	10258	10735	20993	13	14	13	3	2	3	16	4	10	1	-	0
GV+GLD+ZYP	11502	11899	23402	15	4	9	7	3	5	12	6	9	-	-	-
UTR+NH+ZH	29986	32038	62026	15	14	14	5	4	6	24	10	17	3	3	3
ZLL+NB+LIM	16071	16605	32676	11	10	11	4	11	8	17	7	12	2	1	2
TOTAAL	67819	71277	139097	14	11	12	6	5	6	19	8	13	3	2	2

TABEL 3E

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

1985 TOTAAL PER 10.000

UR-ANISATIEK- GROEP	POPULATIE			INFLU <--- CERVIJUITSTRIJKUF --->			ZIEK <-- STERILISATIE --->			MOYN- <- MALIGNITEITEN --->			
	M	V	T	M+V	V	T	INIT /SYMPT	VERZ ARTS	HEPH VROUW	ONDZ	PARK	VERRICHT	AFTEP -PILL
A1+A4	10619	11022	21641	299	85	235	121	94	1	68	32	50	30
B1-B3+C1-C4	41064	43018	84082	428	49	151	116	182	2	39	23	71	29
C5	15936	17237	33173	699	78	288	157	243	1	39	28	73	39
TOTAAL	67819	71277	139097	472	62	197	127	184	1	44	26	35	32

TABEL 3E (VERVOLG)

## CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

1985 TOTAAL PER 10.000

UR-ANISATIEK- GROEP	POPULATIE			<--- DEPRESSIE --->			.SUI <----- HARTINFARCT ----->			NIET-KLINISCH		
	M	V	T	M	V	T	POGING	KLINISCH	POGING	NIET-KLINISCH	POGING	NIET-KLINISCH
A1+A4	10619	11022	21641	16	64	40	2	71	7	19	4	1
B1-B3+C1-C4	41064	43018	84082	31	63	47	6	72	13	22	7	4
C5	15936	17237	33173	61	106	84	11	33	19	26	10	8
TOTAAL	67819	71277	139097	76	73	55	6	32	14	23	7	5



TABLE 3E (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 3

1985 TOTAAL PER 10.000

ADMINISTRATIE- GROEF	POPULATIE ----->			ULCUS PEPTICUM ----->														
	M	V	T	EERSTE MAAL				ZWAER				VERMOEDEN				RECIDIËF		
	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T	M	V	T
ALFA4	10819	11022	21541	10	7	9	7	4	5	10	4	7	1	-	0			
-1-23+21-C4	41064	43018	84082	16	13	15	4	4	4	15	7	11	2	1	1			
C5	15936	17237	33173	9	10	10	11	9	10	36	12	24	7	5	4			
TOTAAL	67519	71277	138797	14	11	12	6	5	6	19	8	13	?	2	2			

TABEL 4A

Aantal patiënten met influenza(-achtig ziektebeeld), per week, per 10 000 inwoners, 1985-1986 (t/m 13e week)

week nr. 1985	provinciegroep				urbanisatiegroep			totaal
	A	B	C	D	1	2	3	
	1	12	8	8	7	5	7	
2	9	7	8	9	5	7	15	8
3	17	6	5	8	5	6	13	8
4	5	6	11	14	4	10	14	10
5	9	8	7	12	8	9	8	8
6	18	10	9	8	9	8	17	10
7	22	17	16	15	18	16	20	17
8	21	28	25	23	20	26	24	25
9	64	29	43	88	26	58	63	54
10	79	35	43	71	30	57	55	53
11	48	26	35	37	25	36	43	36
12	31	14	24	25	18	22	29	23
13	26	14	16	20	11	16	27	18
14	16	9	10	9	10	8	17	10
15	10	5	7	4	4	5	13	7
16	5	4	3	5	1	4	6	4
17	6	4	3	3	2	3	7	4
18	5	3	2	2	0	2	5	3
19	6	3	2	2	2	2	7	3
20	6	3	2	2	2	2	7	3
21	9	2	2	2	1	2	7	3
22	5	5	2	2	3	2	5	3
23	7	5	2	4	3	2	7	4
24	3	3	2	2	1	2	5	3
25	6	3	3	4	2	3	5	4
26	7	3	2	3	1	2	6	3
27	1	3	2	3	2	2	5	2
28	1	4	2	1	-	2	4	2
29	1	3	4	5	-	4	5	4

Tabel 4a (vervolg)

aantal patiënten met influenza(-achtig ziektebeeld), per week, per 10 000 inwoners, 1985-1986 (t/m 13e week)

week nr. 1985	provinciegroep				urbanisariegroep			totaal	
	A	B	C	D	1	2	3		
	30	-	1	2	3	-	2		2
31	3	1	2	3	-	1	5	2	
32	6	3	1	1	2	1	5	3	
33	6	2	1	3	1	2	5	3	
34	9	2	2	4	1	2	8	3	
35	8	7	2	3	1	3	8	4	
36	16	5	3	4	0	4	14	6	
37	10	4	3	7	0	5	10	5	
38	10	4	2	4	2	3	8	4	
39	12	9	3	9	6	6	9	7	
40	9	10	2	7	5	6	7	6	
41	16	4	5	5	1	5	13	6	
42	3	8	3	6	9	4	4	5	
43	8	8	5	7	7	5	8	6	
44	17	11	2	3	9	3	14	6	
45	16	7	6	8	6	5	16	8	
46	9	10	6	7	6	5	15	7	
47	9	9	5	7	6	5	11	7	
48	16	8	4	4	4	5	13	7	
49	6	8	6	7	5	6	10	7	
50	9	10	4	5	3	5	10	6	
51	8	9	8	5	6	6	13	8	
52	1	4	9	5	3	7	6	6	
<u>1986</u>									
1	}	17	15	13	13	7	12	24	17
2									
3	17	17	17	37	12	16	20	16	

Tabel 4a (vervolg)

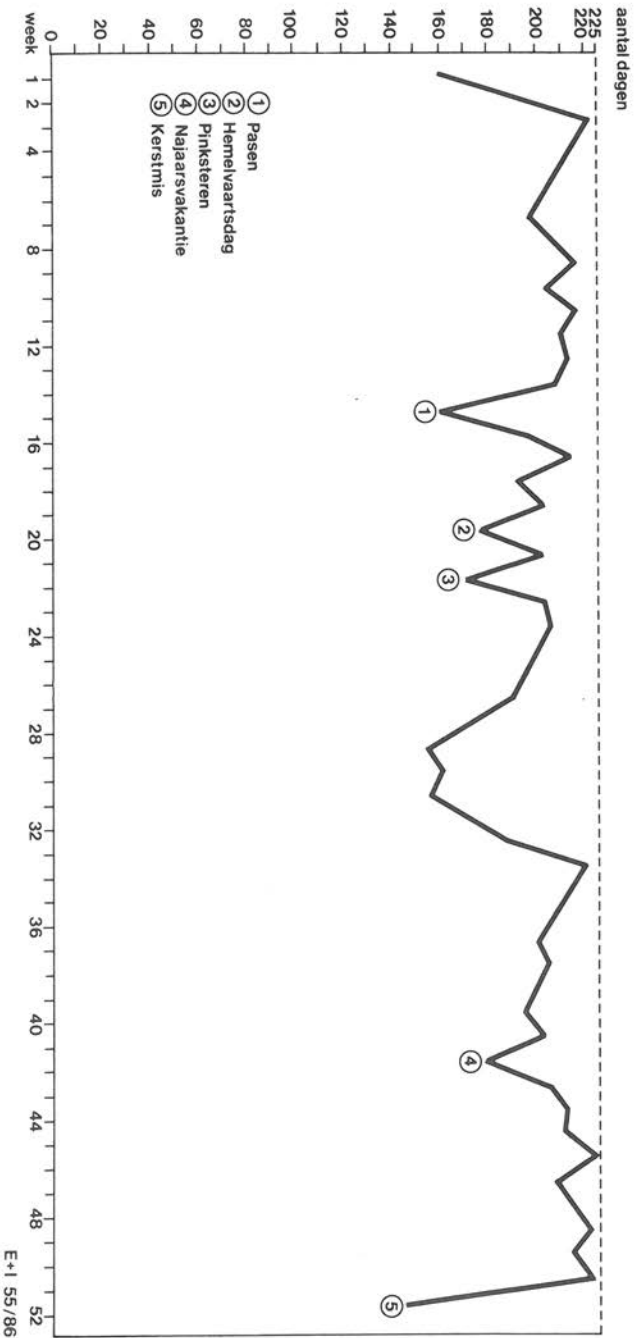
aantal patiënten met influenza(-achtig ziektebeeld), per week, per 10 000 inwoners, 1985-1986 (t/m 13e week)

week nr. 1986	aantal patiënten							
	provinciegroep				urbanisatiegroep			totaal
	A	B	C	D	1	2	3	
4	16	34	19	8	27	13	22	18
5	31	32	28	24	36	24	34	28
6	35	53	28	34	45	30	40	35
7	64	55	45	45	45	47	57	50
8	81	71	68	94	61	79	84	77
9	77	74	75	78	62	77	82	76
10	60	43	53	62	41	54	62	55
11	38	39	33	37	47	31	45	37
12	17	21	23	19	22	18	31	21
13	9	9	9	9	5	9	13	9

Figuur 1  
 PEILSTATIONS  
 CONTINUE MORBIDITEITS REGISTRATIE  
 1985

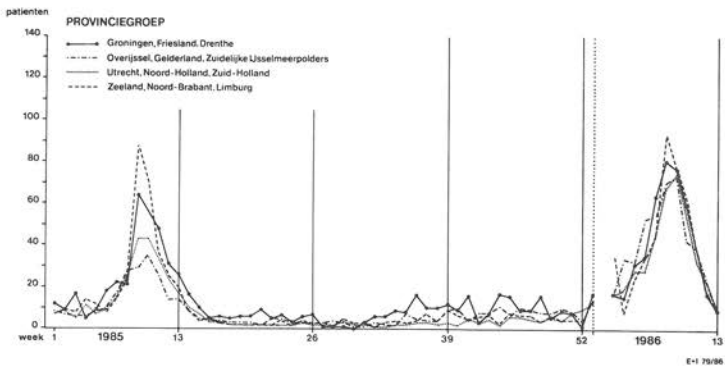
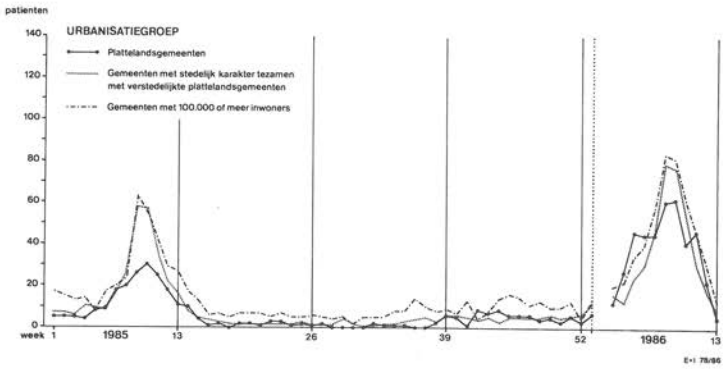
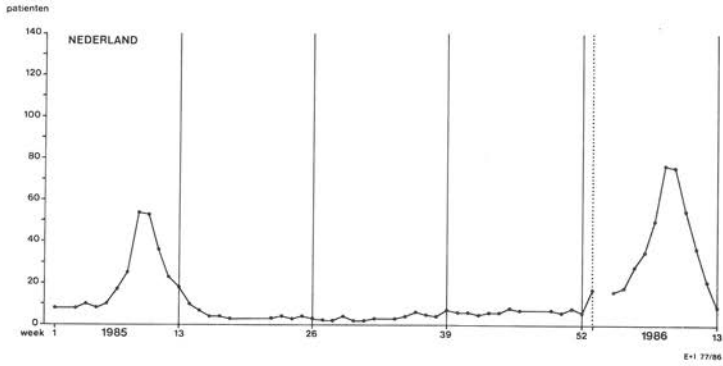


Figuur 2  
 Het aantal dagen, dat in 1985 per week is geregistreerd

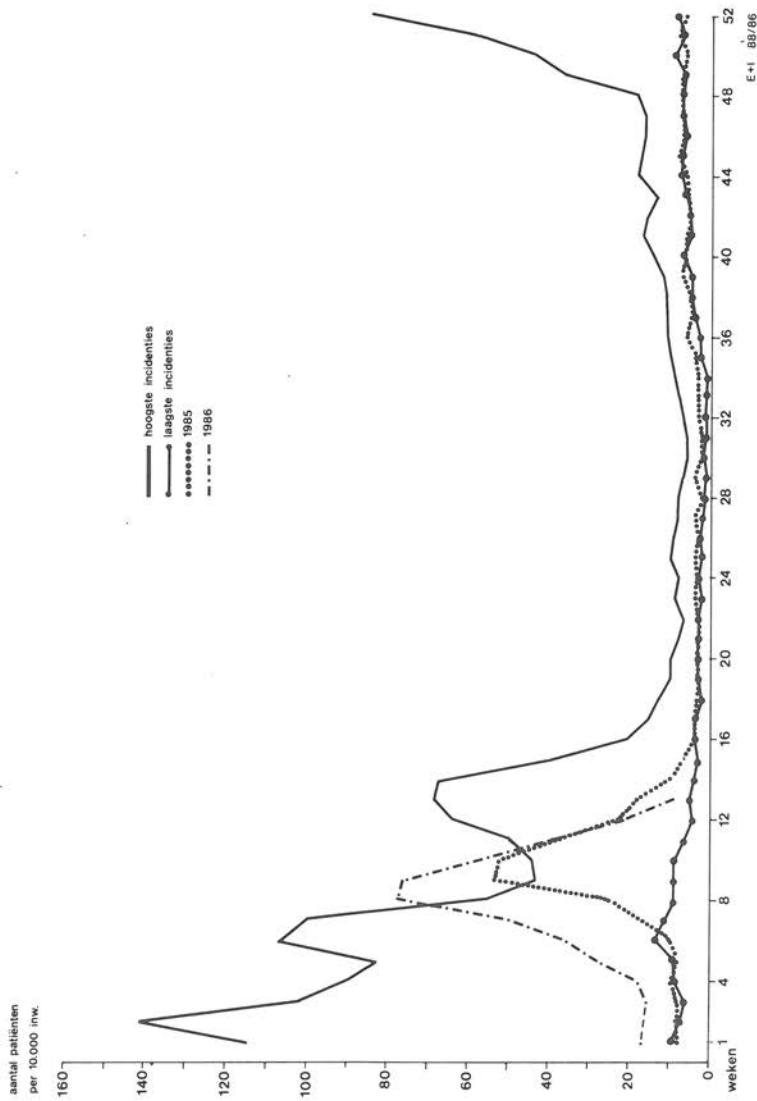


Figuur 3

Aantal patiënten met influenza(-achtig ziektebeeld) per week en per 10.000 inwoners, 1985 - 1986 (t/m 13e week)



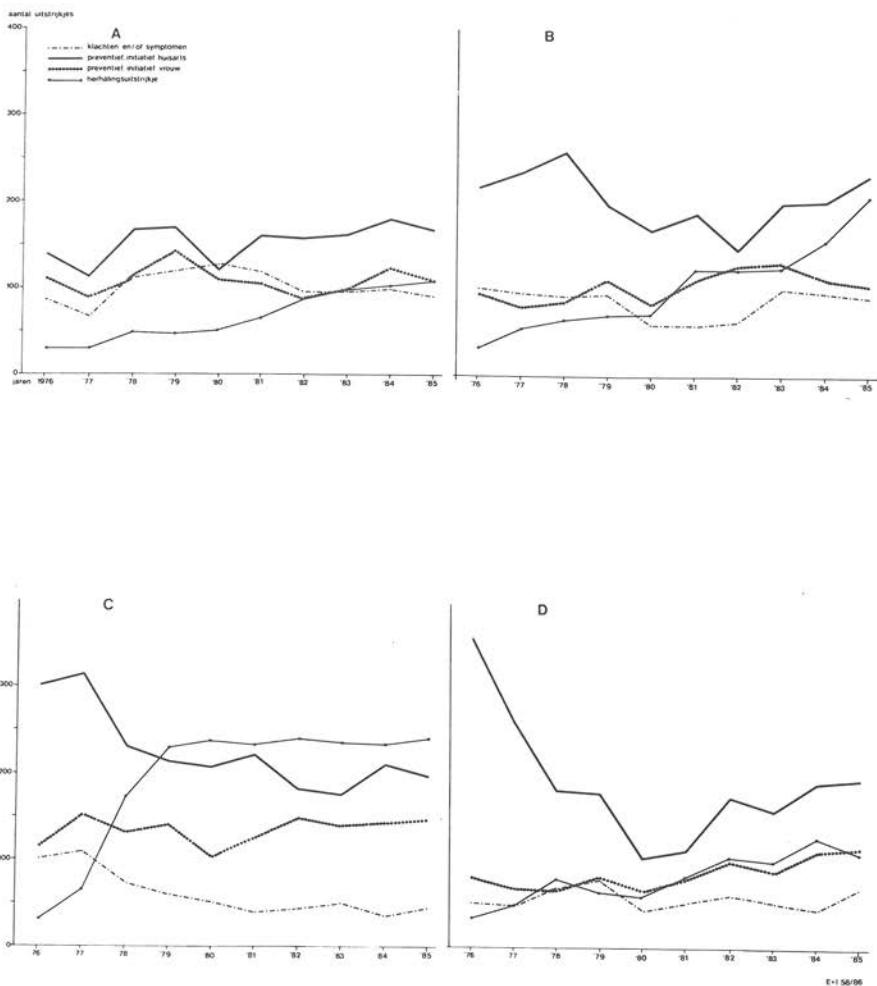
Figuur 4  
 Hoogste en laagste weekincidenties van influenza(-achtig ziektebeeld) per 10.000 inwoners voor de jaren 1970 - 1984 en weekincidenties van 1985 - 1986 (t/m 13e week)





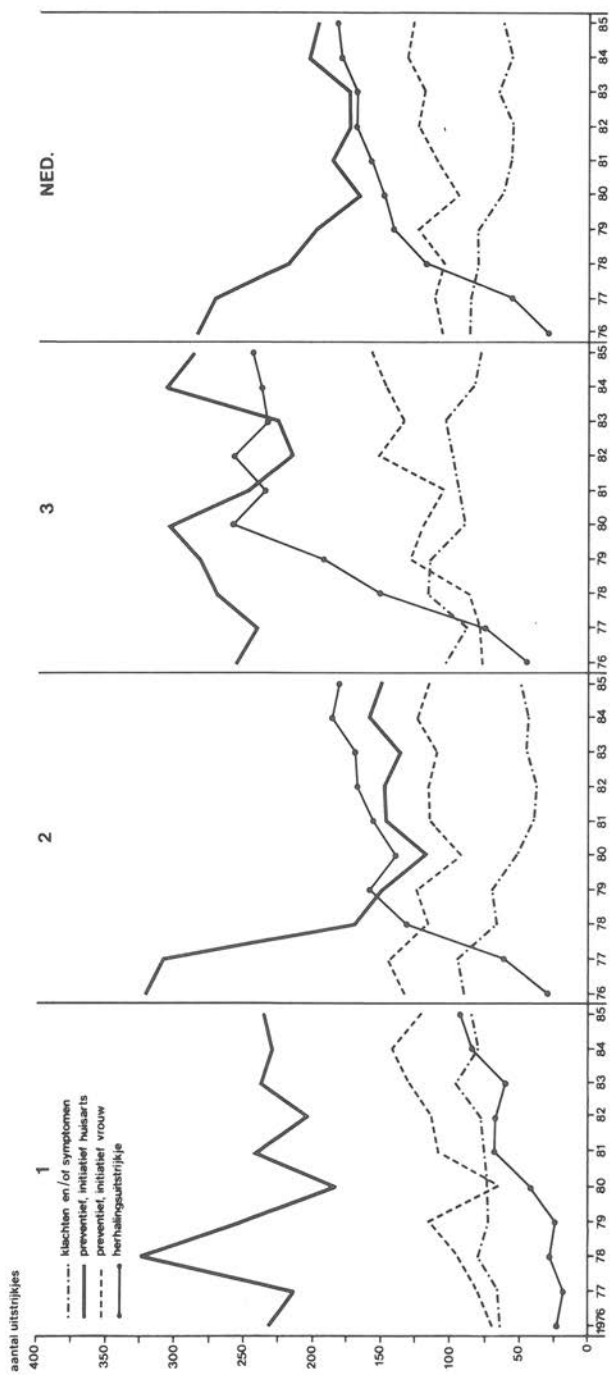
Figuur 5

Aantal uitstrijkjes gemaakt van de cervix uteri, per provinciegroep, naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1976 - 1985



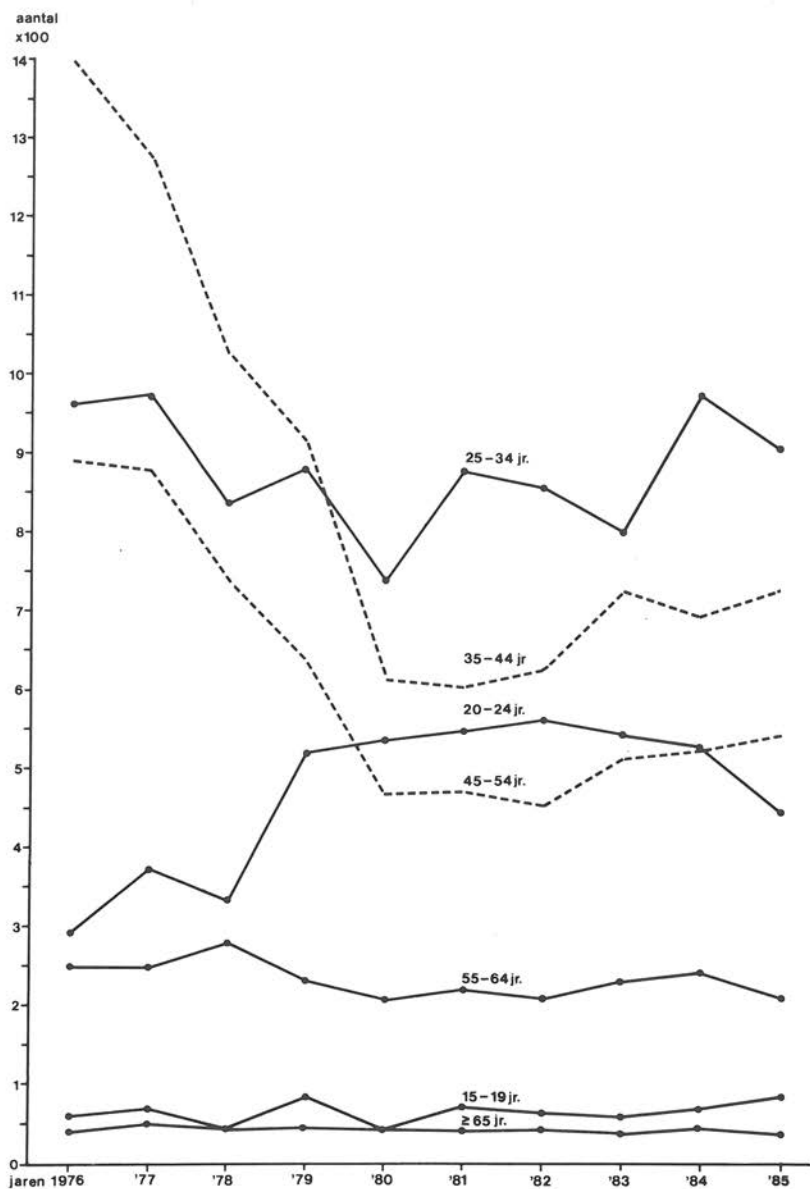
Figuur 6

Aantal uitstrijkjes gemaakt van de cervix uteri, per urbanisatiegroep en voor Nederland, naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1976 - 1985



Figuur 7

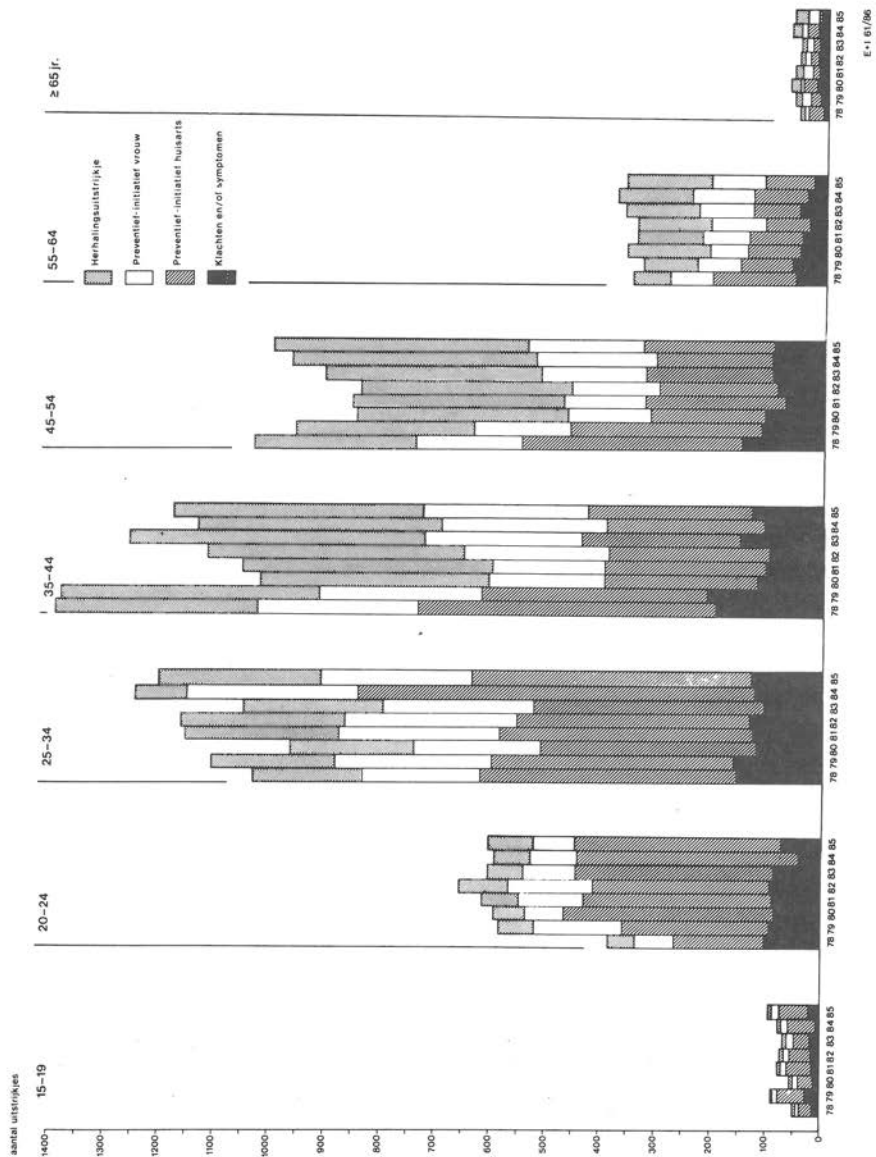
Aantal "eerste" uitstrijkjes gemaakt van de cervix uteri naar leeftijdsgroep, per 10.000 vrouwen, 1976 - 1985



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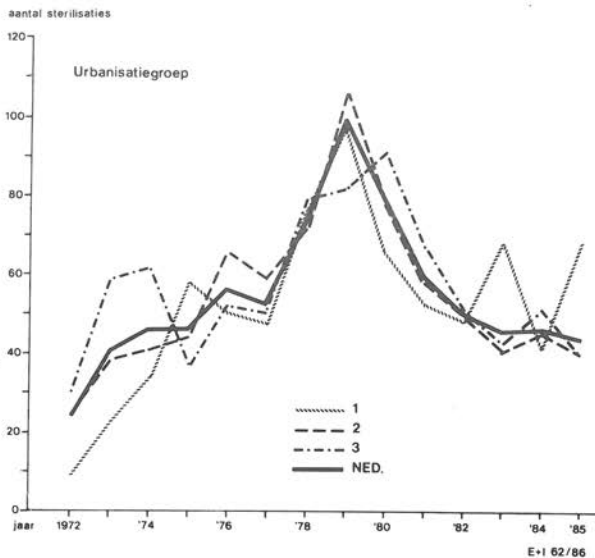
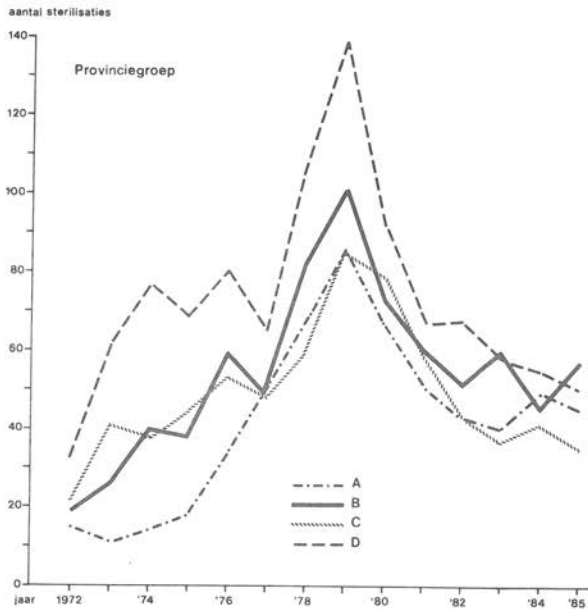
Figuur 8

Aantal uitstrijkjes gemaakt van de cervix uteri naar leeftijdsgroep en naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1978 - 1985



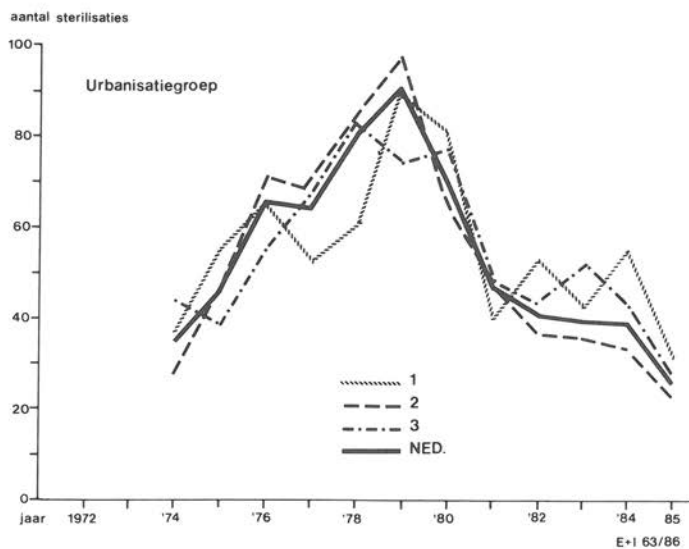
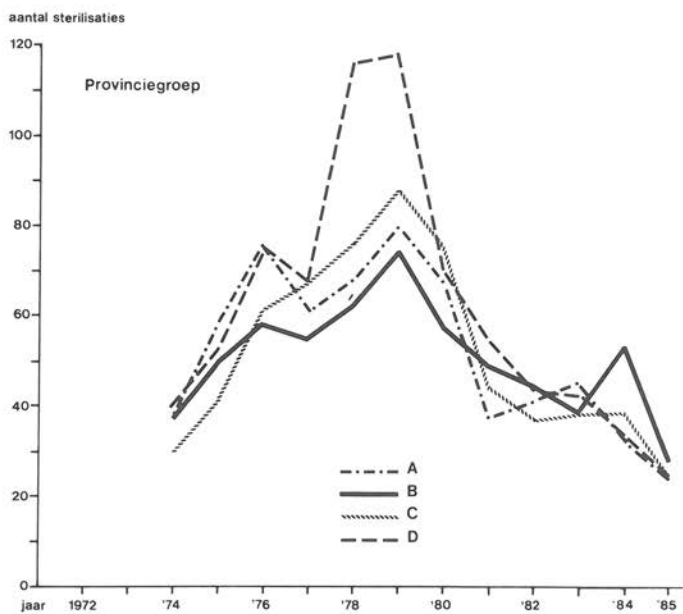
Figuur 9

Aantal bij mannen verrichte sterilisaties, per provincie- en urbanisatiegroep, per 10.000 mannen, 1972 - 1985

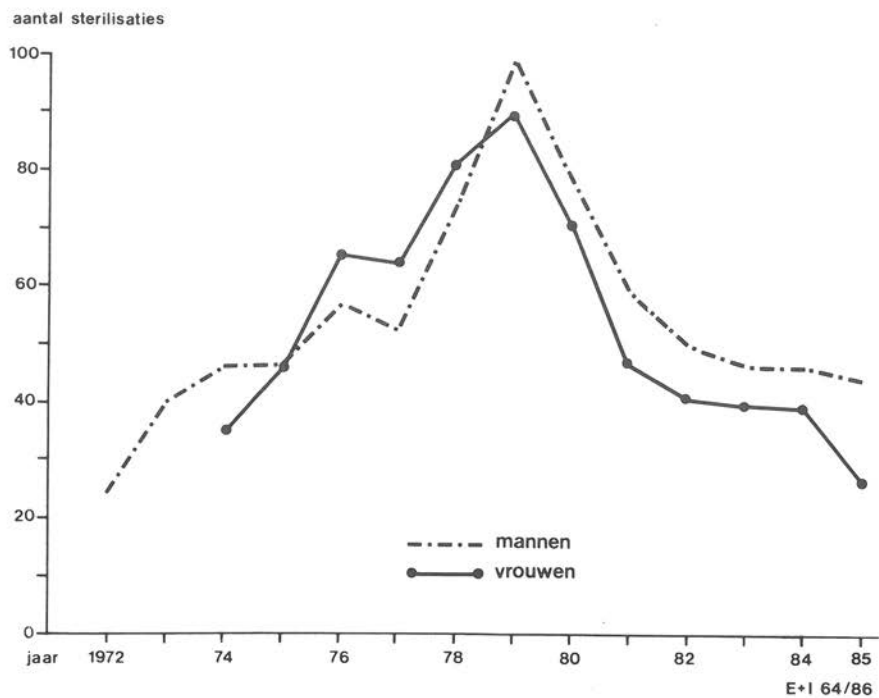


Figuur 10

Aantal bij vrouwen verrichte sterilisaties, per provincie- en urbanisatiegroep, per 10.000 vrouwen, 1974 - 1985



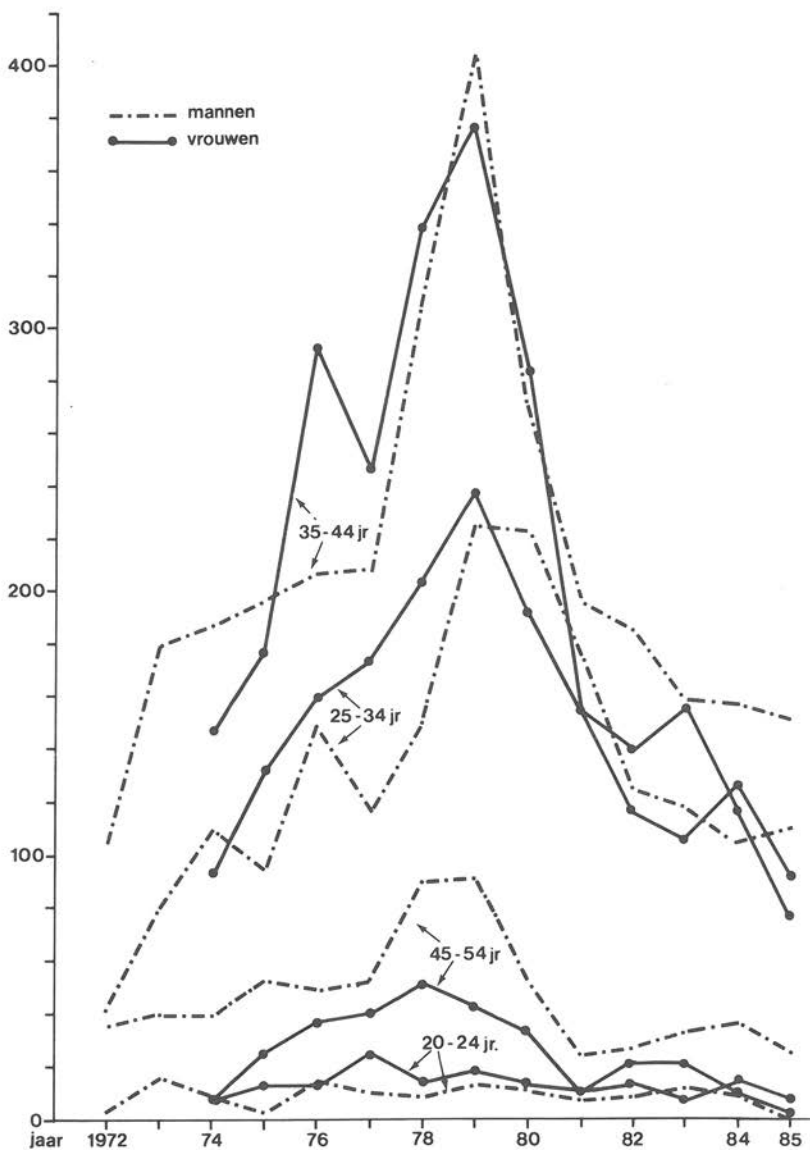
Figuur 11  
Aantal verrichte sterilisaties per 10.000 mannen resp. vrouwen,  
1972 - 1985



Figuur 12

Aantal verrichte sterilisaties naar leeftijdsgroep, per 10.000 mannen resp. vrouwen, 1972 - 1985

aantal sterilisaties

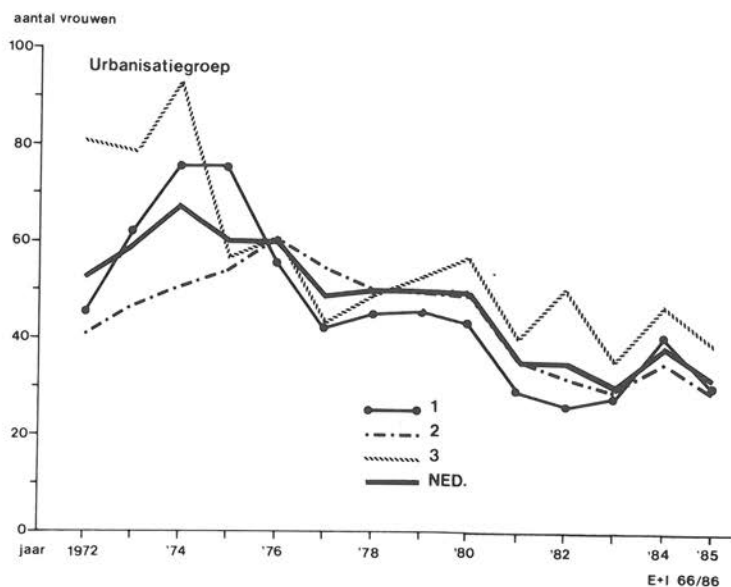
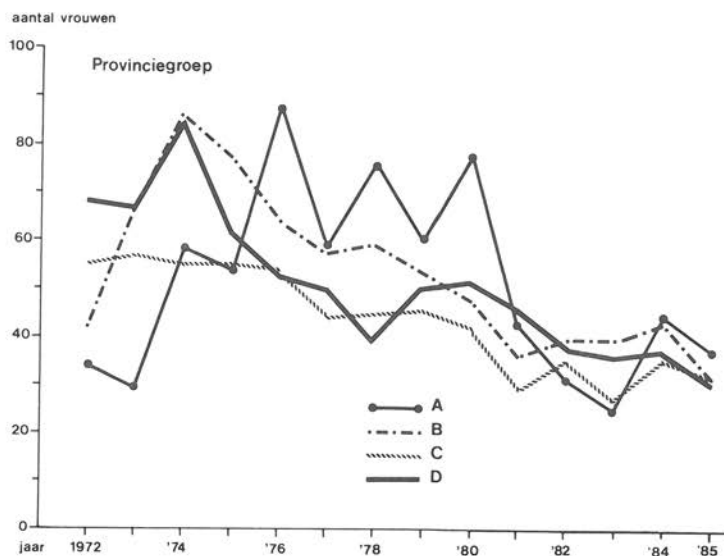


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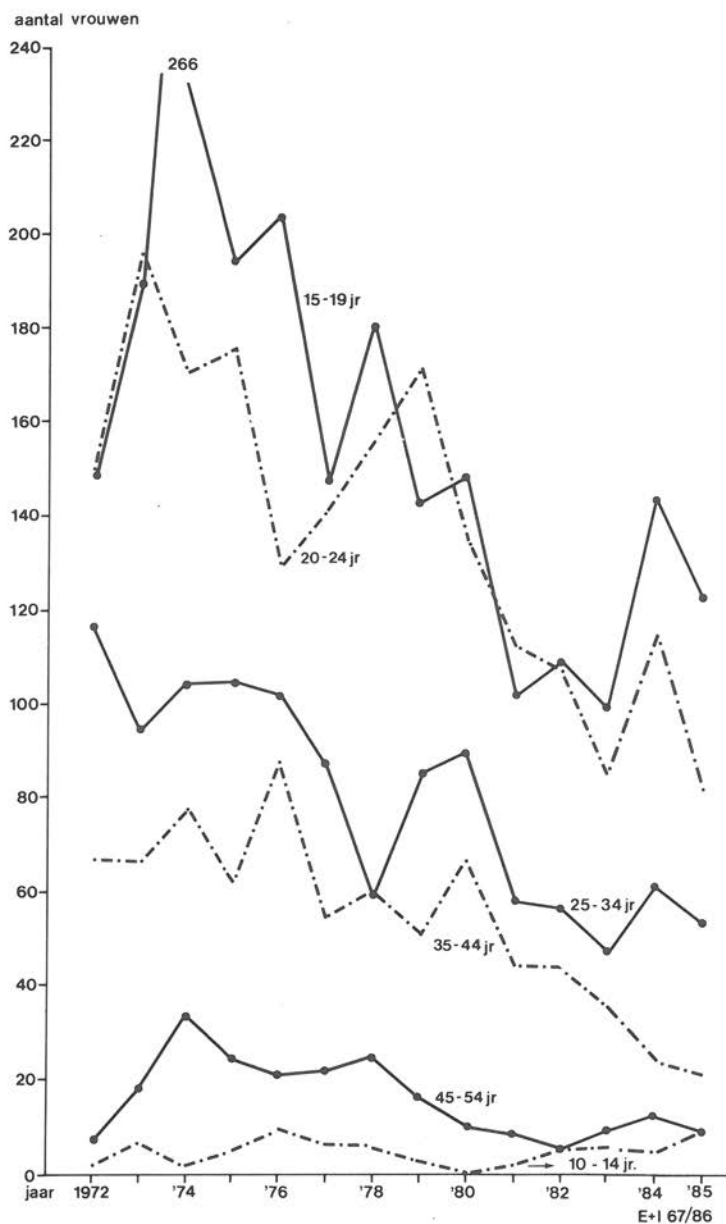
Figuur 13

Aantal malen dat de morning-after pil is voorgeschreven, per provincie- en urbanisatiegroep, per 10.000 vrouwen, 1972 -1985



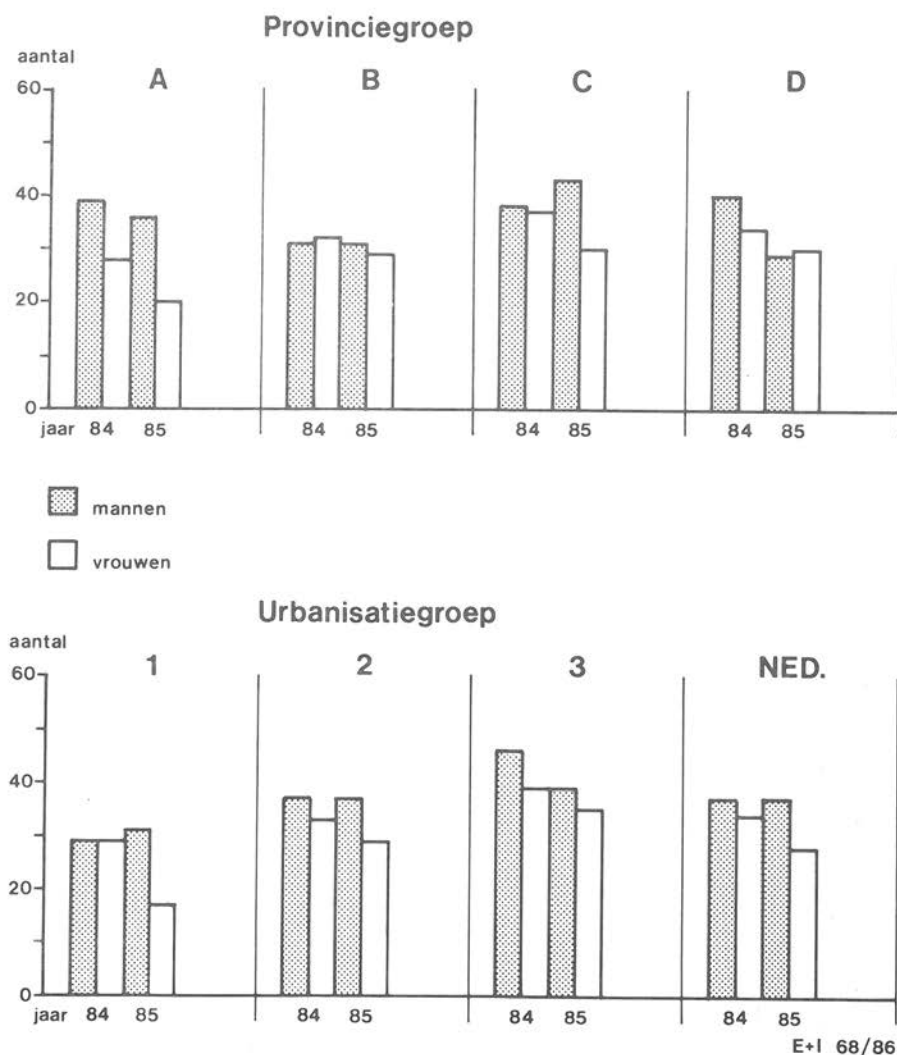
Figuur 14

Aantal malen dat de morning-after pil is voorgeschreven naar leeftijdsgroep, per 10.000 vrouwen, 1972 - 1985



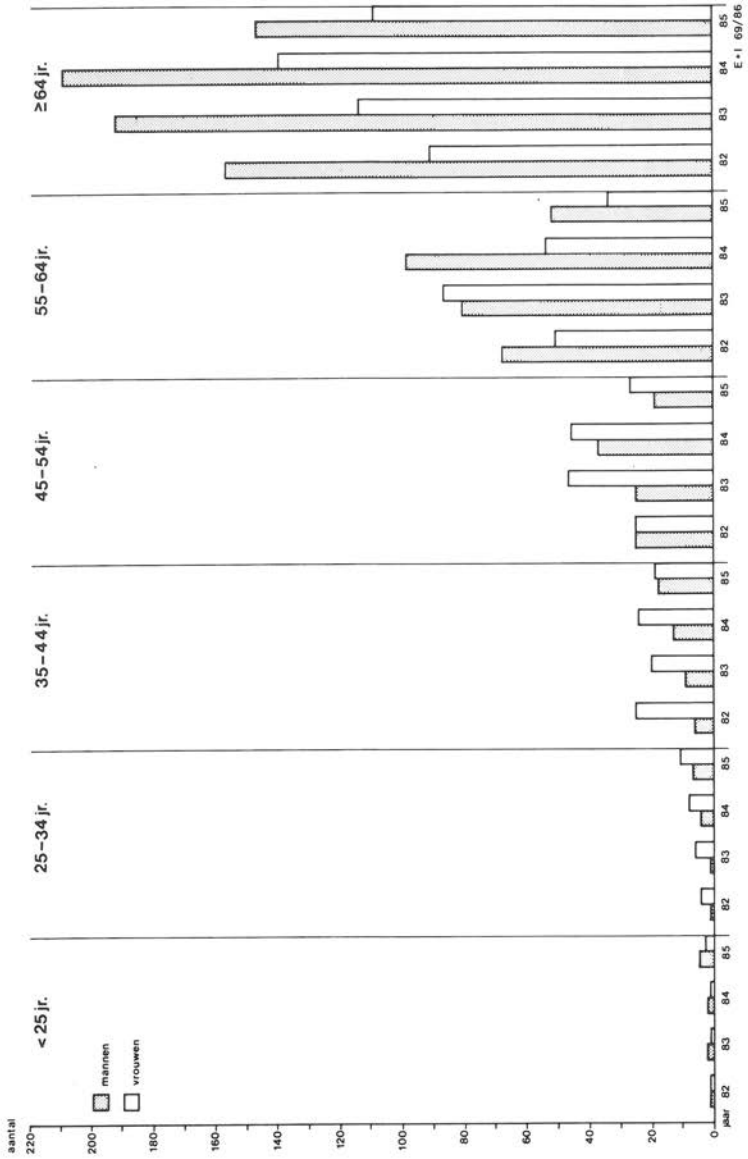
Figuur 15

Aantal nieuwe kankerpatiënten per provincie- en urbanisatiegroep per 10.000 mannen resp. vrouwen en per 10.000 inwoners, 1982 - 1985



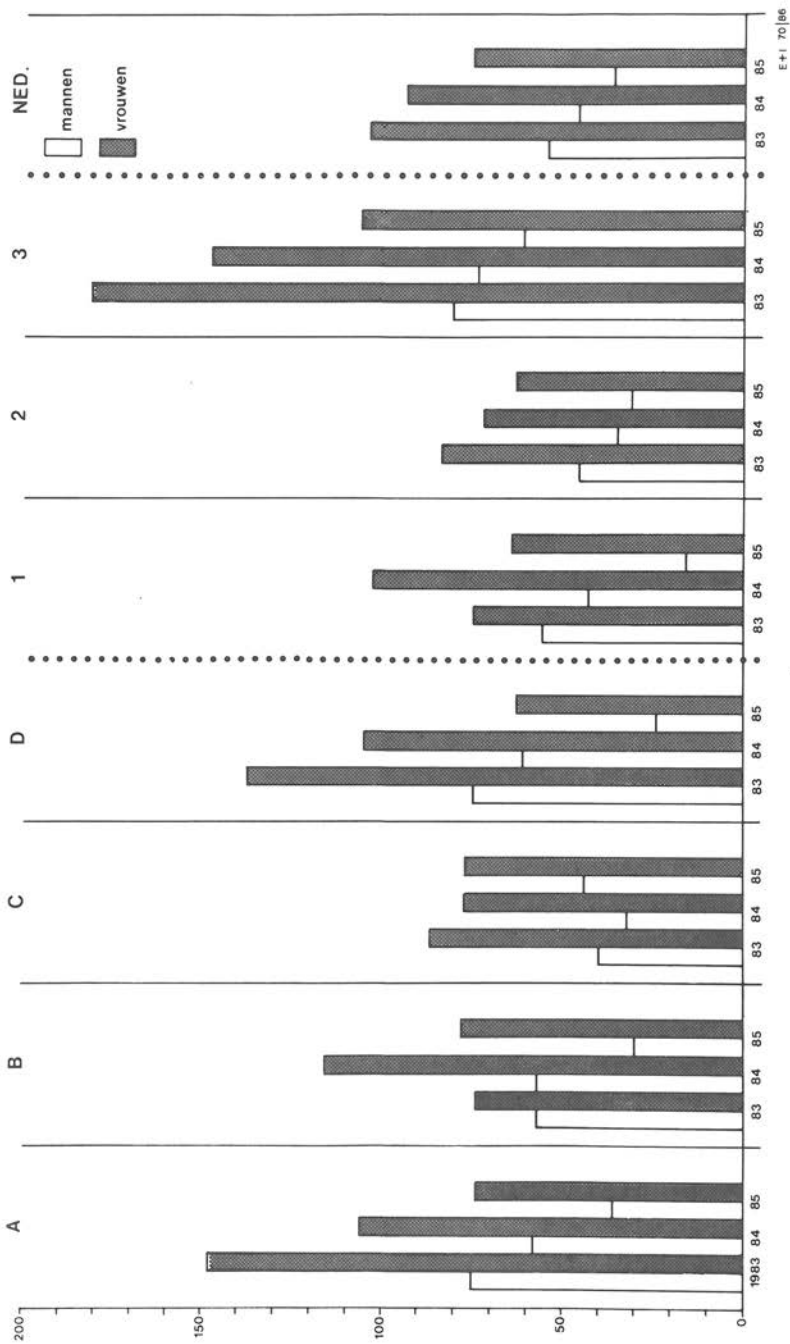
Figuur 16

Absoluut aantal door peilstationarissen gerapporteerde (nieuwe) patiënten met (vermoedelijk) een maligniteit aantal mannen en vrouwen naar leeftijdsgroep, 1982 - 1985



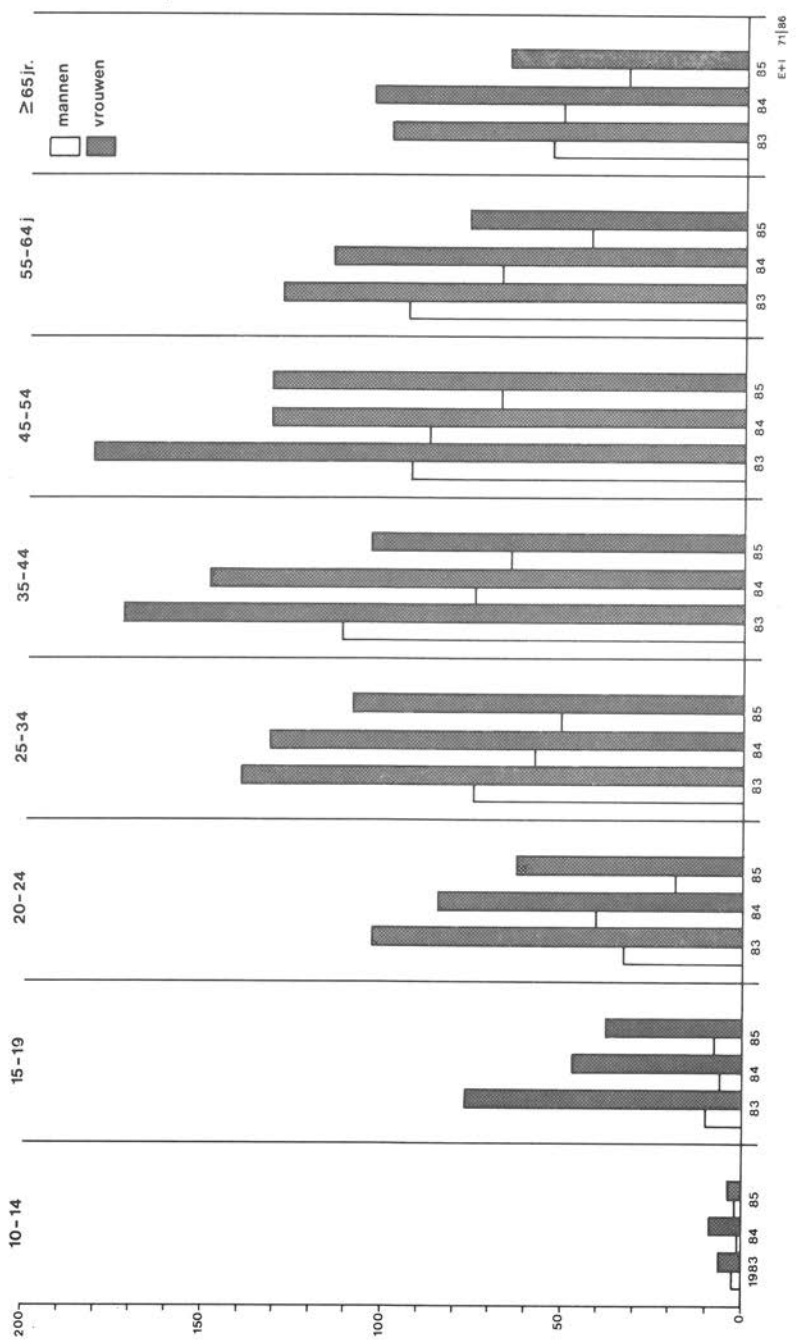
Figuur 17

Aantal nieuwe patiënten "in behandeling" voor een depressief syndroom, per provincie- en urbanisatiegroep, per 10.000 mannen resp. vrouwen, 1983 - 1985

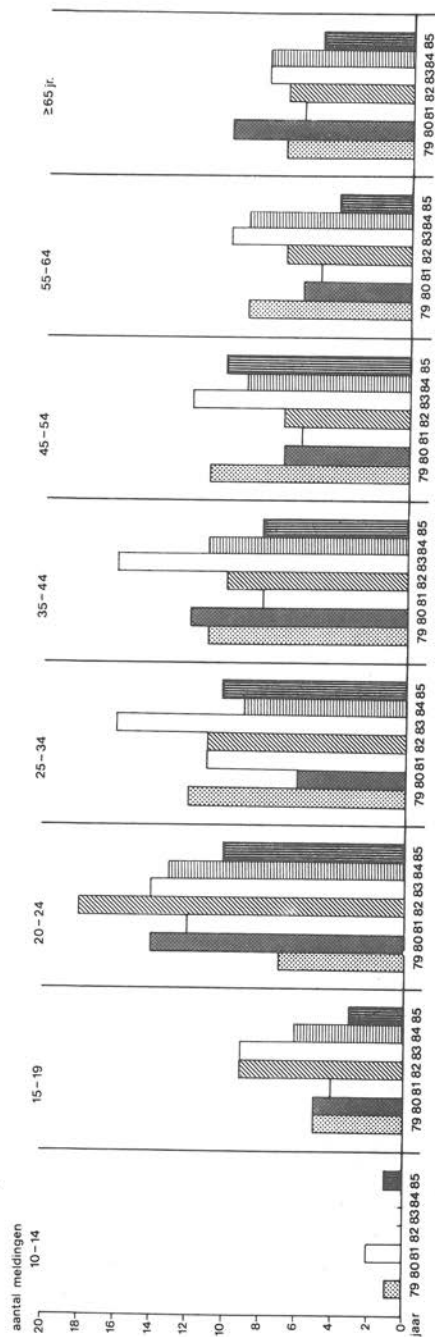


Figuur 18

Aantal nieuwe patiënten "in behandeling" voor een depressief syndroom naar leeftijdsgroep, per 10.000 mannen resp. vrouwen, 1983 - 1985

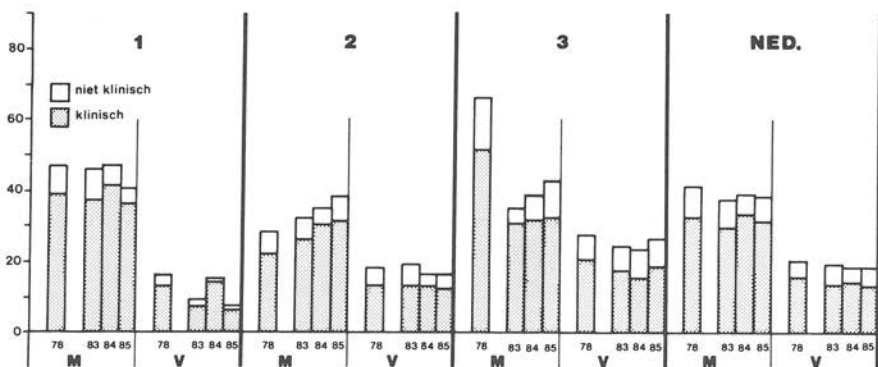
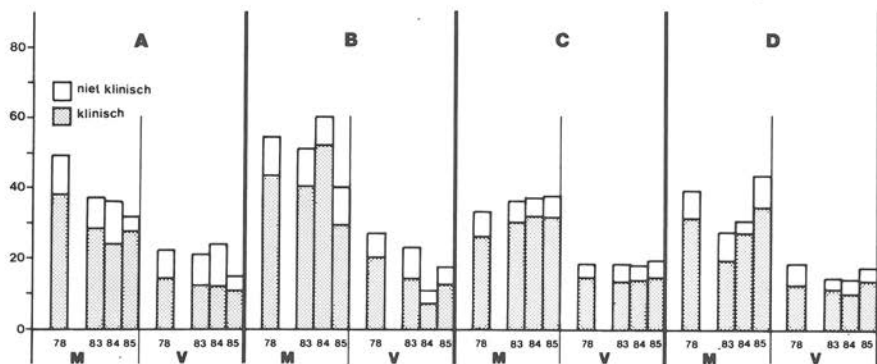


Figuur 19  
 Aantal meldingen van suicide(poging) naar leeftijdsgroep, per 10.000 inwoners, 1979 - 1985



Figuur 20 en 21

Aantal gevallen waarbij de peilstationarts handelt alsof het een acuut hartinfarct betreft, per provincie- en urbanisatiegroep, per 10.000 mannen resp. vrouwen en naar al of geen opname in een ziekenhuis binnen 48 uur, 1978, 1983 - 1985

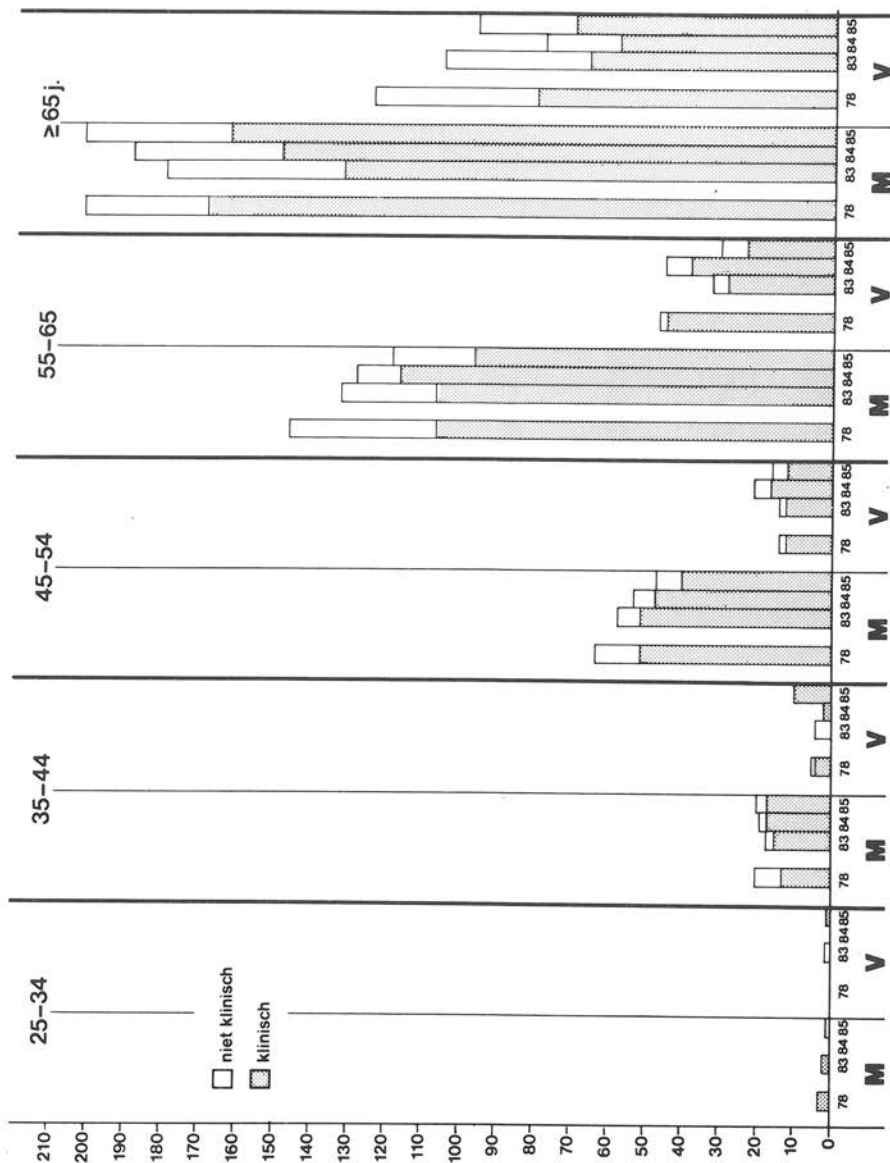


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Figuur 22 en 23

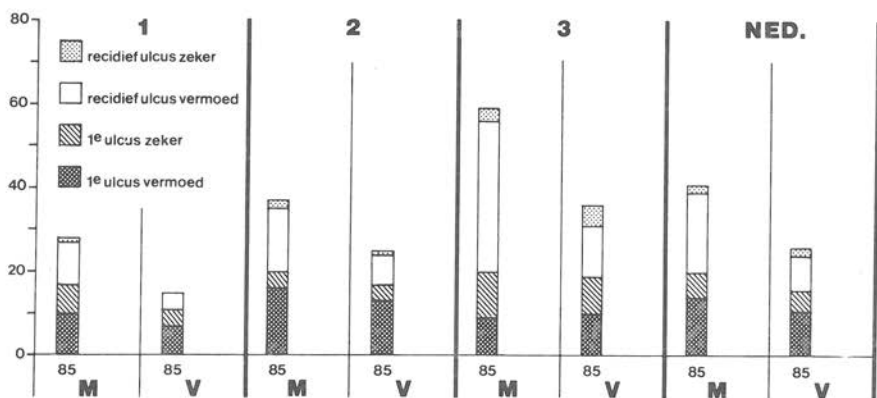
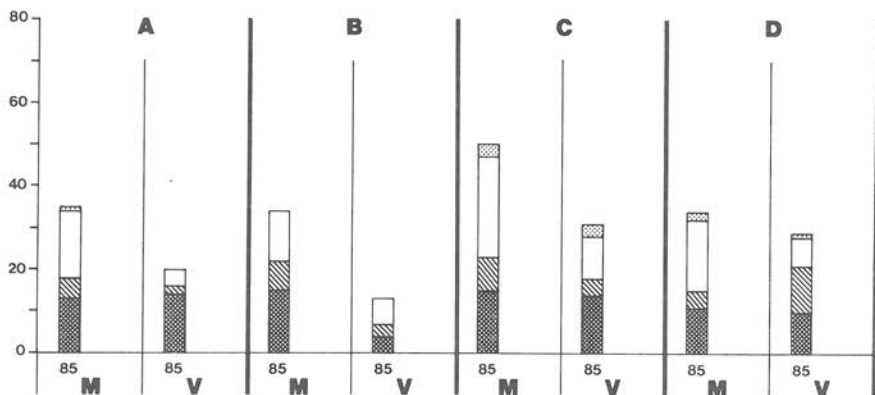
Aantal gevallen waarbij de peilstationarts handelt alsof het een acuut hartinfarct betreft naar leeftijdsgroep, per 10.000 mannen resp. vrouwen en naar al of geen opname in een ziekenhuis binnen 48 uur, 1978, 1983 - 1985



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Figuur 24 en 25

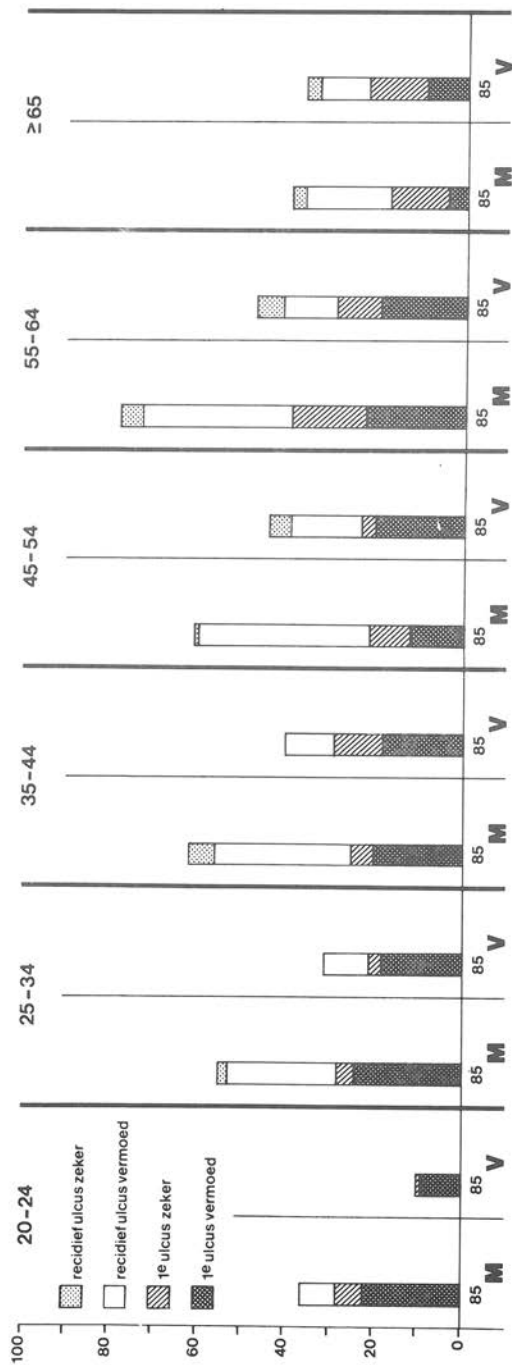
Aantal patiënten met een eerste ulcus pepticum, vermoed of bevestigd en een recidief ulcus pepticum per provincie- en urbanisatiegroep, per 10.000 mannen resp. vrouwen, 1985



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Figuur 26

Aantal patiënten met een eerste ulcus pepticum, vermoed en bevestigd en met een recidief ulcus pepticum vermoed en bevestigd naar leeftijdsgroep, per 10.000 mannen resp. vrouwen, 1985



## FOOTNOTES

- 1) Spreeuwenberg, C. Huisarts en Stervenshulp, Van Loghum Slaterus, Deventer 1981, p. 60-70, 117-120.
- 2) Report by the State Commission on Euthanasia, Part 1, Recommendation 1985, Government Publishing Office, The Hague.
- 3) Meanwhile the general practitioners of the General Practitioners Registration System The Hague have also started from 1985 onwards with the registration of requests for euthanasia and the registration of granted requests. Registration of the granted requests for euthanasia has not been done before (see Oliemans, A.P. and Nijhuis, H.G.J., Euthanasia in de huisartspraktijk, Medisch Contact (1986) p. 691.
- 4) Typology of the Dutch municipalities by degree of urbanization, 1-1-1971 (Central Bureau of Statistics).
- 5) Figures from the registration of professions in primary health care, Jan. 1985, p. 29, Table 13. Published by NIVEL, Utrecht.
- 6) The tables indicated only by figures are text tables. The tables indicated by a combination of a figure and a letter are included in the appendices together with the figures at the back of the text. In the discussion of the various topics the latter tables are not repeatedly cited.
- 7) In these tables and the tables in the text derived from them frequencies are given in all cases per 10 000 men, women or inhabitants, unless stated otherwise.
- 8) This must satisfy the following criteria (Pel, 1965):
  - a. An acute beginning, i.e. at most a prodromal stage of three to four days (including pre-existent infections of the respiratory organs at a non-pathogenic level);
  - b. The infection must be accompanied by a rise in rectal temperature to at least 38°;
  - c. At least one of the following symptoms must be present: cough, coryza, sore throat, frontal headache, retrosternal pain, myalgia.

- Pel, J.Z.S. (1965) Proefonderzoek naar de frequentie en de aetiologie van griepachtige ziekten in de winter 1963-1964 (Experimental investigation of the frequency and aetiology of influenza-like illness in the winter of 1963-1964). Huisarts en wetenschap 8, 321.
- 9) Here and elsewhere in the text incidence or frequency means the frequency per 10 000 inhabitants (either men or women).
  - 10) Letter from the Minister of Public Health and Environment to the President of the Second Chamber of the States-General. Second Chamber, 1981-1982 session, 17 100 Chapter XVII, No. 63.
  - 11) Hoehn en Yahr (1967) Age and death and duration of illness before death. Neurology; nr. 17, p. 427-442.
  - 12) Kessler, Irving I. (1978) Parkinson's Disease in Epidemiologic Perspective, Advances in Neurology, vol. 19, p. 355-384.
  - 13) Ministry of Public Health and Environment, 1982.
  - 14) Recent demographic developments in the member states of the council of Europe (CDDE (83)26).
  - 15) The "fertile age group" consists of women between 15 and 49 years. Since men are on average married to women two years younger than themselves, 17-51 years has been adhered here to as age limit for the men.
  - 16) Schade, E. Overleden patienten. Een huisartsgeneeskundige analyse van doodsoorzaken en van problemen bij diagnostiek en behandeling van patienten overleden aan kanker. Dissertation, Amsterdam 1986, inter alia p. 112-114.
  - 17) Nylenna, M. Diagnosing cancer in general practice: from suspicion to certainty. Br. Med. I. 314-315, 1986.
  - 18) Zelfdoding in Rotterdam, Municipal Medical and Health Service, Information Bureau, Rotterdam 1983.
  - 19) Myocardial infarction: a comparison between home and hospital care for patients. H.G. Mather c.s., British Medical Journal, 17 April 1976, p. 925-929.

A randomised trial of home-versus-hospital management for patients with suspected myocardial infarction. J.D. Hill c.s., The Lancet, 22 April 1978, Vol. 1 p. 837-841.

- 20) Hoogendoorn. "Opmerkelijke verschuivingen in het epidemiologische patroon van het ulcus pepticum", Nederlands Tijdschrift voor Geneeskunde (1984) 128, p. 484-491.
- 21) A euthanasia declaration is a written request for euthanasia on certain conditions.
- 22) Weeda-Mannak, W.L. Anorexia Nervosa, towards an early identification. Dissertation 1984, Maastricht.

Explanatory notes pertaining to:

Bijlage 1

Bijlage	- Appendix
Continue morbiditeits registratie, peilstations	- Continuous morbidity registration, sentinel stations
Deelnemende artsen	- Participating general practitioners
Naam	- Name
Plaats	- Residence
Provincie	- Province
Comb.-praktijk	- Group practice
Apotheek-houdend	- With dispensary

Bijlage 2

Bijlage	- Appendix
Weekstaat t.b.v. centrale registratie	- Weekly return for central registration
Continue morbiditeitsregistratie, peilstations	- Continuous morbidity registration, sentinel stations
Proj. no.	- Project number
Verslagjaar	- Year under review
Week no.	- Number of the week
Code peilstations	- Code number sentinel stations
Rapport. dagen	- Number of days over which reporting took place
Regel no.	- Line number
Leeftijdsgroep	- Age group
Influenza (-achtig ziektebeeld)	- Influenza (-like illness)
Cervixuitstrijkje	- Cervical smear
Na 1-1-1983 voor de eerste maal afgenomen op grond van Klachten/symptomen	- Taken for the first time after 1-1-1983 on the ground of Complaints/symptoms
Louter preventieve overwegingen	- Purely preventive considerations
Initiatief huisarts	- General practitioner's initiative
Verzoek van de vrouw	- Woman's request
Ziekte van Parkinson	- Parkinson's disease
Sterilisatie verricht	- Sterilization performed
Morning-after-pill voorgeschreven	- Prescription of morning-after-pill
Maligniteiten	- Malignancies

Behandeld wegens depressie	- Treated for depression
Suicide(poging)	- (Attempted)suicide
Hartinfarct	- Myocardial infarction
klinisch	- clinical
niet-klinisch	- non-clinical
Ulcus pepticum	- Peptic ulcer
eerste maal	- first ulcer
vermoeden	- suspected
zeker	- certain
recidief	- recurrence
vermoeden	- suspected
zeker	- certain
Verwijzing/machtiging/fysio- therapie	- Referral to/authorization for - the physiotherapist
eerste maal	- new referral
ziekenfonds	- health insurance fund
particulier	- private
verlenging/vervolg	- follow-up treatment
ziekenfonds	- health insurance fund
particulier	- private
M	- Male
V	- Female
Weeknummer	- Number of the week
Opgemaakt d.d.	- Completed on
Aantal dagen gerapporteerd	- Number of days over which re- porting took place
(Zie voetnoot <sup>1</sup> )	- (See footnote number <sup>1</sup> )
Zie ommezijde voor voetnoot	- For footnotes see reverse
1. Door vakantie, ziekte en an- dere oorzaken zal deze rap- portage zich echter ook over minder dan 5 dagen kunnen uitstrekken. Het wordt van belang geacht om, zo moge- lijk, ook tijdens het week- einde waargenomen patiënten te rapporteren. (M.u.v. in fluenzapatiënten.)	1. As a result of vacation, sick- ness and other causes this re- porting may extend over fewer than 5 days. It is considered to be of importance to report, if possible, patients observed during the weekend as well. (Influenza patients excluded.)
2. Betreft uitsluitend nieuwe patiënten, ook telefonisch consult melden.	2. Relates solely to new pa- tients. Report telephone calls as well.
3. Betreft rapportering van vrouwen bij wie na 1-1-1983	3. Concerns reporting of women on whom a cervical smear was ta-



- om welke reden dan ook een cervixuitstrijkje heeft plaatsgevonden. Indien bij een vrouw na 1-1-1983 op nieuw een cervixuitstrijkje wordt gemaakt, dient dit altijd onder de subrubriek 'herhalingsonderzoek' geboekt te worden (zie ook voetnoot 5).
4. Bijvoorbeeld in het kader van pilcontrole.
  5. Bijvoorbeeld wegens verdacht preparaat of wegens technische onvolkomenheden bij onderzoek vorig preparaat.
  6. Betreft alleen nieuwe patiënten met deechteziekte van Parkinson (zie ook de toelichting).  
Geslacht:.....
  7. Indien het een patiënt(e) betreft uit een van de leeftijdsgroepen, waarvan het vak gerasterd is, dan tevens exacte leeftijd hierachter vermelden.  
Leeftijd:.....
  8. Uitsluitend indien er een directe indicatie is. Indien een recept voor de morning-after-pill wordt afgegeven omdat de betrokkene bijvoorbeeld met vakantie naar het buitenland gaat, dient dit niet te worden gerapporteerd. (Zie ook voetnoot 7).  
Naam van de pil:.....
  9. Betreft uitsluitend nieuwe patiënten. Voor de aanvullende gegevens s.v.p. apart formulier invullen en bij de
- ken after 1-1-1983 for whatsoever reason. If a cervical smear was taken again of a woman after 1-1-1983 this should always be entered under the sub-heading 'Repeat examination' (see also footnote 5).
4. For example as part of check up for the pill.
  5. For example on account of suspect preparation or technical imperfections in the examination of the preparation.
  6. Concerns only new patients with genuine Parkinson's disease (see also the explanation).  
Sex:.....
  7. If a patient is concerned in one of the age groups whose box is filled in, also give the exact age here.  
Age:.....
  8. Solely if there is a direct indication. If a prescription for the morning-after-pill is issued because the patient is for instance going on holiday abroad, this should not be reported. (See also footnote 7).  
Name of the pill:.....
  9. Relates solely to new patients. For the supplementary data please complete a separate form and attach in to the

- weekstaat voegen.
10. Alle eerste contacten, waar bij de huisarts wegens een depressie actie (medicatie, terugbestelling, gespreks contact, verwijzing) onder neemt. Zie ook de toelichting op de weekstaat. Risico op suicide (poging): n.v.t./geen/laag/middelmatig/hoog.
  11. Voor de aanvullende gegevens s.v.p. een apart formulier-tje invullen en bij de week staat voegen.
  12. Betreft een vermoeden op een (primair of recidief) hart-infarct, met dien verstande dat een of meer van de gebruikelijke maatregelen zijn genomen (zie ook de toelichting op de weekstaat).
  13. Onder een niet-klinische patiënt wordt in dit verband verstaan een patiënt, die niet binnen 48 uur wordt genomen.
  14. Betreft alleen nieuwe
  15. Vermoeden op anamnestiche gronden: langer dan één à twee weken maagklachten, nachtelijke pijn verlicht door voedsel, melk of antacida, (zie verder de toelichting op de weekstaat)
  16. Code patient  
Op welke wijze gesteld?  
röntgenologie/gastroscopie/  
operatie  
reeds eerder vermeld onder vermoeden? neen/ja, in welke week .....
- weekly return.
10. All first contacts in which the general practitioner takes action on account of a depression (medication, repeat consultation, discussion with the patient, referral). See also the explanation on the weekly return. Danger of (attempted) suicide: n.a./none /slight/moderate/great.
  11. For the supplementary data please complete a separate form and attach it to the weekly return.
  12. Concerns suspicion of a primary or recurrent cardiac infarction, with the proviso that one or more of the usual measures have been taken (see also the explanation on the weekly return).
  13. In this context a non-clinical patient is one who is not admitted to hospital within 48 ophours.
  14. Relates solely to new patients
  15. Suspicion of an ulcer pepticum arises if a patient has stomach complaints for longer than one to two weeks: stomach ache, pain in the night relieved by food, milk or antacids (see also the explanation on the weekly return)
  - Code patient
  - Diagnosis confirmed by X-ray examination/gastroscopy during operation  
Al ready registered by suspicion of? no/yes, in wich week .....

17. Recidief: een nieuwe episode van klachten na een klachten-vrije periode van 3 maanden. Niet registreren indien het een recidief van klachten in 1985 is.
18. Verwijzingen naar oefentherapeuten (César en Mensendieck) vallen hier buiten
19. S.v.p. apart formulier invullen en bij de weekstaat voegen Code patient ..... (als op formulier), zie ook de toelichting op de weekstaat
- Recurrence: a new episode of complaints after a complaint-free period of three months. Not to register if it concerns a recurrence of complaints in 1985.
  - Referrals to training therapist (César and Mensendieck) are to be excluded here.
  - For the supplementary data please complete a separate form and attach in to the weekly return. Code patient ..... (as on the form), See also the explanation on the weekly return

Tables la-3e

Continue morbiditeitsregistratie peilstations	Continuous morbidity registration sentinel stations
Kwartaal	- Quarter
Leeftijdsgroep	- Age group
Influenza (-achtig ziekte beeld)	- Influenza (-like illness)
Cervixuitstrijkje	- Cervical smear
Klacht/symptoom	- Complaint/symptom
Initiatief huisarts	- General practitioner's initiative
Verzoek vrouw	- Woman's request
herhalingsonderzoek	- Repeat smear
Ziekte van Parkinson	- Parkinson's disease
Sterilisatie verricht	- Sterilization performed
Morning-after pill voorgeschreven	- Morning-after pill prescribed
Maligniteiten	- Malignancies
Depressie	- Depression
Suicide(poging)	- (Attempted)suicide
Hartinfarct	- Myocardial infarction
klinisch	- clinical
niet-klinisch	- non-clinical
Ulcus pepticum	- Peptic ulcer

Eerste maal	- First ulcer
vermoeden	- suspected
zeker	- certain
Recidief	- Recurrence
vermoeden	- suspected
zeker	- certain
Verwijzing/machtiging/fysiotherapie	- Referral to/authorization for the physiotherapist
Nieuw	- New referral
ziekenfonds	- health insurance fund
particulier	- private
Verlenging/vervolg	- Follow-up treatment
ziekenfonds	- health insurance fund
particulier	- private
M	- Male
V	- Female
Provinciegroepen	- Province groups
Gr + Fr + Dr	- Groningen, Friesland, Drenthe
Ov + Gld + Zljp	- Overijssel, Gelderland, Southern IJsselmeer Polders
Utr + NH + ZH	- Utrecht, North Holland, South Holland
Zld + NB + Lim	- Zeeland, North Brabant, Limburg
Urbanisatiegroepen	- Urbanization groups
A <sub>1</sub> - A <sub>4</sub>	- Rural municipalities
B <sub>1</sub> - B <sub>3</sub> + C <sub>1</sub> - C <sub>4</sub>	- Municipalities with urban characteristics and urbanized municipalities
C <sub>5</sub>	- Municipalities with a population of 100 000 or more
Voetnoot	- Footnote
N.B. Als gevolg van het afronden bij het berekenen van de relatieve frequenties kunnen kleine verschillen in de totalen zijn ontstaan.	N.B. As a result of the rounding-off when calculating relative frequencies, small differences in the totals may have occurred.

Table 4a

Aantal patiënten met influenza (-achtig ziekte beeld) per week en per 10 000 inwoners, 1985 en 1984 (t/m 17e week)

Weeknr.

Aantal patiënten

Provinciegroep

Figures

- Number of patients with influenza (-like illness) per week and per 10 000, 1985 and 1986 (up to and including the 17th week)

- Number of the week

- Number of patients

- Province group. See for explanation A, B, C and D under tables 1-3

Figure 1

Peilstations

Continue morbiditeits registratie

Grenslijn provinciegroep

- Sentinel stations

- Continuous morbidity registration

- Boundary of province group

Figure 2

Het percentage dagen dat in 1985 per week is gerapporteerd

- Percentage of days weekly reported in 1985

1 = Pasen

- 1 = Easter

2 = Hemelvaartsdag

2 = Ascension Day

3 = Pinksteren

3 = Whitsun

4 = najaarsvakantie

4 = Autumn holiday

5 = Kerstmis

5 = Christmas

Figure 3

Aantal patiënten met influenza (-achtig ziekte beeld) per week, per 10000 inwoners, 1985-1986 (t/m 13e week)

Provinciegroep

- Number of patients with influenza (-like illness) per week, per 10 000 inhabitants, 1985-1986 (up to and including the 13th week)

- Province group

Urbanisatiegroep  
Naar leeftijdsgroep en geslacht

- Urbanization group
- By age group and sex

#### Figure 4

Hoogste en laagste weekincidenties van influenza (-achtig ziektebeeld) per 10000 inwoners voor de jaren 1970-1984 en weekincidenties van 1985-1986 (t/m 13e week)

- Highest and lowest weekly incidences of influenza (-like illness) for 1970-1984 and weekly incidences for 1985-1986 (until the 13th week).

#### Figures 5 - 8

Aantal cervixuitstrijkjes  
Indicaties tot het maken van een uitstrijkje  
Klachten en/of symptomen  
Preventief  
Initiatief huisarts

- Number of cervical smears
- Indications for taking a smear
- Complaints and/or symptoms
- Preventive
- On initiative of general practitioner
- On initiative of woman
- First

Initiatief vrouw  
Eerste

#### Figures 9 and 11

Aantal bij mannen verrichte sterilisaties  
Figures 10 and 12

- Number of sterilizations performed on

Aantal bij vrouwen verrichte sterilisaties

- Number of sterilizations performed on

#### Figures 13 and 14

Aantal malen, dat de morning-after pil werd voorgeschreven

- Number of prescriptions of the morning-after pill

Geografische verdeling  
Leeftijdsgroep

- Geographical distribution
- Age group

## Figures 15 and 16

Aantal nieuwe kankerpatiënten

- Number of new cancer patients

## Figures 17 and 18

Aantal nieuwe patiënten 'in behandeling' voor een depressief syndroom

- Number of new patients treated for depressive syndrome

## Figure 19

Aantal meldingen van een (attemp-suicide(poging)

- Number of reported (attempted) suicide

## Figures 20, 21, 22 and 23

Aantal patiënten waarbij de peilstationarts handelt als of het een acuut hartinfarct betreft, per..... en naar al of geen opname in een ziekenhuis binnen 48 within 48 hours.

- Number of cases in which the physician acts as if an acute myocardial infarction is concerned, per..... and by admission or non-admission to hospital uur.

## Figures 24 and 25

Aantal patiënten met een eerste ulcus pepticum, vermoed of bevestigd en een recidief ulcus pepticum per provincie en urbanisatiegroep, per 10.000 mannen resp. vrouwen, 1985

- Number of patients with a first ulcer pepticum, suspected or confirmed, and a recurrent ulcer pepticum, suspected or certain, per province and urbanization group per 10 000 men and women for 1985.

## Figure 26

Aantal patiënten met een eerste ulcus pepticum, vermoed en bevestigd en met een recidief ulcus pepticum vermoed en bevestigd naar leeftijdsgroep, per leeftijdsgroep, per 10.000 mannen resp. vrouwen, 1985

- Number of patients with a first ulcer pepticum, suspected or confirmed, and a recurrent ulcer pepticum, suspected or certain, by age group, per 10 000 men and per 10 000 women for 1985.

