continuous morbidity registration sentinel stations the netherlands

1988/1989

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FOREWORD

An annual report over a period of two years is unusual in the tradition of the Continuous Morbidity Registration Sentinel Stations.

Nevertheless, in consultation with the Counselling Committee this was decided upon in order to make up arrears in the activities, arrears partly caused by the completion of a number of special projects. The latter resulted in three publications: "Kankerregistratie gepeild", "The Dutch sentinel practice network; relevance for public health policy" and "Cerebro-vasculaire aandoeningen gepeild".

The present report gives information on the trend in a number of phenomena in the years up to and including 1989.
For instance, the decline in the number of sterilizations performed is continuing; as earlier seen among women, the percentage of men sterilized at some time is also falling for the first time.
There is an increase in the number of consultations of the general practitioner in which Aids comes up for discussion, and the impression exists that there is an increase in the number of women becoming pregnant despite contraception considered adequate.
In the period under review compared with 1987 no increase can be noted in the number of requests for application of euthanasia. Nor has an increase been determined in the number of eating disorders over a five-year period.
The report also contains information on subjects that have been registered over a short period.
A glance at the table of contents gives insight into the varied nature of these subjects. The Continuous Morbidity Registration Sentinel Stations is a registration project in primary health care and it is our firm belief that the information collected contributes to insight into the functioning of primary health care.

Prof. Dr. J. van der Zee,
Deputy Chairman, Counselling Committee Sentinel Stations.

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. 8-11).
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. 137-138).
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. 19).
Every 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. 139-141) 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 1988-1989 the contacts in the International Primary Care Network were continued. In this international network no research was performed in 1988-1989.

Since the end of 1988 participation has been taking place in a second international network. Eurosentinel is a cooperative effort of sentinel station networks in countries of the European Community and Switzerland, organized by the Institute for Hygiene and Epidemiology, Brussels. The objective of this project is to promote the creation of sentinel station networks in countries of the European Community and then cooperation between these networks. In 1989 the first research project was performed by Eurosentinel: in October of that year the general practitioners in the various countries collected data on the blood tests requested by them.

The investigations in both the International Primary Care Network and Eurosentinel present the possibility of making comparisons between countries.

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 consist 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 1989 the committee functioned in the following composition:

	Mrs Drs J.M. Bensing,[2]
	Dr H. Bijkerk, M.D.[4] (to 1-4-'89)
	F.K.A. Fokkema, M.D.[5]
	P. van Leeuwen, statistician[7] (from 1-5-'88)
	J.J.L. Pieters, M.D.[4] (to 1-4-'89)
	C.A. Postema, M.D.[4] (from 1-4-'89)
	H.O. Sigling, M.D.[5,6]
	W.A. van Veen, M.D.[1]
	J.J. Zandvliet[1]
	Prof. Dr J. van der Zee, Ph.D.[3]
Project leader:	A.I.M. Bartelds, M.D.
Secretary:	Mrs E. Colet-van Woezik
	Mrs M. Heshusius-van Valen

This committee met twice in 1988 and in 1989. It had one vacancy in that year.

MEETING OF SPOTTER CO-WORKERS 1988 and 1989

Contact between the spotter physicians and their co-workers, the Counselling Committee, those responsible for the topics in the report and the project management is of great importance to a registration project like the Sentinel Stations. Every year, at the beginning of a new registration period, a meeting is held for that purpose.

Accounts are given of concluded registrations and problems with the collection of the data on subjects that appear on the weekly return for several years are discussed; in conclusion new topics on the weekly return are introduced.
If necessary organizational aspects of the Sentinel Stations come up for discussion.

1988 meeting
At the meeting on 9 January 1988 K. van der Meer, M.D., discussed the first results of the registration and follow-up of the patients with a cerebrovascular accident. Registration of this took place in 1986 and 1987.
In the annual reports for 1986 and 1987 the first results of this registration were discussed. In 1990 the definitive results of this investigation were presented in two articles in Huisarts en Wetenschap (see also the list of publications as per 1-1-1991, p. 132).

O. Sigling, M.D. member of the Counselling Committee, discussed in a second presentation some results of his study among the spotter physicians into the experience and views of general practitioners concerning patients with a depressive syndrome. This study took place during the registration of the occurrence of the depressive syndrome in general practice in 1983-1985.
The data that have been collected by the spotter physicians relate to:

a. the extent of medical assistance by general practitioners in the case of a depressive syndrome (the "registration data)" and
b. the qualitative characteristics of therapeutic action in the case of a depressive syndrome (the "questionnaire data").

In the reports for 1983, 1984 and 1985 the data relating to the extent were discussed. In his presentation Sigling now discussed the qualitative characteristics of therapeutic action by the general practitioner in the case of a

depressive syndrome.
The profile of the views and choices of the spotter physicians with regard to action in the case of patients with a depressive syndrome is as follows.
The spotter physician is of the opinion that not every patient with a depressive syndrome has to be treated and that non-medicinal treatment is to be preferred, alone or in combination with medicines. In practice he prescribes medicines somewhat more often than he would prefer, in which the sedating tricyclic compounds enjoy somewhat more preference than the recently developed compounds. The non-sedating tricyclic compounds were also still in use by him in the study period 1983-1985. Finally, for a depressive syndrome the spotter physician preferably refers to a psychiatrist, although the regional institutes for ambulatory mental health care (RIAGG) and general social work form good alternatives. It proves that for the general practitioner it is not the further diagnosis but the lack of his own competence as also the failure of the treatment and the danger of suicide that form the most common indications for referral. Specific psychotherapy more often forms a reason for referral than specific pharmacotherapy. Factors in the doctor-patient relation form for half of the physicians sometimes a reason for referral, but for a quarter of them never.

This no more than broad orientation towards a number of aspects of the general practitioner's action in the case of patients with a depressive syndrome invokes many questions regarding the background to this action, Mr Sigling concluded.
How uniform and consistent is this action? To what extent is it based on insight and expertise, or on intuition and improvisation? What instinctive factors play a part in the contact with depressive patients?
And finally, which ontological views on depression form the basis of all this? In other words, according to Sigling, what kind of a phenomenon is depression actually?
The investigation into these questions is not yet concluded and the presenter hopes to be able to report on this later.

In the third presentation the neurologist Dr E. Wijdicks, employed by the Teaching Hospital of the University of Utrecht, introduced the new topic "acute unusual headache". He discussed the results of a recent case-control study into the occurrence of acute unusual and violent headache among patients who had been admitted to hospital with a subarachnoidal haemorrhage. Of these patients, about half confirmed that they had suffered a headache attack of the above kind in the months preceding the subarach-

noidal haemorrhage. Among patients who had been hospitalized for a cerebral infarction that was significantly less the case and among 100 patients who had been admitted for non-neurological reasons such a headache did not appear in the anamnesis.
It is expected that the prognosis of a subarachnoidal haemorrhage is more favourable upon recognition of the "warning leak" that causes the acute unusual headache and the treatment of its cause: a minor haemorrhage in the aneurysmal wall without this resulting in a rupture or a haemorrhage as the result of a minor non-increasing rupture.
The presenter discussed the clinical picture of the subarachnoidal haemorrhage on behalf of the spotter physicians with the aim of promoting recognition thereof. The procedure of registration was discussed with the spotter physicians.

1989 meeting

The 1989 meeting began with the subject with which the 1988 meeting had ended: acute unusual headache as a possible warning a few months in advance of a subarachnoidal haemorrhage.
Mrs F. Linn, an assistant physician training as a neurologist at the Teaching Hospital of the University of Utrecht, discussed the results of the registration for 1988. The number of reports of patients with acute unusual headache is a small one: 30 for 1988. Of these 30, 21 were referred to a neurologist for further examination. One of them proved to have a subarachnoidal haemorrhage; another patient was suffering from a ruptured arteriovenous malformation. Two patients proved to be suffering from a viral meningitis and 17 of the referred patients from acute unusual headache of unknown cause. Mrs Linn discussed the characteristics of the reported patients.

Prof. Dr J. van Gijn, likewise with the neurology department of the Utrecht Teaching Hospital, considered these results in the light of the objectives of registration of this topic. He noted a lower incidence compared with earlier research in the Netherlands.
He outlined the further planning of the investigation and discussed the expansion of the number of participating general practitioners. This is considered necessary on account of the small number of reports in 1988 of acute unusual headache and the desire to gain more insight into the incidence of subarachnoidal haemorrhages in the Netherlands. An application will be submitted to the Netherlands Heart Foundation for expansion of the project.

An interim report on the registration of eating disorders was given by H.W. Hoek, psychiatrist/epidemiologist, now working in the psychiatry department of the Utrecht Teaching Hospital.
In 1985 and 1986 the physicians reported 101 patients who definitely met the DSM-III criteria used for anorexia nervosa and bulimia nervosa. Of these patients, the majority were women: 96 out of the 101.
There is a difference in age at which the two eating disorders manifest themselves. Anorexia nervosa appears in puberty and in adolescence; bulimia nervosa occurs more among young adults.
Of the patients with an eating disorder, only a small percentage receive no treatment; 50% of the patients with bulimia and 75% of the patients with anorexia nervosa are referred to mental health care.
Registration of these eating disorders continues to 1-1-1990; there are then data available over a five-year period.

In the third presentation Mrs van der Veer, of the Government Institute for Public Health and Environmental Hygiene, described the pattern of antibodies against a number of viruses in the sentinel station population.
In the population three groups may now be distinguished:

1. the people above the age of 40, who have not or only partially been vaccinated and possess a naturally acquired immunity,
2. the transitional group of the 30- to 40-year-olds, some of whom have been partially vaccinated and some not, and
3. the group below the age of 30, among which the percentage of those vaccinated is above 95.

Mrs van der Veer discussed the gaps in the serum collection and emphasized the missing data in the younger age groups. In discussion with the spotter physicians it emerged that the consistent collection of serum samples among young children in particular was at variance with the normal course of events in the practice. In a new round of serum collection allowance will have to be made for this aspect when organizing it.

DISTRIBUTION OF THE SPOTTER PHYSICIANS OVER THE NETHERLANDS

Figure 1
SENTINEL STATIONS
Continuous Morbidity Registration
1989

The number of sentinel stations in 1988 and 1989 was 45.
The number of general practitioners taking part a both years was 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 the Utrecht, North Holland and South Holland (western 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. 135-136) gives a survey of the general practitioners who took part in the sentinel station project during 1988 and 1989. In 13 sentinel stations there is cooperation between two or more general practitioners, viz 11 times 2, once between 3 practitioners and once between 4 practitioners. In January 1988 the percentage of general practitioners cooperating throughout the Netherlands was 55, and among the spotter physicians 50. There are 7 dispensing spotter physicians, 3 in urbanization group 1 and 4 in urbanization group 2, that is 12% of the total number of spotter physicians. For the Netherlands as a whole this percentage is 12[2].

Tables 1 and 2 give a distribution of the number of spotter physicians and sentinel stations per province and urbanization group in the years 1970-1987. 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 1: distribution of the spotter physicians (general practitioners) and sentinel stations per province group in the years 1970-1989[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
1988	10	6	10	8	28	21	14	10
1989	10	6	10	8	28	21	13	10

Table 2: distribution of the spotter physicians (general practitioners) and sentinel stations per urbanization group in the years 1970-1989

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
1988	9	6	39	26	14	13	62	45
1989	9	6	38	26	14	13	61	45

THE PRACTICE POPULATIONS

A complete census of the practice populations took place in 1987; these details are used for processing with effect from 1-1-1988. In 1989 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 90 292 inhabitants (as per 1-1-1989).

Table 3: 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	1 593 456	22 224	(1.4%)
	B	3 012 305	23 662	(0.8%)
	C	6 570 200	65 921	(1.0%)
	D	3 627 811	34 681	(0.9%)
urbanization	1	1 688 736	22 177	(1.3%)
group	2	9 572 574	90 638	(0.9%)
	3	3 542 462	33 694	(0.9%)
sex men		7 316 590	71 714	(1.0%)
woman		7 488 650	74 795	(1.0%)
total		14 805 240	146 509	(1.0%)

Province group A (the northern provinces) and urbanization group 1 (rural municipalities) are relatively somewhat overrepresented.

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	1.3	0.6	0.7	0.8	0.8	0.7	0.8	1.1	1.1	0.7	0.8	0.9	0.9	0.8	0.8
5- 9	1.5	1.5	0.8	0.7	1.1	1.0	1.0	0.9	1.3	1.3	0.9	0.9	1.1	1.0	1.0	1.0
10-14	1.4	1.5	0.7	0.8	1.0	1.1	0.9	1.1	1.3	1.4	0.9	1.0	0.9	0.9	0.9	1.0
15-19	1.4	1.5	0.8	0.8	1.0	1.0	1.1	1.1	1.4	1.5	1.0	1.0	0.9	0.9	1.0	1.1
20-24	1.3	1.5	0.9	0.9	1.0	1.1	1.0	1.0	1.5	1.5	1.0	1.1	0.9	0.9	1.0	1.1
25-29	1.4	1.5	0.9	0.8	1.0	1.0	0.9	0.9	1.2	1.4	1.0	0.9	0.9	1.0	1.0	1.0
30-34	1.4	1.5	0.8	0.7	1.0	1.0	0.9	1.0	1.2	1.3	0.9	0.9	1.0	1.1	1.0	1.0
35-39	1.5	1.6	0.7	0.7	1.0	1.0	1.0	0.9	1.3	1.4	0.9	0.9	1.0	1.0	1.0	1.0
40-44	1.3	1.4	0.7	0.7	1.0	1.0	0.9	1.0	1.3	1.3	0.9	0.9	0.9	0.9	0.9	1.0
45-49	1.3	1.4	0.7	0.8	0.9	1.0	0.9	1.0	1.2	1.3	0.9	1.0	0.9	0.9	0.9	1.0
50-54	1.4	1.3	0.8	0.8	1.0	1.0	0.9	1.0	1.3	1.4	0.9	1.0	0.9	1.0	1.0	1.0
55-59	1.2	1.2	0.9	0.8	1.0	1.1	1.0	1.0	1.3	1.4	1.0	1.0	1.0	1.0	1.0	1.0
60-64	1.3	1.3	0.8	0.8	1.1	1.1	1.0	0.9	1.4	1.3	1.0	1.0	1.0	1.0	1.0	1.0
65-69	1.4	1.2	0.8	0.8	1.0	1.0	0.8	0.8	1.3	1.3	0.9	0.9	0.9	0.9	1.0	0.9
70-74	1.3	1.2	0.8	0.8	1.1	1.0	1.0	1.0	1.4	1.2	1.0	1.0	0.9	0.9	1.0	1.0
75-79	1.4	1.3	0.9	0.7	1.0	0.9	1.0	0.9	1.2	1.1	1.0	0.9	1.0	0.8	1.0	0.9
80-84	1.1	1.2	1.0	0.7	1.0	1.0	0.9	0.9	1.2	1.1	1.0	1.0	0.9	0.9	1.0	0.9
> 84	1.3	1.2	1.0	0.7	1.1	1.0	1.1	1.1	1.3	1.3	1.0	1.0	0.9	1.0	1.1	1.0
total	1.4	1.4	0.8	0.8	1.0	1.0	0.9	1.0	1.3	1.3	1.0	1.0	0.9	1.0	1.0	1.0

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

SCOPE AND CONTINUITY OF THE REPORTING

Since 1975 the number of days reported annually per sentinel station and the number of all days per week of all sentinel stations together have been examined and processed. In this an effort was made to follow the scope and continuity of the reporting. In general the spotter physicians state - or have someone state - whenever they cannot report (vacation, 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 1989 it was 11 700 (52 weeks x 5 days x 45 sentinel stations). Table 4 shows the absolute numbers and percentages.

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

year	maximum number of days which can be reported	actual number of reported days absolute	percentage
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%
1988	11 700	10 307	88.1%
1989	11 700	10 380	88.7%

The percentage of reporting days is practically the same in 1989 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 largez cities are the lowest, 86.6%, and the eastern provinces the highest, 92.2%.

Per province group		Per urbanization group	
A	92.9%	1	92.2%
B	88.5%	2	88.9%
C	87.6%	3	86.6%
D	88.6%		

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 25 (maximum 45 x 5= 225).

Figure 2
The number of days registered in 1989 per week.

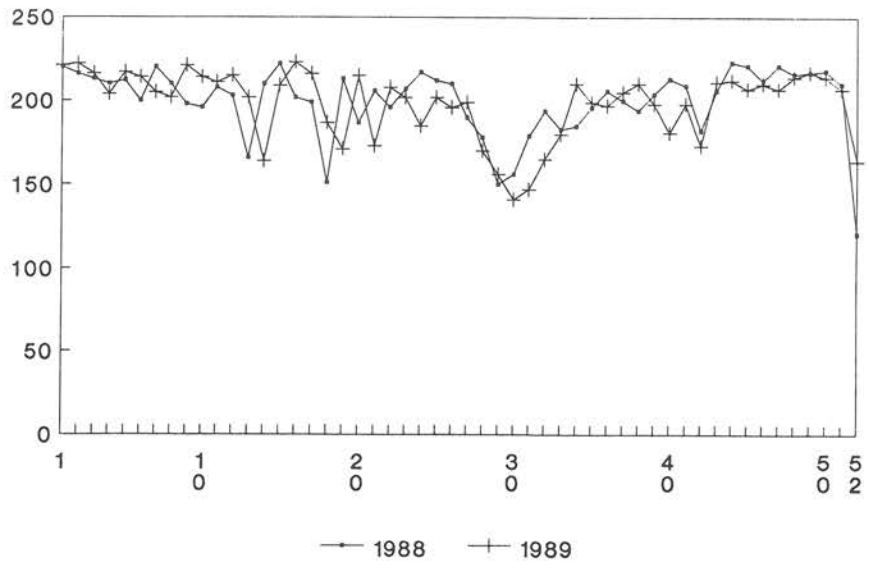


Table 5 presents the frequency distribution of the number of days not reported per sentinel station. The average number of non-reporting days per sentinel station in 1989 is 29, clearly lower than in 1987.
A breakdown into single and group practices shows a clear difference here, viz 35 and 17 days respectively. This is in line with the frequent assertion that forms of cooperation of general practitioners increase the continuity of reporting.

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

number of days not reported on	number of sentinel stations								
	1981	1982	1983	1984	1985	1986	1987	1988	1989
< 0	2	1	2	2	1	0	0	1	1
1- 9	9	9	7	6	8	7	4	7	6
10-19	2	2	5	3	1	4	7	2	6
20-29	3	6	1	7	8	7	1	5	5
30-39	18	15	12	9	10	10	5	15	15
40-49	8	10	14	17	15	13	16	13	9
50-59	2	3	4	1	2	2	10	2	2
60-69	1	0	1	1	0	1	1	0	1
70-79	0	0	0	0	0	0	0	0	0
80-89	1	0	0	0	0	0	0	0	0
90-99	0	0	0	0	0	0	0	0	0
> 99	0	0	0	0	0	1	0	0	0
total number of sentinel stations	46	46	46	46	45	45	44	45	45
average	31	29	31	31	30	31	37	27	29
median	38	34.5	37	35	34	34.5	43	35	33

Further study of this table shows an 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.
In 1987 a deterioration may be noted compared with 1985 and 1986. In 1988 and 1989 a recovery occurs.

THE WEEKLY RETURN (Appendix 2, p. 137-138)

The questions on the weekly return for 1988 and 1989 were composed as follows; it is stated in brackets in which year the topics were added to the return.

		1988	1989
1.	New cases of influenza (-like illness) (1970);	+	+
2.	Cervical smear (1976);	+	+
3.	Admission of psychiatric patients (1988);	+	-
4.	Discharged psychiatric patients (1986);	+	-
5.	Sterilization of the man performed (1972);	+	+
6.	Sterilization of the woman performed (1974);	+	+
7.	Prescription of morning-after pill (1972);	+	+
8.	Burns (1988);	+	+
9.	(Attempted) suicide (1979);	+	+
10.	Acute unusual headache (1988);	+	+
11.	Echography applied for (1988);	+	-
12.	Dementia (1987);	+	-
13.	Prescription of Rohypnol (1987);	+	-
14.	Pregnancy despite conctraception considered adequate (1987).	+	+
15.	Out-patients and clinical mammography (1988);	+	+
16.	Concern about AIDS (1988);	+	+
17.	Referral for logopedics (1989);	-	+

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.

The subjects in alphabetical order can be found in Appendix 3 (p. 139-141) together with the years of registration.

PROCESSING OF THE DATA ON THE WEEKLY RETURN

This report contains the results of the weekly return for 1988 and 1989. 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 142) the age structure as on 1 January 1989 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. 144-159):
Tables 1a, 1b, 1c and 1d: give the number of patients per 10 000 of the age group[6] .
Tables 2a, 2b, 2c and 2d: give the number of patients per 10 000 the urbanization group.
Tables 3a, 3b, 3c and 3d: 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 the worldwide influenza surveillance.

Influenza 1988-1989 and 1989-1990

Figs. 3.1-3.3 give the number of new cases of influenza per 10 000 inhabitants per week for the Netherlands and per province and urbanization group for the 1988-1989[8] season. Figs. 4.1-4.3 give the number of new cases of influenza for the 1989-1990 season. The progress of influenza in the first weeks of 1988 was already described in the 1987 report.

Figure 3.1
Number of patients with influenza(-like illness) per week and per 10 000 inhabitants, for the Netherlands, 1988-1989

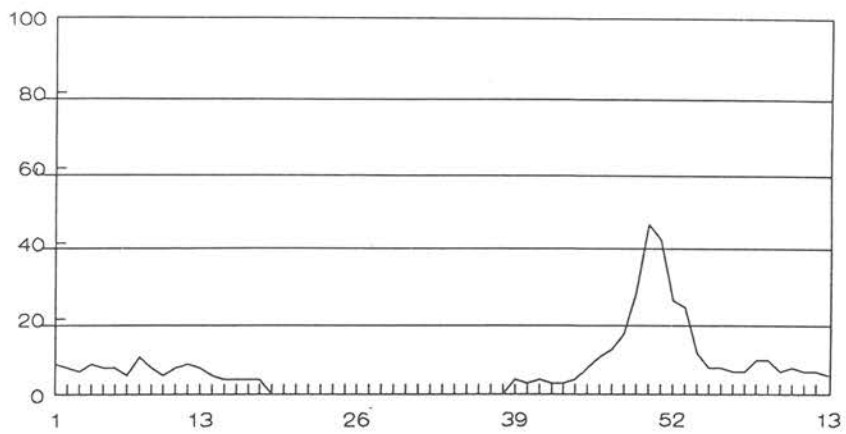


Figure 3.2
Number of patients with influenza(-like illness) per week and per 10 000 inhabitants, per urbanization group,1988-1989

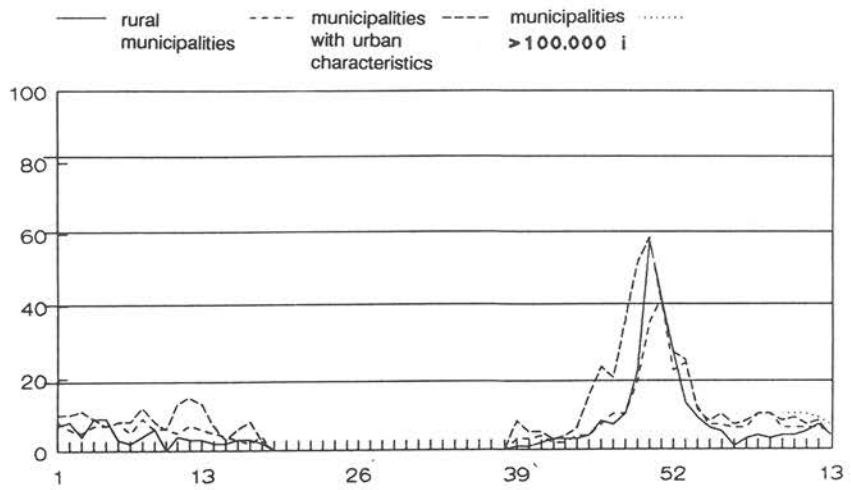


Figure 3.3
Number of patients with influenza(-like illness) per week and per 10 000 inhabitants, per province group, 1988-1989

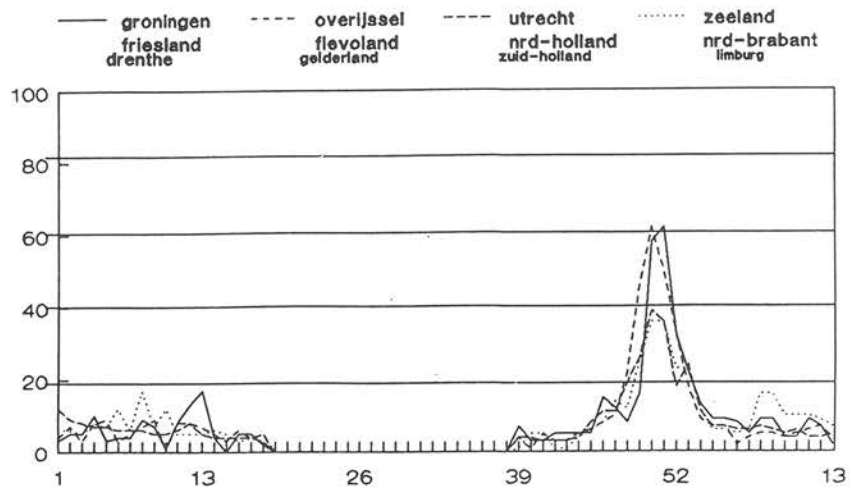


Figure 4.1
Number of patients with influenza(-like illness) per week and per 10 000 inhabitants, for the Netherlands, 1989-1990

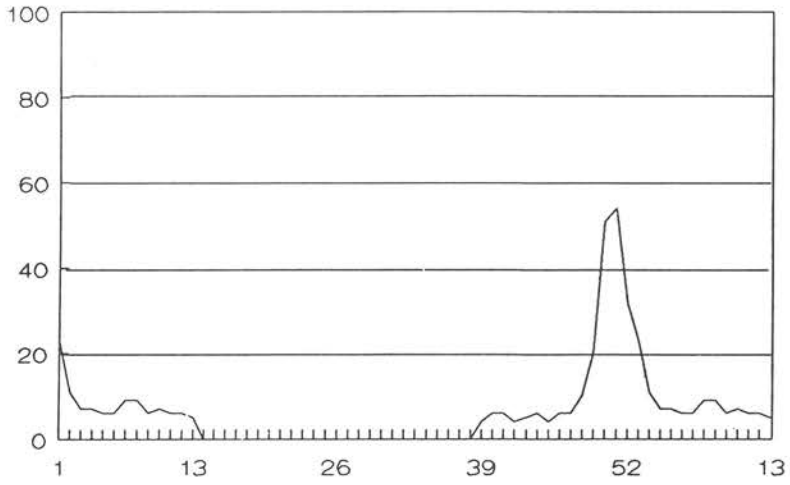


Figure 4.2
Number of patients with influenza(-like illness) per week and per 10 000 inhabitants, per urbanization group, 1989-1990

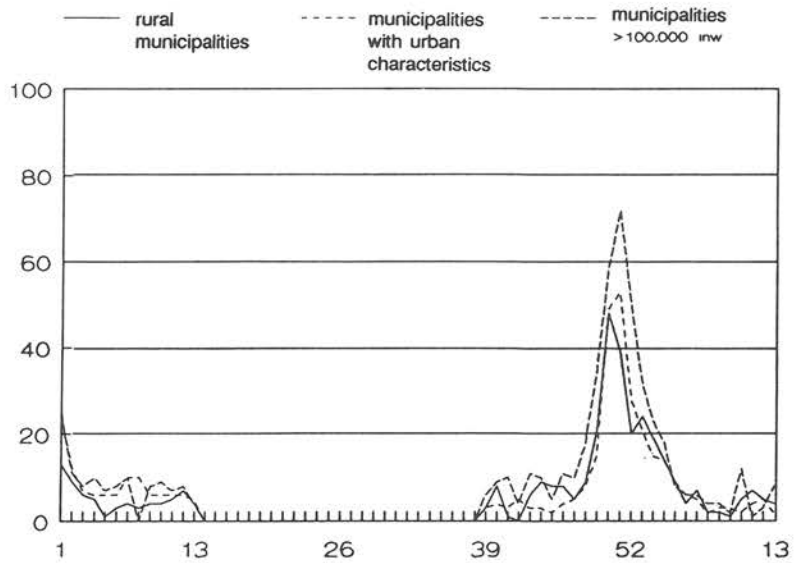
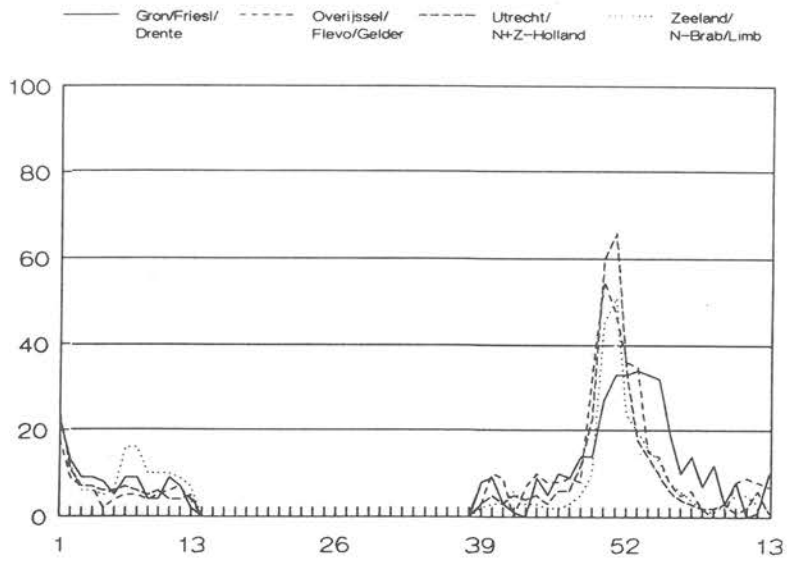


Figure 4.3
Number of patients with influenza(-like illness) per week and per 10 000 inhabitants, per province group, 1989-1990



1987-1988 season

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 formed an exception to this. The trend was milder. The 1987-1988 season had an even milder influenza wave. In the first weeks of 1988 the incidence began to increase slightly; in week 8 the highest incidence was attained: 10 persons per 10 000 inhabitants. This is barely an increase above the level throughout the year. Insofar as isolations were performed, the influenza-A virus was found.

1988-1989 season

For the first time for a number of years there was in 1988 again a clear increase in the reports of influenza-like illnesses in the last weeks of the year. From week 46 onwards the incidence lies above 10 per 10 000 inhabitants. For the country the incidence is the highest in week 50 of 1988: 45 per 10 000 inhabitants.

In the first weeks of January 1989 the weekly reports fell back again quickly. In this season too the size of the influenza epidemic was therefore limited.

The northern and eastern provinces recorded the highest incidence of the provinces in the 1988-1989 season: 62 and 63 per 10 000 respectively. Of the degree of urbanization groups it was this time the rural municipalities where the highest incidence in any week was found: 58 per 10 000 inhabitants in week 50.
However, the cities underwent an "influenza wave" that lasted longer (see also Figs. 3 and 4). In the main influenza A was isolated (H_3N_2 and a single isolation of H_1N_1).

1989-1990 season

In the 1989-1990 season too the start of the epidemic rise in influenza-like illnesses was situated at the end of the calendar year.
From week 48 of 1989 the incidence rates for the Netherlands were above 10 per 10 000 inhabitants. In week 51 the highest incidence of this season was reported: 54 per 10 000 inhabitants.
The highest incidence in the subgroups was found in the eastern provinces in week 51: 66 per 10 000 inhabitants, and in the cities: 72 per 10 000 inhabitants.
In the first weeks of 1990 the incidences of the reports of influenza-like illnesses fell quickly. In week 4 the number of reports was again below 10 per 10 000 inhabitants.
In the 1989-1990 season too mainly influenza A strains were isolated.

Table 6: number of patients with influenza (-like illness), per 10 000 inhabitants, 1980-1989

year	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
total per calendar year	425	491	497	396	502	464	630	365	399	410
highest weekly incidence per "season"	36	20	42	53	57	71	26	9	44	54

If we examine the epidemics of the past ten years, that of the 1986-1987 season was the mildest in that period. In the 1987-1988 season one may not speak of an influenza epidemic at all. In 1988 an "influenza wave" occurred for the first time for years at the end of the calendar year. In 1989 there was again an "influenza wave" at the end of the calendar year.

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. 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 1988 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 1986. And for 1989 it means thats a smear is reported as a repeat smear when the general practitioner hay already taken a smear from the woman in question after 1 Januari 1987. This period is identical with the interval between two mass screenings.

This topic has required a somewhats charged objective, since in March 1982 the then Minister of Public Health and Environment announced the intention to amend the policy regarding mass screening for cervical cancer. On 25 August 1988 agreement was reached between the Association of Netherlands Health Insurance Funds and the professional organizations of general practitioners on reimbursement for the taking of cervical smears from patients covered by a health insurance fund (provisionally directed towards women of 25-54 years, and with a screening interval of three years). This made it possible to start the mass screening for cervical cancer throughout the Netherlands in 1989.
Enquiry among the spotter physicians revealed that mass screening for cervical cancer was in fact a reality in 1989 in 37 of the sentinel stations. In 1988 mass screening was a fact in only 22 of the 45 sentinel stations.

In Table 7 the total number of smears taken has been subdivided by indication for taking the smear, including the repeat smears.

Table 7: number of smears taken by spotter physicians by indication for taking a smear, per 10 000 women, 1980-1989

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
complaints and/or symptoms	62	57	57	65	57	62	65	59	76	72
"preventive" spotter physician's initiative	168	184	171	174	204	197	230	192	176	170
"preventive", woman's initiative	93	110	126	120	132	127	168	153	193	351
repeat smear	148	159	170	168	182	184	170	211	246	237
total	471	510	524	527	575	570	633	615	691	830

The total number of smears (830 per 10 000 women) was considerably higher in 1989 than in any year before. In 1989 the new-style mass screening started at many places in the country. 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 such a smear counts as a repeat smear.

The number of smears on account of complaints and/or symptoms in 1988 and 1989 was at a higher level than in recent years: around 60 per 10 000 women from 1980, in 1988 76 and in 1989 72 per 10 000 women. As regards this category 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 subcategory repeat smears has increased; in 1988 246 and in 1989 237 per 10 000 women.

Since 1987 the subcategory repeat smear has also been subdivided into:

smears on account of complaints and/or symptoms, preventive on the initiative of the general practitioner and preventive on the initiative of the woman. In the period 1987-1989 a practically constant number of approx. 60 repeat smears per 10 000 women were made on account of complaints and/or symptoms. The great majority of these repeat smears were made among women in the 30-54 age group.

The total number of first smears taken on preventive indication, i.e. on the initiative of both the general practitioner and the woman, was higher in 1988 than in 1987, 369 and 345 per 10 000 women respectively. The increase in 1989 was considerable: to 521 per 10 000 women.

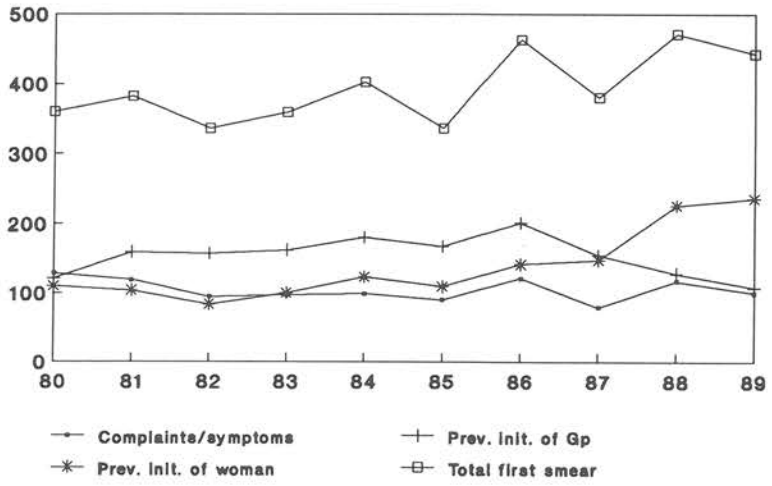
These subcategories make it possible to calculate from the total numbers the number of women who are reached via this method by the general practitioner. The number of women who are reached in this way at least once every three years may be seen in the total of Table 8. This table contains only the numbers 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 increased again in 1988, notably in the category "preventive", woman's initiative: in 1987 153 per 10 000 women as against 193 per 10 000 women in 1988. In 1989 this category in particular rose considerably. If a woman comes with a request for a smear after having been notified to attend the mass screening for cervical cancer, that is tallied in this category. For, even if the woman is "called up" under the mass screening to have a smear taken, it is her decision to have this done or not by her family doctor. At the doctor's initiative a smear was taken less frequently in 1988 and 1989 than was the case in 1987 (179 and 170 per 10 000 women in 1988 and 1989 as against 192 in 1987).

Table 8: number of **"first"** cervical smears taken per province group and urbanization group, by indication for taking a smear and for the Netherlands, per 10 000 women, 1980-1989

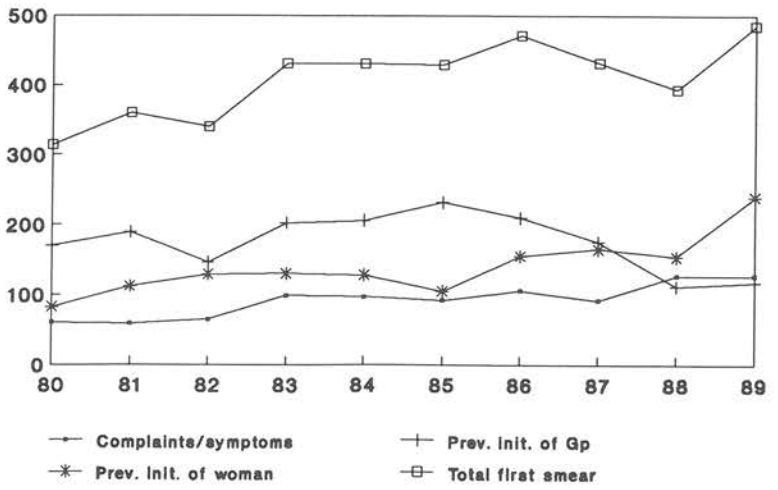
		province group				urbanization group			Nether-lands
		A	B	C	D	1	2	3	
complaints	1980	129	61	52	44	73	51	90	62
and/or	1981	119	59	41	52	73	39	95	57
symptoms	1982	95	65	44	58	78	37	98	57
	1983	97	99	49	53	90	44	105	65
	1984	99	97	37	45	78	42	84	57
	1985	90	92	45	52	85	49	78	62
	1986	121	106	42	43	93	54	75	65
	1987	79	92	46	48	79	49	69	59
	1988	117	127	56	51	118	58	96	76
	1989	100	127	54	48	102	57	90	72
"preventive"	1980	121	170	207	105	186	119	306	168
general	1981	159	189	223	112	239	147	247	184
practitioners's	1982	157	146	183	174	203	148	212	171
initiative	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
	1988	128	112	179	255	128	161	261	179
	1989	107	118	201	189	131	143	271	170
"preventive"	1980	110	83	104	66	67	92	120	93
woman's	1981	104	112	125	80	107	113	104	110
initiative	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
	1988	226	154	233	130	137	174	292	195
	1989	236	240	456	283	234	380	340	351
total	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
	1988	471	393	468	436	383	393	649	450
	1989	443	485	711	520	467	580	701	593

Figure 5
Number of cervical smears taken per province group by indication for taking a smear, per 10 000 women, 1980-1989

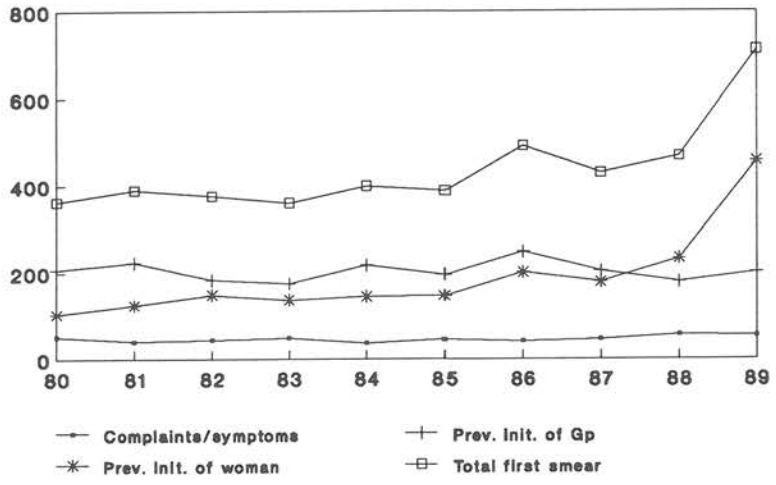
province group A



province group B



province group C



province group D

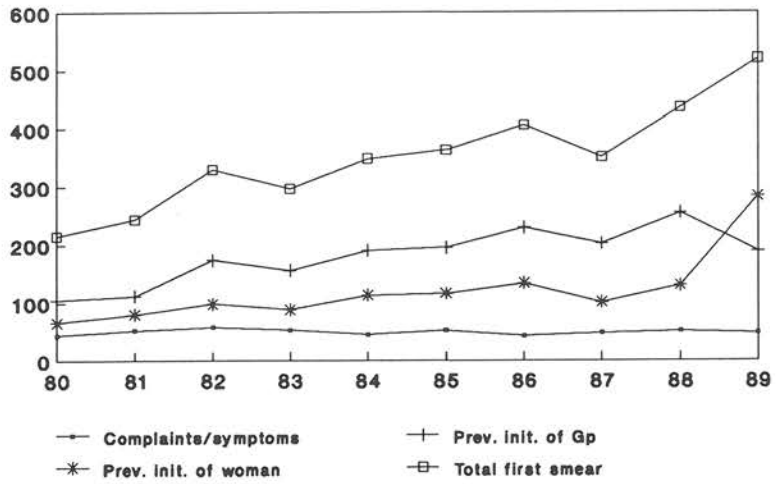
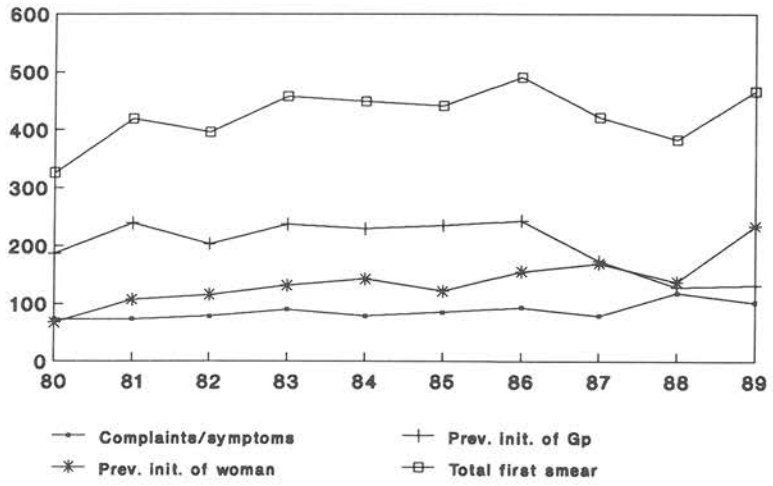
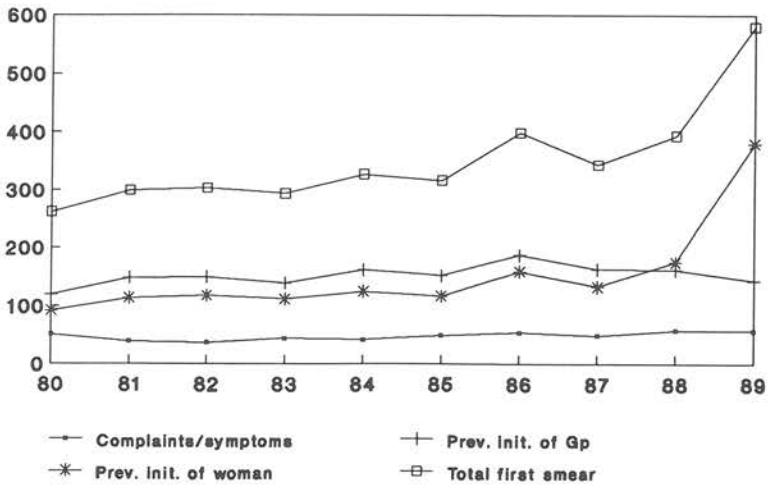


Figure 6
Number of cervical smears taken per urbanization group and for the Netherlands, by indication for taking a smear per 10 000 women, 1980-1989

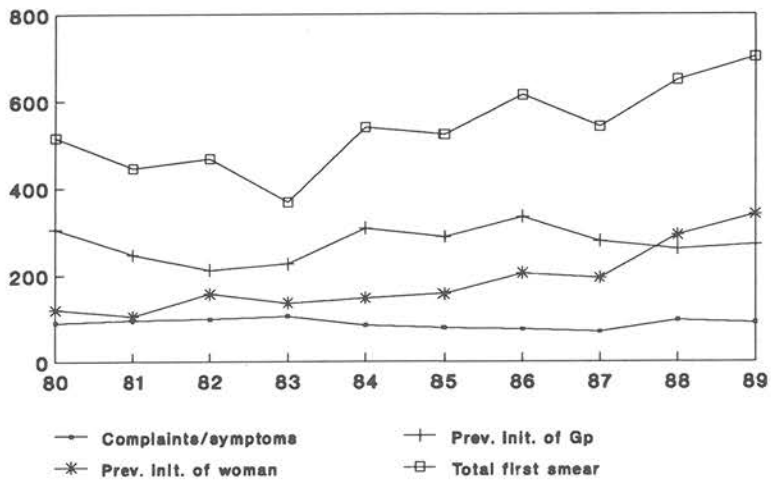
urbanization group 1



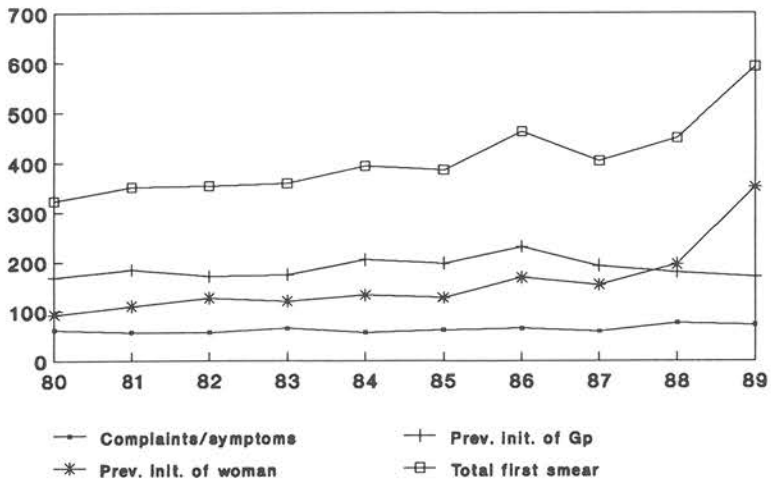
urbanization group 2



urbanization group 3



Netherlands



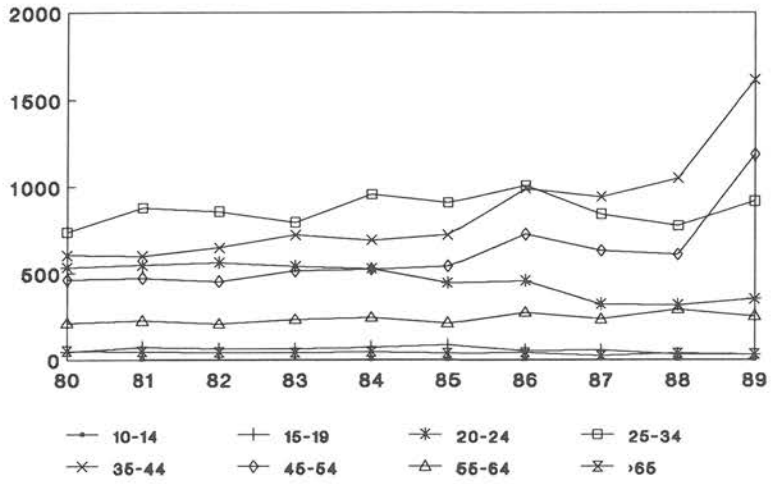
Age distribution

Table 9 gives a survey of the number of **"first"** smears by age group per 10 000 women (cf. Fig. 7).

Table 9: number of **"first"** smears taken by spotter physicians by age group, per 10 000 women, 1980-1989

	age group							
	10-14	15-19	20-24	24-34	35-44	45-54	55-64	>64
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
1988	(2)	33	319	777	1050	612	292	38
1989	(2)	32	353	919	1616	1187	253	32

Figure 7
Number of 'first' cervical smears taken by age group, per 10 000 women, 1980-1989



The increase in the number of "first" smears taken from 1987 onwards is, as expected, found in the 35-54 age group. There is also an increase in the 25-34 age group, but this is considerably smaller. For that matter, in previous years (1984-1986) the number of smears in the latter age group was at a similar level.

Table 10 gives a breakdown by age and indication for taking a smear, including the repeat smear (see also Fig. 8).

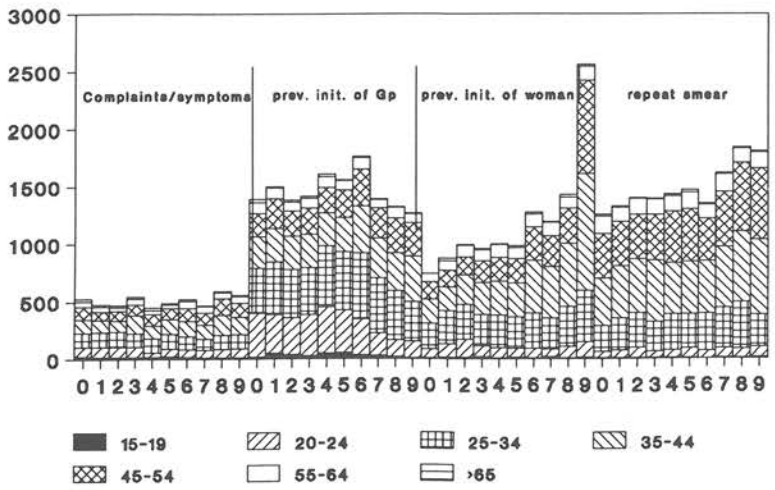
Table 10: number of smears taken by spotter physicians by age group and by indication for taking the smear, per 10 000 women, 1980-1989

		age group						
		15-19	20-24	25-34	35-44	45-54	55-64	>64
complaints and/	1980	21	84	122	121	108	47	20
or symptoms	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
	1988	11	72	126	170	148	51	9
	1989	13	75	123	151	125	54	12
preventive	1980	18	379	389	274	206	95	26
general prac-	1981	47	339	460	291	253	94	13
titioner's	1982	38	318	422	292	214	79	16
initiatief	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
	1988	16	146	431	327	303	99	4
	1989	(6)	146	345	399	290	75	6
preventive	1980	8	73	229	212	150	69	(5)
women's ini-	1981	9	119	292	205	148	85	17
tiative	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
	1988	7	101	345	550	305	94	25
	1989	13	132	451	1067	808	125	15
repeat smear	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
	1988	6	78	408	612	607	123	12
	1989	12	86	282	657	624	137	13

Table 10: number of smears taken by spotter physicians by age group and by indication for taking the smear, per 10 000 women, 1980-1989 (continuation)

		age group						
		15-19	20-24	25-34	35-44	45-54	55-64	>64
total	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
	1988	40	397	1310	1659	1363	367	50
	1989	44	437	1201	2274	1847	391	46

Figure 8
Number of cervical smears taken by age group and by indications for taking a smear, per 10 000 women, 1980-1989



The numbers of smears taken on medical indication do not bring any new aspects to light; compared with 1987 the numbers in practically all age groups are somewhat higher. This is the case in both 1988 and 1989.

The number of preventive smears on the initiative of the spotter physician is lower in most age groups in 1988 than in 1987. Exceptions are formed by the higher age groups: from 45 and older. The smears taken at the woman's request increased all along the line, above all in the age groups between 35 and 54 years. Repeat smears were taken somewhat more often in nearly all age groups in 1988 than was the case in 1987. In 1989 more repeat smears were taken, particularly in the older age groups. In the age groups up to 35 years the number of repeat smears fell.

Table 11: proportional distribution of smears taken per age group for all sentinel stations (as percentages), 1984-1989

	per age group total number of smears			
year	< 35	35-54	> 54	total
1984	45.9	46.8	7.4	100
1985	42.2	48.6	9.2	100
1986	42.5	49.8	7.6	100
1987	35.8	55.0	9.2	100
1988	36.1	57.4	6.5	100
1989	27.0	66.0	7.0	100
	per age group "first smear"			
1984	52.5	40.7	6.8	100
1985	48.7	42.8	8.5	100
1986	45.4	47.1	7.5	100
1987	40.0	51.5	8.5	100
1988	39.7	53.6	6.7	100
1989	29.7	63.8	6.5	100

The percentage of smears in the total increased for the 35-54 age group. The proportion of smears taken from women older than 54 remained about the same.
A decrease may be noted in the percentage of smears in the total for women younger than 35.
From 1987 there is already an increase in the percentage of smears in the 35-54 age group. The further increase seems above all to be the consequence of the new form of mass screening for cervical cancer that got started in 1989.
The increase in the number of smears is the greatest in the 35-54 age group whereby the indication is "woman's initiative". This initiative has probably been strongly stimulated by the letter sent to women in this age group as part of the new mass screening.

The results of this topic will continue to be of importance until the introduction of the national information system for the mass screening for cervical cancer that is currently being developed on the instructions of the Ministry of Welfare, Public Health and Culture.

This topic has been maintained on the weekly return in 1990.

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

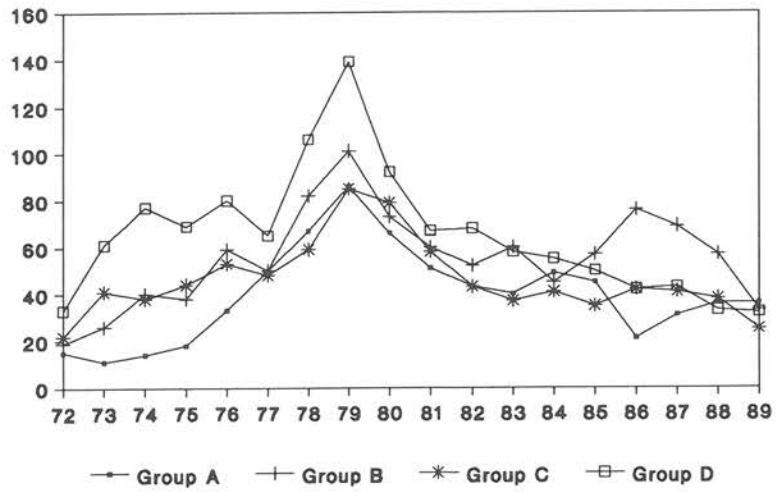
The number of sterilizations of men performed per 10 000 of all men and per province group and urbanization group is given in Table 12 (cf. Fig. 9).

Table 12: number of sterilizations of men performed, per province group and urbanization group per 10 000 men, 1980-1989

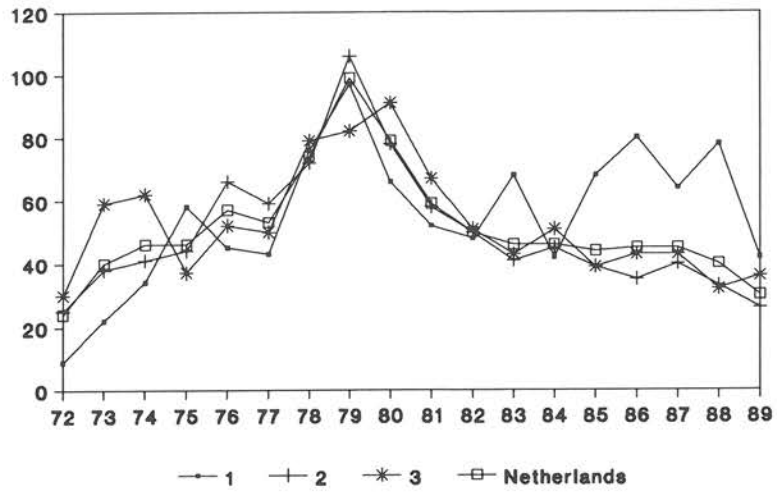
	province group				urbanization group			Nether-lands
	A	B	C	D	1	2	3	
1980	66	73	79	92	66	78	91	79
1981	51	60	58	67	52	58	67	59
1982	43	52	43	68	48	50	51	50
1983	40	60	37	58	68	41	43	46
1984	49	45	41	55	42	45	51	46
1985	45	57	35	50	68	39	39	44
1986	21	76	42	42	80	35	43	45
1987	31	69	41	43	64	40	43	45
1988	36	57	38	33	75	33	32	40
1989	36	33	25	32	42	26	36	30

Figure 9
Number of sterilizations of men performed, per province and urbanization group and for the Netherlands, per 10 000 man, 1972-1989

province group



urbanization group and the Netherlands



After peaks around 1979 the number of sterilizations had stayed around 45 per 10 000 men for five years. In 1988 a fall in this number occurred; this development continued in 1989. In that year 30 sterilizations per 10 000 men still took place.

After extrapolation one arrives at 29 500 sterilizations for the whole Netherlands in 1988 and 22 000 in 1989. A breakdown per quarter offers an opportunity to investigate whether a change in frequency may be a reaction to some event or the other by which the popularity of this method may have been affected. However, there is little difference between the quarters.

As also stated in the previous reports, if no other factors play a part one may expect in the course of time a stabilization as the result of the end of a "historical catching-up effect" coming into sight.
If in 1989 27 000 sterilizations of men had been performed (the "replacement factor"), the percentage of men sterilized at some time would have remained the same as that in 1988. As in reality 22 000 operations were performed, there was in 1989 for the first time a fall in the percentage of men sterilized at some time. This percentage of males in the Dutch population who, statistically speaking, belong to the fertile age category, decreased from 12.4% in 1988 to 12.3% in 1989[9].
An interesting development is that the percentage of men in the younger age group who have had themselves sterilized at some time has displayed a clear decline in recent years. In 1981 5.5% of the men between 22 and 31 had been sterilized, whereas that was only 2.5% in 1989.

In Fig. 11 (see p. 47) the number of sterilizations per 10 000 men of all subgroups together per year 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 12 (cf. Fig. 12 see p. 48).

Table 13: number of sterilizations of men performed, by age group, per 10 000 men, 1980-1989

	age group					
	15-19	20-24	25-34	35-44	45-54	55-64
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)
1988	-	(2)	78	139	33	(3)
1989	-	-	56	121	19	-

The highest frequency may be seen for all years in the 35-44 age group. There is still a reduction in the number of sterilizations performed in the 25-34 age group. Up to 1989 a relatively constant number of men above the age of 44 had themselves sterilized: around 30 per 10 000 men. In 1989, however, that number suddenly fell to 19 per 10 000.
A cumulative calculation shows that in the Netherlands since 1971 at least 614 500 sterilizations of men have been performed, that is on 8.4% of the total male population.
For a further study see the next section, in which the topic 'sterilization of the woman' is dealt with.

The question has been maintained on the 1990 weekly return.

STERILIZATION OF THE WOMAN

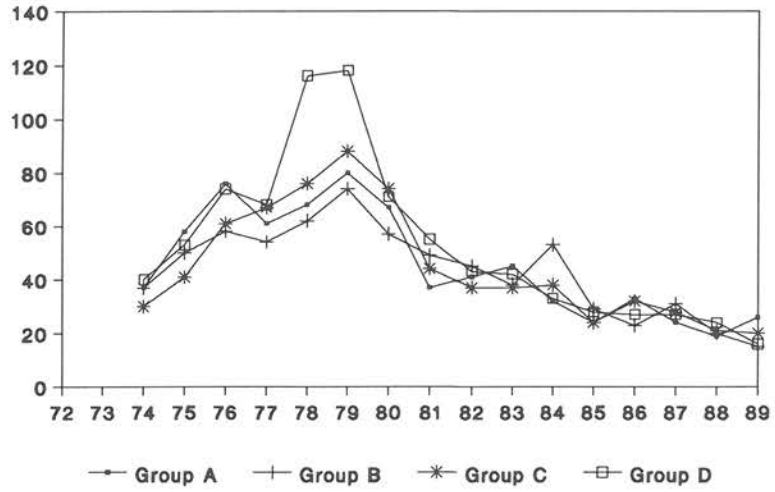
Sterilization of the woman performed was placed on the weekly return in 1974 (of the man performed in 1972).In 1988 22 sterilizations per 10 000 women were performed; in 1989 this was 19. Extrapolation of these figures to the whole of the Netherlands yields a number of 16 000 sterilizations in 1988 and 14 000 in 1989.
The number of sterilizations of women performed per 10 000 of all women and per province group and urbanization group is given in Table 14 (cf. Fig. 10).

Table 14: number of sterilizations of women performed, per province and urbanization group, and for the Netherlands per 10 000 women, 1980-1989

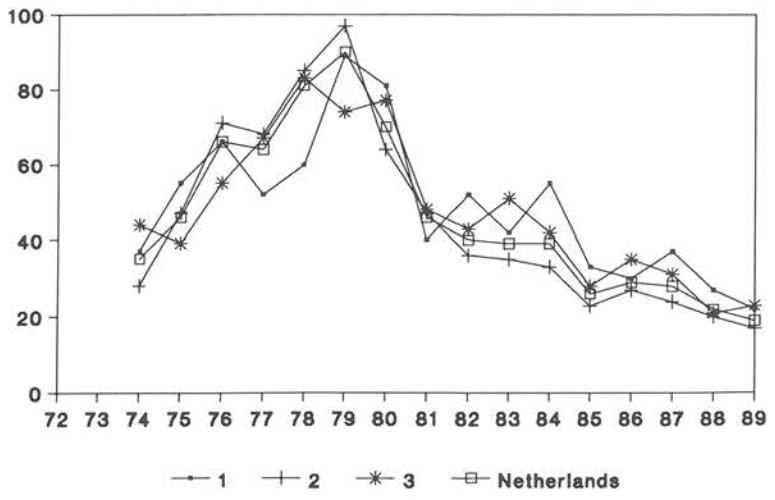
	province group				urbanization group			Nether-lands
	A	B	C	D	1	2	3	
1980	67	57	74	71	81	64	77	70
1981	37	49	44	55	40	47	48	46
1982	41	45	37	43	52	36	43	40
1983	45	38	37	42	42	35	51	39
1984	32	53	38	33	55	33	42	39
1985	24	29	24	28	33	23	28	26
1986	33	23	32	27	30	27	35	29
1987	24	31	28	27	37	24	31	28
1988	19	20	21	24	27	20	21	22
1989	26	15	20	16	22	17	23	19

Figure 10
Number of sterilizations of women performed, per province and urbanization group and for the Netherlands, per 10 000 women, 1972-1989

province group



urbanization group and the Netherlands



In 1988 and 1989, after three years with about the same number of sterilizations, a further decline occurred in the number of women having themselves sterilized. In the various subgroups a number of fluctuations occurred; the tendency over the years is still the same in each subgroup.

Fig. 11 gives a comparison between the number of sterilizations of men and women per year.The curves display a great deal of similarity up to 1985. The remarks made on the trend in the previous chapter are also applicable here. From 1985 onwards the curves for men and women diverged; in 1988 and 1989 more agreements can be determined.

Age distribution

The age-specific distribution of the number of sterilizations performed per 10 000 women is given in Table 15 (cf. Fig. 12).

Figure 11
Number of sterilizations performed per 10 000 men and 10 000 women, for the Netherlands, 1972-1989

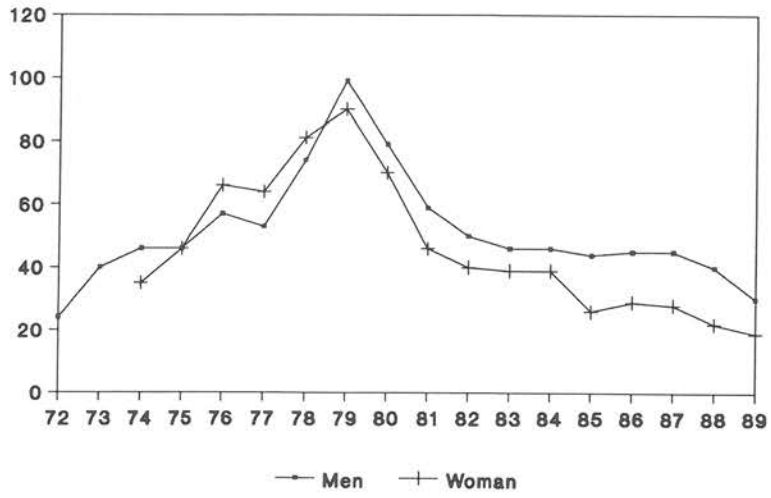


Figure 12
Number of sterilization performed by age group, per 10 000 men and women, 1972-1989

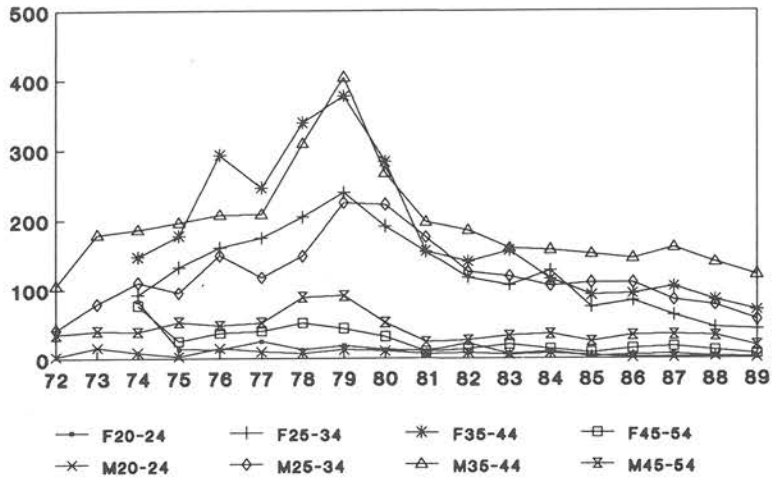


Table 15: number of sterilizations of women performed, by age group per 10 000 women, 1980-1989

	age group					
	10-14	15-19	20-24	25-34	35-44	45-54
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
1988	-	-	(3)	45	85	12
1989	-	(2)	(2)	43	70	(7)

The declining tendency is present in all age groups. The phenomenon sterilization of the woman is happening in the large majority of cases between the age of 25 and 45.

A cumulative calculation shows that in the Netherlands since 1973 sterilization has been performed on a total of at least 502 500 women, i.e. 6.7% of the present-day 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 had been sterilized. This percentage has since risen via approx. 18.5 in 1980, 22.4 in 1984 to 23.0 in 1986. In 1987 this fell slightly for the first time. This fall continued in 1988 and 1989. In 1989 this percentage was 22.3. The number of sterilizations (of men **and** women) that ought to have been performed in 1988 and 1989 together on the basis of this calculation to keep the total percentage equal to that of 1987 was 98 000. In reality this number was 82 000 (51 000 men and 31 000 women). Since 1985 there has been a fall in the percentage of sterilized women in the fertile age group (15-49). In 1984 this percentage reached its peak with 10.9%, after which it gradually declined to 10.2% in 1989. Since in 1989 for the first time the number of sterilizations of men also remained below the replacement value, one can now clearly speak of a decreasing popularity of sterilization as a birth control method. According to Dr E. Ketting, who made these calculations, the above is probably bound up with two factors. In the first place women want to have (further) children at a steadily later age, as a result of which a decision concerning sterilization is increasingly postponed and often also put off indefinitely. And in the second place objections to still using oral contraception at a later age have clearly been reduced in recent years, partly through the introduction of types containing a lighter dose, as a result of which the need for sterilization is decreasing.
Much more clearly even than among men the popularity of sterilization among young women has consequently been declining quickly in recent years. In 1980 6.9% of women aged between 25 and 29 had been sterilized, as against 2.0% in 1989. Since 1985 there has now also been a considerable decline among the 30-34 age group of women (from 13.8% in 1985 to 7.7% in 1989). In the 35-44 age group the decline is much less (from 21.2% in 1985 to 19.9% in 1989).

The topic sterilizations has been maintained on the weekly return for 1990.

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.

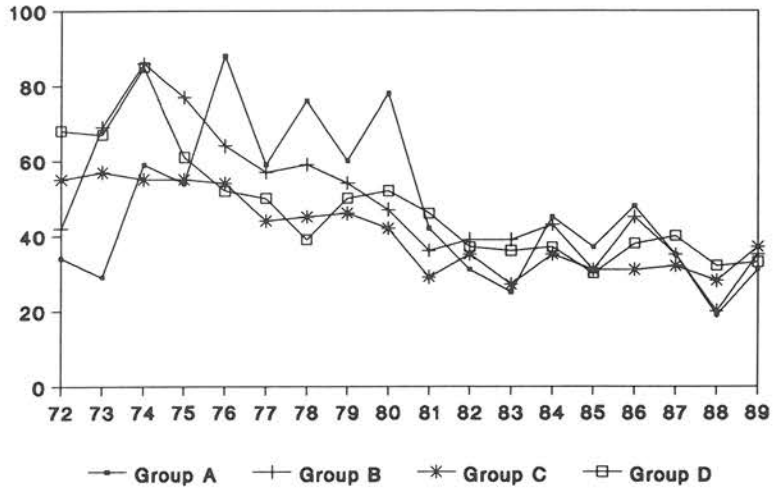
Table 16 gives the frequency with regard to the prescription of the morning-after pill, per province and urbanization group and for the Netherlands (cf. Fig. 13).

Table 16: number of prescriptions of the morning-after pill, per province and urbanization group per 10 000 women, 1980-1989

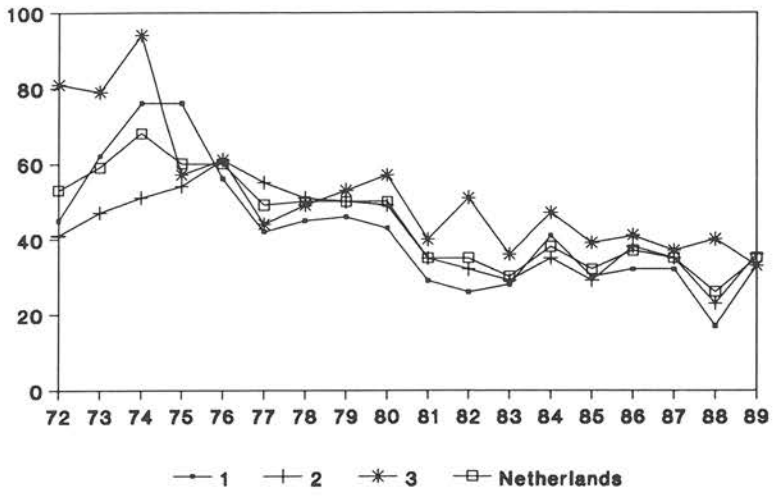
	province group				urbanization group			Nether-lands
	A	B	C	D	1	2	3	
1980	78	47	42	52	43	49	57	50
1981	42	36	29	46	29	35	40	35
1982	31	39	35	37	26	32	51	35
1983	25	39	27	36	28	29	36	30
1984	45	43	35	37	41	35	47	38
1985	37	31	31	30	30	29	39	32
1986	48	45	31	38	32	38	41	37
1987	35	35	32	40	32	35	37	35
1988	19	20	28	32	17	23	40	26
1989	31	35	37	33	33	36	33	35

Figure 13
Number of prescriptions of the morning-after pill, per province and urbanization group, per 10 000 women, 1972-1989

province group



urbanization group



Since 1981 the number of prescriptions issued for the morning-after pill has fluctuated around 35 per 10 000 women. 1988 formed an exception to this. At practice level a check has been made for the 1988 anomaly. There proves to be no question of distortion by a few practices, neither for the decline from 1987 to 1988 nor for the rise from 1988 to 1989.
In 1988 25 spotter physicians wrote fewer prescriptions for the morning-after pill, 10 wrote more and in 9 practices the figures for 1987 and 1988 were the same.
In 1989 the number of prescriptions rose compared with 1988 in 30 sentinel stations. In 12 sentinel stations fewer prescriptions were written; in 2 sentinel stations the same number of prescriptions was issued in 1988 and 1989.

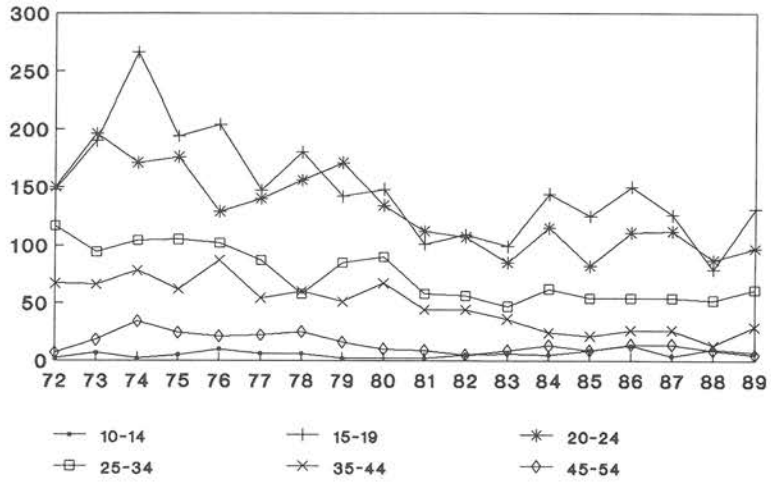
The quarterly figures show that in the second half of 1988 fewer morning-after pills were prescribed than in the quarters before and the four quarters of 1989.

Age distribution
Table 17 gives the age distribution of prescription of the morning-after pill (cf. Fig. 14).

Table 17: number of prescriptions of the morning-after pill, by age group, per 10 000 women, 1980-1989

	age group					
	10-14	15-19	20-24	25-34	35-44	45-54
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
1988	10	79	87	52	13	9
1989	(7)	131	97	61	29	(5)

Figure 14
Number of prescription of the morning-after pill by age group, per 10 000 women, 1972-1989



The temporary decrease in the number of prescriptions of the morning-after pill in 1988 occurred in practically all age, province and urbanization groups.
On the basis of our data it cannot be determined what made 1988 such a special year as regards the prescriptions of the morning-after pill.

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 in 1988 and once in 1989.
The absolute numbers under 20 years are given in Table 18.

Table 18: absolute numbers of prescription of the morning-after pill for women under 20 years, 1980-1989

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
11 years	-	-	-	1	-	-	-	-	-	-
12 years	-	-	-	-	-	-	-	-	-	-
13 years	-	1	1	1	1	1	-	-	-	1
14 years	-	-	1	2	2	4	5	2	1	-
15 years	8	13	12	5	7	3	7	6	1	2
16 years	20	9	14	16	21	18	16	15	9	12
17 years	32	14	17	23	21	32	30	11	10	7
18 years	23	17	16	15	28	15	15	11	3	4
19 years	17	16	16	7	12	6	8	16	22	49
total	100	70	78	70	92	79	81	61	46	75

The data in Table 18 seem to suggest that the age at which prescriptions are issued for the morning-after pill is moving upward somewhat. In 1988 and 1989 in the 10-20 age group it was above all the 19-year-old women that were given a prescription. In the years before it was more the 16-18-year-olds.
The extrapolation of the frequencies found for the morning-after pill to the Dutch population may be found on p. 112.
From 1983 onwards, at the request of Dr M.R. van Santen, gynaecologist in Zoetermeer, it was also requested that the kind of pill prescribed be noted. This was to investigate whether the "new morning-after pill" (now 2x2 tablets with 0.250 mg levonorgestril and 0.050 mg ethinylestradiol, on one day) has displaced the "old" one (5 mg ethinylestradiol for 5 days). This proves to be the case. In 1980 5 mg EE 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 appeared in which doubt was cast on the effectiveness of the "new morning-after pill"[10]. Others too published on the greater risk of failure of the "alternative 2x2 methods"[11]. In those publications it was concluded that the risk of failure is acceptably small; failure with these "alternative 2x2 methods" proves attributable above all to the difficulty of using them. It has also been suggested that a five-day treatment protects more than one coitus.

In 1987 the physicians again administered 5 mg ethynilestradiol to the women for five days in 30% of the prescriptions. Within a year's time a major change seems to have occurred here. In 1988 the percentage of prescriptions for 5 mg ethynilestradiol was 29, and in 1989 23.
Now it would seem that the general practitioner is making more effort accurately to give the correct indication (one coitus) and to prescribe only the correct 50 pill. Confidence in the morning-after pill thus seems to have been restored in this way.
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 1990 weekly return, with reporting of the product prescribed.

BURNS

Burns are described in the literature as the most severe injuries that one can suffer. The severity is caused among other things by the fact that the burns patient is often very much aware of undergoing the accident. Moreover, the permanent effects of the injuries are not infrequently considerable.

No exact data are available on the total number of patients with burns in the Netherlands. The Medical Registration Foundation (S.M.R.) of the Health Care Information Centre (SIG) mentions over 4 000 patients per year with burns who are admitted to Dutch hospitals. Of these patients, 450 are admitted annually to the specialized burns centres in the country (Beverwijk, Groningen and Rotterdam).
It is assumed that per year the general practitioner treats 50 000 people with a burn. However, this figure is based on an estimate.

One of the objectives of the Netherlands Burns Foundation is to undertake information activities regarding primary and secondary prevention of burns. As part of the research into the possibilities of preventing burns it is important that more quantitative information becomes available on the burns treated by the general practitioner. For only after analysis of the total problem of burns, and that includes a further description of the extent thereof, can effective activities of primary and secondary prevention be undertaken.
The Health Information and Education Department of Limburg University (headed by Prof. Dr G.J. Kok) was commissioned by the Netherlands Burns Foundation to perform an analysis of the above kind. For the collection of information on burns treated by the general practitioner the Continuous Morbidity Registration Sentinel Stations were approached.

In the registration attention is devoted to five aspects:
1. the incidence of burns in the Netherlands for which the general practitioner is consulted,
2. the severity of these burns, expressed in the area and depth of the burn,
3. the treatment instituted by the general practitioner,
4. the referrals by the general practitioner of patients with burns,
5. the origin of the burn, the circumstances of the accident.

In this reporting the results are stated on the registration on the weekly return. Reporting of the analysis of the data on the other points of interest collected by means of a supplementary questionnaire will take place elsewhere by Mrs O. van Rijn, of the Health Information and Education Department of Limburg University.

Results of the registration

Table 19 lists the numbers of patients who consult the general practitioner for the first time on account of a burn, by province and urbanization group and for the Netherlands (cf. Fig. 15).

Table 19: number of patients with a burn for which the general practitioner was consulted for the first time per province and urbanization group and for the Netherlands per 10 000 men and 10 000 women, for 1988 and 1989

		province group				urbanization group			Netherlands
		A	B	C	D	1	2	3	
1988	M	17	16	14	17	15	15	17	15
1989		18	19	22	19	19	18	26	20
1988	F	19	12	26	24	16	21	31	22
1989		30	12	23	30	15	25	29	24
1988	T	18	14	20	20	16	18	24	19
1989		24	16	22	25	17	21	27	22

Figure 15
Number of first consultations on account of a burn per province and urbanization group and for the Netherlands, per 10 000 men, 1988-1989

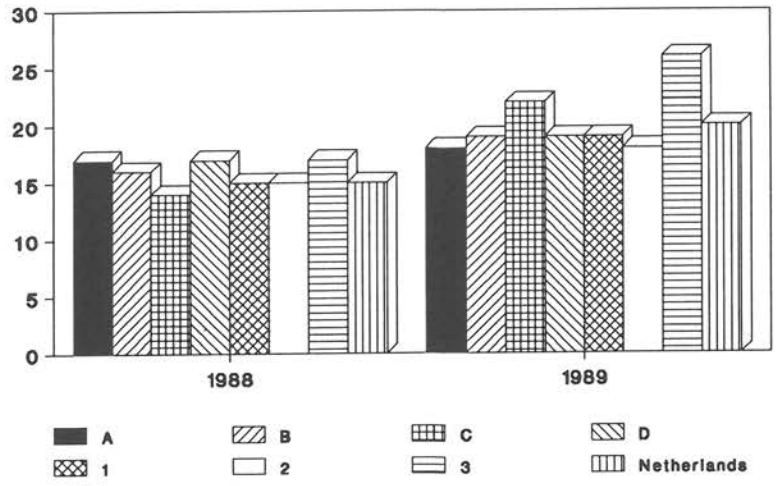
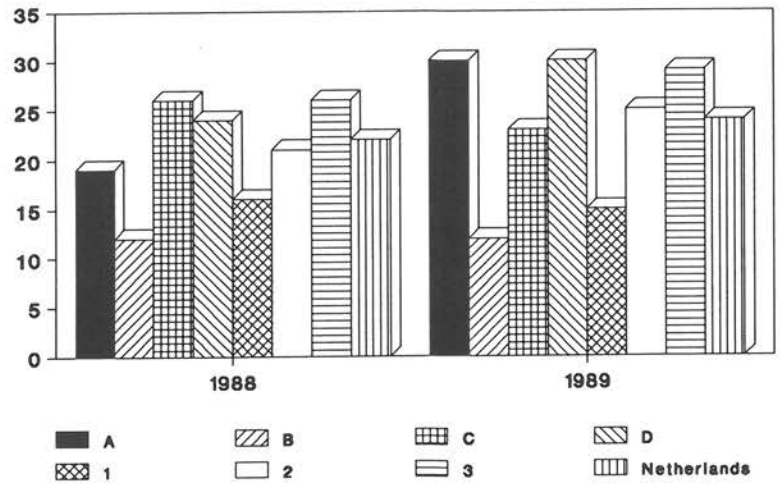


Figure 15
Number of first consultations on account of a burn per province and urbanization group and for the Netherlands, per 10 000 women, 1988-1989



The number of reports of first consultations of the general practitioner for a burn is practically the same in both years (approx. 20 per 10 000 persons). According to this registration women visit their general practitioner with a new burn somewhat more than men (ratio of women to men in 1988 1.47 and in 1989 1.20).
In both years the fewest reports were made in the eastern provinces; from rural municipalities to the cities there is an increasing number of reports (from approx. 16 to approx. 25 per 10 000 inhabitants).

No major differences have been determined between the quarters in either year.

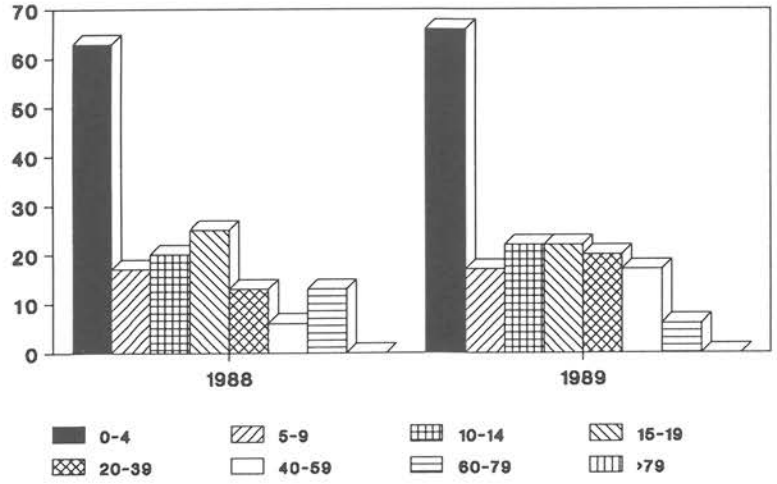
Age distribution
Table 20 gives the numbers of patients who consult the general practitioner for the first time with a burn by age and sex (cf. Fig. 16).

Table 20: number of patients with a burn for which the general practitioner has been consulted for the first time by age group per 10 000 men and per 10 000 women, for 1988-1989

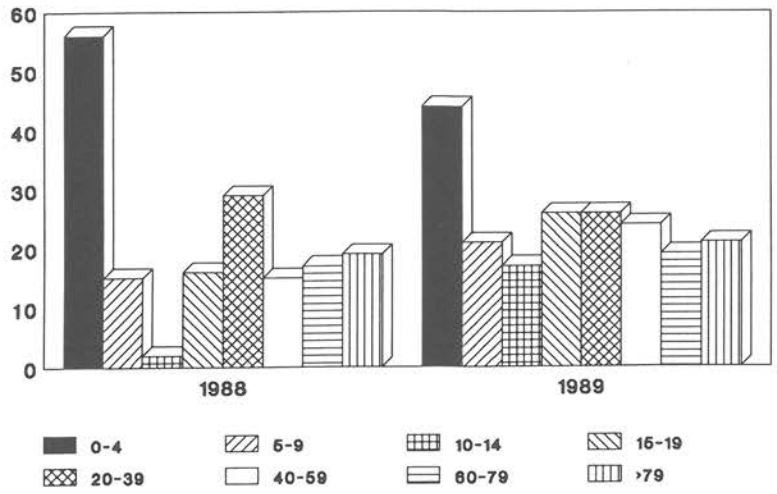
		Age group							
		<4	5-9	10-14	15-19	20-39	40-59	60-79	>79
1988	M	63	17	20	25	13	6	13	0
1989		66	17	22	22	20	17	6	0
1988	F	56	15	2	16	29	15	17	(19)
1989		44	21	17	26	26	24	19	(21)
1988	T	60	16	11	21	21	12	15	(13)
1989		54	19	19	24	23	20	13	(14)

Figure 16
Number of patients with a burn for which the general practitioner has been consulted for the first time by age group, per 10 000 men and per 10 000 women, 1988-1989

men



women



The incidence in the highest among young children.
Among the children under the age of 20 the incidence is the highest among boys. From the age of 20 women display higher incidence rates. Further analysis of the supplementary questionnaires completed in this registration will have to bring to light the expected age-specific accident mechanisms. As stated, this will be reported on separately.

The subject has been removed from the weekly return for 1990.

(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 90, 90, 96, 83 and 89 in 1985-1989.

The number of attempts per province and urbanization group per 10 000 inhabitants may be found in Table 21. The breakdown into subgroups is of limited value, because of the relatively small frequencies.
When the degree of urbanization is considered, most suicide attempts are consistently reported in the cities. This was the case in 1988 and 1989 too, namely 12 and 10 per 10 000 inhabitants respectively.
The distribution by province group displays a less consistent picture, possibly on account of the small numbers.

The figures do **not** support an increase that some suspect in the incidence of (attempted) suicide in the Netherlands.

Table 21: number of reports of (attempted) suicide per province and urbanization group, per 10 000 inhabitants, 1980-1989

	province group				urbanization group			Nether-lands
	A	B	C	D	1	2	3	
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
1988	9	4	7	5	3	5	12	6
1989	6	9	6	8	7	6	10	7

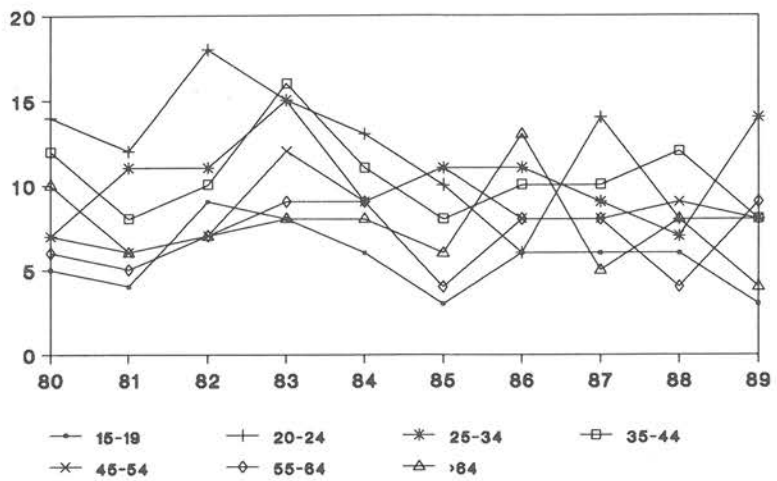
Age distribution

Table 22 gives the frequency of (attempted) suicide per 10 000 inhabitants by age group (see also Fig. 17).

Table 22: number of reports of (attempted) suicide by age group, per 10 000 inhabitants, 1980-1989

	age group							
	10-14	15-19	20-24	25-34	35-44	45-54	55-64	>64
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
1988	-	6	8	7	12	9	4	8
1989	-	(3)	8	14	8	8	9	4

Figure 17
Number of reports of (attempted) suicide by age group, per 10 000 inhabitants, 1980-1989



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 25-34 age group and the over-65s have displayed fluctuations of this kind in recent years.

This topic has been maintained on the weekly return for 1990.

ACUTE UNUSUAL HEADACHE

There are indications that a subarachnoidal haemorrhage is preceded by a "warning leak"[12] (see also the account of the annual meeting, p. 4). This warning bleeding could be a minor haemorrhage in the aneurysmal wall without this leading to a rupture or a haemorrhage as the result of a small, non-continuing rupture. This warning leak is said to express itself in the form of an acute, unusual and violent headache such as the patient has never experienced before.

It is expected that the prognosis of a subarachnoidal haemorrhage is more favourable if the "warning leak" is identified and treated. The patient is still in good condition and the "haemorrhage" as yet of limited size. Neurosurgical intervention in that situation is simpler than when a haemorrhage of greater size has occurred.

The investigation in which the above indications of the occurrence of a "warning leak" were found was a case-control study among hospital patients: patients who had been admitted with a subarachnoidal haemorrhage and, as controls, patients admitted on account of a cerebral infarction and 100 patients who had been admitted for non-neurological reasons.
Among the second control group an acute unusual very violent headache did not occur in the anamnesis. In the control group of neurological patients the occurrence was significantly less.
Besides the question about the incidence of acute unusual violent headache in general practice there is the question whether this acute unusual headache is also followed by a subarachnoidal haemorrhage within a year. Headache is not an unusual complaint that is presented to the general practitioner; can the general practitioner in fact recognize in the midst of this noise the acute violent unusual headache as a signal? Is that possible?

Dr E. Wijdicks, a neurologist with the Neurology Department of the Utrecht Teaching Hospital, is in charge of registration of this topic. Every patient who consults the general practitioner with an acute unusual headache should be reported.

Criteria for the registration are:
- headache that comes about from one second to another or becomes of

maximum intensity within one minute, **and**
- is very violent and unusual **and**
- lasts at least an hour.

The localization of the headache is not important; other symptoms may occur (brief loss of consciousness, nausea and/or vomiting, a drooping eyelid and possible double vision).
In a supplementary questionnaire further data of the patient are recorded. If the patient is referred, the researchers (Dr E. Wijdicks and Mrs F. Linn) contact the neurologist to whom the patient has been referred.
Reporting on this part of the investigation is done elsewhere.

Table 23 gives the numbers of patients with an acute unusual and violent headache per province and urbanization group and for the Netherlands per 10 000 inhabitants.

Table 23: numbers of patients with acute unusual and violent headache per province and urbanization group and for the Netherlands per 10 000 men and per 10 000 women, 1988-1989

		province group				urbanization group			Nether-lands
		A	B	C	D	1	2	3	
1988	M	4	3	1	1	4	2	1	2
1989		1	2	1	3	1	2	3	2
1988	F	1	3	3	2	3	2	3	2
1989		1	1	1	3	1	1	1	1
1988	T	2	3	2	2	3	2	2	2
1989		1	1	1	3	1	2	1	1

With this limited incidence it is not responsible to pronounce on the differences between the subgroups.

Age distribution

Table 24 lists the numbers of patients with acute unusual violent headache by age and sex.

Table 24: number of patients with acute unusual violent headache per age group per 10 000 men and per 10 000 women 1988-1989

Age group	1988		1989	
	M	F	M	F
< 10	-	-	-	-
10-19	(2)	(1)	(2)	-
20-29	(1)	(2)	(1)	(1)
30-39	(5)	(4)	(2)	(1)
40-49	(3)	(2)	(2)	(1)
50-59	-	(4)	(1)	-
60-69	-	(7)	(4)	(5)
70-79	(1)	-	(2)	(2)
> 79	-	-	-	(4)

According to the registration up to now acute unusual and violent headache does not occur below the age of 10.
No specific age distribution seems to exist for this problem.

The topic is maintained on the weekly return for 1990. From the beginning of 1990 the number of general practitioners involved in this registration has been considerably expanded. The latter has been rendered possible partly by a subsidy from the Netherlands Heart Foundation.

PREGNANCY DESPITE CONTRACEPTION CONSIDERED ADEQUATE

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

The 1982 Family Planning Survey of the Central Bureau of Statistics[13] 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. 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[14].

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 Netherlands Institute for Socio-Sexological Research, and Dr M.R. Santen, a Zoetermeer 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.

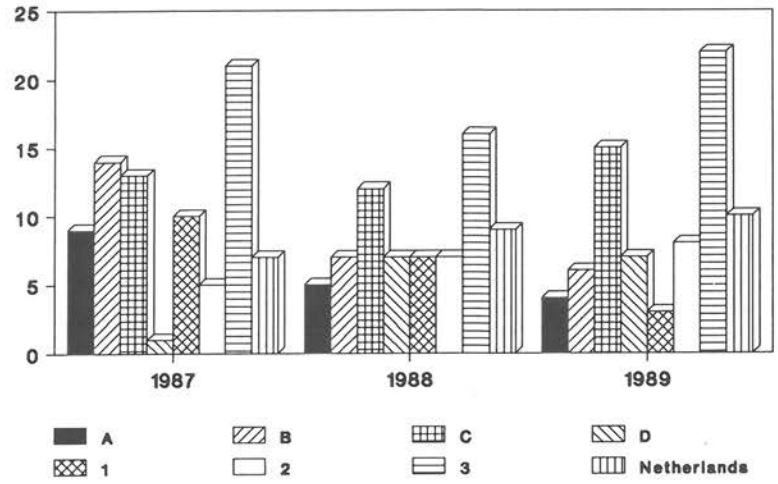
By means of a supplementary questionnaire the spotter physician registers the length of pregnancy, the woman's situation, the method of contraception used, the possible cause of failure and, as far as known, the course of the pregnancy (spontaneous abortion, abortus provocatus, intention to allow the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

In Table 25 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. The figures relate to the fertile age (cf. Fig. 18).

Table 25: number of women with a pregnancy despite contraception considered adequate per province and urbanization group per 10 000 women of 10-49 years and for the Netherlands in 1987-1989

	province group				urbanization group			Nether-lands
	A	B	C	D	1	2	3	
1987	9	14	13	1	10	5	21	7
1988	5	7	12	7	7	7	16	9
1989	4	6	15	7	3	8	22	10

Figure 18
Number of women with a pregnancy despite contraception considered adequate per province group and urbanzation group and for the Netherlands, per 10 000 women, 1987-1989



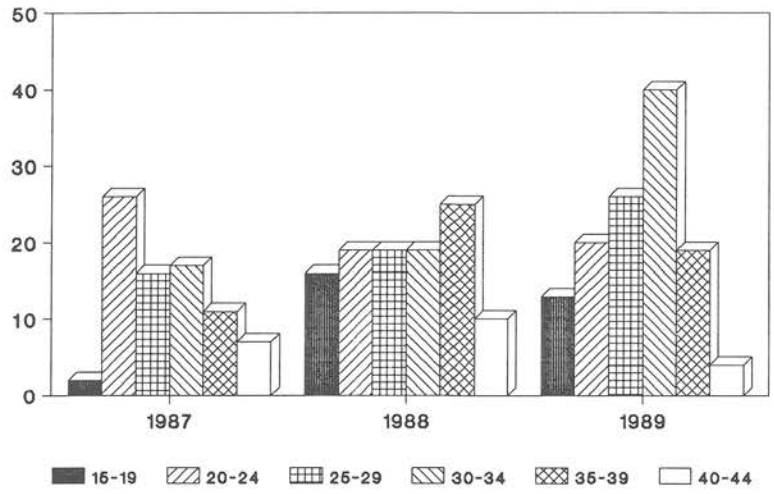
Caution should be observed in the use of these data. In the absolute sense the event occurs infrequently and not regularly.
The figures create the impression that the failure of contraception considered adequate occurs more in the west of the country and in the cities. There also seems to be something of an increase.

Age distribution
Table 26 gives the occurrence of pregnancy despite adequate contraception per age group per 10 000 women in 1987-1989.

Table 26: number of pregnancies despite contraception considered adequate per age group per 10 000 women in 1987-1989

	age group					
	15-19	20-24	25-29	30-34	35-39	40-44
1987	2	26	16	17	11	7
1988	16	19	19	19	25	10
1989	13	20	26	40	19	4

Figure 19
Number of women with a pregnancy despite contraception considered adequate per age group, per 10 000 women, 1987-1989



In this registration in 1987 no pregnancies despite contraception considered adequate occurred below the age of 15 years and above the age of 44 years.

1988

Of the 62 pregnancies reported, 20 went to term. A spontaneous abortion occurred three times and an extra-uterine gravidity twice. Of the 62 women, 30 requested termination of the pregnancy. In seven cases it was not

known at the time of registration what the result of the pregnancy would be. Of the 33 unmarried women, 20 had the pregnancy terminated; in one case an extra-uterine gravidity occurred. In the case of four women no decision is known and eight women opted to go to term. Of the 29 married women, 10 opted for an abortion. Three spontaneous abortions and also an extra-uterine gravidity occurred. Of three no choice is known; 12 went to term.

1989

Of the 68 pregnancies reported, 30 went to term, two spontaneous abortions occurred and in one case a partus at 28 weeks. The remaining pregnancies (33) were or were to be terminated. In two situations it had not yet been decided at the time of registration about the course of the pregnancy. Of the unmarried women, 23 out of the 38 had the pregnancy terminated; 15 pregnancies went to term.
Of the 30 pregnancies that despite contraception occurred in a marital relationship, the number of pregnancies terminated was 10. 15 pregnancies of 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 considered adequate.
The results over the period 1987-1989 show that 52% of the women opt for abortion and 36% for letting the pregnancy go to term. Of the unmarried women, nearly two thirds opt for termination of the pregnancy, as do nearly 40% of the married women.

In 1990 this topic is maintained on the weekly return.

MAMMOGRAPHY 1988-1989

The discussion on national mass screening for breast cancer has lasted for decades. In 1968 the Early Detection and Treatment of Cancer Committee of the Koningin Wilhelminafonds still argued that "mass screening for breast cancer seems to have little point".
However, the results of the H.I.P. study that started in New York in 1963, which became available from 1971, displayed a clear decline in mortality from breast cancer in the group of women older than 50 years. These results were a reason to set up trial projects in Utrecht and Nijmegen. Data resulting from the two projects strongly suggest that screening for breast cancer has a favourable effect on mortality from this disorder.

In 1987 both the Health Council and the National Council for Public Health made a positive recommendation on the acceptability of national mass screening for breast cancer by means of mammography. Thereupon the State Secretary of Public Health took a positive decision in principle on national introduction of the screening in the period 1990-1993.

The number of mammograms made annually in the Dutch hospitals is not properly known. On estimate the number for 1987 is 110-140 thousand. Even less is known about the indications on the basis of which examinations have been requested.
The Ministry of Welfare, Public Health and Culture and the Health Insurance Fund Council consider it important from a policy point of view to be well informed about the present number of mammograms and above all too about shifts that may occur in these when the mass screening is introduced in phases.

The phased introduction of national screening means that during a period of several years screening will be performed at one place but not at another. Where screening does take place, women younger than 50 will for the time being not be enabled to participate in the screening, in anticipation of the results of further research.
These two circumstances may lead to an additional call on the available capacity. Both women in areas where screening is not yet being performed and women below the age of 50 may be of the opinion that they should qualify for mammography.

In this registration the issue is the extent of the mammographic diagnosis requested by the general practitioner. A breakdown has been made into first and repeat examination. In the mass screening for breast cancer an interval of two years between two scanning rounds has been adhered to. This is also the case with the present registration. With a view to this the criterion for the distinction between first and repeat examination is formed by the question whether a mammogram has been made for the woman in question at any time after 1 January 1987 for the year 1988 and after 1 January 1988 for the year 1989. If at any time after the applicable date a mammogram has been made for a woman and such an examination is performed **again**, this should be registered under the subgroup "repeat examination". Both subgroups have a further subdivision by area of indication: complaints and symptoms on the one hand and purely preventive considerations on the other.

It is not important whether during the examination photographs are taken in different directions along with any supplementary enlargements or close-ups. The total examination is registered as one examination. Nor is it important whether a mammogram is made of one or both breasts.

The data of this registration are made available to the group that is performing the investigation into the costs and effects of mass screening for breast cancer for the Ministry of Welfare, Public Health and Culture (Project leader Prof. Dr P.J. van der Maas, Social Health Care Institute, Erasmus University, Rotterdam).

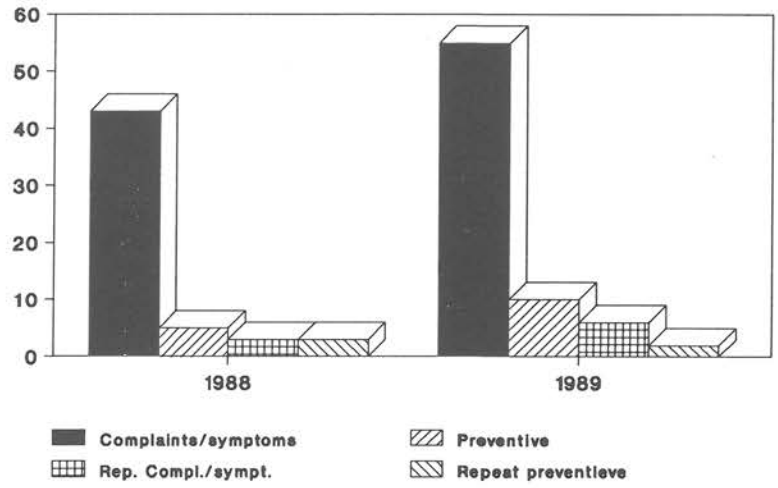
Table 27 gives the numbers of mammograms per province and urbanization group and for the Netherlands (cf. Figs 20 and 21).

Table 27: number of mammograms per province and urbanization group and the Netherlands per 10 000 women in 1988 and 1989

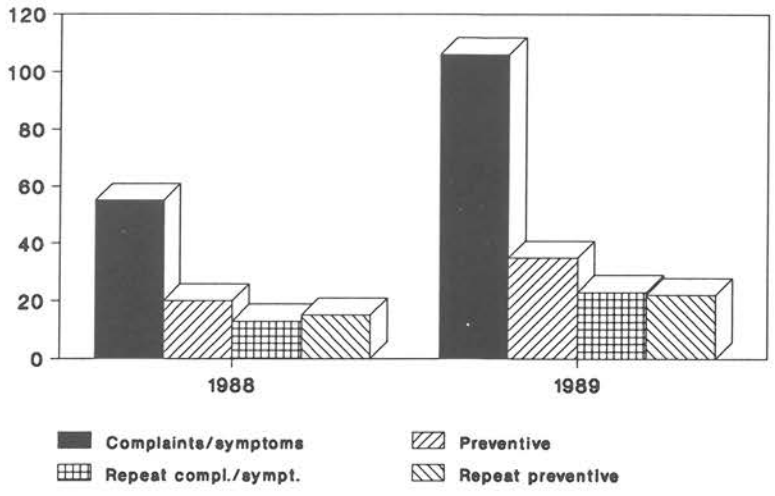
		province group				urbanization group			Netherlands
		A	B	C	D	1	2	3	
first mammography complaints/ symptoms	1988	43	55	67	69	60	62	62	62
	1989	55	106	56	70	112	56	69	67
"preventive"	1988	5	20	25	12	20	17	19	18
	1989	10	35	21	14	42	15	18	20
repeat mammography complaints/ symptoms	1988	3	13	4	9	12	6	4	6
	1989	6	23	4	7	20	6	7	8
"preventive"	1988	3	15	5	8	14	5	4	6
	1989	2	22	2	8	21	4	4	7

Figure 20
Number of mammograms per province group, per 10 000 women, 1988-1989

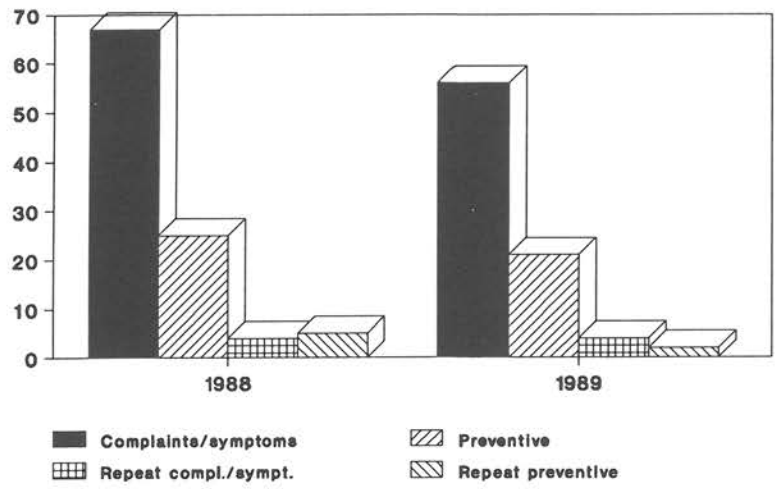
province group A



province group B



province group C



province group D

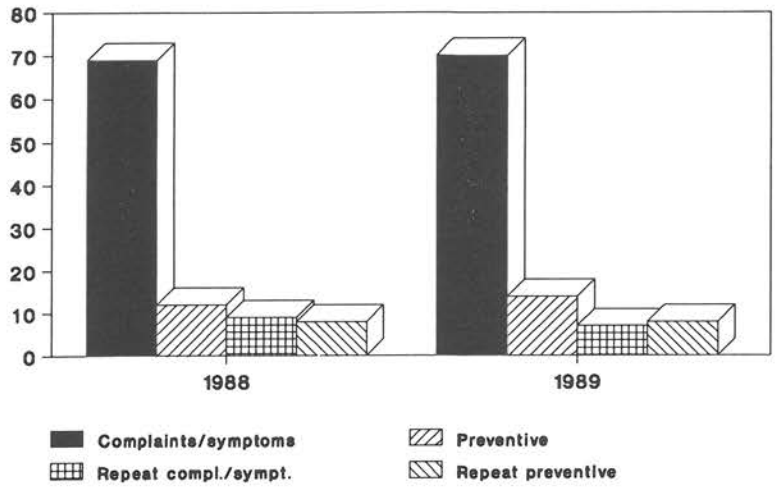
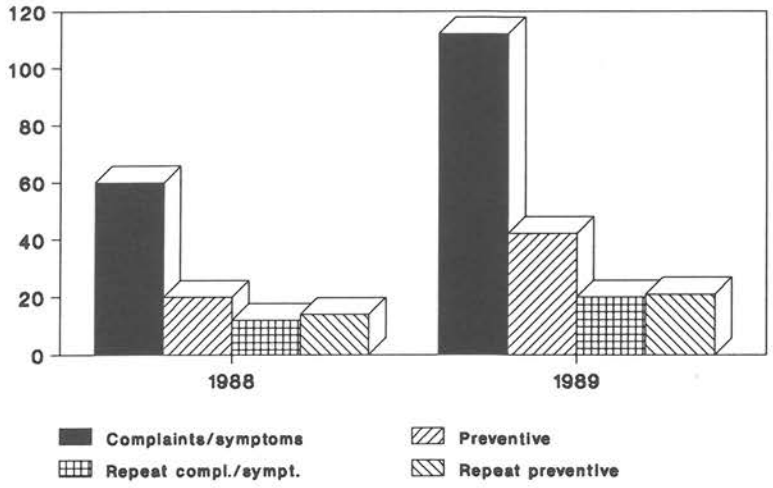
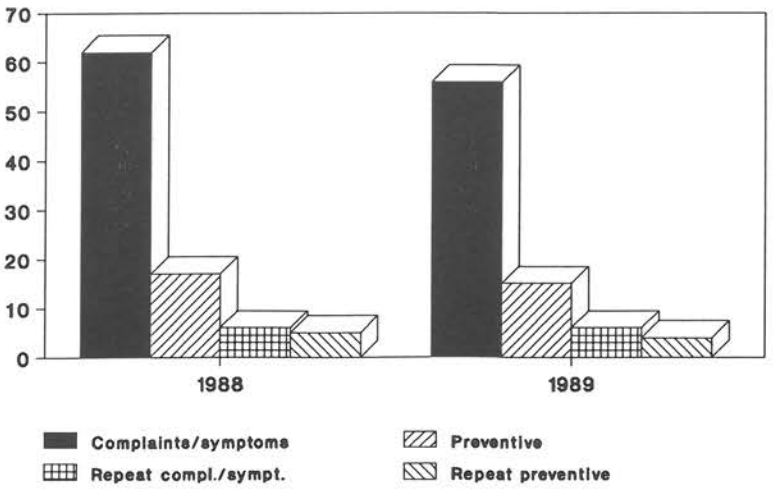


Figure 21
Number of mammograms per urbanization group and for the Netherlands per 10 000 women, 1988-1989

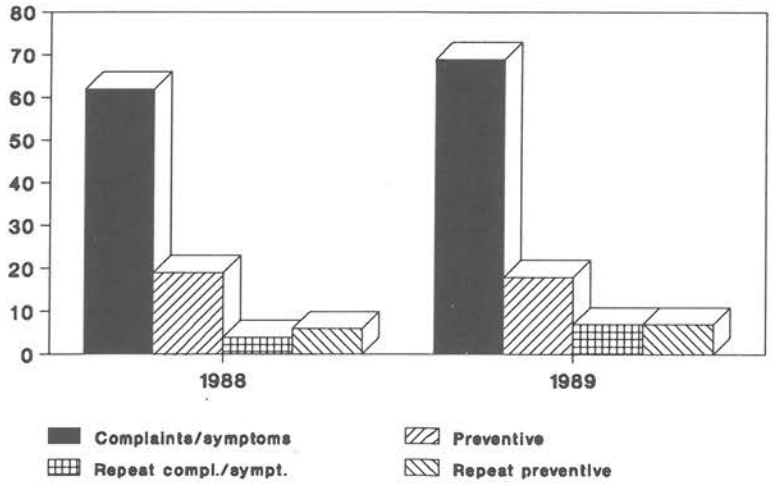
urbanization group 1



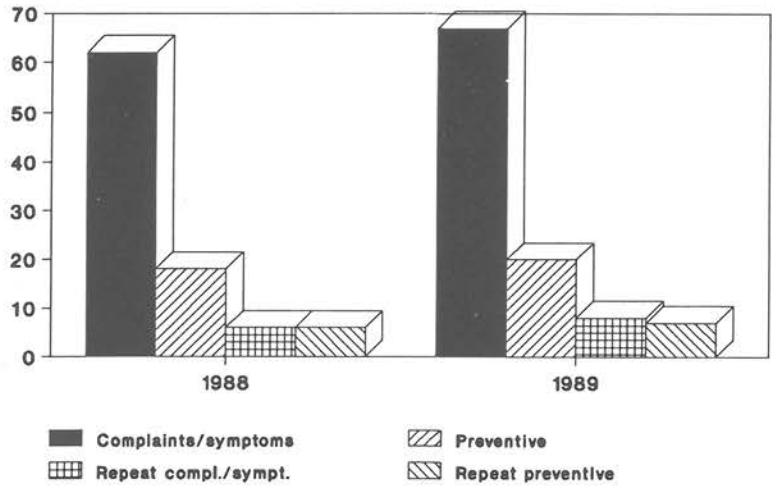
urbanization group 2



urbanization group 3



Netherlands



In the eastern provinces more mammograms are requested in most indication groups than in the other provinces. Only for the first mammograms in 1988 does this not apply.

The same is true of the rural municipalities; there too, except in the first year of registration for the first mammograms, more examinations were requested than in the other two urbanization groups.

The total number of mammograms was eleven percent higher in 1989 than in the year before. This increase proves to occur above all in the eastern provinces and the rural municipalities. A quarter of the mammograms are registered as preventive.

Table 28 lists the numbers of mammograms by age group per 10 000 women.

Table 28: number of mammograms by age group per 10 000 women for 1988 and 1989

age group	indication for first mammography compl./sympt.		("preventive")		repeat mammography compl./sympt.		("preventive")	
	1988	1989	1988	1989	1988	1989	1988	1989
15-19	(4)	(6)	-	-	-	-	(2)	-
20-24	32	34	(2)	(5)	(2)	(2)	-	-
25-29	61	66	11	14	(2)	(5)	(2)	(2)
30-34	114	98	30	26	10	11	(6)	(6)
35-39	135	138	35	51	14	16	(11)	18
40-44	145	181	50	42	18	24	12	18
45-49	134	174	45	39	18	16	16	21
50-54	92	104	32	55	14	14	(9)	14
55-59	75	92	20	35	(9)	14	(12)	17
60-64	65	74	31	28	(3)	(6)	(9)	(12)
65-69	53	35	18	(11)	(4)	(4)	-	(4)
70-74	33	21	(4)	(13)	(4)	(8)	(4)	-
75-79	(10)	31	(5)	-	(5)	(10)	(5)	-
80-84	(7)	-	-	-	-	-	(7)	-
> 84	-	(9)	-	-	-	-	-	-

The registration shows that mammograms are requested above all in the age groups between 35 and 50 years. This "worried-well" pattern is the same for the two years in which registration has been performed so far.

It is remarkable that so far no increase has occurred in the number of **first** preventive mammograms in the age between 40 and 50. In the age between 50 and 60 and the 35-39 age group, however, a pronounced increase is demonstrable for preventive mammograms.

The majority of the mammograms requested by the spotter physicians lie outside those age groups that are covered by the proposed mass screening (see also Table 29).

Table 29: proportional distribution of mammograms by three age groups. Percentages

	age distribution, total number of mammograms			
year	<50	50-69	>69	total
1988	73	24	3	100
1989	72	25	3	100
	age distribution, "first"mammograms			
1988	74	24	2	100
1989	73	25	2	100

In 1990 the topic is maintained on the weekly return.

CONCERN ABOUT AIDS 1988 and 1989

General practitioners are confronted in their practice with AIDS patients and seropositivity to only a limited extent. Only general practitioners in Amsterdam and a few other cities and the occasional general practitioner outside these will have in their practice patients who are suffering from AIDS or who are seropositive.

Nevertheless it is expected that among the population, despite or because of the extensive publicity campaign, there exists a certain degree of anxiety about this disorder. Publicity campaigns are often general in nature and do not give an answer to every question.
The present pattern of (sexual) relationships, often comprising various partners, whether or not simultaneously, may be a reason for questions being asked about the risks of infection with HIV.
It is considered important to obtain insight into these phenomena.

In 1988 the topic "Concern about AIDS" started. The English title of the topic derives from the project in which sentinel station networks from various European countries are simultaneously registering a number of data that relate to the anxiety among the population about AIDS, insofar as this leads to a visit to a general practitioner.

The aim of the registration is to take stock of the requests for help from which concern about or fear of AIDS emerges. These include the requests by patients who do not suffer from AIDS or are not seropositive. In addition in insight into the extent to which general practitioners are confronted with these requests, the aim is to obtain a picture of those making the requests and of the action undertaken by the general practitioners in response to them.
The topic will appear on the weekly return for several years.

The spotter physicians are asked to register each consultation in which either the patient or the general practitioner brings up the subject of AIDS. In the supplementary questionnaire a number of supplementary data on the patient are registered, the reasons for the patient's visit to the general practitioner, whether a request for determination of HIV antibodies is made and whether that request is granted, whether the physician for other

reasons than the patient's request proposes that such a test be performed and, if an examination has been made, what the result is.
Finally, the general practitioners are asked to specify the action that they further undertake in relation to the patient's questions and whether a follow-up contact is arranged. Extensive reporting on this supplementary examination is being done elsewhere[15] (M. Moons and L. Peters, Netherlands Institute for Research into Primary Health Care).

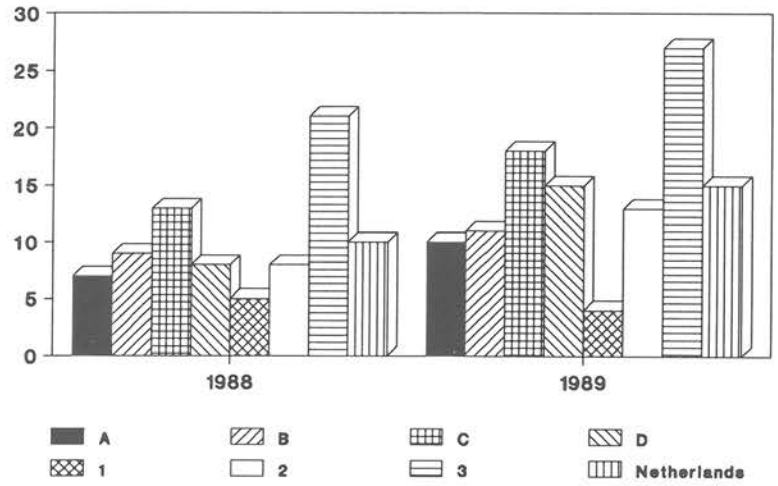
Table 30 lists the number of consultations in which AIDS comes up for discussion, by province and urbanization group and for the Netherlands, per 10 000 inhabitants, 1988-1989.

Table 30: numbers of consultations in which AIDS comes up for discussion, by province and urbanization group and for the Netherlands, per 10 000 inhabitants, 1988-1989

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
1988	7	9	13	8	5	8	21	10
1989	10	11	18	15	4	13	27	15

In 1989 there were more consultations on AIDS than in 1988: 15 as against 10 per 10 000 inhabitants respectively. The general practitioners in the western provinces were confronted in 1988 and 1989 with more questions on AIDS than elsewhere in the Netherlands. This applies even more strongly for the general practitioners in the cities (see Fig. 22).
Supplementary data show that nearly 60% of all consultations are made by a man. Among those who ring the AIDS info line the percentage of men is somewhat higher, nearly 66[16].

Figure 22
Number of consultations in which AIDS comes up for discussion, per province and urbanization group and for the Netherlands, per 10 000 inhabitants, 1988-1989

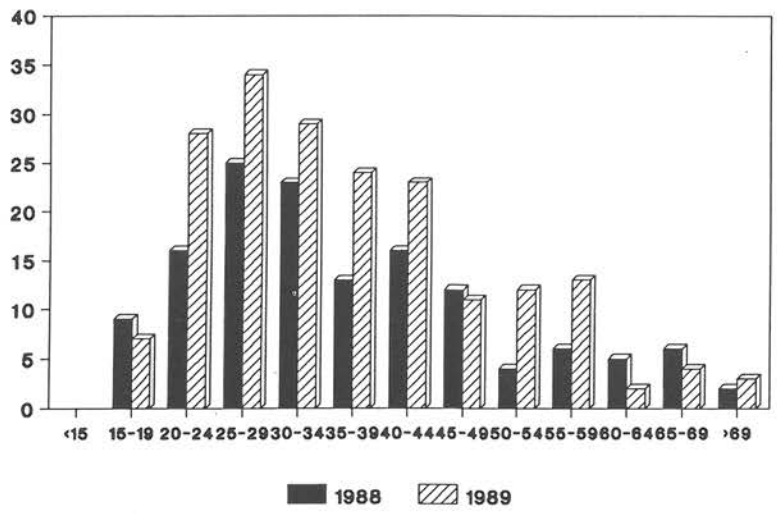


Age distribution
Table 31 gives the number of consultations in which AIDS comes up for discussion per 10 000 inhabitants per age group, for both sexes together (cf. Fig. 23).

Table 31: number of consultations in which AIDS comes up for discussion per age group, per 10 000 inhabitants, 1988-1989

Age group	1988	1989
< 15	-	-
15-19	9	7
20-24	16	28
25-29	25	34
30-34	23	29
35-39	13	24
40-44	16	23
45-49	12	11
50-54	4	12
55-59	6	13
60-64	(5)	(2)
65-69	(6)	(4)
> 69	(2)	(3)

Figure 23
Number of consultations in which AIDS comes up for discussion per age group, per 10 000 inhabitants, 1988-1989



The majority of the questions about AIDS put to general practitioners are asked in the 20-44 age group: in 1988 75% and in 1989 79%. The annual report of the AIDS info line gives practically as high a percentage.
In our registration no seasonal influence has been established; the quarterly figures are at the same level in both years.

The topic has been maintained on the weekly return for 1990.

At the end of 1990 the first data from the joint registration within the project of the European Community (Eurosentinel) are due to be presented.

NEWLY ADMITTED PSYCHIATRIC PATIENTS AND DISCHARGED PSYCHIATRIC PATIENTS 1986-1988

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 nearly 34 000 people are faced with this task[17]. A number of these approx 34 000 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 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. The need for or necessity of professional care atter discharge 15 not considered here.

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 have mean while been reported on elsewhere[18].

Table 32 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 32: number of consultations with or about discharged psychiatric patients by province and urbanization group and for the Netherlands per 10 000 inhabitants, for 1986-1988

	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
1988	13	10	15	9	5	11	20	12

The data of the National Hospital Institute show that nearly 34 000 patients were discharged in 1986 from all psychiatric hospitals together. Of the discharged patients (excluding deceased patients), 63% returned to their own environment. That is over 21 000 patients.
On the basis of these numbers it may be expected that in 1% of the Dutch population 15 patients per 10 000 inhabitants were discharged in 1986 from a psychiatric hospital.
The number of registered **first** contacts after discharge in 1986 is lower than the expected number: 8 as against 15 per 10 000 inhabitants.

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 was adjusted.

In the course of 1987 it became clear that even with the amended registration procedure no change had occurred in the number of reports. In 1988 there was an increase in the number of reports that, however, still lags behind the number of reports expected.

The 1987 figures gave rise to the decision to make changes to the registration again for 1988, now in the form of a new topic on the weekly return: psychiatric patients admitted.

Table 33 gives the reports of the admitted psychiatric patients for the province groups and by degree of urbanization and for the Netherlands.

Table 33: number of newly admitted psychiatric patients by province group and degree of urbanization per 10 000 inhabitants for 1988

	province group				urbanization			Netherlands
	A	B	C	D	1	2	3	
1988	12	12	13	12	6	12	17	12

The number of reports of newly admitted psychiatric patients tallies in broad outline with the number of reports of (first contacts with or about) discharged psychiatric patients.

The problem of the differences between the expected and the reported numbers continues to exist. Possible explanations of these differences have been discussed elsewhere.

Age distribution

Table 34 presents the data on the number of first contacts with or about a discharged psychiatric patient by age group per 10 000 inhabitants.

Table 34: number of first contacts with or about a discharged psychiatric patient by age group per 10 000 inhabitants for 1986-1988

	Age group							
	10-14	15-19	20-24	25-34	35-45	44-54	55-64	>64
1986	(1)	(1)	10	13	13	11	11	7
1987	(1)	5	12	13	16	9	11	6
1988	0	(2)	8	19	26	9	13	13

In Table 35 the data appear on the newly admitted psychiatric patients by age group per 10 000 inhabitants.

Table 35: number of newly admitted psychiatric patients by age group per 10 000 inhabitants for 1988

	Age group							
	10-14	15-19	20-24	25-34	35-44	54-54	55-64	>64
1988	0	(4)	12	19	26	13	8	15

Below the age of twenty few admissions and first contacts with or about discharged patients are reported. This is as expected. The number of children discharged from psychiatric facilities is nationally about 400 per year. Admission to and discharge from a psychiatric facility thus occurs above all above the age of twenty. In 1986 and 1987 the differences between the age groups were not large. 1988 forms an exception to this. In the 25-34 and 35-44 age groups there are clearly more reports in 1988 of admissions and first contacts after a discharge. This may be a result of the different way of registering. The age distribution of admitted and discharged psychiatric patients tallies.

The topic was removed from the weekly return in 1989.

ECHOGRAPHY

Echography is regarded as a reliable and safe aid to the diagnosis of a number of disorders. In specific fields of application, such as the diagnosis of disorders of the gall bladder, the technique has surpassed other methods of examination. As a non-invasive method it can replace more aggressive examinations.
The indication area for the application of echography is still in development. Improvement of the technique will still take place. Whether application of this technique will also increase is the question, however. The accessibility of an organ and the expertise of the echographist remain the limiting factors in the future.

New diagnostic techniques are used in the first instance by specialists. Once improvement of the diagnosis of a disorder by means of a new technique has become apparent, general practitioners also proceed to make use of such a technique. The new method of examination can also be used for ruling out a disorder.

The present situation in the Netherlands is that, with the odd exception, all hospitals have the availability of real-time apparatus. By means of an application to the radiologist the general practitioner can dispose of this examination technique.
The question is to what extent this takes place.

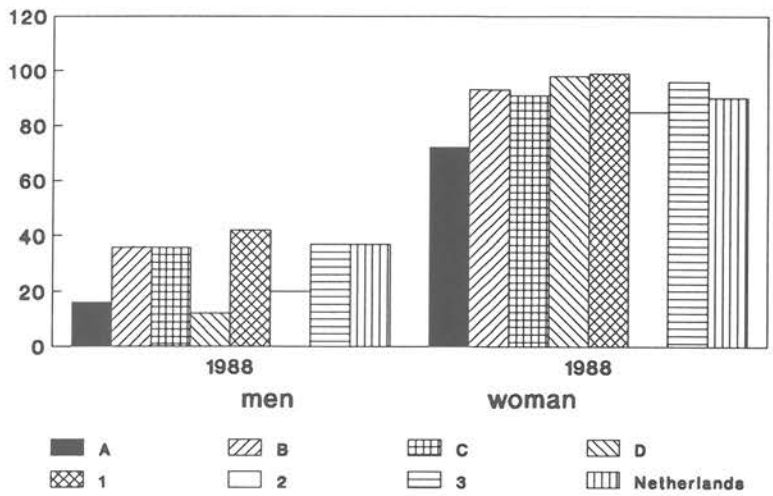
The spotter physicians are asked to report every application for echography, with the reason for the application, the clinical questioning and the region of the body or organ for which an echogram has been requested.

Table 36 lists the numbers of applications for echography per province and urbanization group and for the Netherlands per 10 000 men and per 10 000 women (cf. Fig. 24).

Table 36: number of applications for echography per province and urbanization group for the Netherlands per 10 000 men and per 10 000 women, 1988

	province group				urbanization group			Nether-lands
	A	B	C	D	1	2	3	
M	16	36	36	12	42	20	37	27
F	72	93	91	98	99	85	96	90
T	45	65	64	56	70	53	68	59

Figure 24
Number of applications for echography per province and urbanization group and for the Netherlands, per 10 000 men and per 10 000 women, 1988



In the northern provinces fewer echograms are requested than in one of the other province groups: 45 per 10 000 inhabitants as against approx. 60 per 10 000 inhabitants.
In the urbanized rural municipalities and in the small towns the number of applications is lower than in the other two urbanization groups: 53 per 10 000 inhabitants as against approx. 70 per 10 000 inhabitants.

There is a clear difference in the number of applications that are made for men and for women: 27 per 10 000 men as against 90 per 10 000 women. In the subgroups the ratio of women to men varies from 8.2 : 1 in the southern provinces to 2.4 : 1 in the rural municipalities. These are considerable differences.

In two practices no mention is made at all of echographic examination; the largest number of applications per 10 000 patients in one sentinel station is 141. The median is 51 applications per 10 000 patients: the average is 59 (scatter 0-141).

Between the quarters no major differences have been found with respect to the number of requests per 10 000 men and per 10 000 women.

Age distribution

Table 37 gives the number of applications for echography by age group per 10 000 men and per 10 000 women.

Table 37: number of applications for echography by age group per 10 000 men and per 10 000 women, 1988

Age group	men	women
1- 9	(3)	(4)
10-19	5	19
20-29	14	123
30-39	38	134
40-49	28	122
50-59	43	108
60-69	52	82
70-79	63	76
> 79	(33)	61

The age distribution of the applications for echography is less strange than might appear at first sight. Below the age of one year echography of the hip is a good alternative for X-ray photography in the diagnosis of hip dysplasia[19].

In this registration, in 6 of the 45 sentinel stations echographic examination

of the hip was applied for children below the age of one (2% of all applications). Up to the age of 20 there are then few applications: the disorders that can be detected with echography are of infrequent occurrence in that age range.
In over 38% of the echograms applied for the examination relates to the lower abdomen of a woman, often in the 25-49 age group.
Echographic examination of the upper abdomen takes place more among women than among men. It almost always concerns patients older than 30.

In 12% of the examinations applied for possible pathology in the renal region is sought. The age of the patients varies from 7 to 87; in nearly half of the applications the patient's age is between 30 and 50. (This group forms 29.4% of the population.)

In the case of 6% of the patients echography was applied for on account of suspected abnormalities in the mamma. The youngest patient was 16, the oldest 80. Nearly two thirds of the echography of the mamma applied for relates to women between 30 and 50.
Examination of the thyroid gland by means of this technique is little applied for (1% of all applications; the age lies above 40). The scrotum is also mentioned in 1% of the applications as examination area. Men of 35 and older are then concerned.

The subject has been removed from the weekly return in 1989.

DEMENTIA

In the Memorandum 2000 from tne 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 was 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 1988 the registration procedure for this topic was changed.
After consultation with Prof. Dr B. Meyboom-De Jong of the Family Medicin Department of Groningen University a supplementary questionnaire has been drawn up for the purpose of collecting further information on the patients assessed by general practitioners as dementia sufferers. and on the care that the general practitioners devoted to each of these patients during 1988.
This makes the aim of the registration twofold:

1. to investigate the occurrence of demented behaviour and dementia in general practice and
2. to gain insight into the qualitative aspects of dementia in general practice.

This supplementary investigation will be reported on elsewhere under the

direction of Prof. Dr Meyboom-De Jong.

It has been requested that each contact with or about a patient considered to be a dementia sufferer be registered and that a supplementary questionnaire be completed on each contact.
In this reporting the number of contacts of the general practitioner with or about a patient considered to be a dementia sufferer are discussed.

Age distribution
Table 38 states the numbers of contacts with or about patients considered to be dementia sufferers in 1988 per age group per 10 000 men and per 10 000 women.

Table 38: number of contacts with patients considered to dementia sufferers per age group per 10 000 men and 10 000 women, 1988

		Age group				
		65-69	70-74	75-79	80-84	>84
1988	M	53	302	429	1011	1894
	F	88	341	796	1241	2201
	T	72	324	648	1163	2104

The number of contacts with or about patients considered to be dementia sufferers increases with age from 72 per 10 000 inhabitants aged 65 to 69 to 2104 per 10 000 inhabitants in the age group older than 84.
There are more contacts with female patients considered to be dementia sufferers than with male patients.
There are considerable differences between the sentinel stations in the number of contacts with patients considered to be dementia sufferers.

It may be expected that the supplementary investigation into the care of patients considered to be dementia sufferers will clarify the background to these considerable differences. It would take us too far here to go into these differences.

This topic was removed from the weekly return in 1989.

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.

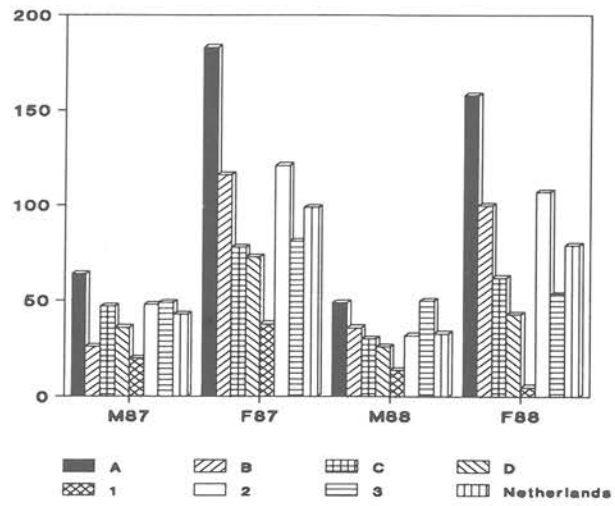
The spotter physicians were asked to record when they write a prescription for flunitrazepam for a patient from their own practice. This concerns the prescribing of both 1 mg and 2 mg tablets.

Table 39 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. 25).

Table 39: number of prescriptions of flunitrazepam per province and urbanization group and the Netherlands per 10 000 men and per 10 000 women in 1987-1988

	province group				urbanization group			Nether-lands
	A	B	C	D	1	2	3	
1987 M	64	26	47	36	20	48	49	43
1988	49	36	30	26	14	32	50	33
1987 F	183	116	78	73	38	121	81	99
1988	158	100	62	43	5	107	53	79
1987 T	124	71	63	55	29	86	66	72
1988	105	68	47	35	9	71	51	56

Figure 25
Number of prescriptions of flunitrazepam per province and urbanization group and for the Netherlands per 10 000 men and women, 1987-1989



In 1988 less Rohypnol[R] was prescribed than in 1987. In both years women were given over twice as many prescriptions for flunitrazepam than men. 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 1987 in 9 sentinel stations and in 1988 in 8 sentinel stations flunitrazepam was not prescribed at all. In one sentinel station a prescription for flunitrazepam was reported more than 100 times in both years.

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

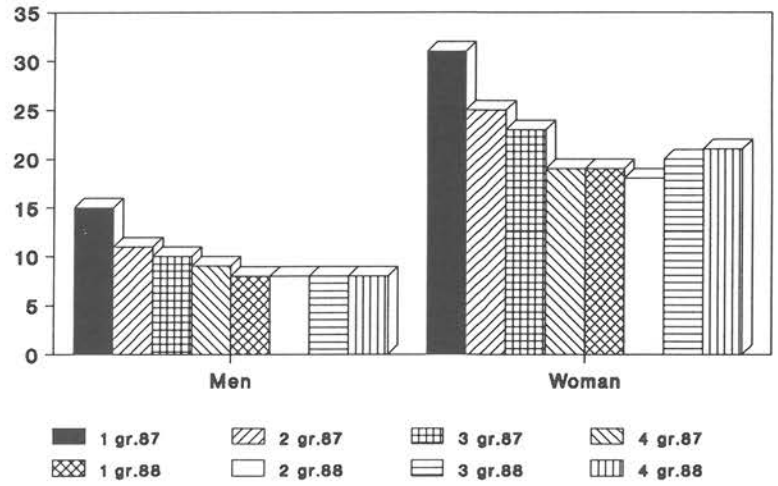
In Table 40 the number of prescriptions of flunitrazepam per quarter for the Netherlands is given (see also Fig. 26).

Table 40: number of prescriptions of flunitrazepam per quarter per 10 000 men and per 10 000 women for the Netherlands for 1987-1988

		1st quarter	2nd quarter	3rd quarter	4th quarter
1987	M	15	11	10	9
	F	31	25	23	19
	T	23	18	17	14
1988	M	8	8	8	8
	F	19	18	20	21
	T	14	13	14	15

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

Figure 26
Number of prescriptions of flunitrazepam per quarter and for the Netherlands per 10 000 men and per 10 000 women, 1987-1988



It is established that the registration in the beginning displays a gradual decline in 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).

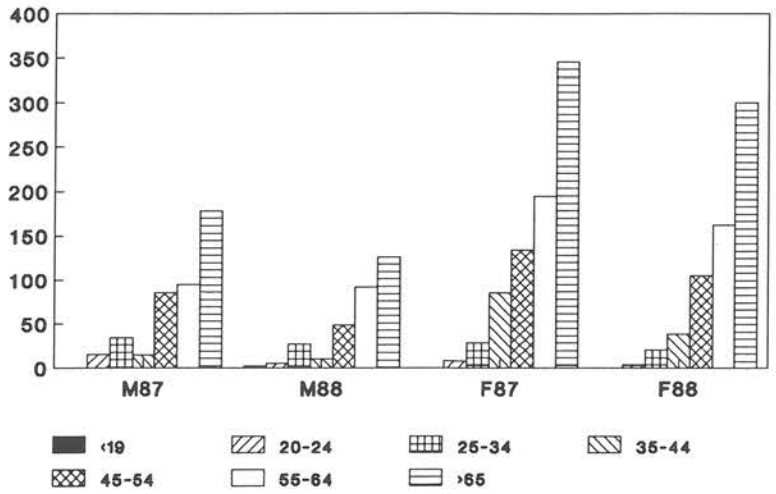
Age distribution

Table 41 gives the age distribution of the men and women who in 1987 received a prescription for flunitrazepam (see also Fig. 27).

Table 41: number of prescriptions for flunitrazepam per age group per 10 000 men and per 10 000 women 1987-1988

	age group						
	<19	20-24	25-34	35-44	45-54	55-64	>64
1987 M	-	15	34	14	85	95	178
1988	(2)	(5)	27	10	48	92	126
1987 F	-	8	28	85	134	195	346
1988	-	(3)	20	38	105	162	300
1987 T	-	12	31	50	109	148	278
1988	(1)	(4)	24	24	77	128	232

Figure 27
Number of prescriptions of flunitrazepam per 10 000 men and per 10 000 women, 1987-1988



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 as exepted at a younger age than with men. For men the 35-44 age group forms an exception: they make relatively little use of flunitrazepam.

This topic has been removed from the weekly return with effect from 1989.

REFERRAL FOR LOGOPEDICS

Disturbances in the use of language (comprehension, speaking, reading and writing) are problems that severely impair the quality of life.

The few data that are available on the number of logopedic treatments give only a quantitative picture: there is an increase in the extent of logopedic aid.
In the light of the absence of a research tradition in this field it is important systematically to gather scientific knowledge, to investigate the effects of treatment and to do epidemiological and theory-developing research. A first step in this process is to acquire insight into the extent of the number of referrals for logopedics by the general practitioner and a number of aspects concerning the content and procedure there of.

The spotter physicians are asked to register every patient for whom a referral to or authorization for logopedics is requested, both new referrals and an extension of a current treatment. On a supplementary registration form questions are asked about three subjects:

1. the disturbance(s) for which logopedics is requested,
2. whether this referral involves a first request or extension or repeat requests,
3. who is taking the initiative for the referral.

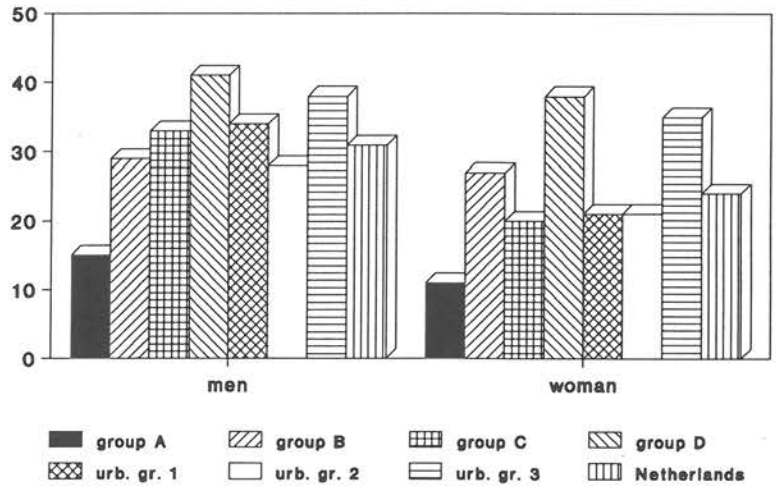
This supplementary investigation is under the direction of Dr J. Dekker (NIVEL) and is being performed in collaboration with members of the logopedics field of study at the Central Netherlands Polytechnic. Reporting takes place elsewhere.

Table 42 lists the numbers of referrals for logopedics in 1989 by province and urbanization group and for the Netherlands per 10 000 men and per 10 000 women (cf. Fig. 28).

Table 42: number of referrals for logopedics by province and urbanization group and for the Netherlands per 10 000 men and per 10 000 women in 1989

		province group				urbanization group			Nether-lands
		A	B	C	D	1	2	3	
1989	M	15	29	33	41	34	28	28	31
	F	11	27	20	38	21	21	35	24
	T	13	28	26	40	28	24	37	28

Figure 28
Number of referrals for logopedics per province and urbanization group and for the Netherlands, per 10 000 men and per 10 000 women, 1989



More men than women are referred for logopedics: 31 and 24 respectively. The fewest referrals for logopedics are made in the northern provinces and the most in the southern provinces. In the eastern and western provinces

the number of referrals is practically identical.
The cities display a clearly higher number of referrals for logopedics than the other two urbanization groups, between which little difference exists.

The quarterly figures show a larger number of referrals for logopedics in the second half of the year: 6, 5, 8 and 9 per 10 000 inhabitants.

Age distribution
Table 43 gives the age distribution of the men and women who were referred for logopedics in 1989.

Table 43: number of referrals for logopedics per age group per 10 000 men and 10 000 women in 1989

Age group	M	F	T
< 10	170	102	138
10-19	27	16	22
20-29	17	25	20
30-39	10	13	12
40-49	(1)	10	6
50-59	10	10	10
60-69	(4)	10	7
70-79	(13)	16	15
> 79	(8)	(16)	14

The age distribution of the referrals for logopedics reflects the age-specific nature of the disturbances for which logopedics is usual.
Below the age of 10 those are the language (development) disturbances, possible preverbal disturbances, stuttering and cluttering and speech (development) disturbances. The number of boys that are referred is clearly larger than the number of girls.
At a later age it is above all the aphasic disturbances and dysarthria that play a part.
The further analysis of the supplementary data will give a more detailed insight into the background to this age distribution.

The subject has been maintained on the weekly return in 1990.

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. 12-13) 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[20].

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, 1980-1989 (Central Bureau of Statistics)*

year	men	women	total
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
1988	7 273	7 441	14 714
1989	7 317	7 488	14 805

* The the numbers as on 1 January of the year in question.

Extrapolation of frequencies found to the Dutch population

	frequency* incidence (per 10 000)				Netherlands** (absolute number)		
category	year	M	F	total	M	F	total***
influenza	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
	1988			399			591 000
	1989			410			607 000
cervical smear	1980		62			44 000	
-with com-	1981		57			41 000	
plaints and/	1982		57			41 000	
or symptoms	1983		65			47 000	
	1984		57			41 000	
	1985		62			45 000	
	1986		65			48 000	
	1987		59			43 500	
	1988		76			56 500	
	1989		72			54 000	

* for footnotes see page 114

Extrapolation of frequencies found to the Dutch population (continuation)

	frequency* incidence (per 10 000)			Netherlands** (absolute numbers)		
category	year	M	F	total	M	F	total***
-"preventive", general practitioners's initiative	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	
	1988		176			131 000	
	1989		170			126 500	
-"preventive", woman's initiative	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	
	1988		193			143 000	
	1989		351			263 000	

* for footnotes see page 114

Extrapolation of frequencies found to the Dutch population (continuation)

		frequency* incidence (per 10 000)			Netherlands** (absolute numbers)		
category	year	M	F	total	M	F	total***
-repeat examination (within 3 years)	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	
	1988		246			183 000	
	1989		237			177 000	
cervical smear total	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	
	1988		691			514 000	
	1989		830			622 000	

* for footnotes see page 114

Extrapolation of frequencies found to the Dutch population (continuation)

	frequency* incidence (per 10.000)				Netherlands** (absolute numbers)		
category	year	M	F	total	M	F	total***
sterilization	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
	1988	40	22		29 500	16 500	46 000
	1989	30	19		22 000	14 000	36 000
cumulative					648 500[1]	524 500[2]	
morning-after pill prescribed	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	
	1988		26			19 500	
	1989		35			26 000	
burns	1988	15	22	19	11 000	16 500	28 000
	1989	20	24	22	15 000	18 000	33 000

1) from 1972

2) from 1974

* for footnotes see page 114

Extrapolation of frequencies found to the Dutch population (continuation)

	frequency* incidence (per 10 000)				Netherlands** (absolute numbers)		
category	year	M	F	total	M	F	total***
(attempted) suicide	1980			7			
	1981			6			
	1982			8			
	1983			10			
	1984			7			
	1985			6			
	1986			7			
	1987			7			
	1988			6			
	1989			7			
pregnancy despite adequate contraception	1987		7			5 000	
	1988		9			6 500	
	1989		10			7 500	
mammograms							
first mammogram							
-complaints/ symptoms	1988		62			46 000	
	1989		67			50 000	
-preventive	1988		18			13 500	
	1989		20			15 000	

* for footnotes see page 114

Extrapolation of frequencies found to the Dutch population (continuation)

	frequency* incidence (per 10 000)			Netherlands** (absolute numbers)		
category	year	M	F	total	M	F	total***
repeat mammo-grams							
-complaints/ symptoms	1988		6			4 500	
	1989		8			6 000	
-preventive	1988		6			4 500	
	1989		7			5 000	

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

** Extrapolation of the incidences 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.

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 1988 and 1989 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 spotter physicians are informed of the beginning of the year of the coming investigations. 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'[21].
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 1988 was 37. The number of patients with a malignancy, as in the past years, was large again, relatively speaking: 61% of them have a usually metastasized malignant neoplasm.
Of the 37 patients, 26 were living at home; five were in a nursing home and five requested euthanasia during a stay in hospital. One patient alternated between hospital and home. The large majority were requests for application of the direct form of euthanasia: 30 patients. In the case of 15 requests use was made of a written declaration.

1989

In 1989 the number of requests was 34. Of the patients requesting euthanasia, 80% had a malignancy.

The number of patients being nursed at home was 29; one patient was living in a nursing home. Three patients were at home but were admitted to hospital in a later phase of the illness. One patient was initially in hospital; after the examination this patient went home.

29 of the 34 patients requested direct euthanasia; in the case of 22 requests the request was supported by a written "euthanasia declaration".

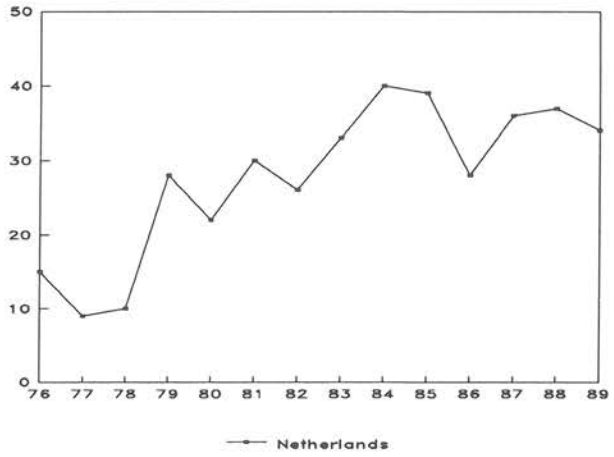
Requests for application of euthanasia 1976-1989

The distribution of the number of requests per province and urbanization group and per sex may be found in Table 44 (cf. Fig. 29).

Table 44: absolute number of patients who requested the general practitioner to apply active euthanasia by sex, per province and urbanization and for the Netherlands 1976-1989

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
1988	19	18	3	1	22	11	1	23	13	37
1989	21	13	7	1	21	5	6	17	11	34

Figure 29
Absolute number of patients who requested the general practitioner for the application of active euthanasia, for the Netherlands, 1976-1989



The average number of requests for euthanasia and the scatter per province and urbanization group are given in Table 45 and Table 46.

Table 45: average number of requests per sentinel station by province group 1976-1989

	province group			
	A	B	C	D
number of sentinel stations	6	7	20	10
average number of requests	8	6	11	6
scatter	0 - 15	2 - 20	0 - 20	1 - 13

Table 46: average number of requests per sentinel station by degree of urbanization 1976-1989

	degree of urbanization		
	1	2	3
number of sentinel stations	6	24	13
average number of requests	6	8	10
scatter	2 - 15	0 - 20	1 - 20

These data show that requests for application of euthanasia are made more in the western provinces and in the cities.

Age distribution

The age distribution may be found in Table 47.

Table 47: absolute number of patients who requested the general practitioner for application of active euthanasia by age group, 1976-1989

	<55	55-64	65-74	75-84	>84	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
1988	6	7	11	10	4	37
1989	4	6	12	11	-	34

Survey of the reported requests

In the collection published on the occasion of the twentieth anniversary of the Continuous Morbidity Registration Sentinel Stations the requests reported up to the end of 1987 are described: in total 316 requests[22].
Meanwhile the data are known on 387 requests for application of euthanasia. Of these requests, 208 were made by a man.

Insight into the disorders for which application of euthanasia is requested has been obtained by using the International Classification of Diseases (1975, 9th revision) as a guide. One of the problems in classification is the multiple pathology that is inherent in old age. Another problem is that sometimes there is no question of known pathology: the group symptoms and incompletely described disorders includes the request of a 92-year-old lady suffering from the disorder "old age".

Five groups of disorders are used:
- malignant neoplasms and leukemia,
- cardio-vascular disease,
- chronic obstructive pulmonary disease,
- symptoms and incompletely described disorders,
- other diseases, including neurological and endocrinological disorders and AIDS.

The classification of the disorders from which the patients who request euthanasia are suffering proceeded in general without difficulty, despite the above-mentioned problems; the general practitioner indicated in the questionnaire what in his or her opinion was the relevant disorder within the framework of the request.
The disorders for which euthanasia was requested are stated in Table 48.

Table 48: disorders for which euthanasia was requested, 1976-1989

	n	%
malignant neoplasms	269	70
cardio-vascular disease	32	8
chronic obstructive pulmonary disease	21	5
symptoms and incompletely described diseases	24	6
other diseases	41	11
total	387	100

The distribution of the disorders for which euthanasia was requested by age is given in Table 49.

Table 49: percentage of requests per disorder of the total number of reports by age (absolute numbers between parentheses), 1976-1989

	< 55		55-64		65-74		75-84		> 84	
	%	n	%	n	%	n	%	n	%	n
malignant disorders	80	(48)	88	(72)	87	(94)	50	(50)	14	(5)
cardio-vascular disease	0	(0)	1	(1)	2	(2)	19	(19)	27	(10)
chronic obstructive pulmonary disease	2	(1)	5	(4)	3	(3)	10	(10)	8	(3)
symptoms and incompletely described diseases	3	(2)	2	(2)	1	(1)	3	(3)	43	(16)
other diseases	15	(9)	4	(3)	7	(8)	18	(18)	8	(3)

At relatively younger age it is above all the malignant disorders that form a reason to ask the general practitioner for euthanasia. Below the age of 55 the group other diseases forms an extremely heterogeneous group: cystic fibrosis, multiple sclerosis and AIDS are mentioned, but also vital depression.

At a later age final stages of endocrinological disorders like diabetes mellitus and advanced stages of terminal renal insufficiency and rheumatoid arthritis are given as reasons for a request.

When someone with a poor vascular system does not die from a myocardial infarction or a cerebro-vascular accident, the quality of life can be seriously impaired at a later age. Chronic obstructive pulmonary disease can also entail serious infirmity and suffering and lead to a request for euthanasia.

Table 50 gives the percentage distribution of the number of requests for application of euthanasia by patients younger and older than 65 per disorder.

Table 50: percentage of requests for application of euthanasia by patients younger and older than 65 by disorder, 1976-1989 (n=absolute numbers of requests)

	< 65		> 64		total
	%	n	%	n	%
all disorders	37	(142)	63	(245)	100
all malignancies	45	(120)	55	(149)	100
cardio-vascular disease	3	(1)	97	(31)	100
chronic obstructive pulmonary disease	24	(5)	76	(16)	100
symptoms and incompletely described diseases	17	(4)	83	(20)	100
other diseases	29	(12)	71	(29)	100

A further subdivision of the malignancies by localization of the tumour and the age of the patient displays an unexpected picture (Table 51).

Table 51: percentage of requests for application of euthanasia by patients younger and older than 65 with a malignancy by localization of the tumour (n=absolute numbers)

	< 65		> 64		total
	%	n	%	n	%
all malignancies	45	(120)	55	(149)	100
stomach	39	(11)	61	(17)	100
colon/rectum	45	(18)	55	(22)	100
trachea/lung	41	(29)	59	(42)	100
breast	62	(18)	38	(11)	100
other	45	(45)	55	(56)	100

When breast cancer is the motive for the request, the percentage of female patients below the age of 65 clearly differs from the percentage for the other localizations.

The use of a "euthanasia declaration" has increased in recent years: from 15% in 1984 to 64% in 1989.

In a possible extrapolation one should also consider that the general practitioners working in the sentinel station practices are not necessarily representative of the Dutch general practitioners as regards the subject of euthanasia.

Extrapolation of these data to the Dutch population is possible, but it should be borne closely in mind that one is relating that number to the total population, whereas this should really be done to the number of persons who are in circumstances in which the possibility of asking the question is envisaged. However, the latter data (morbidity) are not available.

Request by the patient for active euthanasia, 1988

age	sex	disease	motive for the request
95	F	decubitus	misery
88	F	ascites	no further point in life and the wish to die
87	F	cerebro-vascular accident	hard death
85	M	chronic non-specific lung disease/ osteoporosis	pain, dyspnoea and bedridden
84	M	cardiac decompensation	dyspnoea, decay
83	M	metastasized carcinoma of the stomach	pain
83	F	carcinoma of the colon	pain
79	F	cardiac decompensation	range of action 10 m
78	M	non-Hodgkin's lymphoma	extensive skin localizations and ulcerations

Reguest by the patient for active euthanasia, 1988 (continuation)

age	sex	disease	motive for the request
78	F	carcinoma of the colon	feels herself a burden on her children
76	M	carcinoma of the lung	fear of pain and dyspnoea
75	F	severe emphysema	depressive
75	F	Parkinson's disease	useless to carry on living, degeneration
75	F	endogenous depression	does not wish to live further
74	F	metastasized carcinoma of the ovary	pain
73	M	worn out	hard death
73	F	diabetes mellitus with many complications	total disability and pain
72	F	metastasized carcinoma of the ovary	decay, frequent vomiting
69	M	carcinoma of the stomach with metastases	inability to eat and pain
69	F	carcinoma of the stomach	worn out by nursing
68	F	carcinoma of the oesophagus	fear of wasting away
67	F	carcinoma of the mamma and pulmonary hypertension	dyspnoea
66	M	carcinoma of the lung	cachexia, dyspnoea
65	M	carcinoma of the lung	pain, frequent vomiting
65	M	cardiomyopathy	duration, long illness
64	M	carcinoma of the colon, ingrowth in bladder	colic pains
61	F	carcinoma of the ovary with peritonitis	duration
59	M	severe non-specific lung disease and osteogenesis imperfecta	illness, being dependent and mental suffering
57	M	metastasized carcinoma of the lung	lacklustre, decline

Request by the patient for active euthanasia, 1988 (continuation)

age	sex	disease	motive for the request
57	M	fibrosis of lungs	severe dyspnoea
54	M	carcinoma of the rectum	pain, cachexia, enormous oedema of the legs
54	F	Hodgkin's disease	(fear of) dyspnoea
50	M	hypernephroma	hard death
46	M	cerebral metastasis with carcinoma of the lung	fear of loss of decorum
44	M	melanoma	pain, rapid progression
42	F	carcinoma of the colon	pain and total collapse
35	M	AIDS	dignified death

Request by the patient for active euthanasia, 1989

Age	sex	disease	motive for the request
84	M	old-age boredom	enough of life
84	M	hyperthyroidism, paraplegia, non-specific lung disease	pointlessness of life
83	M	carcinoma of the stomach	general malaise
83	F	osteoporosis, incipient dementia	pain, enough of life
81	M	terminal cirrhosis of the liver	hopelessness
81	F	being old	"she'd had enough"
79	M	carcinoma of the lung	fear of dyspnoea
79	F	metastasized carcinoma of the mamma	pain
78	M	carcinoma of the lung	dyspnoea
76	M	non-Hodgkin's lymphoma	fear of undignified end

Request by the patient for active euthanasia, 1989 (continuation)

age	sex	disease	motive for the request
75	M	carcinoma of the lung	fear of lengthy pain
75	F	metastasized carcinoma of the rectum	lacklustre, pain
74	M	carcinoma of the stomach	lacklustre
74	F	metastasized carcinoma of the colon	pain, vomiting
73	M	carcinoma of the stomach	vomiting
72	M	carcinoma of the pharynx	fear of lengthy suffering
72	M	carcinoma of the stomach	pain, vomiting
72	M	pulmonary insufficiency with non-specific lung disease	fear of suffocating
72	M	carcinoma of the lung	pain, dyspnoea
71	F	relapse of carcinoma of the cervix	no further prospect
71	F	carcinoma of the pancreas	pain
66	M	emphysema, peptic ulcer	pointlessness of existence
66	F	hypernephroma	pain
65	M	carcinoma of the sigmoid and metastases	decay
63	F	non-Hodgkin's plus breakdown of own erythrocytes	general malaise
63	F	non-Hodgkin's lymphoma	pain, dependence
60	M	carcinoma of the cardia	pain, terminal stage

Request by the patient for active euthanasia, 1989 (continuation)

age	sex	disease	motive for the request
56	M	carcinoma of the oesophagus	pain
56	F	carcinoma of the mamma	weakness/pain
55	M	pleuritis carcinomatosa	pain
54	F	non-Hodgkin's lymphoma	dyspnoea
51	F	metastases from unknown primary tumour	pain
49	M	metastasized carcinoma of the colon	undignified last years
47	M	metastases from carcinoma of the colon	lacklustre

The investigation is continued in 1990.

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., a psychiatrist/epidemiologist with the Psychiatry Department of Groningen University, to decide to direct a request to the Counselling Committee for permission to investigate the occurrence of these disorders in the spotter station practices. Anorexia is a serious disorder of which it is said that the incidence is on the increase. Others argue, however, that from the fact that anorexia nervosa is now diagnosed more frequently than before, and having regard to the lack of epidemiological data, it may be concluded both that anorexia is increasing and also that this increase is only the result of greater familiarity with and better diagnosis of the syndrome[23].

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. Extensive reporting on this investigation takes place elsenwhere.

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 1988 or in 1989, 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.
Table 52 gives the distribution of these patients, by age ans sex in 1985-1989.

Table 52: absolute number of patients with respect to whom the general practitioner has diagnosed an eating disorder, by age and sex in 1985-1989

		10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	>59
1985	M	2	1	-	2	-	-	-	-	-	-	-
1986		1	1	-	-	1	-	-	-	-	-	-
1987		-	2	1	1	-	-	-	-	-	-	-
1988		-	-	2	-	-	-	-	-	-	-	-
1989		-	-	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
1988		-	6	9	15	7	9	3	1	1	1	2
1989		2	12	13	15	7	5	7	2	1	1	1

Eating disorders occur above all among women of the age of 15 to 44 years.

The distribution per province and urbanization group may be found in Table 53.

Table 53: absolute number of patients with respect to whom the general practitioner has diagnosed an eating disorder, per province and urbanization group, in 1985-1989 and per 10 000 inhabitants. Both sexes together

		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
	1988	4	11	32	9	5	31	20	56
	1989	9	8	40	12	4	43	22	69
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
	1988	2	5	5	3	2	3	6	4
	1989	4	3	6	3	2	5	7	5

To judge by this registration. The frequency of occurrence of eating disorders is somewhat higher in the cities and the westerns provincies than elsewhere. An increase cannot be noted in the national incidences.
The investigation into eating disorders has been stopped from 1990.

Incest

For 1988 an incidental investigation was made into cases of incest that became known to the spotter physicians in the course of 1988.
A distinction was made between :

1. incest committed in the past but no longer current. A patient confides in the general practitioner for the first time in 1988 concerning the problem that occurred in the past.
2. incest also committed in 1988.

Characteristics used for incest are that it takes place within the privacy of the family , girls are often the victim and men the perpetrator and that it concerns sexual acts against the victim's will. Besides father, mother and children grandfather, stepfather, mother's (new) boyfriend and uncle, resident in the household or otherwise, may be the perpetrator(s).

Of the 61 physicians working in the sentinel stations, 23 report in total 32 cases of incest as defined. The 38 other physicians report no new, current cases of incest, and 37 also report no incest problem from the past that has become newly known. For one physician it was not possible to register the latter category.

Of the 32 reports, one concerned the suspicion of an incest problem current at that moment. The other 31 reports related to incest problems that had taken place in the past, were no longer current as per 1 January 1988 but were discussed with the general practitioner for the first time in 1988.
The incest had usually occurred before 1983 (in the case of 24 women).
In six cases incest was concerned that has stopped in the course of 1988.
All reports related to female victims.
Usually the women themselves made the incest known to the general practitioner (25 times). With the girls younger than 20 the mother was usually involved in making the incest problem known (6 out of the 7 cases).
The age of the female victims varied from 4 to 68; 21 out of the 32 women of whom it was known in 1988 that they had been faced with incest problems were between 20 and 45. The age of the victim regarding whom current incest was suspected as per 1 January 1988 was seven.

From this registration it came to the fore that the general practitioner is confronted with incest above all when it is no longer taking place.

The data allow of no pronouncements on the frequencies of occurrence of incest.

GENERAL REMARKS

a. Influenza (-like illness)
b. Cervical smear
c. Referral for logopedics
d. Sterilization of the man performed
e. Sterilization of the woman performed
f. Morning-after pill prescribed
g. Diabetes Mellitus
h. (Attempted) suicide
i. Acute unusual headache
j. Pregnancy despite contraception
k. Out-patient or clinical mammography
l. Concern about AIDS
m. Measles/mumps

2. The incidental investigations for 1990 relate to the subject euthanasia.

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

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

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

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

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Appendix 1

Continuous Morbidity Registration, Sentinel Stations Participating General Practitioners in 1988 and 1989

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(to 1-6-'88)/ F.M. van Soest/R.F. Sparenburg/ H.D.W.A. van Gysel/Mw. J.Kappert (from 1-6-'88) (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
S. Rijpma*)	Laren	Gelderland
J.H. de Boer/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

Appendix 1 (continuation)

Participating General Practitioners in 1988 and 1989

Name:	Residence:	Province:
Ms. A.J. Arbouw/H.O. Sigling/ E.A. Reijnders (group practice)	Amstelveen	Noord-Holland
J.Th. Koop	Amstelveen	Noord-Holland
A.I.M. Bartelds	Huizen	Noord-Holland
J. Hoornweg/E. Hoornweg-Sleeboom (group practice)	Voorhout	Zuid-Holland
A.M. van Meurs	The Hague	Zuid-Holland
R. Kanters	The Hague	Zuid-Holland
J.C.B.M. Rensing	The Hague	Zuid-Holland
B.J.M. Aulbers/J.E.G. Nieuw-kamer (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(to 1-4-'88) R.R. Lankhorst(from 1-4-'88)	Middelburg	Zeeland
P.R.L. Vercauteren/H.J.W.A. Meijerink (group practice)	Terneuzen	Zeeland
R.J.F.M. Leijgraaf(to 25-3-'89)/ A.F.A. van der Reepe/W.L.M. Rijnders (from 1-7-'89) (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
J.P.C. Moors	Rosmalen	Noord-Brabant
A. Hoevenaars	Uden	Noord-Brabant
A.P.M. 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, 1988

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

Regel no.	Leeftijdsgroep	Influenza (-achtig ziektebeeld[2])	Cervixuitstrijkje: Na 1-1-1986 voor eerste maal afgenomen op grond van[3]: Klachten/ symptomen	Cervixuitstrijkje: Na 1-1-1986 voor eerste maal afgenomen op grond van[3]: Louter preventieve overwegingen: Initiatief huisarts[4]	Cervixuitstrijkje: Na 1-1-1986 voor eerste maal afgenomen op grond van[3]: Louter preventieve overwegingen: Verzoek v.d. vrouw	Cervixuitstrijkje: Herhalingsonderzoek: Klachten/ symptomen[5]	Cervixuitstrijkje: Herhalingsonderzoek: Louter preventieve overwegingen: Initiatief huisarts[4]	Cervixuitstrijkje: Herhalingsonderzoek: Louter preventieve overwegingen: Verzoek v.d. vrouw	Opname psychiatrische patiënt[6]	Ontslag psychiatrische patiënt[6]	Sterilisatie verricht[7]		Morning-after pil voorgeschreven[8]	Brandwonden[9]		Suicide(poging)[10]	Acute ongewone hoofdpijn[11]		Echografie aangevraagd[12]		Dementie		Voorschrijven rohypnol		Zwangerschap (ondanks a.c.)[13]	(Poli)klinische Mammografie: Na 1-1-1987 voor 1e maal: Klachten/ symptomen	(Poli)klinische Mammografie: Na 1-1-1987 voor 1e maal: Louter preventief	(Poli)klinische Mammografie: Herhalingsonderzoek: Klachten/ symptomen	(Poli)klinische Mammografie: Herhalingsonderzoek: Louter preventief	C.A.I.D.S.[14]	Leeftijdsgroep	Regel no.	
		M+V	V	V	V	V	V	V	M+V	M+V	M	V	V	M	V	M+V	M	V	M	V	M	V	M	V	V	V	V	V	V	M+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	84-86	87-89	90-92	93-95	96-98	99-101			102-104

Weeknummer : .....

Opgemaakt d.d.: .....

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

Zie ommezijde voor voetnoten

Weekstaat t.b.v. centrale registratie

CONTINUE MORBIDITEITSREGISTRATIE, PEILSTATION 1989

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

Regel no.	Leeftijdsgroep	Influenza (-achtig ziektebeeld[2])	Cervixuitstrijkje: Na 1-1-1987 voor eerste maal afgenomen op grond van[3]: Klachten/ symptomen	Cervixuitstrijkje: Na 1-1-1987 voor eerste maal afgenomen op grond van[3]: Louter preventieve overwegingen: Initiatief huisarts[4]	Cervixuitstrijkje: Na 1-1-1987 voor eerste maal afgenomen op grond van[3]: Louter preventieve overwegingen: Verzoek v.d. vrouw	Cervixuitstrijkje: Herhalingsonderzoek: Klachten/ symptomen[5]	Cervixuitstrijkje: Herhalingsonderzoek: Louter preventieve overwegingen: Initiatief huisarts[4]	Cervixuitstrijkje: Herhalingsonderzoek: Louter preventieve overwegingen: Verzoek v.d. vrouw	Verwijzing voor logopedie[6]		Sterilisatie verricht[7]		Morning-after pil voorgeschreven[8]	Brandwonden[9]		Suicide(poging)[10]	Acute ongewone hoofdpijn[11]		Zwangerschap (ondanks a.c.)[12]	(Poli)klinische Mammografie: Na 1-1-1988 voor 1e maal: Klachten/ symptomen	(Poli)klinische Mammografie: Na 1-1-1988 voor 1e maal: Louter preventief	(Poli)klinische Mammografie: Herhalingsonderzoek: Klachten/ symptomen	(Poli)klinische Mammografie: Herhalingsonderzoek: Louter preventief	C.A.I.D.S.[13]	Leeftijdsgroep	Regel no.	
		M+V	V	V	V	V	V	V	M	V	M	V	V	M	V	M+V	M	V	V	V	V	V	V	M+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			84-86

Week nummer : _____

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 1970-1990

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	1988-1990
admission of psychiatric patient	1988
aids (concern about)	1988-1990
alcoholism	1975
anti-hypertensivum or diuretic (prescription)	1976
battered child syndrome (suspicion of)	1973-1974
bites by pets	1986-1987
burns	1988-1989
cervical smear	1976-1990
cerebrovascular accident	1986-1987
dementia	1987-1988
depression	1983-1985
diabetes mellitus	1980-1983 and 1990
diarrhoea e causa ignota (acute)	1970
discharged psychiatric patient	1986-1988
dog bites	1987
drug-use (consultation)	1972-1973 and 1979-1981
dwelling (certificate for another)	1975
echography applied for	1988
exanthema e causa ignota	1970
family planning (consultations)	1970-1976
hay fever	1978-1982
influenza (-like illness)	1970-1990
malignancies	1984-1985
mammography	1988-1990
measles	1975-1979

Subjects on the weekly returns in alphabetical order 1970-1990 (continuation)

subjects	
measles, mumps	1990
mononucleosis infectiosa	1977-1979 and 1990
morning-after pill (prescription)	1972-1990
musculo-skeletal system (trauma of)	1984
myocardial infarction (suspicion of)	1978 and 1983-1985
otitis media acuta	1971 and 1986
Parkinson's disease	1980-1985
partus immaturus	1982-1983
partus at gravidity >28 weeks	1982-1983
penicillin (prescription and side effects)	1982-1983
pregnancy (despite contraception)	1987-1990
prescription of Rohypnol	1987-1988
psoriasis	1976-1977
referrals	1984
referrals for physiotherapy	1985
referrals for psycho-social problems	1986-1987
referrals for logopedics	1989-1990
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	1972-1990
sterilization of the woman performed	1974-1990
suicide (attempted)	1970-1972 and 1979-1990
tonsillectomy or adenotomy	1971
tranquillizer (prescription)	1972-1974
ulcus ventriculi/duodeni	1975
ulcus pepticum	1985-1986
urinary tract infection (prescription of medicine)	1977

Appendix 3b

Incidental investigations and other extra investigations, 1970-1990 (alphabetical)

subjects	
alternative forms of treatment (registration feasible?)	1980
anorexia nervosa and boulimia	1985-1989
euthanasia (request for application)	1977-1990
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 1989 (C.B.S.)

age	men	women	total*
0- 4	466	446	912
5- 9	452	433	885
10-14	467	445	912
15-19	595	570	1 165
20-24	644	619	1 263
25-29	653	625	1 278
30-34	608	585	1 193
35-39	586	560	1 146
40-44	588	557	1 145
45-49	446	422	868
50-54	388	378	766
55-59	358	368	726
60-64	317	353	670
65-69	277	335	612
70-74	199	272	471
75-79	142	233	375
80-84	81	164	245
>84	50	123	173
total	7 317	7 488	14 805

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

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 1

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD 20-03-91

ALLE PEILSTATIONS JAAR: 1988 WEEK: 01 T/M 52

LEEFTIJDS-GROEP	POPULATIE			"INFLUENZA"	CERVIXUITSTRIJKJE					
				"INFLUENZA"	1.1.86 1E MAAL WEGENS	1.1.86 1E MAAL PR.HUI.	1.1.86 1E MAAL PR.VR.	HERHAL. WEGENS	HERHAL. PR.HUI.	HERHAL. PR.VR.
	M	V	T	M+V	V	V	V	V	V	V
<1 JR	326	318	644	1708	0	0	0	0	0	0
1-4 JR	3117	3026	6143	914	0	0	0	0	0	0
5-9 JR	4220	3896	8116	647	0	0	0	0	0	0
10-14 JR	4036	4231	8267	408	0	0	2	0	0	0
15-19 JR	5570	5475	11045	312	11	16	7	4	2	0
20-24 JR	5965	5959	11924	332	72	146	101	32	29	17
25-29 JR	5887	5715	11602	346	100	392	273	68	126	77
30-34 JR	5320	5292	10612	448	151	469	416	144	282	119
35-39 JR	5232	5134	10366	372	181	372	612	142	177	283
40-44 JR	4945	4972	9917	335	159	282	489	145	165	338
45-49 JR	3771	3798	7569	330	161	277	287	211	182	287
50-54 JR	3473	3463	6936	294	136	329	332	110	127	297
55-59 JR	3235	3470	6705	306	49	161	118	61	40	81
60-64 JR	2968	3232	6200	329	53	37	68	40	9	16
65-69 JR	2438	2859	5297	332	32	7	49	7	18	28
70-74 JR	1857	2401	4258	301	8	4	21	0	4	8
75-79 JR	1306	1936	3242	293	5	10	5	0	0	0
80-84 JR	723	1398	2121	396	0	0	0	0	0	0
>85 JR	497	1071	1568	357	0	0	0	0	0	0
TOTAAL	64886	67646	132532	395	76	176	193	64	81	101

ALLE PEILSTATIONS JAAR: 1988 WEEK: 01 T/M 52

LEEFTIJDS-GROEP	POPULATIE			ONTSLAG PSYCH.PT	STERILISATIE			M.A.PIL		BRANDWONDEN			SUICIDE (POGING)
				ONTSLAG PSYCH.PT	STERILISATIE			M.A.PIL		BRANDWONDEN			SUICIDE (POGING)
	M	V	T	M+V	M	V	T	V	M	V	T	M+V
<1 JR	326	318	644	0	0	0	0	0	92	95	93	0
1-4 JR	3117	3026	6143	0	0	0	0	0	61	53	57	0
5-9 JR	4220	3896	8116	0	0	0	0	0	17	15	16	0
10-14 JR	4036	4231	8267	0	0	0	0	10	20	2	11	0
15-19 JR	5570	5475	11045	2	0	0	0	79	25	16	21	6
20-24 JR	5965	5959	11924	8	2	3	3	87	12	30	21	8
25-29 JR	5887	5715	11602	22	27	7	17	56	17	28	22	7
30-34 JR	5320	5292	10612	15	128	81	105	47	9	30	20	6
35-39 JR	5232	5134	10366	35	166	115	141	16	12	29	20	13
40-44 JR	4945	4972	9917	16	111	54	83	10	4	22	13	10
45-49 JR	3771	3798	7569	12	66	21	44	8	13	13	13	5
50-54 JR	3473	3463	6936	6	0	3	1	9	3	23	13	12
55-59 JR	3235	3470	6705	12	0	0	0	0	3	3	3	3
60-64 JR	2968	3232	6200	13	3	0	2	0	14	16	15	5
65-69 JR	2438	2859	5297	11	4	0	2	0	12	35	25	9
70-74 JR	1857	2401	4258	7	0	0	0	0	11	8	9	2
75-79 JR	1306	1936	3242	9	0	0	0	0	15	10	12	6
80-84 JR	723	1398	2121	24	0	7	5	0	0	29	19	9
>85 JR	497	1071	1568	13	0	0	0	0	0	9	6	13
TOTAAL	64886	67646	132532	12	39	22	30	26	15	22	19	6

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 3

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD 20-03-91

ALLE PEILSTATIONS JAAR: 1990 WEEK: 01 T/M 52

LEEFTIJDS-GROEP	POPULATIE			ACUTE ONGEWONE HOOFDPIJN			ECHOGRAFIE			DEMENTIE		
	ACUTE ONGEWONE HOOFDPIJN			ECHOGRAFIE			DEMENTIE					
	M	V	T	M	V	T	M	V	T	M	V	T
<1 JR	326	318	644	0	0	0	153	378	264	0	0	0
1-4 JR	3117	3026	6143	0	0	0	6	0	3	0	0	0
5-9 JR	4220	3896	8116	0	0	0	0	8	4	0	0	0
10-14 JR	4036	4231	8267	0	2	1	5	5	5	0	0	0
15-19 JR	5570	5475	11045	4	0	2	5	29	17	0	2	1
20-24 JR	5965	5959	11924	0	0	0	20	86	53	0	0	0
25-29 JR	5887	5715	11602	2	4	3	9	164	85	2	2	2
30-34 JR	5320	5292	10612	4	6	5	36	146	90	0	2	1
35-39 JR	5232	5134	10366	6	2	4	40	136	88	0	2	1
40-44 JR	4945	4972	9917	2	2	2	36	113	75	2	2	2
45-49 JR	3771	3798	7569	5	3	4	16	134	75	3	3	3
50-54 JR	3473	3463	6936	0	6	3	46	98	72	0	0	0
55-59 JR	3235	3470	6705	0	3	2	40	112	78	37	38	37
60-64 JR	2968	3232	6200	0	6	3	40	87	65	7	6	6
65-69 JR	2438	2859	5297	0	7	4	66	77	72	53	88	72
70-74 JR	1857	2401	4258	0	0	0	65	87	78	302	341	324
75-79 JR	1306	1936	3242	8	0	3	61	62	62	429	796	648
80-84 JR	723	1398	2121	0	0	0	55	79	71	1011	1241	1163
>85 JR	497	1071	1568	0	0	0	0	37	26	1894	2201	2104
TOTAAL	64886	67646	132532	2	2	2	27	89	58	48	102	75

ALLE PEILSTATIONS JAAR: 1988 WEEK: 01 T/M 52

LEEFTIJDS-GROEP	POPULATIE			VOORSCHRIFT ROHYPNOL			ZWANGER ONDANKS	OPNAME PSYCH.PT	(POLI)KLINISCHE MAMMOGRAFIE				C.AIDS
				VOORSCHRIFT ROHYPNOL			ZWANGER ONDANKS	OPNAME PSYCH. PT.	1.1.87 1E MAAL WEGENS	1.1.87 1E MAAL PREVENT.	HERHAL. WEGENS	HERHAL. PREVENT.	C.AIDS
	M	V	T	M	V	T	V	M+V	V	V	V	V	M+V
<1 JR	326	318	644	0	0	0	0	0	0	0	0	0	0
1-4 JR	3117	3026	6143	0	0	0	0	0	0	0	0	0	0
5-9 JR	4220	3896	8116	0	0	0	0	0	0	0	0	0	0
10-14 JR	4036	4231	8267	0	0	0	0	0	0	0	0	0	0
15-19 JR	5570	5475	11045	2	0	1	16	4	4	0	0	2	9
20-24 JR	5965	5959	11924	5	3	4	19	12	32	2	2	0	16
25-29 JR	5887	5715	11602	22	32	27	19	20	61	11	2	2	25
30-34 JR	5320	5292	10612	32	8	20	19	18	114	30	10	6	23
35-39 JR	5232	5134	10366	12	35	23	25	32	135	35	14	16	13
40-44 JR	4945	4972	9917	8	42	25	10	19	145	50	18	12	16
45-49 JR	3771	3798	7569	29	66	48	0	13	134	45	18	16	12
50-54 JR	3473	3463	6936	66	144	105	0	12	92	32	14	9	4
55-59 JR	3235	3470	6705	136	138	137	0	10	75	20	9	12	6
60-64 JR	2968	3232	6200	47	186	119	0	6	65	31	3	9	5
65-69 JR	2438	2859	5297	90	248	176	0	9	53	18	4	0	6
70-74 JR	1857	2401	4258	151	341	258	0	9	33	4	4	4	5
75-79 JR	1306	1936	3242	61	176	130	0	12	10	5	5	5	3
80-84 JR	723	1398	2121	125	521	386	0	33	7	0	0	7	0
>85 JR	497	1071	1568	202	215	210	0	13	0	0	0	0	0
TOTAAL	64886	67646	132532	33	78	56	9	12	61	18	6	6	10

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

20-03-91

JAAR: 1988 WEEK: 01 T/M 52

URBANISATIE-GROEP	POPULATIE			"INFLU-ENZA"	CERVIXUITSTRIJKJE					
				"INFLU-ENZA"	1.1.86 1E MAAL WEGENS	1.1.86 1E MAAL PR.HUI.	1.1.86 1E MAAL PR.VR.	HERHAL. WEGENS	HERHAL. PR.HUI.	HERHAL. PR.VR.
	M	V	T	M+V	V	V	V	V	V	V
A1+A4	10360	10398	20759	377	118	128	137	64	75	69
B1-B3,C1-C4	40276	42015	82292	333	58	161	174	65	76	112
C5	14241	15233	29474	615	96	261	292	67	101	98
TOTAAL	64877	67646	132525	399	76	179	195	65	82	102

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

20-03-91

JAAR: 1988 WEEK: 01 T/M 52

URBANISATIE-GROEP	POPULATIE			ONTSLAG PSYCH.PT	STERILISATIE		M.A.PIL		BRANDWONDEN		SUICIDE (POGING)	
				ONTSLAG PSYCH.PT	STERILISATIE		M.A.PIL		BRANDWONDEN		SUICIDE (POGING)	
	M	V	T	M+V	M	V	T	V	M	V	T	M+V
A1+A4	10360	10398	20759	5	75	27	51	17	15	16	16	3
B1-B3,C1-C4	40276	42015	82292	11	33	20	27	23	15	21	18	5
C5	14241	15233	29474	20	32	21	26	40	17	31	24	12
TOTAAL	64877	67646	132525	12	40	22	30	26	15	22	19	6

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS — BLAD 3

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD — 20-03-91

JAAR: 1988 — WEEK: 01 T/M 52

URBANISATIE-GROEP	POPULATIE			ACUTE ONGEWONE HOOFDPIJN			ECHOGRAFIE			DEMENTIE		
				ACUTE ONGEWONE HOOFDPIJN			ECHOGRAFIE			DEMENTIE		
	M	V	T	M	V	T	M	V	T	M	V	T
A1+A4	10360	10398	20759	4	3	3	42	99	70	7	15	11
B1-B3,C1-C4	40276	42015	82292	2	2	2	20	85	53	54	97	76
C5	14241	15233	29474	1	3	2	37	96	68	62	182	124
TOTAAL	64877	67646	132525	2	2	2	27	90	59	48	104	76

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS — BLAD 4

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD — 20-03-91

JAAR: 1988 — WEEK: 01 T/M 52

URBANISATIE-GROEP	POPULATIE			VOORSCHRIFT ROHYPNOL			ZWANGER ONDANKS PSYCH.PT	OPNAME (POLI) KLINISCHE		MAMMOGRAFIE		C.AIDS
				VOORSCHRIFT ROHYPNOL			ZWANGER ONDANKS PSYCH. PT.	OPNAME 1.1.87 1E MAAL WEGENS	1.1.87 1E MAAL WEGENS	HERHAL. PREVENT.	HERHAL.	C.AIDS
	M	V	T	M	V	T	V	M+V	V	V	V	M+V
A1+A4	10360	10398	20759	14	5	9	7	6	60	20	12	14	5
B1-B3,C1-C4	40276	42015	82292	32	107	71	7	12	62	17	6	5	8
C5	14241	15233	29474	50	53	51	16	17	62	19	4	4	21
TOTAAL	64877	67646	132525	33	79	56	9	12	62	18	6	6	10

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

20-03-91

JAAR: 1988 WEEK: 01 T/M 52

PROVINCIE-GROEP	POPULATIE			"INFLU-ENZA"	CERVIXUITSTRIJKJE					
				"INFLU-ENZA"	1.1.86 1E MAAL WEGENS	1.1.86 1E MAAL PR.HUI.	1.1.86 1E MAAL PR.VR.	HERHAL. WEGENS	HERHAL. PR.HUI.	HERHAL. PR.VR.
	M	V	T	M+V	V	V	V	V	V	V
GR+FR+DR	10339	10819	21159	425	117	128	226	58	38	83
OV+GLD+FLE	10908	10914	21822	461	127	112	154	61	81	60
UTR+NH+ZH	28291	29939	58230	395	56	179	233	72	106	128
ZLD+NB+LIM	15339	15974	31314	359	51	255	130	61	68	96
TOTAAL	64877	67646	132525	399	76	179	195	65	82	102

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

20-03-91

JAAR: 1988 WEEK: 01 T/M 52

PROVINCIE-GROEP	POPULATIE			ONTSLAG PSYCH.PT	STERILISATIE			M.A.PIL		BRANDWONDEN			SUICIDE (POGING)	
				ONTSLAG PSYCH.PT	STERILISATIE			M.A.PIL		BRANDWONDEN			SUICIDE (POGING)	
	M	V	T	M+V	M	V	T	V	M	V	T	M+V		
GR+FR+DR	10339	10819	21159	13	36	19	27	19	17	19	18	9		
OV+GLD+FLE	10908	10914	21822	10	57	20	39	20	16	12	14	4		
UTR+NH+ZH	28291	29939	58230	13	38	21	30	28	14	26	20	7		
ZLD+NB+LIM	15339	15974	31314	9	33	24	28	32	17	24	20	5		
TOTAAL	64877	67646	132525	12	40	22	30	26	15	22	19	6		

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS — BLAD 3

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD — 20-03-91

JAAR: 1988 WEEK: 01 T/M 52

PROVINCIE-GROEP	POPULATIE			ACUTE ONGEWONE HOOFDPIJN			ECHOGRAFIE			DEMENTIE		
				ACUTE ONGEWONE HOOFDPIJN			ECHOGRAFIE			DEMENTIE		
	M	V	T	M	V	T	M	V	T	M	V	T
GR+FR+DR	10339	10819	21159	4	1	2	16	72	45	10	18	14
OV+GLD+FLE	10908	10914	21822	3	3	3	36	93	65	5	28	16
UTR+NH+ZH	28291	29939	58230	1	3	2	36	91	64	49	116	84
ZLD+NB+LIM	15339	15974	31314	1	2	2	12	98	56	102	191	147
TOTAAL	64877	67646	132525	2	2	2	27	90	59	48	104	76

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS — BLAD 4

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD — 20-03-91

JAAR: 1988 WEEK: 01 T/M 52

PROVINCIE-GROEP	POPULATIE			VOORSCHRIFT ROHYPNOL			ZWANGER ONDANKS PSYCH.PT	OPNAME (POLI)KLINISCHE		MAMMOGRAFIE		C.AIDS
				VOORSCHRIFT ROHYPNOL			ZWANGER ONDANKS PSYCH. PT.	OPNAME 1.1.87 1E MAAL WEGENS	1.1.87 1E MAAL PREVENT.	HERHAL. WEGENS	HERHAL. PREVENT.	C.AIDS
	M	V	T	M	V	T	V	M+V	V	V	V	V	M+V
GR+FR+DR	10339	10819	21159	49	158	105	6	12	43	5	3	3	7
OV+GLD+FLE	10908	10914	21822	36	100	68	7	12	55	20	13	15	9
UTR+NH+ZH	28291	29939	58230	30	62	47	12	13	67	25	4	5	13
ZLD+NB+LIM	15339	15974	31314	26	43	35	7	12	69	12	9	3	8
TOTAAL	64877	67646	132525	33	79	56	9	12	62	18	6	6	10

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 1

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD 20-03-91

ALLE PEILSTATIONS JAAR: 1989 WEEK: 01 T/M 52

LEEFTIJDS-GROEP	POPULATIE			"INFLU-ENZA"	CERVIXUITSTRIJKJE					
				"INFLU-ENZA"	1.1.87 1E MAAL WEGENS	1.1.87 1E MAAL PR.HUI.	1.1.87 1E MAAL PR.VR.	HERHAL. WEGENS	HERHAL. PR.HUI.	HERHAL. PR.VR.
	M	V	T	M+V	V	V	V	V	V	V
<1 JR	335	331	666	1924	0	0	0	0	0	0
1-4 JR	3131	3030	6161	941	0	0	0	0	0	0
5-9 JR	4227	3917	8144	567	0	0	0	0	0	0
10-14 JR	4056	4265	8321	340	2	0	0	0	0	0
15-19 JR	5601	5484	11085	277	13	6	13	4	4	4
20-24 JR	5974	5965	11939	295	76	146	133	42	27	17
25-29 JR	5904	5735	11639	345	122	355	326	70	66	51
30-34 JR	5345	5317	10662	404	122	331	574	109	141	126
35-39 JR	5237	5135	10372	370	158	433	1181	134	152	327
40-44 JR	4982	5010	9992	357	146	363	946	142	158	405
45-49 JR	3790	3803	7593	373	147	260	686	174	179	318
50-54 JR	3486	3471	6957	361	92	320	907	135	147	294
55-59 JR	3243	3469	6712	405	86	118	190	55	58	98
60-64 JR	2977	3224	6201	377	25	31	59	12	22	28
65-69 JR	2444	2865	5309	403	28	24	49	31	7	4
70-74 JR	1864	2415	4279	442	25	4	21	0	8	4
75-79 JR	1308	1942	3250	366	5	5	0	0	10	0
80-84 JR	719	1408	2127	504	0	0	7	0	0	0
>85 JR	498	1075	1573	395	0	0	0	0	0	0
TOTAAL	65121	67861	132982	406	71	168	344	60	65	110

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD

20-03-91

ALLE PEILSTATIONS

JAAR: 1989 WEEK: 01 T/M 52

LEEFTIJDS-GROEP	POPULATIE			VERWIJZING LOGOPEDIE			STERILISATIE			M.A.PIL	BRANDWONDEN		
				VERWIJZING LOGOPEDIE			STERILISATIE			M.A.PIL	BRANDWONDEN		
	M	V	T	M	V	T	M	V	T	V	M	V	T
<1 JR	335	331	666	0	0	0	0	0	0	0	30	0	15
1-4 JR	3131	3030	6161	89	69	80	0	3	2	0	70	50	60
5-9 JR	4227	3917	8144	229	128	181	0	5	3	0	17	20	18
10-14 JR	4056	4265	8321	54	16	35	0	0	0	7	22	16	19
15-19 JR	5601	5484	11085	7	15	11	0	2	1	131	23	27	25
20-24 JR	5974	5965	11939	17	32	24	0	2	1	99	30	25	28
25-29 JR	5904	5735	11639	15	14	15	20	26	23	68	24	33	28
30-34 JR	5345	5317	10662	8	15	11	92	58	75	56	13	30	22
35-39 JR	5237	5135	10372	13	8	11	149	90	120	29	13	16	15
40-44 JR	4982	5010	9992	2	6	4	74	52	63	28	34	24	29
45-49 JR	3790	3803	7593	0	13	7	37	13	25	8	8	24	16
50-54 JR	3486	3471	6957	6	9	7	0	0	0	3	9	23	16
55-59 JR	3243	3469	6712	15	6	10	0	0	0	0	15	23	19
60-64 JR	2977	3224	6201	3	3	3	0	0	0	0	0	19	10
65-69 JR	2444	2865	5309	4	18	11	0	0	0	0	4	14	9
70-74 JR	1864	2415	4279	11	12	12	0	0	0	0	11	37	26
75-79 JR	1308	1942	3250	15	5	9	0	0	0	0	8	5	6
80-84 JR	719	1408	2127	0	29	19	0	0	0	0	0	21	14
>85 JR	498	1075	1573	20	0	6	0	0	0	0	0	0	0
TOTAAL	65121	67861	132982	30	22	26	29	19	24	35	20	24	22

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 3

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD

20-03-91

ALLE PEILSTATIONS

JAAR: 1989 WEEK: 01 T/M 52

LEEFTIJDS-GROEP	POPULATIE			SUICIDE ACUTE ONGEWONE HOOFDPIJNZWANGER (POGING) ONDANKS			
				SUICIDE ACUTE ONGEWONE HOOFDPIJNZWANGER (POGING) ONDANKS			
	M	V	T	M+V	M	V	T	V
<1 JR	335	331	666	0	0	0	0	0
1-4 JR	3131	3030	6161	0	0	0	0	0
5-9 JR	4227	3917	8144	0	0	0	0	0
10-14 JR	4056	4265	8321	0	3	0	1	0
15-19 JR	5601	5484	11085	3	2	0	1	13
20-24 JR	5974	5965	11939	8	2	2	2	20
25-29 JR	5904	5735	11639	11	0	0	0	26
30-34 JR	5345	5317	10662	17	2	0	1	40
35-39 JR	5237	5135	10372	7	2	2	2	20
40-44 JR	4982	5010	9992	8	0	0	0	4
45-49 JR	3790	3803	7593	12	5	3	4	0
50-54 JR	3486	3471	6957	3	0	0	0	0
55-59 JR	3243	3469	6712	7	3	0	2	0
60-64 JR	2977	3224	6201	10	3	6	5	0
65-69 JR	2444	2865	5309	6	4	4	4	0
70-74 JR	1864	2415	4279	7	5	0	2	0
75-79 JR	1308	1942	3250	3	0	5	3	0
80-84 JR	719	1408	2127	5	0	7	5	0
>85 JR	498	1075	1573	0	0	0	0	0
TOTAAL	65121	67861	132982	7	2	1	1	10

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 4

CUMULATIEF ALLE PEILSTATIONS GESTANDAARDISEERD

20-03-91

ALLE PEILSTATIONS

JAAR: 1989 WEEK: 01 T/M 52

LEEFTIJDS-GROEP	POPULATIE			(POLI)KLINISCHE MAMMOGRAFIE		C.AIDS		
				1.1.88 IE MAAL	1.1.88 IE MAAL WEGENS	HERHAL. WEGENS	HERHAL. PREVENT.	C.AIDS
	M	V	T	V	V	V	V	M+V
<1 JR	335	331	666	0	0	0	0	0
1-4 JR	3131	3030	6161	0	0	0	0	0
5-9 JR	4227	3917	8144	0	0	0	0	0
10-14 JR	4056	4265	8321	0	0	0	0	0
15-19 JR	5601	5484	11085	6	0	0	0	7
20-24 JR	5974	5965	11939	34	5	2	0	28
25-29 JR	5904	5735	11639	66	14	5	2	34
30-34 JR	5345	5317	10662	98	26	11	6	29
35-39 JR	5237	5135	10372	138	51	16	18	24
40-44 JR	4982	5010	9992	180	42	24	18	24
45-49 JR	3790	3803	7593	174	42	16	18	11
50-54 JR	3486	3471	6957	104	55	14	14	12
55-59 JR	3243	3469	6712	92	35	14	17	13
60-64 JR	2977	3224	6201	74	28	6	12	2
65-69 JR	2444	2865	5309	35	11	4	4	4
70-74 JR	1864	2415	4279	21	12	8	0	2
75-79 JR	1308	1942	3250	31	0	10	0	6
80-84 JR	719	1408	2127	0	0	0	0	0
>85 JR	498	1075	1573	9	0	0	0	6
TOTAAL	65121	67861	132982	67	20	8	7	14

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

20-03-91

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

JAAR: 1989 WEEK: 01 T/M 52

URBANISATIE-GROEP	POPULATIE			"INFLU-ENZA"	CERVIXUITSTRIJKJE					
	"INFLU-ENZA"	1.1.87 1E MAAL WEGENS	1.1.87 1E MAAL PR.HUI.	1.1.87 1E MAAL PR.VR.	HERHAL. WEGENS	HERHAL. PR.HUI.	HERHAL. PR.VR.			
	M	V	T	M+V	V	V	V	V	V	V
A1+A4	10391	10422	20814	341	103	130	242	53	65	109
B1-B3,C1-C4	40394	42143	82542	354	57	142	379	63	57	130
C5	14328	15300	29628	616	90	271	334	60	87	59
TOTAAL	65113	67865	132984	409	71	169	347	61	65	111

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

20-03-91

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

JAAR: 1989 WEEK: 01 T/M 52

URBANISATIE-GROEP	POPULATIE			VERWIJZING LOGOPEDIE			STERILISATIE			M.A.PIL			BRANDWONDEN		
				VERWIJZING LOGOPEDIE			STERILISATIE			M.A.PIL			BRANDWONDEN		
	M	V	T	M	V	T	M	V	T	V	M	V	T		
A1+A4	10391	10422	20814	34	21	27	41	22	32	35	19	14	17		
B1-B3,C1-C4	40394	42143	82542	28	21	24	26	17	21	36	18	25	21		
C5	14328	15300	29628	35	27	31	33	23	28	33	26	29	27		
TOTAAL	65113	67865	132984	30	22	26	30	19	24	35	20	24	22		

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 3

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

20-03-91

JAAR: 1989 WEEK: 01 T/M 52

URBANISATIE-GROEP	POPULATIE			SUICIDE ACUTE ONGEWONE (POGING)		HOOFDPIJNZWANGER ONDANKS		
				SUICIDE ACUTE ONGEWONE (POGING)		HOOFDPIJNZWANGER ONDANKS		
	M	V	T	M+V	M	V	T	V
A1+A4	10391	10422	20814	7	1	1	1	3
B1-B3,C1-C4	40394	42143	82542	6	2	1	1	8
C5	14328	15300	29628	10	3	1	2	22
TOTAAL	65113	67865	132984	7	2	1	1	10

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 4

URBANISATIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD

20-03-91

JAAR: 1989 WEEK: 01 T/M 52

URBANISATIE-GROEP	POPULATIE			(POLI)KLINISCHE MAMMOGRAFIE		C.AIDS		
				1.1.88 1E MAAL WEGENS	1.1.88 1E MAAL PREVENT.	HERHAL. WEGENS	HERHAL. PREVENT.	C.AIDS
	M	V	T	V	V	V	V	M+V
A1+A4	10391	10422	20814	111	43	20	20	5
B1-B3,C1-C4	40394	42143	82542	56	15	6	4	13
C5	14328	15300	29628	69	18	7	4	27
TOTAAL	65113	67865	132984	67	20	8	7	15

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS — BLAD 1

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD — 20-03-91

JAAR: 1989 — WEEK: 01 T/M 52

PROVINCIE-GROEP	POPULATIE			"INFLU-ENZA"	CERVIXUITSTRIJKJE					
				"INFLU-ENZA"	1.1.87 1E MAAL WEGENS	1.1.87 1E MAAL PR.HUI.	1.1.87 1E MAAL PR.VR.	HERHAL. WEGENS	HERHAL. PR.HUI.	HERHAL. PR.VR.
	M	V	T	M+V	V	V	V	V	V	V
GR+FR+DR	10393	10869	21264	402	100	106	260	49	38	95
OV+GLD+FLE	10875	10878	21754	415	128	118	240	59	80	62
UTR+NH+ZH	28364	30001	58367	434	54	201	453	66	57	130
ZLD+NB+LIM	15481	16117	31599	366	48	189	283	61	88	120
TOTAAL	65113	67865	132984	409	71	169	347	61	65	111

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS — BLAD 2

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD — 20-03-91

JAAR: 1989 — WEEK: 01 T/M 52

PROVINCIE-GROEP	POPULATIE			VERWIJZING LOGOPEDIE			STERILISATIE			M.A.PIL	BRANDWONDEN		
				VERWIJZING LOGOPEDIE			STERILISATIE			M.A.PIL	BRANDWONDEN		
	M	V	T	M	V	T	M	V	T	V	M	V	T
GR+FR+DR	10393	10869	21264	14	11	13	36	26	31	30	17	29	24
OV+GLD+FLE	10875	10878	21754	25	15	20	33	15	24	36	19	12	16
UTR+NH+ZH	28364	30001	58367	32	21	26	25	20	23	37	22	23	22
ZLD+NB+LIM	15481	16117	31599	41	38	40	32	16	24	33	19	30	25
TOTAAL	65113	67865	132984	30	22	26	30	19	24	35	20	24	22

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 3

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD 20-03-91

JAAR: 1989 WEEK: 01 T/M 52

PROVINCIE-GROEP	POPULATIE			SUICIDE (POGING)		ACUTE ONGEWONE HOOFDPIJN		ZWANGER ONDANKS	
	M	V	T	M+V	M	V	T	V	
GR+FR+DR	10393	10869	21264	6	1	1	1	4	
OV+GLD+FLE	10875	10878	21754	9	2	1	1	6	
UTR+NH+ZH	28364	30001	58367	6	1	1	1	15	
ZLD+NB+LIM	15481	16117	31599	8	3	3	3	7	
TOTAAL	65113	67865	132984	7	2	1	1	10	

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 4

PROVINCIEGROEP NAAR ZIEKTEBEELD GESTANDAARDISEERD 20-03-91

JAAR: 1989 WEEK: 01 T/M 52

PROVINCIE-GROEP	POPULATIE			(POLI)KLINISCHE MAMMOGRAFIE 1.1.88 1E MAAL WEGENS	1.1.88 HERHAL. 1E MAAL WEGENS	HERHAL. PREVENT.	C.AIDS	C.AIDS PREVENT.	
	M	V	T	V	V	V	V	M+V	
GR+FR+DR	10393	10869	21264	54	10	6	2	9	
OV+GLD+FLE	10875	10878	21754	106	36	23	21	11	
UTR+NH+ZH	28364	30001	58367	56	21	4	2	18	
ZLD+NB+LIM	15481	16117	31599	70	14	7	8	15	
TOTAAL	65113	67865	132984	67	20	8	7	15	

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. 1989, 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. 1-1-1989, Central Bureau of Statistics. Persons who are entered in the central register of vital statistics have been left out of consideration.

5. Practice census 1987.

6. In these tables and the tables in the text derived from them frequencies are given in all cases 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.
   Pel, J.Z.S. (1965) Proefonderzoek naar de frequentie en de aetiologie van griepachtige ziekten in de winter 1963-1964. (Huisarts en Wetenschap 8, 321).

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 Institute for Socio-Sexological Research

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

11. 1. Rademakers J., Ketting E. Hoe betrouwbaar is de 'alternatieve' 22x2 morning-after pil? Medisch Contact 1987; 42: p. 89-92
    2. Santen M.R. van, Haspels A.A. Ingezonden. Medisch Contact 1987; 42: p. 230.
    3. De 2x2-morning-after pil: een verantwoord alternatief? Gen.Bul. 1987 21: p. 47-49.

12. Warning Headache in Aneurysmal Subarachnoid Hemorrhage. Robert D. Verweij M.D.: Eelco F.M. Wijdicks M.D.; Jan van Gijn M.D., Arch Neurologica Vol 45, Sept. 1988

13. Onderzoek Gezinsvorming C.B.S.

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

15. Moons, M.A.W., L. Peters in Huisarts en vragen over AIDS. M.C.; 45, 1990, no 35, p. 1055-1057

16. National Committee for AIDS control, AIDS info line, annual report. 1988, 1989.

17. Psychiatrische Ziekenhuizen in cijfers. J.U. Brouwer and J.M. Spaan, NZI, June 1988

18. W. Frankenberg and G.H.N.M. ter Horn. Contacts of general practitioners with discharged psychiatric patients. In the Dutch Sentinel Practice Network; relevance for public health policy, p. 235. Nivel, Utrecht 1989.

19. G.A.A. Daries. Echografie in Bijblijven 3, 1987, nr. 10.

20. R.F.W. Diekstra and M. van Egmond. Suicide and attempted suicide in general practice. In the Dutch Sentinel Practice Network; relevance for public health policy, p. 202. Nivel, Utrecht 1989.

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

22. A.I.M. Bartelds. Requests for application of euthanasia. In the Dutch Sentinel Practice Network; relevance for public health policy, p. 259. Nivel, Utrecht 1989.

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

Explanatory notes pertaining to:

Bijlage 1	
Bijlage	- Appendix
Continue morbiditeits registratie, peilstations	- Continuous morbidity registration, - sentinel stations
Deelnemende artsen	- Participating general practitioners
Naam	- Name
Plaats	- Residence
Provincie	- Province
Comb.-praktijk	- Group practice
Apotheek-houdend	- With dispensary
Bijlage 2	
Bijlage	- Appendix
Weekstaat t.b.v. centrale registratie	- Weekly return for central registration
Continue morbiditeits registratie, peilstations	- Continuous morbidity registration, - sentinel stations
Proj. no.	- Project number
Verslagjaar	- Year under review
Week no.	- Number of the week
Code peilstations	- Code number sentinel stations
Rapport. dagen	- Number of days over which reporting took place
Regel no.	- Line number
Leeftijdsgroep	- Age group
Influenza (-achtig ziektebeeld)	- Influenza (-like illness)
Cervixuitstrijkje	- Cervical smear
Na 1-1-1987 voor de eerste maal afgenomen op grond van	- Taken for the first time after 1-1-1987 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
Sterilisatie verricht	- Sterilization performed
Morning-after pil voorgeschreven	- Prescription of morning-after pill
Brandwonden	- Burns
Suïcide(pogingen)	- (Attempted) suicide

Acute ongewone hoofdpijn	- Acute unusual headache
(Poli) klinische mammografie	- mammography
na 1-1-1988 voor eerste maal	- Taken for the first time after 1-1-1988
Klachten/symptomen	- Complaints/symptoms
Louter preventief	- Purely preventive
Herhalingsonderzoek	- Repeat examination
C.A.I.D.S.	- Concern about AIDS
Opname/ontslag psychiatrische patiënt	- Admission/discharge of psychiatric patients
Echografie aangevraagd	- Echography applied for
Dementie	- Dementia
Voorschrijven Rohypnol	- Prescription of Rohypnol
Zwangerschap (ondanks a.c.)	Pregnancy despite adequate contraception
Verwijzing voor logopedie	- Refferal voor logopedics
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 1-1-1986 om welke reden dan ook een cervixuitstrijkje heeft plaatsgevonden. Indien bij een vrouw na 1-1-1986 op-
3. Concerns reporting of women on whom a cervical smear was taken after 1-1-1986 for whatsoever reason. If a cervical smear was taken again of a women after

nieuw een cervixuitstrijkje wordt gemaakt, dient dit altijd onder de subrubriek "herhalingsonderzoek" geboekt te worden (zie ook voetnoot 5).

4. Bijvoorbeeld in het kader van pilcontrole
5. Bijvoorbeeld wegens verdacht preparaat of wegens technische onvolkomenheden bij onderzoek vorig preparaat.
6. 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. S.v.p. apart formulier invullen en bij de weekstaat voegen.
10. S.v.p. apart formulier invullen en bij de weekstaat voegen.
11. S.v.p. apart formulier invullen en bij de weekstaat voegen.
12. S.v.p. apart formulier invullen en bij de weekstaat voegen.
13. S.v.p. apart formulier invullen en bij de weekstaat voegen.

1-1-1986 this should always be entered under the subheading "Repeat examination" (see also footnote 5).

4. For example as part of check-up for the pill.
5. For example on account of suspect preparation or technical imperfections in the examination of the 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. Plaese complete a separate form and attach to the weekly return.
10. Plaese complete a separate form and attach to the weekly return.
11. Plaese complete a separate form and attach to the weekly return.
12. Plaese complete a separate form and attach to the weekly return.
13. Plaese complete a separate form and attach to the weekly return.

14.S.v.p. apart formulier invullen en bij de weekstaat voegen.	14.Plaese complete a separate form and attach to the weekly return.

Tables (p. 144 - p. 159)

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
Sterilisatie verricht	- Sterilization performed
Morning-after pil voorgeschreven	- Morning-after pill prescribed
Brandwonden	- Burns
Suïcide(pogingen)	- (Attempted) suicide
Acute ongewone hoofdpijn	- Acute unusual headache
(poli) klinische mammografie	- (Clinical) mammography
Klachten/symptomen	- Complaints/symptoms
Louter preventief	- Purely preventive
Herhalingsonderzoek	- Repeat examination
C.A.I.D.S.	- Concern about AIDS
Opname onstlag psychiatrische patiënt	- Admission/discharge psychiatric patients
Echografie aangevraagd	- Echography applied for
Dementie	- Dementia
Voorschrijven Rohypnol	- Prescription of Rohypnol
Zwangerschap (ondanks a.c.)	- Pregnancy despite adequate contraception
Verwijzing voor logopedie	- Refferal for logopedics
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