continuous morbidity registration sentinel stations the netherlands

1987

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FOREWORD

In 1987 thirteen subjects of a varying nature were recorded in the Continuous Morbidity Registration Sentinel Stations the Netherlands. An incidental investigation was performed into two subjects.

New topics in 1987 are dementia, the prescription of Rohypnol by general practitioners and pregnancy despite adequate contraception: subjects of a varied nature.

In a country like the Netherlands, with its tolerant attitude towards the use of contraceptive techniques and the use of the latter on a large scale, it is meaningful to investigate when a method fails or is wrongly used. The most logical place to examine this is in general practice, where women appear with a problem of the inexplicable failure of menstruation to materialize.

The expectation that this involves small absolute numbers of women is confirmed in the first year of registration. Registration by means of a network of sentinel stations makes it possible to gain insight into such an event.

The year 1987 was important to the project in another way, which is not visible in this reporting.

A project group of the Ministry of Welfare, Public Health and Culture, Staff Division of Epidemiology and Informatics, under the direction of first Dr. P. Zuidema and later Mr. F.C.L.M. Huynen, made a start with a structural change in the method of processing the data collected by spotter physicians.

At the beginning of 1988 this project was successfully concluded with the implementation of the new Peilhu system. The first step on the road to computerized sentinel stations has been taken.

In the view of the Counselling Committee this road must be followed further in the years to come, though in such a way that the functioning of the present sentinel stations is not impaired.

This reporting may be convincing proof that record-keeping in the Continuous Morbidity Registration Sentinel Stations contributes to insight in the

incidence of disease among the population and the functioning of (primary) health care.

Mrs J.M. Bensing, director NIVEL
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. 11-13).
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 where necessary a distribution by sex (see p. 94).
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. 23).
Everly year the topics that are to be placed in 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 in this report; for the 'old subjects' it is necessary to consult one of the previous reports.
When considering the subjects that have been included during the years on the weekly return (see p. 20-22 and 95-96) the conclusion is reached that the name of the project, Continuous Morbidity Registration, does not in fact cover the whole work. After all, in part it is not diseases that 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 at the end of the year questions about diseases or occurrences that 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 1987 the contacts in the International Primary Care Network were continued.
In this international network no research was performed in 1987.

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 systems consits 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 representatives 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 1987 the committee functioned in the following composition:

	Mrs J.M. Bensing,[2]
	Dr H. Bijkerk, M.D.[4]
	F.K.A. Fokkema, M.D.[5]
	H.O. Sigling, M.D.[6]
	W.A. van Veen, M.D.[1]
	A. Vrij, M.D.[4] (to 3-10-'87)
	J.J. Zandvliet[1]
	Dr J. van der Zee, Ph.D.[3]
Project leader:	A.I.M. Bartelds, M.D.
Secretary:	Mrs F.G. Hoeben-Schaafsma (to 1-2-'87)
	Mrs E. Colet-van Woezik (from 1-3-'87)
	Mrs M. van Valen

This committee met twice in 1987. It had two vacancies in that year.

MEETING OF SPOTTER CO-WORKERS

Contact between the registering physicians and their co-workers and the project management is important to a registration project like the Sentinel Stations. On 10 January 1987 the annual meeting of spotter co-workers was held in Utrecht.

42 persons were present, of whom 24 from the registration practices. The others present were members of the Counselling Committee, speakers and the project leader and his staff.

The chairperson of the Counselling Committee, Mrs J.M. Bensing, welcomed the participants and thanked the spotter physicians present for another year of effort for the registration.

On behalf of the Nivel physiotherapy project group, Messrs J. Kerssens and M. Curfs addressed the meeting. They reported on the investigation into the referrals for physiotherapy that were registered by the spotter physicians in 1985.
This investigation focuses on the following questions:

- which patients are referred by the general practitioner for physiotherapy for what kind of complaints and with what diagnosis, and
- do the general practitioners differ among themselves with regard to the referrals in nature and kind and quality of the referrals, and with what are these differences bound up?

Mr Curfs dealt with the first question. The 6423 reasons for referral that were registered have been centrally classified with the aid of a translation of the ICD-9-CM (International Classification of Diseases, 9th revision, Clinical Modification). It was decided to use this after an assessment of the usefulness of various classification systems. In this part of the investigation use was made solely of the first noted diagnosis per referral. Three surveys were presented of the registered reasons for referral: a survey with a classification by localization, a survey of the 20 most frequent reasons for referral and finally a renewed ranking of the most frequent reasons for referral into 10 clusters of I.C.D. diagnoses (Tables 1, 2 and 3 respectively).

Table 1: I.C.D. diagnosis by localization

Localization	percentage
1. Head	2
2. Back, general	19
3. Back, cervical	11
4. Back, thoracic	1
5. Thorax/lungs	4
6. Back, lumbar	12
7. Shoulder region	11
8. Upper arm and elbow	4
9. Forearm and wrist	1
10. Hand	1
11. Hips, pelvis and upper leg	10
12. Knee and lower leg	9
13. Ankle and foot	4
14. Others	10

Table 2: I.C.D. diagnosis "top twenty"

Description	percentage
1. Disorders of the back musculature (excl. lumbago)	11.3
2. Lumbago	11.1
3. P.h.s., frozen shoulder, rotator cuff syndrome	6.6
4. Disorders of the plexus brachialis and cervical syndrome	4.2
5. Spondylosis	3.1
6. HNP and disc disorders	2.9
7. Tennis elbow	2.8
8. Kyphosis, lordosis, scoliosis	2.8
9. Joint pains in the back	2.7
10. Sciatica	2.5
11. Bronchial infections	2.2
12. Disorders of the shoulder girdle musculature	2.1
13. Disorders of the pelvic girdle musculature	2.0
14. (Pseudo)neuritis/radiculitis	2.0
15. Arthrosis deformans of the knee	1.9
16. Contracture, restricted movement of the back	1.7
17. Sprained ankle	1.6
18. Dislocation of the knee	1.6
19. Headache complaints	1.6
20. Arthrosis deformans of the hip	1.2

Table 3: These chapters have been rearranged into ten clusters. I.C.D. diagnoses, 10 clusters

Description	percentage
1. Case history after operation	1
2. Others	2
3. Mental disturbances	3
4. Disorders of the nervous system	2
5. Bronchial disorders	2
6. Arthropathy	16
7. Dorsopathy	25
8. Rheumatism (excl. back)	36
9. Osteopathy and chondropathy and malformation	2
10. Posttraumatic disorders	9

The differences between general practitioners in the nature and the kind of diagnoses of patients whom they refer for physiotherapy were explained by Mr Kerssens.

The concept "differences between general practitioners" is illustrated by Table 4: the example for a random practice.

Table 4: the percentage of patients that was referred, per I.C.D. cluster, to the physiotherapist. Left-hand column: patients from one practice, centre column: patients from all practices together; right-hand column: difference

Description	practice percentage	total	difference percentage
1. Case history after operation	2	1	1
2. Others	3	2	1
3. Mental disturbances	2	3	-1
4. Disorders of the nervous system	0	2	-2
5. Bronchial disorders	7	2	5
6. Arthropathy	14	16	-2
7. Dorsopathy	38	25	13
8. Rheumatism (excl. back)	24	36	-12
9. Osteopathy and chondropathy and malformation	1	2	-1
10. Posttraumatic disorders	9	9	0

Per I.C.D. cluster the percentage referred in a practice and the percentage sent on for treatment in all practices are stated. The differences are indicated, so that each practice sees itself compared with the pattern of all practices together.

For the section "arthropathy" the further analysis was then described. The result is that differences between general practitioners in the referral pattern with regard to the diagnosis cluster "arthropathy" are connected with the age structure of the practices and the "indication breadth" that general practitioners use. However, these two variables explain only part of the differences between general practitioners.

This analysis route will also be followed for the other diagnosis groups.

Mr J. Fracheboud discussed the results of the investigation into the role and the outcome of home treatment of patients with a myocardial infarction by general practitioners from the sentinel station practices in 1983 and 1984. The aim of the investigation was to arrive at a comparison of the

DISTRIBUTION OF THE SPOTTER PHYSICIANS OVER THE NETHERLANDS

(Fig. 1, page 111)

The number of sentinel stations in 1987 was 44.
The number of general practitioners taking part is 61.

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 Flevoland (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_1-A_4 urbanization group (rural municipalities)[1];
- 2 for the B_1-B_3, C_1-C_4 urbanization group (urbanized rural municipalities together with municipalities with urban characteristics);
- 3 for the C_5 urbanization group (municipalities with a population of 100 000 or more).

Appendix 1 (p. 92-93) gives a survey of the general practitioners who took part in the sentinel station project during 1987. In 14 sentinel stations there is cooperation between two or more general practitioners, viz 12 times 2, once between 3 practitioners and once between 4 practitioners. In January 1987 the percentage of general practitioners cooperating throughout the Netherlands was 45, and among the spotter physicians 50 (31 out of 61). There are 10 dispensing spotter physicians, 6 in urbanization group 1 and 4 in urbanization group 2, that is 16% of the total number of spotter physicians. For the Netherlands as a whole this percentage is 13[2].

Tables 5 and 6 give a distribution of the number of spotter physicians and sentinel stations per province and ubanization group in the years 1970-1987. Adjustment to the standards applicable to the classification by degree of urbanization takes place where and when necessary.
Comparison with the number of general practitioners in the Netherlands in

the various subgroeps shows that the spotter physicians form a proportional representation (see 1981 report, p. 13).

Table 5: distribution of the spotter physicians (general practitioners) and sentinel stations per province group in the years 1970-1987[3]

province group	A		B		C		D	
	Groningen, Friesland and Drenthe		Overijssel, Gelderland and Flevoland		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
1986	10	6	10	8	26	21	14	10
1987	10	6	9	7	28	21	14	10

Table 6: distribution of the spotter physicians (general practitioners) and sentinel stations per urbanization group in the years 1970-1987

urbanization group	1 rural municipalities		2 urbanized rural municipalities together with municipalities with urban characteristics		3 municipalities with a population of 100 000 or more		Netherlands	
	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
1986	10	7	36	25	14	13	60	45
1987	10	7	37	25	14	13	61	44

THE PRACTICE POPULATIONS

A complete census of the practice populations took place in 1985; these details are used for processing with effect from 1-1-1986. In 1987 a new census was 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 held as to whether this aim is still being met. This proved broadly to be so, as the following surveys demonstrate.
The Dutch population increased by over 85 695 inhabitants.

Table 7: comparison of the population of the practices of the spotter physicians with the total population of the Netherlands

		number of inhabitants of the Netherlands[4]	number of patients of sentinel stations[5] (with percentages)	
province group	A	1 591 477	22 143	(1.4%)
	B	2 961 252	22 533	(0.8%)
	C	6 474 415	68 256	(1.1%)
	D	3 568 613	35 069	(1.0%)
urbanization	1	1 688 452	24 348	(1.4%)
group	2	9 406 483	87 894	(0.9%)
	3	3 513 822	35 759	(1.0%)
sex men		7 224 323	73 394	(1.0%)
woman		7 390 802	76 607	(1.0%)
total		14 615 125	148 001	(1.0%)

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 in years	province group								urbanization group						Netherlands	
	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	1.4	0.7	0.6	0.9	0.9	0.8	0.8	1.3	1.3	0.7	0.7	1.0	0.9	0.9	0.9
5- 9	1.4	1.5	0.7	0.7	1.1	1.0	0.9	0.9	1.4	1.5	0.9	0.9	1.1	1.0	1.0	1.0
10-14	1.5	1.5	0.7	0.7	1.1	1.1	1.0	1.1	1.5	1.5	1.0	1.0	1.0	1.0	1.0	1.1
15-19	1.3	1.4	0.8	0.8	1.0	1.0	1.0	1.0	1.4	1.5	0.9	0.9	1.0	0.9	1.0	1.0
20-24	1.3	1.5	0.8	0.8	1.1	1.1	1.0	1.1	1.5	1.7	1.0	1.0	0.9	1.0	1.0	1.1
25-29	1.5	1.6	0.8	0.7	1.1	1.1	1.0	1.0	1.4	1.4	0.9	0.9	1.1	1.2	1.0	1.1
30-34	1.5	1.6	0.7	0.7	1.0	1.1	1.0	1.0	1.3	1.5	0.9	0.9	1.1	1.2	1.0	1.0
35-39	1.5	1.6	0.7	0.7	1.1	1.1	0.9	1.0	1.4	1.5	0.9	0.9	1.0	1.1	1.0	1.0
40-44	1.2	1.2	0.7	0.7	0.9	1.0	0.9	1.0	1.3	1.3	0.9	0.9	0.9	0.9	0.9	0.9
45-49	1.3	1.4	0.7	0.7	1.0	1.0	0.9	1.1	1.4	1.4	0.9	0.9	0.9	1.0	0.9	1.0
50-54	1.3	1.2	0.8	0.8	1.0	1.1	1.0	1.0	1.5	1.5	0.9	1.0	1.0	1.0	1.0	1.0
55-59	1.2	1.3	0.8	0.8	1.1	1.1	0.9	1.0	1.4	1.5	0.9	1.0	0.9	1.0	1.0	1.0
60-64	1.3	1.3	0.8	0.8	1.1	1.0	0.9	0.9	1.5	1.4	0.9	0.9	1.0	1.0	1.0	1.0
65-69	1.4	1.2	0.8	0.7	1.1	1.0	0.8	0.9	1.5	1.4	0.9	0.9	0.9	0.9	1.0	1.0
70-74	1.1	1.2	0.9	0.7	1.0	1.1	1.0	0.9	1.5	1.4	0.9	0.9	0.9	0.9	1.0	0.9
75-79	1.3	1.3	0.9	0.8	1.0	0.9	0.9	0.9	1.4	1.4	0.9	0.9	1.0	0.8	1.0	0.9
80-84	1.3	1.2	1.0	0.8	1.0	1.0	1.0	1.0	1.5	1.3	1.0	1.0	0.9	0.9	1.0	1.0
> 85	1.3	1.3	0.9	0.7	1.1	1.0	0.9	1.1	1.5	1.4	1.0	1.0	1.0	0.8	1.1	1.0
total	1.4	1.4	0.7	0.7	1.0	1.1	0.9	1.0	1.4	1.4	0.9	0.9	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 faithul 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 in time, telephone contact is made.

The maximum number of days that can be reported depends on the number of weeks in the year in question and the number of sentinel stations. In 1987 it was 11 660 (53 weeks x 5 days x 44 sentinel stations). Table 8 shows the absolute numbers and percentages.

Table 8: 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
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%
1986	11 700	10 284	87.9%
1987	11 660	10 035	86.1%

The percentage of reporting days is practically the same as in previous years.
A breakdown by province and urbanization group may be seen in the following table. No great differences prove to exist. The western provinces

are the lowest, 84.2%, and the eastern provinces the highest, 87.5%.

Per province group		Per urbanization group	
A	87.0%	1	86.3%
B	87.5%	2	87.0%
C	85.2%	3	84.2%
D	86.4%		

In Fig. 2 the weekly reporting in all sentinel stations can be found. This figure clearly shows the influence of public holidays. The average number of non-reporting days per week is a little more than 31 (maximum 44 x 5= 220).

Table 9 (see the following page) 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 37, more than in the previous year (31).
A breakdown into single and group practices shows a clear difference here, viz 38 and 16 days respectively. This is in line with the frequent assertion that forms of cooperation of general practitioners increase the continuity of reporting.

Tabel 9: frequency distribution of the number of days not reported on per sentinel station

number of days not reported on	number of sentinel stations										
	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
< 0	0	1	1	2	2	1	2	2	1	0	0
1- 9	11	8	11	7	9	9	7	6	8	7	4
10-19	7	5	2	2	2	2	5	3	1	4	7
20-29	3	3	5	4	3	6	1	7	8	7	1
30-39	9	10	10	11	18	15	12	9	10	10	5
40-49	10	11	10	10	8	10	14	17	15	13	16
50-59	2	6*	4	8	2	3	4	1	2	2	10
60-69	0	1	2	1	1	0	1	1	0	1	1
70-79	1	0	0	0	0	0	0	0	0	0	0
80-89	0	1	0	1	1	0	0	0	0	0	0
90-99	0	0	1	0	0	0	0	0	0	0	0
> 99	1	1**	0	0	0	0	0	0	0	1	0
	44	47	46	46	46	46	46	46	45	45	44
average	29	32	31	34	31	29	31	31	30	31	37
median	32.5	34	34.5	38	38	34.5	37	35	34	34.5	43

* One sentinel station started in February 1978.

** 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 untill 1987.

In 1987 a deterioration may be noted compared with 1985 and 1986.

THE WEEKLY RETURN (Appendix 2, p. 94)

The questions on the weekly return for 1987 were composed as follows; it is stated in brackets in which year the topics were added to the return.

1. New cases of influenza (-like illness) (1970);
2. Cervical smear (1976);
3. Discharged psychiatric patients (1986);
4. Sterilization of the man performed (1972);
5. Sterilization of the woman performed (1974);
6. Prescription of morning-after pill (1972);
7. Dog bites (1986);
8. (Attempted) suicide (1979);
9. Cerebrovascular accident (1986);
10. Referrals for psycho-social problems (1986);
11. Dementia (1987);
12. Prescription of Rohypnol (1987);
13. Pregnancy despite adequate contraception (1987).

The basis in principle is weekly reporting, which means that patients 'seen' by the locum in a "free 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 1970-1988 is given below; the questions of the current year, 1988, are also given. The subjects in alphabetical order can be found in Appendix 3 (p. 95-96) together with the years of registration.

Subjects on the weekly returns 1970-1988

subjects	'70	'71	'72	'73	'74	'75	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85	'86	'87	'88
influenza (-like illness)	x	x	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	x	x	x	x	x	x													
(attempted) suicide	x	x	x							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 pil			x	x	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	x	x
prescription of tranquilizers			x	x	x														
consultation for drug-use			x	x	x					x	x	x							
(suspection of) battered child syndrome				x	x														
sterilization of the women performed					x	x	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													
psoriasis							x	x											

Subjects on the weekly returns 1970-1988 (continuation)

subjects	'70	'71	'72	'73	'74	'75	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85	'86	'87	'88
prescription of anti-hyperten-sivum or diuretic							x												
cervical smear							x	x	x	x	x	x	x	x	x	x	x	x	x
mononucleosis infectiosa								x	x	x									
prescription of medicine for infection of the urinary tract								x											
hay fever									x	x	x	x	x						
myocardial infarct-tion (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 immatutus													x	x					
partus at gravidity >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 systems															x				
referrals															x				
ulcus pepticum (first time/ recurrence)																x	x		
referrals for physiotherapy																x			
discharge of psy-chiatric patient																	x	x	x
bites by pets																	x	x	
bites by dogs																			x
cerebrovascular accident																	x	x	
referrals for psy-chosocial problems																	x	x	

Subjects on the weekly returns 1970-1988 (continuation)

subjects	'70	'71	'72	'73	'74	'75	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85	'86	'87	'88
dementia																		x	x
prescription of rohypnol																		x	x
pregnancy despite adequate contraception																		x	x
admission of psychiatric patient																			x
burns																			x
acute unusual headache																			x
echography requested																			x
out-patient or clinical mammography																			x
concern about AIDS																			x

PROCESSING OF THE DATA ON THE WEEKLY RETURN

This report contains the results of the weekly return for 1987. 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 absolute number of patients by sex and age group.
2. The absolute number of patients by sex and province group.
3. The absolute 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 frequencies 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 98) the age structure as on 1 January 1987 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.
Until 1978 a correction factor was applied to this. Consideration of the number of times it 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 spotter physicians revealed that in the cases of 1 or 2 days' absence the work was simply moved to a later date.
The returns are built up from the weekly return 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 annual tables are included here (p. 100-110):
Tables on p.100-103 give the number of patients per 10 000 of the age group[6] .
Tables on p. 104-105 give the number of patients per 10 000 of the urbanization group.
Tables on p. 106-107 give the number of patients per 10 000 of the province group.

INFLUENZA(-like illness)

Influenza[7] 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 1986-1987 and 1987-1988

Table 4a and Fig. 3 (pages 108 and 113) give the number of new cases of influenza per 10 000 inhabitants per week, per province group and per urbanization group for 1987-1988[8]. Fig. 4 gives the trend in comparison with previous years. The progress of influenza in the first weeks of 1987 was already described in the 1986 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 as outside the influenza season. The 1986-1987 season forms an exception to this. The trend is milder.

In the first weeks of 1987 the incidence begins to rise; in week 5 the highest incidence is attained: 26 persons per 10 000 inhabitants.

After the mild 1986/87 influenza season there are no signs of an obvious epidemic in the first weeks of 1988 (1987/88 season) either. The highest incidence that occurs in this season is 9 per 10 000 inhabitants for the whole of the Netherlands in week 8 of 1988.

The differences in incidence between the province groups are not considerable. In the northern provinces higher incidences are reported for a longer period in the 1986/87 season than is the case in the other province groups. Week 5 with 51 per 10 000 inhabitants is the highest incidence found in this season.

In the 1987/88 season, in which there is hardly any question of an epide-

mic, the highest incidences are found in week 8 in the southern provinces (17 per 10 000 inhabitants) and in week 13 in the northern provinces (likewise 17 per 10 000 inhabitants).

If we consider the whole of 1987, the level of the incidences throughout the year lies somewhat above the level through other years. It is the question whether this is the result of a "missed" epidemic. Possibly 1988 will furnish further information on this, since the 1987-1988 season really does not display any epidemic.

The cities have the most influenza(-like illnesses) in both the 1986/87 and 1987/88 season. In 1986/87 the highest incidence is 35 per 10 000 inhabitants in week 4 of 1987. In 1987/88 week 12 with 15 per 10 000 inhabitants is the week with the highest incidences in the cities. In the rural municipalities there are hardly any more reports of influenza at that time.

In the 1986-1987 season solely influenza A (H_1N_1) is diagnosed, apart from an occasional isolation of influenza B virus. The isolated strains related to A/Singapore/6/86 differ in composition from the influenza A (H_1N_1) strains isolated in previous years. In the 1987-1988 season a limited number of influenza-B and influenza-A infections (A-H_3N_2) are serologically confirmed.

Table 10: number of patients with influenza (-like illness), per 10 000 inhabitants, 1977-1988

jaar	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
total per calendar year	575	829	438	425	491	497	396	502	464	630	365	
total per "season"*	711	502	449	448	392	507	607	465	578	348		
highest weekly incidence per "season"	107	43	15	36	20	42	53	57	71	26	9	

* 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 we survey the epidemics of the past 10 years, that of 1987 was the mildest in that period. It looks as if there is no question at all of an influenza epidemic in 1988.

Age and sex distribution

During the period of registration, no difference has ever been 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 shows as in previous years that the general practitioner is consulted most frequently on influenza-like illnesses for the age group under 5 years. 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 physicians 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 mass screening subsidized by the Ministry as great as possible, three years has been adhered to as the period within which a second or following smear has to be reported as a repeat smear. For 1987 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 1985. 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 Ministry of Public Health and Environment announced the intention to amend the policy regarding mass screening for cervical cancer. On 25 August 1988 agreement was reached between the Association of Netherlands Health Insurance Funds and the professional organization of general practitioners on reimbursement for the taking of cervical smears from patients covered by a health insurance fund. This has made it possible to start mass screening for cervical cancer throughout the Netherlands.

Table 11 gives the total number of smears taken, with a subdivision for the indication for taking the smear, including the repeat smears.

Table 11: number of smears taken by spotter physicians by indication for taking a smear, per 10 000 women, 1978-1987

	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
complaints and/or symptoms	80	80	62	57	57	65	57	62	65	59
"preventive" spotter physician's initiative	218	198	168	184	171	174	204	197	230	192
"preventive", woman's initiative	105	124	93	110	126	120	132	127	168	153
repeat smear	120	143	148	159	170	168	182	184	170	211
total	523	545	471	510	524	527	575	570	633	615

The total number of smears (615 per 10 000 women) is somewhat lower in 1987 than in 1986, but higher than in the years before. When considering these tables, as has also been remarked in the previous reports, one must make allowance for the fixed period of three years within which a smear counts as a repeat smear.

The number of smears on account of complaints and/or symptoms is at the same level as in recent years: around 60 per 10 000 women.

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 smears taken on medical indication will therefore be higher.

The total number of smears taken on preventive indication, i.e. on the initiative of both the general practitioner and the woman, is lower in 1987 than in 1986: 345 and 398 per 10 000 women respectively. The subcategory repeat smears has conversely increased; in 1987 211 and in 1986 170 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 the general practitioner. The number of women who are reached in this way at least once every three years may be seen in the total of Table 12. 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 group and urbanization group (see also Figs. 5 and 6). The total number of first smears fell in 1987, notably in the category "preventive", spotter physician's initiative, in 1986 230 per 10 000 women against 192 per 10 000 women in 1987. In 1987 a smear is taken on the woman's initiative less often than was the case in 1986 (153 and 168 per 10 000 women respectively).

Table 12: number of "**first**" cervical smear taken per province group and urbanization group, by indication for taking a smear and for the Netherlands, per 10 000 women, 1978-1987

		province group				urbanization group			Nether-lands
		A	B	C	D	1	2	3	
complaints	1978	116	93	72	68	78	66	118	80
and/or	1979	130	95	63	79	73	70	114	80
symptoms	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
	1986	121	106	42	43	93	54	75	65
	1987	79	92	46	48	79	49	69	59
"preventive"	1978	170	259	230	183	325	169	269	218
general	1979	170	198	214	178	248	154	280	198
practitioner's	1980	121	170	207	105	186	119	306	168
initiative	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
	1986	201	210	248	229	243	186	334	230
	1987	154	175	204	202	173	162	278	192
"preventive"	1978	110	85	130	64	94	115	89	105
woman's	1979	141	112	142	82	119	125	126	124
initiative	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
	1986	141	155	201	134	155	158	205	168
	1987	147	165	179	101	169	132	194	153
total	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	367	359
	1984	402	431	399	348	449	327	539	393
	1985	366	429	388	363	441	316	523	386
	1986	463	471	491	406	491	398	614	463
	1987	380	432	429	351	421	343	541	404

Age distribution

Table 13 gives a survey of the number of **"first"** smears by age group per 10 000 women (cf. Fig. 7).

Table 13: number of **"first"** smears taken by spotter physicians by age group, per 10 000 women, 1977-1987

	age group							
	10-14	15-19	20-24	24-34	35-44	45-54	55-64	>65
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
1986	(2)	54	459	1008	991	729	273	42
1987	-	57	323	845	943	634	236	24

Although the figures for the number of smears taken are lower than the 1986 figures, they remain above the level of the years before 1985, notably in the 35-44, 45-54 and 55-64 age groups. A decline in the number of first smears desirable in accordance with policy is seen in the younger age groups, those of 20-24 years and 25-34 years.

Table 14 gives for 1978 and following years a breakdown by indication for taking a smear, including the repeat smear (see also Fig. 8). This table gives further information.

The years 1976 and 1977 are not given here, because as a result of the fact that the period adhered to as the period within which a second smear taken on the same woman should be reported as a repeat smear had not yet lapsed then.

Table 14: number of smears taken by spotter physicians by age group and by indication for taking the smear, per 10 000 women, 1978-1987

		age group						
		15-19	20-24	25-34	35-44	45-54	55-64	>65
complaints and/	1978	17	102	153	193	147	55	7
or symptoms	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
	1986	14	67	117	131	11	63	16
	1987	13	63	94	124	110	51	11
preventive	1978	20	162	467	542	401	151	29
general prac-	1979	49	265	442	412	345	94	21
titioner's	1980	18	379	389	274	206	95	26
initiative	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
	1986	35	310	580	405	325	100	10
	1987	26	196	483	345	265	70	5
preventive	1978	(6)	70	215	293	194	74	7
women's ini-	1979	8	162	283	295	176	77	14
tiative	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
	1986	(5)	82	311	455	293	110	18
	1987	18	64	268	431	269	115	8
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
	1986	-	64	325	459	369	125	9
	1987	(8)	79	353	532	483	154	15

Table 14: number of smears taken by spotter physicians by age group and by indication for taking the smear, per 10 000 women, 1978-1987 (continuation)

		age group						
		15-19	20-24	25-34	35-44	45-54	55-64	>65
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
	1986	54	523	1333	1450	1098	398	53
	1987	65	402	1198	1432	1127	390	39

The total number of cervical smears taken on medical indication gives no new information; compared with 1986 the numbers in all subgroups are somewhat lower.

The number of preventive smears on the initiative of the spotter physician is lower in all age groups in 1987 than in 1986. The smears taken at the woman's request remain almost the same in numbers. Repeat smears were taken more often in 1987 in all age groups than was the case in 1986. This may partly be explained by the definition of a repeat smear and the fact that the centrally organized mass screening has been ended for several years now.

Table 15: smears taken per age group for the sentinel stations (as percentages), 1984-1987

age	total number of smears	"first" smear
<35 years		
1984	45.9	52.5
1985	42.2	48.7
1986	42.5	45.4
1987	35.8	40.0
35-54 years		
1984	46.8	40.7
1985	48.6	42.8
1986	49.9	47.1
1987	55.0	51.5
>54 years		
1984	7.4	6.8
1985	9.2	8.5
1986	7.6	7.5
1987	9.2	8.5

In 1984 we wrote that general practitioners are inclined to consider screening for cervical cancer as their task. We are now inclined to state that general practitioners, despite the continuing discussion in 1987 on the remuneration of the general practitioner for this examination and the failure to reach agreement on this, while seeming prepared to assume this task, have not yet achieved a situation in which the performance of that examination is efficient. However, the figures for 1986 and 1987 suggest that the situation is improving. With respect to 1984 and 1985 clear changes may now be seen. This is particularly the case with the 35-44 age group, whereby both the general practitioner and the woman more than before take the initiative for taking a smear for reasons of early diagnosis of a possible cervical carcinoma.
These figures give the impression of being the result of the changed policy regarding the mass screening for cervical cancer.

The results of this topic, as stated at the beginning of this chapter, will acquire greater value when the plans of the central goverment make further progress.

This topic has been maintained on the weekly return in 1988.

DISCHARGED PSYCHIATRIC PATIENTS

After discharge from a psychiatric facility a difficult period generally dawns for a patient, in which a new equilibrium must be found in functioning in a differently regulated environment. Every year over 50 000 people are faced with this task. A number of these 50 000 are faced several times in any one year with the task of coping outside the walls of the institution. For others it is a one-off event.
The question arises whether these people are counselled in this search for a new equilibrium and, if so, by whom. Part of the answer is that in the first three months after discharge half of these people are in touch with an institution for mental health care. Whether the other half of the discharged patients also receive a form of professional care is unknown.

In 1985 an investigation was performed in a municipality in the north of the country by the Social Psychiatry Department of Groningen State University into the contacts of a hundred discharged psychiatric patients with institutions for mental health care and with primary health care. The initiative for this investigation had been taken by the Chief Medical Office of Health.
In the investigation interest was directed above all towards the share of primary health care in after-care for the discharged psychiatric patient.

When this investigation was being set up there was already interest in the question to what extent the findings in the municipality investigated would be representative of the whole country.
Mr W. Frankenberg M.D., a member of this investigating team, requested the Counselling Committee of the C.M.R. Sentinel Stations to repeat some of the questions put in the investigation in the northern municipality in this nationally representative registration system.
The request is to register the first contact with or about a patient after the latter's discharge from a psychiatric facility, irrespective of the time between discharge and the first contact and also irrespective of whether the first contact is connected with the psychiatric problems of the person concerned. This registration therefore also covers the contacts with others than the patient (partner, family, neighbours, police and so on) insofar as the discharged patient is concerned. A questionnaire is completed with reference to this first contact. The questions, which in part are identical with questions put in the above-mentioned investigation, relate to aspects of the

hospitalization of the patient, the discharge, the reporting on the discharge and the first contact after the discharge itself. Questions are also asked about some aspects of the after-care of the discharged patients. The data collected in this way are processed by the Groningen investigation group. They will be reported on elsewhere.

Table 16 shows the number of the first contacts with or about discharged psychiatric patients by province and urbanization group and for the Netherlands per 10 000 persons.

Table 16: number of consultations with or about discharged psychiatric patients by province and urbanization group and for the Netherlands per 10 000 inhabitants, for 1986-1987

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
1986	11	8	8	7	7	7	11	8
1987	8	8	10	8	4	7	17	9

The number of registered first contacts after discharge, 9 per 10 000 inhabitants for the Netherlands, is in 1987 considerably lower than the number of approx. 36 per 10 000 inhabitants (some 50 000 discharges out of over 14 million inhabitants) expected by the Groningen investigators.
At the annual meeting in January 1987 this problem was discussed with the spotter physicians in the presence of the man responsible for the topic, Mr W. Frankenberg. In consultation with the spotter physicians the registration procedure has been adjusted.
The considerable difference between the numbers expected by the Groningen investigators and the numbers found so far in the registration by the spotter physicians calls for caution in the interpretation of the data.

Age distribution

Table 17 presents the data on the number of first contacts with or about a discharged psychiatric patient by age group per 10 000 inhabitants.

Table 17: number of first contacts with or about a discharged psychiatric patient by age group per 10 000 inhabitants, for 1986-1987

	Age group							
	10-14	15-19	20-24	25-34	35-45	44-54	55-64	>65
number of first consultations								
1986	(1)	(1)	10	13	13	11	11	7
1987	(1)	5	12	13	16	9	11	6

According to this registration, under the age of twenty discharges from psychiatric institutions are reported only exceptionally. The number of discharges from psychiatric facilities for children and young people amounts nationally to some 400 per year. In the sentinel station population about 4 dischargeds would therefore be expected (1% of the number for the total Dutch population). From the 20-24 age group onwards the number of first consultations after discharge is about the same for the various age groups. Above the age of 65 the number of first contacts with and about a discharged psychiatric patient declines. It is true that every year approx. 10 000 admissions to psychogeriatric nursing homes are terminated, but in the majority of cases this is as a result of the death of the patient.

As stated, the data must be handled with caution. The results of this registration differ too much from the expected numbers. An explanation of this is being sought. A first step in that direction is that for 1988 admission of a patient to a psychiatric facility is also to be included as a topic on the weekly return.

The topic has been maintained as such on 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" and for computing of the population.
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 18 (cf. Fig. 9).

Table 18: number of sterilizations of men performed, per province group and urbanization group per 10 000 men, 1972-1987

	province group				urbanization group			Nether-lands
	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
1986	21	76	42	42	80	35	43	45
1987	31	69	41	43	64	40	43	45

For some 5 years the number of sterilizations of the man has been approx. 45 per 10 000 men and thus stable.
For the whole country the number of sterilizations in 1987 does not differ from that in 1986. However, there is some movement in the subgroups: a rise in the northern provinces and in the urbanized municipalities. Against this there is a drop in the eastern provinces and in rural municipalities (see also the chapter on sterilization of the woman).
Extrapolation gives approx. 32 500 sterilizations 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. The frequencies in 1987 per quarter match those of 1983-1986.

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 1987 some 25 000 sterilizations of men had been performed (the "replacement factor"), the percentage of men sterilized at some time would have remained the same as in 1986. Since in reality some 32 500 operations were performed, there is still a considerable additional increase of some 7 500. The percentage of men in the Dutch population sterilized at some time who - statistically speaking - form part of the fertile age group increases as a result from 12.2% in 1986 to 12.3% in 1987[9].
An interesting development is that the percentage of men sterilized at some time has in recent years been displaying a clear drop in the younger age group. In 1981 5.5% of the men between 22 and 31 years were sterilized, whereas in 1987 this is only 3.3%.

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 19 (cf. Fig. 12).

Table 19: number of sterilizations of men performed, by age group, per 10 000 men, 1972-1987

	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	(3)
1984	-	8	105	157	36	(3)
1985	-	-	110	151	25	(5)
1986	-	(2)	110	145	34	(3)
1987	-	(2)	85	160	35	(6)

For all years the highest frequency is to be seen in the 35-44 age group. The decline that started in 1980 seems to have come to a definite halt in this group. However, there is still a reduction in the number of sterilizations performed at a younger age: from 25 to 34 years. A relatively constant percentage of men have themselves sterilized above the age of 44: in 1987 35 per 10 000 men, in 1986 34 per 10 000 men.
A cumulative calculation shows that in the Netherlands since 1971 at least 582 000 sterilizations of men have been performed, that is on 7.8% 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 has been maintained on the 1988 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 20 (cf. Fig. 10).

Table 20: number of sterilizations of women performed, per province group, and for the Netherlands per 10 000 women, 1974-1987

	province group				urbanization group			Nether-lands
	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
1986	33	23	32	27	30	27	35	29
1987	24	31	28	27	37	24	31	28

The national frequency of the number of sterilizations performed among women has remained fairly stable since 1985 at a level around 28 per 10 000 women.

For the various subgroups the movements of the figures in the same period differ somewhat without a clear pattern.

In the eastern provinces the decline that had been going on since 1980 seems to be coming to a halt: in 1986 23 sterilizations per 10 000 women and in 1987 31 per 10 000 women. In the rural municipalities the number of sterilizations in 1987 rose in respect of 1986 from 30 to 37 per 10 000 women. A drop occurred in the other two urbanization groups. In the northern provinces the number of sterilizations of men increased in 1987, whereas it fell for women. This contrasts with the figures from the eastern provinces, where the number of sterilizations of the man is precisely falling and the figure for women rising.

In the rural municipalities too the number of sterilizations is falling among men and rising among women, whereas the situation is exactly the opposite in the urbanized rural municipalities and the municipalities with urban characteristics: a rise among men and a fall among women. We see a fall in the number of sterilizations of both men and women in the western provinces. In the cities there is a slight increase among men and a decrease among women.
These are, of course, no more than specifications of how the figures change. However, a certain degree of local colour seems to be starting to occur. Should this trend be confirmed in the years to come, further analysis of these figures seems to be interesting, to say the least.

Fig. 11 gives a comparison between the number of sterilizations of the men and the women per year. The curves display a great degree of similarity up to 1985.
The remarks made on the trend in the previous chapter are also applicable here. In 1985 the curves for men and women seem to diverge; this is also the case in 1986 and 1987. It remains to be seen whether these differences will continue to occur in the years to come.

Age distribution

The age-specific distribution of the number of sterilizations performed per 10 000 women is given in Table 21 (cf. Fig. 12).

Table 21: number of sterilizations of women performed, by age group per 10 000 women, 1974-1987

	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
1986	-	(2)	6	84	94	15
1987	-	-	7	63	104	18

For the 35-44 and 45-54 age groups there is an increase in the number of sterilizations compared with 1986. However, compared with 1984 and the preceding years there is still a lower level of the number of sterilizations of the woman performed. The 45-54 age group forms an exception to this. In the 35-44 age group most sterilizations of the woman are again performed (see also the preceding chapter).

A cumulative calculation shows that in the Netherlands since 1973 sterilization has been performed on a total of at least 472 000 women, i.e. 6.4% of the total female population. However, it is more realistic to relate the figures only to women of fertile age (15-49) and then at the same time to bring in the sterilization pattern of the man. In that case it proves that in 1975 in the case of approx. 6% of (married) couples the woman or the man was sterilized. This percentage has since then risen via approx. 18.5 in 1980 and approx. 22.4 in 1984 to 23.0 in 1986. In 1987 this fell slightly for the first time to 22.9%, but solely as a result of the relatively large number of sterilizations among men. The number of sterilizations that ought to have

been performed in 1987 on the basis of this calculation to keep the total percentage stable is practically identical with the actual number of sterilizations (men and women together) performed in 1987. Dr. E. Ketting, who made this calculation, expects that in the Netherlands a situation will arise in which some 30% of women who reach the age of 50 in a given year will have been sterilized at some time. In 1987 this percentage has already nearly been reached: 27.6. In 1986 this was 26.7%. To keep the percentage of women sterilized at some time stable, approx. 25 500 sterilizations were required in 1987. The number of sterilizations performed (obtained by extrapolation) is 20 500; (fewer thus than required to keep the percentage of 10.8% sterilized women in the 15-49 age group stable). Consequently, the percentage of women sterilized at some time in the above age group has fallen from 10.8 to 10.6.

Much more clearly then even among men, the popularity of sterilization among young women has been falling quickly in recent years. In 1980 6.9% of women aged 25-29 years were sterilized, as against 3.0% in 1987. Since 1985 there has now also been a decline among women aged 30-34 (from 13.8% in 1985 to 10.4% in 1987). In the 35-44 age group the number stays stable, whereas it is still clearly on the increase among women above this age.

These figures show that now women desire on average to have children at a somewhat later age than was the case five years ago.

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 1988.

PRESCRIPTION OF MORNING-AFTER PILL

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

Table 22 gives the frequency with regard to the prescription of the morning-after pill, per province and urbanization group and for the Netherlands (cf. Fig. 13).

Table 22: number of prescriptions of the morning-after pill, per province and urbanization group per 10 000 women, 1972-1987

	province group				urbanization group			Nether-lands
	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
1986	48	45	31	38	32	38	41	37
1987	35	35	32	40	32	35	37	35

Since 1981 the number of prescriptions issued for the morning-after pill has fluctuated arround 35 per 10 000 women. There was no change in this in 1987. Compared with 1986, there is an decrease from 37 to 35 per 10 000 women.

The decline is confined to the northern and eastern province groups; the western provinces and the southern provinces remain practically the same. A breakdown by degree of urbanization shows that the decline occurs notably in the urbanized rural municipalities and in the municipalities with urban characteristics and the cities.

There is little difference between the quarterly figures. In the third quarter prescribing is somewhat higher than the rest of the year.

Age distribution

Table 23 gives the age distribution of 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, 1972-1987

	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
1986	13	150	111	54	26	14
1987	(4)	126	112	54	26	14

The slight decrease in 1987 is attributable to the lower age groups (10-14 and 15-19). As in previous years, prescribing for the 15-19 age group is the highest for 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 twice.
The absolute numbers under 20 years are given in Table 24. The seventeen-year-olds so far stood out as regards the number of prescriptions of the morning-after pill. However, that is not the case in 1987.

Table 24: absolute numbers of prescription of the morning-after pill for women under 20 years, 1978-1987

	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
11 years	-	-	-	-	-	1	-	-	-	-
12 years	-	-	-	-	-	-	-	-	-	-
13 years	-	-	-	1	1	1	1	1	-	-
14 years	4	2	-	-	1	2	2	4	5	2
15 years	11	12	8	13	12	5	7	3	7	6
16 years	20	18	20	9	14	16	21	18	16	15
17 years	36	19	32	14	17	23	21	32	30	11
18 years	21	29	23	17	16	15	28	15	15	11
19 years	26	14	17	16	16	7	12	6	8	16
total	118	94	100	70	78	70	92	79	81	61

The extrapolation of the frequencies found to the Dutch population appears on p. 80. 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-norgestrel on one day) 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, in 1986 that percentage was only 15 according to this registration.

In the course of 1986 publications occurred in which doubt was cast on the effectiveness of the "new morning-after pill" [10]. It was also suggested that a five-day treatment protects more than one coitus.
Now in 1987 physicians again administer 5 mg ethinylestradiol to the women for five days in 30% of the prescriptions. Thus within a year's time a major change seems to have occurred here.

Some caution in interpretation is called for here. There are indications that self-medication is increasingly occurring because the morning-after pill is easily obtainable. Incorrect use, such as several times per cycle, after more than one unprotected coitus or use of the wrong pill is conceivable. This registration establishes how often the general practitioner is asked to prescribe the morning-after pill.

The question has been maintained on the 1988 weekly return, with reporting of the product prescribed.

DOG BITES

The relationship between man and (domestic) animal is not free from problems. One of them is aggressiveness in this relationship, with reciprocal manifestations of violence. Judging by publications in the literature on this subject, it is definitely not infrequent that man and animal injure one another.
Interest in this subject has been remarkable in recent years. In 1985 the general practitioners participating in the Rotterdam Sentinel Stations Project recorded the number of times that they were consulted for a bite by pets[11]. Extrapolation of the data collected in Rotterdam to the Dutch population works out at over 40 000 persons who consult the general practitioner every year for a pet bite. In some 90% of the cases a dog bite is concerned.
Moreover, the data of the Consumer and Safety Foundation show that in 1984 over 16 000 persons were treated in hospital for a dog bite[12]. On estimate between 6 000 and 7 000 people are treated for injuries caused by other animals (horses, cats, wasps).

There is no insight into the extent to which there is an overlap of the population treated by the general practitioners or the hospitals. Nor is it clear to what extent the bites by pets registered by the Rotterdam general practitioners are a clear representation of the occurrence of this problem in the rest of the Netherlands.

For J.J.L. Pieters, Inspector of Health in general service of the Chief Medical Office of Health for non-contagious diseases and road safety, the lack of insight into the problem of bites by pets led to a request to the Counselling Committee of the Continuous Morbidity Registration Sentinel Stations to put forward the topic for registration.
It was requested that the new bites for which the general practitioner is consulted be registered. In 1986 a distinction was made in this between dog bites and bites by other domestic animals. In 1987 the registration has been restricted to bites by dogs. The reporting this year is likewise confined to the data concerning bites by dogs.

A number of supplementary questions were asked to gain insight into further aspects of the problem. Insight into the severity of the injuries

(number of bites), familiarity with the animal (one's own pet or not), the risks of certain occupations (bitten during one's work) and the repeat factor (bitten earlier this year) is pursed.
Finally, the question whether the patient has been referred for treatment to hospital is aimed at gaining insight into the possible overlap in different registration systems and the share of general practitioners in taking care of these patients.
The data concerning this further questioning are being processed by the Consumer and Safety Foundation.

Table 25 states the numbers of patients consulting the general practitioner for a new dog bite per province group and per urbanization group and for the Netherlands (cf. Fig. 15).

Table 25: number of patients consulting the general practitioner for a bite by a dog (first consultation only) by province and urbanization group and the Netherlands, per 10 000 men and women, for 1986-1987

			province group				urbanization group			Nether-lands
			A	B	C	D	1	2	3	
Dog bites	1986	M	29	42	26	35	39	31	25	31
	1987		32	44	19	33	41	29	17	28
	1986	F	28	24	22	18	29	22	17	22
	1987		19	26	17	13	27	18	11	18
	1986	T	28	33	24	26	34	27	21	26
	1987		26	35	18	23	34	24	14	23

In 1987 too men were bitten more than women by dogs: 32 per 10 000 and 19 per 10 000 respectively. The 1987 figures differ little from those found for 1986.

The fewest dog bites out of the total are presented to the general practitioner in the western provinces (18 per 10 000 persons). The number is the highest in the eastern provinces, with 35 patients per 10 000 persons. There is a striking difference in the number of bites for which the general practitioner is consulted between the rural municipalities and the cities: in

1987 more than twice as many in the rural municipalities.

Table 26 surveys the number of first consultations for bites by dogs per quarter per 10 000 men and per 10 000 women.

Table 26: number of first consultations for bites by dogs per quarter per 10 000 men and per 10 000 women, for 1986-1987

		1st quarter	2nd quarter	3rd quarter	4th quarter
dog bites	1986 M	6	10	8	6
	1987	8	8	7	6
	1986 F	5	7	6	4
	1987	4	4	6	4
	1986 T	5	9	7	5
	1987	6	6	6	5

In 1987, unlike 1986, there were hardly any differences between the quarters.

Age distribution

Table 27 gives the frequency of the first consultations of the general practitioner on account of a bite by a pet per 10 000 inhabitants per age group (cf. Fig 16).

Table 27: number of patients consulting the general practitioner on account of a bite by a dog (first consultation only) by age group per 10 000 men and women, for 1986-1987

			age group									
			<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	>65
dog bites	1986	M	-	41	55	49	43	26	31	29	17	28	18
	1987		-	29	25	36	33	32	36	17	28	32	14
	1986	F	-	27	41	26	39	17	21	23	17	20	13
	1987		-	27	13	26	26	20	16	16	24	18	6
	1986	T	-	34	48	38	41	21	26	26	17	24	15
	1987		-	28	19	31	30	26	26	16	26	24	9

In this registration year not one report was recorded in the sentinel station practices in which a baby below the age of one year was bitten by a dog; in 1986 there was only one report in this category.

It is young people aged between 1 and 19 years who are bitten somewhat more by dogs. From the age of 20 the frequency of the number of first consultations on account of a dog bite decreases. This is less pronounced in 1987 than in 1986.

In the majority of the age groups more men than women are again bitten by dogs.

The topic has been removed from the weekly return for 1988.

(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 Counselling Committee decided to repeat this gauging in 1979.
In other fields too (hospital), 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 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 110, 98, 95, 116, 148, 109, 90, 10 and 96 in 1979-1987.
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.

The number of attempts per province and urbanization group per 10 000 inhabitants may be found in Table 28. The breakdown into subgroups is of limited value, because of the relatively small frequencies.
As in 1987, when the degree of urbanization is considered most suicide attempts are reported in the cities, viz 14 per 10 000 inhabitants.
For 1987 the largest number of reports is found in the centre and west of the country.

Table 28: number of reports of (attempted) suicide per province and urbanization group, per 10 000 inhabitants, 1979-1987

	province group				urbanization group			Nether-lands
	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	6	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
1986	8	5	7	6	5	4	15	7
1987	6	6	8	7	5	5	14	7

Age distribution

Table 29 gives the frequency of (attempted) suicide per 10 000 inhabitants per age group (see also Fig. 17).

Table 29: number of reports of (attempted) suicide by age group, per 10 000 inhabitants, 1979-1987

	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
1986	(4)	6	6	11	10	8	8	13
1987	-	6	14	9	10	8	8	5

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. The 20-24 age group and the over-65s have displayed fluctuations of this kind in recent years.

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[13].

This topic has been maintained on the weekly return for 1988.

NEW CEREBROVASCULAR ACCIDENT

The Dutch population is growing older. To an increasing extent health care will have to anticipate the health problems of the ageing population. This requires knowledge of the quantitative and qualitative aspects of the medical problems of elderly persons. And, as is the case with other topics, with respect to cerebrovascular accident too the important question is what, having regard to the nature and the course of this category and syndrome and the possibilities of treatment, a desirable division of tasks is between health care offered in the patient's home and the care that hospital and nursing home have to offer.

What an optimum course of behaviour in general practice is in the case of the occurrence of a cerebrovascular accident is one of the research objectives of the Medicine of General Practice research group of Groningen State University. As part of this investigation the Professor/Director of the above research group, Prof. Dr G.J. Bremer, requested the Counselling Committee of the Continuous Morbidity Registration Sentinel Stations the Netherlands to place cerebrovascular accident on the weekly return and at the same time to examine by means of supplementary questionnaires what happens further to patients with a new cerebrovascular accident.

The spotter physicians are asked to register each new occurrence of a cerebrovascular accident. They are also asked to report cases in which a patient who has formerly been afflicted by a cerebrovascular accident and has retained residual symptoms suffers a new cerebrovascular accident.

Now the term cerebrovascular accident comprises a number of syndromes that are difficult to distinguish in general practice. A distinction has therfore been opted for into only two forms which incidentally usually cannot be differentiated in the first contact with the patient: the transient ischaemic attack (T.I.A.) and the remaining cerebrovascular disorders. In the first contact with the patient both syndromes are registered on the weekly return under a common denominator. They are also discussed together in this reporting. A distinction is made by the sex of the patient. When a patient with a cerebrovascular accident is reported, the spotter physician is asked to complete a supplementary questionnaire. After one week, after eight weeks and after one year the spotter physicians again complete a questionnaire. These supplementary data are analysed. This supplementary research is rendered possible by the Netherlands Heart Foundation. Reporting on the supplementary data will take place separately from this reporting.

Table 30 gives the number of patients who were affected by a new cerebrovascular accident by province and urbanization group and the Netherlands (cf. Fig. 18).

Table 30: number of patients with a new cerebrovascular accident per province and urbanization group and for the Netherlands per 10 000 men and women for 1986-1987

		province group				urbanization group			Netherlands
		A	B	C	D	1	2	3	
1986	M	12	15	17	18	12	15	21	16
1987		16	15	17	14	17	13	23	16
1986	F	13	23	17	14	14	12	28	16
1987		7	20	19	13	13	13	25	16
1986	T	12	19	17	16	13	14	25	16
1987		11	17	18	14	15	13	24	16

The registration indicates that men and women are affected by a cerebrovascular accident to practically the same extent. This applies to the Netherlands and to most subgroups.
This holds good for the Netherlands and for most subgroups.

The subdivision by province group and degree of urbanization should be interpreted with the necessary caution. Per subgroup the number of spotter physicians is small.

Age distribution
Table 31 presents the numbers of patients with a new cerebrovascular accident by age group per 10 000 men and women from the age of 40 years (cf. Fig. 19).

Table 31: number of patients with a new cerebrovascular accident by age group, from 40 years per 10 000 men and per 10 000 women, for 1986-1987

		age group									
		40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	>85
1986	M	5	3	14	24	52	54	82	111	283	146
1987		5	3	20	19	17	39	125	123	265	241
1986	F	2	3	19	8	12	29	66	102	193	225
1987		5	0	14	15	12	48	86	89	163	212
1986	T	4	3	17	16	32	42	74	107	238	186
1987		5	1	12	17	15	44	103	102	198	221

As emerges from this registration, cerebrovascular accident is a disorder of the elderly. From the age of 50 onwards its frequency grows quickly to a maximum of 283 per 10 000 men in the 80-84 age group. Among women, in the age group 80-84 238 per 10 000 women are affected by a cerebrovascular accident: the highest frequency in any age group of women

Seasonal influences

No seasonal influences have been established as regards the occurrence of cerebrovascular accidents.

For 1988 this topic has been removed from the weekly return.

REFERRALS FOR PSYCHO-SOCIAL PROBLEMS

In the contribution by the Netherlands Institute for General Practice to the New Memorandum on Mental Public Health the author, L. Peters, concludes that "the general practitioner is not the only sole discipline that practically every Dutch person sees more or less regularly, he (or she) is also the one who accounts for the great majority of referrals from primary health care to mental health care"[14].

Despite the conclusion that the general practitioner accounts for the majority of the refferrals from primary health care to mental health care, the absolute number of these referrals is small. Of all referrals by a general practitioner to higher levels, not even 3% relate to a mental health facility.

In addition to the institution for mental health care, general social work is also an important agency for the referral of patients with psycho-social problems via the general practitioner. Finally, data make it clear that general practitioners are also major (direct) referrers to psychiatric hospitals and out-patient clinics and independently practising psychiatrists.

Though due research has been performed into the referral of people with psycho-social problems by the general practitioner, some qualitative aspects of this subject are still badly understood.

In order to answer two questions concerning the referral of people with psycho-social problems, relatively large numbers are required.

The questions concerned are:

- to what extent do general practitioners, if they refer people with psycho-social problems, differentiate between general social work and the various extramural facilities for mental health care, and
- to what extent do the various aspects of the distinction between "light" and "heavy" problems (inter alia the kind of problem, the degree of pressure on the patient, the prognosis) play a part in the differentiation in referrals?

The spotter physicians are requested to register all new referrals of those problems, complaints and/or disturbances in which psychological, psycho-social or psychiatric aspects are assigned such a part by the general practitioner and/or the patient that referrals to workers in mental health care, general social work, self-help group and the like are considered necessary by the general practitioner and/or patient.

Only a first referral to a specific institution or worker is registered, not a

repeat referral to the same worker or institution. A referral occurs if the general practitioner, whether or not at the initiative of the patient or another social worker, whether or not accompanied by a referral card or letter or after contact with the institution or social worker referrred to, "advises" the patient in a face-to-face or telephonic contact to get in touch with a given institution or social worker.
Registration does not apply to referrals to somatic specialists for psycho-social reasons, referrals for psysiotherapy and referrals to a clinic for alcohol and drugs abuse or an addiction clinic.
This report is confined to the frequencies of the referrals. Drs L. Peters will report on the results of the investigation into the qualitative aspects of the referrals elsewhere.

For a comparison with other registrations it should be realized that registration has taken place here when it has been decided in a consultation with the general practitioner that the patient is to be referred. It has not been registered whether this referral has in fact occurred, i.e. whether the patient has actually contacted the institution or worker to whom reference was made.

Table 32 presents the new referrals of patients with psycho-social problems by province and urbanization group and for the Netherlands per 10 000 men and 10 000 women (cf. Fig. 20).

Table 32: number of new referrals for psycho-social problems by province and urbanization group and for the Netherlands per 10 000 men and 10 000 women, for 1986-1987

	province group				urbanization group			Nether-lands
	A	B	C	D	1	2	3	
1986 M	40	33	53	37	23	35	80	44
1987	32	26	53	39	22	37	68	42
1986 F	74	56	82	60	41	57	129	71
1987	57	44	76	77	31	62	109	68
1986 T	57	44	68	48	32	46	105	58
1987	45	35	65	59	26	50	89	56

Women are in both years more often referred for psycho-social problems than men: 71 and 68 per 10 000 women against 44 and 42 per 10 000 men.
The differences are less between the various province groups than the differences between the municipalities with a varying degree of urbanzation. The highest frequency of referrals for psycho-social problems is found in the western provinces (approx 65 per 10 000 inhabitants). The number of referrals is the lowest in the provinces (approx 40 per 10 000 inhabitants).

In the cities referrals for psycho-social problems occurs more than three times as much as in the rural municipalities: 89 and 26 per 10 000 inhabitants respectively. The number of referrals in the cities is also more than twice as many as the number in the municipalities with urban characteristics and the urbanized rural municipalities (89 against 50 per 10 000 inhabitants).
Obvious differrences are also found between the quarters. Table 33 shows the quarterly figures for the referrals for psycho-social problems.

Table 33: number of referrals for psycho-social problems per quarter per 10 000 inhabitants for the Netherlands, for 1986-1987

	1st quarter	2nd quarter	3rd quarter	4th quarter
1986 M	14	9	9	12
1987	15	11	5	11
1986 F	20	14	15	22
1987	23	14	14	17
1986 T	17	12	12	17
1987	20	12	10	14

(As a result of rounding-off when calculating relative frequencies, small differences may have occurred in the total.)

In the first and fourth quarter of the year there were more referrals for psycho-social problems than in the second and third quarter: 20 and 14 against 12 and 10 respectively per 10 000 inhabitants.
In the autumn and winter more referrals for psycho-social problems occur than in the spring and summer.

Age distribution

The distribution of the referrals for psycho-social problems by age is shown in Table 34 (cf. Fig. 21).

Table 34: number of referrals for psycho-social problems by age group per 10 000 men and women, for 1986-1987

	age group										
	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	>65
1986 M	(29)	(10)	20	15	31	48	63	76	47	22	42
1987	-	13	15	11	16	57	66	68	64	26	15
1986 F	-	(10)	(10)	11	72	86	120	120	81	60	39
1987	-	-	8	15	27	106	106	130	74	49	33
1986 T	-	10	15	13	51	67	92	98	64	41	40
1987	-	7	11	13	22	82	86	99	68	38	24

Under the age of 15 there are relatively few referrals for psycho-social problems. Up to the age of 5 the numbers are very small in absolute terms. For women the peak in the referrals lies in the 25-54 age group with approx 120 per 10 000 women. Under the age of 20 and after the age of 54 the number of referrals is considerably lower: 27 and 49 respectively per 10 000 women. For men a peak lies in the referrals in the 35-44 age group: 68 referrals per 10 000 men. If such a thing as a midlife crisis exists, this is already being anticipated in the 25-34 age group (66 referrals per 10 000 men). Below the age of 15 the number of referrals is in general higher for boys than for girls. In 1987 the 10-14 age group forms an exception. However, it has already been mentioned above that below the age of 15 small numbers are concerned in absolute terms.

For 1988 this topic has been removed from the weekly return.

DEMENTIA

In the Memorandum 2000 from the Ministry of Welfare, Public Health and Culture there are no data on the occurrence of dementia. Insight into the incidence of mild and more advanced stages of dementia outside the intramural sector is deficient. It is not known what care is required of general practitioners for people who are regarded as dementia sufferers.

It has been decided to place the subject on the weekly return and to try in the course of a number of years to collect data on dementia patients in general practice.

In 1987 the subject appeared for the first time on the weekly return. It was requested that the first contact be registered in 1987 with a patient or concerning a patient regarding whom the general practitioner is of the opinion that this patient is suffering from incipient or evident dementia.

A definition of dementia has not been attempted; in the explanatory notes pertaining to the weekly return a broad description of dementia is given: "Characteristics of dementia, in addition to forgetfulness, are problems with orientation and with judgment. As a general denominator it is sometimes stated that a general mental slowing-down occurs and in demented behaviour the compensatory mechanisms for handling the difficulties caused by the general mental slowing-down fail. Specific disturbances of function of certain areas of the brain, such as apraxia and aphasia, may occur".

In Table 35 the results of this registration of first contacts in 1987 with patients suspected of suffering from dementia are stated per province and urbanization group and for the Netherlands.

Table 35: number of first contacts in 1987 with or concerning a patient regarded as suffering from dementia per province and urbanization group and for the Netherlands per 10 000 men and 10 000 women

		province group				urbanization group			Netherlands
		A	B	C	D	1	2	3	
1987	M	12	13	19	10	17	12	20	15
	F	16	15	37	27	14	27	39	28
	T	14	14	28	18	15	20	30	21

The number of female patients is nearly double the number of male ones, 28 per 10 000 women and 15 per 10 000 men respectively.

Only in the rural municipalities are more male than female patients with dementia reported by the general practitioner. In the rural municipalities half of the number of patients are reported that are registered by general practitioners in the cities.

As regards the province group, the western provinces display a clearly larger number of reports.

From the nature of the definition of the topic, the first contact in 1987 with or concerning a patient regarded as suffering from dementia, it is to be expected that the quarterly figures display a trend in the number of reports. The figures for the last two quarters give some indications of the incidence of dementia or incipient dementia.

Table 36: number of first contacts in 1987 with or concerning a patient regarded as suffering from dementia per quarter per 10 000 men and 10 000 women*)

		1st quarter	2nd quarter	3rd quarter	4th quarter
1987	M	8	3	2	2
	F	14	5	5	4
	T	11	4	4	3

*) As a result of rounding-off when calculating relative frequencies, small differences may have occurred in the totals.

Age distribution

Table 37 gives the frequencies of the first contacts in 1987 with or concerning a patient regarded as suffering from dementia by age group.

Table 37: numbers of first contacts in 1987 with or concerning a patient regarded as suffering from dementia by age group per 10 000 men and per 10 000 women

		Age group						
		<60	60-64	65-69	70-74	75-79	80-84	>85
1987	M	0	(10)	30	45	197	377	526
	F	(1)	(3)	22	90	220	445	554
	T	(1)	(7)	26	71	211	421	545

In the age groups below 25 years there have been no reports. From that age to the age of 60 there are a few reports.

The disorder occurs in essence from the age of 60; the first contacts in 1987 with or concerning a patient regarded as suffering from dementia increase strongly from the age of 75.

The topic has been maintained on the weekly return in a somewhat modified form in 1988.

PRESCRIPTION OF FLUNITRAZEPAM (Rohypnol)

The Chief Medical Office of Health is constantly concerned about the prescribing of psychotropic substances by physicians. This concern relates to the improper use of such agents, that is to say the use for non-medical purposes, often in combination with alcohol and/or other psychotropic substances. The possible side effects of these agents are also a source of concern.
Some of the possible problems are:

- drowsiness in traffic and when operating machinery;
- intoxication, with as possible consequences coma or death;
- physical aggressive behaviour as a result of alcohol-induced agitation;
- criminal conduct of which one can recall little or nothing after the event.

In the course of 1986 reports reached the Chief Medical Office of an increase in the improper use of this time the agent flunitrazepam.

Since there was no insight into the way in which this agent came "on to the market", and officially it is available only on prescription, the Chief Medical Office requested the Counselling Committee of the Continuous Morbidity Registration Sentinel Stations to devote attention to the prescription of flunitrazepam.

The spotter physicians were asked to record when they write a prescription for flunitrazepam for a patient from their own practice. This concerns the prescribing of both 1 mg and 2 mg tablets.

Table 38 gives the number of prescriptions for flunitrazepam per 10 000 men and per 10 000 women per province and urbanization group and for the Netherlands (see also Fig. 22).

Table 38: number of prescriptions of flunitrazepam per province and urbanization group and the Netherlands per 10 000 men and per 10 000 women in 1987

		province group				urbanization group			Nether-lands
		A	B	C	D	1	2	3	
1987	M	64	26	47	36	20	48	49	43
	F	183	116	78	73	38	121	81	99
	T	124	71	63	55	29	86	66	72

Women get over twice the number of prescriptions of flunitrazepam that men do.

The number of prescriptions in the northern provinces is remarkably high compared with the other province groups. The same applies to urbanization group 2. The data per sentinel station show that in nine sentinel stations the agent was not prescribed at all in 1987. In one sentinel station a prescription of flunitrazepam has been reported more than 100 times. This one sentinel station is situated in one of the northern provinces in a municipality in urbanization group 2.

It is being investigated how the number of prescriptions of flunitrazepam has developed per quarter. Both the registration and the negative publicity on this agent are expected to influence prescribing behaviour.

In Table 39 the number of prescriptions of flunitrazepam per quarter for the Netherlands is given (see also Fig. 23).

Table 39: number of prescriptions of flunitrazepam per quarter per 10 000 men and per 10 000 women for the Netherlands for 1987

		1st quarter	2nd quarter	3rd quarter	4th quarter
1987	M	15	11	10	9
	F	31	25	23	19
	T	23	18	17	14

(As a result of rounding-off when calculating relative frequencies, small differences may have occurred in the totals.)

It is established that the registration displays a gradual decline from the beginning of the registration of the number of prescriptions of flunitrazepam. As was expected, this can be the consequence of both the negative publicity on the agent and the registration itself (Hawthorne effect).

Age distribution

Table 40 gives the age distribution of the men and women who in 1987 received a prescription for flunitrazepam (see also Fig. 24).

Table 40: number of prescriptions for flunitrazepam per age group per 10 000 men and per 10 000 women

		age group						
		<19	20-24	25-34	35-44	45-54	55-64	>65
1987	M	-	15	34	14	85	95	178
	F	-	8	28	85	134	195	346
	T	-	12	31	50	109	148	278

These figures speak for themselves: a number of prescriptions for the agent in question sharply increasing with age. For women the increase in the number of prescriptions begins at a younger age than with men.

The topic is maintained on the weekly return in 1988.

PREGNANCY DESPITE CONTRACEPTION REGARDED AS ADEQUATE

In the Netherlands there is a large degree of acceptance and use of methods of contraception regarded as adequate.

The 1982 Family Planning Survey of the Central Bureau of Statistics shows that in that year 38% of the women in the 18-37 age group used the pill or contraceptive injection, 8% an IUD, in 13% of the relations either the man or the woman was sterilized, in 6% a condom was used and in 2% another method of contraception, such as the pessary, the rhythm method or coitus interruptus.

In the age group in question 4% of the women were pregnant, 4% proved infertile and 24% used no contraception[15]. The latter is in most cases because one wants to have a child or because one has no sexual relation.

In opting for a method of contraception one of the criteria is the degree of reliability. The reliability of the method used is one aspect of this and the correct use of the method another. When contraception fails it is often not clear beforehand where the cause lies. Research into the causes of the failure of contraception and into pregnancy as a result of this takes place regularly[16].

However, this research was often performed among women who had approached one of the abortion clinics participating in the Permanent Abortion Registration by Stimezo Nederland for the termination of an undesired pregnancy.

This group of women is of course not representative of those women who become pregnant as a result of the failure of contraception. For a number of women will decide to accept the pregnancy and have the child.

Consultation with Dr E. Ketting, at the time researcher for Stimezo Nederland and now working with the National Centre for Mental Health, and Dr M.R. Santen, a Utrecht gynaecologist, led to the decision to place the topic failing contraception on the weekly return.

The spotter physicians were asked to register when a woman was found

to be pregnant despite adequate measures to avoid pregnancy.

By means of a supplementary questionnaire the spotter physician registers the length of pregnancy, the woman's situation, the method of contraception used, the possible cause of failure and, as far as known, the course of the pregnancy (spontaneous abortion, abortus provocatus, intention to allow the pregnancy to go to term).

In Table 41 the numbers of women with a pregnancy despite adequate contraception are given per province and urbanization group per 10 000 women and for the Netherlands.

Table 41: number of women with a pregnancy despite contraception regarded as adequate per province and urbanization group per 10 000 women of 10-49 years and for the Netherlands in 1987

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
1987	9	14	13	1	10	5	21	10

Caution should be observed in the use of these data. In the absolute sense the event occurs infrequently and not regularly.
The figures create the impression that the failure of contraception regarded as adequate occurs more in the east, centre and west of the country and in the cities.

Age distribution
Table 42 gives the occurrence of pregnancy despite adequate contraception per age group per 10 000 women in 1987.

Table 42: number of pregnancies despite contraception regarded as adequate per age group per 10 000 women in 1987

	age group					
	15-19	20-24	25-29	30-34	35-39	40-44
1987	2	26	16	17	11	7

In this registration in 1987 no pregnancies despite contraception regarded as adequate occurred below the age of 15 years and above the age of 44 years. Of the 45 pregnancies reported, 13 went to term, three spontaneous abortions occurred and in one case a partus at 25 weeks. The other pregnancies (28) were or will be terminated.

Of the unmarried women, 19 out of 26 had or are having the pregnancy terminated; in three of these women a spontaneous pregnancy occurred. One pregnancy ended after nearly 26 weeks. Three pregnancies went to term.

Of the 19 pregnancies that despite contraception came about in a married relationship the number of pregnancies that was terminated was nine. Ten pregnancies among married women went to term.

These data are the first ever collected in the Netherlands to give an impression of whether abortion is opted for or not in an unplanned pregnancy after use of contraception regarded as adequate. Regarded as adequate by the woman or the couple.

These first data show that some two thirds of the women in that case opt for abortion. Among unmarried women this seems to be still more the first option than among married women.

In 1988 this topic is maintained on 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 occurrences 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 tables, that although the population of the sentinel stations is a reasonably good representation (see also p. 14-15) 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 for which 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 there 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 registration 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 year is given, in thousands.

Dutch population by sex in thousands, 1970-1987 (Central Bureau of Statistics)*

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
1986	7 184	7 345	14 529
1987	7 224	7 391	14 615

* 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

	frequency*			Netherlands**		
category	year	M	F	total	M	F	total***
influenza	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
	1986			630			915 000
	1987			365			533 000
cervical smear	1976		87			60 000	
-with com-	1977		86			60 000	
plaints and/	1978		80			56 000	
or symptoms	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	
	1986		65			48 000	
	1987		59			43 500	

* for footnotes see page 81

Extrapolation of frequencies found to the Dutch population (continuation)

	frequency*			Netherlands**		
category	year	M	F	total	M	F	total***
-"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	
	1986		230			169 000	
	1987		192			142 000	
-"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	
	1986		168			124 000	
	1987		153			113 000	

* for footnotes see page 81

Extrapolation of frequencies found to the Dutch population (continuation)

	frequency*			Netherlands**		
category	year	M	F	total	M	F	total***
-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	
	1986		170			125 000	
	1987		211			156 000	
cervical smear total	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	
	1986		633			465 000	
	1987		615			455 000	

* for footnotes see page 81

Extrapolation of frequencies found to the Dutch population (continuation)

	frequency*			Netherlands**		
category	year	M	F	total	M	F	total***
sterilization	1972	24			16 000		
	1973	40			27 000		
	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
	1986	45	29		32 500	21 500	54 000
	1987	45	28		32 500	20 500	53 000
cumulative					576 500	494 000	

* for footnotes see page 81

Extrapolation of frequencies found to the Dutch population (continuation)

	frequency*				Netherlands**		
category	year	M	F	total	M	F	total***
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	
	1986		37			27 000	
	1987		35			26 000	
Dog bites	1986	31	22	26	22 500	16 000	38 500
	1987	28	18	23	20 000	13 500	33 500
(attempted) suicide****	1979			7			
	1980			7			
	1981			6			
	1982			8			
	1983			10			
	1984			7			
	1985			6			
	1986			7			
	1987			7			
cerebrovas-cular accident	1986	16	16	16	11 500	12 000	23 500
	1987	16	16	16	11 500	12 000	23 500

* for footnotes see page 81

Extrapolation of frequencies found to the Dutch population (continuation)

	frequency*			Netherlands**		
category	year	M	F	total	M	F	total***
referrals for psychosocial problems	1986	44	71	58	32 000	52 000	84 000
	1987	39	65	52	28 000	48 000	76 000
pregnancy despite adequate contraception****	1987		7				

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

** Extrapolation of the frequencies to the Dutch population (of the year in question), in round thousands.

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

**** 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 1987 are reported. These 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 and, if so, what the motive was for this. In addition, information is sought on the age, sex disease, place of care or nursing and the use or otherwise of a 'euthanasia declaration'[17].
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 1987 was 36. The number of patients with a malignancy, as in the past years, was large again, relatively speaking: 72% of them have a usually metastasized carcinoma.

Of the 36 patients, 31 were living at home; four were in a nursing 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: 31 patients. In the case of 10 requests use was made of a written declaration.

The distribution by province group and urbanization group is given in Table 43.

Table 43: 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, 1976-1987

absolute	M	F	province group				urbanization group			Netherlands
			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
1986	14	14	3	5	16	4	3	15	10	28
1987	19	17	1	8	22	5	3	17	16	36

Age distribution

The age distribution may be found in Table 44.

Table 44: absolute number of patients who request the general practitioner to apply active euthanasia, by age group 1976-1987

	<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
1986	7	3	12	3	3	28
1987	6	9	8	9	4	36

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.

Requests by the patient for active euthanasia

age	sex	disease	motive for the request
94	M	operation for appendicitis, discharged on account of homesickness	no pain, above all depressive, negative
88	F	amputation of right leg	no future prospects
87	M	emphysema, metastasized carcinoma of the prostate	
86	F	carcinoma of the pancreas head	pain, ascites, humiliation through illness

Request by the patient for active euthanasia (continuation)

age	sex	disease	motive for the request
84	M	chronic non-specific lung disease, depressions, alcoholic	no interest left in life
83	F	diabetes mellitus	confined to wheel-chair, left leg amputated, and now other leg (gangrenous)
83	F	carcinoma of the mamma with herpes zoster	pain, depressive, fear of decay
82	M	hypernephroma	fear of pain
77	M	amyotrophic lateral sclerosis	dyspnoea and pain
77	M	metastasized carcinoma of the the lung	pointlessness of living any longer
77	F	metastasized carcinoma of the colon	not able to bear lengthy illness
76	F	adenocarcinoma of the left lung	pain
75	M	terminal stage of multiple sclerosis	threatening death by suffocation
73	M	pulmonary tumour	suffering
72	M	carcinoma of the urothelium	pain, exhaustion
72	F	metastasized carcinoma of the ovary	
70	M	carcinoma of the bronchus	pain, dyspnoea
70	F	carcinoma of the oesophagus	disturbed swallowing, pain
69	F	metastasized carcinoma of the mamma	hopelessness
68	F	pleurisy	threatening death by suffocation
65	M	carcinoma	unbearable pain, personal suffering
64	M	carcinoma of the lung	pain

Request by the patient for active authanasia (continuation)

age	sex	disease	motive for the request
64	M	carcinoma of the stomach and metastases	vomiting
62	M	carcinoma of the stomach	hopelessness, pain
61	M	carcinoma	unbearable suffering
61	M	final stage of cor pulmonale	extreme dyspnoea
61	M	pulmonary tumour	fear of dyspnoea
60	F	metastasized carcinoma of the rectum	pain, constant illness, lacklustre
59	F	carcinoma of the ovary	hopeless suffering
56	F	proliferating carcinoma of the endometrium	pain
54	F	chronic pain	pain
52	F	metastasized carcinoma of the mamma	pain, suffering, cannot keep it up
42	F	carcinoma	fear of the circumstances before and during dying
37	F	multiple sclerosis	request for the future, in the event of further disablement
35	M	AIDS	hopeless situation, threat of dementia
30	M	metastasized carcinoma of the pancreas head	strongly lacklustre as result of illness

This investigation will be reported for 1988.

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 practi-

ces. 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 both that anorexia is increasing and also that this increase is only the result of greater familiarity with and better diagnosis of the syndrome[18].
Since the general practitioner is envisaged as playing a crucial role in diagnosis of the eating disorders and since above all early diagnosis of these disorders is considered of importance to the 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 1987, and was the patient referred on account of the eating disorder to another source of assistance? A number of data concerning physical aspects of the illness were also sought.
56 patients were registered. Table 45 gives the distribution of these patients.

Table 45: absolute number of patients with respect to whom the general practitioner has diagnosed an eating disorder, by age and sex in 1985-1987

		10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	>60
1985	M	2	1	-	2	-	-	-	-	-	-	-
1986		1	1	-	-	1	-	-	-	-	-	-
1987		-	2	1	1	-	-	-	-	-	-	-
1985	F	3	11	11	17	5	8	4	4	-	2	2
1986		1	8	18	8	4	5	1	-	2	1	2
1987		-	9	8	14	5	7	3	-	1	2	2

Eating disorders occur above all at the age of 15 to 40 years. In the case of 20 patients the eating disorder was diagnosed in 1987; in the case of 36 patients the disorder already existed before 1987. 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 46.

Table 46: absolute number of patients with respect to whom the general practitioner has diagnosed an eating disorder, per province and urbanization group, in 1985-1987 and per 10 000 inhabitants

		province group				urbanization group			Nether-lands
		A	B	C	D	1	2	3	
absolute	1985	8	15	33	16	9	36	27	72
	1986	4	5	39	5	5	27	21	53
	1987	8	9	30	9	6	30	30	56
per 10 000	1985	4	5	4	5	4	4	7	4
	1986	2	2	7	2	2	3	7	4
	1987	4	4	5	3	3	4	6	4

Since the eating disorders occur mainly among women, the frequencies per 10 000 inhabitants stated in Table 46 can be doubled to obtain the incidence per 10 000 women. To judge by this registration, the frequency of occurrence of eating disorders is somewhat higher in the cities than in the other urbanization groups. As regards the incidence per province group, in all years there is a clearly higher frequency in the western provinces.

The investigation will be repeated for 1988.

GENERAL REMARKS

a. Influenza (-like illness)
b. Cervical smear
c. Admission of psychiatric patient
d. Discharged psychiatric patient
e. Sterilization of the man performed
f. Sterilization of the woman performed
g. Morning-after pill prescribed
h. Burns
i. (Attempted) suicide
j. Acute unusual headache
k. Echography requested
l. Dementia
m. Prescription of Rohypnol
n. Pregnancy despite contraception
o. Out-patient or clinical mammography
p. Concern about AIDS

2. The incidental investigations for 1988 relate to the subjects euthanasia, anorexia nervosa and bulimia and incest.

3. Suggestions relating to the questions on the weekly returns will be gladby received by the Counselling Committee.

4. Data from this report may be reproduced with acknowledgment of the source.

Aad I.M. Bartelds, General practitioner/project leader.

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

1e survey as per 1 January 1987

COLLETTE, H.J.A. The Sentinel Practices System in the Netherlands. In Environmental Epidemiology, Paul E. Leaverton (ed), New York. Preager Special Studies, 1982

COLLETTE, H.J.A., H. BIJKERK. Vijftien jaar Peilstations Nederland, 1970-1984 Huisarts en Wetenschap; no. 6, p.270-210

DIEKSTRA, R.F.W., A.C. DE GRAAF, M. VAN EGMOND. Over de epidemiologie van suïcidepogingen: een sample-survey onderzoek in huisartspraktijken. Tijdschrift voor Sociale Geneeskunde; 60, 1982, no. 15, p.398-404

DIEKSTRA, R.F.W., A.C. DE GRAAF, M. VAN EGMOND. On the epidemiology of attempted suicide: a sample survey study among general practitioners. Crises; 5, 1984 no. 24, p.108-118

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EGMOND, M. VAN, R.F.W. DIEKSTRA, A.C. DE GRAAF. Suïcidepogingen onder patiënten in de huisartspraktijk 1979-1984. Tijdschrift voor Sociale Gezondheidszorg 64, 1986, no 24, p.777-783

Epidemiologie van Suïcidepogingen: de naald in de hooiberg. Tijdschrift voor Sociale Geneeskunde; 60, 1982, no 19, p.549-550

INKLAAR, H. Sportletsels in de huisartspraktijk. Huisarts en Wetenschap; 1986, no 9, p.265-268

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KETTING, E. Contraception and Fertility in the Netherlands. International Family Planning Perspectives. Vol 8, no. 4, 1982

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OLTHOF, G. Continue Morbiditeits Registratie Peilstations Nederland 1984. Huisarts en Wetenschap; 1986 (29), p.190-193

SANTEN, M.R. VAN, M.M. HASPELS. Interception 11: Post coital low dose estrogens and norgestrel combination in 633 women. Contraception. March 1985. Vol 31, no 3

SANTEN, M.R. VAN, A.A. HASPELS. A comparison of high dose estrogens in post-coital interception: a study in 493 women. Fertility and Sterility. Vol 43, no 2, 1985

SPIEKSMA, Fr.Th.M., A. VAN DER ASSEM, H.J.A. COLLETTE. Airborne Pollen Concentration in Leiden, The Netherlands, 1977-1981. II Poaceae (grasses), variations and relation to hay fever, Grana 24, 1985, p.99-108

STROOM-KRUYSWIJK, J.H. VAN DER. Residuen van Penicilline G in melk, dissertatie, Utrecht 1985, p.56-58

THIEN, W.M.A.H., W.H.J. Rogmans, Naar een betere registratie van ongevallen in de privésfeer. Medisch Contact; 38, 1983, no. 36, p.1126-1129

Appendix 1

Continuous Morbidity Registration, Sentinel Stations Participating General Practitioners in 1987

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/P.P.A. Kemps (group practice)	Swifterbant	Flevoland
E.J. van Apeldoorn	Heerde	Gelderland
Dr S. Rijpma*)	Laren	Gelderland
J.H. de Boer/Dr J. van Noort (group practice)	Zelhem	Gelderland
B.G.W.M. Arts	Nijmegen	Gelderland
M.A.J. Janssen	Nijmegen	Gelderland
Ms. I.K.I. de Jongh-Killian/ 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. Neijs*)	Broek in Waterland	Noord-Holland
D.E. Kuenen	Haarlem	Noord-Holland
Ms. Y.E.V. van Hazel	Amsterdam	Noord-Holland
Ms. A.J. Arbouw/H.O. Sigling/ E. Reijnders (group practice)	Amstelveen	Noord-Holland

Appendix 1 (continuation)

Participating General Practitioners in 1987

Name:	Residence:	Province:
J.Th. Koop	Amstelveen	Noord-Holland
A.I.M. Bartelds	Huizen	Noord-Holland
J. Hoornweg/E. Hoornweg-Sleeboom (group practice)	Voorhout	Zuid-Holland
Dr A.P. Oliemans	The Hague	Zuid-Holland
R. Kanters	The Hague	Zuid-Holland
J.C.B.M. Rensing	The Hague	Zuid-Holland
Dr B.J.M. Aulbers/J.E.G. Nieuwkamer (group practice)	Delft	Zuid-Holland
D. Pasman/M. Draaisma (group practice)	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 der Reepe (group practice)	Etten	Noord-Brabant
A.M.H.J.G. Sluyters/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-Branant
S.P.F. van Rijn	Eindhoven	Noord-Brabant
R.A.M. de Jong	Maastricht	Limburg

*) With dispensary

Weekstaat t.b.v. centrale registratie

CONTINUE MORBIDITEITSREGISTRATIE, PEILSTATIONS, 1987

Proj. no.	Regel no.	Verslagjaar	Week no.	Code peilstat.	Rapport dagen
4 0 0		8 7		1201 *	
1-3	4-5	6-7	8-9	10-13	14

Regel no.	Leeftijdsgroep	Influenza (-achtig ziektebeeld[2])	Cervixuitstrijkje						Ontslagen psychiatrische patiënt[6]	Sterilisatie verricht[7]		Morning-after pil voorgeschreven[8]	Hondebeten[9]		Suïcide(poging)[10]	Cerebrovasculair accident[11] (nieuw)		Verwijzing psychosociale problematiek[12]		Dementie		Voorschrijven rohypnol		Zwangerschap (ondanks a.c.)[13]	Leeftijdsgroep	Regel no.	
			Na 1-1-1985 voor eerste maal afgenomen op grond van[5]			Herhalingsonderzoek																				
			Klachten/symptomen	Louter preventieve overwegingen: Initiatief huisarts[4]	Louter preventieve overwegingen: Verzoek v.d. vrouw	Klachten/symptomen[3]	Louter preventieve overwegingen: Initiatief huisarts[4]	Louter preventieve overwegingen: Verzoek v.d. vrouw																		
		M+V	V	V	V	V	V	V	M+V	M	V	V	M	V	M+V	M	V	M	V	M	V	M	V	V			
01	< 1																								< 1	01	
02	1-4																								1-4	02	
03	5-9																								5-9	03	
04	10-14																								10-14	04	
05	15-19																								15-19	05	
06	20-24																								20-24	06	
07	25-29																								25-29	07	
08	30-34																								30-34	08	
09	35-39																								35-39	09	
10	40-44																								40-44	10	
11	45-49																								45-49	11	
12	50-54																								50-54	12	
13	55-59																								55-59	13	
14	60-64																								60-64	14	
15	65-69																								65-69	15	
16	70-74																								70-74	16	
17	75-79																								75-79	17	
18	80-84																								80-84	18	
19	≥ 85																								≥ 85	19	
4-5		15-17	18-20	21-23	24-26	27-29	30-32	33-35	36-38	39-41	42-44	45-47	48-50	51-53	54-56	57-59	60-62	63-65	66-68	69-71	72-74	75-77	78-80	81-83			99-101

Weeknummer : _____

Opgemaakt d.d.: _____

Aantal dagen gerapporteerd (zie voetnoot 1) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Zie ommezijde voor voetnoten

Appendix 3a

Subjects on the weekly returns in alphabetical order 1970-1988

subjects	
abortion (spontaneous)	1982-1983
abortion (request)	1970-1975
abortus provocatus	1971-1979
accidents	1971
accidents in the private sector	1981-1983
acute unusual headache	1988
admission of psychiatric patient	1988
aids	1988
alcoholism	1975
anti-hypertensivum or diuretic (prescription)	1976
battered child syndrome (suspicion of)	1973-1974
bites by pets	1986-1987
burns	1988
cervical smear	1976-1988
cerebrovascular accident	1986-1987
dementia	1987-1988
depression	1983-1985
diabetes mellitus	1980-1983
diarrhoea e causa ignota (acute)	1970
discharged psychiatric patient	1986-1988
dog bites	1988
drug-use (consultation)	1972-1973 and 1979-1981
dwelling (certificate for another)	1975
echography requested	1988
exanthema e causa ignota	1970
family planning (consultations)	1970-1976
hay fever	1978-1982
influenza (-like illness)	1970-1988
malignancies	1984-1986
measles	1975-1979
mononucleosis infectiosa	1977-1979

Subjects on the weekly returns in alphabetical order 1970-1988 (continuation)

subjects	
morning-after pill (prescription)	1972-1988
musculo-skeletal system (trauma of)	1984
myocardial infarction (suspicion of)	1978 and 1983-1985
otitis media acuta	1971 and 1986
out-patient or clinical mammography	1988
Parkinson's disease	1980-1985
partus immaturus	1982-1983
partus at gravidity >28 weeks	1982-1983
penicillin (prescription and side effects)	1982-1983
pregnancy (despite contraception)	1987-1988
prescription of Rohypnol	1987-1988
psoriasis	1976-1977
referrals	1984
referrals for physiotherapy	1985
referrals for psycho-social problems	1986-1988
rubella (-like illness)	1971
skull traumas in traffic	1975-1977
smoking (consultation with regard to addiction)	1974
sport traumas	1979-1983
sterilization of the man performed	1972-1988
sterilization of the woman performed	1974-1988
suicide (attempted)	1970-1972 and 1979-1988
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, 1977-1988 (alphabetical)

subjects	
alternative forms of treatment (registration feasible?)	1980
anorexia nervosa and boulimia	1985-1988
euthanasia (request application)	1977-1988
incest	1988
malignancies	1982-1983
mastitis puerperalis	1982
multiple sclerosis	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 1987 (C.B.S.)

age	men	women	total*
0- 4	449	431	880
5- 9	456	436	892
10-14	498	476	974
15-19	625	598	1 223
20-24	650	624	1 274
25-29	630	608	1 238
30-34	594	571	1 165
35-39	604	573	1 177
40-44	525	494	1 019
45-49	423	402	825
50-54	379	373	752
55-59	352	367	719
60-64	317	357	674
65-69	258	314	572
70-74	201	276	477
75-79	137	225	362
80-84	79	155	234
>85	47	111	158
total	7 224	7 391	14 615

* As a results of rounding-off, small differences may have occurred in the totals.

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD

ALLE PEILSTATIONS

JAAR: 1987 WEEK: 01 T/M 53

LEEFTIJDS-GROEP	POPULATIE			INFLU-ENZA	CERVIXUITSTRIJKJE					
				INFLUENZA	1-1-'85 1E MAAL WEGENS	1-1-'85 1E MAAL PREV.HUI	1-1-'85 1E MAAL PREV.VR.	HERHAL. WEGENS I.	HERHAL. PREV.HUI	HERHAL. PREV.VR.
	M	V	T	B	V	V	V	V	V	V
< 1 JR	351	335	686	1451	0	0	0	0	0	0
1-4 JR	3153	3011	6164	641	0	0	0	0	0	0
5-9 JR	4056	3912	7968	448	0	0	0	0	0	0
10-14 JR	4669	4609	9278	275	0	0	0	0	0	0
15-19 JR	5689	5498	11187	305	13	26	18	2	6	0
20-24 JR	5931	6065	11996	334	63	196	64	28	31	20
25-29 JR	5866	5755	11621	387	90	478	221	89	150	71
30-34 JR	5259	5342	10601	416	99	489	315	97	182	118
35-39 JR	5449	5436	10885	365	120	359	410	151	160	204
40-44 JR	4309	4222	8531	338	128	431	452	168	168	204
45-49 JR	3640	3651	7291	311	132	280	274	162	112	184
50-54 JR	3481	3449	6930	306	87	250	244	168	197	142
55-59 JR	3143	3412	6555	319	62	100	149	59	82	82
60-64 JR	2932	3242	6174	264	40	40	80	37	6	22
65-69 JR	2304	2702	5006	260	15	15	33	7	19	37
70-74 JR	1769	2323	4092	298	26	9	0	4	9	0
75-79 JR	1218	1915	3133	278	5	0	5	0	0	0
80-84 JR	714	1348	2062	373	7	0	0	0	0	0
>=85 JR	460	992	1452	283	0	0	0	0	0	0
TOTAAL	64393	67219	131612	357	59	192	153	64	76	71

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD

ALLE PEILSTATIONS

JAAR: 1987 WEEK: 01 T/M 53

LEEFTIJDS-GROEP	POPULATIE			ONTSL.PSSTERILISATIE Y.PT.				M.A.PIL HONDEBETEN				SUICIDE (POGING)
	M	V	T	B	M	V	T	V	M	V	T	M+V
< 1 JR	351	335	686	0	0	0	0	0	0	0	0	0
1-4 JR	3153	3011	6164	0	0	0	0	0	29	27	28	0
5-9 JR	4056	3912	7968	0	0	0	0	0	25	13	19	0
10-14 JR	4669	4609	9278	1	0	0	0	4	36	26	31	0
15-19 JR	5689	5498	11187	5	0	0	0	126	33	26	30	6
20-24 JR	5931	6065	11996	12	2	7	4	112	32	20	26	14
25-29 JR	5866	5755	11621	10	32	28	30	64	44	9	27	6
30-34 JR	5259	5342	10601	17	139	97	118	43	29	24	26	12
35-39 JR	5449	5436	10885	18	219	118	168	33	20	4	12	8
40-44 JR	4309	4222	8531	14	111	90	101	19	14	28	21	11
45-49 JR	3640	3651	7291	8	66	33	49	22	28	25	26	7
50-54 JR	3481	3449	6930	9	3	3	3	6	29	23	26	9
55-59 JR	3143	3412	6555	9	6	0	3	0	25	23	24	5
60-64 JR	2932	3242	6174	13	0	0	0	0	38	12	24	11
65-69 JR	2304	2702	5006	6	0	0	0	0	17	0	8	8
70-74 JR	1769	2323	4092	7	0	0	0	0	23	9	15	2
75-79 JR	1218	1915	3133	3	0	0	0	0	16	21	19	10
80-84 JR	714	1348	2062	15	0	0	0	0	14	0	5	5
>=85 JR	460	992	1452	0	0	0	0	0	0	0	0	0
TOTAAL	64393	67219	131612	9	45	28	36	35	28	18	23	7

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 3

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD 30-08-88

ALLE PEILSTATIONS JAAR: 1987 WEEK: 01 T/M 53

LEEFTIJDS-GROEP	POPULATIE			CVA (NIEUW)			VERWIJZING P.S.P.			DEMENTIE		
				CVA (NIEUW)			VERWIJZING P.S.P.			DEMENTIE		
	M	V	T	M	V	T	M	V	T	M	V	T
< 1 JR	351	335	686	0	0	0	0	0	0	0	0	0
1-4 JR	3153	3011	6164	0	0	0	13	0	7	0	0	0
5-9 JR	4056	3912	7968	0	0	0	15	8	11	0	0	0
10-14 JR	4669	4609	9278	0	0	0	11	15	13	0	0	0
15-19 JR	5689	5498	11187	0	0	0	16	27	22	0	0	0
20-24 JR	5931	6065	11996	2	0	1	57	106	82	0	0	0
25-29 JR	5866	5755	11621	3	0	2	55	106	80	0	2	1
30-34 JR	5259	5342	10601	2	0	1	78	105	92	0	0	0
35-39 JR	5449	5436	10885	2	0	1	70	138	104	2	2	2
40-44 JR	4309	4222	8531	5	5	5	65	123	94	0	2	1
45-49 JR	3640	3651	7291	3	0	1	71	71	71	0	0	0
50-54 JR	3481	3449	6930	20	3	12	57	76	66	0	0	0
55-59 JR	3143	3412	6555	19	15	17	25	73	50	0	0	0
60-64 JR	2932	3242	6174	17	12	15	27	25	26	10	3	7
65-69 JR	2304	2702	5006	39	48	44	17	56	38	30	22	26
70-74 JR	1769	2323	4092	125	86	103	17	39	29	45	90	71
75-79 JR	1218	1915	3133	123	89	102	41	31	35	197	220	211
80-84 JR	714	1348	2062	265	163	198	0	52	34	377	445	421
>=85 JR	460	992	1452	241	212	221	0	40	28	526	554	545
TOTAAL	64393	67219	131612	16	16	16	42	68	56	15	28	21

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD

30-08-88

ALLE PEILSTATIONS

JAAR: 1987 WEEK: 01 T/M 53

LEEFTIJDS-GROEP	POPULATIE			VOORSCHRIFT ROHYPNOL			ZWANGERS CHAP
				VOORSCHRIFT ROHYPNOL			ZWANGERS CHAP (ONBEKEND A.C.)
	M	V	T	M	V	T	V
< 1 JR	351	335	686	0	0	0	0
1-4 JR	3153	3011	6164	0	0	0	0
5-9 JR	4056	3912	7968	0	0	0	0
10-14 JR	4669	4609	9278	0	0	0	0
15-19 JR	5689	5498	11187	0	0	0	2
20-24 JR	5931	6065	11996	15	8	12	26
25-29 JR	5866	5755	11621	17	31	24	16
30-34 JR	5259	5342	10601	51	26	39	17
35-39 JR	5449	5436	10885	7	44	26	11
40-44 JR	4309	4222	8531	21	126	73	7
45-49 JR	3640	3651	7291	66	96	81	0
50-54 JR	3481	3449	6930	103	171	137	0
55-59 JR	3143	3412	6555	140	179	160	0
60-64 JR	2932	3242	6174	51	210	135	0
65-69 JR	2304	2702	5006	139	307	230	0
70-74 JR	1769	2323	4092	158	413	303	0
75-79 JR	1218	1915	3133	140	287	230	0
80-84 JR	714	1348	2062	167	511	392	0
>=85 JR	460	992	1452	285	212	235	0
TOTAAL	64393	67219	131612	43	99	72	7

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

21-10-88

JAAR: 1987 WEEK: 01 T/M 53

URBANISATIE-GROEP	POPULATIE			INFLU-ENZA	CERVIXUITSTRIJKJE					
				INFLUENZ 1E MAAL	1-1-'85 1E MAAL WEGENS PREV.HUI	1-1-'85 1E MAAL WEGENS PREV.VR.	HERHAL. WEGENS	HERHAL. PREV.HUI	HERHAL. PREV.VR.	
	M	V	T	%	V	V	V	V	V	V
A1-A4	10796	10780	21575	276	79	173	172	56	80	56
B1-B3,C1-C4	38518	40407	78924	320	50	165	134	59	74	72
C5	15069	15032	31102	536	69	280	195	83	81	80
TOTAAL	64383	67219	131601	363	59	194	155	65	77	71

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

21-10-88

JAAR: 1987 WEEK: 01 T/M 53

URBANISATIE-GROEP	POPULATIE			ONTSL.PSSTERILISATIE Y.PT.			M.A.PIL HONDEBETEN			SUICIDE(POGING)		
				ONTSL.PSSTERILISATIE Y.PT.			M.A.PIL HONDEBETEN			SUICIDE(POGING)		
	M	V	T	F	M	V	T	V	M	V	T	M+V
A1+A+	10796	10730	21575	4	65	37	51	33	42	27	34	5
B1-B3,C1-C4	38518	40407	78924	8	41	24	32	35	30	18	24	5
C5	15069	15032	31102	17	44	32	38	38	17	13	15	14
TOTAAL	64383	67219	131601	9	45	28	37	36	29	18	23	7

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

JAAR: 1987 WEEK: 01 T/M 53

URBANISATIE-GROEP	POPULATIE			CVA (NIEUW)			VERWIJZING P.S.P.			DEMENTIE		
	M	V	T	M	V	T	M	V	T	M	V	T
A1+A4	10796	10780	21575	17	13	15	23	31	27	17	14	15
B1-B3,C1-C4	38518	40407	78924	13	13	13	38	68	51	12	25	20
C5	15069	16032	31102	23	25	24	69	109	90	20	33	30
TOTAAL	64383	67219	131601	16	16	16	43	69	56	15	23	22

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

JAAR: 1987 WEEK: 01 T/M 53

URBANISATIE-GROEP	POPULATIE			VOORSCHRIFT ROHYPNOL			ZWANGERSCHAP
	M	V	T	M	V	T	V
A1+A4	10796	10780	21575	20	38	29	7
B1-B3,C1-C4	38518	40407	78924	49	123	86	4
C5	15069	16032	31102	50	84	69	15
TOTAAL	64383	67219	131601	44	100	72	7

VOORSCHRIFT ROHYPNOL — ZWANGERSCHAP (CONDANKS A.C.)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

21-10-88

JAAR: 1987 WEEK: 01 T/M 53

PROVINCIE-GROEP	POPULATIE			INFLU-ENZA	CERVIXUITSTRIJKJE					
				INFLUENZA	1-1-'85 1E MAAL WEGENS PREV.HUI	1-1-'85 1E MAAL PREV.VR.	1-1-'85 1E MAAL	HERHAL. WEGENS	HERHAL. PREV.HUI	HERHAL. PREV.VR.
	M	V	T	%	V	V	V	V	V	V
GR+FR+DR	9893	10301	20194	429	82	157	149	56	78	62
OV+GLD+FLE	10034	10109	20191	329	92	178	167	83	73	39
UTR+NH+ZH	28849	30703	59552	324	46	205	181	63	82	83
ZLD+NB+LIM	15557	16107	31664	417	49	205	103	62	70	62
TOTAAL	64333	67219	131601	363	59	194	155	65	77	71

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

21-10-88

JAAR: 1987 WEEK: 01 T/M 53

PROVINCIE-GROEP	POPULATIE			ONTSL.PSSTERILISATIE Y.PT.		M.A.PIL HONDEBETEN			SUICIDE (POGING)		
				ONTSL.PSSTERILISATIE Y.PT.		M.A.PIL HONDEBETEN			SUICIDE (POGING)		
	M	V	T	%	%	V	T	V	M	V	T	M+V
GR+FR+DR	9893	10301	20194	7	16	25	30	36	32	20	25	6
OV+GLD+FLE	10034	10108	20191	7	59	31	50	37	44	26	35	6
UTR+NH+ZH	28849	30703	59552	10	42	29	35	33	19	17	18	8
ZLD+NB+LIM	15557	16107	31664	9	43	27	35	40	33	13	23	7
TOTAAL	64333	67219	131601	9	45	28	37	36	29	18	23	7

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

JAAR: 1987 WEEK: 01 T/M 53

BLAD 3

21-10-88

PROVINCIE-GROEP	POPULATIE			CVA (NIEUW)			VERWIJZING P.S.P.			DEMENTIE		
	M	V	T	M	V	T	M	V	T	M	V	T
GR+FR+DR	9893	10301	20194	16	7	11	34	58	47	12	16	14
OV+GLD+FLE	10084	10108	20191	15	20	17	28	44	36	13	15	14
UTR+NH+ZH	28849	30703	59552	17	19	18	53	76	65	19	37	28
ZLD+NB+LIM	15557	16107	31664	14	14	14	39	78	59	10	29	20
TOTAAL	64383	67219	131601	16	16	16	43	69	56	15	29	22

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

JAAR: 1987 WEEK: 01 T/M 53

BLAD 4

21-10-88

PROVINCIE-GROEP	POPULATIE			VOORSCHRIFT ROHYPNOL			ZWANGERSCHAP	
	M	V	T	M	V	T	V	
GR+FR+DR	9893	10301	20194	64	183	124	7	
OV+GLD+FLE	10084	10108	20191	26	116	71	9	
UTR+NH+ZH	29849	30703	59552	47	81	65	9	
ZLD+NB+LIM	15557	16107	31664	37	73	55	1	
TOTAAL	64383	67219	131601	44	100	72	7	

TABLE 4A

Number of patients with influenza(-like illness) per week, per 10 000 inhabitants, 1987-1988 (to 10th week inclusive)

week 1987	number of patients							
	province group				urbanization group			total
	A	B	C	D	1	2	3	
1	0	2	4	3	1	2	6	3
2	20	9	13	5	10	7	24	11
3	10	12	15	6	12	7	22	12
4	32	13	21	15	13	16	35	20
5	51	19	19	32	21	26	32	26
6	19	23	14	25	19	18	21	19
7	23	17	16	24	20	20	16	19
8	10	9	10	11	8	10	10	10
9	13	12	7	10	8	9	10	9
10	8	6	9	6	4	7	11	8
11	6	10	4	11	8	7	8	7
12	9	4	4	7	2	5	7	5
13	3	9	4	5	8	4	4	5
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								

Table 4A (continuation)

Number of patients with influenza(-like illness) per week, per 10 000 inhabitants, 1987-1988 (to 10th week inclusive)

week 1987	number of patients							
	province group				urbanization group			total
	A	B	C	D	1	2	3	
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								
37								
38								
39								
40	10	3	4	7	3	5	8	5
41	6	5	4	11	4	5	9	6
42	7	4	5	8	5	5	10	6
43	1	1	5	7	1	4	6	4
44	13	7	7	7	6	6	12	8
45	7	12	6	7	4	5	14	7
46	16	8	7	6	6	6	16	8
47	12	6	8	8	7	8	12	8
48	3	8	6	7	8	6	6	6
49	1	8	6	7	5	5	9	6
50	4	7	8	10	8	7	11	8

TABLE 4A (continuation)

Number of patients with influenza(-like illness) per week, per 10 000 inhabitants, 1987-1988 (to 10th week inclusive)

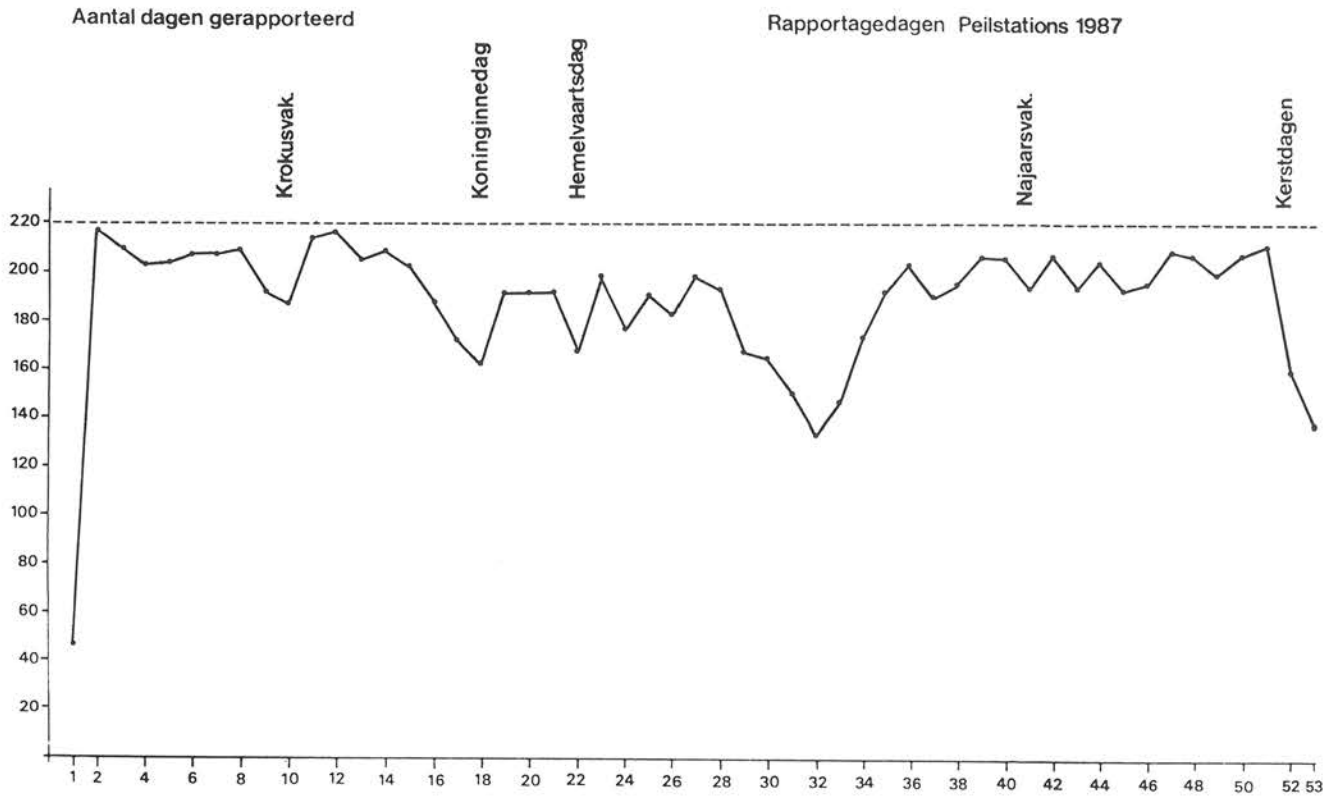
week 1987	number of patients							
	province group				urbanization group			total
	A	B	C	D	1	2	3	
51	3	7	7	12	6	7	11	8
52	5	2	5	11	2	7	7	6
53	7	4	7	8	3	7	8	7
1988								
1	3	4	12	6	7	8	10	8
2	3	7	9	6	8	6	10	7
3	5	3	8	5	4	5	11	6
4	10	8	7	8	9	7	9	8
5	3	9	7	7	9	7	7	7
6	4	3	6	12	3	8	8	7
7	4	5	6	16	2	5	8	5
8	9	7	6	17	4	9	12	9
9	7	9	5	7	6	6	8	7
10	1	1	5	8	0	5	6	4

The figures from week 1-1987 are provisional ones.

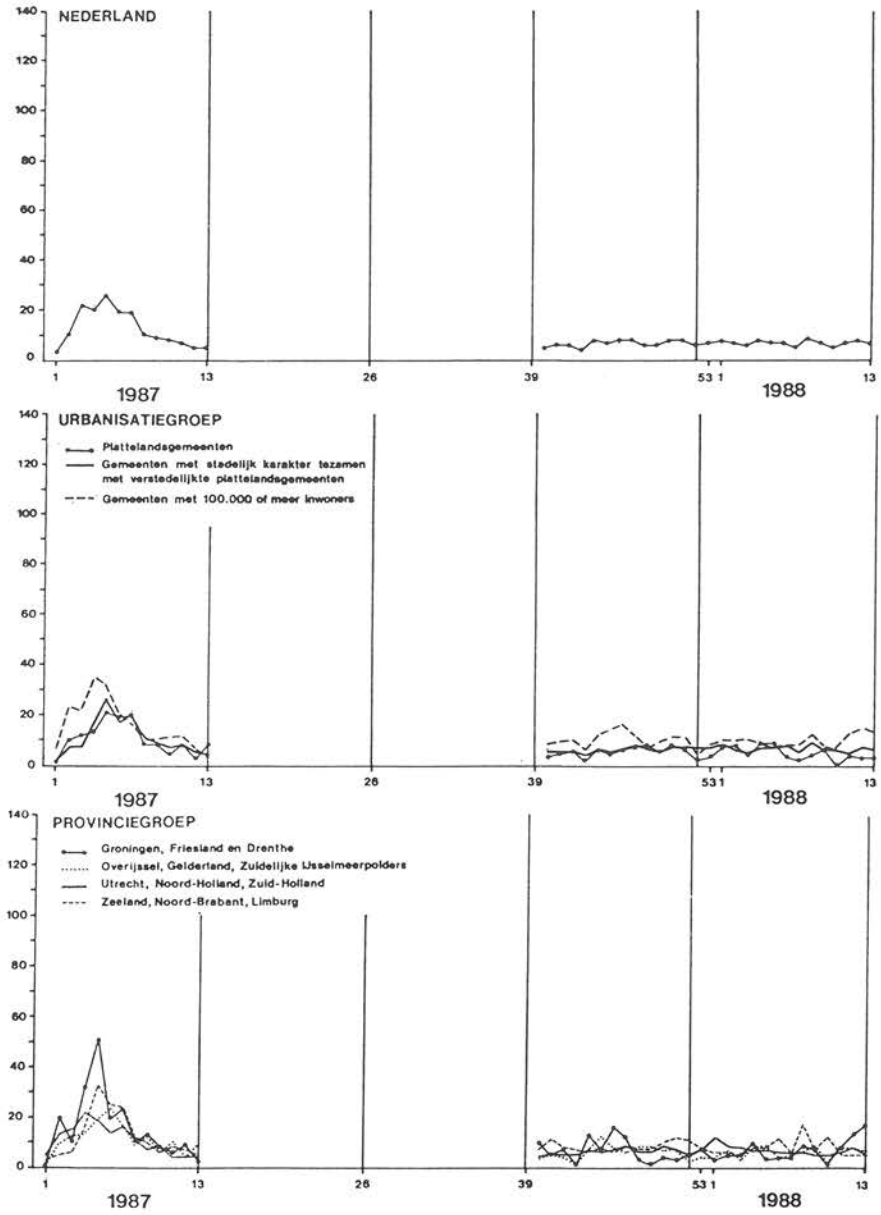
FIGUUR 1

PEILSTATIONS
CONTINUE MORBIDITEITS REGISTRATIE
1987

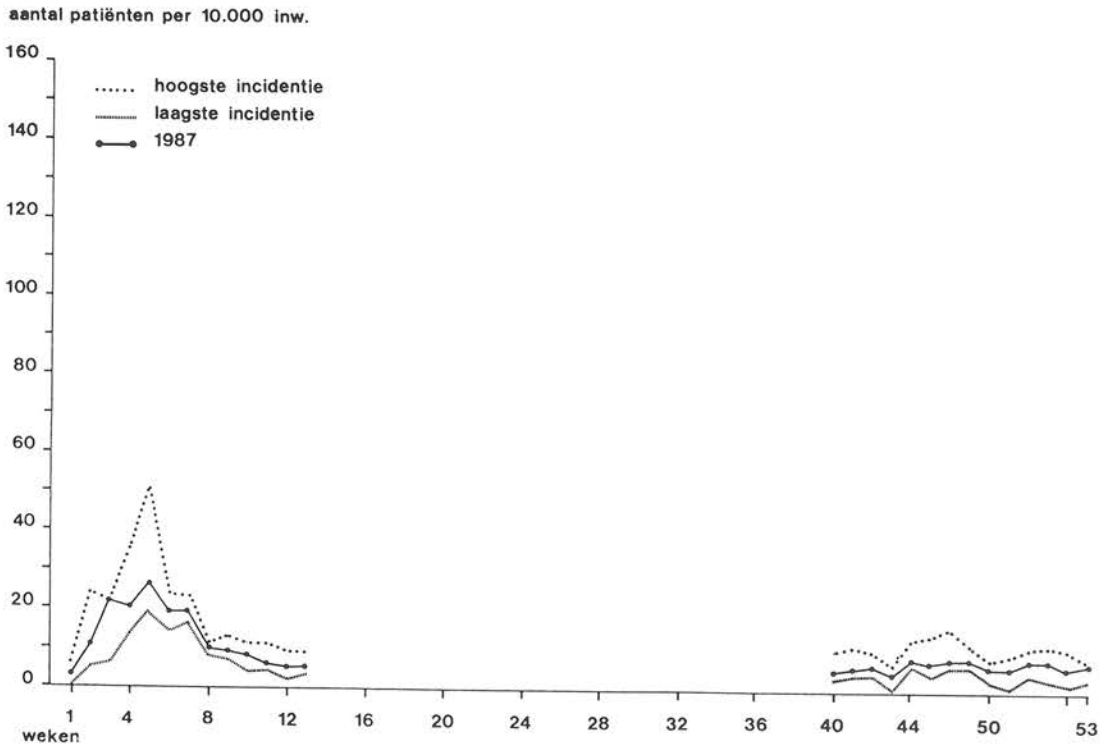
Figuur 2
Het aantal dagen, dat in 1987 per week is geregistreerd



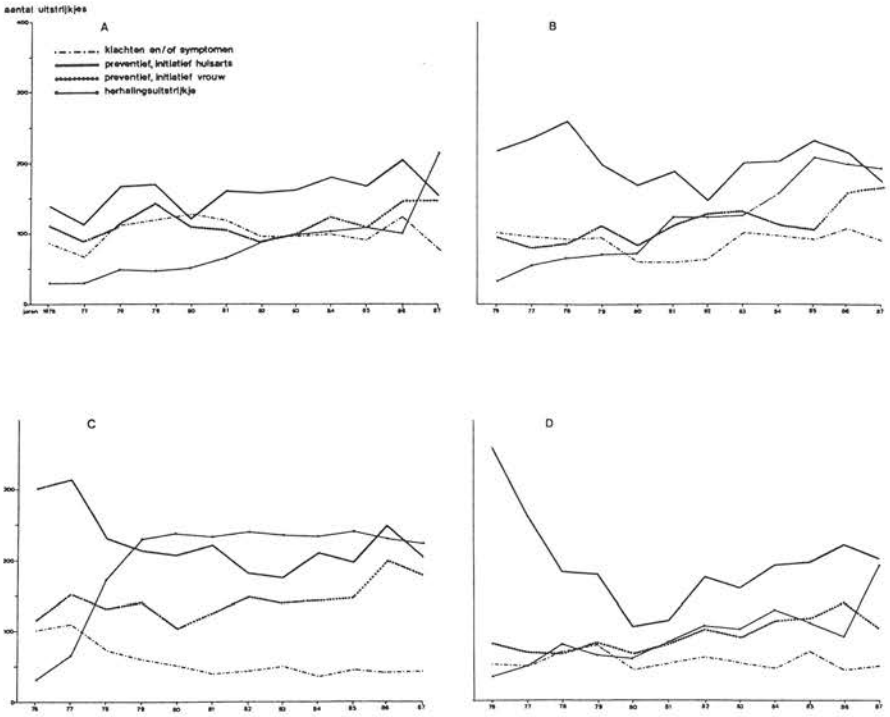
Figuur 3
Aantal patiënten met influenza(-achtig ziektebeeld) per week en per 10.000 inwoners, 1987 - 1988 (t/m 13e week)



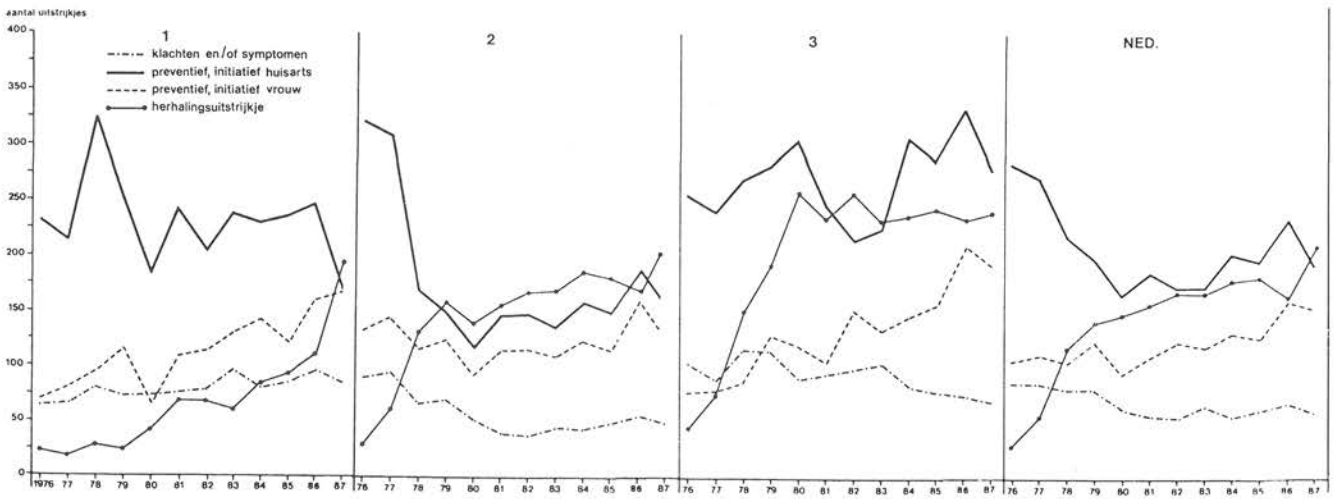
Figuur 4
Hoogste en laagste weekincidenties van influenza(-achtig ziektebeeld) per 10.000 inwoners voor de jaren 1970 - 1986 en weekincidenties van 1987



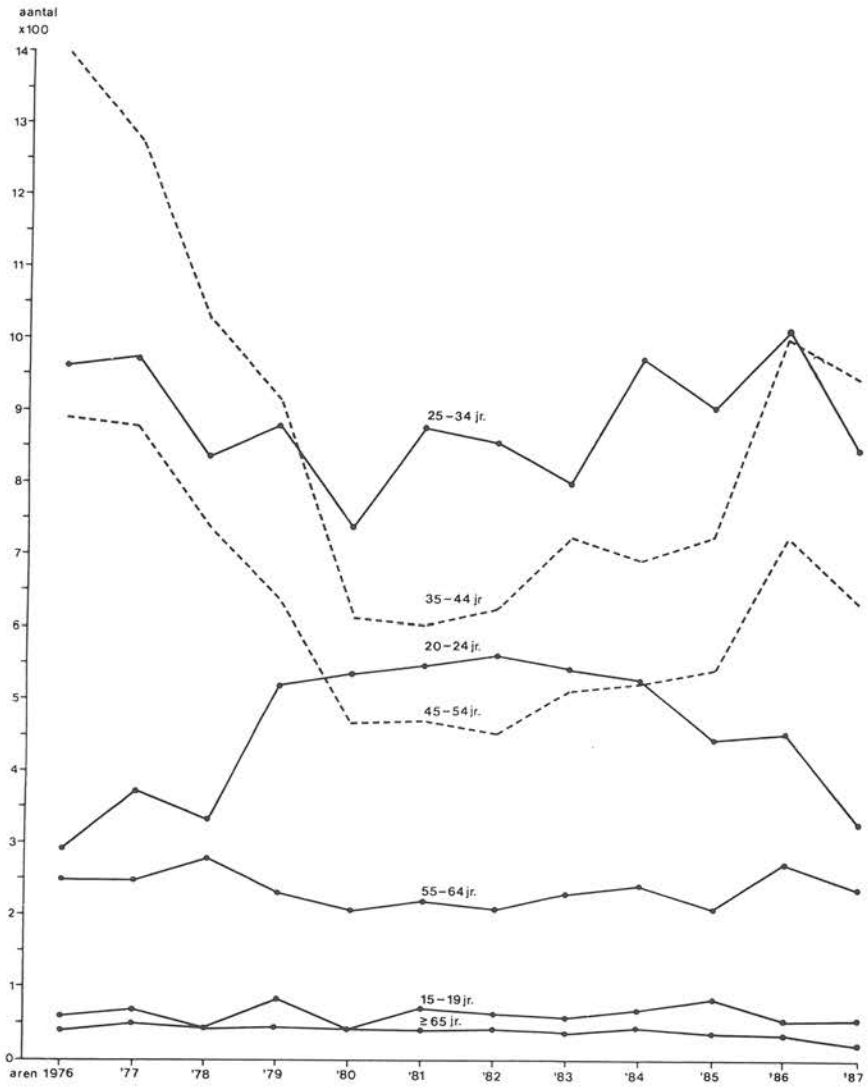
Figuur 5
Aantal uitstrijkjes gemaakt van de cervix uteri, per provinciegroep naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1976 - 1987



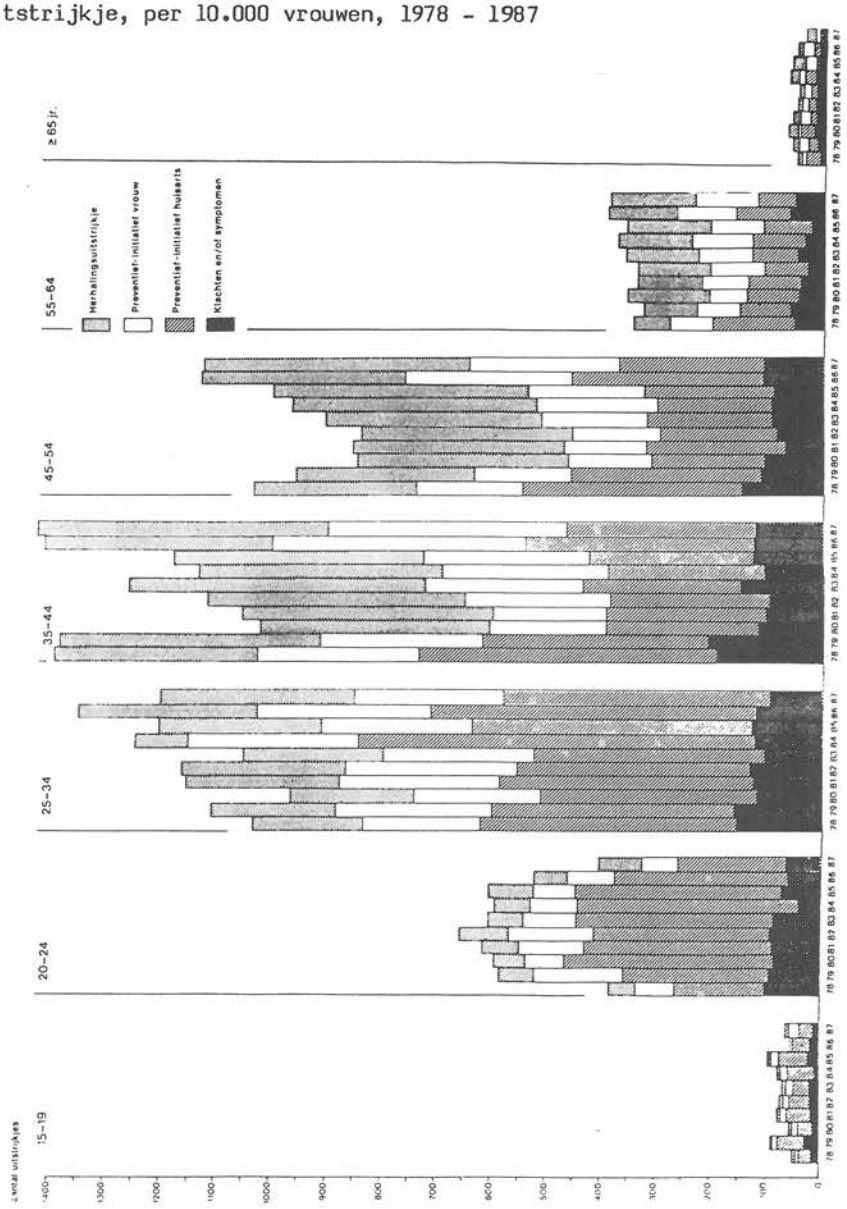
Figuur 6
Aantal uitstrijkjes gemaakt van de cervix uteri, per urbanisatiegroep en voor Nederland, naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1976 - 1987



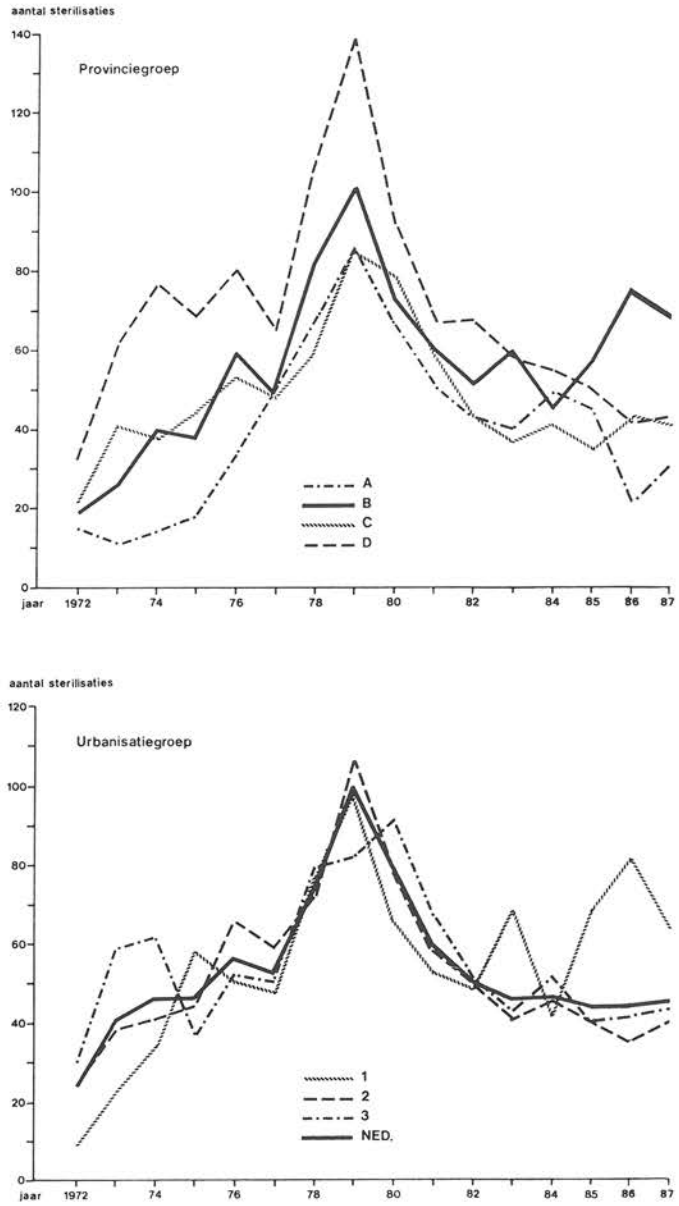
Figuur 7
Aantal "eerste" uitstrijkjes gemaakt van de cervix uteri naar leeftijdsgroep, per 10.000 vrouwen, 1977 - 1987



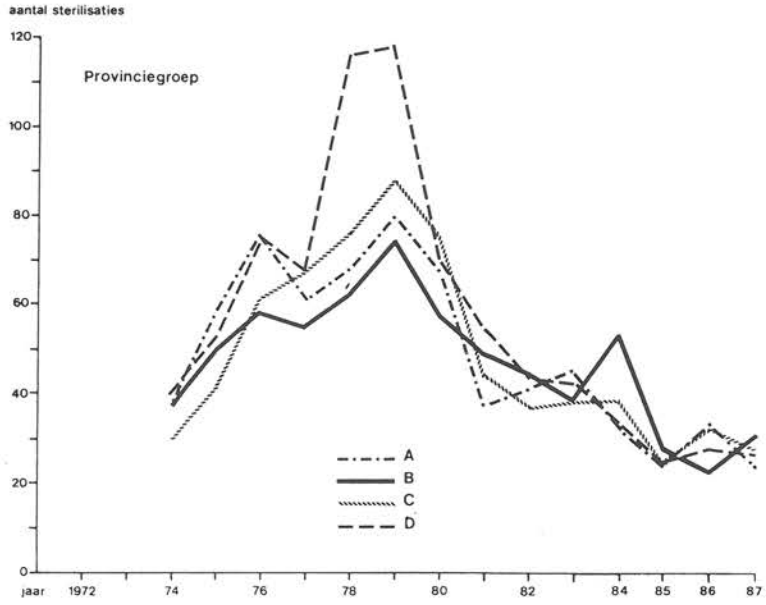
Figuur 8
Aantal uitstrijkjes gemaakt van de cervix uteri naar leeftijdsgroep en naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1978 - 1987

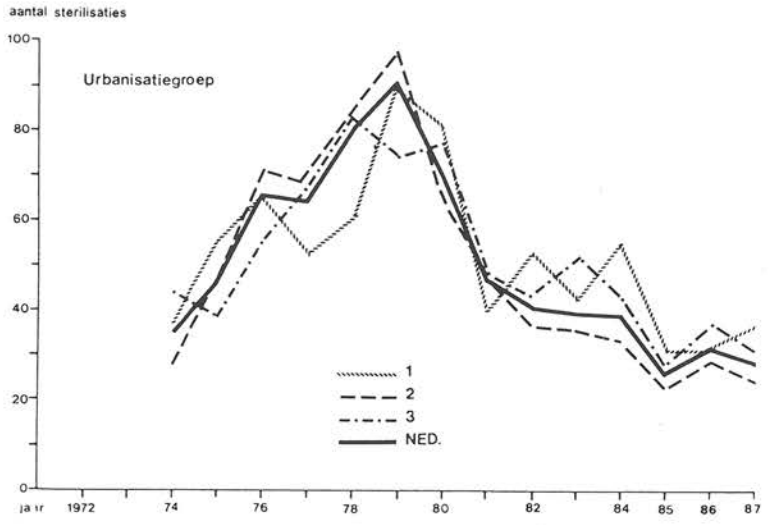


Figuur 9
Aantal bij mannen verrichte sterilisaties, per provincie- en urbanisatiegroep en voor Nederland, per 10.000 mannen, 1972 - 1987

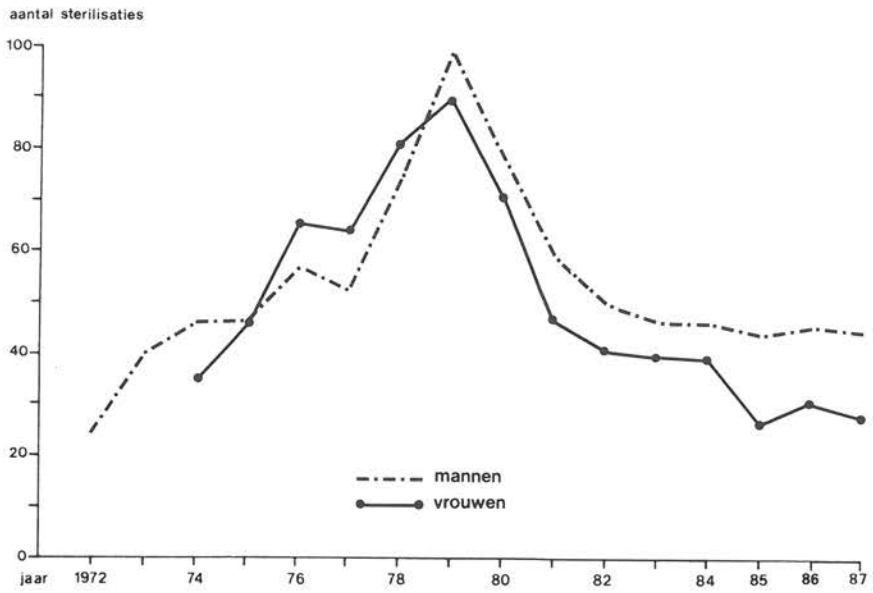


Figuur 10
Aantal bij vrouwen verrichte sterilisaties, per provincie- en urbanisatiegroep en voor Nederland, per 10.000 vrouwen, 1974 - 1987

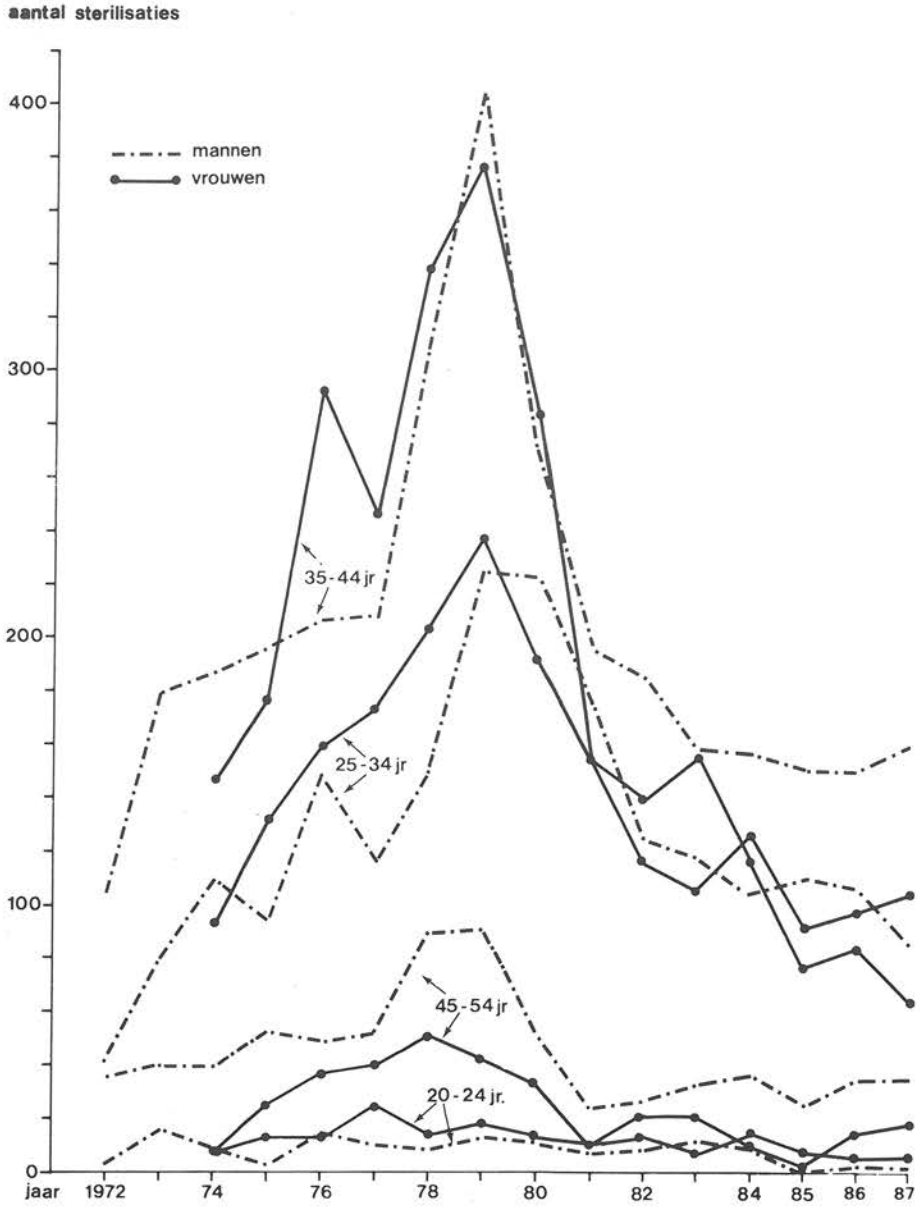




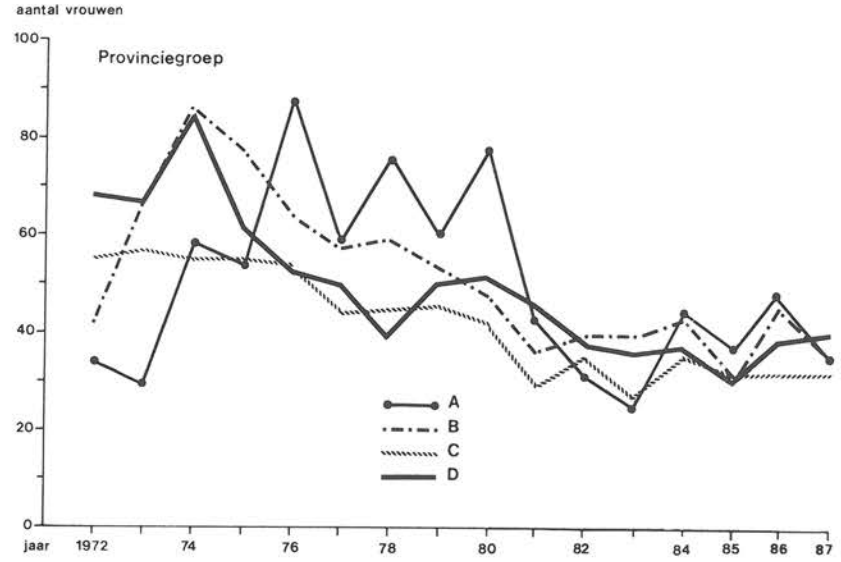
Figuur 11
Aantal verrichte sterilisaties per 10.000 mannen en 10.000 vrouwen, 1972 - 1987

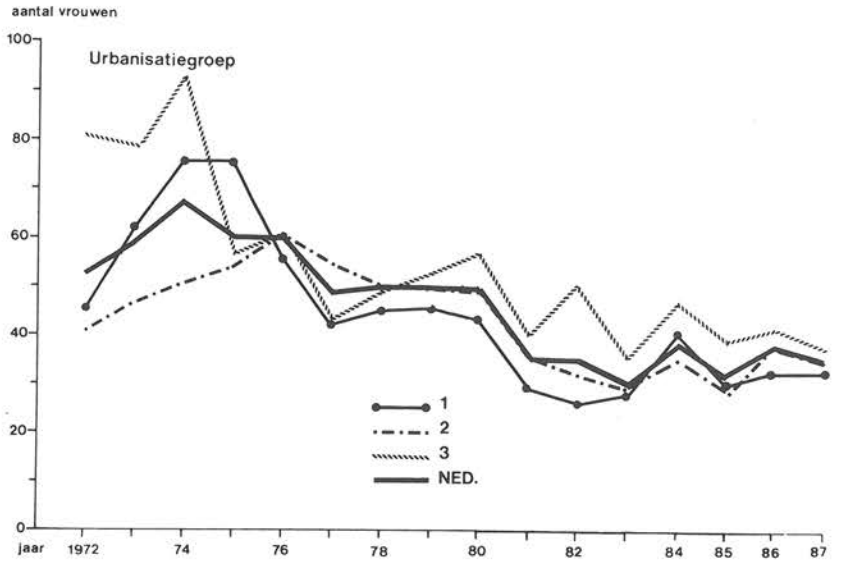


Figuur 12
Aantal verrichte sterilisaties naar leeftijdsgroep, per 10.000 mannen en 10.000 vrouwen, 1972 - 1987



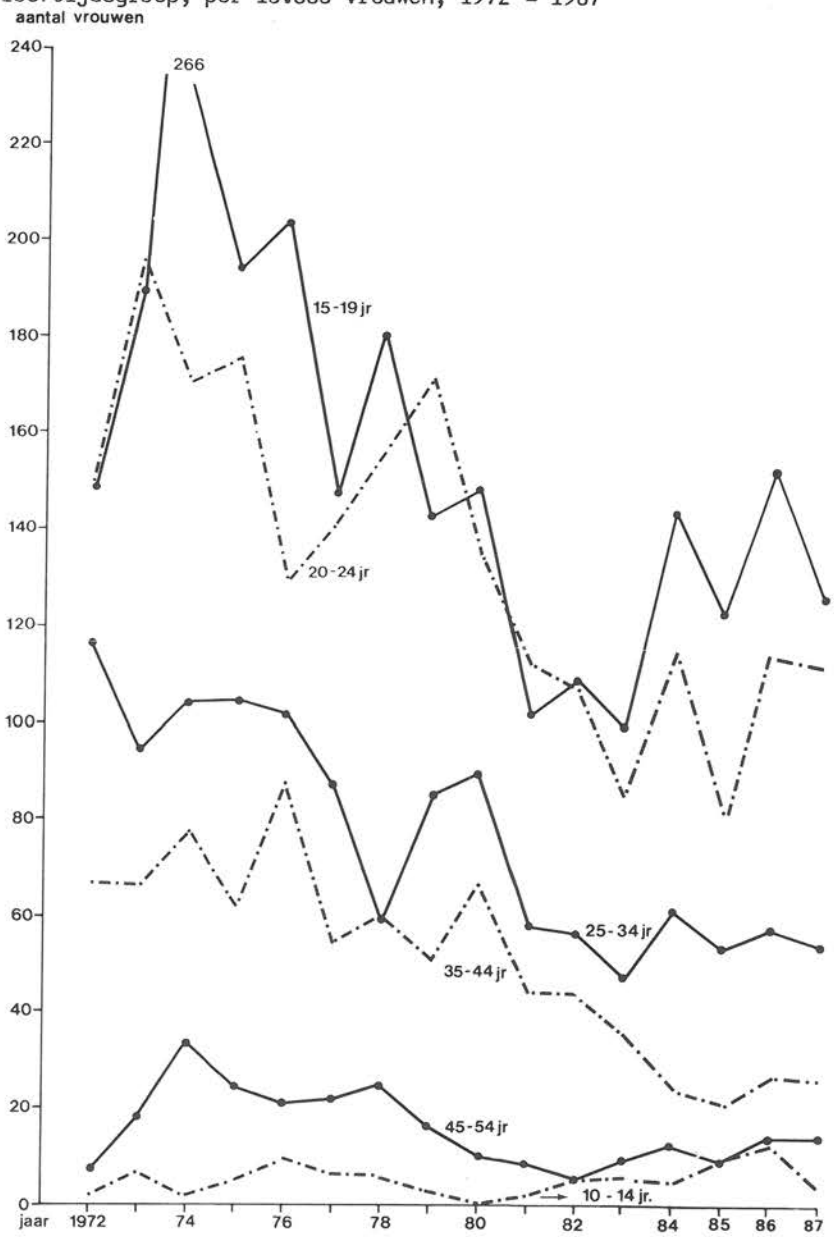
Figuur 13
Aantal malen dat de morning-after pil is voorgeschreven, per provincie- en urbanisatiegroep, per 10.000 vrouwen, 1972 -1987



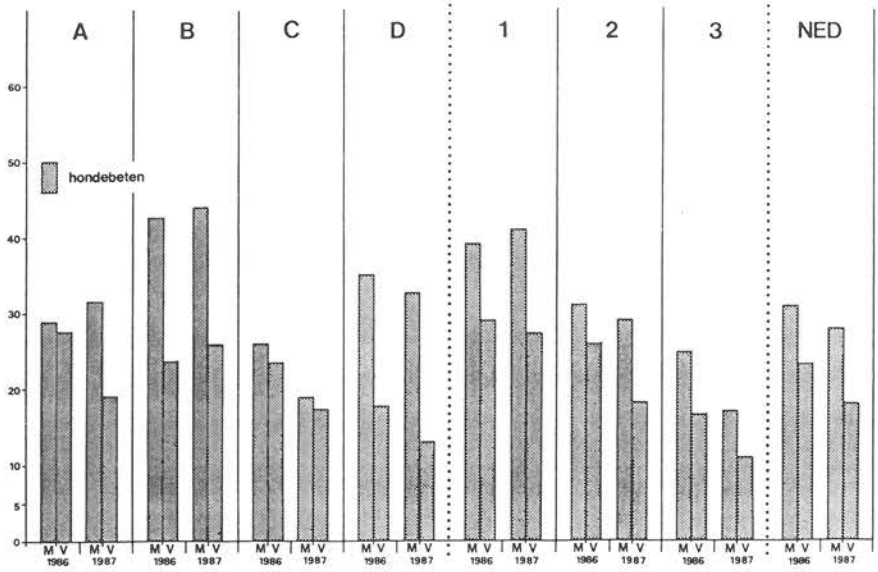


Figuur 14

Aantal malen dat de morning-after pil is voorgeschreven naar leeftijdsgroep, per 10.000 vrouwen, 1972 - 1987

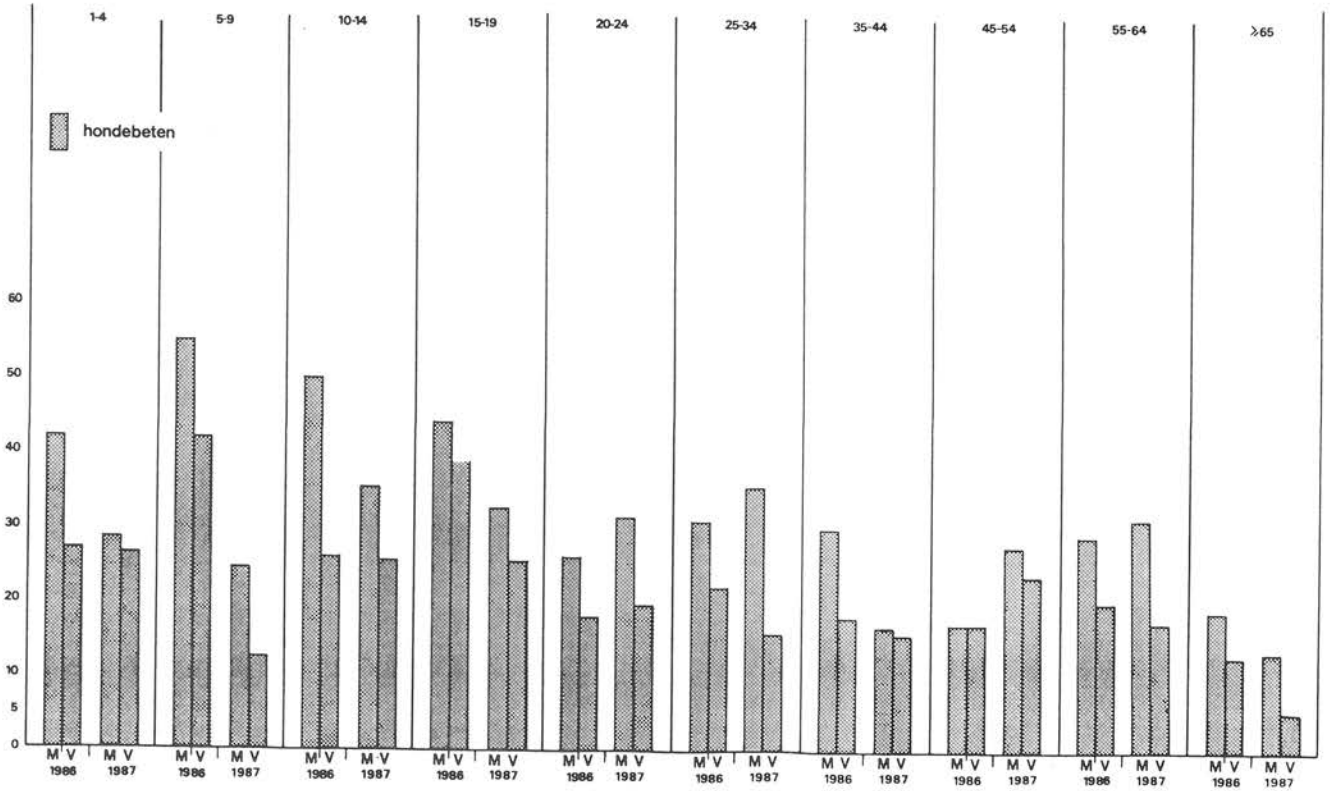


Figuur 15
Aantal patiënten dat wegens een beet de huisarts consulteert, per provincie- en urbanisatiegroep en voor Nederland, per 10.000 mannen en 10.000 vrouwen, voor 1986 en 1987

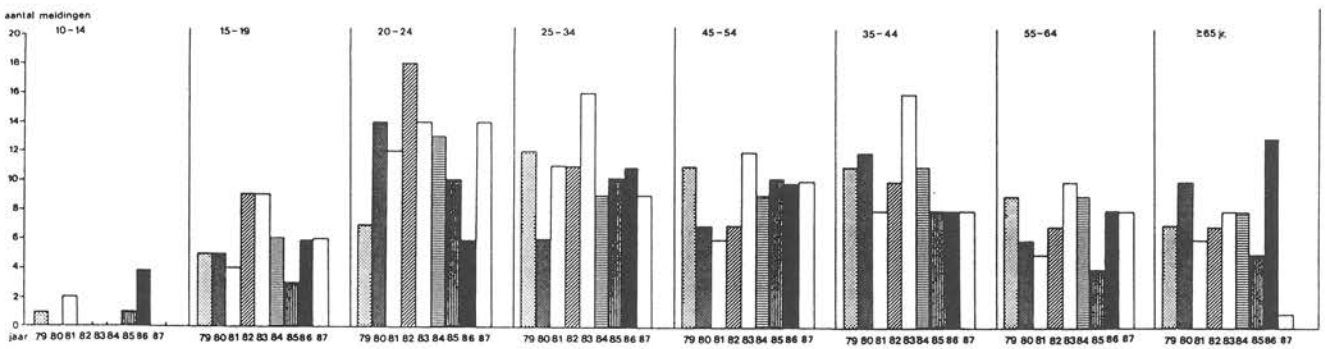


Figuur 16

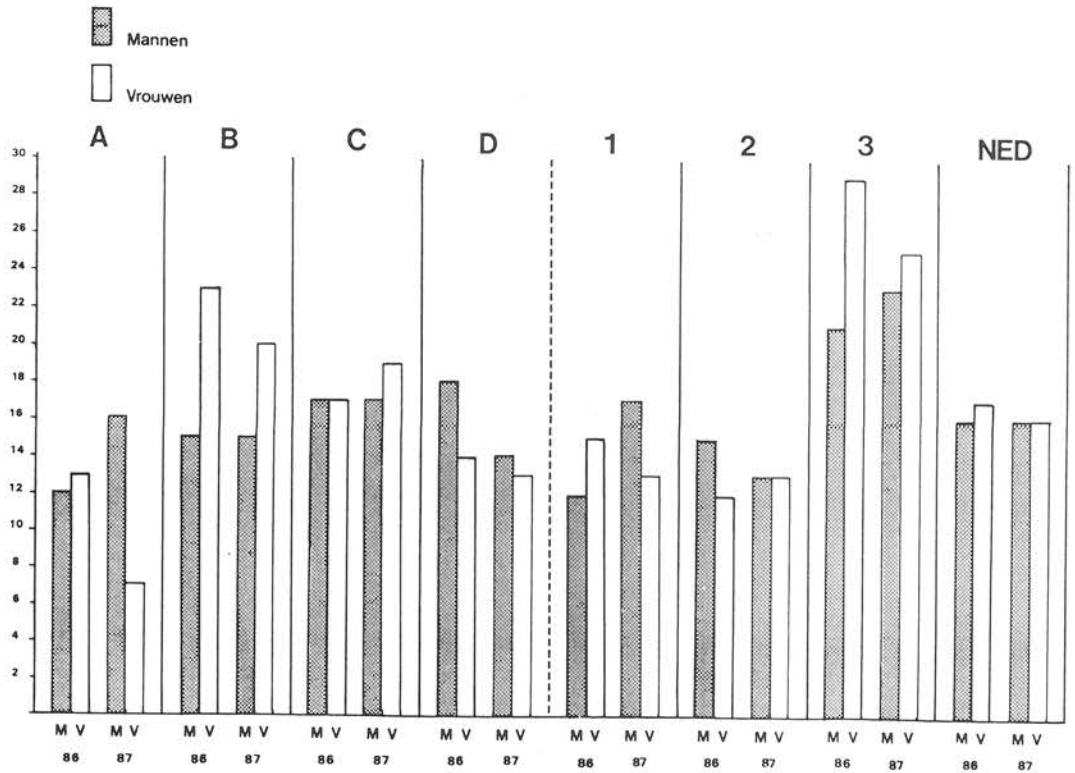
Aantal patiënten dat wegens een beet van een hond de huisarts consulteert (enkel eerste consult) naar leeftijdsgroep, per 10.000 mannen en 10.000 vrouwen, voor 1986 en 1987



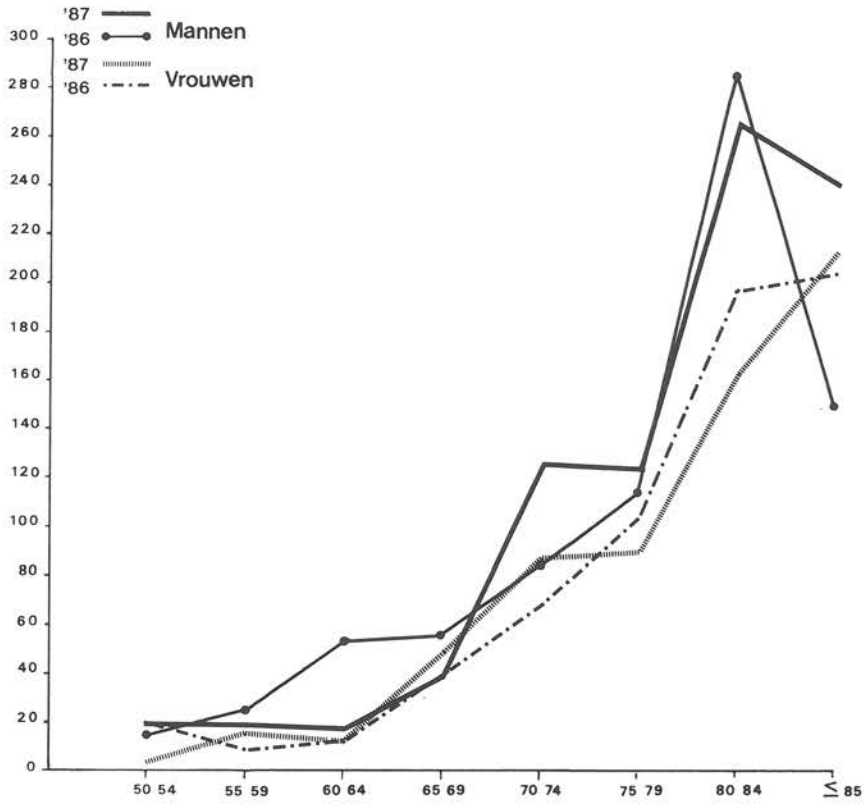
Figuur 17
Aantal meldingen van suicide(poging) naar leeftijdsgroep, per 10.000 inwoners, 1979 - 1987



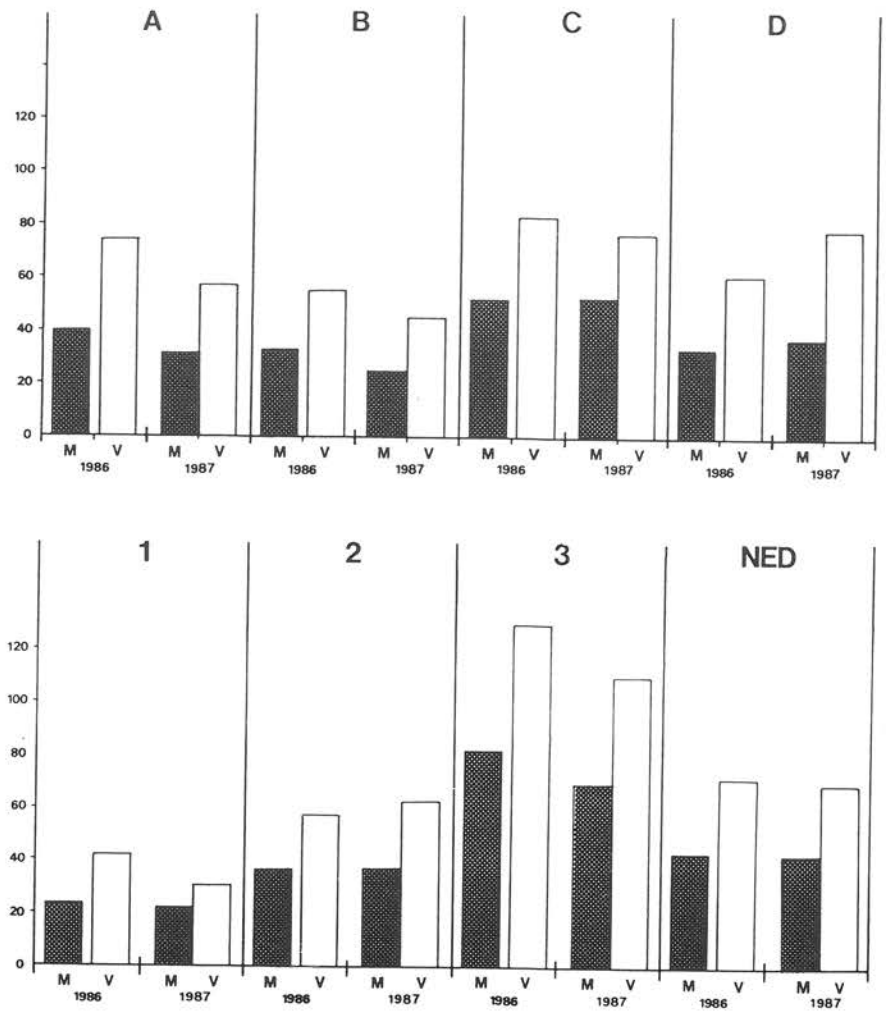
Figuur 18
Aantal patiënten met een nieuw cerebrovasculair accident, per provincie- en urbanisatiegroep en voor Nederland, per 10.000 mannen en 10.000 vrouwen, voor 1986 en 1987



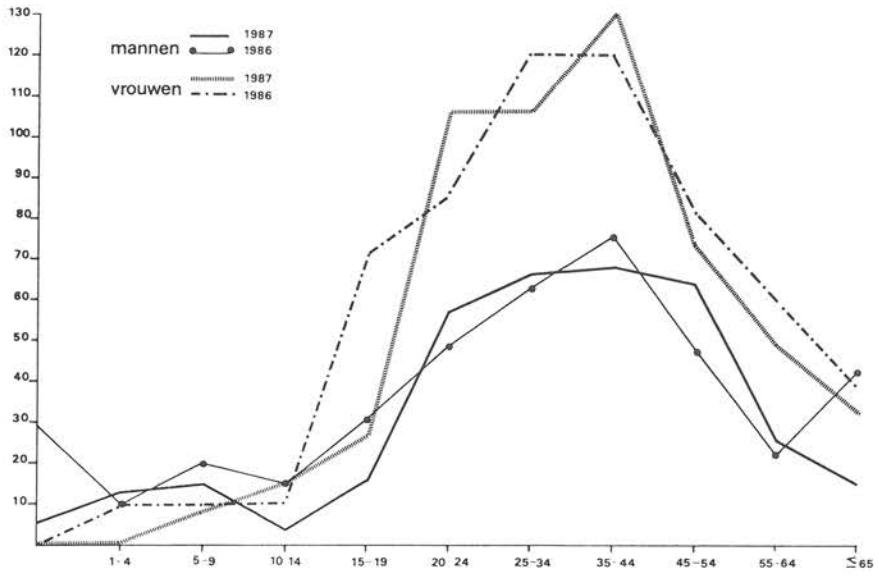
Figuur 19
Aantal patiënten met een nieuw cerebrovasculair accident, naar leeftijdsgroep boven de 50 jaar per 10.000 mannen en 10.000 vrouwen, voor 1986 en 1987



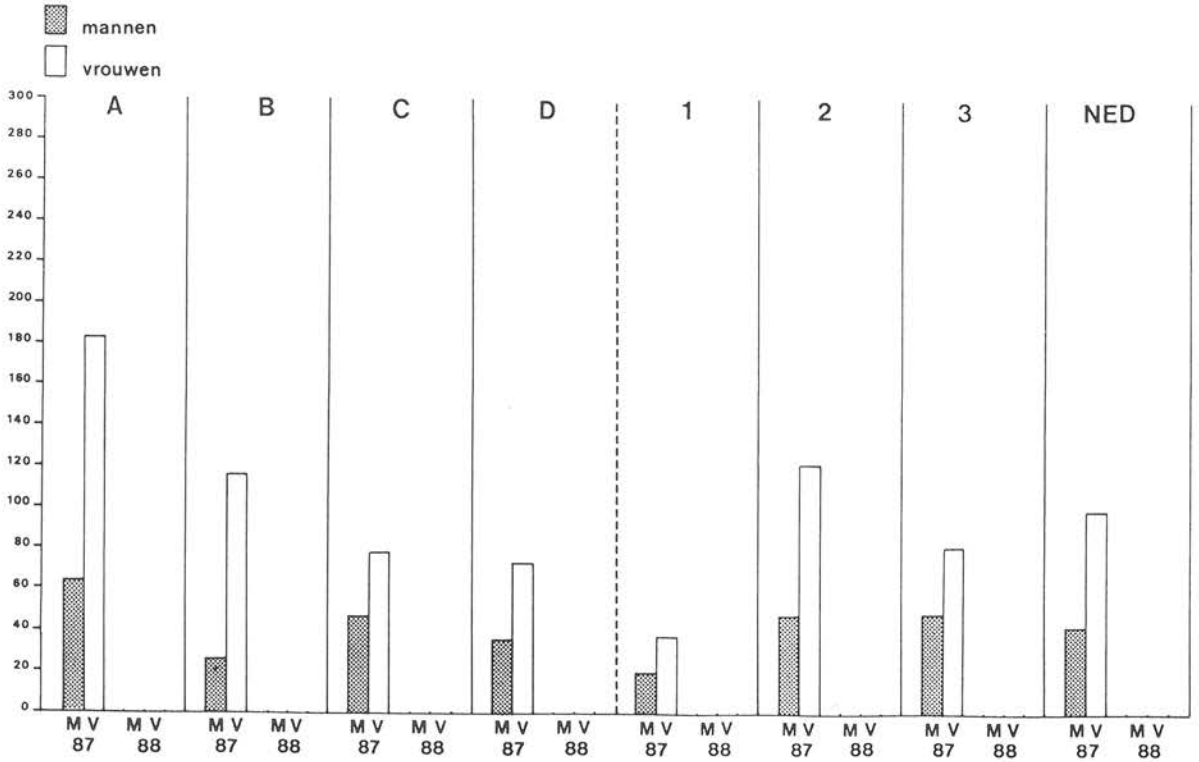
Figuur 20
Aantal nieuwe verwijzingen wegens psychosociale problematiek naar provincie- en urbanisatiegroep en voor Nederland, per 10.000 mannen en 10.000 vrouwen, voor 1986 en 1987



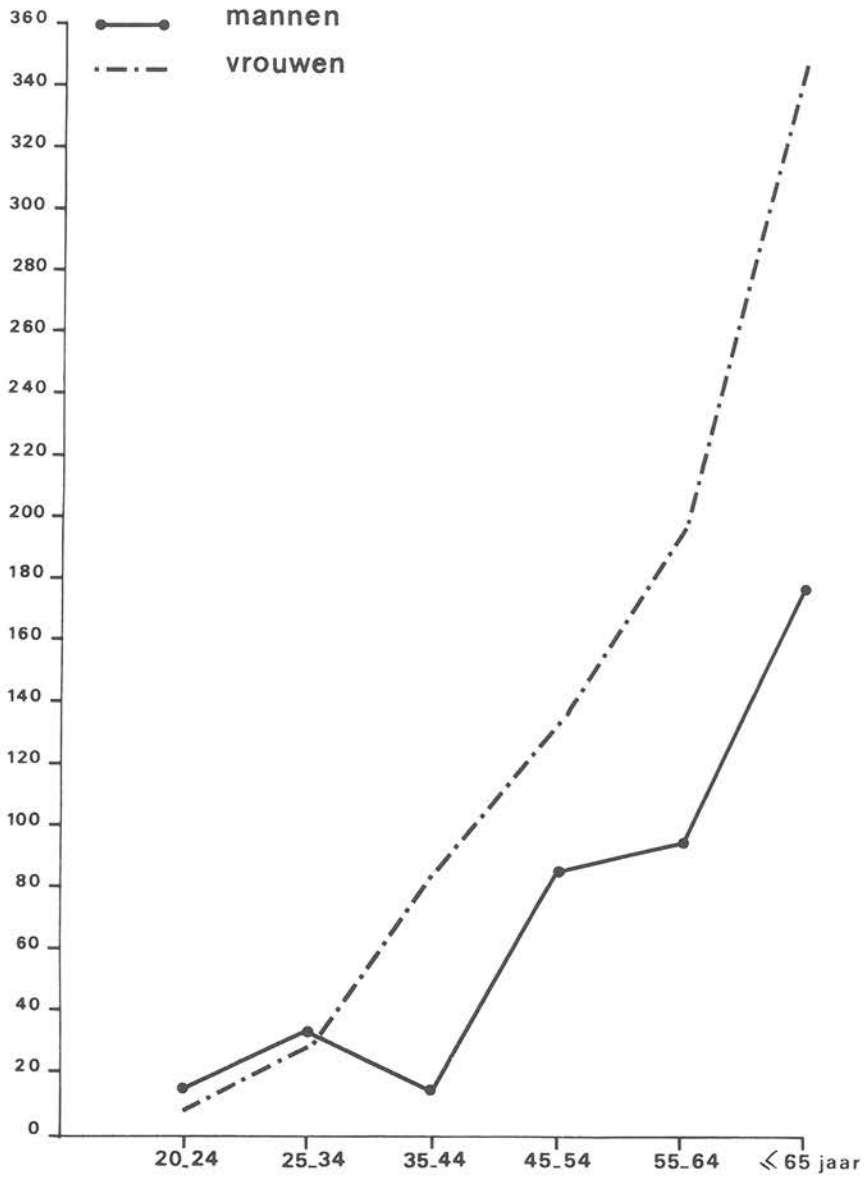
Figuur 21
Aantal verwijzingen wegens psychosociale problematiek, naar leeftijdsgroep, per 10.000 mannen en 10.000 vrouwen, voor 1986 en 1987



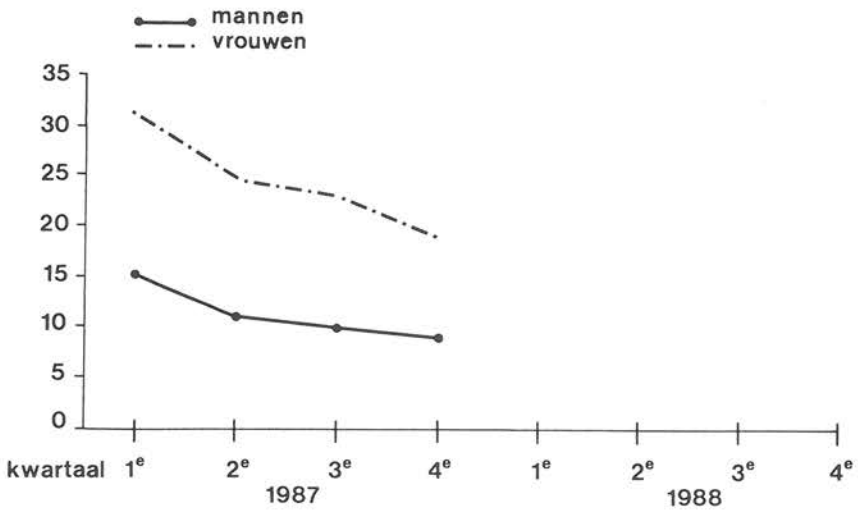
Figuur 22
Aantal voorschriften flunitrazepam, per provincie- en urbanisatiegroep en voor Nederland, per 10.000 mannen en 10.000 vrouwen, voor 1987



Figuur 23
Aantal voorschriften flunitrazepam, per kwartaal per 10.000 mannen en per 10.000 vrouwen, voor 1987



Figuur 24
Aantal voorschriften flunitrazepam, naar leeftijdsgroep boven de 20 jaar, per 10.000 mannen en per 10.000 vrouwen, voor 1987



FOOTNOTES

1. Typology of the Dutch municipalities by degree of urbanization, 1-1-1971 (Central Bureau of Statistics).

2. Figures from the registration of professions in primary health care, Jan. 1987, p. 32, Table 10. Published by NIVEL, Utrecht.

3. 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.

4. 1-1-1987, Central Bureau of Statistics. Persons who are entered in the central register of vital statisics have been left out of consideration.

5. Practice census 1985.

6. In these tables and the tables in the text derived from them frequencies are given in all eases per 10 000 men, women or inhabitiants, unless stated otherwise.

7. 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 infection 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.

8. Here and elsewhere in the text incidence or frequency means the frequency per 10 000 inhabitants (either men or women).

9. The calculations made in this chapter have been performed by Dr E. Ketting, now employed by the Netherlands Centre for Mental Public Health.

10. Wibaut, p. De onbetrouwbaarheid van de alternatieve morning-after pil, Huisarts en Wetenschap, 1986, p. 306-307.

11. Huisman, J. Huisdierenbeten in Rotterdam in 1984. Epidemiologisch Bulletin van de GGD Rotterdam 19 (1) 1985, p. 1-2.

12. Stichting Consument en Veiligheid: Jaaroverzicht 1984, Privé Ongevallen Registratiesysteem, Amsterdam, May 1985.

13. Zelfdoding in Rotterdam, Municipal Medical and Health Service, Information Bureau, Rotterdam 1983.

14. Peters, L. Relatie eerstelijnszorg geestelijke gezondheidszorg. Nederlands Huisartsen Instituut 1984, p. 22-23.

15. Onderzoek Gezinsvorming C.B.S.

16. See inter alia the report Abortus en anticonceptie 1985/'84. Dr E. Ketting and O. Leseman, Stimezo Nederland, The Hague 1986.

17. A euthanasia declaration is a written request for euthanasia on certain conditions.

18. Weeda-Mannak, W.L. Anorexia Nervosa, towards an early identification. Dissertation 1984, Maastricht.

Explanatory notes pertaining to:

Bijlage 1	
Bijlage	- Appendix
Continue morbiditeits registratie,	- Continuous morbidity registration,
peilstations	- 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 morbiditeits registratie,	- Continuous morbidity registration,
peilstations	- 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 1-1-1985 voor de eerste maal afgenomen op grond van	- Taken for the first time after 1-1-1985 on the ground of
Klachten/symptomen	- Complaints/symptoms
Louter preventieve overwegingen	- Purely preventive considerations
Initiatief huisarts	- General practitioner's initiative
Verzoek van de vrouw	- Woman's request
Ontslagen psychiatrische patiënt	- Discharged psychiatric patients
Sterilisatie verricht	- Sterilization performed
Morning-after pil voorgeschreven	- Prescription of morning-after pill
Cerebrovasculair accident	- Cerebrovascular accident

Verwijzingen psychosociale problematiek	- Referrals for psycho-social problems
Dementie	- Dementia
Voorschrijven Rohypnol	- Prescription of Rohypnol
Zwangerschap (ondanks a.c.)	Pregnancy despite adequate contraception
M	- Male
V	- Female
Weeknummer	- Number of the week
Opgemaakt d.d.	- Completed on
Aantal dagen gerapporteerd	- Number of days over which reporting took place
(zie voetnoot[1])	- (See footnote number[1])
Zie ommezijde voor voetnoot	- For footnotes see reverse

1. Door vakantie, ziekte en andere oorzaken zal deze rapportage zich echter ook over minder dan 5 dagen kunnen uitstrekken. Het wordt van belang geacht om, zo mogelijk, ook tijdens het weekeinde waargenomen patiënten te rapporteren. (M.u.v. influenzapatiënten.)

1. As a result of vacation, sickness and other causes this reporting 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 patients. Report telephone calls as well.

3. Betreft rapportering van vrouwen bij wie na 1-1-1985 om welke reden dan ook een cervixuitstrijkje heeft plaatsgevonden. Indien bij een vrouw na 1-1-1985 opnieuw een cervixuitstrijkje wordt gemaakt, dient dit altijd onder de subrubriek "herhalingsonderzoek" geboekt te worden (zie ook voetnoot 5).

3. Concerns reporting of women on whom a cervical smear was taken after 1-1-1985 for whatsoever reason. If a cervical smear was taken again of a women after 1-1-1985 this should always be entered under the subheading "Repeat examination" (see also footnote 5).

4. Bijvoorbeeld in het kader van pilcontrole

4. For example as part of check-up for the pill.

5. Bijvoorbeeld wegens verdacht preparaat of wegens technische onvolkomenheden bij onderzoek vorig preparaat.
6. S.v.p. apart formulier invullen en bij de weekstaat voegen Code patiënt .....
7. Indien het een patient(e) betreft uit een van de leeftijdgroepen, 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 pil 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. Uitsluitend eerste contact vermelden.
   betreft het meerdere beten bij de patiënt?
   betreft het een beet van een eigen hond?
   is de beet opgedaan tijdens beroepsuitoefening?
   is de patiënt naar een ziekenhuis verwezen?
   is deze patiënt dit jaar eerder gebeten?
10. Voor de aanvullende gegevens s.v.p. een apart formulier invullen en bij de weekstaat voegen.
11. Betreft alleen nieuwe patiënten
12. S.v.p. apart formulier invullen en bij de weekstaat voegen.

5. For example on account of suspect preparation or technical imperfections in the examination of the previous preparation.
6. For the supplementary data please complete and attach to the weekly return. Code patient .....
7. If a patient is concerned in one of the age groups whose box is filled in, also give the exact 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. State only first contact.

   relates to more than one bite of the patient?
   relates to a bite by the patient's own dog?
   did the bite occur during the patient's work?
   was the patient referred to a hospital?
   has the patient been bitten before this year?
10. For the supplementary data please complete a separate form and attach it to the weekly return.
11. Relates solely to new patients
12. Please complete a separate form and attach to the weekly return.

13. S.v.p. apart formulier invullen en bij de weekstaat voegen.

Code patiënt .....
(als op formulier), zie ook de toelichting op de weekstaat.

13. For the supplementary data please complete a separate form and attach to the weekly return.
Code patient .....
(as on the form), See also the explanation on the weekly return.

Tables (p.100 - p.110)

Continue morbiditeits registratie peilstations	- Continuous morbidity registration sentinel stations
Kwartaal	- Quarter
Leeftijdsgroep	- Age group
Influenza (-achtig ziektebeeld)	- Influenza (-like illness)
Cervixuitstrijkje	- Cervical smear
Klacht/symptoom	- Complaint/symptom
Initiatief huisarts	- General practitioner's initiative
Verzoek vrouw	- Woman's request
Herhalingsonderzoek	- Repeat smear
Ontslagen psychiatrische patiënt	- Discharged psychiatric patients
Sterilisatie verricht	- Sterilization performed
Morning-after pil voorgeschreven	- Morning-after pill prescribed
Hondebeten	- Dog bites
Suïcide(poging)	- (Attempted) suicide
Cerebrovasculair accident	- Cerebrovascular accident
Verwijzingen psychosociale problematiek	- Referrals for psycho-social problems
Dementie	- Dementia
Voorschrijven Rohypnol	- Prescription of Rohypnol
Zwangerschap (ondanks a.c.)	- Pregnancy despite adequate contraception
M	- Male
F	- Female

Provinciegroepen	- Province group
Gr + Fr = Dr	Groningen, Friesland, Drenthe
Ov + Gld + Fl	- Overijssel, Gelderland, Flevoland
Utr + NH + ZH	- Utrecht, North Holland, South Holland
Zld + NB + Lim	- Zeeland, North Brabant, Limburg
Urbanisatiegroepen	- Urbanization groups
A_1 - A_4	- Rural municipalities
B_1 - B_3 + C_1 - C_4	- Municipalities with urban characteristics and urbanized municipalities
C_5	- 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 rounding off when calculating relative frequencies, small differences may have occurred in the totals

Table 4a

Aantal patiënten met influenza (-achtig ziektebeeld) per week en per 10.000 inwoners, 1986 en 1987 (t/m 13e week)	- Number of patients with influenza (-like illness) per week and per 10 000, 1986 and 1987 (up to and including the 13th week)
Weeknr.	- Number of the week
Aantal patiënten	- Number of patients
Provinciegroep	- Province group. See for explanation A, B, C and D under Tables 1-3

Figures

Figure 1

Peilstations	- Sentinel stations
Continue morbiditeits registratie	- Continuous morbidity registration
Grenslijn provinciegroep	- Boundary of province group

Figure 2

Het percentage dagen dat in 1986 per week is gerapporteerd	-	Percentage of days weekly reported in 1986
1.= Krokusvakantie	-	1.= Spring half-term holiday
2.= Pasen		2.= Easter
3.= Hemelvaartsdag		3.= Ascension Day
4.= Najaarsvakantie		4.= Autumn holiday
5.= Kerstmis		5.= Christmas

Figure 3

Aantal patiënten met influenza (-achtig ziektebeeld) per week, per 10.000 inwoners, 1987-1988 (t/m 13e week)	-	Number of patients with influenza (-like illness) per week, per 10 000 inhabitants, 1987-1988 (up to and including the 13th week)
Provinciegroep	-	Province group
Urbanisatiegroep	-	Urbanization group
Naar leeftijdsgroep en geslacht	-	By age group and sex

Figure 4

Hoogste en laagste weekincidenties van influenza (-achtig ziektebeeld) per 10.000 inwoners voor de jaren 1970-1986 en weekincidenties van 1987	-	Highest and lowest weekly incidences of influenza (-like illness) for 1970-1986 and weekly incidences for 1987

Figures 5 - 8

Aantal cervixuitstrijkjes	-	Number of cervical smear
Indicaties tot het maken van een uitstrijkjes	-	Indications for taking a smear
Klachten en/of symptomen	-	Complaints and/or symptoms
Preventief	-	Preventive
Initiatief huisarts	-	On initiative of general practitioner
Initiatief vrouw	-	On initiative of woman
Eerste	-	First

Figures 9 and 11

Aantal bij mannen verrichte sterilisaties	-	Number of sterilizations performed on men

Figures 10 and 12

Aantal bij vrouwen verrichte sterilisaties	-	Number of sterilizations performed on women

Figures 13 and 14

Aantal malen, dat de morning-after pil werd voorgeschreven	-	Number of prescriptions of the morning-after pill
Geografische verdeling	-	Geographical distribution
Leeftijdsgroep	-	Age group

Figures 15 and 16

Aantal patiënten met een hondebeet	-	Number of patients with a dog bite

Figure 17

Aantal meldingen van een suïcide (poging)	-	Number of reported (attempted) suicides

Figures 18 and 19

Aantal patiënten met een nieuw cerebrovasculair accident voor 1986-1987	-	Number of patients with a new cerebrovascular accident for 1986-1987

Figures 20 and 21

Aantal nieuwe verwijzingen wegens psychosociale problematiek, naar leeftijdsgroep, per 10.000 mannen en vrouwen 1986-1987	-	Number of new referrals for psychosocial problems, by age group per 10 000 men and women for 1986-1987

Figures 22

Aantal voorschriften flunitrazepam (=Rohypnol), per provincie- en urbanisatiegroep en voor Nederland per 10.000 mannen en 10.000 vrouwen voor 1987

- Number of prescriptions of flunitrazepam (Rohypnol), per province and urbanization group and for the Netherlands per 10 000 men and 10 000 women for 1987

Figures 23

Aantal voorschriften flunitrazepam per leeftijdsgroep per 10.000 mannen en per 10.000 vrouwen voor 1987

- Number of prescriptions of flunitrazepam per age group per 10 000 men and per 10 000 women for 1987

Figures 24

Aantal voorschriften flunitrazepam per kwartaal per 10.000 mannen en per 10.000 vrouwen voor 1987

- Number of prescriptions of flunitrazepam per quarter per 10 000 men and 10 000 women for 1987