CONTINUOUS MORBIDITY REGISTRATION
SENTINEL STATIONS

THE NETHERLANDS
1982

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FOREWORD

This is the thirteenth report of the sentinel stations project, and it again shows how this modest project, thanks to a well-organized set-up and the motivated assistance of many, is capable of furnishing interesting and important information.

The sentinel stations perform a number of gaugings in unknown territory: the terra incognita of primary health care. And, as usually happens, the information gained summons up new questions which may themselves give rise to further investigation.

In 1982 the subject "hay fever" was concluded. There are new topics: on the course of pregnancy (spontaneous abortion, premature deliveries and deliveries at term) and on the prescribing of penicillin and the occurrence of side effects.
There were two new "incidental investigations": that into mastitis puerperalis and registration of (new) cancer patients. Added to the topic "accidents in the private sector" was a survey on the action of the general practitioner with respect to these accidents.
Every "gauging" yields more insight into aid within primary health care. I cannot refrain from mentioning a few results.
In the case of ten percent of the registered patients with cancer no histological examination was performed in this population; if registration were performed only by the pathologist-anatomists, these would have remained unknown. Seventy percent of patients with an accident in the private sector go first to their family doctor; of these patients, eighty percent are treated by the family doctor himself.
Finally in only three of the sixty-five cases reported of mastitis puerperalis was an incision necessary.

Those are important new data for policy, teaching and practice of health care.

S. van der Kooij,

Chairman of the Sentinel Stations Counselling Committee.

INTRODUCTION

Continuous Morbidity Registration is a method of registration based on general practice. A national network of general practices, the sentinel stations, covers 1% of the Dutch population. In the composition of this network allowance has been made for a geographical spread over regions with a varying degree of urbanization.

The participating general practitioners, the spotter physicians, submit a form every week on which certain illnesses and occurrences are reported, the weekly return. This weekly return comprises a distribution by age and where necessary a distribution by sex (see p. 98).

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. 21).

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

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

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

When considering the subjects which have been included during the years on the weekly return (see p. 19 and 99) the conclusion is reached that the name of the project, Continuous Morbidity Registration, no longer covers the entire work. After all, in part these are not diseases which are registered but actions or occurrences. The name sentinel stations is better: a watch is kept, sometimes for one year, sometimes longer or even continuously. That is why the name "Continuous Morbidity Registration, Sentinel Stations" is used.

In addition to the submission of weekly returns, a start was made in 1976 with incidental investigations. This entails the physicians being asked non-recurrent questions about diseases or occurrences which do not happen frequently.

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

COUNSELLING COMMITTEE

In the course of 1982, on account of the changed status of the project, it was decided henceforth to speak of the Counselling Committee instead of Programme Committee.

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

- two representatives of the Ministry of Welfare, Public Health and Culture
- the Director of the Netherlands Institute for General Practice (Chairman)
- one representative of the policy council of the Netherlands Institute for General Practice
- two representatives of the Chief Medical Office of Health
- one representative of the spotter physicians
- one representative of the joint Institutes for General Practice of Dutch Universities
- two members on the basis of specific expertise.

In 1982 the committee still functioned in the following composition:

Programme committee:	*S. van der Kooij, M.D. (Chairman)* [1]
	H.J. van der Leen, M.D. [2]
	W.A. van Veen, M.D. [3]
	A. Vrij, M.D. [4]
Advisers:	*Dr H. Bijkerk, M.D.* [4]
	W.M.J. van Duyne, M.D. [5]
	H.O. Sigling, M.D. [6]
Coordinator:	*Dr H.A. van Geuns, M.D.* [4]
Financial expert:	*A. Schaap* [3]

[1] *Foundation of the Netherlands Institute for General Practice*
[2] *Representing spotter physicians*
[3] *Ministry of Welfare, Public Health and Culture*
[4] *Chief Medical Office of Health*
[5] *Netherlands Institute of Preventive Health Care-T.N.O.*
[6] *Institute of General Practice of Amsterdam Free University*

Project leader:	*Dr Bertine J.A. Collette, M.D.*
Secretary:	*Mrs. F.G. Hoeben-Schaafsma since 1-6-1982*
	Mrs. M. Mijderwijk-van Valen
	Mrs. A.C.A.M. Verweij till 1-5-1982

This committee met three times in 1982.

MEETING OF SPOTTER CO-WORKERS

The annual meeting of co-workers on the project in 1982 was held on Saturday, 23 February in Utrecht.
In all there were 46 participants. This meeting is always held at the beginning of the calender year, so that problems relating to the new topics on the weekly return can be discussed in good time. It is endeavoured to invite as speakers experts on the subjects to be registered. In this way the project acquires more substance for the co-workers.

The first speaker was Mrs. J.H. van der Stroom-Kruyswijk, a staff-member of the Food Inspection Service for the Utrecht region. She gave a short talk on the background to the desire to have registration performed of hypersensitivity reactions to penicillin. This subject appeared on the weekly return in 1982 (see p 59).
The late Professor G.L. Kalsbeek, at the time Professor of Dermatology at Utrecht University, explained the subject by means of slides. A not inconsiderable part of the hypersensitivity reactions is probably based on non-immunological reactions, but is a consequence of a reaction to breakdown products (formerly the so-called "toxic" reaction also fell into this category). Clinically the reactions are hardly distinguishable if at all from the "real" allergic or immunological reactions. The difference can be established only with the aid of a carefully performed examination.

The second subject to be discussed was "accidents in the private sector in the Netherlands", elucidated by Mr. W. Rogmans, of the Safety Institute. This subject already appeared on the weekly return in 1981. A long list showed the great variety of causes. The number of fatalities is approximately 2450. The number of cases per year requiring rehabilitation is, however, much greater, approximately 42 000; 35% of the patients undergoing treatment in a rehabilitation institution or a rehabilitation ward of a hospital are there because of an accident in the private sector. And in addition the costs on account of absence due to illness are considerable. Specific information, advice and education are needed to reduce this number.

Messrs. A. Hofman and J.P. Vandenbroucke, epidemiologists at the Erasmus University, Rotterdam, dealt with the subject "case-control investigation". Is such an investigation feasible for the sentinel stations and, if so, what are the advantages? The unique feature of such an investigation by the sentinel stations would be the fact that the controls could be selected from the whole population and not from the hospital.
It was unanimously decided to perform a feasibility study within the project.

In conclusion a discussion of the subjects on the weekly return took place.

DISTRIBUTION OF THE SPOTTER PHYSICIANS OVER THE NETHERLANDS

(Fig. 1 page 124)

The number of sentinel stations stayed the same in 1982 (46). A few small changes occurred, such as taking over a practice or forming a group practice, but the number of general practitioners taking part did not change (61).

Appendix 1 (page 96) gives a survey of the general practitioners who took part in the sentinel station project during 1982. In 13 sentinel stations there is cooperation between two or more general practitioners, viz 12 between 2 and 1 between 4 practitioners. In January 1982 the percentage of general practitioners cooperating throughout the Netherlands was 41, and among the spotter physicians 46 (28 out of the 61)[1]. There are 11 dispensing spotter physicians, 5 in urbanization group 1 and 6 in urbanization group 2, that is 18%. For the whole of the Netherlands the percentage is 23%[2]).

The following table gives a distribution of the number of spotter physicians and sentinel stations per province group and urbanization group in the years 1970-1982. 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 subgroups shows that the spotter physicians form a proportional representation (1981, p. 13).

[1]) *The structure of the professional group of general practitioners*
Netherlands Institute of General Practice, Jan. 1982, p. 5, N.H.I. Publication.
[2]) *Idem, p. 15, Table 3.*

Survey of the distribution of the spotter physicians and sentinel stations in the years 1970 - 1982.

Province-group	A		B		C		D	
	Groningen, Friesland and Drenthe		Overijssel, Gelderland and the Southern IJsselmeer polders		Utrecht, North and South Holland		Zeeland, North Brabant and Limburg	
	Number		Number		Number		Number	
	GPs	Sentinel stations	GPs	Sentinel stations	GPs	Sentinel stations	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

Survey (continuation)

Urbanization group[1])	1 Rural municipalities		2 Municipalities with urban characteristics together with urbanized rural municipalities		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

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

THE PRACTICE POPULATIONS

A complete census of the practice populations again took place in 1981; these details are used for processing with effect from 1-1-1982.
When the project was set up the aim was to take a sample of about 1% of the Dutch population. A geographical distribution (the above-mentioned province groups) was taken into account, as also a distribution of regions with various degrees of urbanization (urbanization groups). An enquiry was made as to whether this aim is still being met. This proved to be so, as the following surveys demonstrate.
Province group A (the northern provinces) and urbanization group 1 (rural municipalities) are relatively somewhat overrepresented. However, this is favourable, since these are precisely the smallest groups for the Netherlands as a whole, while the difference is not of such a nature that the proportional representation is seriously disturbed by it.

Comparisation of the population of the percentages of the spotter physicians with the total population of the Netherlands.

	Number of inhabitants of the Netherlands[1])	*Number of patients Sentinel stations*[2]) *(with percentages)*	
Province group			
A	*1 567 649*	*21 575*	*(1.4%)*
B	*2 812 471*	*28 667*	*(1.0%)*
C	*6 330 102*	*78 022*	*(1.2%)*
D	*3 496 950*	*35 313*	*(1.0%)*
Urbanizationgroup			
1	*1 646 930*	*27 370*	*(1.7%)*
2	*8 991 152*	*99 429*	*(1.1%)*
3	*3 569 090*	*36 778*	*(1.0%)*
Sex			
Men	*7 047 676*	*80 049*	*(1.1%)*
Women	*7 159 496*	*83 528*	*(1.2%)*
Total	*14 207 172*	*163 577*	*(1.2%)*

[1]) *1-1-1981. Centraal Bureau for Statistics. Persons on the Central Register of Persons (CPR) are excluded.*

[2]) *Practice censuses 1981.*

At the last census a breakdown was adhered to for health insurance funds and non-health insurance funds. The percentage of patients who were members of a health insurance fund was 65%. The annual report of the Health Insurance Fund Council gives for the whole of the Netherlands as on 31 December 1981 69%. In this respect too, therefore, no selection has taken place.

SCOPE AND CONTINUITY OF THE REPORTING

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

The maximum number of days which can be reported was:

- for 1975: 11 960 (52 weeks × 5 days × 46 sentinel stations[1]))
- for 1976: 11 925 (53 × 5 × 45)
- for 1977: 11 440 (52 × 5 × 44)
- for 1978: 12 090 (26 × 5 × 46 + 26 × 5 × 47)
- for 1979: 11 960 (52 × 5 × 46)
- for 1980: 12 190 (53 × 5 × 46)
- for 1981: 11 960 (52 × 5 × 46)
- for 1982: 11 960 (52 × 5 × 46)

The actual number of reporting days was:

- for 1975: 9 505 (79.5%)
- for 1976: 10 095 (84.7%)
- for 1977: 10 163 (88.8%)
- for 1978: 10 592 (87.6%)
- for 1979: 10 518 (87.9%)
- for 1980: 10 618 (87.1%)
- for 1981: 10 520 (88.0%)
- for 1982: 10 627 (88.8%)

The percentage of reporting days is the same as in 1977;
A breakdown by province and urbanization group may be seen in the following table.
No great differences prove to exist.

Per province group		Per urbanization group	
A	91.0%	1	91.0%
B	89.2%	2	89.4%
C	87.8%	3	86.0%
D	89.3%		

[1]) *In 1975 one physician terminated his sentinel station activities at the beginning of the year; this has not been taken into consideration in this processing.*

Table 1[1]) gives the frequency distribution of the number of days not reported on per sentinel station. Comparing this with 1981 no difference of any significance is visible. The average number of non-reporting days per sentinel station is 29; a little lower than in 1981 and the same as in 1977. A subdivision into single and group practices displays a clear difference here, viz 37 and 8 days respectively. This tallies with the frequently voiced assertion that group practices enhance the continuity of reporting.

In Fig. 2 the 1982 weekly reporting can be found. This figure clearly shows the influence of public holidays. The average number of non-reporting days per week is nearly 26 (maximum $46 \times 5 = 230$).
The data show that, even after correction for days not reported on, the target of collecting data from a sample of 1% of the Dutch population by means of this project is being attained. This is valid for all subgroups.

Table 1: Frequency distribution of the number of days not reported on per sentinel station.

Number of days not reported on	*Number of sentinel stations*							
	1975	*1976*	*1977*	*1978*	*1979*	*1980*	*1981*	*1982*
0	*1*	*0*	*0*	*1*	*1*	*2*	*2*	*1*
1- 9	*2*	*5*	*11*	*8*	*11*	*7*	*9*	*9*
10-19	*3*	*6*	*7*	*5*	*2*	*2*	*2*	*2*
20-29	*5*	*3*	*3*	*3*	*5*	*4*	*3*	*6*
30-39	*10*	*16*	*9*	*10*	*10*	*11*	*18*	*15*
40-49	*8*	*6*	*10*	*11*	*10*	*10*	*8*	*10*
50-59	*7*	*2*	*2*	*6*[3])	*4*	*8*	*2*	*3*
60-69	*3*	*3*	*0*	*1*	*2*	*1*	*1*	*0*
70-79	*1*	*0*	*1*	*0*	*0*	*0*	*0*	*0*
80-89	*2*	*1*	*0*	*1*	*0*	*1*	*1*	*0*
90-99	*0*	*1*	*0*	*0*	*1*	*0*	*0*	*0*
>99	*4*	*2*	*1*	*1*[4])	*0*	*0*	*0*	*0*
	46[2])	*45*	*44*	*47*	*46*	*46*	*46*	*46*
Average	*53*	*41*	*29*	*32*	*31*	*34*	*31*	*29*
Median	*46*	*36*	*32.5*	*34*	*34.5*	*38*	*38*	*39*

[1]) *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.*

[2]) *See footnote 1 on page 16.*

[3]) *One sentinel station started in February 1978.*

[4]) *One sentinel station finished in August 1978.*

THE WEEKLY RETURN (Appendix 2, p. 98)

The questions on the weekly return for 1982 were selected as follows by the Programme Committee:

1. New cases of influenza (-like illness)
2. Diabetes mellitus
3. Cervical smear
4. Parkinson's disease
5. Sterilization of the man performed
6. Sterilization of the woman performed
7. Prescription of morning-after pill
8. Hay fever
9. (Attempted) suicide
10. Spontaneous abortion or partus immaturus and partus at gravidity $\geqslant$ 28 weeks
11. Penicillin, prescriptions and side effects
12. Accidents in the private sector
13. Traumas in sport: accidents/overstrain

Just as in previous years, the basis in principle was weekly reporting, the "week" consisting of the period from Monday to Friday inclusive. The exceptions to this are reporting of prescriptions of the morning-after pill, hay fever, (attempted) suicide, spontaneous abortion or partus immaturus, partus at gravidity $\geqslant$ 28 weeks, penicillin, accidents in the private sector and traumas in sport, when reports were also made on Saturdays and Sundays. Diagnoses made or advice given by telephone are not entered in the weekly return in principle; an exception is formed by reports of influenza by telephone.

A survey of the questions included on the weekly return in the years 1970-1982 is given below; the questions of the current year, 1983, are also given. The subjects in alphabetical order can be found in Appendix 3 (p. 99) together with the years of registration.

Subjects on the weekly returns 1970 - 1983

Subject	*'70*	*'71*	*'72*	*'73*	*'74*	*'75*	*'76*	*'77*	*'78*	*'79*	*'80*	*'81*	*'82*	*-'83*
Influenza (-like illness)	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Exanthema e causa ignota	x													
Acute diarree e causa ignota	x													
Consultations for family planning	x	x	x	x	x	x	x							
Request for abortion	x	x	x	x	x	x								
(Attempted) suicide	x	x	x							x	x	x	x	x
Rubella (-like illness)		x												
Otitis media acuta		x												
Abortus provocatus		x	x	x	x	x	x	x	x	x				
Accidents		x												
Tonsillectomy or adenotomy		x												
Prescription of morning-after pill			x	x	x	x	x	x	x	x	x	x	x	x
Sterilization of the man performed			x	x	x	x	x	x	x	x	x	x	x	x
Prescription of tranquillizers			x	x	x									
Consultation for drug-use			x	x	x					x	x	x		
(Suspicion of) battered child syndrome				x	x									
Sterilization of the woman performed					x	x	x	x	x	x	x	x	x	x
Consultation with regard to addiction to smoking					x									

Subjects on the weekly returns 1970 - 1983 (continuation)

Subject	*'70*	*'71*	*'72*	*'73*	*'74*	*'75*	*'76*	*'77*	*'78*	*'79*	*'80*	*'81*	*'82*	*-'83*
Measles						x	x	x	x	x				
Alcoholism						x								
Ulcus ventriculi/ duodeni						x								
Skull traumas in traffic						x	x	x						
Certificate for another dwelling issued						x								
Psoriasis							x	x						
Prescription of anti-hypertensivum or diuretic							x							
Cervical smear							x	x	x	x	x	x	x	x
Mononucleosis infectiosa								x	x	x				
Prescription of medicine for infection of the urinary tract								x						
Hay fever									x	x	x	x	x	
(Suspicion of) myocardial infarction									x					x
Traumas in sport										x	x	x	x	x
Diabetes mellitus											x	x	x	x
Parkinson's disease											x	x	x	x
Accidents in the private sector												x	x	x
Spontaneous abortion or partus immaturus													x	x
Partus at gravidity ⩾ 28 weeks													x	x
Penicillin (prescriptions and side effects)													x	x
Depression														x

PROCESSING OF THE DATA ON THE WEEKLY RETURN

This report contains the results of the weekly return for 1982. The data were processed by the Computer Centre of the Ministry of Welfare, Public Health and Culture as usual.

Three tables are produced on a routine basis:

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

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

With the exception of the information furnished per sentinel station, the data are expressed per 10 000 of the total practice population (relative frequencies). The frequencies are given in round figures. In the case of a frequency of under 0.5 per 10 000 inhabitants, the figure is rounded off to "0". When no cases at all have been reported, this is indicated by "-". A frequency that is based on fewer than 5 reports is put between brackets.
When the frequency of new cases of a disease in a given period is concerned, one also speaks of incidence; if, on the other hand, all existing cases of that disease in a given period or at a given moment in time are concerned, that is designated as prevalence. There is also a subdivision into absolute and relative incidence or prevalence. In this report the relative incidence or prevalence is in all cases calculated per 10 000 inhabitants or men or women. So as to be able, if desired, to calculate absolute numbers for the Netherlands, in Appendix 4 (page 100) the age structure as on 1 January 1982 is given.

In principle a sentinel station reports over a five-day week. However, in practice it proves that in some weeks fewer days are reported on, or none at all (sickness, vacation, etc.). 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 3, 4 or 5 days of the week are processed. Till 1978 a correction factor was applied to this. Consideration of the number of times that this was applied showed that the influence on the total was so small that this correction has been done away with effect from 1 January 1978. Moreover, enquiries among the spotter physicians revealed that in the case of 1 or 2 days' absence the work was simply moved to a later date.

The returns are built up from the weekly figures, the frequencies being calculated on the average population present in the quarter.

SOME RESULTS OF THE WEEKLY REPORTING FOR 1982[1])

This annual report will not attempt to give a complete analysis of the material, as already mentioned in the introduction.

The following quarterly and annual tables are included here (page 102 - 121):
Tables 1a, 1b, 1c, 1d and 1e: the number of patients per 10 000 of the age group[2]).
Tables 2a, 2b, 2c, 2d and 2e: the number of patients per 10 000 of the province group.
Tables 3a, 3b, 3c, 3d and 3e: the number of patients per 10 000 of the urbanization group.

In the discussion of the tables the following abbreviations or codes are used:
- influenza for influenza (-like illness)
- A for the Groningen, Friesland and Drenthe (northern provinces) province group
- B for the Overijssel, Gelderland and Southern IJsselmeer Polders (eastern provinces) province group
- C for the Utrecht, North Holland and South Holland (western and central provinces) province group
- D for the Zeeland, North Brabant and Limburg (southern provinces) province group
- 1 for the A1 - A4 urbanization group (rural municipalities)
- 2 for the B1 - B3, C1 - C4 urbanization group (municipalities with urban characteristics together with urbanized rural municipalities)
- 3 for the C5 urbanization group (municipalities with a population of 100 000 or more)

[1]) *See footnote 2 on page 17.*

[2]) *In this tables and the tables in the text derived from them frequencies are given in all cases per 10 000 men, women or inhabitants, unless stated otherwise.*

INFLUENZA (-like illness) [1])

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

Influenza 1982/1983

Table 4a and Fig. 3 (page 122 and 126) give the number of new cases, the incidence, of influenza per 10 000 inhabitants per week, per province group and per urbanization group[2]).
The progress of influenza at the beginning of 1982 was already described in the 1981 report.

In the 1982/83 season there were somewhat more reports of influenza than in the preceding season. However, there was no question of an epidemic rise.
The first isolations of influenza virus (H3N2) were reported in the first half of November. The highest incidence occurred in the 52nd week of 1982, with 42 cases per 10 000 inhabitants (Table 4a). Most cases were reported in the 1st week of 1983 in the north of the country, 72 per 10 000 inhabitants.
In the cities the highest incidence was reached in the 51st week of 1982 (63); in the municipalities with urban characteristics and the rural municipalities the highest incidences were attained in the 52nd week (38 and 43 respectively).
Influenza A (H3N2) was regularly isolated. Occasionally influenza A (H1N1) and influenza B were diagnosed by means of serological tests.

[1]) *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 preexistent infections of the respiratory organs at a non-pathogenic level)*
- *b. The infection must be accompanied by a rise in rectal temperature to at least 38°*
- *c. At least one of the following symptoms must be present: cough, coryza, sore throat, frontal headache, retrosternal pain, myalgia.*

Pel, J.Z.S. (1965) Proefonderzoek naar de frequentie en de aetiologie van griepachtige ziekten in de winter 1963 - 1964 (Experimental investigation of the frequency and aetiology of influenza-like illness in the winter 1963 - 1964). Huisarts en Wetenschap 8, 321.

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

Table 2: Number of patients with influenza (-like illness), per 10 000 inhabitants, 1970 - 1983.

Year	*1970*	*1971*	*1972*	*1973*	*1974*	*1975*	*1976*	*1977*	*1978*	*1979*	*1980*	*1981*	*1982*	*1983*
Total per calendar year	*904*	*889*	*779*	*699*	*885*	*695*	*717*	*575*	*829*	*438*	*425*	*491*	*497*	
Total per "season"[1])	*782*	*879*	*785*	*813*	*651*	*701*	*557*	*711*	*502*	*449*	*448*	*392*		
Highest weekly incidence per "season"	*47*	*64*	*115*	*78*	*90*	*68*	*44*	*107*	*43*	*15*	*36*	*20*	*41*	

[1]) *For these totals the limit of 30 June - 1 July is adhered to give a more realistic picture of the size of the epidemic than per calendar year.*

If the annual figures for 1970 to 1982 inclusive (i.e. not just the figures during an epidemic) are compared, 1982 with 497 cases per 10 000 inhabitants (Table 2) joins together with the preceding years the years with relatively few influenza patients.

Age and sex distribution

During the period of registration, no difference was ever found in the frequency of influenza between men and women, so that a division is not included in the weekly return for this category.
The age distribution (table 1a - 1e) shows as in the preceding years the highest frequencies in the age group under 5 year. In the other groups the numbers are nearly identical.

Influenza and mortality

For the period 1970-1981 Mr. R. Peter, a statistician with the Infectious Diseases Division of the Chief Medical Office of Health, has compared the influenza data of the sentinel stations with mortality resulting from influenza, together with that resulting from pneumonia, bronchitis, emphysema and asthma, these being syndromes often aggravated by influenza (CBS data, ICD code, 9th revision, 487, 480-486, 490-491, 492 and 493 respectively). Fig. 4 shows the results per quarter. In the mortality the consequences of influenza epidemics can be seen. The absence of epidemics of any great extent after

1978 leads to the curve of mortality from syndromes often aggravated by influenza proceeding to display a much flatter trend.

This topic is to be maintained on the weekly return.

DIABETES MELLITUS

The disease diabetes mellitus appears on the weekly return for the second year in succession. In 1980 both new and old patients were concerned; in the following years only the new patients were reported.
The reporting is being done in consultation with Dr H.F. Dankmeijer, specialist in internal medicine and diabetes, medical adviser to the Netherlands Diabetes Society (D.V.N.).
The following criterion applies: a blood sugar level higher than 10 m mol/L (or 180 mg%) two hours after a meal with a high carbohydrate content, of course before commencement of treatment.
In addition, in order to gain more insight into the epidemiology of diabetes mellitus and the method of treatment, for each new patient a questionnaire is sent to the spotter physician about four months after reporting of the patient.

Meanwhile the criteria at international level have been changed, viz from $\geqslant$ 10.0 m mol/L or 180 mg% to $\geqslant$ 11.0 m mol/L or 200 mg%. The limit has therefore been raised, which entails that fewer people are wrongly (?) labelled as suffering from diabetes mellitus[1]).
However, it is necessary to adjust to these new criteria, and therefore the registration has been amended somewhat with effect from 1 January 1981, though without impairing the value of the data already collected. By adding to the follow-up form the question how high the glucose concentration was when the diagnosis was made data can be supplied that are comparable at international level.

The incidence remains the same, 12 to 13 per 10 000 inhabitants, which points to stable registration, since there are no reasons to expect a change in such a short time. Nor are there any fluctuations present in the seasonal figures.
Table 3 states the frequencies per province and urbanization group (see also Fig. 5).

Table 3: Number of new patients with diabetes mellitus per province and urbanization group, per 10 000 inhabitants, 1980 - 1982.

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
1980	*14*	*10*	*12*	*16*	*9*	*12*	*17*	*13*
1981	*8*	*14*	*11*	*14*	*10*	*11*	*15*	*12*
1982	*14*	*10*	*13*	*10*	*9*	*10*	*18*	*12*

[1]) *Reitsma, W.D., Terpstra, J. (1981) WHO Expert Committee on diabetes mellitus. N.T.v.G. p. 101-103.*

In the various province groups the frequency fluctuates around 12 per 10 000 inhabitants.
In the urbanization groups the relatively large difference between the rural municipalities and the cities that was already signalled in 1980 is again present (in rural municipalities 9, 10 and 9 in 1980, 1981 and 1982, in the cities 17, 15 and 18).

Age distribution

In Table 4 the frequencies per age group may be found (see also Fig. 6).

Table 4: Number of new patients with diabetes mellitus by age group, per 10 000 inhabitants, 1980 - 1982.

	Age group									
	<5	*5-9*	*10-14*	*15-19*	*20-24*	*25-34*	*35-44*	*45-54*	*55-64*	*≥65*
1980	*(1)*	*(1)*	*-*	*(1)*	*4*	*3*	*8*	*23*	*26*	*56*
1981	*-*	*5*	*(3)*	*(1)*	*(1)*	*3*	*4*	*19*	*27*	*53*
1982	*-*	*(2)*	*(1)*	*(1)*	*(1)*	*3*	*10*	*18*	*26*	*50*

The number of new patients increases from fewer than 1 per 10 000 inhabitants at a (very) young age to 50 and more in the age group older than 64 years. The frequencies found here tally reasonably well with those in the Nijmegen Continuous Morbidity Registration[1]). Per standard practice (i.e. a practice population of 2800) an incidence of 2.8 for men and 2.9 for women is found there. That corresponds to more than 10 per 10 000 inhabitants. The age-specific figures also display similarity to this registration.
The figures for the young age groups have been compared with those of the national working party for "Epidemiology of diabetes mellitus in childhood"[2]). The incidences stated there correspond reasonably well to those from the sentinel stations: 1.1 and 1.4 respectively per 10 000 for the 0-19 age group. (The 90% reliability interval for the data from the sentinel stations is 0.9-2.1.) The difference in degree of urbanization for all ages together found by the sentinel stations is not observed in this registration. The numbers for the young age are too small at the sentinel stations to check this.

The data from the above-mentioned follow-up forms have been processed for 1980 and 1981 (M.C.Z. Hingst). The most important results are as follows.

[1]) *Continue Morbiditeits Registratie, Nijmeegs Universitair Huisartsen Instituut, 1971 - 1978.*
[2]) *Vaandrager, G.J. en Veenhof, F.J. (NIPG-TNO), De incidentie van insuline-afhankelijke diabetes mellitus in Nederland; eerste resultaten van een landelijk onderzoek. N.T.v.G. 1983, 127:5 p.220.*

With reference to 1981 172 follow-up forms were processed, of which 46% for men and 54% for women. As in 1980, approximately 10% dropped out in respect of the weekly return reports. This was for various reasons, such as revision of the diagnosis, double reports, pregnancy diabetes.
The age group older than 64 years, further broken down, shows a clear increase with age; here numbers per 10 000 inhabitants with reference to 1980 and 1981 are concerned.

Number of new patients with diabetes mellitus per 10 000 inhabitants, 1980 and 1981.

	Age group										
	0-4	*5-14*	*15-24*	*25-34*	*35-44*	*45-54*	*55-64*	*65-74*	*75-84*	*85-94*	*⩾95*
Men	*(1)*	*3*	*(1)*	*2*	*4*	*19*	*20*	*27*	*55*	*89*	*-*
Women	*-*	*(1)*	*2*	*(1)*	*5*	*19*	*29*	*48*	*59*	*60*	*-*
Total	*(1)*	*2*	*1*	*2*	*4*	*19*	*24*	*39*	*57*	*70*	*-*

It is striking that the increase among men occurs a decade later, but continues more strongly. However, in view of the relatively small numbers in the highest age group caution is called for with regard to interpretation of the results.
Once again the diagnosis was made by the general practitioner in the case of 67% of the patients, while nationally the general practitioner treated 57% of all new patients. Both in 1980 and in 1981 province group A (Groningen, Friesland, Drenthe) displayed for the latter category a lower and province group D a higher percentage, approx. 45% and 65% respectively. The following table shows the method of treatment per treating physician.

		Diet only	*Oral medicines for lowering the blood sugar level*	*Insulin*	*Total*
General practitioner	*1980*	*52 (54%)*	*45 (46%)*	*- (0%)*	*97 (56%)*
	1981	*60 (62%)*	*37 (38%)*	*- (0%)*	*97 (57%)*
Specialist	*1980*	*35 (47%)*	*18 (24%)*	*22 (29%)*	*75 (44%)*
	1981	*25 (34%)*	*27 (36%)*	*22 (30%)*	*74 (43%)*
Total	*1980*	*87 (50%)*	*63 (37%)*	*22 (13%)*	
	1981	*85 (50%)*	*64 (37%)*	*22 (13%)*	

The Queteletindex[1]) could be calculated in 1981 for 94% of the newly reported patients. From this overweight was established for 74% of the women and 28% of the men for patients of 25 years and older.
For 1982 a comparable number of follow-up forms to be processed is expected, in view of the reports on the weekly return and the broad survey of the first half of the year.
When the follow-up for the complete year 1982 has been received, a start can be made with comparison of the registration for 1980, 1981 and 1982.

Further analysis of the data is continuing. After the processing and checking of the results for 1980 to 1982 against each other, it will be endeavoured, where possible, to make a comparison with recent epidemiological studies in other countries.

The topic has been maintained on the weekly return for 1983.

[1]) *Quetelet index: weight in kg/height^2 in m; ⩾ 120% of ideal weight is regarded as overweight, which means ⩾ 25 for women and ⩾ 27 for men.*

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 on 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 by the indication for taking a cervical smear, i.e. following complaints and/or symptoms, on "preventive" grounds at the initiative of the spotter physician or the woman, and a separate column in the case of a repeat smear, irrespective of the indication for taking the previous smear. To make comparability with the investigation subsidized by the Ministry as great as possible, *3 years* has been adhered to as the period within which a second or following smear has *to be reported as a repeat smear.* For 1981 that therefore means that a smear is reported as a repeat smear when the spotter physicians had already taken a smear from the woman in question after 1 January 1979. This period is identical with the interval between two mass screenings.

The results of this topic will acquire greater importance in the near future, since in March 1982 the then Minister of Public Health and Environment decided to amend the policy regarding mass screening for cervical cancer[1]). Consideration is being given to entrusting the performance of this method of early detection to the general practitioner.

Table 5 gives the total number of smears taken, with a subdivision for the indication for taking the smear, including the repeat smears.

Table 5: Number of smears taken by spotter physicians, by indication for taking a smear, per 10 000 women, 1976 - 1982.

	1976	*1977*	*1978*	*1979*	*1980*	*1981*	*1982*
Complaints and/or symptoms	*87*	*86*	*80*	*80*	*62*	*57*	*57*
"Preventive", general practitioner's initiative	*282*	*268*	*218*	*198*	*168*	*184*	*171*
"Preventive", woman's initiative	*103*	*112*	*105*	*124*	*93*	*110*	*126*
Repeat smear	*31*	*55*	*120*	*143*	*148*	*159*	*170*
Total	*503*	*521*	*523*	*545*	*471*	*510*	*524*

[1]) *Letter from the Minister of Public Health and Environment to the President of the Second Chamber of the States-General. Second Chamber, 1981-1982 session, 17 100 Chapter XVII,*

The total number of smears (524 per 10 000 women) is again higher than in the previous year, 1981; as stated in previous reports, only in 1979 was the number higher (545 per 10 000 women). However, allowance must be made here for the fixed period of three years within which a smear counts as a repeat smear. As a result of this, only in 1978 and following years are the subdivisions comparable. Moreover, it should be realized that the extent of the organized application of this method in the form of mass screening gradually increased after 1976. For the years 1976, 1977 and 1978 a subdivision was therefore made between sentinel stations where mass screening was organized in the area covered by the practice and where this was not the case. There then proved to be major differences that could be explained by this activity (see the 1978 report, p. 30-33).
The spotter physicians were again asked whether mass screening was organized in the area covered by their practice in 1982. Whereas in 1980 and 1981 only two to three physicians had to reply in the negative, this time there were six. It therefore looks as if the above-mentioned plans are already being implemented in some places. The number is still too small for the material to be divided into whether or not mass screening has been organized and to examine possible effects of not continuing with the mass screening. Though the relative numbers of smears taken by these physicians have been examined, no difference could be demonstrated; in particular there was *no* increase in the number of smears taken on preventive indication. Probably it is also too early to expect that.
For an analysis of the influence of mass screening in past years on the number of smears taken in general practice see the 1981 report (p. 31 et seq.).

The number of smears on account of complaints and/or symptoms does not display any further decrease.
The total number of smears taken on preventive indication has remained the same, on the initiative of both the spotter physician and the women.
There is, however, a slight indication that through the years the general practitioner's initiative decreases and that of the women increases. The category repeat smears still displays an increase, though only a small one. The latter means that one may not simply regard the difference in totals between the years as an increase or decrease in the number of women who are reached by this method within primary health care. The number of women who are reached in this way at least once every three years may be seen in the total of Table 6. This table contains only the numbers of *first* smears per 10 000 women, with a subdivision for the indication for taking the smear and per province and urbanization group (cf. also Figs 7 and 8). Compared to 1981 the total number of *first* smears has remained the same, 354 to 351 per 10 000 women.
The differences that are seen in the totals may be found again in the same direction in practically all subgroups. The decline in the number of smears taken on the general practitioner's initiative with a preventive indication, which in the previous year occurred only in the cities, is now also found in a number of other subgroups. Woman's initiative

is increasing everywhere, with the exception of the north of the country, where a gradual decline has been occurring since 1979.

Table 6: Number of *first* cervical smears taken per province group and urbanization group, per 10 000 women of all age groups, by indication for taking a smear and for the total, 1976 - 1982.

		Province group				*Urbanization group*			*Nether-lands*
		A	*B*	*C*	*D*	*1*	*2*	*3*	
Complaints									
and/or	*1976*	*85*	*102*	*100*	*52*	*62*	*91*	*103*	*87*
symptoms	*1977*	*65*	*95*	*109*	*48*	*64*	*96*	*88*	*86*
	1978	*116*	*93*	*72*	*68*	*78*	*66*	*118*	*80*
	1979	*130*	*95*	*63*	*79*	*73*	*70*	*114*	*80*
	1980	*129*	*61*	*52*	*44*	*73*	*51*	*90*	*62*
	1981	*119*	*59*	*41*	*52*	*73*	*39*	*95*	*57*
	1982	*95*	*65*	*44*	*58*	*78*	*37*	*98*	*57*
"Preventive",									
general	*1976*	*139*	*218*	*302*	*360*	*228*	*322*	*257*	*282*
practitioner's	*1977*	*112*	*234*	*327*	*260*	*214*	*308*	*240*	*268*
initiative	*1978*	*170*	*259*	*230*	*183*	*325*	*169*	*269*	*218*
	1979	*170*	*198*	*214*	*178*	*248*	*154*	*280*	*198*
	1980	*121*	*170*	*207*	*105*	*186*	*119*	*306*	*168*
	1981	*159*	*189*	*223*	*112*	*239*	*147*	*247*	*184*
	1982	*157*	*146*	*183*	*174*	*203*	*148*	*212*	*171*
"Preventive",									
woman's	*1976*	*112*	*95*	*114*	*79*	*66*	*134*	*79*	*103*
initiative	*1977*	*88*	*79*	*151*	*68*	*80*	*146*	*77*	*112*
	1978	*110*	*85*	*130*	*64*	*94*	*115*	*89*	*105*
	1979	*141*	*112*	*142*	*82*	*119*	*125*	*126*	*124*
	1980	*110*	*83*	*104*	*66*	*67*	*92*	*120*	*93*
	1981	*104*	*112*	*125*	*80*	*107*	*113*	*104*	*110*
	1982	*84*	*129*	*149*	*98*	*115*	*117*	*157*	*126*
Total	*1976*	*336*	*415*	*516*	*491*	*356*	*547*	*439*	*472*
	1977	*265*	*408*	*587*	*376*	*358*	*550*	*405*	*466*
	1978	*396*	*437*	*432*	*315*	*497*	*350*	*476*	*403*
	1979	*441*	*405*	*419*	*339*	*440*	*349*	*520*	*402*
	1980	*360*	*314*	*363*	*215*	*326*	*262*	*516*	*323*
	1981	*382*	*360*	*389*	*244*	*419*	*299*	*446*	*351*
	1982	*336*	*340*	*376*	*330*	*396*	*302*	*467*	*354*

Age distribution

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

Table 7: Number of (first) smears taken by age group, per 10 000 women, 1976 - 1982.

		Age group							
		10-14	*15-19*	*20-24*	*25-34*	*35-44*	*45-54*	*55-64*	*⩾65*
Total	*1976*	*(2)*	*41*	*288*	*962*	*1397*	*884*	*248*	*62*
	1977	-	*50*	*347*	*974*	*1276*	*880*	*248*	*70*
	1978	-	*43*	*334*	*835*	*1028*	*742*	*280*	*43*
	1979	-	*85*	*520*	*883*	*914*	*634*	*233*	*48*
	1980	-	*47*	*536*	*740*	*607*	*464*	*211*	*51*
	1981	*(2)*	*72*	*548*	*879*	*602*	*473*	*225*	*47*
	1982	-	*64*	*565*	*859*	*651*	*455*	*207*	*43*

The increase in the 20-24 age group mentioned in preceding reports is still continuing. In the other age groups some fluctuations may be seen, but it does not seem possible to draw conclusions from this. These data will become interesting when the proposed policy of the central government is put into effect. It is to be expected that then the frequency in the age groups towards which the mass screening is directed (35-44 years and 45-54 years) will increase.

Table 8 gives for 1978 and following years a breakdown by indication for taking a smear, including the repeat smear (see also Fig. 10). This table gives more information. The years 1976 and 1977 are not given here, as a result of the fact that the period that has been adhered to as the period within which a second smear from the same woman must be reported as a repeat smear had not yet lapsed then.

Table 8: Number of smears taken by spotter physicians by age group and by indication for taking the smear, per 10 000 women, 1978 - 1982.

		Age group						
		15-19	20-24	25-34	35-44	45-54	55-64	⩾65
Complaints and/or symptoms	1978	17	102	153	193	147	55	7
	1979	28	93	158	207	113	62	13
	1980	21	84	122	121	108	47	20
	1981	16	90	127	106	72	46	17
	1982	16	92	130	97	85	31	17
Preventive, general practitioner's initiative	1978	20	162	467	542	401	151	29
	1979	49	265	442	412	345	94	21
	1980	18	379	389	274	206	95	26
	1981	47	339	460	291	253	94	13
	1982	38	318	422	292	214	79	16
Preventive, woman's initiative	1978	(6)	70	215	293	194	74	7
	1979	8	162	283	295	176	77	14
	1980	8	73	229	212	150	69	(5)
	1981	9	119	292	205	148	85	17
	1982	10	155	307	262	156	97	10
Repeat smear	1978	(5)	50	199	367	293	70	8
	1979	(2)	63	225	470	324	99	12
	1980	6	55	224	416	385	149	17
	1981	(6)	68	279	454	385	119	14
	1982	(6)	89	304	468	387	135	8
Total	1978	48	384	1034	1395	1035	350	51
	1979	87	583	1108	1384	958	332	60
	1980	53	591	964	1023	849	360	68
	1981	78	616	1158	1056	858	344	61
	1982	70	654	1163	1119	842	342	51

The total number of smears taken on medical indication brings no new aspects to light; the numbers fluctuate somewhat. The number of smears taken on preventive indication on the general practitioner's initiative is falling in all age groups, with the exception of the 35-44 age group, in which the number has remained the same. The number that was

made on the woman's initiative is on the other hand rising in practically all age brackets, as is the number of repeat smears.

As stated at the beginning of this chapter, the results of this topic will be of greater value when the government's plans enter into effect. Partly for this reason, the topic has been maintained on the weekly return for 1983.

PARKINSON'S DISEASE

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

The definition used is as follows:
The genuine Parkinson's disease is a disorder that begins unilaterally, usually with tremors in the hand. In the course of the years these gradually spread to the other extremities. Further typical characteristics are hypokinesis and extrapyramidal hypertonicity.

Only new cases of genuine Parkinson's disease are concerned. Disorders accompanying Parkinsonism are not registered.
Since the life expectancy of patients with Parkinson's disease is below the norm, a correction has to be made for age when it is desired to calculate the prevalence with the aid of these data[1]). The data collected up to now are, however, too few in number for this calculation to be made in a responsible fashion.
When the diagnosis is made both age and sex are stated.

The Princess Beatrix Fund has given a grant for further research into this disease. In cooperation with Dr A. Hofman, an epidemiologist with the Epidemiology Institute of the Erasmus University, Rotterdam, a "patient-control investigation" is being set up, aimed at gaining insight into possible risk factors for Parkinson's disease. In this investigation the general practitioner gives the patient a form with questions on certain ways of life. An identical form is given, also via the general practitioner, to two persons of the same age and sex chosen at random from this practice. The investigation is also intended to examine the feasibility of a patient-control investigation in the sentinel stations project; it is a feasibility study.
The chance of bias is now less, owing to the fact that a control is chosen from the same general practice, than if one is obliged to utilize a hospital population. The same also applies to the patients.

Table 9 states the incidence per 10 000 men and women per province and urbanization group.

[1]) *Hoehn en Yahr (1967) Age and death and duration of illness before death. Neurology; nr. 17, p. 427-442.*

Table 9: Number of new cases of Parkinson's disease, per province group and urbanization group, per 10 000 inhabitants, 1980 - 1982.

	Province group				Urbanization group			Netherlands
	A	B	C	D	1	2	3	
1980	12	11	4	(1)	12	5	3	6
1981	4	5	2	2	5	2	1	3
1982	3	6	1	2	5	2	(1)	2

The absolute number of reports is, as in 1981, lower than in 1980, 32, 38 and 85 respectively for 1982, 1981 and 1980. In view of the small numbers, only slight value may be attached to frequencies diplayed here. However, the thought occurs that overreporting took place in 1980 as the result of confusion with "old patients". Some of the prevalent cases are registered as incidental cases, a phenomenon that must be guarded against especially in the case of chronic diseases declaring themselves slowly. There *seems* to be a difference between town and country, but this pronouncement is a very tentative one, having regard to the above.

Age distribution

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

Table 10: Number of new cases of Parkinson's disease by age group, per 10 000 men and women, 1980 - 1982.

		Age group					
		25-34	35-44	45-54	55-64	⩾65	Total
Men	1980	-	(1)	8	10	54	7
	1981	-	-	(4)	8	28	4
	1982	-	-	-	-	19	2
Women	1980	(1)	(1)	(4)	9	29	5
	1981	-	-	-	4	10	2
	1982	-	-	-	4	17	2
Total	1980	(0)	(1)	6	9	40	6
	1981	-	-	(2)	6	17	3
	1982	-	-	-	(2)	18	2

The incidence among men seems to be higher than among women. This manifests itself in particular above the age of 64 years. This tallies with data in the literature[1]).

The topic has been maintained in the weekly return for 1983.

[1]) *Kessler, Irving I. (1978) Parkinson's Disease in Epidemiologic Perspective, Advances in Neurology, vol. 19, p. 355-384.*

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"[1]) and for computing the trend of the population[2]).

The number of sterilizations of men performed per 10 000 of all men and per province group and urbanization group is given in Table 11 (cf. Fig. 11).

Table 11: Number of sterilizations of men performed, per province group and urbanization group per 10 000 of all men, 1972 - 1982.

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

The fall in the number of sterilizations that became clear in 1980 continued, though to a smaller extent, in 1982. The fall is present in nearly all subgroups. Extrapolation gives 35 000 for the total population of the Netherlands.
A breakdown per quarter offers an opportunity for investigating whether a change in frequency may be a reaction to some event by which the popularity of this method may be influenced. (Table 12).

[1]) *Study on trends in the demographic structure in the European region: Health and social implications, Ministry of Public Health and Environment, September 1981.*

[2]) *Explanatory memorandum of the Ministry of Public Health and Environment, Second Chamber, 1981-1982 session, 17100 Chapter XVII No. 2, Appendix A.*

Table 12: Number of sterilizations of men performed, per quarter, per 10 000 men, 1972 - 1982[1]).

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

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

The frequency per quarter in 1982 varied around that of the last two quarters of 1981.

If no other factors play a role, one may in the course of time expect a stabilization as a result of the end of a "historical catching-up effect" caming into sight.
The stabilization level for sterilization of the man will in the long run work out at 10 000 to 15 000 per year (E. Ketting), which means that for 1982 an additional increase of over 20 000 sterilizations still took place (see also sterilization of the woman).

In Fig. 13 the number of sterilizations per 10 000 men of all subgroups together is compared with that of women. There proves to be great agreement.

Age distribution

The age-specific distribution of the number of sterilizations performed per 10 000 men is given in Table 13 (cf. Fig. 14).

Table 13: Number of sterilizations of men performed, by age group, per 10 000 men, 1972 - 1982.

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

As in past years, the highest frequency is found in the 35-44 age group. The decline that started in 1980 has continued more strongly among men younger than 35 years than in the group with the highest frequency, by 28% and 5% respectively in respect of 1981.

A cumulative calculation shows that in the Netherlands since 1971 at least 433 000 sterilizations of men have been performed, that is on over 6% of the total male population. If the number is related to the 25-64 age group, this being approximately the cohort that has entered into consideration for this operation since the start of registration, one arrives over 10%.
For a further study see the next section, in which the topic "sterilization of the woman" is dealt with.

The question is maintained in the 1983 weekly return.

STERILIZATION OF THE WOMAN

Sterilization of the woman performed was placed on the weekly return in 1974 (of men performed in 1972).
The number of sterilizations of women performed per 10 000 of all women and per province group and urbanization group is given in Table 14 (cf. Fig. 12).

Table 14: Number of sterilizations of women performed, per province group and urbanization group, per 10 000 of all women, 1974 - 1982

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
1974	*37*	*37*	*30*	*40*	*37*	*28*	*44*	*35*
1975	*58*	*50*	*41*	*53*	*55*	*47*	*39*	*46*
1976	*76*	*58*	*61*	*74*	*66*	*71*	*55*	*66*
1977	*61*	*54*	*67*	*68*	*52*	*68*	*67*	*64*
1978	*68*	*62*	*76*	*116*	*60*	*85*	*83*	*81*
1979	*80*	*74*	*88*	*118*	*89*	*97*	*74*	*90*
1980	*67*	*57*	*74*	*71*	*81*	*64*	*77*	*70*
1981	*37*	*49*	*44*	*55*	*40*	*47*	*48*	*46*
1982	*41*	*45*	*37*	*43*	*52*	*36*	*43*	*40*

The national frequency with regard to the number of sterilizations of women performed, as observed with that of men, fell in 1982 too. The decline is, however, a gradual one, 34%, 22% and 13% respectively in 1980, 1981 and 1982 respectively (for men this is 25%, 20% and 15%). However, the decline is *no longer* present in all subgroups; the north of the country and the rural municipalities give higher figures than in 1981.

In Fig. 13 a comparison is given between the number of sterilizations of men and of women. The curves display a large measure of agreement.
The remarks made on the trend in the preceding chapter are also applicable here.

The number per 10 000 of all women per quarter is given in Table 15.

Table 15: Number of sterilizations of women performed, per quarter and per 10 000 women, 1974 - 1982[1]).

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

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

The quarterly figures of 1982 correspond to those of the last two quarters of 1981.

Age distribution

The age-specific distribution of the number of sterilizations performed per 10 000 women is given in Table 16 (cf. Fig. 14).

Table 16: Number of sterilizations of women performed, by age group per 10 000 women, 1974 - 1982.

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

The decline in respect of 1981, as is the case with men, is greater in the 25-34 age group than in the 35-44 one, viz 24% and 10% respectively.
With the increase in the number of sterilizations the use of the pill is decreasing in certain age groups. However, total use of the pill is not declining; there is even a slight increase (in sales) to be seen[1]).
A cumulative calculation shows that in the Netherlands since 1973 sterilization has been performed in total on at least 377 000 women, i.e. over 5% of the total female population. However, it is more realistic to relate the figures solely to women of fertile age (15-49 years) and at the same time to include the sterilization pattern of the man. It then proves that at the end of 1981 the woman or the man was sterilized in approximately 20% of (married) couples.

Dr E. Ketting, who made these calculations, expects that in the Netherlands a situation will come about in which about 30% of all women who reach the age of 50 in a given year will have been sterilized at some time[1]). The number of sterilizations which has then to be performed annually on the basis of this calculation to keep the total percentage stable would then be about 25 000 (men and women together). To have the percentage of sterilized women remain stable, some 9 000 sterilizations were required in 1982. The number of sterilizations performed (obtained by extrapolation) is, however, 29 000, and there was thus a real surplus of 20 000. In 1981 this surplus was 25 000. The difference may be an indication of the approach of the end of the "historical catching-up effect".
In addition, one must not underestimate the influence of the number of hysterectomies on female fertility, (and thus on the need for sterilization), as has also been stated in the previous reports. In the last 12 years the absolute frequency of this operation has increased by more than 170%. (Data of Foundation for Medical Registration extrapolated for the whole of the Netherlands; number of operations in which the uterus has been removed: in 1968 10 200 and in 1980 27 800).

This question is maintained on the weekly return for 1983.

[1]) Ketting, E. Contraception and fertility in the Netherlands.
Family Planning Perspectives, Vol. 15 (1983) No. 1 p. 19-25.

PRESCRIPTION OF THE MORNING-AFTER PILL

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

Table 17 gives the frequency with regard to the prescription of the morning-after pill, per province and urbanization group (cf. Fig. 15).

Table 17: Number of prescriptions of the morning-after pill, per province group and urbanization group per 10 000 of all women, 1972 - 1982.

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

The pronounced decline that was to be seen in 1981 did not continue in 1982. The number of times that the spotter physician prescribed the morning-after pill remained the same, 35 per 10 000 women. The fluctuations displayed by the various subgroups allow of no conclusions. The quarterly figures (Table 18) do not show an obvious difference from those for 1981 either.

Table 18: Number of times that the morning-after pill was prescribed, per quarter, per 10 000 women, 1978 - 1982[1]).

	1st quarter	2nd quarter	3rd quarter	4th quarter	Total
1978	11	15	10	13	50
1979	15	11	12	12	50
1980	13	11	14	12	50
1981	11	9	8	8	35
1982	9	10	8	8	35

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

Age distribution

Table 19 gives the age distribution of the prescription of the morning-after pill (cf. Fig. 16).

Table 19: Number of prescriptions of the morning-after pill, by age group, per 10 000 women, 1972 - 1982.

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

With respect to age too there is no difference from 1981.

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 45 years. Over age 45 it occurred 4 times, viz. 46, 48, 49 and 51 years once. The absolute numbers under 20 years are given in Table 20.

Table 20: Absolute numbers of prescription of the morning-after pill for women under 20 years, 1977 - 1982.

	1977	*1978*	*1979*	*1980*	*1981*	*1982*
13 years	*1*	-	-	-	*1*	*1*
14 years	*4*	*4*	*2*	-	-	*2*
15 years	*12*	*11*	*12*	*8*	*13*	*12*
16 years	*18*	*20*	*18*	*20*	*9*	*14*
17 years	*23*	*36*	*19*	*32*	*14*	*17*
18 years	*17*	*21*	*29*	*23*	*17*	*16*
19 years	*19*	*26*	*14*	*17*	*16*	*16*
Total	*94*	*118*	*94*	*100*	*70*	*78*

To try to determine the cause of the decline in 1981 the spotter physicians were sent a short questionnaire. For it is possible that use of the morning-after coil might have increased, partly as a result of information supplied on this at the meeting in 1981 (colleague M.R. van Santen), including sending literature. Thereafter attention was also devoted to this method of contraception in the Geneesmiddelenbulletin[1]). The answers show that use of the morning-after coil *cannot* be the cause of the decline in prescription of the morning-after pill. Of the 61 physicians, 34 (56%) place an I.U.D. themselves, varying from sporadically to 50 times a year. Of these 34 physicians, 12 state that in 1981 and 1982 they changed in principle to the use of the morning-after coil. The number of times that they actually did so is, however, small: 16 in total. This is a negligible number compared with the absolute number of times that the spotter physician prescribed the morning-after pill: 273 times in 1981 and 273 times in 1982.

This question is maintained on the 1983 weekly return.

[1]) *Geneesmiddelenbulletin, published by the Ministry of Public Health and Environment. Vol. 16, No. 4, 18 March 1982. "Het morning-after-dilemma".*

HAY FEVER

Hay fever, rhinitis vasomotorica allergica, was placed on the weekly return for the first time in 1978.
In 1978 a subdivision by sex and one by "old and new" patients were adhered to. In 1979 only the new patients were registered, the breakdown by sex also being omitted.
New patients are considered to be those patients who consult a physician for the first time in their lives on account of this complaint.

This is the typical allergy to grass pollen, which is characterized by one or more of the following symptoms:
- tickling and/or stinging sensation in the nose and/or nasopharynx;
- tickling and/or stinging sensation in the eyes;
- violent sneezing fits;
- abundant watery secretion from the nose;
- red and watering eyes;
- swollen eyelids.

The complaints must usually reach a climax in the period from the end of May to mid July[1]).
By keeping to these criteria other allergic reactions, caused for instance by domestic animals or pollen of the birch, are excluded.

The data of this topic are processed in consultation with Dr F.Th.M. Spieksma, a biologist with the University Hospital, Leiden. Dr Spieksma attends to the radio message broadcast at certain times on behalf of hay fever patients.

Table 21 states the frequencies per province and urbanization group for the different categories (see also Fig. 17).

Table 21: Number of new patients with hay fever, per province and urbanization group, per 10 000 men or women, 1978 - 1981.

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
1978	*34*	*36*	*17*	*25*	*37*	*21*	*22*	*24*
1979	*41*	*46*	*24*	*33*	*37*	*32*	*29*	*32*
1980	*21*	*45*	*24*	*16*	*45*	*21*	*25*	*26*
1981	*20*	*42*	*14*	*16*	*43*	*16*	*15*	*20*
1982	*18*	*44*	*21*	*15*	*55*	*15*	*23*	*24*

[1]) *See conclusion 4 in the summary, p. 53.*

At 4 per 10 000 inhabitants, the total frequency in 1982 is practically the same as the frequencies reported in 1978 and 1980. In the subgroups no new aspects can be observed. Province group B (the east of the country, see also Fig. 1) and urbanization group 1 (the rural municipalities) continue to display high frequencies, however. The other two urbanization groups, like the west and south of the country, display a relatively low frequency. In province group A and urbanization group 1 there seems to be a decreasing and increasing trend respectively. An explanation for this cannot be given (Spieksma).
The numbers in the other subgroups tend to "jump about" somewhat here and there.

Age distribution

Table 22 contains the frequencies per age group (see also Fig. 18).

Table 22: Number of new patients with hay fever by age group, per 10 000 men or women, 1978 - 1982.

	Age group									
	<5	*5-9*	*10-14*	*15-19*	*20-24*	*25-34*	*35-44*	*45-54*	*55-64*	*⩾65*
1978	*7*	*29*	*28*	*55*	*44*	*25*	*28*	*12*	*7*	*(2)*
1979	*7*	*39*	*55*	*75*	*54*	*41*	*24*	*13*	*8*	*(2)*
1980	*(2)*	*15*	*34*	*58*	*58*	*34*	*24*	*14*	*9*	*3*
1981	*(4)*	*24*	*38*	*47*	*38*	*20*	*13*	*14*	*(2)*	*(1)*
1982	*8*	*18*	*40*	*55*	*45*	*25*	*25*	*13*	*(2)*	*(2)*

The incidences per age group display some fluctuations through the years. However, the highest frequency is always in or around the 15-19 age group.
A breakdown by age and by province and urbanization group shows in the above-mentioned groups with a high frequency (province group B and urbanization group 1) a clearly higher frequency in all age groups.

Seasonal influences

For the occurrence of hay fever the time of the year is of considerable influence. Consequently the numbers per quarter are given in Table 23[1]).

Table 23: Number of new patients with hay fever, per quarter and per 10 000 men or women, 1978 - 1982.

	1st quarter	*2nd quarter*	*3rd quarter*	*4th quarter*
1978	*3*	*17*	*4*	*0*
1979	*3*	*24*	*5*	*0*
1980	*2*	*20*	*3*	*0*
1981	*1*	*15*	*4*	*0*
1982	*1*	*19*	*4*	*0*

[1]) *As a result of rounding-off when calculating relative frequencies, small differences may have occurred in the totals. The same applies to the table with weekly frequencies.*

The 2nd quarter gives by far the highest frequencies every year. A week by week breakdown during the period with the highest incidences (mid April-July) may be found in Table 24.

Table 24: Number of new patients with hay fever, per week and per 10 000 inhabitants, 1978 - 1982.

Weeknumber					*May*				*June*				*July*			
	16	*17*	*18*	*19*	*20*	*21*	*22*	*23*	*24*	*25*	*26*	*27*	*28*	*29*	*30*	*31*
1978	*0*	*1*	*0*	*1*	*1*	*1*	*2*	*3*	*2*	*3*	*1*	*0*	*1*	*0*	*1*	*0*
1979	*1*	*0*	*0*	*1*	*1*	*1*	*2*	*3*	*4*	*8*	*3*	*2*	*1*	*0*	*0*	*0*
1980	*0*	*1*	*1*	*1*	*3*	*2*	*2*	*2*	*5*	*3*	*1*	*1*	*0*	*0*	*0*	*0*
1981	*0*	*0*	*0*	*0*	*1*	*2*	*2*	*3*	*2*	*2*	*1*	*1*	*1*	*1*	*0*	*0*
1982	*0*	*0*	*0*	*2*	*2*	*2*	*3*	*6*	*2*	*1*	*1*	*1*	*1*	*1*	*1*	*0*

The reports of complaints of hay fever started somewhat later in 1982 and continued for several weeks longer than in previous years, which is in accordance with the pattern of the complaint score as registered at Leiden (Laboratory for Aerobiology and Ear, Nose and Throat Dept., University Hospital, Leiden). The maximum of the grass pollen concentrations and of the hay fever complaints lay clearly in the first half of June (notably on 9 an 10 June, week 23) and, after a drop in the second half of June, displayed a second lower maximum in July, which was not reflected in the national data, however.

In Table 25 a number of the other relevant data are presented (Dr F.Th.M. Spieksma).

Tabel 25: Relation between weather conditions and number of grains of pollen on the one hand and complaints of hay fever on the other.

	Average daily complaint score of approx. 120 hay fever patients	*Total number of grains of pollen (grass) Municipality of Leiden*	*Data from the Royal Netherlands Meteorological Institute*	
			Approximate radiation in June (joules/mm²)	*Duration of precipitation in June (hours)*
1977	*35,8*	*5.653*	*42.433*	*24,4*
1978	*31.3*	*5.290*	*50.951*	*40,1*
1979	*24,0*	*5.445*	*48.514*	*43,0*
1980	*30,7*	*5.779*	*47.648*	*38,8*
1981	*18,4*	*3.837*	*42.926*	*60,2*
1982	44,4[1])	*4.346*	*59.057*	*39,2*
		normal:	*55.808*	*37,0*

[1]) *33 patients only.*

Although the total pollen concentration in 1982 was reatively low, the average daily complaint score was much higher than in previous years. The radiation measured by the Royal Netherlands Meteorological Institute in De Bilt was little higher than normal. This is cxonnected with the great differences in the weather in the course of June. The Institute has the following to say about this: "The first decade was sunny and very warm..... In the cool second and normal third decade numerous showers fell.....". The result was that in a relatively short period with dry, sunny and warm weather during the first decade of June the hay fever complaint score attained very high values, which also strongly increased the average. The 1982 hay fever season was short but intense, with a late revival in July.

Summarizing conclusions (Dr F.Th.M. Spieksma, biologist)

After five years of registration of new hay fever patients the following very brief conclusions can be drawn.

1. With a frequency of approximately 25 reports per 10 000 inhabitants the annual total of the number of new hay fever patients is some 35 000.

Bearing in mind that the "duration" of hay fever in general is not less than five seasons, a very tentative estimate of the total number of hay fever patients who sought treatment at least once works out in the Netherlands at at least 175 000.

2. As was to be expected, the highest frequencies of new hay fever patients were registered in the rural municipalities (urbanization group 1), where the grass pollen concentrations are higher than in urbanized surroundings. The frequencies per province group were less constant, although the eastern provinces (province group B) always scored highest.
3. Age distribution displayed the highest frequency in the 15-19 age group, which tallies with data from allergological literature.
4. By far the highest incidences were of course found in the second quarter, in which the main flowering period of the grass falls, with a maximum in week numbers 20 to 26 (mid May to early July). This is the typical hay fever season.
5. The relations between meteorological variables (such as radiation and precipitation), grass pollen concentrations and hay fever complaint scores were only very broadly visible from the monthly or seasonal totals. These factors are often too greatly fluctuating and the connections are not simple and direct.

The above conclusions not only confirm a number of known or self-evident facts with regard to the incidences of hay fever in the Netherlands, but they also provide major support for views on the epidemiology of grass pollen and of the importance of aerobiological examination of pollen in the diagnosis of hay fever and in the treatment and if possible prevention of hay fever complaints.

This topic has been removed from the weekly return for 1983.

(ATTEMPTED) SUICIDE

In 1970-1972 attempted suicide, successful and unsuccessful, appeared on the weekly return. In consultation with the Chief Medical Office for Mental Health the Programme Committee decided to repeat this gauging in 1979.
In other fields too (hospitals) research into suicide is being performed at present. In this way it is being attempted to get an insight into the extent, the trend and other aspects of the problem. The name of the topic is the definition.
The Chief Office also requested that more data be collected on the cases reported. For this purpose a questionnaire has been compiled in co-operation with Professor R.F.W. Diekstra, Dr, clinical psychologist, Leiden. On this form the question whether the attempt was successful or not and how the attempt was made also appears. At the same time questions are asked about contacts with the medical sector prior to the (attempted) suicide.
However, the essential aspect here is not whether the attempt was successful; the primary concern is the patient's intention, with the possibility that suicide is a consequence of the action.

The absolute number of *reports* (which is *not* equal to the number of patients, since recidivists are not uncommon) was 106, 98, 95 and 116 in 1979-1982. That is of the same order of size as in 1970-1972. In those years 109, 135 and 110 cases respectively were reported, in a population of practically the same size.

The number of attempts per province and urbanization group per 10 000 inhabitants may be found in Table 26. The breakdown into subgroups is of limited value, because of the relatively small frequencies.

Table 26: Number of reports of (attempted) suicide per province and urbanization group, per 10 000 inhabitants, 1979 - 1982.

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
1979	*8*	*6*	*8*	*5*	*5*	*7*	*9*	*7*
1980	*9*	*4*	*8*	*5*	*4*	*7*	*9*	*7*
1981	*6*	*4*	*7*	*7*	*3*	*7*	*7*	*6*
1982	*10*	*5*	*9*	*6*	*2*	*6*	*15*	*8*

From this table it can only be concluded that (attempted) suicide is reported the most infrequently to the general practitioner in rural municipalities.

Age distribution

Table 27 gives the frequency of (attempted) suicide per 10 000 inhabitants per age group (see also Fig. 19).

Table 27: Number of reports of (attempted) suicide by age group, per 10 000 inhabitants, 1979 - 1982.

	Age group							
	10-14	*15-19*	*20-24*	*25-34*	*35-44*	*45-54*	*55-64*	*⩾65*
1979	*(1)*	*5*	*7*	*12*	*11*	*11*	*9*	*7*
1980	-	*5*	*14*	*7*	*12*	*7*	*6*	*10*
1981	*(2)*	*4*	*12*	*11*	*8*	*6*	*5*	*6*
1982	-	*9*	*18*	*11*	*10*	*7*	*7*	*7*

The highest frequencies are to be found in the 20-44 age groups. However, the difference from the older age groups is not a considerable one.

The data from the above-mentioned forms have meanwhile been processed partly. It is the intention to devote some publications to this (Prof. R.F.W. Diekstra et al.). In the 1981 report the summary of the first article was included (p. 52). It is not surprising that this article, which is devoted to suicide and aid workers, has aroused discussion[1]).

The summary of the second publication[2]) reads as follows:

> Further to data reported earlier on suicide attempts among patients in general practice, this article, likewise based on data from Continuous Morbidity Registration, Sentinel Stations over the period 1971-1981, discusses a number of characteristics of persons who committed suicide.
> Although the results of the study show that general practitioners, as they themselves say, are relatively seldom confronted with patients who commit suicide, is still a remarkable fact that, as in the case of those who attempt suicide, nearly half the patients have been in contact with the general practitioner shortly before the suicide.

The topic has been maintained on the weekly return for 1983.

[1]) *Diekstra, R.F.W., de Graaf, A.C. en van Egmond, M. Over de epidemiologie van suicidepogingen. T. soc. geneesk. 60 (1982) p. 398-404.*
Schudel. W.J., discussies over epidemiologie van suicidepogingen. T. soc. geneesk. 60 (1982) p. 549-550 en p. 576.

[2]) *van Egmond, M., Diekstra, R.F.W. en de Graaf, A.C. Suicides onder patiënten in de huisartspraktijk; aangeboden aan T. Soc. Gezondheidszorg.*

SPONTANEOUS ABORTION AND PARTUS IMMATURUS

The desire to collect more data on the frequency of spontaneous abortion had already been felt for some time by the Chief Medical Office of Health, but it became pressing when reports were received in 1981 of an increased frequency of spontaneous abortion in the Westland market gardening area. A connection was suggested with the presence of methyl bromide in the drinking water. Further investigation revealed no connection. However, when there are suspicions of such "disasters" action has to be taken as quickly as possible, and a frame of reference is required for this. However, so far data from hospitals are the only ones available, which doubtless involves selection. This was why spontaneous abortion was placed on the weekly return in 1982. In addition, more information on the entire process of pregnancy was required, and therefore partus immaturus was also included.
In registration determination of the population-at-risk (the denominator of the epidemiological fraction) is a prerequisite. Here that is the total number of pregnancies. Data on the number of deliveries are therefore necessary. It seemed a sensible idea to collect these data from the sentinal stations themselves and not to use only those from the Central Bureau of Statistics. (For the number of cases of abortus provocatus the Stimezo figures can apply.)
In the decision-making contact was established with Professor P.E. Treffers, professor of obstetrics and gynaecology at Amsterdam University. The criteria were also compiled in consultation with him.

Criteria

a. Spontaneous abortion: 6 weeks to 15 weeks inclusive after the first day of the last menstruation. Pregnancy must have been established clinically or with the aid of a pregnancy test. Observation of a pregnancy product is also sufficient.
b. Partus immaturus: 16 weeks to 27 weeks inclusive after the last menstruation.
c. Partus at gravidity: 28 weeks and more after the last menstruation, of both live births and stillbirths.

When these criteria were compiled one was aware that they are not watertight, notably as regards the assumption of 6 weeks as the lower limit. However, adopting a still lower limit would cause even greater inaccuracy.

Table 28 states the relative frequencies per province and urbanization group and for the total (see also Fig. 20). The frequencies of partus at gravidity are also included in this table.

Table 28: Number of cases of spontaneous abortion, partus immaturus and partus at gravidity per province and urbanization group, per 10 000 women, 1982.

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
Spontaneous abortion	*15*	*23*	*16*	*19*	*18*	*17*	*22*	*18*
Partus immaturus	*(2)*	*4*	*2*	*5*	*5*	*2*	*4*	*3*
Partus at gravidity	*223*	*181*	*167*	*220*	*178*	*179*	*220*	*188*

For all sentinel stations together the number of cases of spontaneous abortion, of partus immaturus and of partus at gravidity is 18, 3 and 188 respectively per 10 000 women. With the definition adhered to here the ratio between abortion and partus at gravidity is 1 : 10. However, this must be followed immediately by a remark. Extrapolation of the numbers of partus at gravidity to the Dutch population yields over 135 000 The Central Bureau of Statistics, on the other hand, reports over 172 000 births. This would mean that only 80% have been reported by the spotter physicians or that only 80% are known to them.

The question immediately arises of how reliable the other data of this topic are. Is the general practitioner not kept informed of what goes on in the obstetrician's practice?

A questionnaire has been sent out to gain insight into the reliability of these data. The following can be briefly said about this. The reliability of the number of reports of partus immaturus and spontaneous abortion seems "adequate". Only the occasional spotter physician is worried, but this then relates to a suspicion or fear that the reporting is only a few percentage points too low.

More problems prove to exist with regard to reporting partus at gravidity. In 20% (12 spotter physicians) there was more or less well-founded doubt about the reliability, either because the subject had escaped their attention, or through poor communication with other disciplines. This amounts to underreporting of approximately 2%. This small percentage cannot therefore explain the difference. It will be endeavoured to find another explanation. Perhaps the practice censuses, which are to take place again in 1983, can throw some light on this matter. However, as long as there is no clarity, it is pointless to make pronouncements. All that can be said is that the interrelations in all subgroups are practically identical.

Age distribution

Table 29 gives the data per age group (see also Fig. 20).

Table 29: Number of cases of spontaneous abortion, partus immaturus and partus at gravidity by age group, per 10 000 women, 1982.

	Age group				
	15-19	*20-24*	*25-34*	*35-44*	*⩾45*
Spontaneous abortion	*12*	*46*	*61*	*12*	-
Partus immaturus	-	*11*	*14*	*(2)*	-
Partus at gravidity	*61*	*584*	*686*	*93*	*(1)*

As was to be expected, the highest frequencies fall in the 20-24 and 25-34 age groups. Above the age of 44 years partus is reported only once, viz for a woman of 47 years. One was aware that for this question a breakdown into five-year classes would yield more information, and therefore the physicians were asked also to state the exact age above 24 years. The (manual) processing of these data is still going on.
Apart from the fact that here too the interrelations do not differ much in the classes with the highest frequencies, little can be said about this topic at present.

This topic has been maintained on the weekly return for 1983.

PENICILLIN, PRESCRIPTIONS AND SIDE EFFECTS

The subject "hypersensitivity to penicillin" was placed on the weekly return in 1982. Therapeutic administration of penicillin may cause an allergic reaction. This reaction may be of an immunological or non-immunological, toxic or pseudoallergic nature. In the case of people who are hypersensitive to penicillin, non-therapeutic contact with penicillin may also lead to hypersensitivity reactions. This non-therapeutic contact could come about through small amounts of penicillin in food[1]). Residues of penicillin may remain in foodstuffs of animal origin after a treatment of the producing animal with antibiotic. These residues could in this way form a risk for the consumer who is hypersensitive to penicillin. Partly on account of this, milk and meat are intensively checked on penicillin residues. The Utrecht Food Inspection Service (Mrs J.H. van der Stroom-Kruyswijk) now came forward with the question how large the group that could be at risk is. In other words, how large the group of people hypersensitive to penicillin is in the Netherlands. Since the Bureau for Side Effects of Medicines cannot answer this question, the problem was submitted to the Continuous Morbidity Registration, Sentinel Stations.
The procedure and a list of the preparations to be registered (penicillin and cephalosporin preparations) have been compiled in consultation with the late Professor G.L. Kalsbeek (at the time professor at Utrecht University) and Dr P. de Haan (staff-member of the dermatology department of the Free University, Amsterdam).

The topic consists of three columns: penicillin prescribed (or administered) for the first time in 1982, repeated in 1983 and reactions to this medicament. The physician is requested to note on the patients' card all side effects that occurred within 14 days. At a later stage these data will be asked for and processed. One was aware that in this way a return is not obtained of all patients with a penicillin allergy, since another medicine will be chosen for the patients for whom this is known. However, this drawback is less applicable to young children. Therefore, the physicians were asked to state for children younger than 5 years whether this therapy was or was not being given for the first time in their lives.
Use of penicillin not prescribed by the general practitioner falls outside this registration. No distinction by sex was made.

In Table 30 the frequencies per province and urbanization group, per 10 000 inhabitants, are given (see also Fig. 21).

[1]) *Boonk, W.J., Ketel, W.G., Chronische urticara, penicilline-allergie en melkprodukten in de voeding. Ned. T. Geneesk. 124, No. 42, 1980, 1771-1773.*

Table 30: The number of patients for whom penicillin was prescribed for the first time by the spotter physician per province and urbanization group, per 10 000 inhabitants, stating the number of repeat prescriptions and the number of reactions to penicillin, 1982.

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
Penicillin prescribed for the first time in 1982	*731*	*501*	*499*	*698*	*557*	*547*	*662*	*574*
Repeated	*223*	*151*	*78*	*175*	*189*	*110*	*146*	*131*
Reactions to use of penicillin	*12*	*7*	*10*	*10*	*6*	*11*	*9*	*10*

In total in 1982 the spotter physicians prescribed a penicillin preparation for 574 out of every 10 000 patients (i.e. 1 in 17). Off all prescriptions, there was a repeat in 1982 for nearly 19%. It has not been registered how frequently a repeat prescription concerned the same patient, and therefore this figure could not be given per 10 000 patients.
If one examines the subgroups one sees that in the north and south of the country penicillin is prescribed the most frequently: for approximately 700 of every 10 000 patients, as against 500 in the rest of the country. The number of repeat prescriptions is the lowest in the west of the country, over 13% as against some 23% in the rest of the country.
In the classification by degree of urbanization the cities head the list with 662 per 10 000 as opposed to approximately 550 in the rest of the country. However, the percentage of repeat prescriptions in the cities lies with 21 between the rural municipalities (25%) and urbanization group 2 (17%). With this material an analysis to discover the background to these differences is not possible.

Age distribution

In Table 31 the data are related to age (see also Fig. 22).

Table 31: The number of patients for whom penicillin was prescribed for the first time in 1982 by the spotter physician per age group, per 10 000 inhabitants, stating the number of repeat prescriptions and the number of reactions to penicillin, 1982.

	Age group									
	<5	*5-9*	*10-14*	*15-19*	*20-24*	*25-34*	*35-44*	*45-54*	*55-64*	*⩾65*
Penicillin prescribed for the first time in 1982	*1628*	*922*	*465*	*429*	*462*	*459*	*457*	*433*	*404*	*686*
Repeated	*583*	*216*	*77*	*72*	*66*	*62*	*79*	*70*	*118*	*227*
Reactions to use of penicillin	*32*	*9*	*7*	*9*	*6*	*8*	*4*	*7*	*10*	*17*

There proves to be a considerable difference between the age groups. In the case of children younger than 5 years penicillin is prescribed nearly twice as frequently as for children in the 5-9 age group, 1628 and 922 respectively per 10 000, i.e. about 1 in 6 and 1 in 11. Above that age the frequency is practically constant with approximately 450 per 10 000 patients, increasing again in the case of patients older than 64 years to nearly 700 (1 out of 22) (1 out of 15). The percentages of repeat prescriptions also prove to be age-dependent: at an early age that is more than 25%, followed by a fairly rapid decline to 12% in the 25-34 age group, rising again to 25% for patients older than 64 years.

Side effects

The number of side effects to use of penicillin does not display any great differences, neither in the age groups nor in the province and urbanization groups. Related to the number of first prescriptions it is around 1-2%. For children younger than 5 years this percentage is 2 (32 as against 1628 per 10 000). The question whether it was for the first time in the child's life that penicillin was prescribed can give an insight here into the real percentage of hypersensitive patients. The absolute number of reports of a reaction is 28 here, i.e. in 5% of the number of children to whom penicillin was administered for the first time. Without skin tests or blood tests it cannot be stated for certain, however, whether the side effects recorded are all of an immunological nature. It will be endeavoured by verification of the data to exclude the obviously non-allergic reactions.

Seasonal influences

It is to be expected that there are differences between the various quarters. Table 32 shows this.

Table 32: The number of patients for whom penicillin was prescribed for the first time in 1982 by the spotter physician per quarter, per 10 000 inhabitants, stating the number of repeat prescriptions and the number of reactions to penicillin, 1982[1]).

	1st quarter	*2nd quarter*	*3rd quarter*	*4th quarter*
Penicillin prescribed				
for the first time in 1982	*177*	*130*	*118*	*147*
Repeated	*13*	*29*	*33*	*56*
Reaction to use of penicillin	*3*	*2*	*2*	*2*

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

The number of repeat prescriptions is higher at the end of the year; this too was to be expected, in view of the fact that the chance of prescribing penicillin more than once for the same patient grows with the increase in the time of registration.
Further analysis will take place.

This topic has been maintained on the weekly return for 1983.

ACCIDENTS IN THE PRIVATE SECTOR

In 1981 accidents in the private sector appeared for the first time on the weekly return, at the request of Mr W. Rogmans of the Safety Institute.
Criteria: by an accident is meant a sudden unintended, unforeseen event resulting in recognizable harm to physical well-being. This definition is derived from a WHO publication[1]) and is considered to be universally accepted.
With regard to the concept "private sector" an "exclusive" definition is taken as the basis: all those accidents occurring neither during participation in traffic on the public highway, nor during practice of employment.
A subdivision is made for sex. In 1981 the spotter physician reported whether the patient had been referred or not in the *first* instance to a specialist, along the lines of the reporting of traumas in sport in 1979. In 1982 they were asked briefly to state how the accident happened, in order to investigate whether preventive measures could be taken. No distinction is made between home visits or consultations.

Table 33 gives the number of consultations for an accident in the private sector per 10 000 men and women per province and urbanization group (see also Fig. 23).

Table 33: Number of (first) consultations for an accident in the private sector per province and urbanization group, per 10 000 inhabitants, 1981 and 1982.

		Province group				*Urbanization group*			*Netherlands*
		A	*B*	*C*	*D*	*1*	*2*	*3*	
Men	*1981*	*572*	*418*	*240*	*347*	*334*	*353*	*311*	*340*
	1982	*302*	*301*	*183*	*415*	*263*	*271*	*278*	*271*
Women	*1981*	*410*	*270*	*218*	*280*	*213*	*276*	*280*	*267*
	1982	*194*	*236*	*168*	*324*	*226*	*193*	*279*	*217*
Total	*1981*	*489*	*343*	*228*	*313*	*274*	*313*	*295*	*303*
	1982	*246*	*269*	*176*	*369*	*245*	*231*	*278*	*244*

It is striking that the number of consultations on account of an accident in the private sector has decreased in nearly all subgroups.
The relative difference between the number of (reported) consultations on account of an accident in the private sector of men and women has, on the contrary, continued to exist, in 1981 340 and 267 respectively per 10 000 and in 1982 271 and 217. The "decrease" may have been caused by the extra questions that were asked. It was learned from

[1]) *Accidents in Childhood, Rep. Ser. 118, Geneva 1957.*

various sides that this was difficult to comply with. Allowance should be made for this when making use of the result. Arguing against this conclusion is the fact that there is no difference between the first and the second half year (see below).

Age distribution

In Table 34 the numbers per age group may be found (see also Fig. 24).

Table 34: Number of (first) consultations for an accident in the private sector by age group, per 10 000 inhabitants, 1981 and 1982.

		Age group									
		<5	*5-9*	*10-14*	*15-19*	*20-24*	*25-34*	*35-44*	*45-54*	*55-64*	*⩾65*
Men	*1981*	*605*	*458*	*485*	*453*	*475*	*281*	*241*	*224*	*192*	*188*
	1982	*759*	*499*	*383*	*330*	*258*	*167*	*192*	*177*	*142*	*168*
Women	*1981*	*408*	*286*	*326*	*367*	*279*	*190*	*194*	*216*	*259*	*285*
	1982	*469*	*228*	*263*	*223*	*171*	*145*	*194*	*156*	*212*	*274*
Total	*1981*	*506*	*372*	*407*	*410*	*373*	*236*	*218*	*220*	*225*	*244*
	1982	*616*	*365*	*323*	*277*	*213*	*156*	*193*	*166*	*178*	*231*

The difference from 1981 found in the province and urbanization groups may be found again in all age groups, with the exception of the lowest one. The age-dependence signalled in the previous year is present again: among men there is a practically continuous decrease; among women an increase may be seen in older age. In the oldest age brackets the frequency among women is even higher than among men, in contrast to the other age groups.

The extra question on how the accident happened, and the product involved in the accident, were asked only in the first half year. The answers have been processed by Mr. Rogmans.

In brief they are as follows:

> In 85% of the cases reported a product proves to have been involved in the occurrence of the accident injury. It is striking that, as in the registration of patients treated in hospitals, here too the product categories dwelling components (sills, doors, stairs), glass and playground equipment (swings, climbing frames, etc.) are frequently mentioned as being involved in the accident: these products are involved in 34% of all accident injuries.
> A random sample follows of 50 out of the 1855 collected accident descriptions (in order of age of the patient).

Age: 3 Caught finger in door of toddlers' playroom
Age: 3 Fell with scooter through scooter wheel breaking
Age: 4 Caught finger between iron chain of swing in playground
Age: 4 Fell with bike
Age: 4 Ran into slide in public playground, banging head on angle iron
Age: 6 Got a wig in eye while playing, perforation of eye
Age: 6 Fell from climbing frame at school, forearm bruised
Age: 7 Stepped on glass fragment while playing
Age: 10 Stumbled when stepping off rope ladder
Age: 10 Stumbled and fell through pane of glass with wrist
Age: 12 Fell on ice, wrist injury
Age: 13 Got hand jammed during carpentry
Age: 14 Chair pulled away; fell on ground on coccyx
Age: 15 Crashed into cupboard during rough-and-tumble
Age: 15 Slipped and cut little finger of left hand whith knife
Age: 15 Dog-bite
Age: 15 Sprained ankle
Age: 16 Lost balance while sitting on stool, fell on the ground
Age: 16 Slipped while holding chisel at school
Age: 17 Something (?) fell on hand while cleaning caravan
Age: 17 Stairs
Age: 17 Thorn splinter in right forearm
Age: 18 Cut with knife
Age: 20 Glass injury in finger through beer glass
Age: 21 Stumbled over sill
Age: 24 Fell through window-pane during rough-and-tumble
Age: 27 Stepped on rusty nail (at home)
Age: 28 Broken pane, glass splinters
Age: 30 Banged head on boat
Age: 30 Foot, shoe
Age: 31 Slipped on polished parquet floor
Age: 32 Child jabbed screwdriver into mother's eye
Age: 33 While working under car corpus alienum in right eye
Age: 35 Row between husband and wife, hit on head with copper pan, cut
Age: 40 Spring shot out of door closer and hit head
Age: 41 Fell from loft stairs with piece of linoleum under arm, twisted foot
Age: 41 Stood on nail
Age: 44 Slipped at top of stairs, had just got out of bed
Age: 48 Slipped on linoleum
Age: 50 Dog bite
Age: 52 Fell with bicycle

Age: 54 Slipped on dog dirt, fell against wall
Age: 56 Slipped while working on holiday, twisted knee
Age: 57 While playing with dog latter jumped on abdomen
Age: 63 Fell backwards from chair while closing window
Age: 65 Jammed toe under door
Age: 68 Dislocated shoulder through carrying heavey bag
Age: 71 Tripped over bucket in bathroom, struck edge of bathtub
Age: 73 While cleaning kitchen struck point of cupboard with head
Age: 80 Fell from stairs in dark, fractured vetebra in neck
Age: 81 Stepped in hole that had been dug outside front door
Age: 87 Fell out of bed, fractured hip.

When collecting the data it soon became clear that there were great differences between the sentinel stations. Consequently a questionnaire has been compiled with questions relating to the practice and the distance from hospitals or out-patient clinics.

The processing was done by Mr. Rogmans. In brief the answers are as follows.

The supplementary enquiry has shown that the distance between the practice address and the closest hospital open 24 hours a day for emergencies is rarely great.
Expressed in kilometers, 52% live 0 to 5 km from a hospital, 15% 5 to 15 km, 18% 10 to 15 km, 9% 15 to 20 km and 6% 20 km or more.
In terms of car-minutes, this would amount to: 0 to 10 minutes: 54%, 10 to 20 minutes 36% and 20 to 30 minutes 10%.
In addition it provis that three quarters of the practices are established in residential districts in which or near which two or more hospitals at a reasonable distance from the practice address, in the sense that the general practitioner usually refers patients to them.
As regards the activities that are usual as part of first aid, 95% of the general practitioners questioned said that they use slings. 33% als use clamps and 5% use neither of these aids.
Of the general practitioners, 4% never stitch skin injuries themselves, 11% do so in fewer than 50% of the cases, 30% do so in 50% or more of the cases, while 55% always do it themselves.
With regard to removing a foreign body from the eye themselves, 67% say that they always do, 28% ususally do (in 70% to 99% of the cases) and 6% do in about half of the cases. 80% of the general practitioners always try themselves to remove a foreign body from ear or nose.
20% of the physicians never have an X-ray photograph made of a suspected sprain, 43% do so in fewer than 50% of the cases, 30% do so in

50% of the cases and 8% do so in more than half of the cases.
Of the patients who need medical treatment (or think that they do) as the result of an accident in the private sector, a large proportion go first to the family doctor (approx. 70%). He can usually treat these patients himself (80%); if not they are referred to a specialist.
This refferral is somewhat more common in the larger towns and cities where the distance (both in kilometres and in car-minutes) from the closest out-patient clinic is shorter than in less urbanized areas.
Factors such as distance and range of actions performed by the family doctor are of much stronger influence on the behaviour of patients themselves in seeking aid. About one third of the accident patients do not go to the family doctor but direct to the out-patient clinic or a first aid post.
This happens particularly in those cases in which such an aid post is near by and when the family doctor in question preferably does not perform certain actions himself.
On the strength of the results of this survey it must be concluded that registration which is confined to accident patients treated clinically or in out-patient clinics, certainly in less urbanized regions, will not give a full picture of the whole problem. Supplementation of the out-patient clinic registration system started by the Safety Institute bij - intermittent - investigation in general practices is therefore to be recommended.

More extensive reporting is taking place in the journal Medisch Contact[1]).

This topic has been maintained on the weekly return for 1983, though with somewhat amended questions.

[1]) *Thien, W.H.A.M. en Rogmans, W.H.J. Naar een betere registratie van ongevallen in de privé-sfeer. M.C. nr. 36/1983 p. 1126.*

TRAUMAS IN SPORT

Traumas in sport were placed on the weekly return in 1979. The criteria were established as follows: all first contacts in connection with a sport injury, irrespective of whether this is acute or not. Thus the consequence of both a non-recurrent effect of violence and a chronic overload is concerned.
No distinction is made between the sexes nor between consultations, house calls or aid on the spot. To gain an impression of the severity of the occurrence a subdivision was made in 1979 for referral or otherwise to a specialist at the time of the first contact.
As a second subdivision membership or otherwise of a sports club was adhered to. Membership for at least one year was regarded as a criterion of "regular engagement in sport".

For 1980 the questions were changed (in consultation with Dr G.P.H. Hermans, vice-chairman of the Association of Sport Medicine). By making a distinction between indoor and field sports and in the second instance between individual sport and team sport, it is being endeavoured to gain insight into the nature of the injury. The injury mechanism is influenced by the size and nature of the area on which the sport is practised. In the case of indoor sports the area is relatively small and the flooring artificial; in the case of field sports the area is larger and usually natural.
Team sports present the possibility of (involuntary) contact with another sportsman. The definition used here was: team sports are sports that can be practised exclusively with a number of persons.

For 1981 a classification by various forms of sport was made. Those branches were chosen with a high membership. In this way handball, hockey, "korfbal" and football were arrived at. Initially it was thought that it would be possible to calculate the number of traumas caused by other sports by means of subtraction. At the time of that decision it was not felt that there were factors that would influence the total frequency. However, these did in fact prove to exist: the frequencies of the corresponding quarters differed very clearly. It was therefore decided with effect from 1 July 1981 to replace the category "korfbal" - the one with the lowest frequency - by "other sports". This has had a quite definite influence on the number of reports of consultations for a sport trauma.

In 1982 it was endeavoured to gain an impression of the nature of the trauma and also whether or not it was a recurrence.
The nature of the trauma: is it an accident or an overstrain injury? The answer to this question is important in connection with the possibility of taking preventive measures. Accidents have in general an exogenous cause and therefore need external preventive measures.

Overstrain traumas, on the other hand, have a more endogenous origin and need more "internal" prevention in the sense of recommendations regarding the load during training, forms of training, etc.
Knowledge of the incidence of recurrences is necessary to be able to build up optimum treatment and counselling.
The criteria were determined as sharply as possible: an accident is any acute trauma that occurs during engagement in sport either directly or indirectly in connection therewith. An overstrain injury, on the other hand, occurs gradually, such as "tennis elbow".
If complaints occurred again within the period of one year, that was counted as a recurrence.

In 1982 a questionnaire was again circulated to examine the effect of the Sport Medical Advisory Centres on the practice of the spotter physicians. As in 1979 the number of patients who approach such a centre directly seems negligible. The intention of this topic is not to gain an impression of the total extent of the problem, but to find out how heavily the general practitioner is burdened with it and how the interrelations are. The data of the past years are being processed by and in collaboration with H. Inklaar and Dr. F. Kessel, sport physicians with the Royal Netherlands Football Association, and Mr. P.J.S. Boon, a statistician with Nijmegen University, in close cooperation with colleague Hermans. A grant given by the Ministry of Culture, Recreation and Social Work makes this possible. It is being reported on elsewhere. The data presented here contain only a simple representation of the results. As in previous years, only traumas for which the general practitioner is consulted are reported. Consultations in an out-patient clinic without the intermediary of the general practitioner, or assistance given at first aid posts only, are not recorded.

Table 35 gives the frequencies per province and urbanization group in the various subgroups stated (see also Fig. 25).

Table 37: Number of consultations of the general practitioner for a trauma in sport, per province and urbanization group, per 10 000 inhabitants, 1979 - 1982.

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
1979	*170*	*167*	*100*	*127*	*160*	*115*	*120*	*126*
1980	*211*	*183*	*117*	*175*	*197*	*142*	*155*	*155*
1981	*152*	*152*	*121*	*196*	*136*	*139*	*173*	*146*
1982	*218*	*196*	*133*	*200*	*191*	*161*	*180*	*171*

The total frequency (171 per 10 000 inhabitants) was higher in 1982 than in previous years; this applies to all subgroups.
Comparison of the subgroups shows that at all times the lowest frequencies are in province group C (the centre and west of the country).

Seasonal influences

Table 36 gives the frequencies per quarter.

Table 36: Number of consultations of the general practitioner for a trauma in sport, per quarter, per 10 000 inhabitants, 1979 - 1982[1]).

	1st quarter	*2nd quarter*	*3rd quarter*	*4th quarter*
1979	*27*	*32*	*26*	*41*
1980	*44*	*40*	*33*	*39*
1981[1])	*(24)*	*(34)*	*31*	*36*
1982	*57*	*43*	*34*	*36*

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

[2]) *For further information on the 1st and 2nd quarter see the 1981 report (p. 60 et seq.).*

Viewed relatively, the 3rd quarter is always the lowest, which can be satisfactorily explained by the summer holidays. The 1st quarter of 1982, with 57 traumas per 10 000 inhabitants, easily heads the list. This can be explained by climatic conditions and the related changes in the pattern of engagement in sport.

Age distribution

Table 37 gives the frequencies per age group (see also Fig. 26).

Table 37: Number of consultations of the general practitioner for a trauma in sport by age group, per 10 000 inhabitants, 1979 - 1982.

	Age group									
	<5	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	⩾65
1979	(2)	33	187	373	331	178	83	26	13	5
1980	5	38	226	421	419	202	115	40	8	(2)
1981	(3)	32	209	411	384	215	102	20	5	(2)
1982	9	62	288	476	372	214	139	60	14	7

Comparison of the years displays a fairly consistent picture. The highest frequencies occur in the 15-19 and 20-24 age groups. The difference in the total frenquency, on the other hand, is mainly caused by a higher frequency in the 10-14 and 15-19 age group.

In Table 38 the data for 1982 per age group are broken down in accordance with the nature of the trauma; also given here are the frequency of a recurrence of the complaints.

Tabel 38: Number of first consultations on account of a sport accident or for an overstrain injury and the number of (first) consultations on account of a recurrence of the complaints per age group, per age group, per 10 000 inhabitants, 1982.

	Age group									
	<5	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	⩾65
Accident										
first consultation	8	61	257	407	310	175	114	44	13	7
recurrence of complaints	-	(2)	6	40	35	21	9	(1)	(1)	(1)
Overstrain										
first consultation	(1)	(1)	31	69	62	39	25	16	(1)	-
recurrence of complaints	-	-	2	18	22	14	16	(2)	(1)	-

In all subgroups too the frequencies in the 15-19 and 20-24 age groups prove to be the highest.

If the various groups are compared with one another, there proves to be an obvious connection with age: the ratio of the number of first consultations on account on an acute trauma, a genuine sport accident, to the number on account of an overstrain injury gradually decreases with age: from over 8 in the 10-14 age group to nearly 3 in the 45-54

age group. That means that the number of overstrain injuries, viewed relatively, increases with the years. This can be explained by the fact that in general those branches of sport are engaged in to a greater extent that are characterized by lengthy repetitive movements, as in tennis. In the presence of indirectly provocative factors this predisposes one to overstrain. Instances of provocative factors are lack of technique, inadequate gear and/or footwear, poor accommodation, condition of the ground etc.
The ratio between the number of first consultations on account of a sport accident and the number of (first) consultations on account of recurrence of the complaints is also bound up with age, though less strongly. The same applies to overstrain injuries.

If the same classification, but then per province and urbanization group (Table 39), is considered, fairly strong fluctuations may be seen in the interrelations.

Tabel 39: Number of first consultations on account of a sport accident or for an overstrain ijury and the number of (first) consultations on account of a recurrence of the complaints per province and urbanization group, per 10 000 inhabitants, 1982.

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
Accident								
first consultation	*195*	*115*	*108*	*180*	*159*	*141*	*138*	*144*
recurrence of complaints	*14*	*26*	*9*	*10*	*19*	*10*	*15*	*13*
Overstrain								
first consultation	*23*	*41*	*25*	*20*	*32*	*20*	*42*	*27*
recurrence of complaint	*7*	*22*	*6*	*5*	*16*	*5*	*15*	*9*

The only thing that may be concluded from these data is that the ratio of first consultations on account of a sport accident to (first) consultations on account of a recurrence of the complaints is always the highest (on average 11); this is followed by the ratio of first consultations on account of an accident to first consultations on account of an overstrain injury (on average in excess of 5) and finally by the ratio of first consultations on account of an overstrain injury to first consultations on account of recurrence of these complaints (on average 3).
One of the possible causes of these differences may be situated in the fact that a sport accident has more serious consequences for ADL (Daily Life Activities) and is less

acceptable to the patient. This is in contrast to overstrain injuries, to which some form of adjustment is possible and which often impose less drastic restrictions on the patient.

This subject has been maintained on the weekly return for 1982, again with changed questions. That year will probably be the last year for this topic.

EXTRAPOLATION OF FREQUENCIES FOUND TO THE DUTCH POPULATION

The following survey gives an approximate impression of the number of patients, consultations, actions and occurrences and so on in the Netherlands, on the basis of the frequencies calculated from the results of the continuous morbidity registration by sentinel stations. As was remarked in the previous reports, it must be borne in mind, when studying the following table, that although the population of the sentinel stations is a reasonably good representation (see also p. 15) the spotter physicians are a selected group. Consequently it cannot be automatically established to what extent the results differ from the actual situation; the differences can vary depending on the nature of the question. Particular caution should be observed regarding those topics where there is intervention by 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 case of the (attempted) suicide question there proves to be a difference in respect of registrations from elsewhere, as a result of the fact that this event is presumably not always reported to the general practitioner. With regard, too, to the registration of diseases and occurrences in itself it may be stated almost with certainty that the spotter physicians act as a select group. However, this can only be to the benefit of the project. Nevertheless, the reader is advised not only to look at the extrapolated numbers but also to consult the relevant chapters.
For a correct interpretation of the extrapolated numbers first the total Dutch population per year is given, in thousands.

Dutch population by sex in thousands, 1970 - 1982 (Central Bureau for Statistics)[1]).

Year	*Men*	*Women*	*Total*
1970	*6 507*	*6 531*	*13 038*
1971	*6 587*	*6 607*	*13 194*
1972	*6 650*	*6 679*	*13 329*
1973	*6 699*	*6 740*	*13 439*
1974	*6 747*	*6 798*	*13 545*
1975	*6 804*	*6 862*	*13 666*
1976	*6 854*	*6 920*	*13 774*
1977	*6 889*	*6 967*	*13 856*
1978	*6 907*	*6 991*	*13 898*
1979	*6 945*	*7 040*	*13 985*
1980	*6 994*	*7 097*	*14 091*
1981	*7 048*	*7 159*	*14 207*
1982	*7 082*	*7 204*	*14 286*

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

Extrapolation of frequencies found to the Dutch population.

		Frequency[1])			*Netherlands*[2])		
Category	*Year*	*M*	*F*	*Total*	*M*	*F*	*Total*[3])
Influenza[4])	*1970*			*904*			*1 179 000*
	1971			*889*			*1 173 000*
	1972			*779*			*1 038 000*
	1973			*699*			*939 000*
	1974			*885*			*1 199 000*
	1975			*695*			*945 000*
	1976			*717*			*987 000*
	1977			*575*			*797 000*
	1978			*829*			*1 152 000*
	1979			*438*			*613 000*
	1980			*425*			*599 000*
	1981			*491*			*697 000*
	1982			*497*			*710 000*
Diabetes mellitus							
- new patients	*1980*			*13*			*18 000*
	1981			*12*			*17 000*
	1982			*12*			*17 000*

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

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

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

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

Extrapolation of frequencies found to the Dutch population (continuation).

		Frequency[1]			Netherlands[2]		
Category	Year	M	F	Total	M	F	Total[3]
Cervical smear	1976		87			60 000	
- with complaints	1977		86			60 000	
and/or symptoms	1978		80			56 000	
	1979		80			56 000	
	1980		62			44 000	
	1981		57			41 000	
	1982		57			41 000	
- "preventive",	1976		282			194 000	
general practi-	1977		268			186 000	
tioner's	1978		218			153 000	
initiative	1979		198			140 000	
	1980		168			119 000	
	1981		184			132 000	
	1982		171			123 000	
- "preventive",	1976		103			71 000	
woman's initiative	1977		112			78 000	
	1978		105			73 000	
	1979		124			87 000	
	1980		93			66 000	
	1981		110			79 000	
	1982		126			91 000	
- repeat examina-	1976		31			21 000	
tion (within	1977		55			38 000	
3 years)	1978		120			84 000	
	1979		143			101 000	
	1980		148			105 000	
	1981		159			114 000	
	1982		170			122 000	
Total[3]	1976		503			346 000	
	1977		521			362 000	
	1978		523			366 000	
	1979		545			384 000	
	1980		471			334 000	
	1981		510			365 000	
	1982		524			377 000	

[1], [2] and [3] See footnotes, page 75.

Extrapolation of frequencies found to the Dutch population (continuation).

		Frequency[1]			Netherlands[2]		
Category	Year	M	F	Total	M	F	Total[3]
Parkinson's	1980	7	5	6			
disease[4]	1981	4	2	3			
	1982			2			
Sterilization	1972	24			16 000		
	1973	40			27 000		
	1974	46	35		31 000	24 000	55 000
	1975	46	46		31 000	31 000	62 000
	1976	57	66		39 000	45 000	84 000
	1977	53	64		37 000	45 000	82 000
	1978	74	81		51 000	57 000	108 000
	1979	99	90		69 000	63 000	132 000
	1980	79	70		55 000	50 000	105 000
	1981	59	46		42 000	33 000	74 000
	1982	50	40		35 000	29 000	64 000
cumulatief					433 000	377 000	
Morning-after-pill	1972		53			35 000	
prescribed	1973		59			40 000	
	1974		68			46 000	
	1975		60			41 000	
	1976		60			41 000	
	1977		49			34 000	
	1978		50			35 000	
	1979		50			35 000	
	1980		50			35 000	
	1981		35			25 000	
	1982		35			25 000	
Hay fever							
- new patients	1978	26	22		18 000	15 000	33 000
	1979			32			45 000
	1980			26			37 000
	1981			20			28 000
	1982			24			34 000

[1]), [2]) and [3]) See footnotes, page 75.

[4]) *In view of the very small numbers, extrapolation has been omitted here.*

Extrapolation of frequencies found to the Dutch population (continuation).

		Frequency[1]			Netherlands[2]		
Category	Year	M	F	Total	M	F	Total[3]
(Attempted	1979			7			
suicide[4])	1980			7			
	1981			6			
	1982			8			
Spontaneous abortion[5])	1982		18				
Partus immaturus[5])	1982		3				
Partus at gravidity[5])	1982		188				
Penicillin prescriptions	1982						
- for the first time in 1982				574			820 000
- repeat				131			187 000
- side effects				10			14 000
Accidents in the private sector[6])	1981	340	267		239 000	191 000	431 000
	1982	271	217		192 000	156 000	348 000
Traumas in sport[6])	1979			126			177 000
	1980			155			218 000
	1981			146[7])			207 000
	1982			171			244 000
Sportaccident							
- first consultation				144			206 000
- recurrence of complaints				13			19 000
Overstrain							
- first consultation				27			39 000
- recurrence of complaints				9			13 000

[1]), [2]) and [3]) *See footnotes, page 75.*

[4]) *See footnote, page 77.*

[5]) *Not extrapolated on account of probably incomplete registration.*

[6]) *Extrapolation here relates solely to the number for which the general practitioner is consulted.*

[7]) *Corrected, see page 68 and 70.*

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. Since 1976 the disease multiple sclerosis and the request for application of active euthanasia have been the subject of investigation. In 1980 the request to reverse sterilization, "persons regretting sterilization", was added and in 1982 the occurrence of mastitis puerperalis and malignancies.

Multiple sclerosis

In 1976 attention was devoted for the first time to multiple sclerosis. The first time the physicians were asked to investigate how many multiple sclerosis patients they had in their practice on 31-12-76 (an approximation of the prevalence). Thereafter only the reporting of new patients was concerned (the incidence). In addition to age and sex, questions were asked about living conditions, the use or otherwise of a wheelchair inside or outside the home and by whom the diagnosis was made.

In 1982 the diagnosis of multiple sclerosis was reported 7 times for a new patient (Table 40); five times a patient new to the practice proved to have this disease. The latter cases have not been included in the tables.
The diagnosis was made in all cases by the neurologist. Likewise in all cases the disease was in such an early stage that extra provisions were not yet necessary.

Table 40: Absolute number of patients diagnosed as having multiple sclerosis by age group and sex, 1977 - 1982.

		Age group							
		<20	20-24	25-34	35-44	45-54	55-64	⩾65	Total
Men	1977	-	-	1	1	-	-	-	2
	1978	-	-	1	1	-	-	-	2
	1979	1	-	-	-	-	-	-	1
	1980	1	-	-	-	-	-	-	1
	1981	-	-	-	-	1	-	-	1
	1982	-	-	-	-	-	-	1	1
Women	1977	-	1	1	3	1	-	1	7
	1978	-	-	1	1	1	1	-	4
	1979	-	1	2	1	1	-	-	5
	1980	-	-	-	-	1	1	-	2
	1981	-	-	-	1	-	1	-	2
	1982	-	1	1	2	1	1	-	6
Total	M	2	-	2	2	1	-	1	8
	V	-	3	5	8	5	4	1	26
1977 -	1982	2	3	7	10	6	4	2	34

The mean age at diagnosis is 41 and 37.5 years for men and women respectively.

Table 41 shows the distribution by province group and urbanization group.

Table 41: Absolute number of patients for whom the diagnosis multiple sclerosis was made per province and urbanization group, 1977 - 1982.

Abso-			Province group				Urbanization group			Netherlands
lute	M	V	A	B	C	D	1	2	3	
1977	2	7	-	1	5	3	-	6	3	9
1978	2	4	-	1	5	-	1	3	2	6
1979	1	5	-	1	5	-	-	5	1	6
1980	1	2	-	2	1	-	-	2	1	3
1981	1	2	-	-	1	2	-	3	-	3
1982	1	6	-	1	5	1	1	3	3	7
1977 - 1982										
	8	26	-	6	22	6	2	22	10	34
Per 10 000 inhabitants per year										
	0.17	0.52	-	0.33	0.47	0.30	0.13	0.37	0.46	0.35

The numbers per 10 000 inhabitants do display some differences per subgroup, but only the difference between the incidence for men and for women is significant ($p < 0.05$).

For the whole the Netherlands the average number of reports per 10 000 inhabitants come to 0.35 per year, with a 95% reliability interval of 0.26-0.46. This tallies reasonably well with the incidence in Denmark (4.4 per 10 000[1]).

At the start of this registration a (causal) relation between measles and multiple sclerosis was envisaged. One of the consequences of vaccination against measles might therefore also be a fall in the frequency of multiple sclerosis. However, this hypothesis can only be tested over a large number of years.

Provisionally this registration will not be repeated.

[1]) *Dassel, H. e.a. Multipele Sclerose, een verkenning vooral gericht op de revalidatie, p. 101, 1977. De nederlandse bibliotheek der Geneeskunde, deel 108. (Uitg. Stafleu, Leiden).*

Euthanasia

The second incidental investigation concerns the subject of euthanasia. Attention was devoted to this for the first time in 1976.
The form of the investigation is retrospective. A form was sent to all spotter physicians at the end of 1982 with the request that they report whether the question was asked of them in 1982 by a patient himself or herself for the application of active euthanasia directly or indirectly[1]) and if so, what the motive for this was. In addition, information was sought on the age, sex, current disease, place of care or nursing and the use or otherwise of an "euthanasia declaration"[2]).

The results per patient can be found at the end of this section. This table does not require much explanation. There is not much difference between the numbers of requests through the years.
The number of patients with a carcinoma, as in previous years, is again large, relatively speaking; more than 60% of them have a carcinoma. Mortality from cancer, on the other hand, in the Netherlands is about 25% of total mortality. The patients with a carcinoma are younger than the other patients. Only three times was a request for indirect euthanasia made (all cancers).
In the other cases the request was for application of direct euthanasia. In five cases too use was made of a written euthanasia declaration. On seven occasions was the patient not nursed at home (twice in hospital, twice in a nursing home, twice in an old people's home and once in different institutes). These numbers resemble the numbers from the previous years.

[1]) "Active euthanasia manifests itself in the deliberate application of life-shortening or life-terminating treatment. Active euthanasia can be further divided into:

- Indirect euthanasia: this is the deliberate application of treatment to alleviate suffering, without the intention of shortening or terminating life but with the recognition and acceptance of the risk that shortening or termination of life can occur.

- Direct euthanasia: this is the deliberate application of a treatment to alleviate suffering in such a way that reasonably speaking a considerable shortening or termination of life may be expected."
Medisch Contact: 1977, 32 p. 1058.

[2]) *An euthanasia declaration is a written request for euthanasia on certain conditions.*

The distribution by province group and urbanization group is given in Table 42.

Tabel 42: Absolute numbers and number per 10 000 inhabitants of requests to the general practitioner made by the patient himself or herself for the application of active euthanasia, per province and urbanization group, 1976 - 1982.

Abso-			Province group				Urbanization group			Netherlands
lute	M	V	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
1976 - 1982										
	77	63	18	25	81	16	22	74	44	140
Per 10 000 inhabitants per year										
	1.4	1.1	1.2	1.2	1.5	0.7	1.2	1.1	1.7	1.2

In the south of the country the question was asked least often, with the exception of 1981; this is also reflected in the numbers per 10 000 inhabitants.
If one considers the sentinel stations individually, great differences emerge: from 8 sentinel stations no report came; in the other sentinel stations this question was asked once to nine times. This varies from 0.0 to 6.1 per 10 000 inhabitants per year.
Of course the small numbers give a large spread which, however, does not alter the fact that considerable differences prove to exist.

Age distribution

The age distribution may be found in Table 43.

Table 43: Absolute number of patients who request the general practitioner to apply active euthanasia, by age group, 1976 - 1982.

	<55	55-64	65-74	75-84	⩾85	Total
1976	2	4	3	3	3	15
1977	2	3	2	2	-	9
1978	3	2	3	2	-	10
1979	3	7	12	2	4	28
1980	2	5	5	7	3	22
1981	8	4	5	10	3	30
1982	-	6	10	8	2	26

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

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

Requests by the patient for active euthanasia.

Age	Sex	Disease	Motive for the request
58	M	Emphysema	Dyspnoea
59	M	Carcinoma of the caecum	Pain
60	M	Amyotrophic lateral sclerosis	Progressive paralysis, complaints when swallowing
62	M	Carcinoma of the prostate with metastases	Pain, retention of urine
62	M	Grawitz tumour	Pain
63	M	Breast cancer with metastases	Cachexia, pain did not want to become dependent
65	M	Carcinoma of the lung	Decay
65	M	Carcinoma of the lung	Fear of unworthy suffering
66	M	Carcinoma of the head of the pancreas	Pain, suffering
67	M	Carcinoma of the head of the pancreas	Pain
67	F	Carcinoma of the stomach	Pain

Requests by the patient for active euthanasia (continuation).

Age	*Sex*	*Disease*	*Motive for the request*
68	*M*	*Metastases, primary focus undetected*	*Fear of increasing complaints and failure*
68	*M*	*Carcinoma of the lung with metastases*	*"This last suffering is senseless"*
70	*F*	*Breast cancer with metastases*	*Pain*
72	*M*	*Carcinoma of the lung*	*Pain*
72	*F*	*Breast cancer*	*Pain*
75	*M*	*Carcinoma of the lung*	*Complaints when swallowing*
75	*M*	*Carcinoma of the lung*	*Fear of unworthy suffering*
77	*M*	*Severe arteriosclerosis generalis*	*Amputation of a leg, dementia*
78	*M*	*Progressive renal insufficiency*	*Aware of loss of dignity*
78	*F*	*Spondylarthritis*	*Pain, old age*
80	*M*	*Chronic aspecific respiratory disease arthritis of the hip*	*Does not want to be dependent*
82	*F*	*Coronary disease*	*Objection to old age and accompanying complaints*
83	*F*	*Osteoporosis, chronic bronchitis*	*Pain, fear, need of attention*
88	*F*	*Chronic aspecific, respiratory disease*	*Chronic depression "I don't want to go on"*
91	*F*	*Old age, loneliness depression*	*"Life is useless"*

This investigation will be repeated over 1983.

Persons regretting sterilization

Registration of the request to have a performed sterilization reversed took place for the first time in 1980. The reporting was done in the form of an incidental investigation. The interest in figures with regard to this subject was aroused by the increasing demand on physicians and by the publicity in the lay press in 1980.

In addition to data on age and sex, a number of other data were collected in consultation with Prof. E.V. van Hall, professor of gynaecology and obstetrics at Leiden University. These relate to number of children, length of time married, reason for the request and compliance with the request. However, the number of requests reported so far is too small to be able to make pronouncements about these additional data.

Table 44 gives the results of the investigation at the sentinel stations. In 1982 15 cases are added, 3 men and 12 women. With regard to age there prove to be little differences between the sexes, as the table shows.

Table 44: Absolute number of patients who made a request for restotation of sterilization, per age group, 1980 - 1982.

	25-29	*30-34*	*35-39*	*40-44*	*45-49*	*Total*
Men	*3*	*5*	*4*	*1*	*2*	*15*
Women	*1*	*12*	*11*	*2*	*-*	*26*

The average age is 35 years 1 month ands 34 years respectively. The number of women regretting sterilization is (in these data) larger than the number of men.
The distribution among the province and urbanization groups may be seen in Table 45.

Table 45: Absolute number of patients who made a request for restoration of sterilization per provincie and urbanization group, 1980 - 1982.

		Province group				Urbanization group			Netherlands
		A	B	C	D	1	2	3	
Men 1980	1980	2	2	3	2	2	6	1	9
	1981	1	1	-	1	1	1	1	3
	1982	-	1	2	-	1	2	-	9
Women	1980	3	1	3	1	1	4	3	8
	1981	2	1	2	1	1	1	4	6
	1982	5	1	4	2	2	6	4	12
Total 1980 - 1982		13	7	14	7	8	20	13	41

When considering the absolute numbers in this table allowance must be made for the size of the different subgroups (province group C, the western provinces and the centre of the country, and urbanization group 2, the urbanized rural municipalities, are by far the largest groups). However, the calculation of relative frequencies is not yet meaningful, having regard to the small numbers.
The only conclusion that may be drawn is that this request is being made in all province and urbanization groups.

The investigation will be repeated for 1983.

Mastitis puerperalis

The editorial staff of the Nederlands Tijdschrift voor Geneeskunde have often been asked questions in recent years by general practitioners on the treatment of the acute form of mastitis puerperalis[1]).
Consulted advisers, who were assumed as heads of out-patient clinics repeatedly to see the late, abscess-forming stages of mastitis, stated that they had treated few or no patients with the subacute and chronic form. It was concluded that apparently it is only general practitioners who observe mastitis in women in child-bed with some regularity.
In approaching this problem, lack of knowledge of the number of patients with mastitis puerperalis was also encountered. Do general practitioners not know how to treat this

[1]) *Nederlands Tijdschrift voor Geneeskunde 1981, question 2 on p. 21, reactions on pp. 471, 971, 1465.*

disorder because they are confronted with it insufficiently and do they become uncertain because this disorder no longer leads to referral?
This matter was discussed at the meeting of the counselling committee. It did not seem a sensible idea to place it as a topic on the weekly return, having regard to the probably small number. It was therefore decided to make an "incidental investigation" of it. The spotter physicians were informed well in advance that this question would be asked for 1982.

The definition is as follows: local flush, induration, pain and warmth in the mamma, accompanied by a rise in temperature (> 38°5, to obviate the reporting of cases of galactostasis (milk retention) with a rise in temperature). Induration is to be interpreted as a part of the mamma that feels firmer than the surrounding tissue.
A glandular swelling in the armpit is not obligatory.
The age of the patient was requested, and also the therapy applied.

In all mastitis puerperalis was reported 65 times. If that is related to the number of deliveries reported by the spotter physicians (the population-at-risk: 1465), one arrives at 4-5 cases per 100 deliveries.

In Table 46 the numbers per province and urbanization group may be found.

Table 46: Absolute number of cases of mastitis puerperalis for which the family doctor was consulted and the number per 100 deliveries by province and urbanization group, 1982.

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
Absolute	*11*	*10*	*23*	*20*	*13*	*40*	*12*	*65*
Per 100 deliveries	*4.6*	*4.2*	*3.9*	*5.5*	*5.8*	*4.7*	*3.1*	*4.4*

The rural municipalities and the south of the country display somewhat higher relative frequencies; however, the numbers on which these differences are based are small.
If one examines the age groups, one also sees some differences: for 20-24, 25-34 and 35-44 years 2.4, 5.7 and 3.6 respectively per 100 deliveries (absolute numbers 10, 52 and 3). An explanation of these differences cannot be given here.

Therapy

By far the majority of women with mastitis puerperalis were given antibiotics: 50 out of

the 65; in 28 cases this was accompanied by some form or the other of conservative therapy (ice bag, cooling etc.). Of the eight different antibiotics (all penicillin preparations), Clamoxyl was prescribed the most frequently. The prolactin inhibitor Parlodel (bromocriptin) was used in only 4 cases. Conservative therapy sufficed 13 times. In only 3 cases was an incision made (by a surgeon); this is 0.2 per 100 deliveries. The idea put forward at the beginning of this investigation that this disorder is seen in most cases only by the general practitioner is herewith confirmed.

This registration is not being repeated in 1983.

Cancer registration

Cancer forms one of the greatest problems of this century for public health. Every year over 30 000 Dutch die as a result of cancer, over 25% of the total mortality.
Seven years after the termination of central cancer registration in the Netherlands, which existed for some twenty years from the Fifties, it has been decided to reintroduce national cancer registration.
One of the problems to be contended with when devising a structure for this undertaking is a lack of insight into the flows of patients insofar as malignant disorders are concerned. It seems that the majority of patients at some time come into contact with an institution of intramural health care, either with regard to diagnosis or for treatment or both.

At the 1981 meeting of co-workers the spotter physicians were asked whether it occurred in their practice that a patient with (suspicion of) cancer was not known in the intramural sector. The answer was in the affirmative. It happened above all with older patients. However, it was difficult to state an exact number or percentage without prior registration.
In the consideration to have the collection of data for cancer registration performed by the intramural sector it is important to have a quantitative and qualitative insight into this group of patients who receive their diagnosis and treatment exclusively within primary care. Consequently, at the request of and in consultation with Mr. A.A.M. Vloemans, M.D., a member of the cooperative group for combating cancer and at the time member of the programme committee, it was decided to include cancer registration as an incidental investigation.
The questioning was kept simple in the first instance. The aim was to arrive at a classification into a number of groups on the basis of the question whether the patient was known to intramural health care or whether in particular pathological-anatomical examination had been made and whether the diagnosis was definite.
The age, sex and localization of the malignancy were requested for all patients. A few

supplementary data were requested on patients who were known only to the general practitioner, such as the stage and the reason for non-referral.

Table 47 contains the results. These are data from 45 sentinel stations. One sentinel station had not maintained any registration, and therefore the patients from this practice have been removed from the population-at-risk.

Table 47: Absolute number of (new) patients with cancer reported by spotter physicians and number per 10 000 inhabitants, per province and urbanization group, 1982.

	Province group				*Urbanization group*			*Netherlands*
	A	*B*	*C*	*D*	*1*	*2*	*3*	
Absolute	*46*	*65*	*189*	*72*	*53*	*207*	*112*	*372*
Per 10 000 inhabitants	*21*	*23*	*27*	*20*	*19*	*22*	*30*	*24*

In total 374 cases of cancer were reported in 372 patients. Twice a double tumour occurred. In the processing and description the number of patients was taken as the basis - with the exception of the breakdown by localization - see Table 49. There is a small difference between the sexes, 25 and 23 per 10 000 men and women respectively (Table 48). For the total 24 per 10 000 inhabitants is arrived at. This figure tallies with the results of a registration for ten years in a general practice by Roolvink[1]). On the other hand, it is somewhat lower than the figures found in the Continuous Morbidity Registration in Nijmegen[2]), 3.5 and 3.3 per 1 000 men and women respectively. However, these registrations relate to a small area. Comparison with registration from all parts of the Netherlands would be more correct, but unfortunately recent data are not available, as stated at the beginning of this chapter.

Comparison of the various province and urbanization groups shows the highest frequencies in the centre and west of the country (province group C) and in the cities (urbanization group 3), 27 and 30 respectively per 10 000 inhabitants. This tallies with the data on cancer mortality[3]). The differences cannot be explained by differences in age structure.

[1]) *Roolvink, E.G.J.J., Registratie van kanker in een huisartspraktijk, Huisarts en Wetenschap 1983; 26, p. 84.*

[2]) *"Gewone ziekten", Nijmeegs Universitair Huisartsen Instituut, 1971-1978, p. 157.*

[3]) *Atlas van de kankersterfte in Nederland 1969-1978, Central Bureau of Statistics, p. 8.*

Age distribution

Table 48 shows how the reported cases of cancer are distributed among the various age groups.

Table 48: Absolute number of (new) patients with cancer reported by spotter physicians and number per 10 000 men and women by age group, 1982.

	Age group						
	<25	*35-34*	*35-44*	*45-54*	*55-64*	*⩾64*	*Total*
Men							
absolute	*3*	*2*	*6*	*21*	*47*	*110*	*189*
per 10 000	*(1)*	*(1)*	*6*	*25*	*68*	*157*	*25*
Women							
absolute	*4*	*6*	*23*	*21*	*38*	*91*	*183*
per 10 000	*(1)*	*4*	*25*	*25*	*51*	*91*	*23*

As was to be expected, there proves to be a strong relation with age: a low incidence at a young age and a high one at an older age. In the case of men this increase begins later, viz at 45 years (in the case of women at 35 years) but on the other hand the increase continues more strongly, to 157 per 10 000 men at an age above 64 years, as against 91 per 10 000 women of that age. The "surplus" of carcinomas among women younger than 45 years is caused largely by carcinoma of the mamma, cervix uteri and skin.

Localization

In Table 44 a breakdown by localization may be found. In the table the ICD coding[1]), with a breakdown by frequency, has been adhered to. For the sake of clarity and in view of the relatively small numbers for some locations a number of groups have been taken together here.

[1]) *ICD (1979, 9th revision) Manual of the international statistical classification of diseases, injuries and causes of death. WHO, Geneva.*

Table 49: Absolute numbers of (new) patients with cancer reported by spotter physicians (and percentages) by localization, 1982.

Localization	*ICD-code (9th revision)*	*Number*	*(%)*
Lung	*162*	*74*	*(20)*
Mamma	*174*	*59*	*(16)*
Colon + rectum	*153, 154*	*50*	*(13)*
Skin	*172, 173*	*37*	*(10)*
Female sexual organs	*180, 182, 183*	*32*	*(9)*
Stomach	*151*	*20*	*(5)*
Male sexual organs	*185, 186*	*19*	*(5)*
Lymphatic and hematopoeitic tissue	*200 - 209*	*19*	*(5)*
Other of digestive tract	*150 - 159 exclud. 151, 153, 154*	*18*	*(5)*
Other of urogenital tract	*188, 189*	*18*	*(5)*
Other codes from	*140 - 209*	*23*	*(6)*
Unclassifiable		*5*	*(1)*
		374[1]	

[1]) *Two patients had a double tumour, viz a mamma carcinoma on both sides and a rectum plus prostate carcinoma.*

In this table lung cancer and breast cancer head the list. Together they form more than a third of the total number (133 of the 374). They are followed by the colon and the rectum, the skin and the female sexual organs, which together also yield a third.

The distribution by localization has been compared with the data from the cancer registration performed by the Queen Wilhelmina Fund in 1969[1]). After applying the same classification and arrangment from high to low the ranking proves to be exactly the same. The percentage distribution, on the other hand, does display some differences; this will be reverted to.

The registration discussed here served solely as a pilot study to investigate whether a number of cases of cancer were not known to the pathological-anatomical laboratories and, if so, how many. The form devised for the purpose was very brief so that, of the questions that arise with regard to this subject, only a few can be approximately answered.

[1]) *Harmse, N.S., Waard, Prof. F. de, Recente ontwikkeling van de kankerfrequentie in drie registratiegebieden in Nederland, T. soc. Geneesk., 51 (1973), p. 670-678.*

The principal question can be answered in the affirmative. In 37 cases (10%) there proved to have been no histological examination. This is more than was stated as an expectation at the annual meeting of co-workers; then the physicians present estimated this number at 2-3%.

At present no definitive pronouncement can be made as to the reason why this examination was not performed. It is, however, clear that age plays a part: in the group without pathological-anatomical examination the age for both sexes is on average 75 years. Of all cancer patients reported, this average is 63 and 65 years for men and women respectively.

In this group more men than women prove to be represented, which fits in with the fact that in a third of the cases lung carcinomas were involved (about 3% of the total). In these cases the diagnosis was often made on the basis of an X-ray photograph. These findings may also partly explain one of the differences from the cancer registration in 1969. In the sentinel stations this category forms 20% of the total, and in the latter registration over 14%. The remaining difference could be explaned by an increase in this form of cancer.

The same reasoning holds good for the colon and mamma carcinoma, though less strongly.

It can further be reported that in this group complaints of and symptoms in the abdomen were registered relatively often.

Summarizing, one may say, even though the numbers are not large, that the general practitioners form an important source for the obtaining of (supplementary) data on the occurrence of cancer.

Further investigation is necessary, with more specific questions.

This investigation will be repeated in a more elaborate form in 1983.

(The data were processed with the aid of Mr. P.A.H. van Noord, M.D., of the Epidemiology Division of the Institute for General Health Care and Epidemiology of Utrecht University.)

SERA COLLECTION AND ANTIBODIES AGAINST INFECTIOUS DISEASES

In 1979 the initiative was taken to build up a serum sample bank of the Dutch population in cooperation with the National Public Health Institute, for the purpose of gaining insight into the immunity status for various infectious diseases vaccinated against as part of the national vaccination programme.

To achieve this aim the spotter physicians were each invited to collect if possible 24 blood samples, namely one from a female and one from a male from each of the following 12 age groups: 10-14 years, 15-19 years etc. up to 60-64 years and older than 64 years. At the same time forms were included for the purpose of collecting data on any infectious diseases suffered and the vaccination history per person.
In the period from January 1980 to August 1981 a total of 810 samples were received from 42 sentinel stations. The blood sample and forms were sent in under code so that the anonymity of those concerned was guaranteed. The groups consisted on average of 34 persons; the smallest group contained 25 persons.

So far determinations have been performed regarding toxoplasmosis, Toxocare and T. spiralis, rubella, measles and polio, diphtheria, tetanus and whooping cough[1]). The value of the investigation would be greatly increased if it could be repeated every five years: in addition to the snapshot an impression is then also obtained of the trend of antibodies in the course of time.

[1]) Reports are obtainable from the National Public Health Institute, Bilthoven.

GENERAL REMARKS

1. The questions on the weekly return for 1983 have been compiled as follows by the Counselling Committee:

   a. Influenza (-like illness)
   b. Diabetes mellitus
   c. Cervical smear
   d. Parkinson's disease
   e. Sterilization of the man performed
   f. Sterilization of the woman performed
   g. Prescription of the morning-after pill
   h. Spontaneous abortion or partus immaturus
   i. Partus at gravidity $\geqslant$ 28 weeks
   j. Depression
   k. (Attempted) suicide
   l. Penicillin, prescriptions and side effects
   m. Myocardial infarction (suspicion of)
   n. Accidents in the private sector
   o. Traumas in sport - knee
      - ankle
      - muscle
      - or tendontraumas
      all other sporttraumas

2. No definite decision has yet been taken about incidental investigations for 1983.

3. Suggestions relating to the questions on the weekly returns will be gladly received by the Counselling Committee and evaluated insofar as they relate to their application to this project.

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

Dr Bertine J.A. Collette.

Appendix 1

Continuous Morbidity Registration, Sentinel Stations
Participating General Practitioners in 1982

Name:	Residence:	Province:
A.A.E.E. Brockmöller*)	't Zand	Groningen
J.Th. Ubbink	Groningen	Groningen
J. Vennema/IJ. Wapstra (group practice)	Franeker	Friesland
S. Vriesinga*)	Oostermeer	Friesland
H.W. Reinking/F.M. van Soest/ R.F. Sparenburg/H.D.W.A. van Gysel (group practice)	Assen	Drenthe
H.E. Maillette de Buy Wenniger*)	Schoonoord	Drenthe
H. Nap	Gramsbergen	Overijssel
Th.J. van Dam/J.B.M. Stolte (group practice)	Swifterbant	Zuidelijke IJsselmeer-polders
E.J. van Apeldoorn	Heerde	Gelderland
Dr S. Rijpma*)	Laren	Gelderland
W. Bodegom*)	Ruurlo	Gelderland
J.H. de Boer/Dr J. van Noort (group practice)*)	Zelhem	Gelderland
F.C.M. Ummels	Velp	Gelderland
J.P. van Dam	Nijmegen	Gelderland
M.A.J. Janssen	Nijmegen	Gelderland
Mw. I.K.I. de Jongh-Kilian/F.K.A. Fokkema (group practice)	Amersfoort	Utrecht
P.J. Kromeich/J.J. Dijkstra (group practice)	Utrecht	Utrecht
W.J. van Bodegom*)	Linschoten	Utrecht
M.M. Spoor	Alkmaar	Noord-Holland
C.W. Willeboordse	Heiloo	Noord-Holland
C. den Hartoog*)	Broek in Waterland	Noord-Holland
D.E. Kuenen	Haarlem	Noord-Holland
Mw. P.J. Ypenburg-Visser (till 1-4-1982) Mw. A.M. Reijnierse (from 1-4-1982)	Amsterdam	Noord-Holland
Mw. A.J. Arbouw/J.Th. Koop (group practice)	Amstelveen	Noord-Holland
H.J. van der Leen	Hilversum	Noord-Holland

Appendix 1 (continuation)

Participating General Practitioners in 1982

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

*) With dispensary

Appendix 2

Weekly return for central registration

Appendix 3

Subjects on the weekly returns in alphabetical order 1970 - 1983

Subject	
Abortion (spontaneous)	*1982 - 1983*
Abortion (request)	*1970 - 1975*
Abortus provocatus	*1971 - 1979*
Accidents	*1971*
Accidents in the private sector	*1981 - 1983*
Alcoholism	*1975*
Anti-hypertensivum or diuretic (prescription)	*1976*
Battered child syndrome (suspicion of)	*1973 - 1974*
Cervical smear	*1976 - 1983*
Diabetes mellitus	*1980 - 1983*
Diarrhoea e causa ignota (acute)	*1970*
Depression	*1983*
Drug-use (consultation)	*1972 - 1973 and 1979 - 1982*
Dwelling (certificate for another)	*1975*
Exanthema e causa ignota	*1970*
Hay fever	*1978 - 1982*
Family planning (consultations)	*1970 - 1976*
Influenza (-like illness)	*1970 - 1983*
Measles	*1975 - 1979*
Mononucleosis infectiosa	*1977 - 1979*
Morning-after pill (prescription)	*1972 - 1983*
Myocardial infarction (suspicion of)	*1978 and 1983*
Otitis media acuta	*1971*
Parkinson's disease	*1980 - 1983*
Partus immaturus	*1982 - 1983*
Partus at gravidity $\geqslant$ 28 weeks	*1982 - 1983*
Penicillin (prescriptions and side effects)	*1982 - 1983*
Psoriasis	*1976 - 1977*
Rubella (-like illness)	*1971*
Skull traumas in traffic	*1975 - 1977*
Smoking (consultation with regard to addiction)	*1974*
Sport(trauma)	*1979 - 1983*
Sterilization of the man performed	*1972 - 1983*
Sterilization of the woman performed	*1974 - 1983*
Suicide (attempted)	*1970 - 1972 and 1979 - 1983*
Tonsillectomy or adenotomy	*1971*
Tranquillizer (prescription)	*1972 - 1974*
Ulcus ventriculi/duodeni	*1975*
Urinary tract infection (prescription of medicine)	*1977*

Appendix 4

Age structure of the population of the Netherlands by sex, in thousands, 1 January 1982 (C.B.S.).

Age	*Men*	*Women*	*Total*[1])
0 - 4	*454*	*434*	888
5 - 9	*496*	*475*	971
10 - 14	*621*	*593*	1 214
15 - 19	*644*	*614*	1 258
20 - 24	*626*	*603*	1 229
25 - 34	*1 206*	*1 146*	2 352
35 - 44	*964*	*900*	1 864
45 - 54	*756*	*751*	1 507
55 - 64	*634*	*700*	1 334
⩾ 65	*681*	*988*	1 669
Total	*7 082*	*7 204*	14 286

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

TABEL 1A

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1E KWARTAAL 1982 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			INFLU ENZA	DIAB MELL	KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
< 1 JR	938	821	1759	284	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3634	3634	7268	282	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	5479	5368	10847	171	-	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	6763	6674	13437	129	-	-	-	-	-	-	-	-	-	-	-	-
15 - 19 JR	7061	7142	14202	144	1	4	14	1	-	-	-	-	-	-	1	-
20 - 24 JR	7210	7485	14695	161	1	29	112	44	25	-	1	8	5	31	1	5
25 - 34 JR	13833	13633	27466	159	1	37	145	101	78	-	35	28	31	18	1	4
35 - 44 JR	9699	9444	19143	184	3	25	100	82	123	-	54	37	45	11	1	2
45 - 54 JR	8219	8431	16650	154	5	26	78	60	114	-	7	4	5	1	1	2
55 - 64 JR	6831	7379	14211	153	5	5	22	37	37	1	-	-	-	-	-	1
> 64 JR	6992	10053	17045	145	12	6	4	2	3	5	-	-	-	-	1	2
TOTAAL	76658	80065	156723	164	3	16	59	41	46	1	14	10	12	9	1	2

N.B. Als gevolg van het afronden bij de berekeningen kunnen kleine verschillen in de totalen zijn ontstaan.
Voor spontane abortus, partus immaturus en partus à terme wordt naar het betreffende hoofdstuk verwezen.

TABEL 1A (VERVOLG) CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1E KWARTAAL 1982 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
< 1 JR	938	821	1759	-	-	608	51	6	149	49	102	-	-	-	-
1 - 4 JR	3634	3634	7268	-	-	548	51	12	248	179	213	4	-	-	-
5 - 9 JR	5479	5368	10847	-	-	296	16	3	159	50	105	29	1	-	-
10 - 14 JR	6763	6674	13437	-	-	135	10	2	90	64	77	93	-	9	1
15 - 19 JR	7061	7142	14202	3	7	107	4	2	89	59	74	130	13	23	5
20 - 24 JR	7210	7485	14695	7	138	122	6	1	55	57	56	104	5	18	5
25 - 34 JR	13833	13633	27466	23	153	130	6	1	56	40	48	56	4	10	4
35 - 44 JR	9699	9444	19143	2	23	142	6	3	54	50	52	35	3	8	4
45 - 54 JR	8219	8431	16650	-	-	114	7	2	69	47	58	19	1	5	1
55 - 64 JR	6831	7379	14211	-	-	120	13	2	41	58	50	5	-	1	1
> 64 JR	6992	10053	17045	-	-	260	34	5	56	65	61	4	-	-	-
TOTAAL	76658	80065	156723	5	42	177	13	3	79	59	69	49	3	8	2

TABEL 18 CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

2E KWARTAAL 1982 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			INFLU ENZA	DIAB MELL	KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
< 1 JR	926	809	1734	110	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3604	3612	7215	121	-	-	-	-	-	-	-	-	-	-	8	-
5 - 9 JR	5442	5328	10770	107	-	-	-	-	-	-	-	-	-	-	16	-
10 - 14 JR	6666	6567	13233	57	1	-	-	-	-	-	-	-	-	3	30	-
15 - 19 JR	6885	6969	13854	58	1	1	3	3	1	-	-	1	1	43	43	1
20 - 24 JR	7012	7237	14248	64	-	17	64	25	14	-	3	1	2	30	37	4
25 - 34 JR	13544	13391	26935	75	0	28	90	70	75	-	22	31	26	10	20	2
35 - 44 JR	9563	9294	18857	80	3	27	62	72	113	-	52	39	46	9	19	3
45 - 54 JR	8009	8209	16218	72	6	19	44	33	90	-	4	5	4	-	10	1
55 - 64 JR	6633	7157	13790	75	7	11	20	20	35	-	2	-	1	-	2	1
> 64 JR	6785	9695	16480	61	16	4	4	2	3	4	-	-	-	-	1	2
TOTAAL	75069	78267	153336	74	3	13	36	29	41	0	11	11	11	10	19	2

TABEL 1B (VERVOLG) CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

2E KWARTAAL 1982 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
< 1 JR	926	809	1734	-	-	369	121	12	54	49	52	-	-	-	-
1 - 4 JR	3604	3612	7215	-	-	349	134	7	219	141	180	1	-	-	-
5 - 9 JR	5442	5328	10770	-	-	189	49	2	112	60	86	9	-	-	-
10 - 14 JR	6666	6567	13233	-	-	96	16	2	95	53	74	63	4	8	-
15 - 19 JR	6885	6969	13854	-	16	89	10	1	89	59	74	110	7	14	9
20 - 24 JR	7012	7237	14248	18	145	114	13	1	66	29	47	75	13	15	6
25 - 34 JR	13544	13391	26935	15	154	117	14	2	41	34	38	46	4	10	3
35 - 44 JR	9563	9294	18857	3	24	102	15	1	54	39	47	30	4	8	5
45 - 54 JR	8009	8209	16218	-	1	97	17	2	32	41	37	8	-	7	1
55 - 64 JR	6633	7157	13790	-	-	103	28	4	26	49	38	3	1	1	1
> 64 JR	6785	9695	16480	-	-	151	55	5	49	53	51	1	-	-	-
TOTAAL	75069	78267	153336	5	45	130	29	2	66	49	58	36	3	7	3

TABEL 1C

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

3E KWARTAAL 1982 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	CERVIXUITSTRIJKJE HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER-PILL	HOOI KOORTS	SUICIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
< 1 JR	856	748	1604	62	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3295	3307	6602	77	-	-	-	-	-	-	-	-	-	-	2	-
5 - 9 JR	4996	4879	9875	36	-	-	-	-	-	-	-	-	-	-	2	-
10 - 14 JR	6148	6054	12202	33	-	-	-	-	-	-	-	-	-	2	9	-
15 - 19 JR	6387	6455	12843	29	-	2	14	3	3	-	-	-	-	29	9	1
20 - 24 JR	6505	6792	13297	47	-	12	62	35	28	-	3	6	5	25	6	5
25 - 34 JR	12569	12409	24979	35	1	23	98	69	73	-	25	26	26	12	3	2
35 - 44 JR	8833	8593	17426	41	2	14	52	62	101	-	35	34	34	8	5	3
45 - 54 JR	7408	7603	15011	47	6	14	51	34	87	-	9	1	5	-	1	2
55 - 64 JR	6155	6639	12794	30	11	8	20	14	21	-	-	-	-	-	-	4
> 64 JR	6284	9021	15305	31	16	1	7	4	1	6	-	-	-	-	-	1
TOTAAL	69436	72501	141937	39	4	9	38	28	39	1	10	9	10	8	4	2

TABEL 1C (VERVOLG) CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

3E KWARTAAL 1982 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
< 1 JR	856	748	1604	-	-	256	100	-	70	67	69	-	-	-	-
1 - 4 JR	3295	3307	6602	-	-	262	141	3	194	106	150	-	-	-	-
5 - 9 JR	4996	4879	9875	-	-	196	57	2	122	66	94	13	1	1	-
10 - 14 JR	6148	6054	12202	-	-	113	25	2	93	83	88	45	1	6	-
15 - 19 JR	6387	6455	12843	5	17	107	20	3	69	62	65	74	8	16	-
20 - 24 JR	6505	6792	13297	16	163	99	16	2	74	37	55	58	9	14	5
25 - 34 JR	12569	12409	24979	19	187	100	15	3	37	36	37	38	4	10	4
35 - 44 JR	8833	8593	17426	7	27	102	24	1	43	56	49	23	1	4	1
45 - 54 JR	7408	7603	15011	-	-	104	18	1	50	33	41	10	-	3	1
55 - 64 JR	6155	6639	12794	-	-	80	32	3	41	65	53	2	-	-	-
> 64 JR	6284	9021	15305	-	-	114	52	5	37	78	61	2	1	-	-
TOTAAL	69436	72501	141937	6	52	118	33	2	65	58	61	28	3	6	1

TABEL 1D CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

4E KWARTAAL 1982 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	CERVIXUITSTRIJKJE HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
< 1 JR	930	807	1737	351	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3571	3588	7159	423	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	5404	5283	10688	321	2	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	6648	6554	13202	170	-	-	-	-	-	-	-	-	-	-	-	-
15 - 19 JR	6907	6998	13905	155	-	9	7	3	1	-	-	-	-	19	1	2
20 - 24 JR	7038	7310	14348	169	1	33	78	51	22	-	1	7	4	21	1	5
25 - 34 JR	13548	13381	26929	186	0	41	87	67	78	-	42	33	38	15	0	3
35 - 44 JR	9532	9288	18820	215	2	30	75	46	129	-	43	30	37	16	1	3
45 - 54 JR	8047	8254	16301	188	2	24	40	28	95	-	6	4	5	4	-	2
55 - 64 JR	6655	7183	13839	215	4	7	18	26	42	1	2	-	1	-	-	1
> 64 JR	6808	9776	16583	216	7	5	1	2	1	2	-	-	-	-	-	2
TOTAAL	75089	78421	153510	212	2	18	38	27	45	0	14	10	12	8	0	2

TABEL 1D (VERVOLG) CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

4E KWARTAAL 1982 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
< 1 JR	930	807	1737	-	-	535	138	12	118	112	115	-	-	-	-
1 - 4 JR	3571	3588	7159	-	-	419	299	10	190	84	137	4	-	1	-
5 - 9 JR	5404	5283	10688	-	-	237	95	2	105	53	80	9	-	-	-
10 - 14 JR	6648	6554	13202	-	-	120	26	2	105	64	85	54	2	8	2
15 - 19 JR	6907	6998	13905	4	21	126	37	3	83	44	63	91	13	15	4
20 - 24 JR	7038	7310	14348	18	142	125	31	2	64	47	55	70	8	16	6
25 - 34 JR	13548	13381	26929	18	196	111	27	1	32	34	33	34	9	9	3
35 - 44 JR	9532	9288	18820	2	18	111	35	1	41	51	46	26	2	5	6
45 - 54 JR	8047	8254	16301	-	-	117	28	2	25	34	29	7	-	1	-
55 - 64 JR	6655	7183	13839	-	-	99	46	1	35	40	38	3	-	-	-
> 64 JR	6808	9776	16583	-	-	153	87	2	26	80	58	-	-	-	-
TOTAAL	75089	78421	153510	5	51	147	56	2	60	51	56	30	4	6	2

TABEL 1E CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1982 TOTAAL PER 10.000

LEEFTIJDS-GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	CERVIXUITSTRIJKJE HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
< 1 JR	912	796	1709	819	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3526	3535	7061	915	-	-	-	-	-	-	-	-	-	-	10	-
5 - 9 JR	5331	5215	10545	644	2	-	-	-	-	-	-	-	-	-	18	-
10 - 14 JR	6556	6462	13019	395	1	-	-	-	-	-	-	-	-	5	40	-
15 - 19 JR	6810	6891	13701	393	1	16	38	10	6	-	-	1	1	109	55	9
20 - 24 JR	6941	7206	14147	448	1	92	318	155	89	-	9	22	16	107	45	18
25 - 34 JR	13374	13204	26577	461	3	130	422	307	304	-	125	117	121	56	25	11
35 - 44 JR	9407	9155	18561	527	10	97	292	262	468	-	185	140	163	44	25	10
45 - 54 JR	7921	8124	16045	467	18	85	214	156	387	-	27	14	20	5	13	7
55 - 64 JR	6569	7090	13659	480	26	31	79	97	135	2	3	-	1	-	2	7
> 64 JR	6717	9636	16353	461	50	17	16	10	8	18	-	-	-	-	2	7
TOTAAL	74063	77314	151377	497	12	57	171	126	170	2	50	40	45	35	24	8

TABEL 1E (VERVOLG) CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1982 TOTAAL PER 10.000

LEEFTIJDS-GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
< 1 JR	912	796	1709	-	-	1785	410	29	395	276	339	-	-	-	-
1 - 4 JR	3526	3535	7061	-	-	1590	625	33	854	512	683	10	-	1	-
5 - 9 JR	5331	5215	10545	-	-	922	216	9	499	228	365	61	2	1	-
10 - 14 JR	6556	6462	13019	-	-	465	77	7	383	263	323	257	6	31	2
15 - 19 JR	6810	6891	13701	12	61	429	72	9	330	223	277	407	40	69	18
20 - 24 JR	6941	7206	14147	58	584	462	66	6	258	171	213	310	35	62	22
25 - 34 JR	13374	13204	26577	75	686	459	62	8	167	145	156	175	21	39	14
35 - 44 JR	9407	9155	18561	14	93	457	79	4	192	194	193	114	9	25	16
45 - 54 JR	7921	8124	16045	-	1	433	70	7	177	156	166	44	1	16	2
55 - 64 JR	6569	7090	13659	-	-	404	118	10	142	212	178	13	1	1	1
> 64 JR	6717	9636	16353	-	-	686	227	17	168	274	231	7	1	-	-
TOTAAL	74063	77314	151377	21	188	574	131	10	271	217	244	144	13	27	9

TABEL 2A

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1E KWARTAAL 1982 PER 10.000

PROVINCIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	CERVIXUITSTRIJKJE HERH ONDZ	CERVIXUITSTRIJKJE ZIEK PARK	STERILISATIE VERRICHT			MORN- AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
GR+FR+DR	10346	10847	21193	275	3	30	50	31	20	1	15	14	14	9	1	3
OV+GLD+ZYP	13357	13435	26791	183	2	13	56	40	37	1	14	10	12	12	0	2
UTR+NH+ZH	36257	38614	74871	126	3	14	66	48	64	0	12	9	10	9	1	3
ZLD+NB+LIM	16699	17169	33868	163	4	15	52	33	29	1	19	11	15	7	0	1
TOTAAL	76658	80065	156723	164	3	16	59	41	46	1	14	10	12	9	1	2

TABEL 2A (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1E KWARTAAL 1982 PER 10.000

PROVINCIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER		SPORTLETSELS ONGEVAL			SPORTLETSELS SURMENAGE	
											EERSTE	RECIDI		EERSTE	RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
GR+FR+DR	10346	10847	21193	2	43	243	27	2	92	60	76	77	1	8	2
OV+GLD+ZYP	13357	13435	26791	7	42	141	16	4	57	47	52	52	5	13	6
UTR+NH+ZH	36257	38614	74871	5	37	153	6	3	60	48	54	36	2	7	1
ZLD+NB+LIM	16699	17169	33868	6	54	216	18	2	133	94	113	58	3	7	1
TOTAAL	76658	80065	156723	5	42	177	13	3	79	59	69	49	3	8	2

TABEL 2B

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

2E KWARTAAL 1982 PER 10.000

PROVINCIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER -PILL	HOOI KOORTS	SUICIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
GR+FR+DR	10084	10572	20656	118	6	13	37	16	22	0	6	9	7	7	13	2
OV+GLD+ZYP	13614	13622	27236	88	3	17	31	32	32	1	14	13	14	10	34	2
UTR+NH+ZH	34473	36696	71168	58	3	10	36	31	55	0	9	10	10	10	17	1
ZLD+NB+LIM	16898	17377	34276	70	3	17	38	29	29	0	17	12	14	10	14	1
TOTAAL	75069	78267	153336	74	3	13	36	29	41	0	11	11	11	10	19	2

TABEL 2B (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

2E KWARTAAL 1982 PER 10.000

PROVINCIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER		SPORTLETSELS ONGEVAL			SPORTLETSELS SURMENAGE	
											EERSTE	RECIDI		EERSTE	RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
GR+FR+DR	10084	10572	20656	3	49	168	41	2	59	36	47	50	3	4	1
OV+GLD+ZYP	13614	13622	27236	6	35	102	36	1	71	49	60	35	8	10	7
UTR+NH+ZH	34473	36696	71168	4	44	104	17	3	47	35	41	28	2	8	2
ZLD+NB+LIM	16898	17377	34276	6	51	182	44	2	107	87	97	46	2	5	1
TOTAAL	75069	78267	153336	5	45	130	29	2	66	49	58	36	3	7	3

TABEL 2C

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

3E KWARTAAL 1982 PER 10.000

PROVINCIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN- AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
GR+FR+DR	9609	10068	19678	49	3	16	25	19	27	1	16	7	11	6	4	2
OV+GLD+ZYP	12151	12161	24312	63	4	12	35	30	26	2	7	12	9	8	10	0
UTR+NH+ZH	32896	35066	67962	26	5	7	41	35	53	0	9	9	9	9	3	3
ZLD+NB+LIM	14780	15206	29986	42	2	7	44	17	23	1	12	9	10	8	1	2
TOTAAL	69436	72501	141937	39	4	9	38	28	39	1	10	9	10	8	4	2

TABEL 2C (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

3E KWARTAAL 1982 PER 10.000

PROVINCIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	VOLG KEER	REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	ONGEVAL RECIDI	SURMENAGE EERSTE	SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
GR+FR+DR	9609	10068	19678	7	88	166	49	4	78	46	61	30	5	3	1
OV+GLD+ZYP	12151	12161	24312	9	47	107	36	1	88	71	79	29	5	11	4
UTR+NH+ZH	32896	35066	67962	5	43	101	21	2	35	47	41	22	1	6	1
ZLD+NB+LIM	14780	15206	29986	6	55	135	46	3	104	80	92	40	2	3	0
TOTAAL	69436	72501	141937	6	52	118	33	2	65	58	61	28	3	6	1

TABEL 2D

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

4E KWARTAAL 1982 PER 10.000

PROVINCIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	CERVIXUITSTRIJKJE HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER -PILL	HOOI KOORTS	SUICIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
GR+FR+DR	9881	10385	20267	240	2	35	44	17	19	0	7	12	9	9	-	2
OV+GLD+ZYP	13848	13905	27753	279	1	22	25	27	29	2	16	11	13	9	-	0
UTR+NH+ZH	34736	37058	71794	203	2	12	40	35	67	-	12	9	11	7	1	3
ZLD+NB+LIM	16624	17073	33697	161	1	19	40	18	25	-	20	11	15	11	-	2
TOTAAL	75089	78421	153510	212	2	18	38	27	45	0	14	10	12	8	0	2

TABEL 2D (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

4E KWARTAAL 1982 PER 10.000

PROVINCIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
GR+FR+DR	9881	10385	20267	6	50	150	107	3	73	52	62	36	5	7	2
OV+GLD+ZYP	13848	13905	27753	5	56	150	62	0	86	70	78	39	8	8	5
UTR+NH+ZH	34736	37058	71794	5	43	138	35	2	41	38	40	23	2	5	1
ZLD+NB+LIM	16624	17073	33697	6	63	160	67	3	70	63	67	37	3	5	1
TOTAAL	75089	78421	153510	5	51	147	56	2	60	51	56	30	4	6	2

TABEL 2E

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1982 TOTAAL PER 10.000

PROVINCIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	CERVIXUITSTRIJKJE HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN- AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
GR+FR+DR	9980	10468	20448	689	14	95	157	84	88	3	43	41	42	31	18	10
OV+GLD+ZYP	13242	13281	26523	626	10	65	146	129	125	6	52	45	49	39	44	5
UTR+NH+ZH	34590	36859	71449	418	13	44	183	149	239	1	43	37	40	35	21	9
ZLD+NB+LIM	16250	16706	32957	443	10	58	174	98	105	2	68	43	55	37	15	6
TOTAAL	74063	77314	151377	497	12	57	171	126	170	2	50	40	45	35	24	8

TABEL 2E (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1982 TOTAAL PER 10.000

PROVINCIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
GR+FR+DR	9980	10468	20448	17	229	731	223	12	302	194	246	195	14	23	7
OV+GLD+ZYP	13242	13281	26523	27	181	501	151	7	301	236	269	155	26	41	22
UTR+NH+ZH	34590	36859	71449	18	167	499	78	10	183	168	176	108	9	25	6
ZLD+NB+LIM	16250	16706	32957	24	220	698	175	10	415	324	369	180	10	20	5
TOTAAL	74063	77314	151377	21	189	574	131	10	271	217	244	144	13	27	9

TABEL 3A

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1E KWARTAAL 1982 PER 10.000

URBANISATIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER -PILL	HOOI KOORTS	SUICIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
A1+A4	13078	12697	25775	135	2	20	71	40	17	1	13	12	12	8	0	2
B1-B3+C1-C4	46576	49051	95627	152	3	11	54	41	43	1	14	8	11	8	0	2
C5	17004	18317	35321	216	4	29	63	42	74	0	15	14	14	11	3	4
TOTAAL	76658	8C065	156723	164	3	16	59	41	46	1	14	10	12	9	1	2

TABEL 3A (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1E KWARTAAL 1982 PER 10.000

URBANISATIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
A1+A4	13078	12697	25775	6	46	147	23	3	57	50	53	52	4	10	5
B1-B3+C1-C4	46576	49051	95627	5	41	168	9	3	86	52	68	50	2	6	1
C5	17004	18317	35321	5	43	223	16	3	80	85	83	44	4	12	3
TOTAAL	76658	8C065	156723	5	42	177	13	3	79	59	69	49	3	8	2

TABEL 3B

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

2E KWARTAAL 1982 PER 10.000

URBANISATIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN- AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
A1+A4	13578	13189	26766	56	2	17	45	29	19	1	12	13	12	6	38	1
B1-B3+C1-C4	45734	48089	93824	67	4	8	28	26	39	0	10	10	10	9	13	1
C5	15757	16989	32746	111	4	25	51	35	63	-	15	11	13	15	19	4
TOTAAL	75069	78267	153336	74	3	13	36	29	41	0	11	11	11	10	19	2

TABEL 3B (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

2E KWARTAAL 1982 PER 10.000

URBANISATIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	VOLG KEER	REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	RECIDI	SURMENAGE EERSTE	RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
A1+A4	13578	13189	26766	4	30	109	40	1	52	48	50	35	6	9	5
B1-B3+C1-C4	45734	48089	93824	5	42	128	26	3	67	46	56	35	2	5	2
C5	15757	16989	32746	5	64	151	30	2	76	59	67	40	4	11	5
TOTAAL	75069	78267	153336	5	45	130	29	2	66	49	58	36	3	7	3

TABEL 3C

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

3E KWARTAAL 1982 PER 10.000

URBANISATIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
A1+A4	12024	11664	23689	36	3	19	45	25	21	1	7	13	10	3	15	-
B1-B3+C1-C4	43048	45333	88381	28	3	5	29	24	39	0	12	9	10	8	1	2
C5	14364	15504	29868	73	7	14	59	43	51	1	9	6	8	14	1	4
TOTAAL	69436	72501	141937	39	4	9	38	28	39	1	10	9	10	8	4	2

TABEL 3C (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

3E KWARTAAL 1982 PER 10.000

URBANISATIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
A1+A4	12024	11664	23689	9	52	136	36	2	78	64	71	31	3	6	3
B1-B3+C1-C4	43048	45333	88381	5	52	113	31	3	64	50	57	27	2	5	1
C5	14364	15504	29868	7	54	118	38	1	56	76	67	28	3	8	2
TOTAAL	69436	72501	141937	6	52	118	33	2	65	58	61	28	3	6	1

TABEL 3D

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

4E KWARTAAL 1982 PER 10.000

URBANISATIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	CERVIXUITSTRIJKJE HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER-PILL	HOOI KOORTS	SUICIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
A1+A4	13292	12911	26202	206	2	22	41	21	12	2	16	15	15	9	1	-
B1-B3+C1-C4	45646	48021	93667	174	1	14	36	26	44	-	14	9	11	8	0	2
C5	16151	17490	33641	324	3	28	40	37	70	-	12	11	11	11	-	3
TOTAAL	75089	78421	153510	212	2	18	38	27	45	0	14	10	12	8	0	2

TABEL 3D (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

4E KWARTAAL 1982 PER 10.000

URBANISATIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	PENICILLINE VOLG KEER	PENICILLINE REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	SPORTLETSELS ONGEVAL RECIDI	SPORTLETSELS SURMENAGE EERSTE	SPORTLETSELS SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
A1+A4	13292	12911	26202	5	50	166	89	1	77	65	71	40	5	6	3
B1-B3+C1-C4	45646	48021	93667	4	47	136	45	2	54	45	49	29	3	4	1
C5	16151	17490	33641	9	63	162	63	2	64	58	61	26	4	11	5
TOTAAL	75089	78421	153510	5	51	147	56	2	60	51	56	30	4	6	2

TABEL 3E

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1982 TOTAAL PER 10.000

URBANISATIE GROEP	POPULATIE			INFLU ENZA	DIAB MELL	CERVIXUITSTRIJKJE KLACH SYMP	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN-AFTER -PILL	HOOI KOORTS	SUI CIDE POGING
	M	V	T	M+V	M+V	V	V	V	V	M+V	M	V	T	V	M+V	M+V
A1+A4	12993	12615	25608	440	9	78	203	115	68	5	48	52	50	26	55	2
B1-B3+C1-C4	45251	47623	92875	426	10	37	148	117	165	2	50	36	43	32	15	6
C5	15819	17075	32894	740	18	98	212	157	261	1	51	43	47	51	23	15
TOTAAL	74063	77314	151377	497	12	57	171	126	170	2	50	40	45	35	24	8

TABEL 3E (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1982 TOTAAL PER 10.000

URBANISATIE GROEP	POPULATIE			SPONT ABORT P.IMM	PART GRAV >28W	PENICILLINE EERST KEER	VOLG KEER	REAC TIE	ONGEVALLEN PRIVESFEER			SPORTLETSELS ONGEVAL EERSTE	ONGEVAL RECIDI	SURMENAGE EERSTE	SURMENAGE RECIDI
	M	V	T	V	V	M+V	M+V	M+V	M	V	T	M+V	M+V	M+V	M+V
A1+A4	12993	12615	25608	23	178	557	189	6	263	226	245	159	19	32	16
B1-B3+C1-C4	45251	47623	92875	18	180	547	110	11	271	193	231	141	10	20	5
C5	15819	17075	32894	26	224	662	146	9	278	279	278	138	15	42	15
TOTAAL	74063	77314	151377	21	188	574	131	10	271	217	244	144	13	27	9

Tabel 4a

Continue morbiditeitsregistratie peilstations

Aantal patiënten met influenza(-achtig ziektebeeld), per week, per 10.000 inwoners, 1982-1983 (t/m 13e week).

Week nr. 1982	Aantal patiënten							
	Provinciegroep				Urbanisatiegroep			Totaal
	A	B	C	D	1	2	3	
1	13	9	5	14	6	9	9	8
2	15	11	4	11	6	8	10	8
3	28	16	4	11	8	11	13	11
4	16	4	6	13	2	11	7	8
5	26	11	6	12	6	10	17	11
6	13	18	7	13	12	10	14	11
7	16	14	7	15	6	10	19	11
8	11	14	10	10	8	9	19	11
9	13	17	12	21	12	15	17	15
10	28	12	12	10	6	12	26	14
11	24	9	19	13	5	18	23	17
12	43	24	15	10	29	17	13	19
13	30	23	20	9	26	14	29	20
14	14	14	14	7	12	10	18	12
15	16	11	8	5	7	8	14	9
16	8	10	6	2	6	6	8	6
17	6	10	4	5	3	6	5	5
18	16	5	4	9	4	6	10	7
19	6	5	4	5	2	5	6	4
20	7	4	3	9	3	6	5	5
21	7	2	2	7	1	4	7	4
22	4	3	2	3	1	2	5	2
23	4	2	2	6	1	3	8	3
24	8	3	3	4	2	3	7	4
25	15	11	3	7	11	6	7	7
26	9	7	3	2	5	2	11	5
27	3	6	2	4	3	2	8	4
28	1	9	3	3	7	2	7	4
29	4	5	3	2	4	2	9	3
30	1	3	1	1	1	1	2	1
31	-	1	1	4	1	1	3	2
32	-	4	1	3	-	1	5	2

Tabel 4a (vervolg)

Week nr. 1982	Aantal patiënten							
	Provinciegroep				Urbanisatiegroep			Totaal
	A	B	C	D	1	2	3	
33	-	1	1	3	-	2	0	1
34	2	2	1	4	1	3	1	2
35	2	5	1	0	4	1	2	2
36	4	7	2	5	5	4	4	4
37	8	4	2	3	2	3	8	4
38	11	6	3	5	3	3	11	5
39	10	7	3	5	3	3	10	5
40	10	8	6	4	5	3	15	6
41	12	7	8	3	8	3	19	7
42	8	8	4	6	2	4	12	6
43	6	7	4	11	5	6	8	6
44	2	11	5	6	6	5	9	6
45	9	7	6	5	4	5	13	7
46	15	13	5	5	8	5	18	8
47	12	19	9	4	13	7	15	10
48	8	15	9	8	10	9	13	10
49	22	37	32	20	30	26	39	29
50	39	50	31	19	40	26	49	33
51	48	41	45	27	31	35	63	41
52	49	54	37	39	43	38	53	42
1983								
1	33	29	34	34	32	31	39	33
2	35	21	16	18	17	18	29	20
3	34	18	13	17	16	18	17	18
4	25	19	12	17	16	12	28	16
5	17	15	7	16	13	10	14	11
6	17	13	7	11	12	8	15	10
7	13	13	4	20	10	10	9	10
8	9	19	11	26	11	13	25	14
9	12	10	10	21	6	12	18	12
10	12	14	7	14	2	9	18	10
11	12	9	6	10	7	7	14	8
12	15	8	6	9	7	7	10	7
13	7	8	6	8	5	6	9	6

Figuur 1

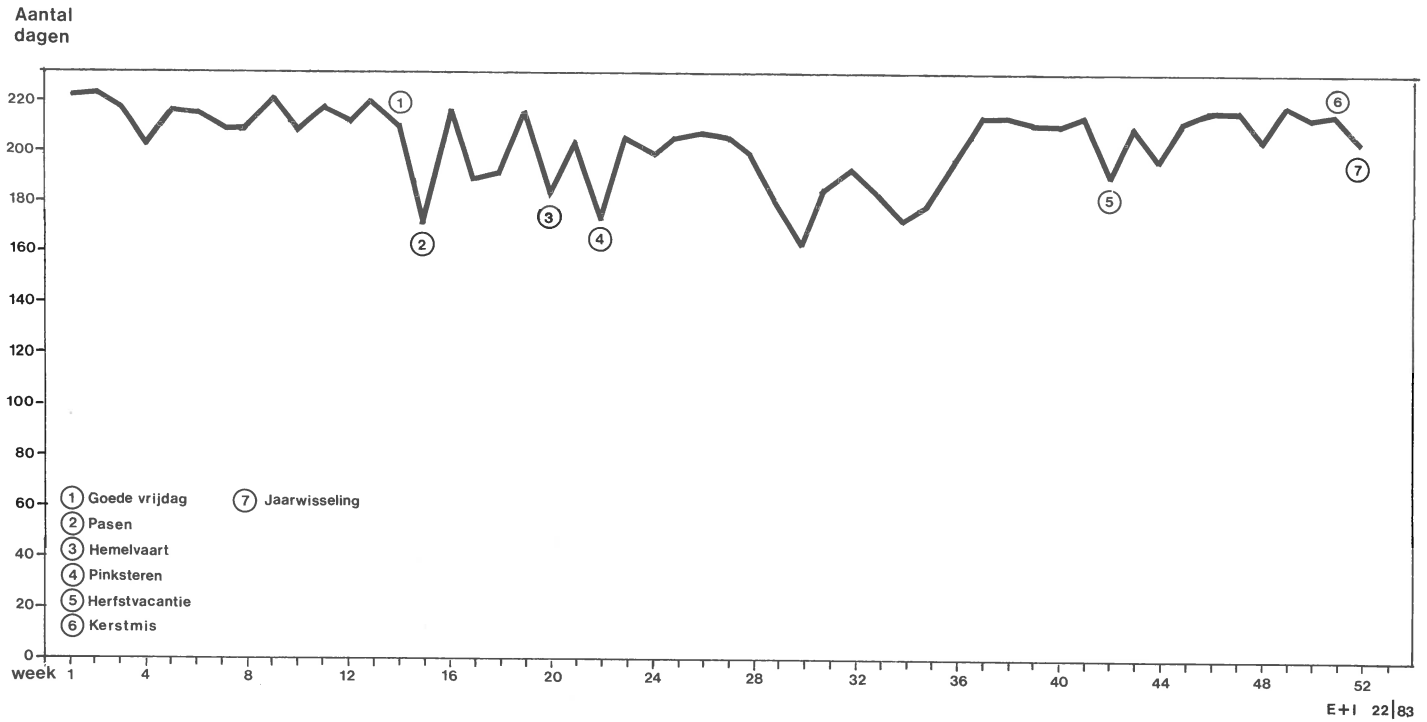
PEILSTATIONS

CONTINUE MORBIDITEITS REGISTRATIE

1982

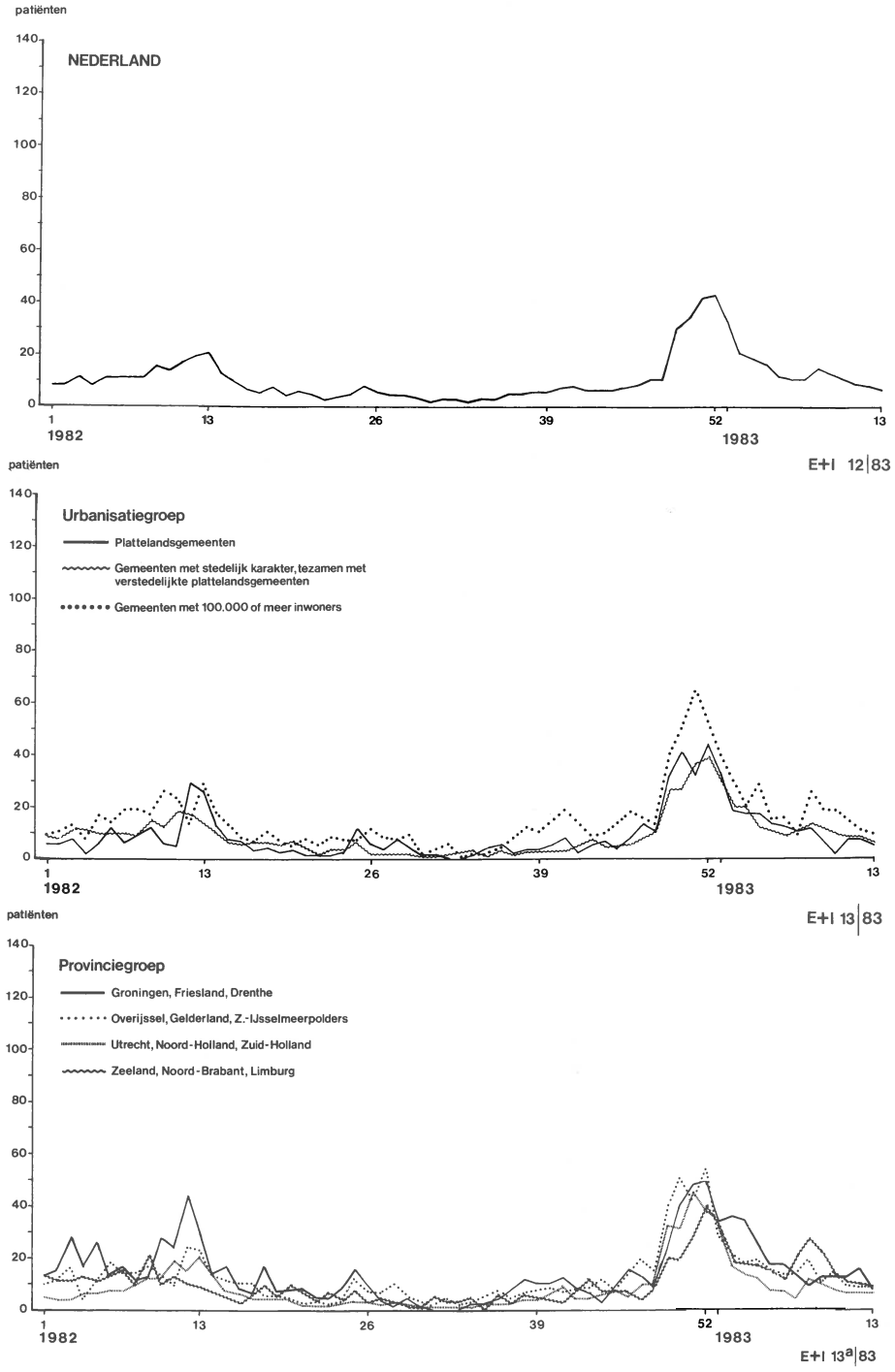
Figuur 2

Het aantal dagen, dat in 1982 per week is gerapporteerd



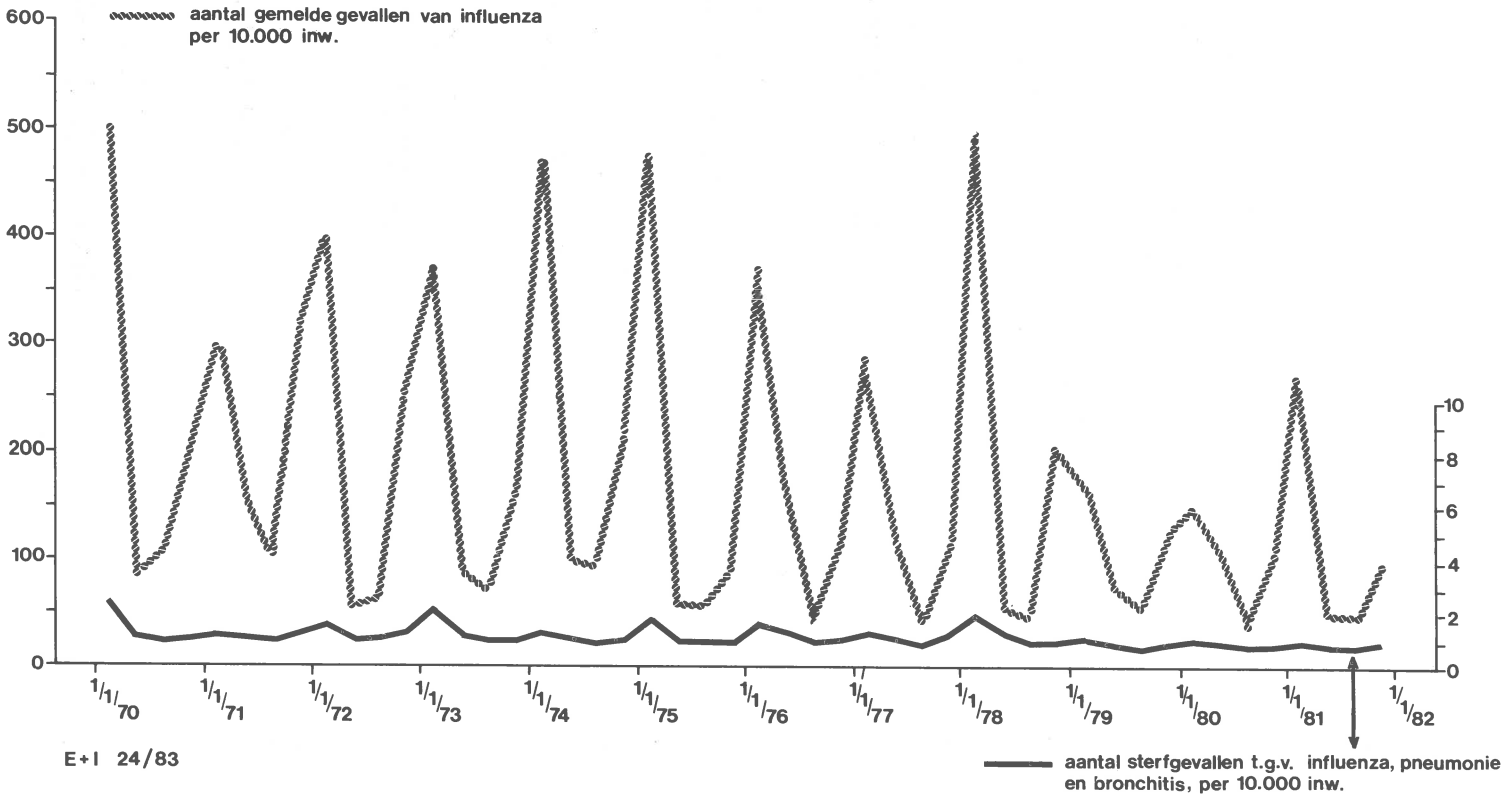
Figuur 3

Aantal patiënten met influenza(-achtig ziektebeeld) per week en per 10.000 inwoners, 1982 - 1983 (t/m 13e week)



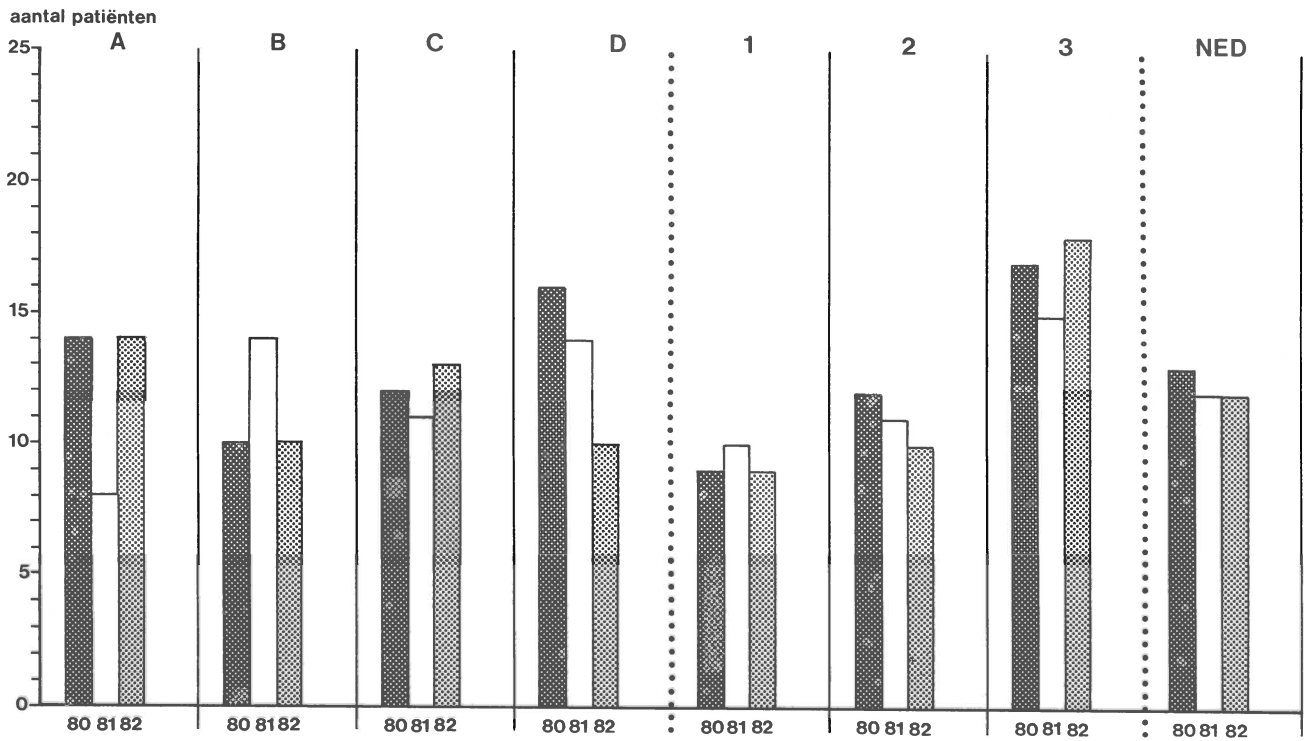
Figuur 4

Aantal gemelde gevallen van influenza(-achtig ziektebeeld) en aantal sterfgevallen t.g.v. influenza, pneumonie en bronchitis (ICD-code, zie de tekst) per 10.000 inwoners per kwartaal, 1970 - 1982. (Let op tweeërlei schaal van de Y-as)



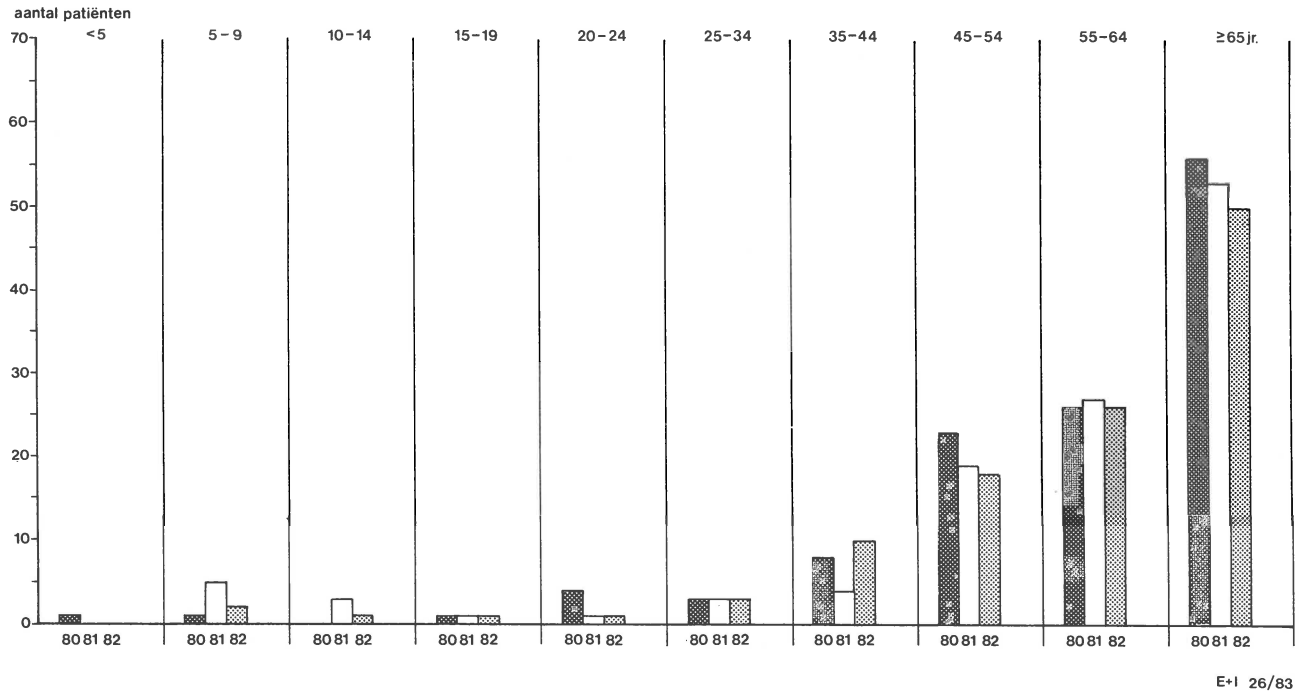
Figuur 5

Aantal nieuwe patiënten met diabetes mellitus, per provincie- en urbanisatiegroep, per 10.000 inwoners, 1980 - 1982



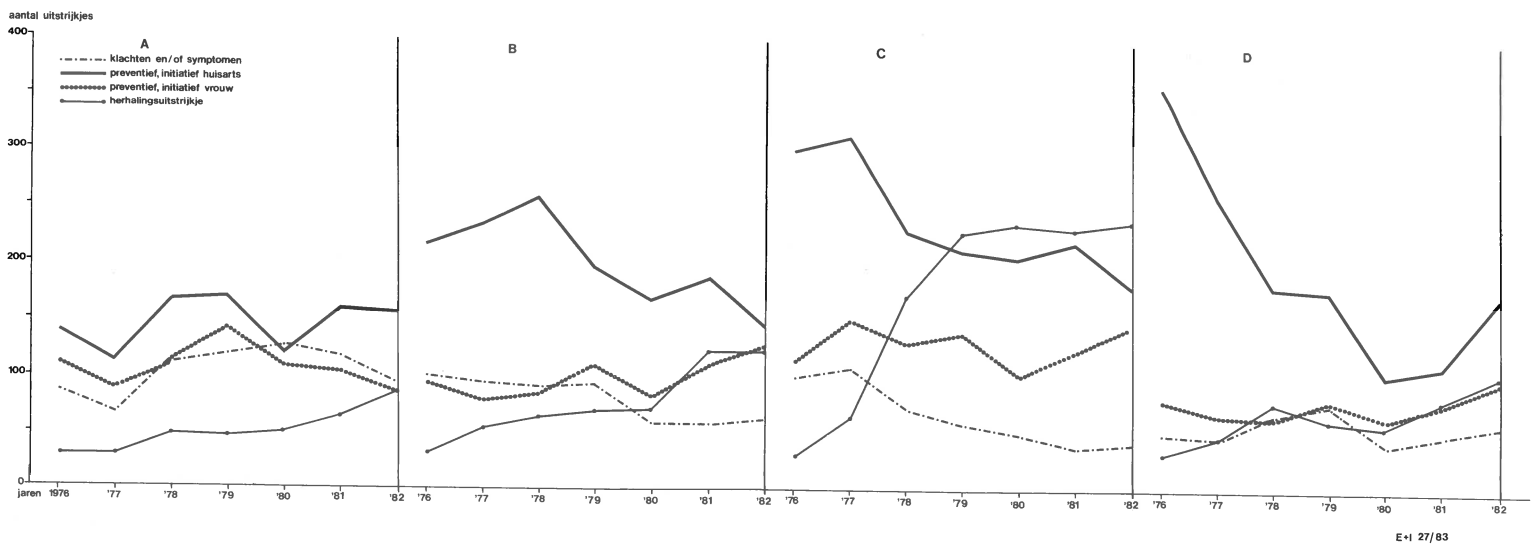
Figuur 6

Aantal nieuwe patiënten met diabetes mellitus naar leeftijdsgroep, per 10.000 inwoners, 1980 - 1982



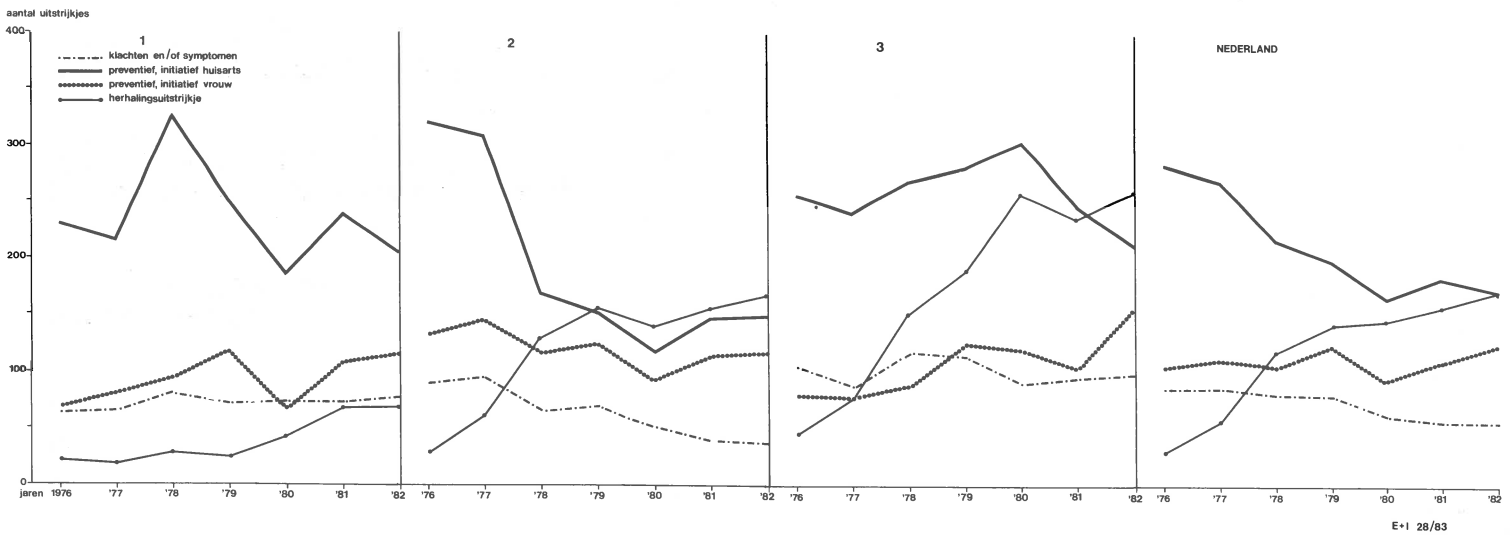
Figuur 7

Aantal uitstrijkjes gemaakt van de cervix uteri, per provinciegroep, naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1976 - 1982



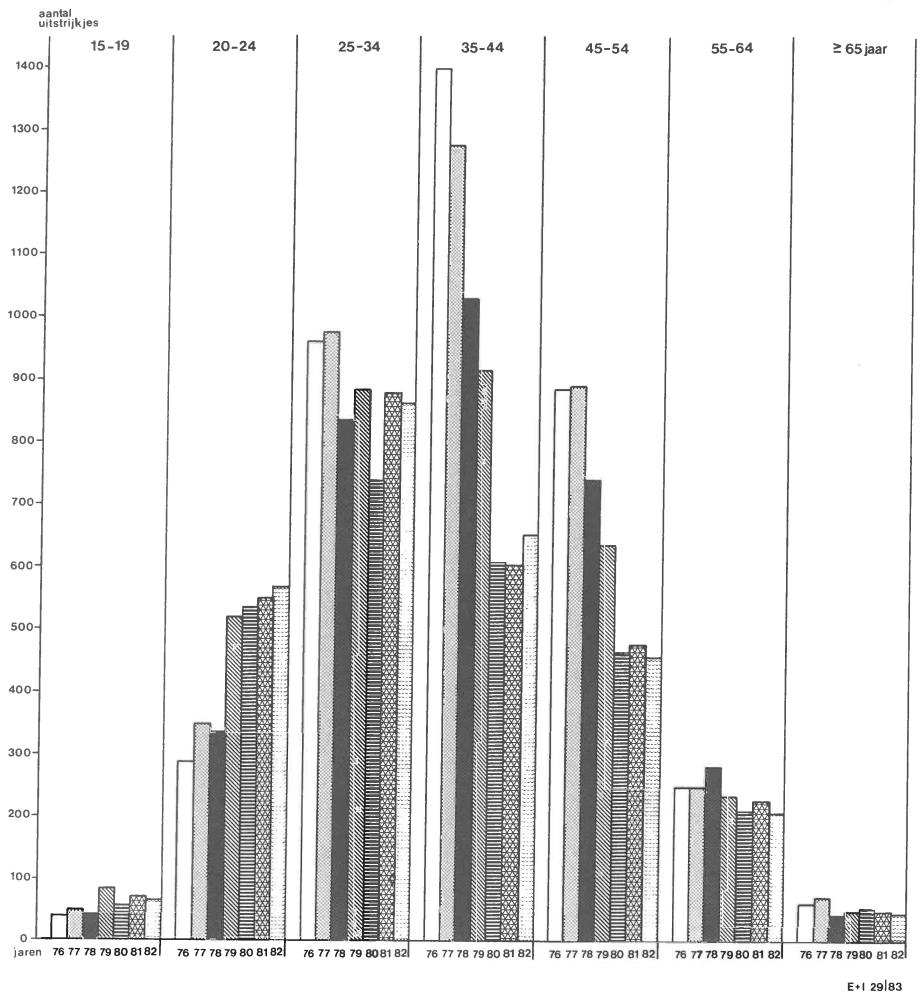
Figuur 8

Aantal uitstrijkjes gemaakt van de cervix uteri, per urbanisatiegroep en voor Nederland, naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1976 - 1982



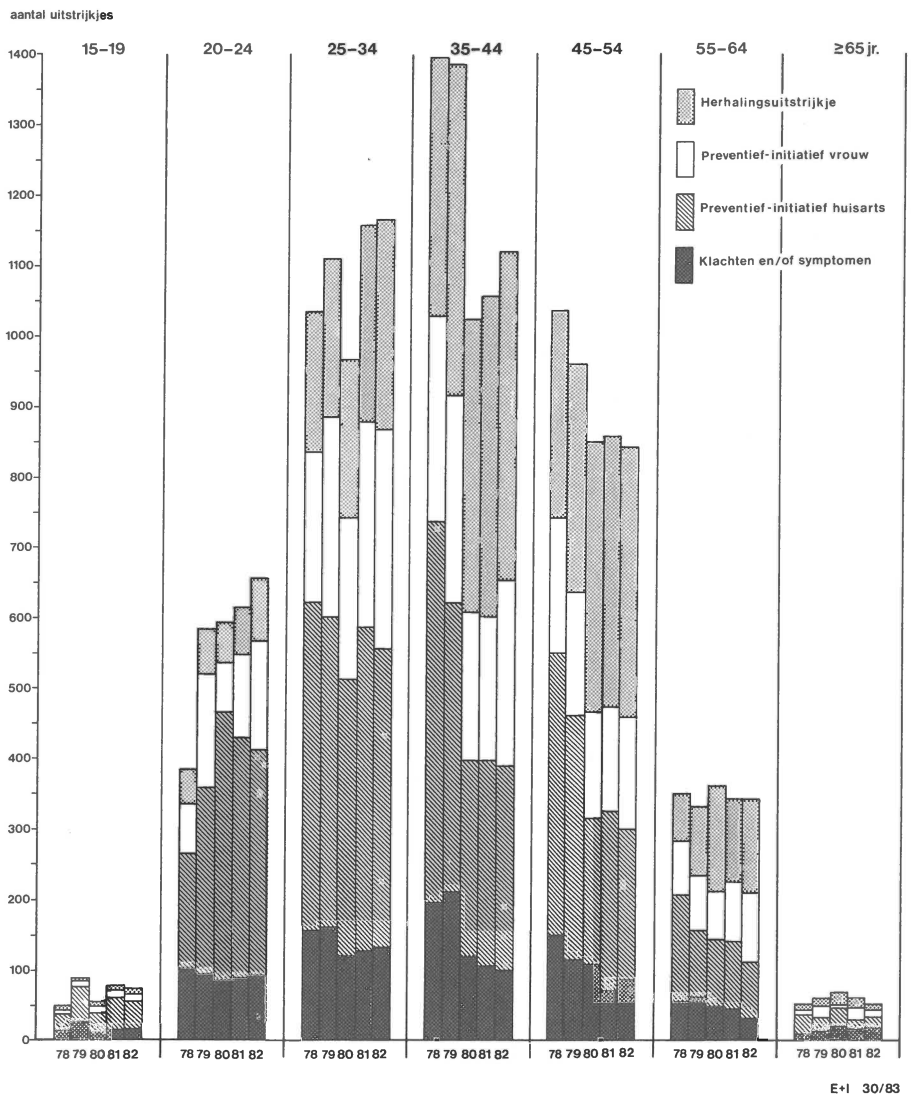
Figuur 9

Aantal "eerste" uitstrijkjes gemaakt van de cervix uteri naar leeftijdsgroep, per 10.000 vrouwen, 1976 - 1982



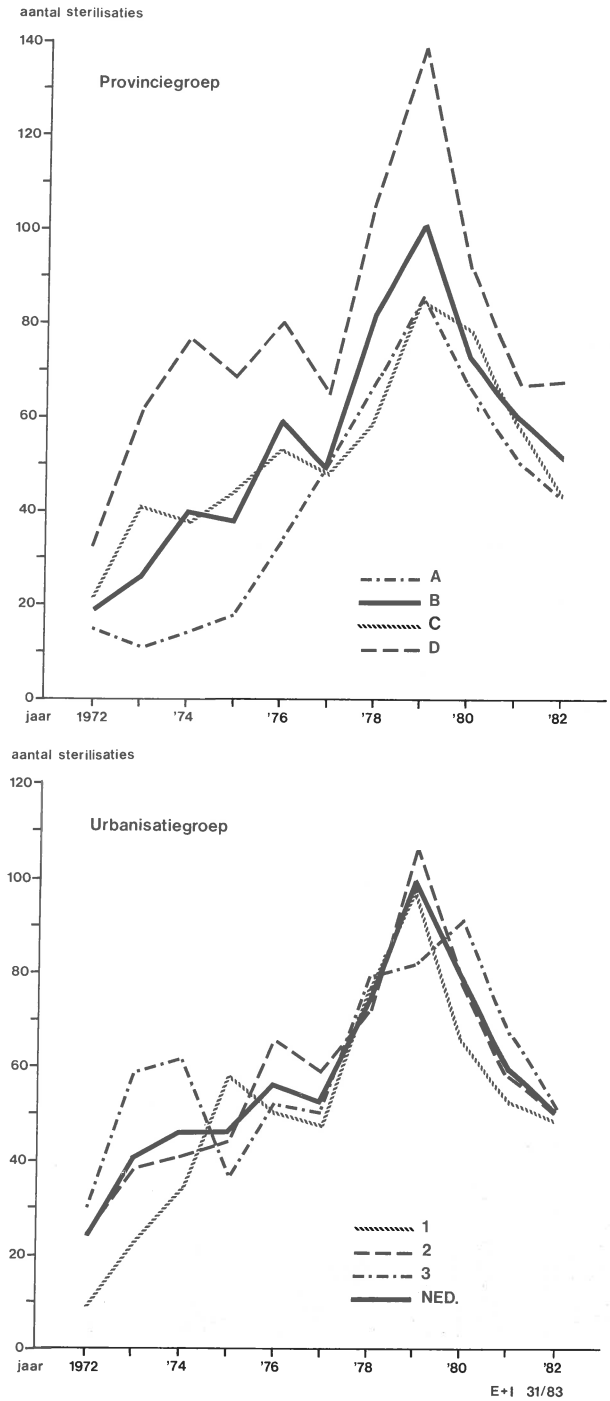
Figuur 10

Aantal uitstrijkjes gemaakt van de cervix uteri naar leeftijdsgroep en naar indicatie tot het maken van het uitstrijkje, per 10.000 vrouwen, 1978 - 1982



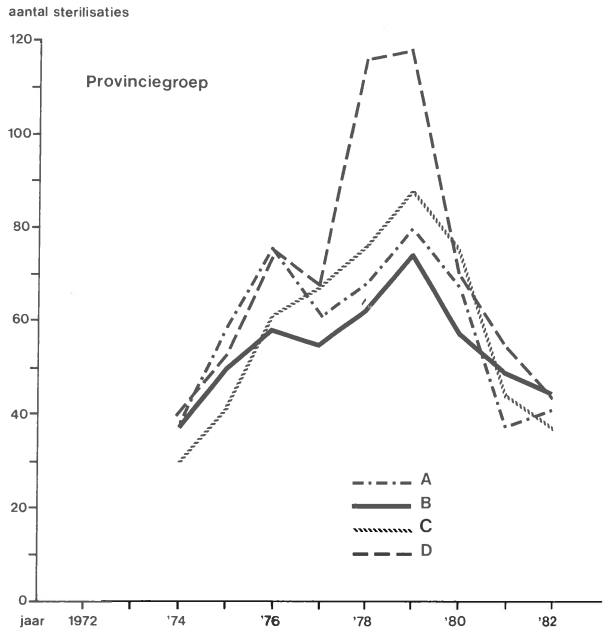
Figuur 11

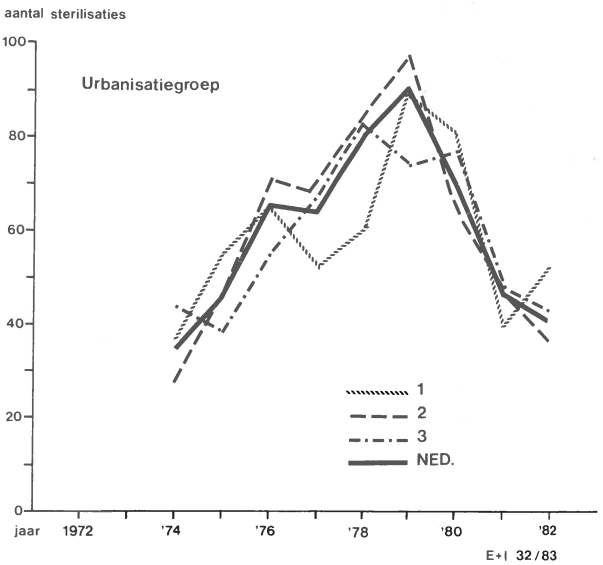
Aantal bij mannen verrichte sterilisaties, per provincie- en urbanisatiegroep, per 10.000 mannen, 1972 - 1982



Figuur 12

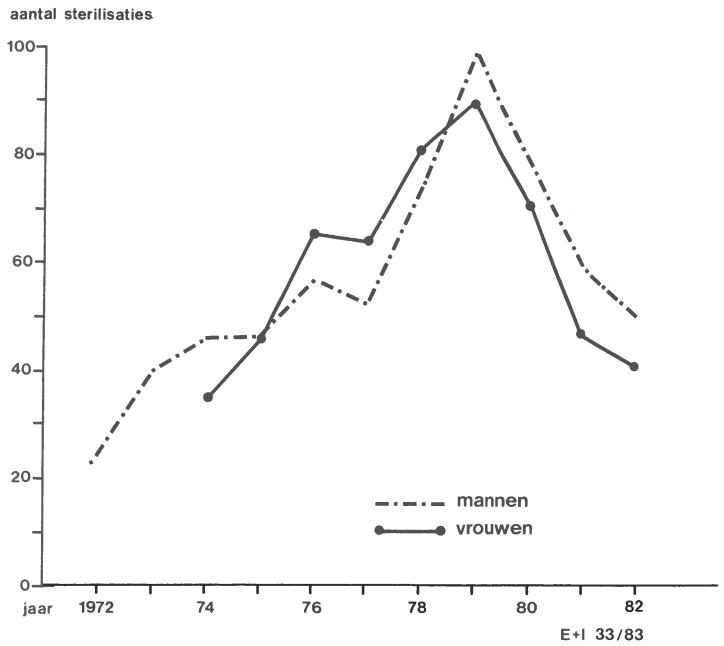
Aantal bij vrouwen verrichte sterilisaties, per provincie- en urbanisatiegroep, per 10.000 vrouwen, 1974 - 1982





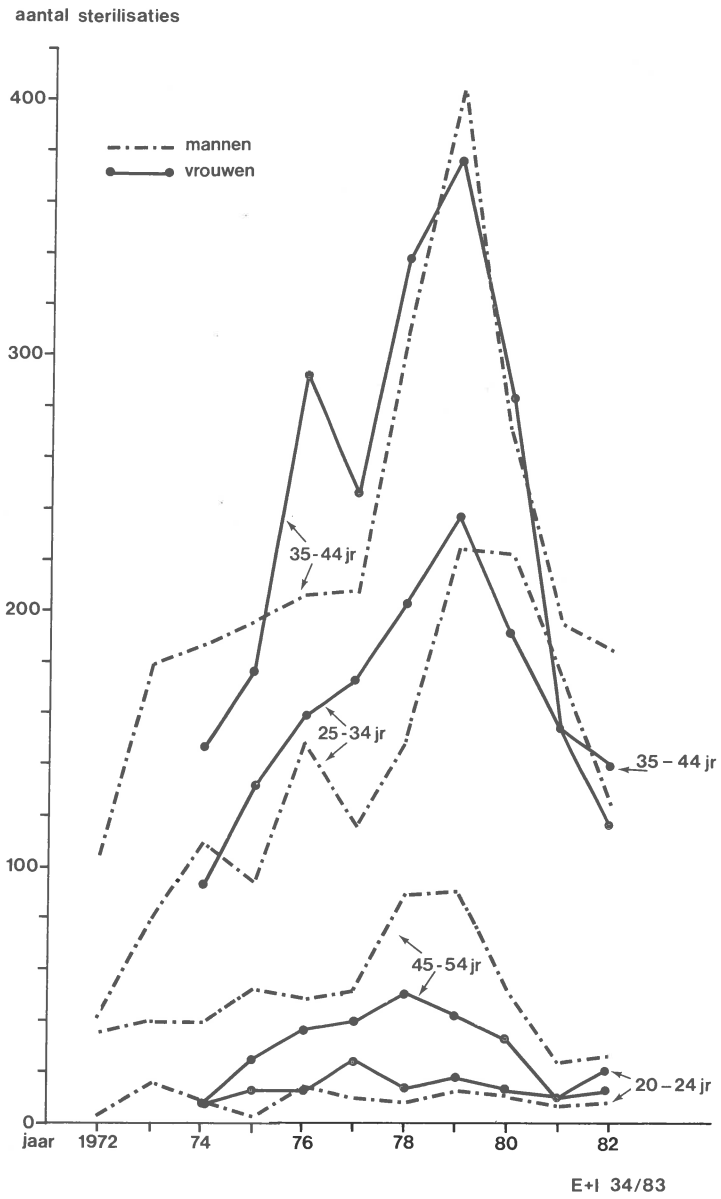
Figuur 13

Aantal verrichte sterilisaties per 10.000 mannen resp. vrouwen, 1972 - 1982



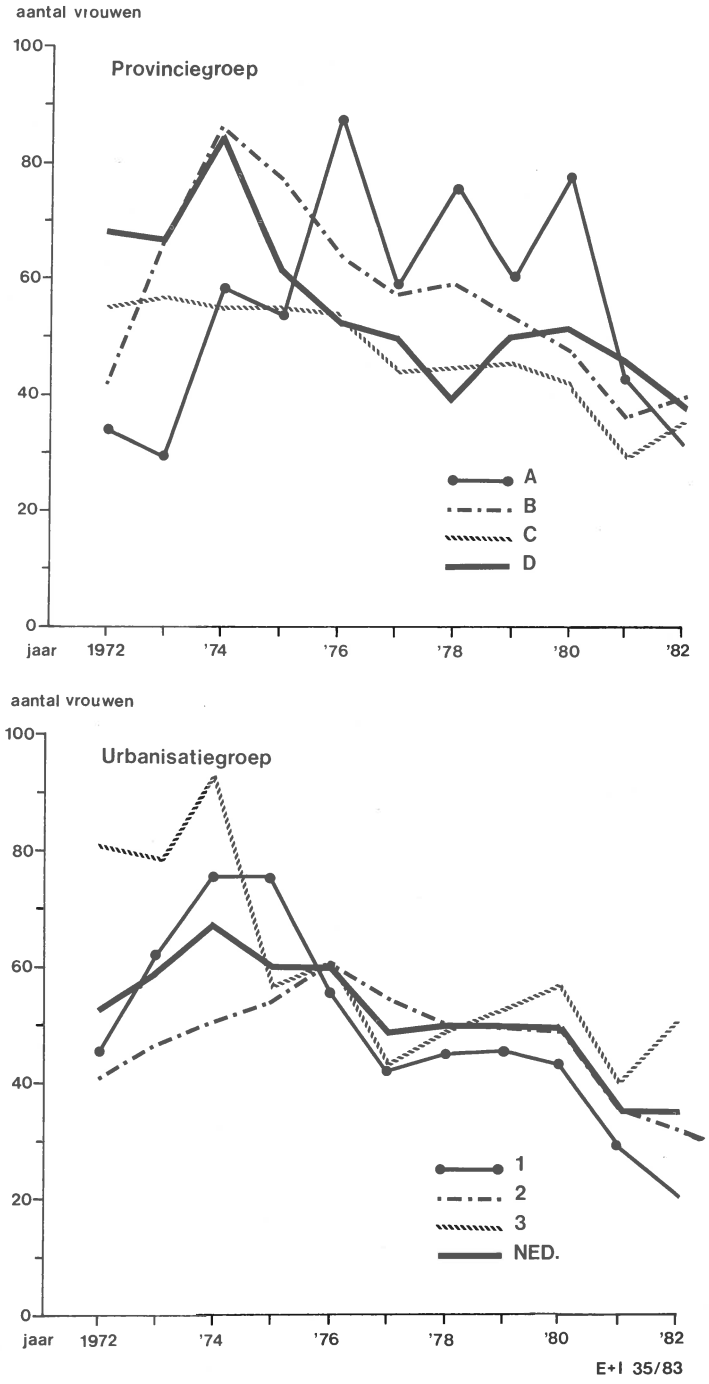
Figuur 14

Aantal verrichte sterilisaties naar leeftijdsgroep, per 10.000 mannen resp. vrouwen, 1972 - 1982



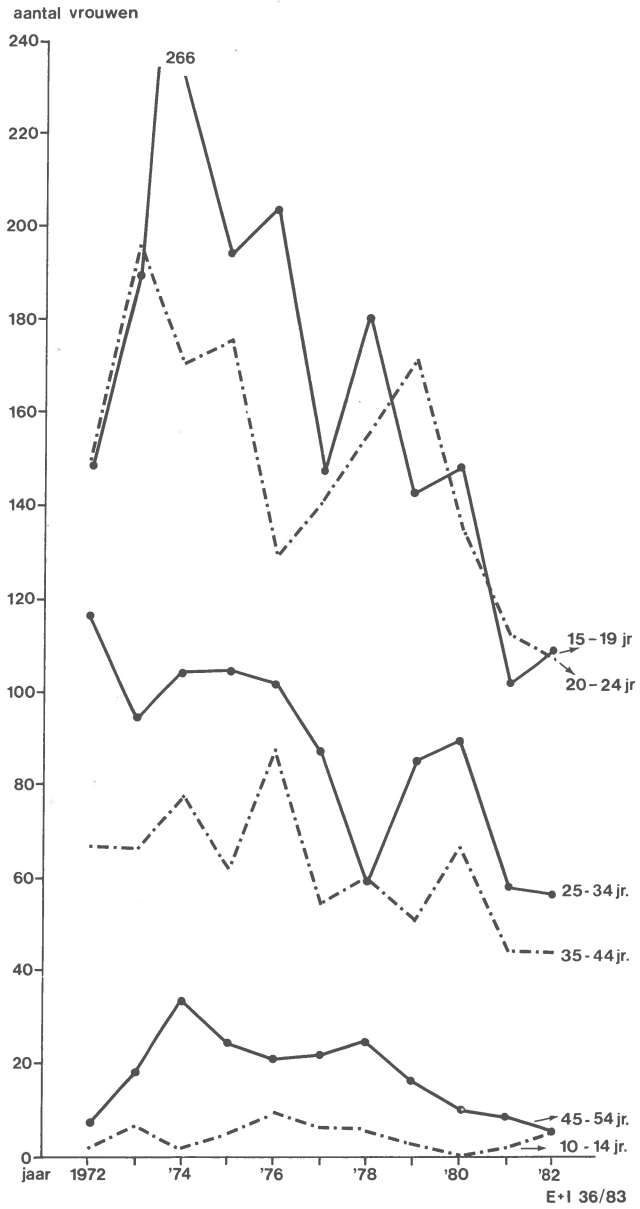
Figuur 15

Aantal malen dat de morning-after-pill is voorgeschreven, per provincie- en urbanisatiegroep, per 10.000 vrouwen, 1972 - 1982



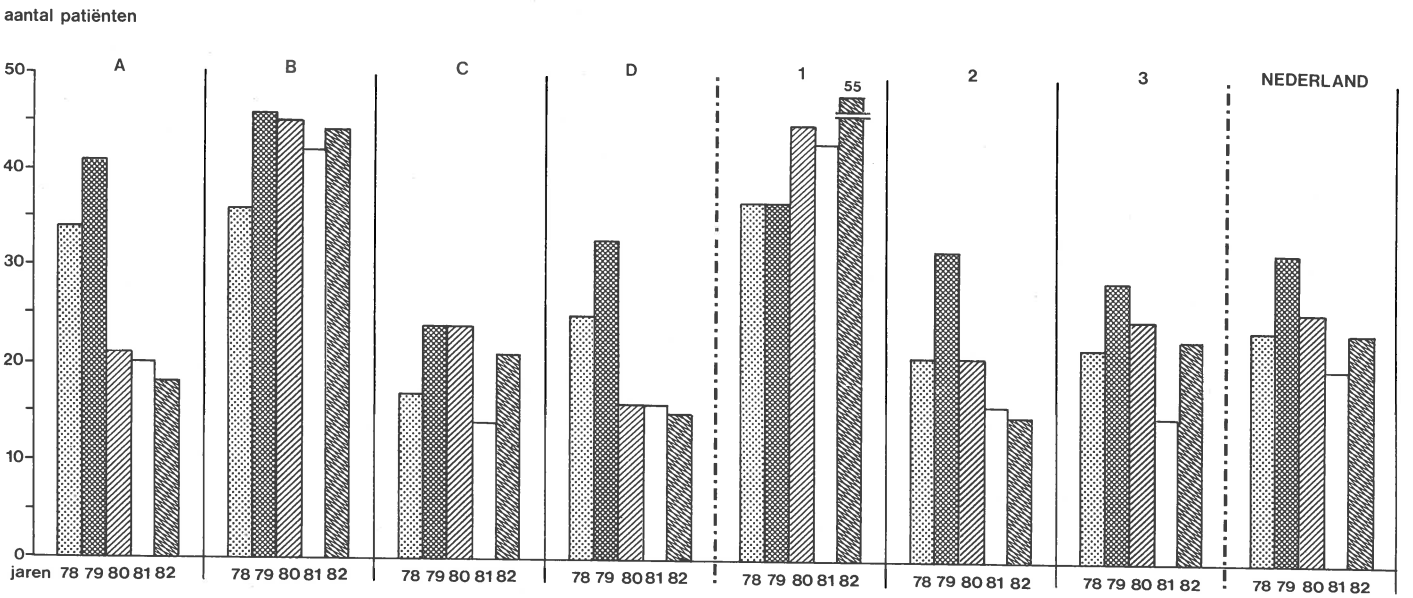
Figuur 16

Aantal malen dat de morning-after-pill is voorgeschreven naar leeftijdsgroep, per 10.000 vrouwen, 1972 - 1982



Figuur 17

Aantal patiënten dat zich voor de eerste maal wegens hooikoortsklachten tot de huisarts wendde, per provincie- en urbanisatiegroep, per 10.000 inwoners, 1978 - 1982



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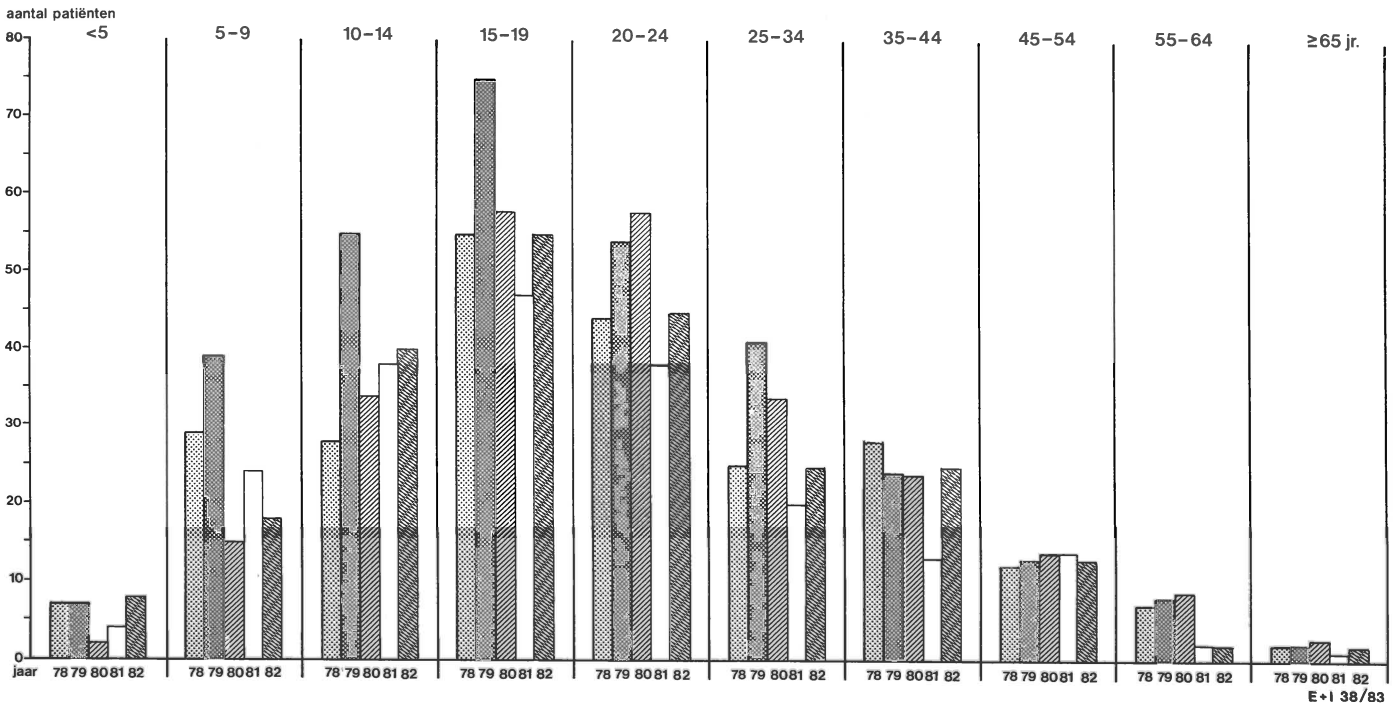
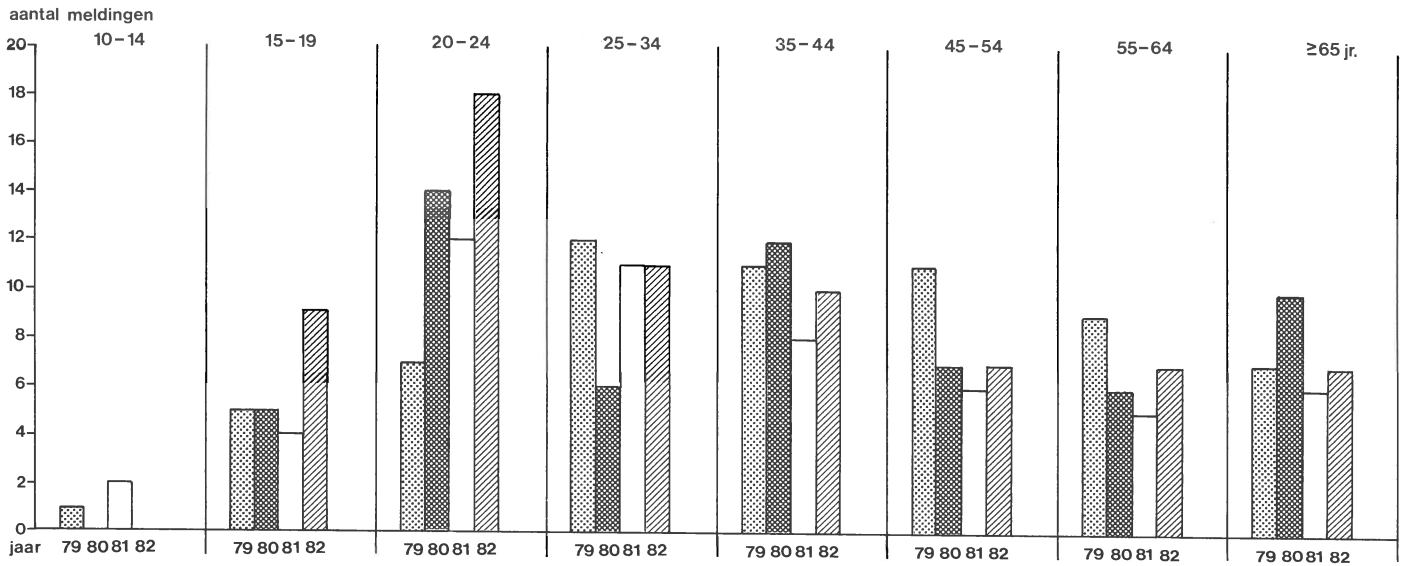
Figuur 18

Aantal patiënten dat zich voor de eerste maal wegens hooikoortsklachten tot de huisarts wendde naar leeftijdsgroep, per 10.000 inwoners, 1978 - 1982



Figuur 19

Aantal meldingen van een suicide(poging) naar leeftijdsgroep, per 10.000 inwoners, 1979 - 1982



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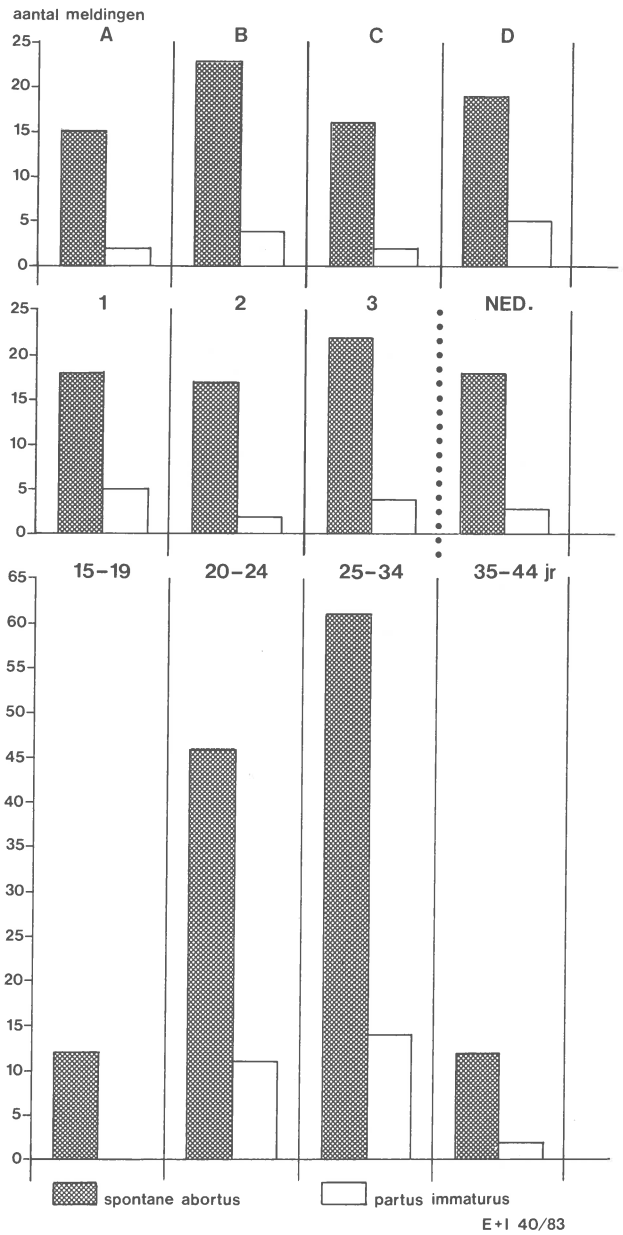
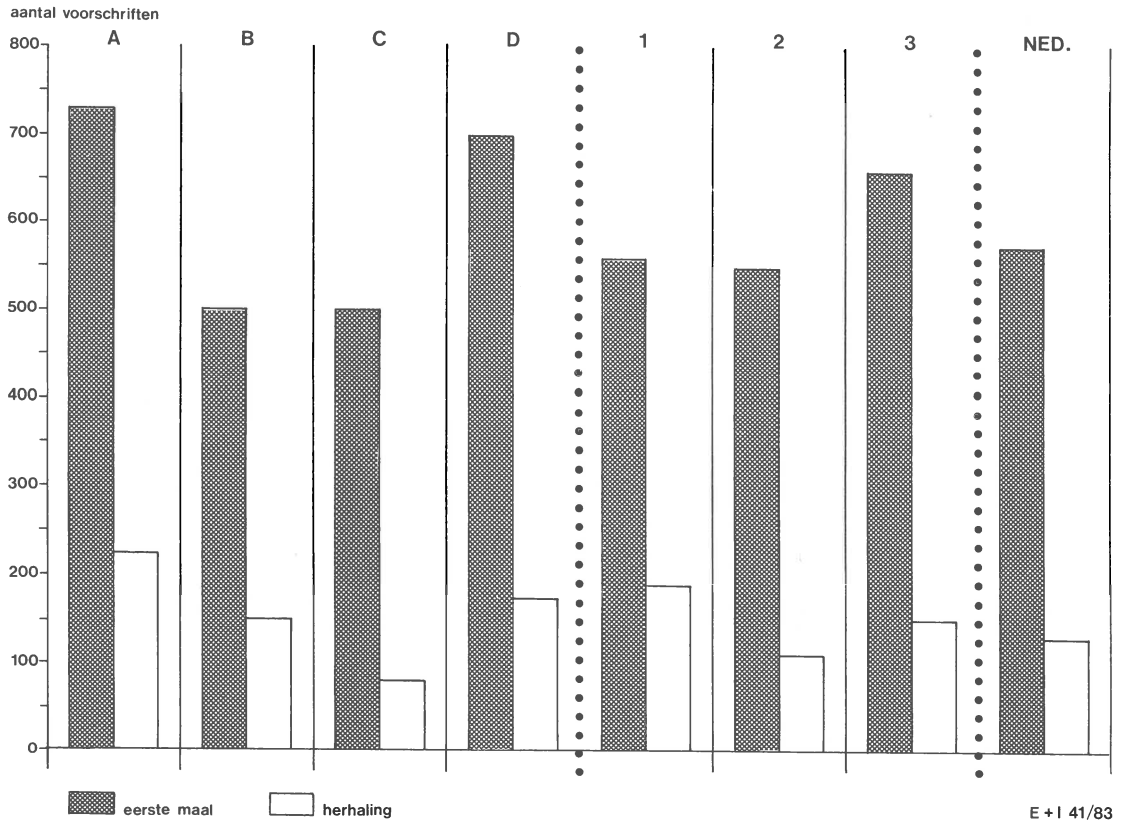
Figuur 20

Aantal meldingen van spontane abortus en partus immaturus per 10.000 vrouwen, per provincie- en urbanisatiegroep en naar leeftijdsgroep, 1982



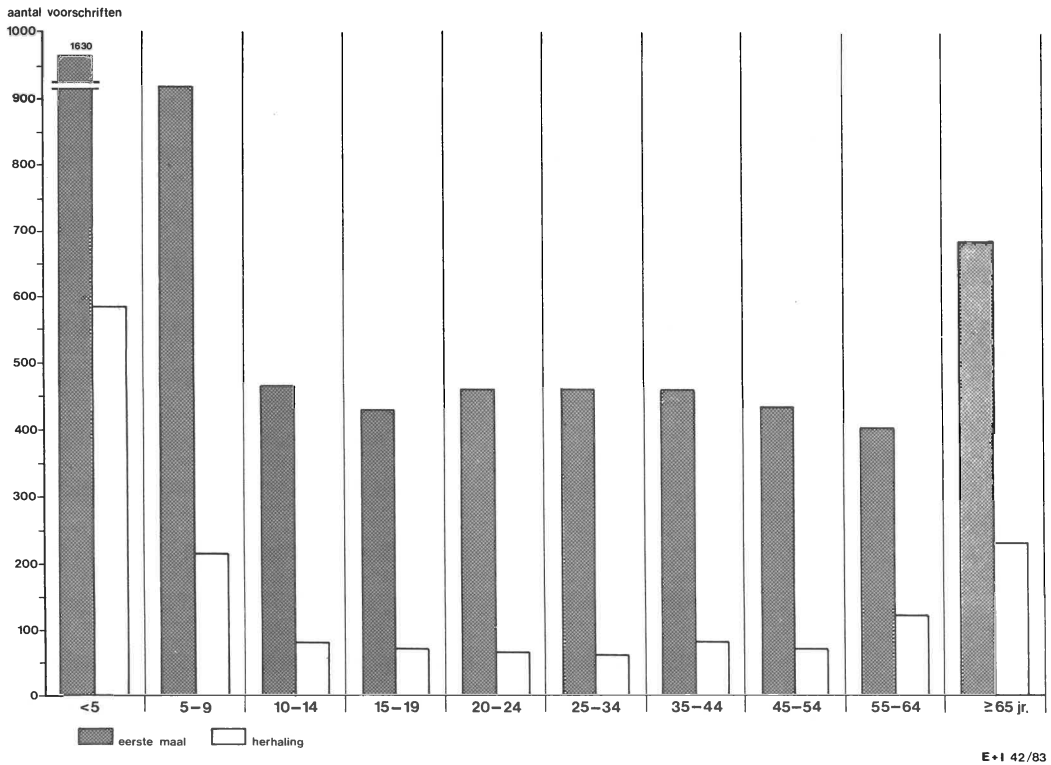
Figuur 21

Aantal patiënten aan wie voor de eerste maal in 1982 door de peilstationarts penicilline werd voorgeschreven, per provincie- en urbanisatiegroep, per 10.000 inwoners, met opgave van het aantal herhalingsvoorschriften per 10.000 inwoners in 1982



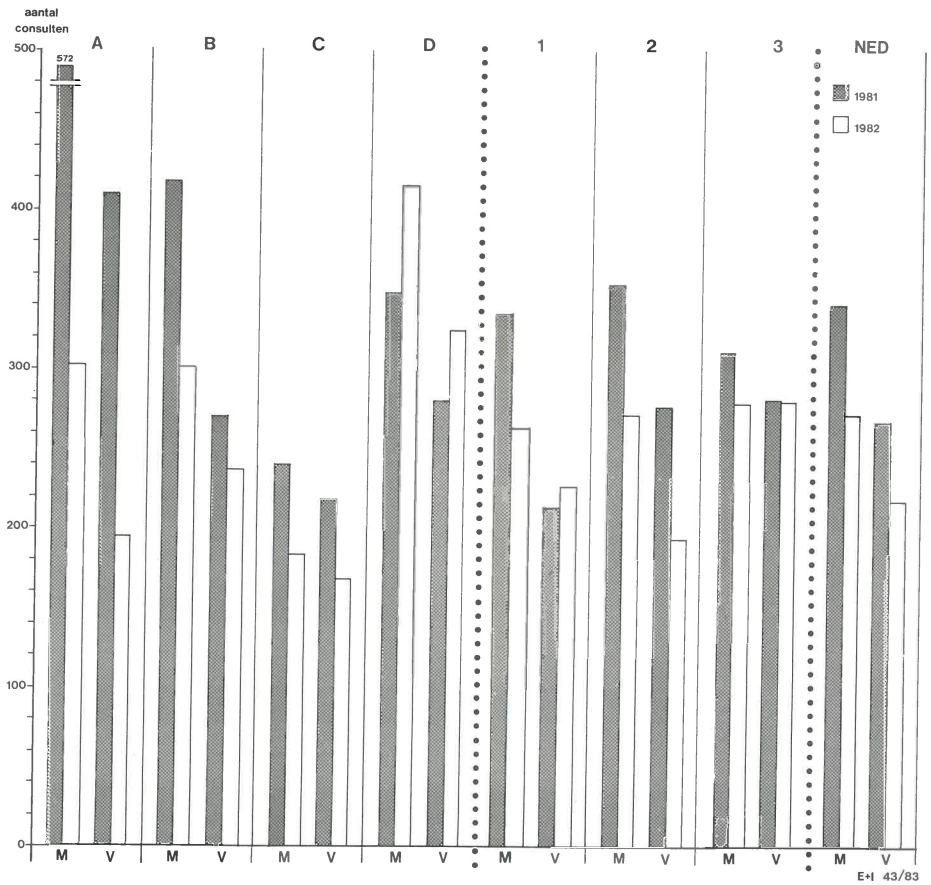
Figuur 22

Aantal patiënten aan wie voor de eerste maal in 1982 door de peilstationarts penicilline werd voorgeschreven naar leeftijdsgroep, per 10.000 inwoners in 1982



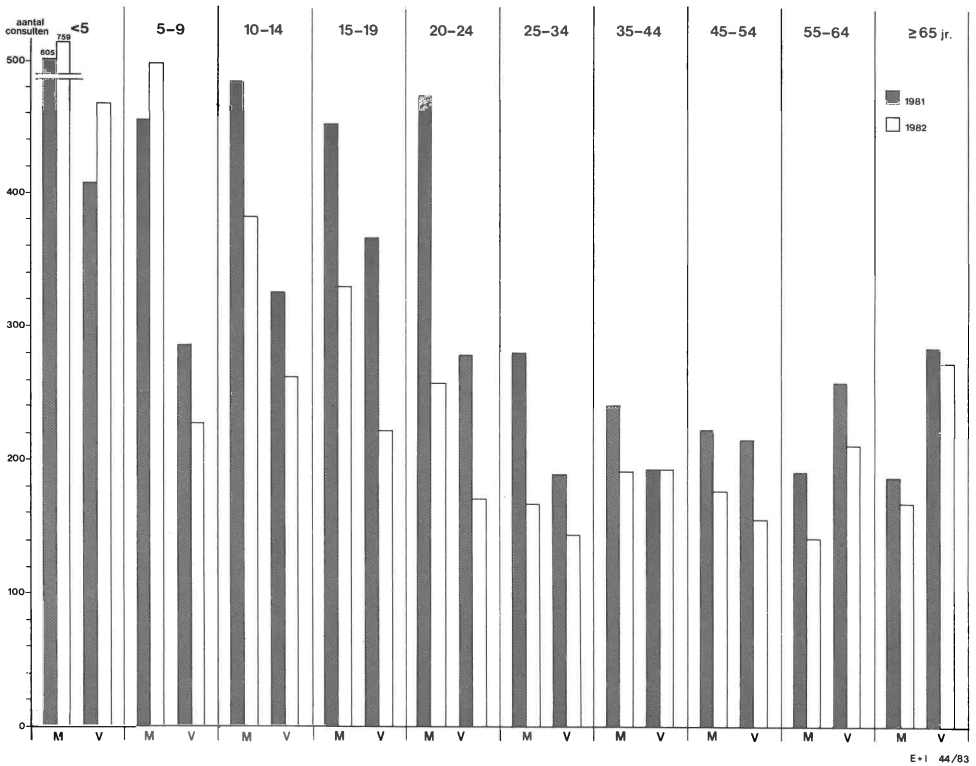
Figuur 23

Aantal (eerste) consulten bij de huisarts wegens een ongeval in de privé-sfeer, per provincie- en urbanisatiegroep, per 10.000 inwoners, 1981 - 1982



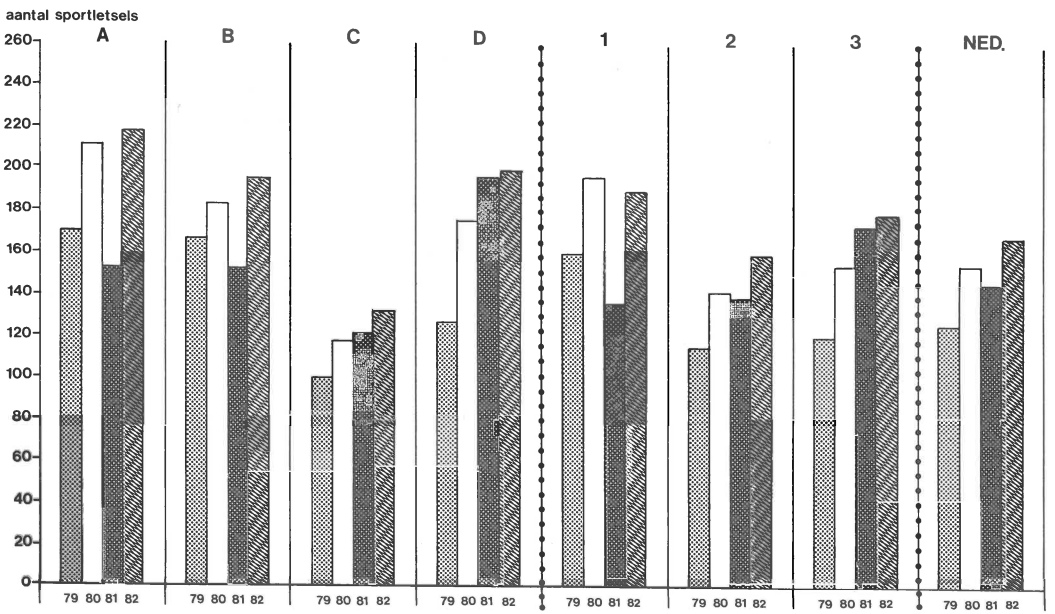
Figuur 24

Aantal (eerste) consulten bij de huisarts wegens een ongeval in de privé-sfeer naar leeftijdsgroep, per 10.000 inwoners, 1981 - 1982



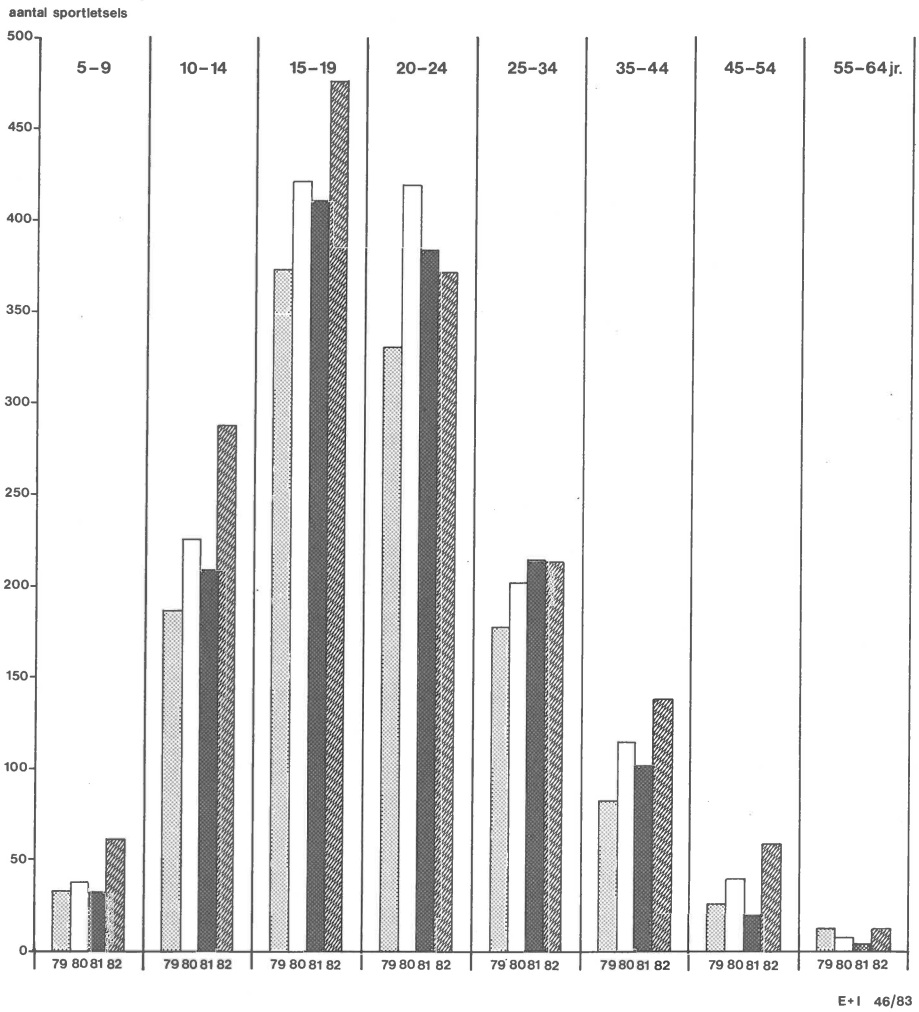
Figuur 25

Aantal sportletsels waarvoor de huisarts werd geconsulteerd, per provincie-en urbanisatiegroep, per 10.000 inwoners, 1979 - 1982



Figuur 26

Aantal sportletsels waarvoor de huisarts werd geconsulteerd naar leeftijdsgroep, per 10.000 inwoners, 1979 - 1982



Explanatory notes pertaining to:

Bijlage 1	
Bijlage	– Appendix
Continue morbiditeits registratie, peilstations	– Continuous morbidity registration, sentinel stations
Deelnemende artsen	– Participating general practitioners
Naam	– Name
Plaats	– Residence
Provincie	– Province
Comb.-praktijk	– Group practice
Apotheek-houdend	– With dispensary
Bijlage 2	
Bijlage	– Appendix
Weekstaat t.b.v. centrale registratie	– Weekly return for central registration
Continue morbiditeitsregistratie, peilstations	– Continuous morbidity registration, sentinel stations
Proj. no.	– Project number
Verslagjaar	– Year under review
Week no.	– Number of the week
Code peilstations	– Code number sentinel stations
Rapport. dagen	– Number of days over which reporting took place
5-daagse rapportering	– Five-day reporting
Weekrapportering	– Weekly reporting
Regel no.	– Line number
Leeftijdsgroep	– Age group
Influenza (-achtig ziektebeeld)	– Influenza (-like illness)
Diabetes mellitus	– Diabetes mellitus
Cervixuitstrijkje	– Cervical smear
Na 1-1-1980 voor de eerste maal afgenomen op grond van	– Taken for the first time after 1-1-1980 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
Ziekte van Parkinson	– Parkinson's disease
Sterilisatie van de man verricht	– Sterilization of the man performed
Sterilisatie van de vrouw verricht	– Sterilization of the woman performed
Morning-after pill voorgeschreven	– Prescription of morning-after pill
Hooikoorts	– Hay fever

Suicide(poging)	– (Attempted) suicide
Spontane abortus of partus immaturus	– Spontaneous abortion or partus immaturus
Partus bij graviditeit ⩾ 28 weken	– Partus at gravidity ⩾ 28 weeks
Penicilline	– Penicillin
Voorgeschreven of toegediend	– Prescribed or injected
Eerste maal in 1982	– First time in 1982
Reeds eerder in 1982	– Already before in 1982
Reactie	– Reaction
Ongevallen in de privésfeer	– Accidents in private sector
(m.u.v. in het verkeer, sport of bedrijf)	– (excl. accidents in traffic, sport or at work)
Sportletsel	– Traumas in sport
Ongeval	– Accident
Surmenageblessure	– Overstrain
Eerste	– First
Recidief	– Recurrence
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])
1. De kolommen hebben deels betrekking op een 5-daagse rapportering (maandag tot en met vrijdag). Door vakantie, ziekte en andere oorzaken zal deze rapportage zich echter ook over minder dan 5 dagen kunnen uitstrekken. Ten aanzien van de overige vragen wordt het van belang geacht om, zo mogelijk, ook tijdens het weekeinde waargenomen patiënten te rapporteren.	1. The columns partly relate to 5-day reporting (Monday to Friday incl.). However, as a result of vacation, sickness and other causes this reporting may extend over fewer than 5 days. With respect to the other questions it is considered to be of importance to report, if possible, patients observed during the weekend as well.
2. Betreft uitsluitend nieuwe patiënten	2. Relates solely to new patients
3. > 10 mmol/L (> 180 mg%) glucose na een koolhydraatrijke maaltijd of belasting. Code voor follow-up formulier:	3. > 10 mmol/L (> 180% mg) glucose after a high-carbohudrate meal or equivalent. Code for follow-up form: .....

4. Betreft rapportering van vrouwen bij wie na 1-1-1980 om welke reden dan ook een cervixuitstrijkje heeft plaatsgevonden. Indien bij een vrouw na 1-1-1980 opnieuw een cervixuitstrijkje wordt gemaakt, dient dit altijd onder de subrubriek "herhalingsonderzoek" geboekt te worden (zie ook voetnoot 6).
5. Bijvoorbeeld in het kader van pilcontrole.
6. Bijvoorbeeld wegens verdacht preparaat of wegens technische onvolkomenheden bij onderzoek vorig preparaat.
7. Betreft alleen *nieuwe* patiënten met de *echte* ziekte van Parkinson (zie ook de toelichting).
   Geslacht: .....
8. Indien het een patiënt(e) betreft uit een van de leeftijdsgroepen, waarvan het vak gerasterd is, dan tevens exacte leeftijd hierachter vermelden.
   Leeftijd: .....
9. Uitsluitend indien er een directe indicatie is. Indien een recept voor de morning-after-pill wordt afgegeven omdat de betrokkene bijvoorbeeld met vakantie naar het buitenland gaat, dient dit niet te worden gerapporteerd. (Zie ook voetnoot 8).
10. Betreft uitsluitend patiënten met de typische graspollenallergie (zie de toelichting op de weekstaat).
11. Voor de aanvullende gegevens s.v.p. een apart formuliertje invullen en bij de weekstaat voegen.
12. Aantal weken na de laatste menstruatie. Exacte leeftijd van de vrouw (zie ook de toelichting op de weekstaat).
13. Zie voetnoot 8.
14. Betreft *alle* penicilline- en daaraan verwante preparaten (zie ook de toelichting op de weekstaat en de lijst).

4. Concerns reporting of women on whom a cervical smear was taken after 1-1-1980 for whatsoever reason. If a cervical smear was taken again of a woman after 1-1-1980 this should always be entered under the subheading "Repeat examination" (see also footnote 6).
5. For example as part of check-up for the pill.
6 For example on account of suspect preparation or technical imperfections in the examination of the preparation.
7 Concerns only *new* patients with *genuine* Parkinson's disease (see also the explanation).
   Sex: .....
8. If a patient is concerned in one of the age groups whose box is filled in, also give the exact age here.
   Age: .....
9. 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 8).
10. Concerns only patients with the typical grass pollen allergy (see the explanation on the weekly return).
11. For the supplementary data please complete a separate form and attach it to the weekly return.
12. Number of weeks after last menstruation. Age of women in years (see also the explanation on the weekly return).
13. See footnote 8.
14. Concerns *all* penicillin and related preparations (see also the explanation on the weekly return).

15. Voor kinderen jonger dan 5 jaar: eerste maal in het leven? ja neen
16. Noteer zoveel mogelijk gegevens op de patiëntenkaart (zie ook de toelichting op de weekstaat). Code patiënt:
17. Onder ongeval wordt verstaan: een plotselinge, ongewilde, onvoorziene gebeurtenis, die resulteert in herkenbare schade aan fysiek welzijn. Zie ook de toelichting op de weekstaat, met name i.v.m. *exclusies.*

15. For children younger than 5 years: first time in their lives? yes no
16. Note as many details as possible on the patient's card! (See also the explanation on the weekly return.) Patient's code:
17. By an accident is meant a sudden, unintentional, unforeseen event resulting in recognizable harm to physical well-being. See also the explanation on the weekly return, especially in connection with *exclusions.*

Tables 1a – 3e

Continue morbiditeitsregistratie peilstations	Continuous morbidity registration sentinel stations
Kwartaal	– Quarter
Leeftijdsgroep	– Age group
Influenza (-achtig ziektebeeld)	– Influenza (-like illness
Diabetes mellitus	– Diabetes mellitus
Cervixuitstrijkje	– Cervical smear
Klacht/symptoom	– Complaint/symptom
Initiatief huisarts	– General practitioner's initiative
Verzoek vrouw	– Woman's request
Herhalingsonderzoek	– Repeat smear
Ziekte van Parkinson	– Parkinson's disease
Sterilisatie verricht	– Sterilization performed
Hooikoorts	– Hay fever
Suicide(poging)	– (Attempted) suicide
Eerste keer	– First time
Volgende keer	– Following times
Reactie	– Reaction
Ongevallen in privésfeer	– Accidents in the private sector
Sportletsels	– Traumas in sport
Ongeval	– Accident
Surmenage	– Overstrain
Eerste	– First
M	– Male
V	– Female
Provinciegroepen	– Province groups
Gr + Fr + Dr	– Groningen, Friesland, Drenthe

Ov + Gld + Zijp	– Overijssel, Gelderland, Southern IJsselmeer Polders
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 N.B. Als gevolg van het afronden bij het berekenen van de relatieve frequenties kunnen kleine verschillen in de totalen zijn ontstaan.	– Footnote N.B. As a result of the rounding-off when calculating relative frequencies, small differences in the totals may have occurred.
Voor abortus, partus immaturus en partus à terme wordt naar het betreffende hoofdstuk verwezen.	– For abortion, partus immaturus and partus at gravidity see the relevant chapter.

Table 4a

Aantal patiënten met influenza (-achtig ziektebeeld) per week en per 10.000 inwoners, 1982 en 1983 (t/m 13e week)	– Number of patients with influenza (-like illness) per week and per 10 000, 1982 and 1983 (up to and including the 13th week)
Weeknr.	– Number of the week
Aantal patiënten	– Number of patients
Provinciegroep	– Province group. See for explanation A, B, C and D under tables 1-3

Figures

Figure 1

Peilstations	– Sentinel stations
Continue morbiditeitsregistratie	– Continuous morbidity registration
Grenslijn provinciegroep	– Boundary of province group

Figure 2

Het percentage dagen dat in 1982 per week is gerapporteerd	– Percentage of days weekly reported in 1982

1 = Nieuwjaarsdag	– 1 = New Year's Day
2 = Pasen	2 = Easter
3 = Hemelvaartsdag	3 = Ascension Day
4 = Pinksteren	4 = Whitsun
5 = Kerstmis	5 = Christmas

Figure 3

Aantal patiënten met influenza (-achtig ziektebeeld) per week, per 10.000 inwoners, 1982-1983 (t/m 13e week)	– Number of patients with influenza (-like illness) per week, per 10 000 inhabitants, 1982-1983 (up to and including the 13th week)
Provinciegroep	– Province group
Urbanisatiegroep	– Urbanization group
Naar leeftijdsgroep en geslacht	– By age group and sex

Figure 4

Aantal gemelde gevallen van influenza (-achtig ziektebeeld) en aantal sterfgevallen t.g.v. influenza, pneumonie en bronchitis (ICD code, zie de tekst) per 10.000 inwoners per kwartaal	– Number of reported cases of influenza (-like illness) and number of deaths as a result of influenza, pneumonia and bronchitis (ICD code, see the text) per 10 000 inhabitants per quarter

Figures 5 and 6

Aantal nieuwe patiënten met diabetes mellitus	– Number of new patients with diabetes mellitus

Figures 7 - 10

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

Figures 11 and 13

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

Figures 12 and 14

Aantal bij vrouwen verrichte sterilisaties	– Number of sterilizations performed on men

Figures 15 and 16

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

Figures 17 and 18

Aantal patiënten, dat zich voor de eerste maal wegens hooikoortsklachten tot de huisarts wendt.	– Number of patients visiting their family doctor for the first time on account of hay fever.

Figure 19

Aantal meldingen van een suicide(poging)	– Number of reported (attempted) suicide

Figure 20

Aantal meldingen van spontane abortus en partus immaturus	– Number of reports of spontaneous abortion and partus immaturus

Figures 21 and 22

Aantal patiënten aan wie voor de eerste maal in 1982 door de peilstationarts penicilline werd voorgeschreven, met opgave van het aantal herhalingsvoorschriften	– Number of patients for whose penicilline was prescribed for the first time in 1982 by the spotter physician, stating the number of repeat prescriptions

Figures 23 and 24

Aantal (eerste) consulten bij de huisarts wegens een ongeval in de privésfeer, met een onderverdeling naar in eerste instantie al of niet verwijzen naar een specialist.	– Number of (first) consultations of the general practitioner for an accident in the private sector, subdivided into referred or not to a specialist in the first instance.

Figures 25 and 26

Aantal sportletsels waarvoor de huisarts werd geconsulteerd.	– Number of consultations of the general practitioner for traumas in sport.