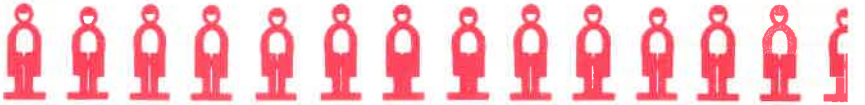
continuous morbidity registration sentinel stations the netherlands



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CONTINUOUS MORBIDITY REGISTRATION

SENTINEL STATIONS

THE NETHERLANDS

1984

TABLE OF CONTENTS Page

FOREWORD

The Continuous Morbidity Registration, Sentinel Stations the Netherlands, to give the sentinel stations their full name, have for many years been used for reporting not only morbidity but also certain actions performed in general practice. Classic examples are the registered cases of sterilization of the man and of the woman since 1972 and 1974 respectively and the cervical smears noted since 1976. In 1984 various kinds of referral to medical specialists were registered (for diagnosis, for treatment, for reassurance), because the classic 'referral card' has had its day and, together with repeat card made out by the specialist, will probably be replaced by a system of advice and treatment cards.
A registration of certain actions performed in general practice can give insight into major changes in the structure of health care, certainly if the registration can be repeated after a certain period or extends over several years. Thus the trend in the number of cervical smears taken by general practitioners is of particular importance to the evaluation of the policy of transferring these activities of preventive health care to curative care by 1986.

The clearly observed increase in the number of 'first smears', to be classified as 'preventive initiative by the spotter physician' in itself indicates that the proposed shift is already in full swing.

The value of longitudinal analyses is also demonstrated in the repetition (1983 and 1984) of the registration of acute myocardial infarctions also performed in 1978. Two questions were of importance here. Firstly the question whether the decrease in (in any case death from) myocardial infarctions noted throughout the world was also visible in the sentinel stations and secondly whether a shift has occurred from hospitalization to home care.

The first question can in fact be answered in the affirmative, although it must be realized that those who died from a myocardial infarction in the period 1979-1984 may distort this sligth decline. However, the fluctuations between 1983 and 1984 are too great to allow of an answer to the second question.

In times when data are increasingly required to see whether a

certain policy with regard to care in general practice has had the effect aimed at, the simple but reliable technique of registration by means of the sentinel stations continues to be an important instrument of evaluation.

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

INTRODUCTION

Continuous Morbidity Registration is a method of registration based on general practice. A national network of general practices, the sentinel stations, covers 1% of the Dutch population. In the composition of this network allowance has been made for a geographical spread over regions with a varying degree of urbanization (see p. 8-12). The participating general practitioners, the spotter physicians, submit a form every week on which certain illnesses, occurrences and actions are reported, the weekly return. This weekly return comprises a distribution by age and where necessary a distribution by sex (see p. 90).

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 of women (see p. 19).

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

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

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

When considering the subjects which have been included during the years on the weekly return (see p. 17-18 and 90-91) 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 the Netherlands" is used.

In addition to the submission of weekly returns, a start was made in

1976 with incidental investigations. This entails the physicians being asked non-recurrent questions about diseases or occurrences which do not happen frequently.
The report gives neither an exhaustive (statistical) analysis of the collected material nor an extensive contemplation; the aim of the project is to collect basic details on certain subjects and to pass them on.

In 1984 contacts were established with comparable systems of "sentinel stations" in other countries. In the future projects for cooperation with these other sentinel station systems may perhaps be set up.

COUNSELLING COMMITTEE

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

1. two representatives of the Ministry of Welfare, Public Health and Culture
2. the Director of the Netherlands Institute for General Practice (Chairman), from 1-1-'85 the Netherlands Institute of Primary Health Care
3. one representative of the policy council of the Netherlands Institute for General Practice, from 1-1-'85 the Netherlands Institute of Primary Health Care
4. two representatives of the Chief Medical Office of Health
5. one representative of the spotter physicians
6. one representative of the joint Institutes for General Practice of Dutch Universities
7. two members on the basis of specific expertise.

In 1984 the committee functioned in the following composition:

	Mrs. J.M. Bensing, Ph.D. [2]
	Dr H. Bijkerk, M.D. [4]
	W.M.J. van Duyne, M.D. [7]
	F.K.A. Fokkema, M.D. [5]
	H.J. van der Leen, M.D. [5]
	A. Schaap [1]
	H.O. Sigling, M.D. [6]
	W.A. van Veen, M.D. [1]
	A. Vrij, M.D. [4]
	Dr J. van der Zee Ph.D. [3]
Project leader:	Dr Bertine J.A. Collette, M.D. (to 1-3-'85)
	A.I.M. Bartelds M.D. (from 1-3-'85)
Secretary:	Mrs. F.G. Hoeben-Schaafsma
	Mrs. M. van Valen
	Mrs. C.M. van Welie-de Leeuw (substitute secretary)

This committee met twice in 1984, it had one vacancy in that year.

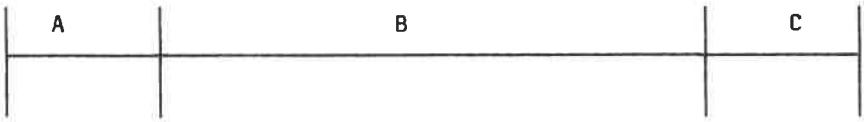
MEETING OF SPOTTER CO-WORKERS

The annual meeting of co-workers on the project was held on 14 January 1984 in Utrecht.
There were 46 participants, of whom 34 from the sentinel station practices. Holding the meeting at the beginning of the calender year makes it possible to discuss any problems relating to new topics on the weekly return in good time. In addition it is endeavoured to invite speakers who are experts on the subjects to be registered.

Dr J. van der Zee, a sociologist and staff-member of the Netherlands Institute for General Practice, discussed the subject of 'Referral'. Within Dutch health care referrals by general practitioners continue to stir up feelings. Changes in the system are imminent: the referral card, together with the repeat card for the specialist, will be replaced by a system of advice and treatment cards. The background to this change is the desire of policy-making bodies to arrive at a better control of the influx into secondary health care. The cost aspect plays a role in this.
At present the referral card plays a number of rather different roles: on the one hand administrative referral cards made out routinely, on the other active referral decisions by the general practitioner, whether or not induced by the patient's wishes.
Insight into the varied occurrence of referral of patients to a specialist is desirable, as is establishment of the possible effect of introduction of the advice and treatment card.
It has therefore been decided to register a number of differing significances of the present referral card.

The patient-control investigation of Parkinson's disease was discussed by Dr A. Hofman, epidemiologist at the Erasmus University, Rotterdam.
The specific hypothesis that is being tested is that nicotine consumption (through smoking cigarettes) reduces the chance of occurrence of Parkinson's disease via an effect on the nicotinic acid and a change in the tryptophan/tyrosine balance which causes an increased dopa concentration. A low frequency of Parkinson's disease among smokers in comparison with non-smokers is expected and is being investigated by the patient-control method.

Possibilities and impossibilities of cancer registration formed the third subject. It was discussed by H.P.A.H. van Noord, M.D., of the Epidemiology Department of the Institute for General Health Care and Epidemiology of Utrecht State University.
First of all he emphasized two unique aspects of Dutch health care: the fact that patients in the Netherlands are first seen by general practitioners before they go to a specialist and the existence of a sentinel station system of general practitioners that is representative of the Dutch population. Of no less importance is the representation of the disorder which is being registered as regards the various stages of the disorder and the number of persons with that disorder.
An illustration may elucidate this for the process of carcinogenesis.



Part A of the line shows that the process of carcinogenesis in general manifests itself only partly as a disease process. People with a carcinoma die of other causes, e.g. an accident or a myocardial infarction.
General practitioners come into contact with patients with carcinomas, as indicated by part B of the line. Part C represents a part of the process of carcinogenesis that is never registered anywhere.
Of the patients with a carcinoma whom the general practitioner sees, some 10% have for various reasons never been admitted to hospital, according to the retrospective registration at the end of 1982. With his registration the general practitioner covers a larger number of manifestations of cancer than any system based on hospital records can ever comprise. The completeness of registration by the sentinel stations as regards the registration of a many people with cancer as possible is higher than that of other types of cancer registration (see also the relevant chapter in this report).

The meeting was concluded with a listing of new subjects to be registered and a discussion of the topics on the weekly return.

DISTRIBUTION OF THE SPOTTER PHYSICIANS OVER THE NETHERLANDS
(Fig. 1, page 13)

The number of sentinel stations stayed the same in 1983 (46).
The number of general practitioners taking part is 62.

In the processing and discussion the following abbreviations or codes are used:
- A for the Groningen, Friesland and Drenthe (northern provinces) province group;
- B for the Overijssel, Gelderland and Southern IJsselmeer Polders (eastern provinces) province group;
- C for Utrecht, North Holland and South Holland (western and central provinces) province group;
- D for the Zeeland, North Brabant and Limburg (soutern provinces) province group;
- 1 for the A_1-A_4 urbanization group (rural municipalities)[1])*
- 2 for the B_1-B_3, C_1-C_4 urbanization group (urbanized rural municipalities together with (municipalities with urban characteristics)
- 3 for the C_5 urbanization group (municipalities with a population of 100 000 or more).

Appendix 1 (page 87-88) gives a survey of the general practitioners who took part in the sentinel station project during 1984. In 14 sentinel stations there is cooperation between two or more general practitioners, viz 13 between 2 and 1 between 4 practitioners. In January 1984 the percentage of general practitioners cooperating throughout the Netherlands was 42, and among the spotter physicians 46 (28 out of the 61) [2]). There are 12 dispensing spotter physicians, 6 in urbanization group 1 and 6 in urbanization group 2, that is 18%. For the whole of the Netherlands the percentage is 17.3).

Tables 1 and 2 give a distribution of the number of spotter physicians and sentinel stations per province and urbanization group in the years 1970-1983. 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

* Footnotes, notper taining the tables, are placed on pages 153-155.

Netherlands in the various subgroups shows that the spotter physicians form a proportional representation (see 1981 report p. 13).

Table 1 [4]).: survey of the distribution of the spotter physicians and sentinel stations per province group in the years 1970-1984

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 GPs	sentinel stations	number GPs	sentinel stations	number GPs	sentinel stations	number GPs	sentinel stations
1970	7	6	10	9	22	22	14	14
1971	7	6	10	9	23	22	13	13
1972	7	6	9	8	23	22	12	12
1973	8	6	10	9	25	22	13	12
1974	8	6	10	9	27	21	13	12
1975	8	6	9	8	28	21	14	12
1976	8	6	9	7	29	21	14	11
1977	8	6	10	7	28	20	13	11
1978	9	6	12	9	27	21	13	11
1979	10	6	12	9	27	21	12	10
1980	10	6	13	9	27	21	12	10
1981	10	6	11	9	27	21	13	10
1982	10	6	11	9	27	21	13	10
1983	10	6	11	9	27	21	14	10
1984	10	6	11	9	27	21	14	10

Table 2.: survey of the distribution of the spotter physicians and sentinel stations per urbanization group in the years 1970-1984

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

THE PRACTICE POPULATIONS

A complete census of the practice populations again took place in 1983; these details are used for processing with effect from 1-1-1984. In 1985 a new census is to be held. When the project was set up the aim was to take a sample of about 1% of the Dutch population. A geographical distribution (the above-mentioned province groups) was taken into account, as also a distribution of regions with various degrees of urbanization (urbanization groups). An enquiry was made to whether this aim is still being met. This proved to be so, as the following surveys demonstrate.
Comparison with the census in 1981 (1982 report, p. 15) does, however, reveal that opposite changes have taken place: the Dutch population increased (by about 130 000 inhabitants); the sentinel station population decreased (by about 10 000). So far this has had no far-reaching consequences.

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

	number of inhabitants of the Netherlands[1])	number of patients sentinel stations[2]) (with percentages)
province group A	1 586 104	21 998 (1.4%)
B	2 889 080	28 057 (1.0%)
C	6 376 037	77 438 (1.2%)
D	3 542 078	35 133 (1.0%)
urbanization group 1	1 655 320	26 237 (1.6%)
2	9 238 308	99 506 (1.1%)
3	3 499 671	36 883 (1.1%)
sex Men	7 124 935	79 267 (1.1%)
Women	7 270 944	83 359 (1.2%)
total	14 395 879	162 626 (1.1%)

Footnotes of table 3 see next page.

1) 1-1-1984, Central Bureau for Statistics. Persons on the Central Register of Persons (CPR) are excluded.
2) Practice censuses 1983.

Province group A (the northern provinces) and urbanization group 1 (rural municipalities) are relatively somewhat overrepresented. However, this is favourable, since these are precisely the smallest groups for the Netherlands as a whole, while the difference is not of such a nature that the proportional representation is seriously disturbed by it.

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

	province group								urbanization group						Netherlands	
age years	A		B		C		D		1		2		3			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0- 4	1.3	1.3	0.7	0.7	1.0	1.0	0.8	0.9	1.3	1.3	0.8	0.9	1.1	1.1	0.9	1.0
5- 9	1.4	1.4	0.8	0.8	1.1	1.2	0.9	1.0	1.4	1.5	1.0	1.0	1.1	1.0	1.0	1.1
10-14	1.4	1.4	0.9	0.9	1.2	1.2	1.0	1.0	1.5	1.6	1.0	1.0	1.0	1.0	1.1	1.1
15-19	1.4	1.4	1.0	1.0	1.1	1.2	1.0	1.0	1.6	1.7	1.1	1.1	0.9	1.0	1.1	1.1
20-24	1.3	1.5	1.0	1.1	1.2	1.4	1.0	1.0	1.5	1.9	1.1	1.2	1.0	1.2	1.1	1.3
25-34	1.4	1.6	0.9	0.9	1.3	1.3	1.0	1.0	1.4	1.5	1.1	1.1	1.2	1.3	1.2	1.2
35-44	1.3	1.4	0.9	0.9	1.2	1.2	1.0	1.0	1.5	1.6	1.0	1.1	1.0	1.1	1.1	1.1
45-54	1.3	1.3	1.1	1.1	1.2	1.2	1.0	1.0	1.6	1.7	1.1	1.2	1.0	1.0	1.1	1.1
55-64	1.3	1.3	1.1	1.0	1.3	1.2	0.9	0.9	1.7	1.6	1.1	1.1	1.0	1.0	1.1	1.1
≥65	1.3	1.3	1.2	1.1	1.2	1.1	0.9	1.0	1.7	1.6	1.1	1.1	1.0	0.9	1.1	1.1
total	1.4	1.4	1.0	1.0	1.2	1.2	1.0	1.0	1.5	1.6	1.1	1.1	1.0	1.1	1.1	1.1

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

SCOPE AND CONTINUITY OF THE REPORTING

Since 1975 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 this case of a weekly return not being submitted on time, telephone contact is made.

The maximum number of days which can be reported depends on the number of weeks in the year in question and the number of sentinel stations. In 1984 it was 11 960 (52 weeks x 5 days x sentinel stations). Table 3 shows the absolute numbers and percentages.

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

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

The percentage of reporting days is a little more than in 1983. A breakdown by province and urbanization group may be seen in the following table. No great differences prove to exist. The cities are lowest, 84.5%, the northern provinces highest, 91,7%.

Per province group		Per urbanization group	
A	91.7%	1	89.4%
B	87.8%	2	89.5%
C	86.6%	3	84.5%
D	89.7%		

In fig. 2 the 1983 weekly reporting can be found. This figure clearly shows the influence of public holidays. The average number of non-reporting days per week is a little more than 27 (maximum 46 x 5 = 230).

Table 5 presents the frequency distribution of the number of days not reported per sentinel station. The average number of non-reporting days per sentinel station is 31, the same as in the previous year.
A breakdown into single and group practices shows a clear difference here, viz 39 and 11 days respectively. This is in line with the frequent assertion that forms of cooperation of general practitioners increase the continuity of reporting.

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

number of days not reported on	number of sentinel stations									
	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
< 0	1	0	0	1	1	2	2	1	2	2
1- 9	2	5	11	8	11	7	9	9	7	6
10-19	3	6	7	5	2	2	2	2	5	3
20-29	5	3	3	3	5	4	3	6	1	7
30-39	10	16	9	10	10	11	18	15	12	9
40-49	8	6	10	11	10	10	8	10	14	17
50-59	7	2	2	6[2])	4	8	2	3	4	1
60-69	3	3	0	1	2	1	1	0	1	1
70-79	1	0	1	0	0	0	0	0	0	0
80-89	2	1	0	1	0	1	1	0	0	0
90-99	0	1	0	0	1	0	0	0	0	0
≥ 99	4	2	1	1[3])	0	0	0	0	0	0
	46[1])	45	44	47	46	46	46	46	46	46
average	53	41	29	32	31	34	31	29	31	31
mediaan	46	36	32.5	34	34.5	38	38	34.5	37	35

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

[2]) One sentinel station started in February 1978.

[3]) One sentinel station finished in August 1978.

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

This is also observed when one considers the failure to report per week: in 1975 there were 15 weeks with more than 50 days' failure to report for all sentinel stations together (maximum 46 sentinel stations x 5 days = 230 days); in 1984 that was the case in 6 weeks.

THE WEEKLY RETURN (Appendix 2, p.89)

The questions on the weekly return for 1983 were selected as follows by the counselling Committee:

1. New cases of influenza (-like illness)
2. Cervical smear
3. Parkinson's disease
4. Sterilization of the man performed
5. Sterilization of the woman performed
6. Prescription of morning-after pill
7. Malignancies
8. Depression (treated for)
9. (Attempted) suicide
10. Myocardial infarction (suspicion of)
11. Traumas of the musculo-skeletal systems
12. Referrals

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

A survey of the questions included on the weekly return in the years 1970-1984 is given below; the questions of the current year, 1985, are also given. The subjects in alphabetical order can be found in Appendex 3 (p.90-91) together with the years of registration.

Subjects on the weekly returns 1970-1985

subject	'70	'71	'72	'73	'74	'75	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85
influenza (-like illness)	x	x	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															
consulations for family planning	x	x	x	x	x	x	x									
request for abortion	x	x	x	x	x	x										
(attempted) suicide	x	x	x							x	x	x	x	x	x	x
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	x	x
sterilization of the men performed			x	x	x	x	x	x	x	x	x	x	x	x	x	x
prescription of tranquillizers			x	x	x											
consulation 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	x	x
consultation with regard to addiction to smoking					x											
measles						x	x	x	x	x						
alcoholism						x										

Subjects on the weekly returns 1970-1985 (continuation)

subjects	'70	'71	'72	'73	'74	'75	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85
ulcus ventriculi/ duodeni						x										
skull traumas in traffic						x	x	x								
certificate for another dwelling issued						x										
psoriasis							x	x								
prescription of anti-hyperten-sivum or diuretic							x									
cervical smear							x	x	x	x	x	x	x	x	x	x
mononucleosis infectiosa								x	x	x						
prescription of medicine for infection of the urinary tract								x								
hay fever									x	x	x	x	x			
myocardial infarc-tion (suspicion of)									x					x	x	x
traumas in sport										x	x	x	x	x		
diabetes mellitus											x	x	x	x		
Parkinson's disease											x	x	x	x	x	x
accidents in the private sector												x	x	x		
spontaneous abortion or partus immaturus													x	x		
partus at gravidity ➨28 weeks													x	x		
penicillin (prescription and side effects)													x	x		
depression (treated for)														x	x	x
malignancies															x	x
traumas of the musculo-skeletal system															x	
referrals															x	
ulcus pepticum (first time, relapse)																x
referrals physio-therapy																x

PROCESSING OF THE DATA ON THE WEEKLY RETURN

This report contains the results of the weekly return for 1984. 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 92) the age structure as on 1 January 1984 is given.

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

the calculation of the frequencies. The data from the practices that have reported on more than 2 days of the week are processed. Till 1978 a correction factor was applied to this. Consideration of the number of times that this was applied showed that the influence on the total was so small that this correction has been done away with effect from 1 January 1978. Moreover, enquiries among the spotter physicians revealed that in the case of 1 of 2 days' absence the work was simply moved to a later date.
The returns are built up from the weekly figures, the frequencies being calculated on the average population present in the quarter.
This annual report will not attempt to give a complete analysis of the material, as already mentioned in the introduction.

The following quarterly and annual tables are included here (page 93-130):
Tables 1a, 1b, 1c, 1d and 1e: the number of patients per 10 000 of the age group[5]).
Tables 2a, 2b, 2c, 2d and 2e: the number of patients per 10 000 of the province group.
Tables 3a, 3b, 3c, 3d and 3e: the number of patients per 10 000 of the urbanization group.

In 1982 it was decided to introduce age groups in 5-year classes. Unfortunately the computer program could not be modified in time, so that the reporting for 1984 still uses the old classification (see tabels 1a-1e).

INFLUENZA (-like illness) [6]

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 1983/84 and 1984/85

Table 4a and fig. 3 (pages 128-130 and 133) give the number of new cases, the incidence, of influenza per 10000 inhabitants per week, per province group and per urbanization group for 1984-85 [7]. Fig. 4 gives the trend in comparison with previous years. The progress of influenza at the beginning of 1984 was already described in the 1983 report.
After a number of years, from 1979 to 1982 inclusive, in which no significant epidemic rises occurred in the Netherlands (see also table 6), we see for the 82/83, 83/84 and 84/85 season weekly incidences of influenza-like illnesses which, during a certain period, were up to ten times a high as those noted outside the influenza season. For the 1983/84 season the highest incidences were observed in the 10th to the 14th week of 1984, with 28, 52, 44, 49 and 32 cases per 10 000 inhabitants respectively. The highest incidences in the 1984/85 season were observed from the 8th to the 12th week of 1985, with 23, 50, 57, 38 and 24 cases respectively. In the 1983/84 season the incidences, with the exception of the western provinces, were more or less equally high in the province groups. In the southern provinces a peak of 111 cases per 10 000 inhabitants was reached in the 11th week of 1984; two weeks later, in the 13th week, the eastern provinces displayed a peak of 84 cases per 10 000 inhabitants.

In the 1984/85 season the main emphasis of the moderate epidemic lay in the northern and southern provinces, with as highest incidences 79 and 88 cases per 10 000 inhabitants respectively.

In the 1983/84 season both the influenza A virus and the influenza B virus were isolated. See the 1983 annual report. In the 1984/85 season it was influenza A virus that was mainly isolated (H3N2). Occasionally influenza A virus (H1N1) was found, while influenza B virus was also demonstrated in a number of patients.

Table 6.: number of patients with influenza (-like illness), per 10 000 inhabitants, 1975-1985

year	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
total per calendar year	695	717	575	829	438	425	491	497	396	502	
total per 'season'[1]		701	557	711	502	449	448	392	507	607	
highest weekly incidence per 'season'		68	44	107	43	15	36	20	42	53	57

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

If the annual figures for 1970 to 1984 inclusive (i.e. not just the figures during an epidemic) are compared, the year 1983, with 396 cases per 10 000 inhabitants, proves to give the smallest number since reporting started. This is a result of the fact that the peak of the minor epidemic in the 1982/1983 season was located largerly in 1982, whereas the peak of this last epidemic lay in 1984.

Age and sex distribution

During the period of registration, no difference was ever found in the frequency of influenza between men and women, so that a division is not included in the weekly return for this category.
The age distribution (table 1a-1e) shows as in the preceding years the highest frequencies in the age group under 5 years and the lowest in the 10-14 age group. In the other groups the numbers are nearly identical.
This topic is to be maintained on the weekly return.

CERVICAL SMEAR

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

The question is subdivided into the indication for taking a cervical smear, i.e. following complaints and/or symptoms, on 'preventive' grounds at the initiative of the spotter physician or the woman, and a separate column in the case of a repeat smear, irrespective of the indication for taking the previous smear. To make comparability with the investigation subsidized by the Ministry as great as possible, 3 years has been adhered to as the period within which a second or following smear has to be reported as a repeat smear. For 1984 that therefore means that a smear is reported as a repeat smear when the spotter physician himself already has taken a smear from the woman in question after 1 January 1982. This period is identical with the interval between two mass screenings.

The results of this topic will acquire greater importance in the near future, since in March 1982 the then Minister of Public Health and Environment announced the intention amend the policy regarding mass screening for cervical cancer[8]). It is being endeavoured to entrust the performance of this method of early detection to the general practitioner as per 1 January 1986.

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

Table 7.: number of smears taken by spotter physicians, by indication for taking a smear, per 10 000 women, 1976-1984

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

The total number of smears (575 per 10 000 women) is higher as in any year before. 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 gradually increased after 1976, reached a climax in 1981 and 1982 and thecather decreased. For the years 1976, 1977 and 1978 a subdivision was therefore made between sentinel stations where mass screening was organized in the area covered by the practice and where this was not the case. There then proved to be major differences that could be explained by this activity (see the 1978 report, p. 30-33). The spotter physicians were again asked whether mass screening was organized in the area covered by their practice in 1984. In 1982 and 1983 there were six physicians who had to reply in the negative; by 1984 it's number had grown to thirteen. It therefore looks as if the above-mentioned plans have already been implemented in some places.

In 1984 one practice did in fact start with mass screening; however, in view of the poor attendance the screening was halted midway. In the following comparison between practices in regions or municipalities where mass screening was held and was not held in 1984, this practice has been left out of consideration.

Smears of the cervix uteri taken by age group per 10 000 women in 1984.

No mass screening:

20-24	25-34	35-44	45-54	55-64
584	1322	1431	1200	490

Mass screening:

20-24	25-34	35-44	45-54	55-64
584	1142	951	711	286

In the practices in areas in which no mass screening was held, the numbers of smears taken, notably in the age groups qualifying for screening, are considerably higher than in areas where mass screening was still performed. The differences between the two groups of practices are considerably smaller for the age groups that do not qualify for mass screening: the women of 20-24 and 25-34 years.
These figures suggest that general practitioners are inclined to regard screening for cancer of the cervix uteri as their task, both for those age groups that do not yet qualify for mass screening and in that situation in which mass screening is no longer performed.

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

The total number of smears taken on preventive indication has increased on the initiative of both the spotter physician and the women. The category repeat smears displays an increase. This category offers the possibility of calculating from the totals through the years the number of women who are reached by this method by the general practitioner. The number of women are reached in this way at least once every three years may be seen in the total of table 8. This table contains only the numbers of first smears per 10 000 women, with a subdivision for the indication for taking the smear and per province and urbanization group (cf. also figs 5 and 6). The total number of **first** smears has clearly increased, notably in the category 'Preventive, general practitioners initiative'.

In the subgroups a number of differences may be observed. An obvious rise in the number of smears taken by spotter physicians may be seen in the northern, western and southern provinces and in the cities. The eastern provinces displayed a considerable rise in 1983; in that same year the number of smears taken by the spotter physicians also increased to a large extent in rural regions.

Table 8.: number of first cervical smear 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, 1976-1984

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

Age distribution

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

Table 9.: number of (first) smears taken by age group, per 10 000 women, 1976-1984

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

There are some discrepancies with the figures from previous years; the principal one is the increase in the number of 'first' smears taken in the 25-34 age group from 797 to 957 per 10 000 women. The 35-44 and 45-54 age groups, the category for which mass screening has been or is being organized, display a fluctuating picture: in the 35-44 age group there is a decline. The drop in the number of 'first' smears in this age group occurs as the result of the smaller number of smears in connection with complaints and/or symptoms (see table 10). Conversely, a slight increase may be seen in the 45-54 age group. However, one can hardly speak of a trend as yet, though it can be established that the numbers of 'first' smears taken by spotter physicians, as in 1983 was in 1984 too above the 1982 numbers.

Table 10 gives for 1978 and following years a breakdown by indication for taking a smear, including the repeat smear (see also fig. 8). This table gives 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 from the same woman must be reported as a repeat smear had not yet lapsed then.

Table 10.: number of smears taken by spotter physicians by age group and by indication for taking the smear, per 10 000 women, 1978-1984

		age group						
		15-19	20-24	25-34	35-44	45-54	55-64	≥ 65
complaints and/ or symptoms	1978	17	102	153	193	147	55	7
	1979	28	93	158	207	113	62	13
	1980	21	84	122	121	108	47	20
	1981	16	90	127	106	72	46	17
	1982	16	92	130	97	85	31	17
	1983	19	88	117	153	96	51	18
	1984	14	44	123	110	98	36	19
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
	1983	29	357	410	288	230	85	14
	1984	50	400	533	287	222	97	20
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
	1983	15	98	270	283	189	97	10
	1984	8	85	287	296	205	111	9
repeat smear	1978	(5)	50	199	367	293	70	8
	1979	(2)	63	225	470	324	99	12
	1980	6	55	224	416	385	149	17
	1981	(6)	68	279	454	385	119	14
	1982	(6)	89	304	468	387	135	8
	1983	(3)	60	255	539	397	132	8
	1984	5	65	318	446	444	136	15
total	1978	48	384	1034	1395	1035	350	51
	1979	87	583	1108	1384	958	332	60
	1980	53	591	964	1023	849	360	68
	1981	78	616	1158	1056	858	344	61
	1982	70	654	1163	1119	842	342	51
	1983	66	603	1052	1263	912	365	50
	1984	77	594	1275	1139	969	380	63

The total number of smears taken on medical indication brings no new aspects to light; the numbers fluctuate somewhat.

There is an obvious increase in the number of smears taken on the initiative of the spotter physician. This increase is particularly noticeable in those age groups that lie outside mass screening, viz the age groups up to 35 years. In the other age groups and in the other categories there are some differences in respect of previous years, but these are not striking. In the repeat smears category we see greatly varying figures for the different age groups: a clear decline in the 35-44 age group; conversely a rise in the 25-34 age group and - to a smaller extent - in the 45-54 age group. As also previously mentioned, it is as yet too early to be able to say whether these figures are in fact a result of the changed policy regarding mass screening for cervical cancer.

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

This topic has been maintained on the weekly return for 1985.

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[9]). The data collected up to now are, however, too few in number for this calculation to be made in a responsible fashion.
When the diagnosis is made both age and sex are stated.

The 'patient-control investigation' announced in the 1982 report started in mid 1983 retroactively. So far the results as regards the feasibility of such an investigation in the sentinel stations are statisfactory, from the side of both the general practitioner and the patients.
A provisional report has been submitted to the Princess Beatrix Fund; upon publication of a final report the latter will be discussed in a later year.

Table 11 (see next page) states the incidence per 10 000 men and women per province and urbanization group.

Table 11.: number of new cases of Parkinson's disease, per province group and urbanization group, per 10 000 inhabitants, 1980-1984

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

The absolute number of reports is lower again, namely 14 as against 16, 32, 38 and 85 respectively for 1983, 1982, 1981 en 1980. In view of the small numbers, only slight value may be attached to frequencies displayed here. However, the thought occurs that overreporting took place in 1980 as the result of confusion with 'old patients'. Some of the prevalent cases are registered as incidental cases, a phenomenon that must be guarded against, especially in the case of chronic diseases declaring themselves slowly.
Differences existing between 1983/1984 and 1981/1982 have probably also been caused by this phenomenon. The incidences found in 1983 and 1984 (1 out of 10 000 inhabitants) correspond to the extent of occurrence of this disorder elsewhere.

Age distribution

Table 12 (see next page) gives the incidence per 10 000 men and women of Parkinson's disease.

Table 12.: number of new cases of Parkinson's disease by age group, per 10 000 men and women, 1980-1984

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

The literature[10]) suggest that the incidence of Parkinson's disease is higher among men than among women. The data from this registration do not support this supposition.

The topic has been maintained in the weekly return for 1985.

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 alia for the compilation of a Dutch contribution to the Council of Europe's report: 'Country Report of the Netherlands'[11]) and for computing the trend of the population[12]).

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

The number of sterilization of men performed per 10 000 of all men and per province group and urbanization group is given in table 13 (cf. fig. 9).

Table 13.: number of sterilization of men performed, per province group and urbanization group per 10 000 of all men, 1972-1984

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

The fall in the number of sterilizations that became clear in 1980 seems to be drawing to a close.

In an occasional subgroup the decline is still occurring; opposed to this is some increase in a few other subgroups.

Extrapolation gives 32 500 for the total population of the Netherlands.
A breakdown per quarter offers an opportunity for investigating whether a change in frequency may be a reaction to some event by which the popularity of this method may be influenced (table 14).

Table 14.: number of sterilizations of men performed, per quarter, per 10 000 men, 1972-1984 [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	11	10	14
1983	13	10	12	12
1984	12	12	8	13

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

The frequencies per quarter in 1984 correspond to those of 1983. As has been said in the previous reports, if no other factors play a role, one may in the course of time expect a stabilization as a result of the end of a 'historical catching-up effect' coming into sight.

If in 1984 some 10 000 sterilizations of men had been performed (the 'replacement factor'), the percentage of men sterilized at some time would have remained the same as in 1982. Since in reality some 32 500 operations were performed, there was an additional increase of some 22 500 (Dr E. Ketting).

In fig. 11 the number of sterilizations per 10 000 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 15 (cf. fig. 12).

Table 15.: number of sterilizations of men performed, by age group, per 10 000 men, 1972-1984

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

For all years the highest frequency is to be seen in the 35-44 age group. The decline that started in 1980 seems to be coming to a halt in this group. Respect to 1970 a drop of 61% occurred as against 54%

in the 25-34 age group.

A cumulative calculation shows that in the Netherlands since 1971 at least 498 500 sterilizations of men have been performed, that is on 7% of the total male population. If the number is related to the 20-64 age group, this being approximately the cohort that has entered into consideration for this operation since the start of registration, one arrives al over 11.7%.
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 1985 weekly return.

STERILIZATION OF THE WOMAN

Sterilization of the woman performed was placed on the weekly return in 1974 (of the man performed in 1972).
The number of sterilizations of women performed per 10 000 of all woman and per province group and urbanization group is given in table 16 (cf. fig. 10).

Table 16.: number of sterilizations of women performed, per province group and urbanization group, per 10 000 of all women, 1974-1984

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

The national frequency with regard to the number of sterilizations of women performed, as observed with that of men, did not fall in 1984. A striking feature is the increase in 1984 in sterilization of the woman performed in the eastern provinces (from 38 to 53 per 10 000 women) and in rural regions (from 42 to 55 per 10 000 women). In the northern and southern provinces there is a decline in respect of 1983 (from 45 to 32 per 10 000 and from 42 to 33 per 10 000 women respectively). This is also the case in the cities (51 and 42 per 10 000 women respectively.

In fig. 11 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 17. The quarterly figures of 1984 correspond to those of 1983.

Table 17.: number of sterilizations of women performed, per quarter and per 10 000 women, 1974-1984 [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
1983	11	10	9	9
1984	11	8	9	10

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

Age distribution

The age-specific distribution of the number of sterilizations performed per 10 000 women is given in table 18 (cf. fig. 12).

Table 18.: number of sterilizations of women performed, by age group per 10 000 women, 1974-1984

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

In the case of women of 35 years old and older there is a decrease in the frequency of sterilization. Below the age of 35 an increase may be seen in 1984, in contrast to 1983, when there was a decline. The 25-34 age group displays the highest frequency for the first time. In other years the highest frequency was always to be found in the 35-44 age group.

A cumulative calculation shows that in the Netherlands since 1973 sterilization has been performed in total on at least 433 000 women, i.e. 6% of the total female population. However, it is more realistic to relate the figures solely to women of fertile age (15-49 years) and at the same time to include the sterilization pattern of the man.
In that case it proves that in 1975 the woman or the man was sterilized in some 6% of (married) couples. This percentage has since risen via approx. 18.5 in 1980 and approx. 21 in 1982 to approx. 23.4 in 1984. 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. The number of sterilizations which has then to be performed annually on the basis of this calculation to

keep the total percentage stable would then be about 25 000 (men and women together).

To keep the percentage of women sterilized at some time stable, only 13 000 sterilizations were required in 1984. The number of sterilizations performed (obtained by extrapolation) is, however, 28 500; there was thus a real surplus of 15 500. In 1983 and 1982 this surplus was still 17 000 and 20 000; this declining trend may be an indication that the "historical catching-up effect" is drawing to a close.

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

This question has been maintained on the weekly return for 1985.

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

Table 19.: number of prescriptions of the morning-after pill, per province group and urbanization group per 10 000 of all women, 1972-1984

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

After three years (1981 to 1983) with lower frequencies regarding prescription of the morning-after pill, an abvious increase occurred in 1984 in all province and urbanization groups with the exception of the southern provinces. The increase is particularly striking in the northern provinces and in rural regions. If we look at the quarterly figures, the increase in the 3rd quarter is striking.

Table 20.: number of times that the morning-after pill was prescribed, per quarter, per 10 000 women, 1978-1984 [1])

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

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

Age distribution

Table 21 gives the age distribution of the prescription of the morning-after pill (cf. fig. 14).

Table 21.: number of prescriptions of the morning-after pill, by age group, per 10 000 women, 1972-1984

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

The increase already mentioned for 1984 relates in particular to the younger age groups: in the 15-19 year age group the increase in respect of 1983 is no less than 45.5%, in the 20-24 age group 35% and even in the 25-34 age group of women 32%.

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 49 years. Reports above 49 years occurred three times. The absolute numbers under 20 years are given in table 22.

Table 22.: absolute numbers of prescription of the morning-after pill for women under 20 years, 1977-1984

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

In 1983, at the request of M.R. van Santen M.D. (at that time gynaecologist at the University Hospital, Rotterdam) it was requested that the kind of pill prescribed be noted. The background to this request was to investigate whether in the Netherlands, as in the surrounding countries, the 'new morning-after pill' (200 mcg ethinylestradiol + 1 mg dl-normgestrel, 'EE2 + Norg') has displaced the 'old' one (5 mg ethinylestradiol, 5 mg "EE2" for 5 days). This proved to be the case. In 1980 5 mg EE2 was still being used in practically 100% of the cases; now that 21% according to this registration.

The question has been maintained on the 1985 weekly return, with reporting of the kind of the prescription.

MALIGNANCIES

In the Netherlands national cancer registration is being prepared. When setting it up an important question was which information sources should form the basis of this national system. The pathological-anatomical laboratories entered into consideration for this. However, the question was how many cases are **not** registered via those laboratories because no referral to a specialist takes place or the general practitioner, after an excision, does not send in any material for pathological-anatomical assesment.

The Sentinel Stations Project was approached by the Ministry with this question (A.A.M. Vloemans, M.D.). The spotter physicians were requested to make a return for 1982 of the patients with regard to whom the diagnosis 'cancer' had been made, stating the manner and place of diagnosis. The results were surprising: in the case of 10% of the patients neither histological nor cytological examination proved to have been performed.

This unexpected finding led to the decision to repeat the question for 1983, again in the form of an incidental investigation with a more elaborate questionnaire.

The investigation was performed in collaboration with P.A.H. van Noord, M.D., an epidemiologist with the Epidemiology Department of the Institute for General Health Care and Epidemiology of Utrecht State University. The summarizing conclusion of that incidental investigation was that for 1983 too the general practitioners form an important source for the gathering of (supplementary) data on the occurrence of cancer.

It was decided to include this subject as a topic on the weekly return, starting in 1984. The Counselling Committee realized that the non-longitudinal set-up of the gauging, whereby registrations are concluded per year or per week, means that the figures presented relate to incidental cases of cancer found in a calendar year, and the deceased or clinically confirmed cancer cases also (still) within that calendar year. In this way the average follow-up time is thus 6 months. However, the impression exists that, having regard to the trend of the tumours reported, this will have little effect on the percentage of 10 stated, an impression which is also confirmed by a publication by Schadé and IJzermans[13]), who had the availability of a longer follow-up.

The patients qualifying for registration consist of two groups:

1. patients with regard to whom the diagnosis has been confirmed by the specialist. The moment of registration is the moment when the spotter physician is informed of this diagnosis;
2. patients with regard to whom the spotter physician himself suspects the diagnosis, but for whom no further diagnosis is made, for some reason or the other. The moment when the spotter physicians starts to act as if a patient with a carcinoma was concerned is the moment of registration.

Table 23 gives the results for 1982-1984. These are relative frequencies per province and urbanization group and for the total (cf. fig. 15).

Table 23.: numbers of new cancer patients per province and urbanization group, per 10 000 men, per 10 000 women and per 10 000 inhabitants, 1982-1984

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

In the course of the period 1982-1984 the method of registration was adapted, so that the considerable differences between the three years may not be regarded as differences in incidence. For 1982 the general practitioners were afterwards asked to report patients with new malignancy, and in 1983 an incidental investigation was performed into this. Not until 1984 was the subject placed on the weekly return. The figures for 1984 may be regarded as the most reliable

incidences in this series.
A constant factor in the incidence series is that most patients with cancer (confirmed or suspected, whereby the spotter physician acts as if) are registered in the centre and the west of the country (province group C) and the cities (urbanization group 3). This is in accordance with the data on cancer mortality[14]), and the differences cannot be explained by differences in age structure.

Age distribution

Table 24 shows how the reported cases of cancer or suspected cancer are subdivided among the various age groups (cf. fig. 16).

Table 24.: absolute and relative numbers of (new) patients with a (suspected) malignancy reported by spotter physicians and number of men and women by age group, 1982-1984

		age group						
		< 25	35-34	35-44	45-54	55-64	≥65	Total
men absolute	1982	3	2	6	21	47	110	189[1])
	1983	5	2	8	20	53	129	217
	1984	5	5	13	29	67	148	267
per 10 000	1982	(1)	(1)	6	25	68	157	25
	1983	2	(1)	9	25	81	193	29
	1984	2	4	13	37	99	210	37
women	1982	4	6	23	21	38	91	183[1])
absolute	1983	4	8	18	38	61	109	238
	1984	3	10	24	37	39	143	256
per 10 000	1982	(1)	4	25	25	51	91	23
	1983	(1)	6	20	47	87	114	31
	1984	(1)	8	24	46	54	140	34

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

As was to be expected, there proves to be a close link with age: a low incidence in youth and a high one at a greater age. For men this

increase (in both years) begins later than for women, viz at 45-54 years, for women at 35-44 years, but on the other hand the increase continues more strongly. The remarks made above regarding the differences between the years 1982-1984 naturally also apply to the age groups. Comparison of the years should be treated with caution.

Localization

In the 1983 report data were also presented on the localization of the registered malignancies. As a result of uncertainty about financing of the further research into the data for 1984, the present report does not contain this information. The uncertainty has meanwhile been removed, but there was insufficient time to process all the information for this report.

Autopsies (desired and performed)

Out of all reports made in 1984 of patients with a confirmed or suspected malignancy, 119 patients died before the end of 1984. The spotter physicians were asked whether the general physician, in the event of decease, would have appreciated confirmation of the diagnosis by means of an autopsy. It was also asked whether the general practitioner considered it possible to obtain permission for an autopsy.
Table 25 contains the answers to these questions subdivided by place of decease.

Table 25.: patients qualifying for autopsy and autopsies desired by the general practitioner

Total deceased in 1983	autopsy desired	no opinion	autopsy unnecessary	total
permission no problem	14	9	15	38
unknown	18	7	23	38
permission problematic	8	4	31	43
total	30	20	69	119

subdivided into:
deceased in hospital:

	autopsy desired	no opinion	autopsy unnecessary	total
permission no problem	12 [1]	8 [2]	5	25
unknown	2	6	8	16
permission problematic	4	2	8	14
subtotal	18	16	21	55

deceased in a home:

	autopsy desired	no opinion	autopsy unnecessary	total
permission no problem	0	0	2	2
unknown	1	1	6	8
permission problematic	2	0	4	6
subtotal	3	1	12	16

deceased at home:

	autopsy desired	no opinion	autopsy unnecessary	total
permission no problem	2	1	8	11
unknown	5	0	9	14
permission problematic	2	2	19	23
subtotal	9	3	36	48

[1]) of which 4 were actually performed
[2]) of which 5 were actually performed

Three persons suddenly died outside their homes; no further data are known on these cases, for one of which the general practitioner desired an autopsy of the patient (not included in the table).

These data show that the general practitioners consider an autopsy necessary in only a small number of the situations (25%) in which

someone with a (suspected) malignancy dies.
There is a difference in the need for further information depending on the place where the patient dies. In the case of decease in hospital the general practitioner considers the further information via an autopsy desirable in 33% of the cases, and in decease at home in 19% of the cases. If decease in a home is counted as decease at home in 19% of the cases. If decease in a home is counted as decease at home the percentage is likewise 19.

Obtaining permission for an autopsy is considered less problematic in the hospital situation than in the situation in which a patient dies at home: in 45.5% and 23% of the cases obtaining permission would form no problem.

The topic malignancies has been maintained on the weekly return for 1985.

DEPRESSION (treated for)

Little is known about depression (depressive syndrome) as a medical problem for the general practitioner. For the psychiatrist it is one of the large groups of illnesses that form a major part of polyclinical and clinical morbidity.
On the other hand, a depressed state is often designated as a variation of mood forming part of a normal life and experienced from time to time by very many people. In such a mental state one is inclined to take a more sombre view at things, to interpret harmless physical defects more darkly and, possibly as a result of this, to visit the general practitioner sooner or later.
In many of those cases the physical problem and not the depressed state of mind will be to the fore. At that moment there is thus no question (as yet) of depression as a medical problem.
Few if any objective criteria are available for making a clear distinction between a depressed mood as a general human state of mind and a depressive syndrome as a problem calling for specific medical approach. In fact one cannot speak of depression as a medical problem until the general practitioner and patient (of the latter's family) call it a problem.
In the discussion whether or not to include depression on the weekly return, one was well aware of the probability of an 'interdoctor variation' with regard to using this diagnosis. It was therefore decided forthwith that an investigation would be made into this. Because action by the spotter physician could be influenced, it was agreed not to perform that investigation until the second year of registration. At present only the observed frequencies are being reported.

Criteria:

By depressive syndrome is meant a syndrome recognized as such by the general practitioner in which the sombre negative state of mind occupies a central position.
Registration was not to take place until the seriousness of the depression led the physician to take some form of action, viz:
- antidepressive medication;
- treatment by discussion with the patient;
- follow-up contacts (i.e. repeat consultations or visits);

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

Only the first contact with a patient is reported. A breakdown in accordance with sex is age and sex is made.
The criteria were drawn up by colleague H.O. Sigling, a former spotter physician who is at present a member of the medicine of general practice subject group of the Free University, Amsterdam. He will also perform the further investigation mentioned above.

Table 26 states the frequencies of the actions per provinces and urbanization group, subdivided by sex (see also fig. 17).

Table 26.: number of new patients "treated" for a depressive syndrome, by province and urbanization group, per 10 000 men and women, 1984

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

With regard to the figures for 1983 there were some changes in 1984. The overall picture is that of a fall in the frequencies. The exceptions are formed by the eastern provinces, with an increase in the frequency of occurrence among women of 54%, and the rural municipalities, with an increase of 37% for women.

The differences between the province groups noted in 1983 are smaller in 1984; only in the provinces of Utrecht, North and South Holland are clearly fewer depressions registered.

The differences in the urbanization groups are also still present,

as in 1983. In the cities the frequency is twice as high as within the urbanized rural municipalities and municipalities with urban characteristics (112 and 55 per 10 000 inhabitants respectively).

Between men and women there is again an obvious difference: the woman-man ratio is 2:1 for the whole of the Netherlands. In the subgroups that varies from 1.7 to 2.2; a somewhat less great variation than in 1983 was found (1.3 to 2.2).

Age distribution

Table 27 gives the frequencies per age group and per sex (see also fig. 18).

Table 27.: number of new patients 'treated' for a depressive syndrome by age group, per 10 000 inhabitants, 1983-1984

		age group								
		5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-65	≥65
men	1983	-	(2)	10	35	75	112	93	94	54
	1984	-	-	(6)	41	58	75	88	67	51
women	1983	-	(6)	67	103	140	173	182	129	99
	1984	(2)	9	47	85	132	149	132	115	104
total	1983	-	(4)	39	69	108	142	138	112	81
	1984	(1)	4	27	64	95	112	110	92	82

Below the age of 15 years the physician hardly takes little action (see the criteria for registration) on account of a depressive syndrome; above that age this rises quickly, with a maximum of 112 times per 10 000 inhabitants of the 35-44 age group. Above that group a gradual decline occurs, ending with a frequency of 82 per 10 000 at an age greater than 64 years. The above-mentioned difference per sex is present in all age groups, with the proviso that the woman-man ration in the case of patients younger than 25 years is nearly 1:3; above that age it fluctuates between 1:1.5 and 1:2.6. As already stated, further analysis will take place in the background of a

possible interdoctor variation.

This topic has been maintained on the weekly return for 1985.

(ATTEMPTED) SUICIDE

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

The absolute number of **reports** (which is **not** equal to the number of patients, since recidivists are not uncommon) was 106, 98, 95, 116, 148 and 109 in 1979-1984.
The number of reports in 1983 proves to be the largest in comparison with those of the preceding years and of the period 1970-1972, when 109, 135 and 110 cases respectively were reported in an population of practically the same size. To what extent this is attributable to oscillations occurring, or whether the increase noted in the number of suicide attempts in data registered elsewhere is now also reflected in the sentinel station data, is for the time being not clear (see 1982 report, p. 50).

The number of attempts per province and urbanization group per 10 000 inhabitants may be found in table 28. The breakdown into subgroups is of limited value, because of the relatively small frequencies.

The decline in the national frequency is mainly the result of the decline in the northern provinces, where the frequency fell by 75%

(from 16 per 10 000 inhabitants in 1983 to 4 in 1984). When considering the urbanization group in which the decline particularly occurred, group 2 catches the eye (from 8 per 10 000 inhabitants in 1983 to 5 per 10 000 inhabitants in 1984).

Table 28.: number of reports of (attempted) suicide per province and urbanization group, per 10 000 inhabitants, 1979-1984

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

Age distribution

Table 29 gives the frequency of (attempted) suicide per 10 000 inhabitants per age group (see also fig. 19).

Table 29.: number of reports of (attempted) suicide by age group, per 10 000 inhabitants, 1979-1984

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

With regard to age groups too the breakdown is of limited value on account of the small absolute numbers and the ease with which oscillations can occur.
What is striking is that the decline has taken place in the age group up to 54 years. Above that age the frequencies have remained more or less the same.
Despite the decline mentioned above, the frequency in the 20-24 age group continues to lie that of the other age groups.

The highest frequencies are to be found in the 20-44 age groups.

Seasonal influences

In contrast to what is occasionally asserted, there proves to be no connection between the number of suicides or attempts and the seasons. This was likewise found by the Rotterdam Municipal Medical and Health Service in the period 1954-1981 [15].

This topic has been maintained on the weekly return for 1985.

MYOCARDIAL INFARCTION (suspicion of)

In 1978 the topic 'myocardial infarction (suspicion of)' was included in the weekly return. This was because the number of myocardial infarctions in the Netherlands was still not declining; there was nothing yet to be seen of the drop noted in the USA. Knowledge of the number of cases of myocardial infarction is important for adapting policy with regard to both health care and scientific research.

There was a desire to gain insight the number of cases in which the physician acts as if an **acute** myocardial infarction is concerned. What is meant by this is that the diagnosis 'infarction' - both a primary and a recurrent infarction - is considered so probable that the usual measures for this are taken. This refers to the administration of antiarrhythmic agents and agents for combating pain and shock, possible resuscitation and reanimation, or (acute) admission to hospital.
Partly in connection with publications[16]) pointing to favourable experience with home nursing, even compared with the coronary care units, there was increasing interest in the question whether the diagnosis is verified or not is not important in the first instance. Such a verification can be obtained from other sources.

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

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

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

the registration.

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

Table 30 gives the frequencies of (suspicion of) myocardial infarction per province and urbanization group and for the Nehterlands (see also figs. 20 and 21).

Table 30.: number of cases in which the spotter physician acts as if an acute myocardial infarction in concerned, per province and urbanization group, per 10 000 men or women, and by admission or non-admission to hospital within 48 hours, 1978 and 1984

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

If the figures for clinical and non-clinical patients for 1983 and 1984 are compared with those for the whole of the Netherlands, little or no difference is registered as regards (suspicion of) myocardial infarction in both men and women (37 and 39 per 10 000 men and 19 per 10 000 women respectively).
In the case of men admitted to hospital the increase occurs above all in the eastern and southern provinces (40 and 52 per 10 000 men and 19 and 27 per 10 000 men respectively). The northern provinces display a decline with respect to 1983.

There are obvious differences - for both sexes together and for both clinical and non-clinical patients - between province groups: in the eastern provinces (suspicion of) myocardial infarction is registered 1.8 times more frequently than in the southern provinces, and 1.6 times more frequently than in the northern provinces.
For women the frequency is the highest in the cities: as in 1983, 23 per 10 000 women.
The ratio between men and women, with 39 and 19 per 10 000 respectively, is practically the same as in 1983. This factor of two is found in practically all subgroups.
The quarterly figures display no striking differences.

Age distribution

In table 31 the frequencies per age group are given (see also figs 22 and 23).

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

The percentage of patients with (suspicion of) myocardial infarction being nursed at home in 1984 was 17.7%. In 1983 the figure was 25% and in 1978 23%. In 1984 the percentage is higher for women than for men (21.1 and 15.4% respectively). These percentages are lower than in 1978 and 1983, 25% and 35% for women and 22 and 22 for men respectively.

The difference can be largely explained by the considerable percentage of women above the age of 64 years nursed at home: in 1984 25% for women as against 21% for men and in 1983 37% for women as against 27% for men. In 1978 this was 36% for women as against 16% for men. A further analysis may perhaps bring to light other factors which influence this decision. The Netherlands Heart Foundation has given a subsidy for this. It will also be attempted to gain insight into the severity of the disorder and the follow-up in the various groups of patients. This research will be performed by J. Fracheboud, M.D., under the supervision of Dr J. Berkel, specialist in internal medicine, and Dr F.H. Bonjer, cardiologist.

Table 31.: number of cases in which the physician acts as if an acute myocardial infarction in concerned, per age group, per 10 000 men or women, and by admission or non-admission to hospital within 48 hours, 1983 and 1984

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

This topic has been maintained on the weekly return for 1984.

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

TRAUMAS OF THE MUSCULO-SKELETAL SYSTEM

In 1982 a textbook on traumas of the musculo-skeletal system edited by Professor M.J. Kingma was published. In a discussion of the work by F. Meyman[17]) the comment was made that the epidemiological data used were based solely on hospital patients and dated registrations from general practice.
Prior to that it had been the editor-in-chief, Professor Kingma himself who, not entirely satisfied with the epidemiology chapter of the publication, had already contacted the sentinel stations project leader with the request for further data on the occurrence of traumas of the musculo-skeletal system in general practice. In a second edition of the publication he wanted more complete and recent data.

When next in 1983 the Traumatology working party of the Netherlands Orthopedic Association also asked for the same data, the Counselling Committee decided to place the subject on the weekly return for 1984 and in this way to attend to further information on the occurrence of these trauma among the Dutch population, information supplementing the results of the registration systems in the out-patient clinics and hospitals and the mortality statistics.
The purpose of this topic is thus to complete the data on traumas of the musculo-skeletal system and to establish the share of general practitioners in the care of patients with these traumas.
The following criteria were formulated by Professor Kingma:

a. The musculo-skeletal system comprises the bones, the joints, the muscles and the soft tissue covering them.
b. The traumas that should be registered are the mechanical traumas as the result of an accident. Traumas as a result of thermal and chemical causes are excluded. Also excluded are traumas as a result of repeated effect on the system, such as is the case with traumas caused by over-exertion.
c. An accident is defined as a sudden, unforeseen happening that results in recognizable harm to physical well-being.
d. In the event of more than one trauma the most serious one is registered, in the event of an uncertain diagnosis that diagnosis which is most probable, and only the first contact is reported.
e. A breakdown is made into:
   1. contusion: bruising of the skin and underlying structures, with the symptoms pain, swelling,coloration.

2. distortion: damage to the capsule and ligaments of the joint as a result of the surfaces of the joint separating and springing back. The symptoms are pain, swelling and disturbed function and, in the case of a torn capsule, bleeding in the joint;
3. luxation: a permanent interruption of contact between the surfaces of the joint with damage to the ligaments and capsule, with the occurrence of pain swelling, disturbance of function and existence of a deformation;
4. fracture: an interruption of the continuity of the bone;
5. soft tissue: in this context, the tissue covering joints and muscles.

In the final version of the breakdown it was decided to combine the categories luxation and fracture, and to make no distinction between women and men.

Table 32 shows the relative frequencies for the first contacts with the general practitioners for the various categories of traumas by province group and degree of urbanization. The table also contains the total number for the Netherlands.

Table 32.: number of first contacts on account of traumas of the musculo-skeletal system per province and urbanization group per 10 000 inhabitants for 1984

	province group				urbanization group			Netherlands
	A	B	C	D	1	2	3	
nature of trauma								
contusion	205	172	152	167	166	150	212	166
distortion	160	166	109	140	180	124	124	133
luxation/fracture	91	83	45	61	86	58	52	61
soft tissue trauma	172	160	107	207	168	140	154	147
total	628	581	413	575	500	472	542	507

The most important difference that can be established in the different groups, is that between province group C (the centre of west of the country) and the rest of the Netherlands.

Such a finding, the lowest frequency in province group C, was also made in the period 1979-1983 in the registration of first consultations of the general practitioners in connection with a trauma in sport (see reports for 1979-1983). Since sport traumas will form an important part of alle mechanical traumas of the musculo-skeletal system, this finding is consistent with the earlier data.

Comparison with the frequencies of accidents in the private sector, where in part there will also be cases of mechanical damage to the musculo-skeletal system, displays the same picture.
It is striking that consultation of the general practitioner for luxation/fracture in the west and centre of the country is about a factor or 2 lower than in the north and east. The southern provinces stand out as regards the highest frequency of first consultations of the general practitioner for soft tissue traumas.

If we consider the distribution for the urbanization group, group 3, the cities, scores highest as regards first consultations on account of contusions but lowest as regards consultations on account of luxations/fracture.

Seasonal influences

Table 33 (see next page) gives the frequencies of the first consultations on account of traumas of the musculo-skeletal system per quarter.

Table 33.: number of first consultations of the general practitioner on account of traumas of the musculo-skeletal system per quarter, per 10 000 inhabitants in 1984 [1])

	1st quarter	2nd quarter	3rd quarter	4th quarter
contusion	43	43	38	41
distortion	33	36	30	31
luxation/fracture	14	15	16	15
soft tissue	32	39	39	35
Total	122	133	123	122

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

No seasonal influences can be established, unlike the case with the registration of sport traumas (see the 1983 report). It may be assumed that in the summer holidays the 'holiday traumas' take the place of the sport traumas in the other quarters. Further analysis, for which this registration offers no possibilities, ought to be able to demonstrate that.

Age distribution

The frequencies of the first consultations on account of traumas of the musculo-skeletal system per age group are illustrated in table 34 (see also Fig. 24).

Table 34.: number of first consultations on account of traumas of the musculo-skeletal system by age group, per 10 000 inhabitants in 1984

age group	contusion	distortion	luxation/ fracture	soft tissue	total
< 5 years	184	57	77	384	702
5- 9 years	166	102	96	208	572
10-14 years	278	232	106	175	791
15-19 years	306	257	83	210	856
20-24 years	230	240	57	185	712
25-34 years	174	177	46	144	541
35-44 years	115	97	43	134	389
45-54 years	109	68	37	109	293
55-64 years	100	62	37	77	276
≥ 65 years	117	42	93	91	343

There seems to be some age-specificity as regards the nature of the trauma (contusion, distortion, luxation/fracture and soft tissue traumas) and therefore probably the preceding accident. It is notably the younger age groups up to 34 years among which traumas as the result of mechanical violence occur. Above that age up to 65 years there is a decrease in consultation of the general practitioner on account of this problem. Among 65-year-olds and older there is a clear increase in the number of luxations/fractures for which the

general practitioner is consulted.

Besides age and the accompanying risks of accidents, the place where an accident occurs which results in trauma of the musculo-skeletal system (in the home, on the street, at work or on a sport field) is probably responsible for this pattern of incidence.

For 1985 this topic has been removed from the weekly return.

REFERRALS

It is the intention of policy-making bodies in health care to replace the existing system of referral and repeat cards by a system of advice and treatment cards for members of health insurance funds (at least that has been the subject of discussion for some years now between health insurance funds, specialists and general practitioners). The idea behind the new system is to be able to make a separation between a diagnostic referral and therapeutic advice and a resultant referral. The complaint of general practitioners is that they 'lose' patients at the moment when a referral card is made out and that from then on they can exert no further on what happens to the patient in secondary care. The new system offers in theory the possibility of meeting these objections.

It is not generally known what the ratio is between referral cards made out principally on account of a need for advice and referral cards on which treatment is in the forefront or is included. Only the gross health insurance fund figure for the number of referrals per 100 or 1000 members is published as a rule.

In order to acquire an impression of the ratio between referrals for diagnosis and/or treatment the sentinel station practices registered a number of kinds of referrals in 1984. It is the intention, if and when the new system enters into effect, also to register advice and treatment cards over a year and thus to compare the results from both years with each other.

The following subdivisions of the referral figure have been made (only referral figures of health insurance fund members have been registered):

1. referrals to reassure the patient;
2. referrals for diagnosis;
3. referrals for treatment;
4. a combination of 1, 2 and/or 3 (usually 2 and 3);
5. referrals to the ophthalmologist on account of refractive error;
6. other referrals (often referrals of an administrative nature, for instance if a specialist wishes to continue the treatment after a year)[18].

On account of shortage of space on the registration form it has been decided to make no distinction between men and women and to record only data of health insurance fund members. Referrals to a supporting specialism (radiodiagnosis or clinical chemistry) without the intermediary of a treating specialist) have not been counted as referrals.

Results

Total referral rate

Per 10 000 patients 2180 referral cards were made out. Converted to an average size of the health insurance fund practice of approx. 68% [19], this amounts to a referral rate of 3206 per 10 000 inhabitants. In 1983 the referral rate of the National Information System for Health Insurance Funds was 4580 per 10 000 inhabitants and the LISZ referral rate of the spotter physicians 4232 per 10 000 inhabitants[20]. We encounter a difference, presumably caused in part by underreporting (especially in administrative referrals - a phenomenon also found by Dopheide and Nijhout (1984)), but which may also be the result of a more reticent referral policy inspired by the registration (the "Hawthorne effect"). The 1984 LISZ figures may give a definite answer about this, as soon as they are available.

Ratio between advice and treatment

If we proceed from the total referral rate of 2180, the subdivision is shown in table 35.

Table 35.: referral cards per 10 000 persons by separate categories (cumulative)

	absolute	percentage
for reassuring the patient	44	2
for diagnosis	172	8
for treatment	408	19
combinations	267	12
refractive errors	475	22
other referrals	814	37
total	2180	100

The number of referrals for reassuring the patient or for diagnosis is small (2 and 8% of the total respectively). The combination reassurance/diagnosis and treatment occurs in 12% of the cases. Usually the specialist is asked here to act according to circumstances in the event of differing results.

Thus in 10% of the cases only an advice card would be prescribed, in 19% of the cases a treatment card (for varying duration) and in 12% of the cases it would depend on the instructions whether an advice and a treatment card would be simultaneously issued. Incidentally it is notes that the proportion of referrals to the ophthalmologist does not differ greatly from the proportion of ophthalmologist referrals in the total LISZ figure (1983: 23%). It is a pity that the category of 'other' referrals is so large: in any case these are not referrals falling within the complaint-diagnosis-treatment model. It is the question how that type of referral can be fitted into the advice and treatment card.

All in all the proportion of cases in which the general practitioner runs the risk of 'losing' the patient is not higher than a maximum 20% and probably somewhere between 10 and 20%, at least on the basis of these sentinel station data (see the cumulative table on the preceding page: the categories 'for reassuring the patient', 'for diagnosis' and 'for treatment' together form nearly 20%). This would mean that only a limited effect is to be expected of the model as regards the general practitioner's referral rate. How matters will be with regard to the specialist's repeat card cannot be derived from these data. Processing of the various kinds of referral card by age displays no striking results. Of course everything increases at greater age (except the reassurance referral card); without the age distribution of the health insurance fund practice further conclusions are rather meaningless.

Work is still continuing on an analysis to explain the variations between general practitioners and practices. This will be published separately by the NIVEL.

EXTRAPOLATION OF FREQUENCIES FOUND TO THE DUTCH POPULATION

The following survey gives an approximate impression of the number of patients, consultations, actions and occurrences in the Netherlands, on the basis of the frequencies calculated from the results of the continuous morbidity registration by sentinel stations. As was remarked in the previous reports, it must be borne in mind, when studying the following table, that although the population of the sentinel stations is a reasonably good representation (see also p. 11-12) the spotter physicians are a selected group. Consequently it cannot be automatically established to what extent the results differ from the actual situation; the differences can vary depending on the nature of the question. Particular caution should be observed regarding those topics where there is intervention by a general practitioner. As an example one may think of the 'cervical smear' question; it is quite feasible that the spotter physicians differ from the typical general practitioner in this respect.
In the 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 - 1984 (Central Bureau of 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
1983	7 103	7 237	14 340
1984	7 125	7 269	14 394

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

Extrapolation of frequencies found to the Dutch population

category	year	frequency[1] M	F	total	Netherlands[2] 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
	1983			396			568 000
	1984			502			722 000
cervical smear							
- with complaints	1976		87			60 000	
and/or symptoms	1977		86			60 000	
	1978		80			56 000	
	1979		80			56 000	
	1980		62			44 000	
	1981		57			41 000	
	1982		57			41 000	
	1983		65			47 000	
	1984		57			41 000	
- 'preventive',	1976		282			194 000	
general practi-	1977		268			186 000	
tioner's initia-	1978		218			153 000	
tive	1979		198			140 000	
	1980		168			119 000	
	1981		184			132 000	
	1982		171			123 000	
	1983		174			126 000	
	1984		204			148 000	

* for footnotes see page 78

Extrapolation of frequencies found to the Dutch population (continuation)

category	year	frequency[1] M	F	total	Netherlands[2] M	F	total[3]*
- 'preventive', woman's initiative	1976		103			71 000	
	1977		112			78 000	
	1978		105			73 000	
	1979		124			87 000	
	1980		93			66 000	
	1981		110			79 000	
	1982		126			91 000	
	1983		120			87 000	
	1984		132			96 000	
- repeat examination (within 3 years)	1976		31			21 000	
	1977		55			38 000	
	1978		120			84 000	
	1979		143			101 000	
	1980		148			105 000	
	1981		159			114 000	
	1982		170			122 000	
	1983		168			121 000	
	1984		182			132 000	
cervical smear 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	
	1983		527			381 000	
	1984		575			417 000	
Parkinson's disease[4]	1980	7	5	6			
	1981	4	2	3			
	1982			2			
	1983			1			
	1984			1			

* for footnotes see page 78

Extrapolation of frequencies found to the Dutch population (continuation)

category	year	frequency[1] M	F	total	Netherlands[2] M	F	total[3]*
sterilization	1972	24			16 000		
	1973	40			27 000		
	1974	46	35		31 000	24 000	55 000
	1975	46	46		31 000	31 000	62 000
	1976	57	66		39 000	45 000	84 000
	1977	53	64		37 000	45 000	82 000
	1978	74	81		51 000	57 000	108 000
	1979	99	90		69 000	63 000	132 000
	1980	79	70		55 000	50 000	105 000
	1981	59	46		42 000	33 000	74 000
	1982	50	40		35 000	29 000	64 000
	1983	46	39		33 000	28 000	61 000
	1984	46	39		33 000	28 000	61 000
cumulative					499 000	433 000	
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	
	1983		30			22 000	
	1984		38			28 000	
malignancies	1984	37	34	36 000	26 000	25 000	52 000
depression	1983	55	104		39 000	75 000	114 000
(treated for)	1984	46	94	71	33 000	68 000	102 000

* for footnotes see page 78

Extrapolation of frequencies found to the Dutch population (continuation)

category	year	frequency[1] M	frequency[1] F	frequency[1] total	Netherlands[2] M	Netherlands[2] F	Netherlands[2] total[3]*
(attempted)suicide[5]	1979			7			
	1980			7			
	1981			6			
	1982			8			
	1983			10			
	1984			7			
myocardial infarction (suspicion of)							
- clinical	1978	32	15		22 000	10 000	32 000
	1983	29	13		21 000	9 000	30 000
	1984	33	15	23	24 000	11 000	33 000
- non-clinical	1978	9	5		6 000	3 500	9 500
	1983	8	6		6 000	4 000	10 000
	1984	6	4	5	4 000	3 000	7 000
traumas of the musculo-skeletal system							
- contusion	1984			166			239 000
- distortion	1984			133			191 000
- luxation/fracture	1984			61			88 000
- soft tissue	1984			147			212 000

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 questions.

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 docter.

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

INCIDENTAL INVESTIGATIONS

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

Euthanasia (request for application)

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

The form of the investigation is retrospective. A form is sent to all spotter physicians at the end of the year with the request that they report whether the question was asked of them in the past year by a patient himself or herself for the application of active euthanasia directly or indirectly[21]) and if so, what the motive was for this. In addition, information is sought on the age, sex, current disease, place of care or nursing and the use or otherwise of an 'euthanasia declaration'[22]).
The physicians are informed at the beginning of the year of the coming investigation.
The results per patient can be found at the end of this section. This table does not require much explanation.
The number of requests in 1984 was higher than in one of the preceding years, viz 40 (see table 36).
The number of patients with a malignancy, as in the years before 1984, is relatively speaking large again: 72.5% of them have a carcinoma. On the other hand, mortality from cancer in the Netherlands is about 25% of total mortality. Kenter[23]) describes the application of euthanasia **(thus not the request)** in a single practice in the period 1976-1981. There too by far the majority of cases are cancer

patients, viz 15 out of the 19 (79%). The patients with a carcinoma are younger than the other patients.
In 1984 five requests were made for indirect euthanasia: in the other cases the request was for direct euthanasia. In six cases use was made of a written euthanasia declaration. On seven occasions the patient was not nursed at home (twice in hospital and five times in an old people's home or nursing home). The use of a written declaration in the request for euthanasia seems to be on the increase.

The distribution by province group and urbanization group is given in table 36.

Table 36.: absolute of requests to the general practitioner made by the patient himself or herself for the application of active euthanasia, per province and urbanization group, 1976-1984

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

In 1984 the request was made considerably more often in the south of the country than in other years, except for 1981. Whether this is a trend or an anomaly will have to become apparent in the years to come.

Age distribution

The age distribution may be found in table 37.

Table 37.: absolute number of patients who request the general practitioner to apply active euthanasia, by age group, 1976 - 1984

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

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
34	m	carcinoma of the bronchi	does not want to suffer long
51	m	carcinoma of the lung	dyspnoea
52	f	carcinoma of the colon	physical decay

Requests by the patient for active euthanasia (continuation)

age	sex	disease	motive for the request
53	f	carcinoma of the ovary	ileus
54	m	vital depression	depression
55	m	pulmonary emphysema with untreatable fungal infection	shortage of breath, without prospects
56	m	carcinoma of the lung	pain, fear
56	f	mamma carcinoma	pain, fear of suffocation
57	f	carcinoma of the lung	pain, metastases in the brain
60	m	metastasized carcinoma of the lung	pain, vomiting
61	m	carcinoma of the colon	pain
61	v	metastasized mamma carcinoma	pain, mastectomy not possible, fits
62	f	carcinoma of the colon	decay
63	m	carcinoma of the parotid gland with extensive metastases	pain, invalidity
63	m	carcinoma of the lung	pain
63	f	carcinoma of the pancreas	unbearable pain
64	m	metastasized carcinoma	combating pain, dying with dignity
64	m	none	would not accept dependence on others as a result of lengthy illness or invalidity
67	m	hypernephroma	pain, total decay
68	m	carcinoma of the lung	dyspnoea, general malaise, anorexia
69	m	carcinoma of the lung	rapid decline, adhesion, complete dependence
69	m	carcinoma of the lung	pain, long duration
69	f	carcinoma of the lung with inter alia metastases in the brain and chronic pleurisy	severe dyspnoea
72	m	carcinoma of the lung	pain

Requests by the patient for active euthanasia (continuation)

age	sex	disease	motive for the request
73	f	carcinoma of the stomach	pain, cannot lie without pain, can do nothing any more
74	m	adenocarcinoma of the rectum	pain, fear of pain
74	f	carcinoma of the auditory canal with invasion (after extirpation of the auditory canal and radical mastoidectomy	dizziness plus symptoms of loss
75	m	squamous-cell carcinoma of the lung	local invasion, problems with swallowing, pain
75	m	carcinoma of the lung	increasing dyspnoea, unbearable suffering, fear of decay
75	v	chronic rheumatism plus depression	pain, without prospects
76	m	metastasized carcinoma of the prostate with spontaneous fractures	pain
79	m	carcinoma of the lung	dyspnoea
81	f	old and terminal	
82	m	carcinoma of the pancreas	loss of dignity
82	f	Parkinson's disease	decrease in physical strength plus arthrosis pain
82	f	carcinoid	age, pain, loneliness
83	f	diabetes blindness	pain, tired of life, vomiting
85	f	carcinoma of the lung plus decompensatio cordis and metastases	
86	m	rheumatoid arthritis	pain
91	m	Parkinson's disease, blindness	pain, invalidity, incontinence, physical ruin

This investigation will be repeated.

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 request reported so far has remained too small to allow it pronouncements about these additional data.

The number of requests made to the spotter physicians in the successive years 1980 to 1984 was 17, 9, 15, 15 and 12 together 68.

Table 38 gives the absolute numbers per sex and per age. The number of women requesting restoration of sterilization is twice as large as the number of men requesting this, in spite of the fact that more men than women are sterilized (see p. 36 and 44 and 147).

Table 38.: absolute number op patients who made a request for restoration of sterilization, per age group, 1980-1984

	25-29	30-34	35-39	40-44	45-49	total
men	5	10	5	2	2	24
women	5	22	14	3	-	44

The average age is 34 years 7 months and 4 years respectively: compared with 1983, the average age has increased somethats.
The distribution among the province and urbanization groups may be seen in table 39.

Table 39.: absolute number of patients who made a request for restoration of sterilization per province and urbanization group, 1980-1984

		province group				urbanization group			Netherlands
		A	B	C	D	1	2	3	
men	1980	2	2	3	2	2	6	1	9
	1981	1	1	-	1	1	1	1	3
	1982	-	1	2	-	1	2	-	3
	1983	-	1	2	1	1	2	1	4
	1984	1	-	4	-	1	1	3	5
woman	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
	1983	3	1	5	2	1	2	8	11
	1984	-	1	4	2	-	3	4	7
total 1980-1984		17	10	25	12	11	28	29	68

When considering the absolute numbers in this table allowance must be made for the sized of the different subgroups (province group C, the western provinces and the centre of the country, and urbanization group 2, municipalities with urban characteristics together with urbanized rural municipalities, are by far the largest groups). However, the calculation of relative frequencies is not 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 not repeated for 1985.

GENERAL REMARKS

1. The questions on the weekly return for 1985 have been compiled as follows by the Counselling Committee:

   a. Influenza (-like illness)
   b. Cervical smear
   c. Parkinson's disease
   d. Sterilization of the man performed
   e. Sterilization of the woman performed
   f. Prescription of the morning-after-pill
   g. Malignancies
   h. Depression (treated for)
   i. (Attempted) suicide
   j. Myocardial infarction (suspicion of)
   k. Ulcus pepticum
   l. Referrals for physiotherapy

2. The incidental investigations for 1985 relate to the subject's euthanasia and anorexia nervosa and boulimia.

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.

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

Appendix 1

Continuous Morbidity Registration, Sentinel Stations
Participating General practitioners in 1984

Name:	Residence:	Province:
A.A.E.E. Brockmöller*)	't Zand	Groningen
J.Th. Ubbink	Groningen	Groningen
Y. Wapstra/K. Tanis (group practice)	Franeker	Friesland
S. Vriesinga*)	Oostermeer	Friesland
H.W. Reinking/F.M. van Soest/ R.F. Sparenburg/H.D.W.A. van Gysel (group practice)	Assen	Drenthe
H.E. Maillette de Buy Wenniger*)	Schoonoord	Drenthe
H. Nap*)	Gramsbergen	Overijssel
Th.J. van Dam/J.B.M. Stolte (group practice)	Swifterbant	Zuiderlijke 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 pratice)	Utrecht	Utrecht
W.J. van Bodegom*)	Linschoten	Utrecht
M.M. Spoor	Alkmaar	Noord-Holland
C.W. Willeboordse	Heiloo	Noord-Holland
H.R. Neys*)	Broek in Waterland	Noord-Holland
D.E. Kuenen	Haarlem	Noord-Holland
Mw. A.M. Reijnierse	Amsterdam	Noord-Holland
Mw. A.J. Arbouw/J.Th. Koop (group practice)	Amstelveen	Noord-Holland
H.J. van der Leen	Hilversum	Noord-Holland
J. Hoornweg/E. Hoornweg-Sleeboom (group practice)	Voorhout	Zuid-Holland

Appendix 1 (continuation)

Participating General Practitioners in 1983

Name:	Residence:	Province:
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/A. Hoevenaars (group practice)	Uden	Noord-Brabant
A.M.P. Linsen	Oirschot	Noord-Brabant
S.P.F. van Rijn	Eindhoven	Noord-Brabant
R.A.M. de Jong	Maastricht	Limburg

*) With dispensary

Weekstaat t.b.v. centrale registratie

CONTINUE MORBIDITEITSREGISTRATIE, PEILSTATIONS, 1984

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

Regel no.	Leeftijdsgroep	Influenza (-achtig ziektebeeld)[2]	Cervixuitstrijkje				Ziekte van Parkinson[3]	Sterilisatie verricht[7]		Morning-after-pill voorgeschreven[8]	Maligniteiten[6]		"Behandeld" wegens depressie[10]		Suicidepoging[11]	"Hartinfarct"[12]				Letsels van steun- en bewegingsapparaat[14]				Verwijzingen[15]						Leeftijdsgroep	Regel no.
			Na 1-1-1982 voor eerste maal uitgenomen op grond van[1]: Klachten/symptomen	Louter preventieve overwegingen: Initiatief huisarts[4]	Louter preventieve overwegingen: Verzoek v.d. vrouw	Herhalings-onderzoek[5]										Klinisch		Niet-klinisch[13]		Contusie	Distorsie	Luxatie/ fractuur	Vele delen	actief: Gemist stelling	actief: Diag-nose	actief: Behan-deling	actief: Combi-naties	passief: Refractie afwijken	passief: Overige		
		M+V	V	V	V	V	M+V	M	V	V	M	V	M	V	M+V	M	V	M	V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V		
01	< 1																												< 1	01
02	1-4																												1-4	02
03	5-9																												5-9	03
04	10-14																												10-14	04
05	15-19																												15-19	05
06	20-24																												20-24	06
07	25-29																												25-29	07
08	30-34																												30-34	08
09	35-39																												35-39	09
10	40-44																												40-44	10
11	45-49																												45-49	11
12	50-54																												50-54	12
13	55-59																												55-59	13
14	60-64																												60-64	14
15	65-69																												65-69	15
16	70-74																												70-74	16
17	75-79																												75-79	17
18	80-84																												80-84	18
19	≥ 85																												≥ 85	19
4-5		15-17	18-20	21-23	24-26	27-29	30-32	33-35	36-38	39-41	42-44	45-47	48-50	51-53	54-56	57-59	60-62	63-65	66-68	69-71	72-74	75-77	78-80	81-83	84-86	87-89	90-92	93-95	96-98		99-101

Weeknummer: _____

Opgemaakt d.d.: _____

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

Zie ommezijde voor voetnoten

Appendix 3a

Subjects on the weekly returns in alphabetical order 1970-1985

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	1976-1985
depression	1983-1985
diabetes mellitus	1980-1983
diarrhoea e causa ignota (acute)	1970
drug-use (consultation)	1972-1973 and 1979-1981
dwelling (certificate for another)	1975
exanthema e causa ignota	1970
family planning (consultations)	1970-1976
hay fever	1978-1982
influenza (-like illness)	1970-1985
malignancies	1984-1985
measles	1975-1979
mononucleosis infectiosa	1977-1979
morning-after-pill (prescription)	1972-1985
musculo-skeletal system (trauma of)	1984
myocardial infarction (suspicion of)	1978 and 1983-1985
otitis media acuta	1971
Parkinson's disease	1980-1985
partus immaturus	1982-1983
partus at gravidity 28 weeks	1982-1983
penicillin (prescriptions and side effects)	1982-1983
psoriasis	1976-1977
referrals	1984
referrals for physiotherapy	1985
rubella (-like illness)	1971
skull traumas in traffic	1975-1977
smoking (consultation with regard to addiction)	1974

Subjects on the weekly returns in alphabetical order 1970-1985 (continuation)

subject	
sport traumas	1979-1983
sterilization of the man performed	1972-1985
sterilization of the woman performed	1974-1985
suicide (attempted)	1970-1972 and 1979-1985
tonsillectomy or adenotomy	1971
tranquillizer (prescription)	1972-1974
ulcus ventriculi/duodeni	1975
ulcus pepticum	1985
urinary tract infection (prescription of medicine)	1977

Appendix 3b

Incidental investigations and other extra investigations, 1977-1985. (alphabetical)

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

Appendix 4

Age structure of the population of the Netherlands by sex, in thousands, 1 January 1984 (C.B.S.)

age	men	women	total[1)]
0- 4	448	428	876
5- 9	463	441	904
10-14	588	562	1 150
15-19	633	604	1 237
20-24	640	617	1 257
25-34	1 190	1 141	2 331
35-44	1 046	982	2 028
45-54	774	758	1 532
55-64	653	717	1 370
65	690	1 019	1 709
totaal	7 125	7 269	14 394

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

TABEL 1A CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 1

1E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------->			INFLU-ENZA	<--- CERVIXUITSTRIJKJE ---> KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	<-- STERILISATIE --> VERRICHT			MORN-AFTER-PILL	<- MALIGNITEITEN -->		
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
< 1 JR	391	444	835	719	-	-	-	-	-	-	-	-	-	-	23	12
1 - 4 JR	3635	3500	7135	395	-	-	-	-	-	-	-	-	-	3	-	1
5 - 9 JR	4616	4603	9219	358	-	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	6156	5984	12140	278	-	2	-	-	-	-	-	-	2	-	-	-
15 - 19 JR	6706	6669	13375	227	3	14	2	2	-	-	-	-	22	-	-	-
20 - 24 JR	6939	7461	14400	251	15	99	19	6	-	1	4	3	20	-	1	1
25 - 34 JR	13215	13077	26292	272	37	142	83	70	-	24	35	30	12	1	2	1
35 - 44 JR	10775	10701	21476	252	22	88	81	110	-	45	35	40	6	4	5	4
45 - 54 JR	8283	8401	16683	218	19	76	54	99	-	8	2	5	5	13	7	10
55 - 64 JR	7143	7624	14767	185	10	25	22	28	1	-	-	-	-	31	14	22
> 64 JR	7479	10846	18326	224	5	7	-	3	2	-	-	-	-	47	30	37
TOTAAL	75337	79311	154647	257	15	57	34	41	0	12	11	11	7	10	7	9

IE KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------->			<--- DEPRESSIE ---->			SUI CIDE POGING	<---------- HARTINFARCT ---------->					
								KLINISCH			NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
< 1 JR	391	444	835	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3635	3500	7135	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4616	4603	9219	-	2	1	-	-	-	-	-	-	-
10 - 14 JR	6156	5984	12140	-	7	3	-	-	-	-	-	-	-
15 - 19 JR	6706	6669	13375	5	21	12	2	-	-	-	-	-	-
20 - 24 JR	6939	7461	14400	16	27	22	6	-	-	-	-	-	-
25 - 34 JR	13215	13077	26292	19	42	30	2	-	-	-	1	-	0
35 - 44 JR	10775	10701	21476	27	43	35	1	4	1	2	-	-	-
45 - 54 JR	8283	8401	16683	18	32	25	4	18	4	7	1	2	2
55 - 64 JR	7143	7624	14767	22	41	32	3	32	5	18	1	3	2
> 64 JR	7479	10846	18326	8	23	17	3	35	11	21	7	3	4
TOTAAL	75337	79311	154647	14	28	21	2	8	3	5	1	1	1

1E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------>			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEDL	GERUSTSTELLN	DIAGNOSE	BEHANDELING	COMBINATIES	REFRACTIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
< 1 JR	391	444	835	12	-	12	24	24	216	443	144	12	311
1 - 4 JR	3635	3500	7135	31	20	6	50	7	31	114	69	59	119
5 - 9 JR	4616	4603	9219	35	20	20	44	5	27	77	29	81	102
10 - 14 JR	6156	5984	12140	67	54	22	39	2	17	53	32	112	91
15 - 19 JR	6706	6669	13375	69	73	16	45	15	25	96	51	108	93
20 - 24 JR	6939	7461	14400	57	58	13	44	13	55	117	60	104	123
25 - 34 JR	13215	13077	26292	47	43	13	29	10	46	111	66	81	142
35 - 44 JR	10775	10701	21476	32	25	10	29	17	58	112	69	96	150
45 - 54 JR	8283	8401	16683	32	16	9	28	11	61	101	77	156	215
55 - 64 JR	7143	7624	14767	16	15	12	16	11	52	94	67	210	345
> 64 JR	7479	10846	18326	29	13	21	19	9	71	116	99	250	412
TOTAAL	75337	79311	154647	41	33	14	32	11	49	104	66	129	190

TABEL 2A

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

1E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			INFLU ENZA	<--- CERVIXUITSTRIJKJE ---> KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	<-- STERILISATIE --> VERRICHT			MORN- AFTER -PILL	<- MALIGNITEITEN -->		
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
GR+FR+DR	10746	11252	21998	357	22	51	34	20	-	12	8	10	7	9	8	9
OV+GLD+ZYP	12757	13111	25868	314	26	56	37	41	0	17	11	14	7	7	9	8
UTR+NH+ZH	35563	38124	73692	164	10	60	40	53	0	9	10	10	6	9	7	8
ZLD+NB+LIM	16266	16824	33090	355	11	56	19	27	-	14	15	15	10	14	7	10
TOTAAL	75337	79311	154647	257	15	57	34	41	0	12	11	11	7	10	7	9

TABEL 2A (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

1E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			<--- DEPRESSIE ---->			SUI CIDE POGING	<---------- HARTINFARCT ----------> KLINISCH			NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
GR+FR+DR	10746	11252	21998	26	33	30	1	8	4	6	2	1	1
OV+GLD+ZYP	12757	13111	25868	15	32	22	1	13	2	7	1	1	1
UTR+NH+ZH	35563	38124	73692	8	26	17	3	7	3	5	1	1	1
ZLD+NB+LIM	16266	16824	33090	18	27	23	3	6	2	4	1	1	1
TOTAAL	75337	79311	154647	14	28	21	2	8	3	5	1	1	1

IE KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEGL	GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	REFRAC TIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
GR+FR+DR	10746	11252	21998	45	38	19	36	15	55	113	70	113	177
OV+GLD+ZYP	12757	13111	25868	46	42	23	32	10	45	87	65	123	167
UTR+NH+ZH	35568	38124	73692	39	28	11	26	11	44	105	70	139	189
ZLD+NB+LIM	16266	16824	33090	39	35	13	43	8	59	108	53	123	218
TOTAAL	75337	79311	154647	41	33	14	32	11	49	104	66	129	190

TABEL 3A

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

1E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE			INFLU ENZA	CERVIXUITSTRIJKJE KLACHT /SYMPT		INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	STERILISATIE VERRICHT			MORN- AFTER -PILL	MALIGNITEITEN		
	M	V	T	M+V	V		V	V	V	M+V	M	V	T	V	M	V	T
A1+A4	12343	12490	24833	239	20		57	43	22	0	13	10	12	7	6	8	7
B1-B3+C1-C4	46862	49287	96149	234	9		49	32	41	0	10	10	10	6	11	7	9
C5	16132	17534	33666	336	26		82	35	54	0	17	15	16	10	11	9	10
TOTAAL	75337	79311	154647	257	15		57	34	41	0	12	11	11	7	10	7	9

TABEL 3A (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

1E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE			DEPRESSIE			SUI CIDE POGING	HARTINFARCT KLINISCH			HARTINFARCT NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
A1+A4	12343	12490	24833	15	26	21	1	9	2	6	1	-	0
B1-B3+C1-C4	46862	49287	96149	10	23	16	1	8	2	5	1	1	1
C5	16132	17534	33666	25	46	36	6	8	3	6	1	2	2
TOTAAL	75337	79311	154647	14	28	21	2	8	3	5	1	1	1

1E KWARTAAL 1984 PER 10.000

URBANISATIE-GROEP	<------ POPULATIE ------>			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEDL	GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	REFRAC TIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
A1+A4	12343	12490	24833	45	45	24	32	10	50	96	73	105	118
B1-B3+C1-C4	46862	49287	96149	34	29	13	29	8	46	99	60	128	193
C5	16132	17534	33666	57	37	12	39	20	56	122	75	149	233
TOTAAL	75337	79311	154647	41	33	14	32	11	49	104	66	129	190

TABEL 18 CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 1

2E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------>			INFLU ENZA	<--- CERVIXUITSTRIJKJE --->				ZIEK PARK	<-- STERILISATIE -->			MORN-AFTER-PILL	<- MALIGNITEITEN -->		
					KLACHT/SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ		VERRICHT						
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
< 1 JR	379	438	818	379	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3578	3423	7006	181	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4554	4529	9083	144	-	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	6043	5874	11916	101	-	-	-	-	-	-	-	-	3	-	-	-
15 - 19 JR	6541	6509	13050	82	2	11	2	2	-	-	-	-	43	-	-	-
20 - 24 JR	6712	7226	13938	79	8	112	29	22	-	1	-	1	26	1	-	1
25 - 34 JR	12889	12784	25673	121	23	138	69	89	-	27	31	29	14	-	2	1
35 - 44 JR	10599	10476	21076	121	34	73	65	98	-	40	21	30	5	3	7	5
45 - 54 JR	8041	8132	16173	95	20	52	58	118	-	12	4	8	1	6	17	12
55 - 64 JR	6891	7334	14225	96	5	34	29	29	-	-	-	-	-	15	16	15
> 64 JR	7194	10387	17582	115	5	8	2	4	2	-	-	-	-	54	34	42
TOTAAL	73422	77117	150539	112	13	54	32	46	0	12	8	10	9	8	9	9

2E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			DEPRESSIE			SUICIDE POGING	HARTINFARCT KLINISCH			HARTINFARCT NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
< 1 JR	379	438	818	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3578	3428	7006	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4554	4529	9083	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	6043	5874	11916	-	2	1	-	-	-	-	-	-	-
15 - 19 JR	6541	6509	13050	2	11	6	2	-	-	-	-	-	-
20 - 24 JR	6712	7226	13938	3	14	9	3	-	-	-	-	-	-
25 - 34 JR	12889	12784	25673	14	30	22	1	-	-	-	-	-	-
35 - 44 JR	10599	10476	21076	17	39	28	4	6	-	3	1	-	0
45 - 54 JR	8041	8132	16173	25	28	27	2	15	4	9	2	2	2
55 - 64 JR	6891	7334	14225	13	30	22	1	38	15	26	1	1	1
> 64 JR	7194	10387	17582	13	37	27	1	39	15	25	10	6	7
TOTAAL	73422	77117	150539	10	23	17	2	10	4	7	2	1	1

2E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------->			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
								GERUST	DIAG	BEHAN	COMBI	REFRAC	OVERIG
	M	V	T	CONTUS	DISTOR	LUX/FR	WEKEDL	STELLN	NOSE	DELING	NATIES	TIEAFW	
< 1 JR	379	438	818	37	-	-	24	37	159	293	98	24	306
1 - 4 JR	3578	3428	7006	33	3	7	63	9	24	121	50	53	131
5 - 9 JR	4554	4529	9083	53	36	23	63	3	24	75	44	77	107
10 - 14 JR	6043	5874	11916	80	64	30	43	7	17	51	36	104	104
15 - 19 JR	6541	6509	13050	83	61	19	52	8	28	75	30	77	110
20 - 24 JR	6712	7226	13938	56	59	19	49	14	47	103	49	74	123
25 - 34 JR	12889	12784	25673	43	55	11	44	11	42	134	62	70	142
35 - 44 JR	10599	10476	21076	30	27	9	38	17	50	86	59	65	142
45 - 54 JR	8041	8132	16173	21	20	10	24	10	45	83	83	127	216
55 - 64 JR	6891	7334	14225	27	16	7	18	11	30	92	83	170	344
> 64 JR	7194	10387	17582	28	11	20	20	8	53	113	97	254	414
TOTAAL	73422	77117	150539	43	36	15	39	11	40	97	62	109	192

TABEL 2B

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

2E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			INFLU ENZA	<--- CERVIXUITSTRIJKJE ---> KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	<-- STERILISATIE --> VERRICHT			MORN- AFTER -PILL	<- MALIGNITEITEN -->		
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
GR+FR+DR	10144	10615	20759	120	15	43	22	26	-	12	9	11	13	7	9	8
OV+GLD+ZYP	13103	13440	26543	153	28	54	34	37	1	16	12	14	14	9	7	8
UTR+NH+ZH	33468	35794	69261	108	8	58	34	62	0	10	8	9	6	8	9	9
ZLD+NB+LIM	16707	17269	33976	83	8	52	33	32	0	13	6	9	10	8	10	9
TOTAAL	73422	77117	150539	112	13	54	32	46	0	12	8	10	9	8	9	9

TABEL 2B (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

2E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			<--- DEPRESSIE ---->			SUI CIDE POGING	<---------- HARTINFARCT ----------> KLINISCH			NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
GR+FR+DR	10144	10615	20759	10	26	18	0	7	3	5	3	1	2
OV+GLD+ZYP	13103	13440	26543	16	33	25	1	14	9	11	2	1	2
UTR+NH+ZH	33468	35794	69261	8	17	13	2	11	4	7	1	1	1
ZLD+NB+LIM	16707	17269	33976	11	27	19	2	5	1	3	1	1	1
TOTAAL	73422	77117	150539	10	23	17	2	10	4	7	2	1	1

2E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) -> GERUST	DIAG	BEHAN	COMBI	REFRAC	OVERIG
				CONTUS	DISTOR	LUX/FR	WEKEDL	STELLN	NOSE	DELING	NATIES	TIEAFW	
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
GR+FR+DR	10144	10615	20759	54	46	20	46	20	48	100	51	87	167
OV+GLD+ZYP	13103	13440	26543	43	46	21	48	9	34	79	70	100	154
UTR+NH+ZH	33468	35794	69261	38	30	10	25	10	28	94	66	121	193
ZLD+NB+LIM	16707	17269	33976	47	36	16	54	7	63	118	55	108	234
TOTAAL	73422	77117	150539	43	36	15	39	11	40	97	62	109	192

TABEL 3B CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 1

2E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE			INFLU ENZA	CERVIXUITSTRIJKJE KLACHT /SYMPT				ZIEK PARK	STERILISATIE VERRICHT			MORN- AFTER -PILL	MALIGNITEITEN		
						INIT ARTS	VERZ VROUW	HERH ONDZ								
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
A1+A4	12246	12380	24626	141	23	72	32	23	1	14	10	12	14	9	7	8
B1-B3+C1-C4	45468	47780	93248	99	8	43	30	47	0	13	7	10	9	8	10	9
C5	15708	16956	32664	127	17	71	40	60	-	9	11	10	8	8	8	8
TOTAAL	73422	77117	150539	112	13	54	32	46	0	12	8	10	9	8	9	9

TABEL 3B (VERVOLG) CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 2

2E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE			DEPRESSIE			SUI CIDE POGING	HARTINFARCT KLINISCH			HARTINFARCT NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
A1+A4	12246	12380	24626	15	32	24	1	13	4	9	2	1	1
B1-B3+C1-C4	45468	47780	93248	8	17	12	1	10	4	7	1	1	1
C5	15708	16956	32664	14	36	25	3	8	5	6	3	2	2
TOTAAL	73422	77117	150539	10	23	17	2	10	4	7	2	1	1

2E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE M	POPULATIE V	POPULATIE T	LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT CONTUS	DISTOR	LUX/FR	WEKEDL	(ACTIEF) GERUST STELLN	DIAG NOSE	VERWIJZINGEN BEHAN DELING	COMBI NATIES	(PASSIEF) REFRAC TIEAFW	OVERIG
	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
A1+A4	12246	12380	24626	45	45	22	44	14	34	91	83	86	105
B1-B3+C1-C4	45468	47780	93248	40	36	14	38	8	40	94	55	114	206
C5	15708	16956	32664	52	30	13	36	16	43	111	68	114	216
TOTAAL	73422	77117	150539	43	36	15	39	11	40	97	62	109	192

TABEL 1C

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

3E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------->			INFLU ENZA	<--- CERVIXUITSTRIJKJE ---> KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HEPH ONDZ	ZIEK PARK	<-- STERILISATIE --> VERRICHT			MORN-AFTER -PILL	<- MALIGNITEITEN -->		
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
< 1 JR	355	403	758	237	-	-	-	-	-	-	-	-	-	28	-	13
1 - 4 JR	3321	3193	6514	71	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4227	4219	8445	34	-	-	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	5661	5482	11143	25	-	-	-	2	-	-	-	-	-	-	-	-
15 - 19 JR	6149	6115	12264	29	-	10	2	2	-	-	-	-	38	-	-	-
20 - 24 JR	6329	6797	13127	35	12	84	21	15	-	-	1	1	49	-	-	-
25 - 34 JR	11993	11899	23893	37	31	126	65	80	-	21	27	24	17	2	3	3
35 - 44 JR	9865	9802	19668	35	20	52	74	116	-	22	28	25	7	2	4	3
45 - 54 JR	7557	7681	15239	39	29	53	29	104	-	5	3	4	4	9	5	7
55 - 64 JR	6491	6924	13415	42	6	16	26	25	1	3	-	1	1	29	10	19
> 64 JR	6785	9815	16600	39	3	1	4	5	2	-	-	-	-	60	41	49
TOTAAL	68735	72330	141064	38	13	44	29	45	0	8	9	8	12	10	8	9

3E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	POPULATIE			DEPRESSIE			SUICIDE POGING	HARTINFARCT KLINISCH			HARTINFARCT NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
< 1 JR	355	403	758	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3321	3193	6514	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4227	4219	8445	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	5661	5482	11143	-	-	-	-	-	-	-	-	-	-
15 - 19 JR	6149	6115	12264	-	8	4	1	-	-	-	-	-	-
20 - 24 JR	6329	6797	13127	11	16	14	4	-	-	-	-	-	-
25 - 34 JR	11993	11899	23893	7	33	20	3	-	-	-	-	-	-
35 - 44 JR	9865	9802	19668	14	41	27	1	4	-	2	1	-	1
45 - 54 JR	7557	7681	15239	28	33	30	1	15	5	10	1	-	1
55 - 64 JR	6491	6924	13415	14	16	15	2	26	12	19	2	1	1
> 64 JR	6785	9815	16600	13	20	17	2	35	13	22	10	7	8
TOTAAL	68735	72333	141064	10	21	16	2	8	3	6	1	1	1

3E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------->			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEDL	GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	REFRAC TIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
< 1 JR	355	403	758	13	-	-	66	40	172	198	132	13	251
1 - 4 JR	3321	3193	6514	34	12	21	86	8	17	107	38	46	154
5 - 9 JR	4227	4219	8445	41	21	31	52	2	27	62	27	77	135
10 - 14 JR	5661	5482	11143	56	46	27	51	4	22	52	22	93	100
15 - 19 JR	6149	6115	12264	61	57	19	54	9	15	69	46	69	111
20 - 24 JR	6329	6797	13127	56	66	14	40	14	38	93	77	84	165
25 - 34 JR	11993	11899	23893	38	32	12	32	16	44	125	62	67	167
35 - 44 JR	9865	9802	19668	25	19	11	31	8	43	110	65	66	166
45 - 54 JR	7557	7681	15239	30	20	9	31	9	51	88	66	139	221
55 - 64 JR	6491	6924	13415	25	18	10	27	11	47	93	78	172	330
> 64 JR	6785	9815	16600	28	10	21	27	10	57	131	117	256	475
TOTAAL	68735	72333	141064	38	30	16	39	10	40	99	65	110	212

TABEL 2C

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

3E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			INFLU ENZA	<--- CERVIXUITSTRIJKJE ---> KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	<-- STERILISATIE --> VERRICHT			MORN- AFTER -PILL	<- MALIGNITEITEN -->		
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
GR+FR+DR	9813	10255	20069	55	21	26	24	34	-	10	8	9	17	12	4	8
OV+GLD+ZYP	11806	12102	23908	60	19	40	22	37	1	4	17	11	13	8	5	6
UTR+NH+ZH	32170	34536	66706	26	9	51	34	54	0	6	8	7	11	12	11	11
ZLD+NB+LIM	14946	15436	30382	38	12	42	27	36	-	12	5	8	10	9	7	8
TOTAAL	68735	72330	141064	38	13	44	29	45	0	8	9	8	12	10	8	9

TABEL 2C (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

3E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			<--- DEPRESSIE ---->			SUI CIDE POGING	<---------- HARTINFARCT ----------> KLINISCH			NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
GR+FR+DR	9813	10255	20069	8	23	16	2	4	4	4	1	-	1
OV+GLD+ZYP	11806	12102	23908	12	23	18	1	13	2	8	3	2	2
UTR+NH+ZH	32170	34536	66706	8	16	12	2	8	4	6	1	1	1
ZLD+NB+LIM	14946	15436	30382	13	29	21	2	8	3	5	2	1	2
TOTAAL	68735	72330	141064	10	21	16	2	8	3	6	1	1	1

3E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEDL	GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	REFRAC TIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
GR+FR+DR	9813	10255	20069	52	33	22	43	16	65	112	58	89	203
OV+GLD+ZYP	11806	12102	23908	39	35	18	36	10	26	86	72	83	149
UTR+NH+ZH	32170	34536	66706	33	25	12	31	11	26	86	73	133	208
ZLD+NB+LIM	14946	15436	30382	38	34	17	56	5	65	128	46	95	277
TOTAAL	68735	72330	141064	38	30	16	39	10	40	99	65	110	212

TABEL 3C

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

3E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE			INFLU ENZA	CERVIXUITSTRIJKJE KLACHT /SYMPT		INIT ARTS		VERZ VROUW		HERH ONDZ		ZIEK PARK	STERILISATIE VERRICHT			MORN- AFTER -PILL	MALIGNITEITEN		
	M	V	T	M+V	V		V		V		V		M+V	M	V	T	V	M	V	T
A1+A4	11559	11715	23275	40	15		49		28		16		-	4	19	12	13	5	8	6
B1-B3+C1-C4	42957	45145	88101	31	10		34		27		48		0	9	7	8	11	9	7	8
C5	14219	15469	29687	59	20		70		35		56		1	8	6	7	16	18	11	14
TOTAAL	68735	72330	141064	38	13		44		29		45		0	8	9	8	12	10	8	9

TABEL 3C (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

3E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE			DEPRESSIE			SUICIDE POGING	HARTINFARCT KLINISCH			HARTINFARCT NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
A1+A4	11559	11715	23275	10	20	15	1	10	3	7	2	-	1
B1-B3+C1-C4	42957	45145	88101	7	17	12	1	7	4	5	1	1	1
C5	14219	15469	29687	18	34	26	3	10	3	6	2	1	2
TOTAAL	68735	72330	141064	10	21	16	2	8	3	6	1	1	1

3E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE M	POPULATIE V	POPULATIE T	LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT CONTUS M+V	DISTOR M+V	LUX/FR M+V	WEKEDL M+V	(ACTIEF) - GERUST STELLN M+V	VERWIJZINGEN - DIAG NOSE M+V	BEHAN DELING M+V	COMBI NATIES M+V	(PASSIEF) - REFRAC TIEAFW M+V	OVERIG M+V
A1+A4	11559	11716	23275	38	40	18	41	12	32	95	82	72	122
B1-B3+C1-C4	42957	45145	88101	35	28	16	37	7	40	98	61	118	216
C5	14219	15469	29687	46	28	13	43	18	46	105	63	118	270
TOTAAL	68735	72330	141064	38	30	16	39	10	40	99	65	110	212

TABEL 1D CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 1

4E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------->			INFLU ENZA	<--- CERVIXUITSTRIJKJE ---> KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	<-- STERILISATIE --> VERRICHT			MORN-AFTER -PILL	<- MALIGNITEITEN -->		
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
< 1 JR	382	440	822	328	-	-	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3592	3442	7033	185	-	-	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4561	4542	9103	101	-	-	-	-	-	-	-	-	-	2	-	1
10 - 14 JR	6073	5904	11977	57	-	-	-	-	-	-	-	-	-	-	2	1
15 - 19 JR	6598	6559	13156	74	9	15	3	-	-	-	-	-	38	-	-	-
20 - 24 JR	6783	7288	14070	86	8	96	15	19	-	4	4	4	19	1	-	1
25 - 34 JR	12954	12832	25785	109	30	115	78	73	-	31	30	31	18	2	2	2
35 - 44 JR	10622	10526	21148	90	30	67	69	113	-	45	29	37	6	4	8	6
45 - 54 JR	8129	8232	16361	84	29	36	60	114	-	9	5	7	2	7	16	12
55 - 64 JR	6973	7426	14399	88	13	20	32	53	-	-	-	-	-	23	12	17
> 64 JR	7292	10543	17832	80	6	3	3	3	1	-	-	-	-	45	33	38
TOTAAL	73959	77730	151689	93	16	45	34	47	0	13	10	12	9	9	9	9

4E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------>			<--- DEPRESSIE ---->			SUI CIDE POGING	<---------- HARTINFARCT ----------> KLINISCH			NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
< 1 JR	382	443	822	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3592	3442	7033	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4561	4542	9103	-	-	-	-	-	-	-	-	-	-
10 - 14 JR	6073	5904	11977	-	-	-	-	-	-	-	-	-	-
15 - 19 JR	6598	6559	13156	2	6	4	-	-	-	-	-	-	-
20 - 24 JR	6783	7288	14070	10	26	18	1	-	-	-	-	-	-
25 - 34 JR	12954	12832	25785	16	25	21	2	-	1	0	-	-	-
35 - 44 JR	10622	10526	21148	15	24	19	4	3	1	2	-	-	-
45 - 54 JR	8129	8232	16361	16	36	26	2	7	4	6	1	-	1
55 - 64 JR	6973	7426	14399	16	26	21	2	17	5	11	7	1	4
> 64 JR	7292	10540	17832	16	22	20	2	37	17	25	12	4	7
TOTAAL	73959	77730	151689	11	20	15	2	6	3	5	2	1	1

4E KWARTAAL 1984 PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------>			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEDL	GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	REFRAC TIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
< 1 JR	382	440	822	-	12	12	12	61	134	231	134	61	389
1 - 4 JR	3592	3442	7033	21	9	14	55	7	17	112	63	53	112
5 - 9 JR	4561	4542	9103	35	23	21	45	4	23	75	29	86	110
10 - 14 JR	6073	5904	11977	70	63	25	40	4	28	67	32	91	104
15 - 19 JR	6598	6559	13156	87	61	25	55	8	30	80	46	98	110
20 - 24 JR	6783	7288	14070	57	53	11	49	17	48	93	67	68	159
25 - 34 JR	12954	12832	25785	42	43	9	36	15	36	126	61	66	155
35 - 44 JR	10622	10526	21148	26	24	12	33	11	47	111	80	81	166
45 - 54 JR	8129	8232	16361	25	10	9	24	10	46	108	76	152	226
55 - 64 JR	6973	7426	14399	30	13	7	15	11	50	71	88	178	343
> 64 JR	7292	10540	17832	29	7	28	24	13	52	118	111	267	450
TOTAAL	73959	77730	151689	41	31	15	35	11	40	101	69	117	206

TABEL 2D

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

4E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			INFLU ENZA	<--- CERVIXUITSTRIJKJE ---> KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	<-- STERILISATIE --> VERRICHT			MORN- AFTER -PILL	<- MALIGNITEITEN -->		
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
GR+FR+DR	10317	10803	21120	181	38	56	40	23	-	14	6	10	7	10	6	8
OV+GLD+ZYP	12964	13313	26275	135	21	51	31	47	-	6	12	9	8	7	10	8
UTR+NH+ZH	34066	36448	70513	52	9	43	34	61	-	15	12	13	11	9	9	9
ZLD+NB+LIM	16612	17173	33781	91	13	36	32	30	0	14	7	11	7	8	8	8
TOTAAL	73959	77733	151689	93	16	45	34	47	0	13	10	12	9	9	9	9

TABEL 2D (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

4E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			<--- DEPRESSIE ---->			SUI CIDE POGING	<---------- HARTINFARCT ----------> KLINISCH			NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
GR+FR+DR	10317	10803	21120	10	21	16	-	4	1	2	6	1	3
OV+GLD+ZYP	12964	13313	26275	15	25	20	2	11	4	7	3	-	2
UTR+NH+ZH	34066	36448	70513	6	17	12	2	5	4	4	1	1	1
ZLD+NB+LIM	16612	17173	33781	17	19	18	1	7	5	6	1	1	1
TOTAAL	73959	77733	151689	11	20	15	2	6	3	5	2	1	1

4E KWARTAAL 1984 PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------>			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEDL	GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	REFRAC TIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
GR+FR+DR	10317	10803	21120	50	40	28	44	26	59	99	70	89	188
OV+GLD+ZYP	12964	13310	26275	41	40	19	41	10	28	88	80	99	148
UTR+NH+ZH	34066	36443	70513	39	24	10	24	10	28	87	76	129	210
ZLD+NB+LIM	16612	17170	33781	40	33	14	50	5	65	140	47	124	253
TOTAAL	73959	77730	151689	41	31	15	35	11	40	101	69	117	206

TABEL 3D

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

4E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE M	POPULATIE V	POPULATIE T	INFLUENZA M+V	CERVIXUITSTRIJKJE KLACHT/SYMPT V	CERVIXUITSTRIJKJE INIT ARTS V	CERVIXUITSTRIJKJE VERZ VROUW V	CERVIXUITSTRIJKJE HERH ONDZ V	ZIEKPARK M+V	STERILISATIE VERRICHT M	STERILISATIE VERRICHT V	STERILISATIE VERRICHT T	MORN-AFTER-PILL V	MALIGNITEITEN M	MALIGNITEITEN V	MALIGNITEITEN T
A1+A4	12163	12295	24459	81	19	47	36	16	-	10	15	13	7	8	6	7
B1-B3+C1-C4	45744	48045	93789	67	14	32	33	48	0	13	9	11	8	8	9	9
C5	16052	17388	33440	174	18	78	34	64	-	16	9	12	13	9	11	10
TOTAAL	73959	77730	151689	93	16	45	34	47	0	13	10	12	9	9	9	9

TABEL 3D (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

4E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	POPULATIE M	POPULATIE V	POPULATIE T	DEPRESSIE M	DEPRESSIE V	DEPRESSIE T	SUICIDE POGING M+V	HARTINFARCT KLINISCH M	KLINISCH V	KLINISCH T	NIET-KLINISCH M	NIET-KLINISCH V	NIET-KLINISCH T
A1+A4	12163	12296	24459	12	23	17	1	8	4	6	2	-	1
B1-B3+C1-C4	45744	48045	93789	9	15	12	1	5	4	4	2	0	1
C5	16052	17388	33440	16	29	23	3	11	3	7	2	2	2
TOTAAL	73959	77730	151689	11	20	15	2	6	3	5	2	1	1

4E KWARTAAL 1984 PER 10.000

URBANISATIE GROEP	<------ POPULATIE ------>			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEDL	GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	REFRAC TIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
A1+A4	12163	12295	24459	35	46	21	47	17	26	94	81	97	125
B1-B3+C1-C4	45744	48045	93789	38	28	14	33	8	39	101	67	124	211
C5	16052	17388	33440	53	26	14	33	17	54	106	65	111	250
TOTAAL	73959	77733	151689	41	31	15	35	11	40	101	69	117	206

TABEL 1E CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS BLAD 1

1984 TOTAAL PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------->			INFLU ENZA	<--- CERVIXUITSTRIJKJE --->				ZIEK PARK	<-- STERILISATIE --> VERRICHT			MORN-AFTER-PILL	<- MALIGNITEITEN -->		
					KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ								
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
< 1 JR	370	423	793	1715	-	-	-	-	-	-	-	-	-	27	24	25
1 - 4 JR	3465	3327	6791	858	6	-	-	-	-	-	-	-	-	3	-	1
5 - 9 JR	4405	4389	8793	662	-	-	-	-	-	-	-	-	-	2	-	1
10 - 14 JR	5870	5701	11572	478	-	2	-	2	-	-	-	-	5	-	2	1
15 - 19 JR	6376	6341	12717	827	14	50	8	5	-	-	-	-	144	-	-	-
20 - 24 JR	6564	7057	13622	468	44	400	85	65	-	8	10	9	115	3	1	2
25 - 34 JR	12522	12409	24931	560	123	533	301	318	-	105	127	116	62	4	8	6
35 - 44 JR	10268	10181	20449	515	110	287	296	446	-	157	115	136	24	13	24	18
45 - 54 JR	7852	7958	15810	452	98	222	205	444	-	36	14	25	13	37	46	42
55 - 64 JR	6745	7189	13933	424	36	97	111	136	2	3	-	1	1	99	54	76
> 64 JR	7052	10201	17253	476	19	20	9	15	6	-	-	-	-	210	140	169
TOTAAL	71488	75176	146664	519	57	204	132	182	1	46	39	42	38	37	34	36

1984 TOTAAL PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------>			<--- DEPRESSIE ---->			SUICIDE POGING	<---------- HARTINFARCT ---------->					
								KLINISCH			NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
< 1 JR	370	423	793	-	-	-	-	-	-	-	-	-	-
1 - 4 JR	3465	3327	6791	-	-	-	-	-	-	-	-	-	-
5 - 9 JR	4405	4389	8793	-	2	1	-	-	-	-	-	2	1
10 - 14 JR	5870	5701	11572	-	9	4	-	-	-	-	-	-	-
15 - 19 JR	6376	6341	12717	6	47	27	6	-	-	-	-	-	-
20 - 24 JR	6564	7057	13622	41	85	64	13	-	-	-	-	-	-
25 - 34 JR	12522	12409	24931	58	132	95	9	-	1	0	1	-	0
35 - 44 JR	10268	10181	20449	75	149	112	11	17	2	9	2	-	1
45 - 54 JR	7852	7958	15810	88	132	110	9	47	16	32	6	5	6
55 - 64 JR	6745	7189	13933	67	115	92	9	116	38	75	12	7	9
> 64 JR	7052	10201	17253	51	104	82	8	149	58	95	40	20	28
TOTAAL	71488	75176	146664	46	94	71	7	33	14	23	6	4	5

1984 TOTAAL PER 10.000

LEEFTIJDS-GROEP	<------ POPULATIE ------>			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEDL	GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	REFRAC TIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
< 1 JR	370	423	793	63	13	25	126	164	694	1198	517	113	1286
1 - 4 JR	3465	3327	6791	121	44	52	258	31	91	464	225	215	524
5 - 9 JR	4405	4389	8793	166	102	96	208	16	103	295	132	328	461
10 - 14 JR	5870	5701	11572	278	232	106	175	17	85	227	124	409	407
15 - 19 JR	6376	6341	12717	306	257	83	210	40	101	327	177	360	432
20 - 24 JR	6564	7057	13622	230	240	57	185	60	192	415	257	336	580
25 - 34 JR	12522	12409	24931	174	177	46	144	54	171	505	257	290	616
35 - 44 JR	10268	10181	20449	115	97	43	134	54	202	426	278	314	635
45 - 54 JR	7852	7958	15810	109	68	37	109	42	206	388	309	587	894
55 - 64 JR	6745	7189	13933	100	62	37	77	45	183	357	321	746	1390
> 64 JR	7052	10201	17253	117	42	93	91	41	238	485	431	1047	1782
TOTAAL	71488	75176	146664	166	133	61	147	44	172	408	267	475	814

TABEL 2E

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

1984 TOTAAL PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			INFLU ENZA	<--- CERVIXUITSTRIJKJE ---> KLACHT /SYMPT	INIT ARTS	VERZ VROUW	HERH ONDZ	ZIEK PARK	<-- STERILISATIE --> VERRICHT			MORN- AFTER -PILL	<- MALIGNITEITEN -->		
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
GR+FR+DR	10062	10529	20590	742	99	180	123	105	-	49	32	40	45	39	28	34
OV+GLD+ZYP	12419	12746	25164	682	97	206	128	166	2	45	53	49	43	31	32	32
UTR+NH+ZH	33180	35542	68721	362	37	217	145	234	1	41	38	40	35	38	37	38
ZLD+NB+LIM	15828	16360	32188	584	45	190	113	128	1	55	33	44	37	40	32	36
TOTAAL	71488	75176	146664	519	57	204	132	182	1	46	39	42	38	37	34	36

TABEL 2E (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

1984 TOTAAL PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			<--- DEPRESSIE ---->			SUI CIDE POGING	<---------- HARTINFARCT ----------> KLINISCH			NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
GR+FR+DR	10062	10529	20590	58	106	83	4	24	12	18	12	3	7
OV+GLD+ZYP	12419	12746	25164	57	116	87	4	52	17	34	8	4	6
UTR+NH+ZH	33180	35542	68721	32	77	55	9	32	14	23	5	4	4
ZLD+NB+LIM	15828	16360	32188	61	105	83	9	27	10	18	4	4	4
TOTAAL	71488	75176	146664	46	94	71	7	33	14	23	6	4	5

TABEL 2E (VERVOLG) CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

1984 TOTAAL PER 10.000

PROVINCIE GROEP	<------ POPULATIE ------->			<- LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT ->				<- (ACTIEF) - VERWIJZINGEN - (PASSIEF) ->					
				CONTUS	DISTOR	LUX/FR	WEKEDL	GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	REFRAC TIEAFW	OVERIG
	M	V	T	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
GR+FR+DR	10062	10529	20590	205	160	91	172	78	231	433	254	387	748
OV+GLD+ZYP	12419	12746	25164	172	166	83	160	40	136	346	292	414	630
UTR+NH+ZH	33180	35542	68721	152	109	45	107	44	129	379	291	531	814
ZLD+NB+LIM	15828	16360	32188	167	140	61	207	25	256	504	206	460	998
TOTAAL	71488	75176	146664	166	133	61	147	44	172	408	267	475	814

TABEL 3E

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 1

1984 TOTAAL PER 10.000

URBANISATIEGROEP	POPULATIE			INFLUENZA	CERVIXUITSTRIJKJE KLACHT/SYMPT	CERVIXUITSTRIJKJE INIT ARTS	CERVIXUITSTRIJKJE VERZ VROUW	CERVIXUITSTRIJKJE HERH ONDZ	ZIEKPARK	STERILISATIE VERRICHT			MORN-AFTER-PILL	MALIGNITEITEN		
	M	V	T	M+V	V	V	V	V	M+V	M	V	T	V	M	V	T
A1+A4	11850	11990	23840	517	78	229	142	79	1	42	55	49	41	29	29	29
B1-B3+C1-C4	44404	46667	91071	448	42	161	124	108	1	45	33	39	35	37	33	35
C5	15235	16519	31754	725	84	308	147	239	1	51	42	47	47	46	39	43
TOTAAL	71488	75176	146664	519	57	204	132	182	1	46	39	42	38	37	34	36

TABEL 3E (VERVOLG)

CONTINUE MORBIDITEITSREGISTRATIE PEILSTATIONS

BLAD 2

1984 TOTAAL PER 10.000

URBANISATIEGROEP	POPULATIE			DEPRESSIE			SUICIDE POGING	HARTINFARCT KLINISCH			HARTINFARCT NIET-KLINISCH		
	M	V	T	M	V	T	M+V	M	V	T	M	V	T
A1+A4	11850	11990	23840	53	103	78	4	41	14	28	6	1	3
B1-B3+C1-C4	44404	46667	91071	35	72	54	5	30	13	21	5	3	4
C5	15235	16519	31754	74	148	112	15	37	15	25	9	8	8
TOTAAL	71488	75176	146664	46	94	71	7	33	14	23	6	4	5

1984 TOTAAL PER 10.000

URBANISATIE GROEP	POPULATIE M	V	T	LETSELS VAN STEUN- EN BEWEGINGSAPPARAAT CONTUS	DISTOR	LUX/FR	WEKEDL	(ACTIEF) - VERWIJZINGEN - GERUST STELLN	DIAG NOSE	BEHAN DELING	COMBI NATIES	(PASSIEF) -> REFRAC TIEAFW	OVERIG
	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V	M+V
A1+A4	11850	11990	23840	166	180	86	168	54	144	383	326	368	478
B1-B3+C1-C4	44404	46667	91071	150	124	58	140	31	169	399	248	494	842
C5	15235	16519	31754	212	124	52	154	73	203	453	277	503	985
TOTAAL	71488	75176	146664	166	133	61	147	44	172	408	267	475	814

Tabel 4a

aantal patiënten met influenza(-achtig ziektebeeld), per week, per 10.000 inwoners, 1984-1985 (t/m 13e week)

week nr. 1984	aantal patiënten							
	provinciegroep				urbanisatiegroep			totaal
	a	b	c	d	1	2	3	
1	12	6	7	5	4	6	13	7
2	9	8	4	7	6	5	10	6
3	10	8	5	3	6	5	9	6
4	12	7	5	3	3	4	14	6
5	15	15	7	5	6	6	16	9
6	15	8	5	5	2	6	13	7
7	17	5	5	11	1	8	13	8
8	39	8	7	16	3	14	20	14
9	45	14	12	22	12	17	29	19
10	44	28	15	52	24	29	29	29
11	37	65	24	111	59	48	61	53
12	52	50	28	66	39	41	55	44
13	51	84	39	45	69	43	54	50
14	27	46	31	20	36	31	26	31
15	27	29	23	19	31	21	23	23
16	7	8	15	8	8	13	10	12
17	9	10	9	6	10	6	13	8
18	7	7	6	5	7	6	8	6
19	4	10	3	4	10	3	5	5
20	6	9	4	5	9	4	5	5
21	11	6	3	1	4	3	9	5
22	8	8	3	2	8	3	5	4
23	5	3	3	4	2	2	7	3
24	6	4	2	2	3	2	7	3
25	4	4	2	3	3	2	5	3
26	4	7	1	3	7	2	5	3
27	1	1	3	2	1	2	3	2
28	1	-	2	1	-	1	5	2

Tabel 4a (vervolg)

aantal patiënten met influenza(-achtig ziektebeeld), per week, per 10.000 inwoners, 1984-1985 (t/m 13e week)

week nr. 1984	aantal patiënten							
	provinciegroep				urbanisatiegroep			totaal
	a	b	c	d	1	2	3	
29	1	2	2	4	1	2	2	2
30	-	2	1	2	1	1	1	1
31	-	2	2	1	2	1	3	2
32	-	3	1	3	2	1	1	1
33	3	1	1	1	1	1	3	1
34	4	3	2	1	1	2	1	2
35	2	5	1	2	3	1	3	2
36	7	12	2	4	7	4	8	5
37	9	11	4	4	7	4	11	6
38	13	7	3	5	5	4	13	6
39	12	10	4	7	8	7	7	7
40	10	12	3	8	10	5	8	7
41	18	11	5	4	8	5	16	8
42	13	15	3	4	8	4	14	7
43	9	15	3	7	10	5	10	7
44	6	10	3	5	8	4	7	5
45	10	11	2	4	6	3	8	5
46	13	9	4	9	4	6	12	7
47	19	12	4	10	8	6	14	9
48	19	8	5	10	6	6	17	9
49	14	11	4	8	4	5	18	7
50	19	11	7	6	6	6	21	9
51	24	7	6	12	1	8	21	10
52	3	3	5	4	1	4	9	4
1985[1])								
1	12	6	7	7	5	6	13	8
2	11	7	8	8	5	6	15	8
3	16	5	6	9	5	6	14	8

Tabel 4a (vervolg)

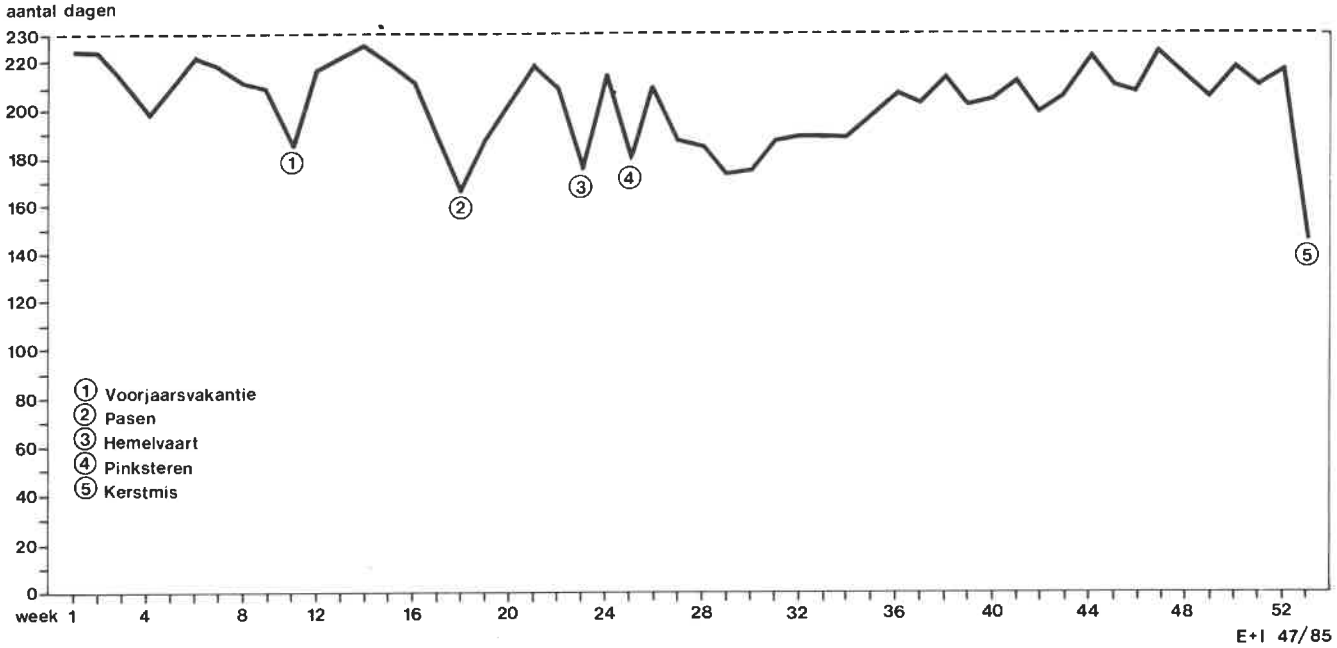
aantal patiënten met influenza(-achtig ziektebeeld), per week, per 10.000 inwoners, 1984-1985 (t/m 13e week)

week nr. 1985 [1]	aantal patiënten							
	provinciegroep				urbanisatiegroep			totaal
	a	b	c	d	1	2	3	
4	5	6	11	12	3	9	14	9
5	9	6	7	10	6	8	8	8
6	18	9	9	6	9	7	16	10
7	22	17	14	15	17	15	18	16
8	21	21	24	23	15	23	27	23
9	60	28	35	88	22	55	54	50
10	79	35	48	78	30	60	65	57
11	46	27	40	37	26	39	44	38
12	33	13	25	26	18	24	30	24
13	26	10	17	19	8	16	27	17

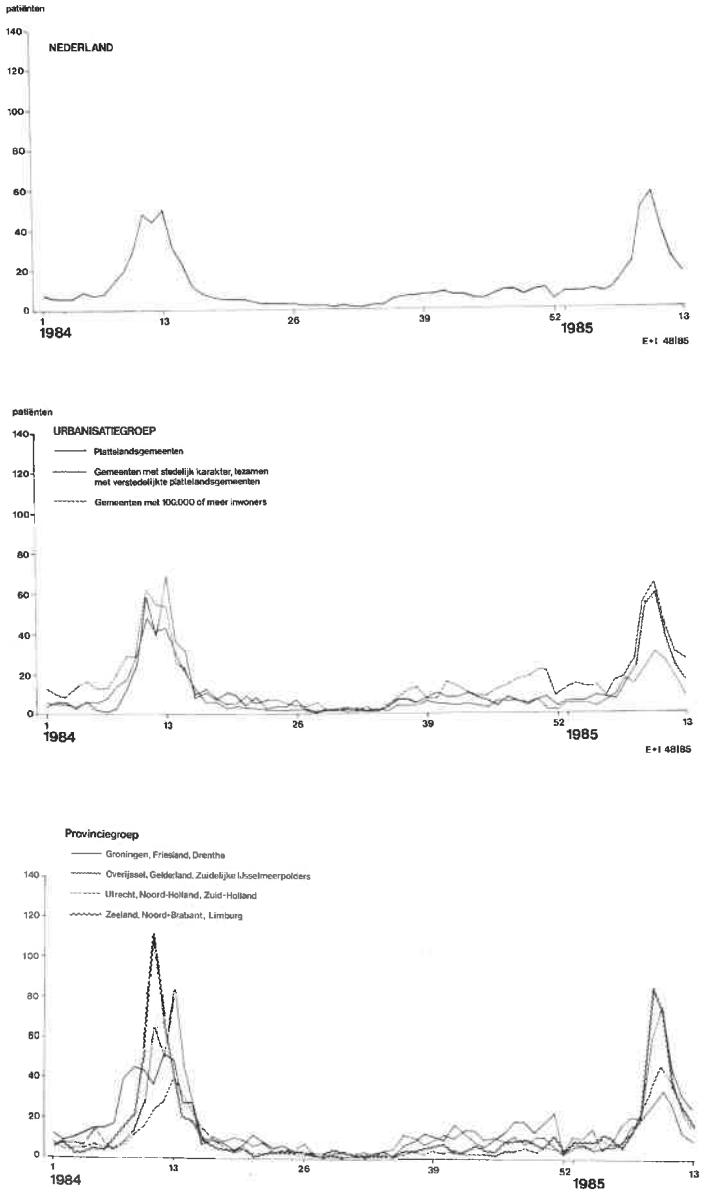
[1]) De cijfers vanaf week 1-1985 zijn voorlopig.

Figuur 1
PEILSTATIONS
CONTINUE MORBIDITEITS REGISTRATIE
1984

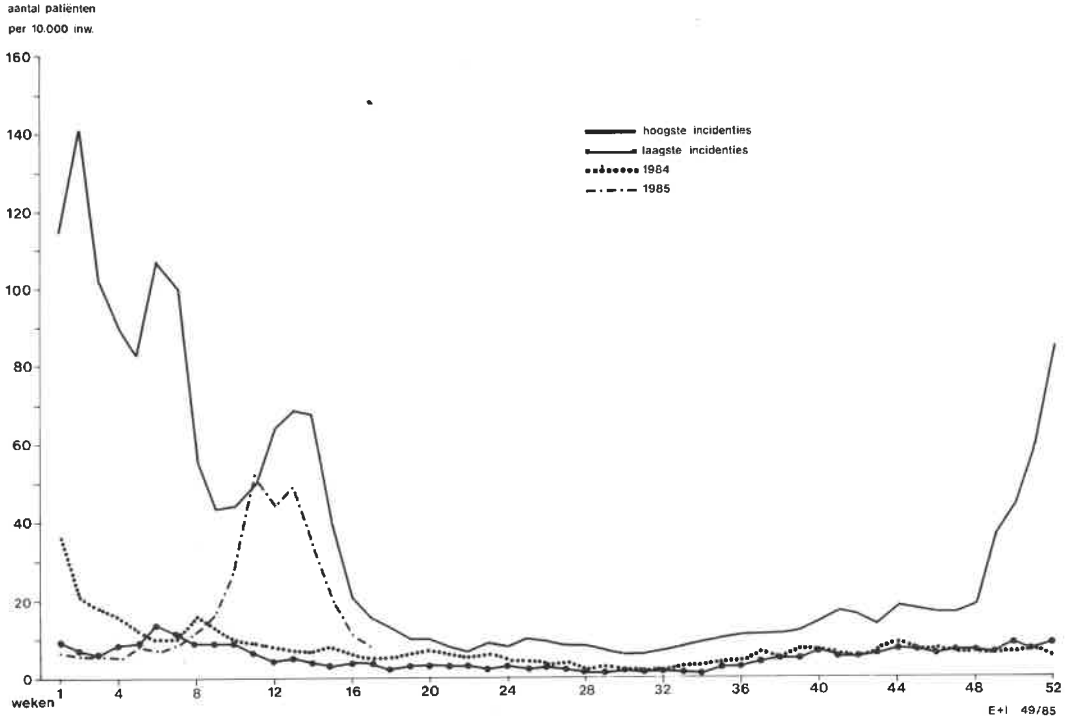
Figuur 2
Het aantal dagen, dat in 1984 per week is gerapporteerd



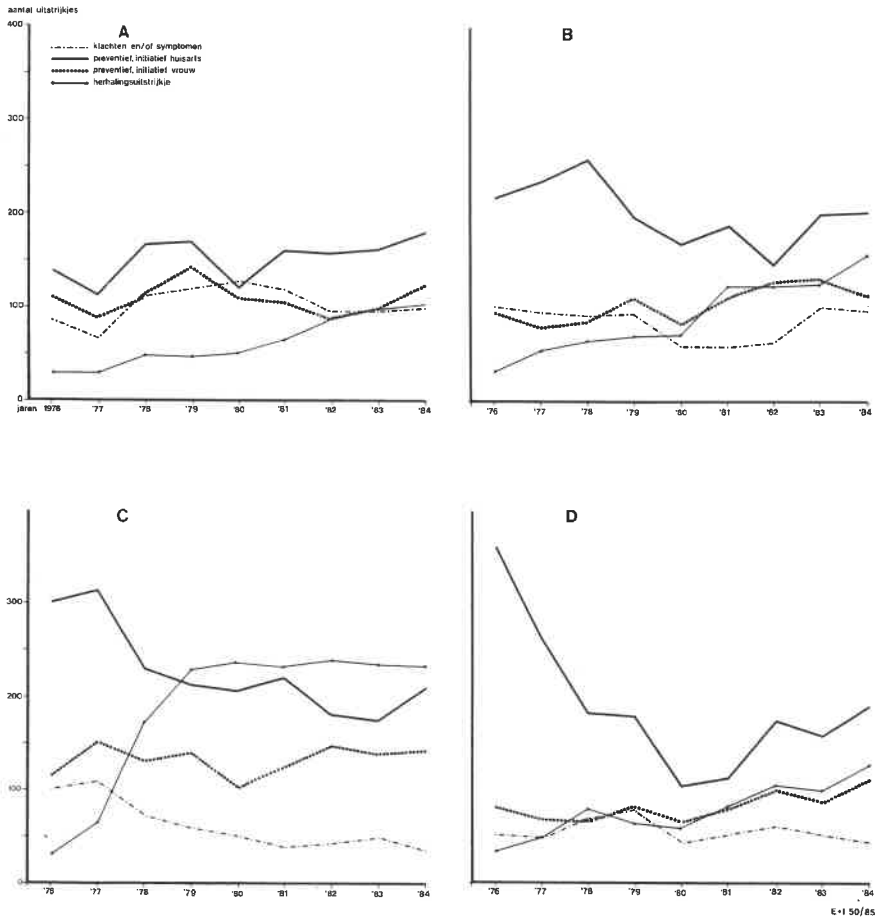
Figuur 3
Aantal patiënten met influenza(-achtig ziektebeeld) per week en per 10.000 inwoners, 1984 - 1985 (t/m 13e week)



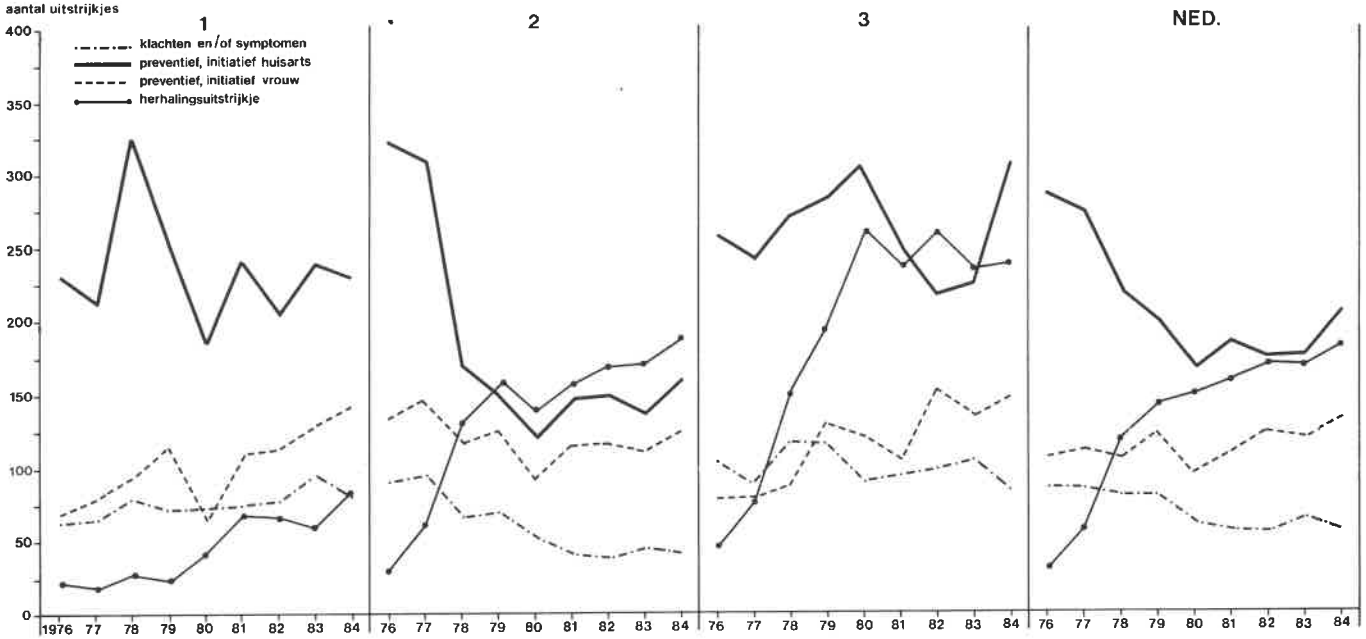
Figuur 4
Hoogste en laagste weekincidenties van influenza(-achtig ziekte-beeld) per 10.000 inwoners voor de jaren 1970 - 1983 en week-incidenties van 1984 - 1985 (t/m 13e week)



Figuur 5
Aantal uitstrijkjes gemaakt van de cervix uteri, per provinciegroep, naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1976 - 1984

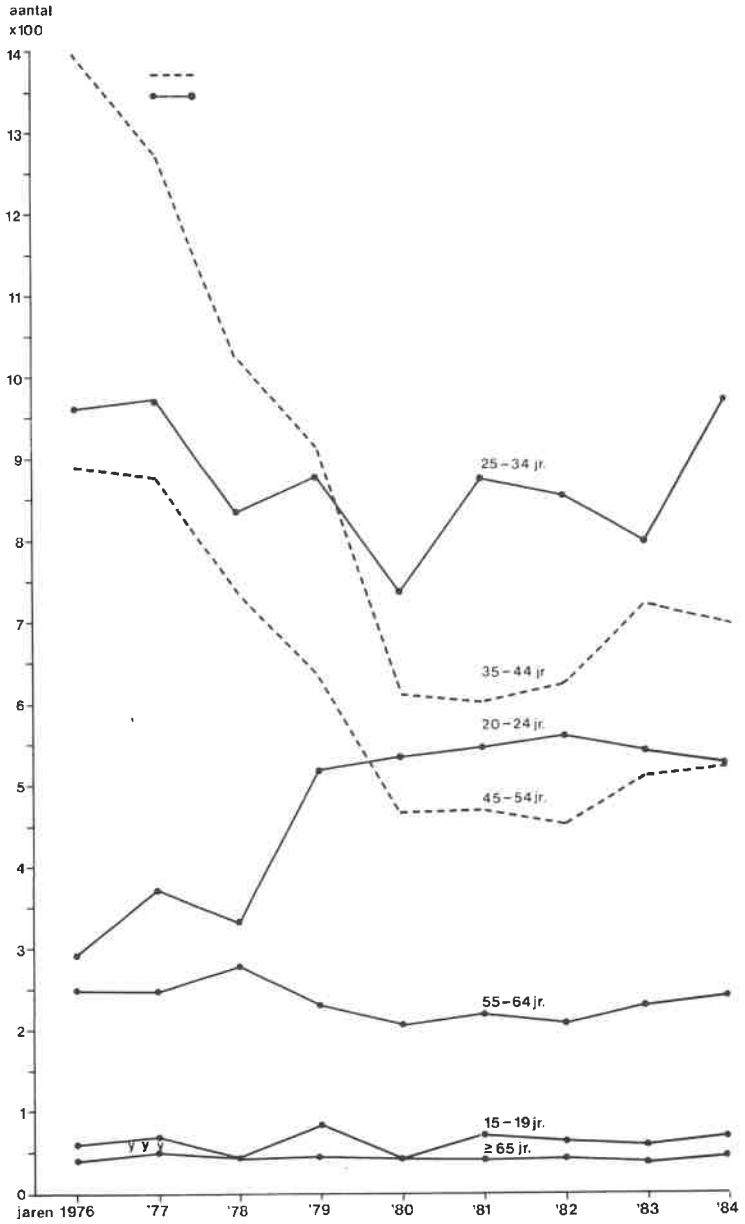


Figuur 6
Aantal uitstrijkjes gemaakt van de cervix uteri, per urbanisatiegroep en voor Nederland, naar indicatie tot het maken van een uitstrijkje, per 10.000 vrouwen, 1976 - 1984



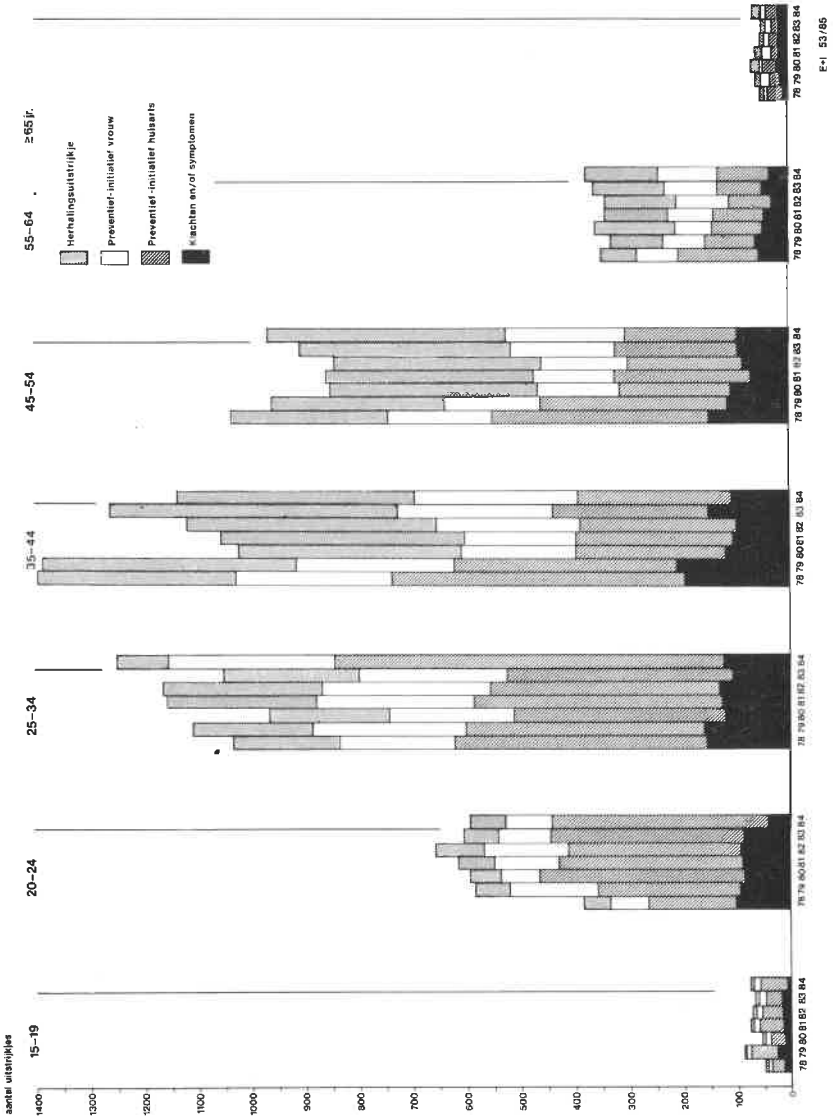
E+I 51/85

Figuur 7
Aantal "eerste" uitstrijkjes gemaakt van de cervix uteri naar leeftijdsgroep, per 10.000 vrouwen, 1976-1984

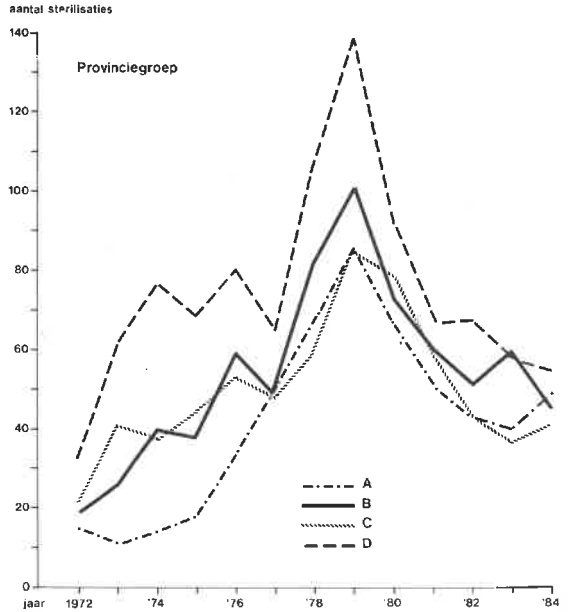


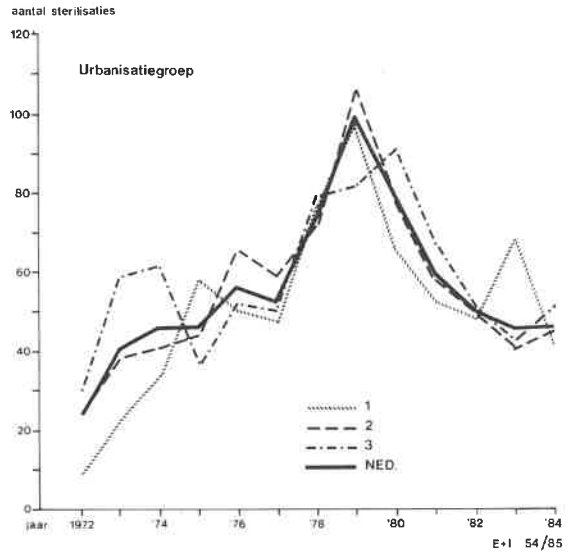
E+I 52/85

Figuur 8
Aantal uitstrijkjes gemaakt van de cervix uteri naar leeftijdsgroep en naar indicatie tot het maken van het uitstrijkje, per 10.000 vrouwen, 1978 - 1984

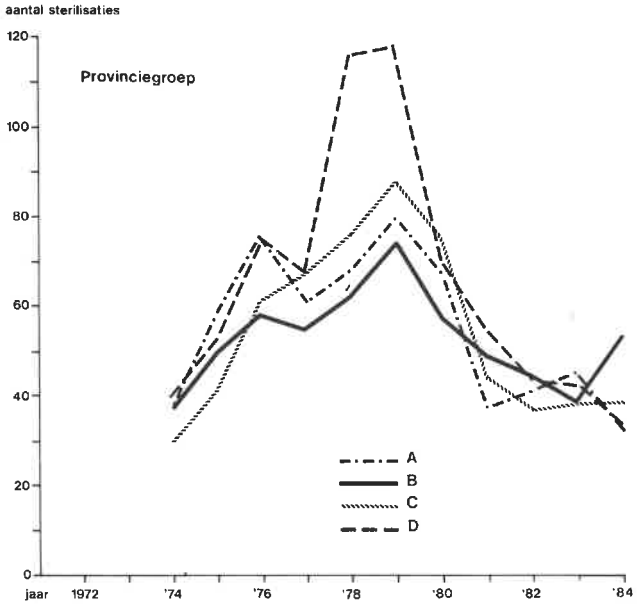


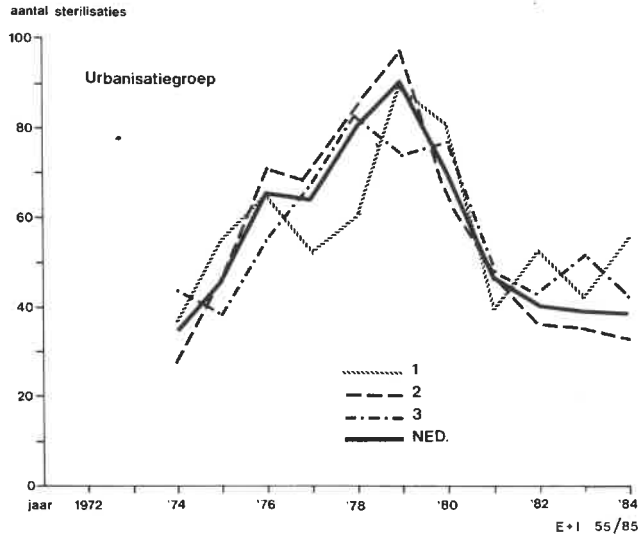
Figuur 9
Aantal bij mannen verrichte sterilisaties, per provinciegroep- en urbanisatiegroep, per 10.000 mannen, 1972 - 1984



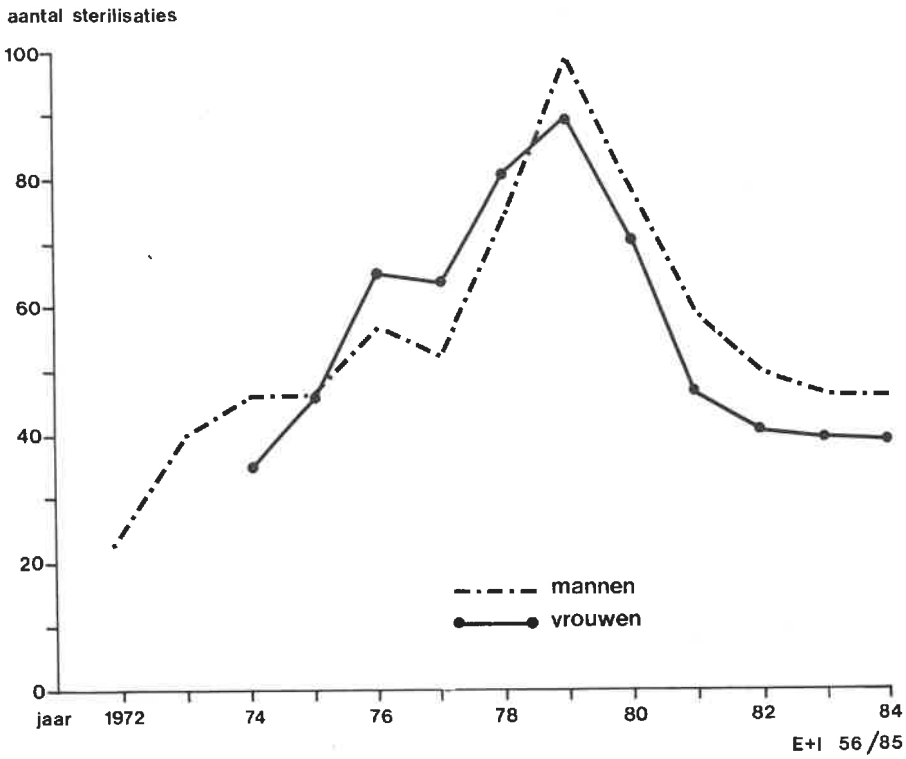


Figuur 10
Aantal bij vrouwen verrichte sterilisaties, per provincie- en urbanisatiegroep, per 10.000 vrouwen, 1974 - 1984

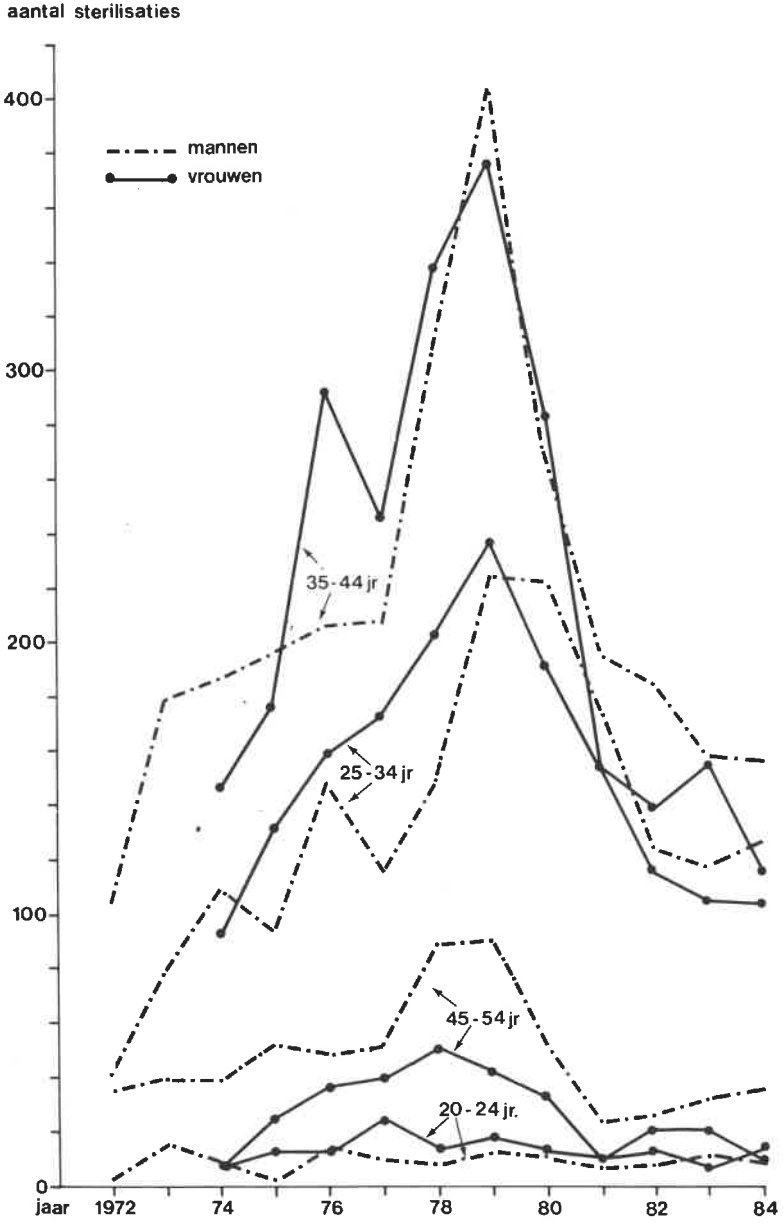




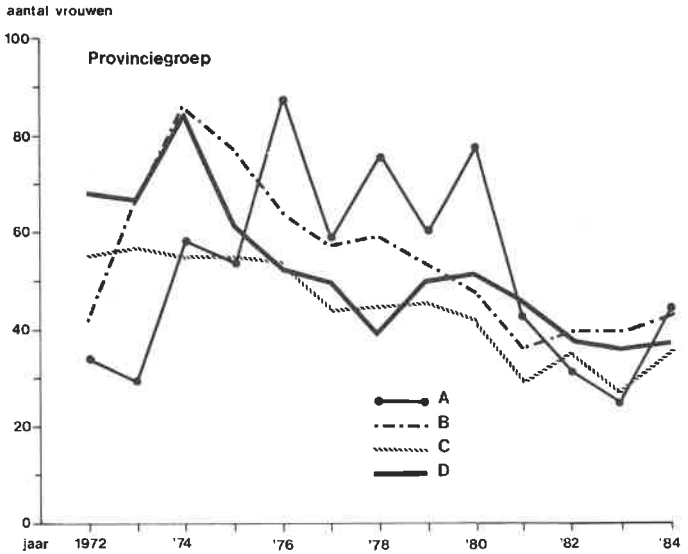
Figuur 11
Aantal verrichte sterilisaties per 10.000 mannen resp. vrouwen, 1972 - 1984

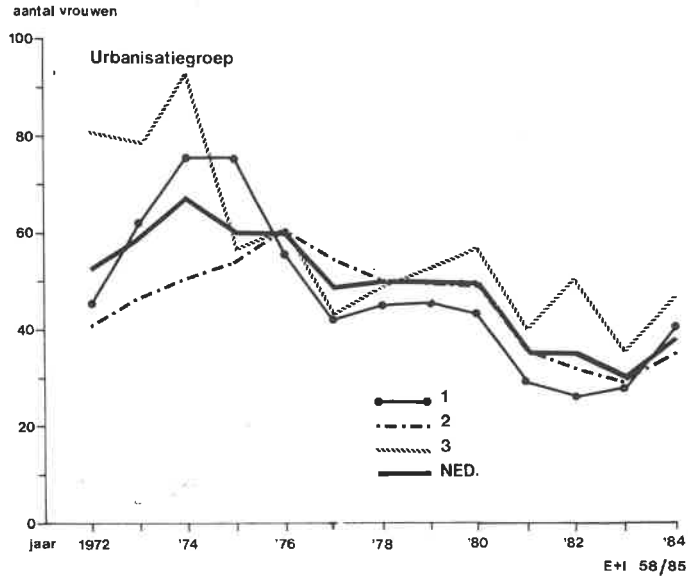


Figuur 12
Aantal verrichte sterilisaties naar leeftijdsgroep, per 10.000 mannen resp. vrouwen, 1972 - 1984

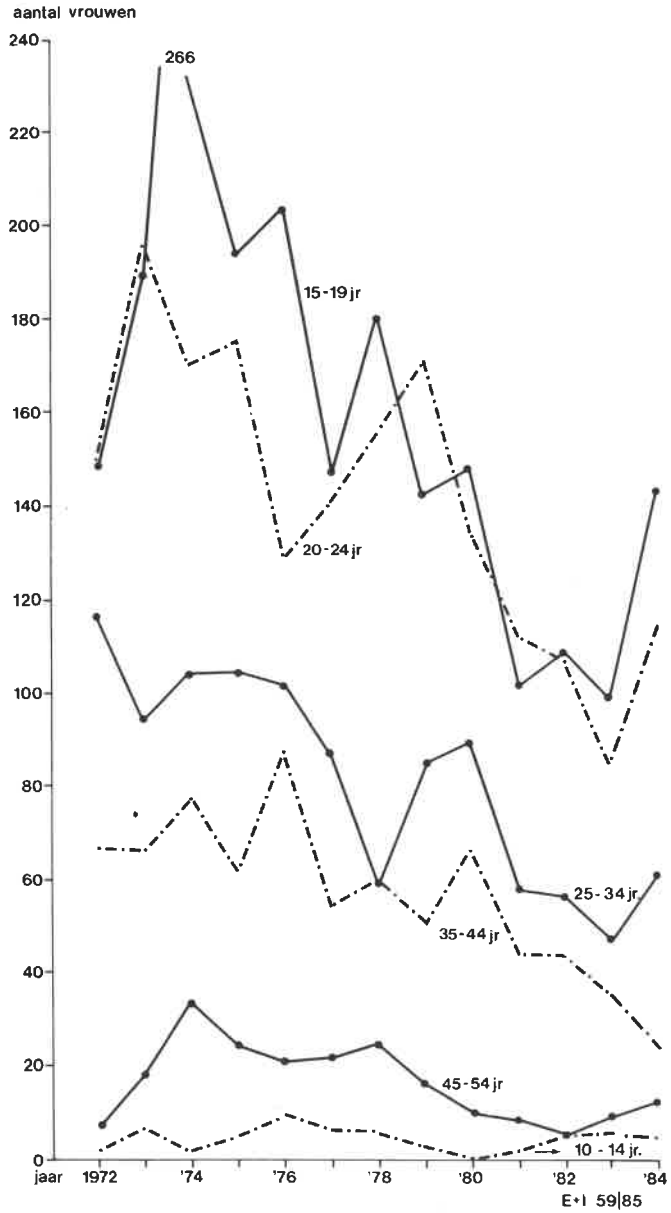


Figuur 13
Aantal malen dat de morning-after pil is voorgeschreven, per provincie- en urbanisatiegroep, per 10.000 vrouwen, 1972 - 1984

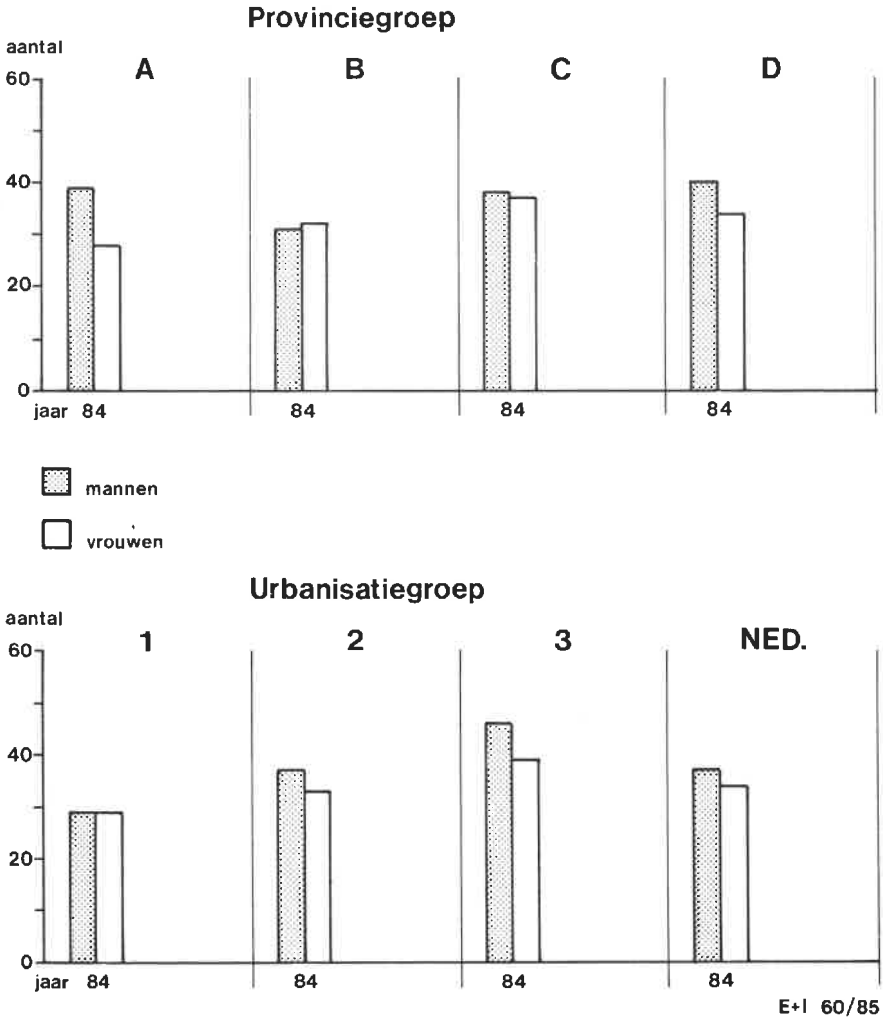




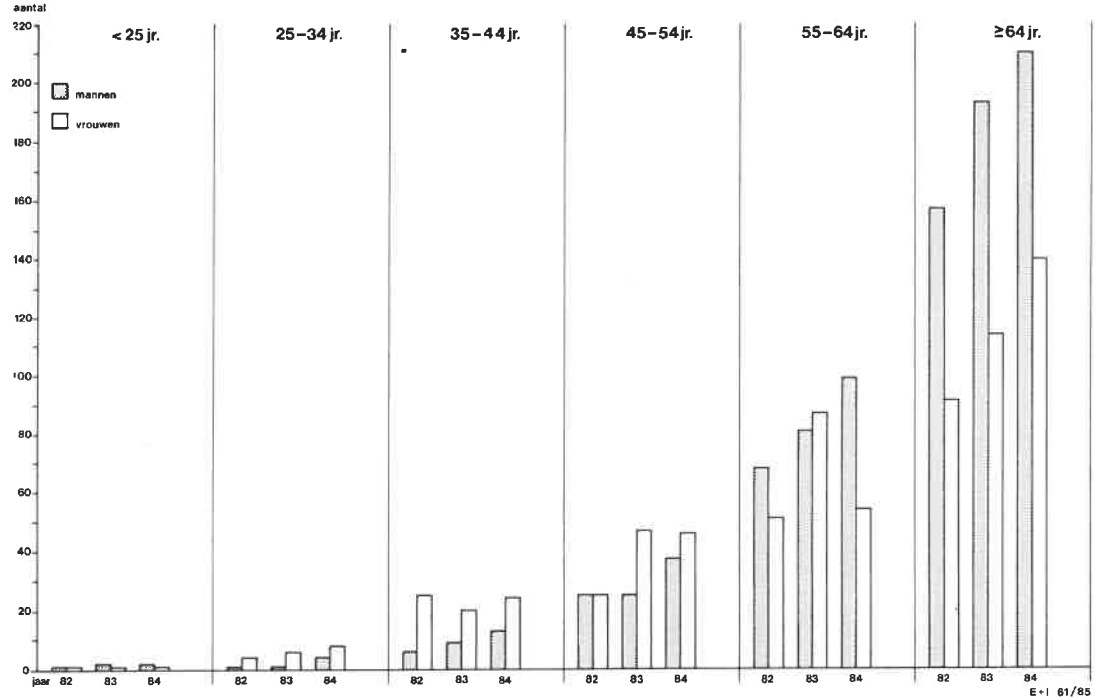
Figuur 14
Aantal malen dat de morning-after pil is voorgeschreven naar leeftijdsgroep, per 10.000 vrouwen, 1972 - 1984



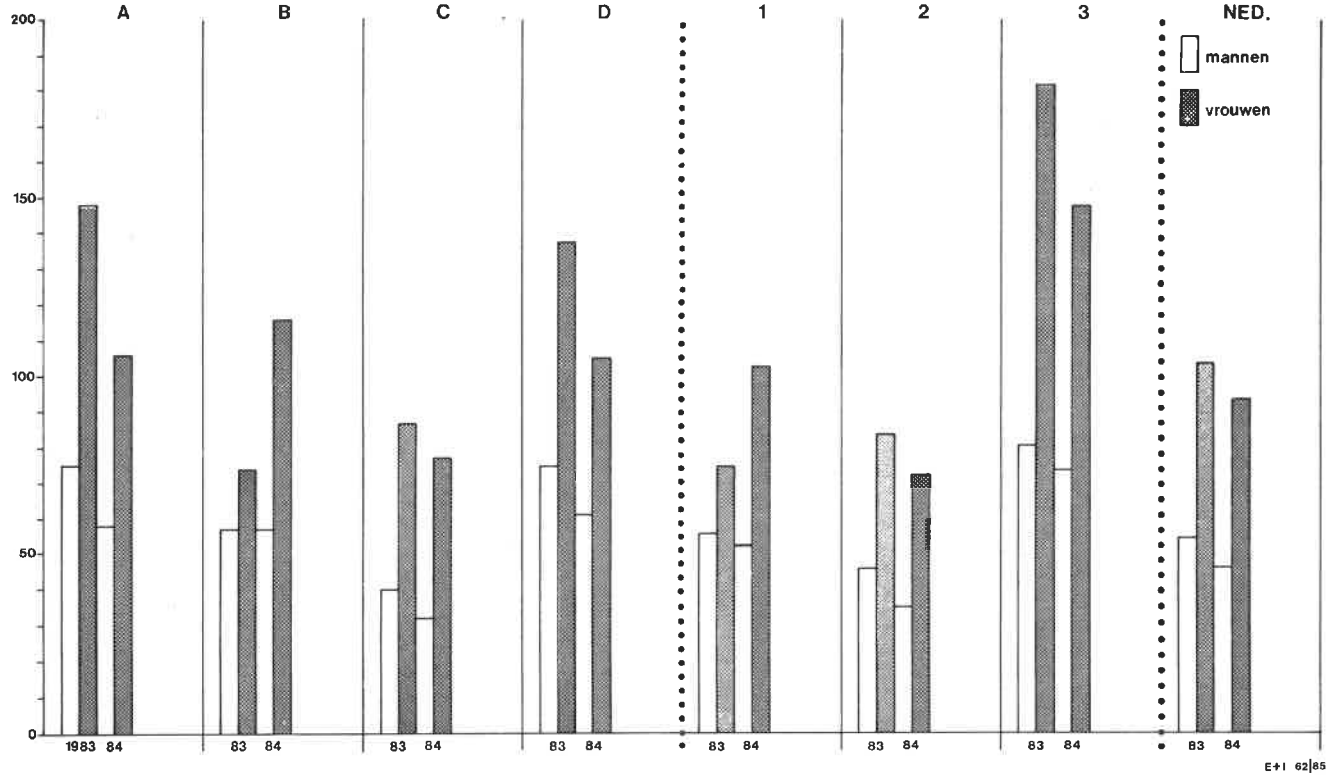
Figuur 15
Aantal nieuwe kankerpatiënten per provincie- en urbanisatiegroep per 10.000 mannen resp. vrouwen en per 10.000 inwoners,
1982 - 1984



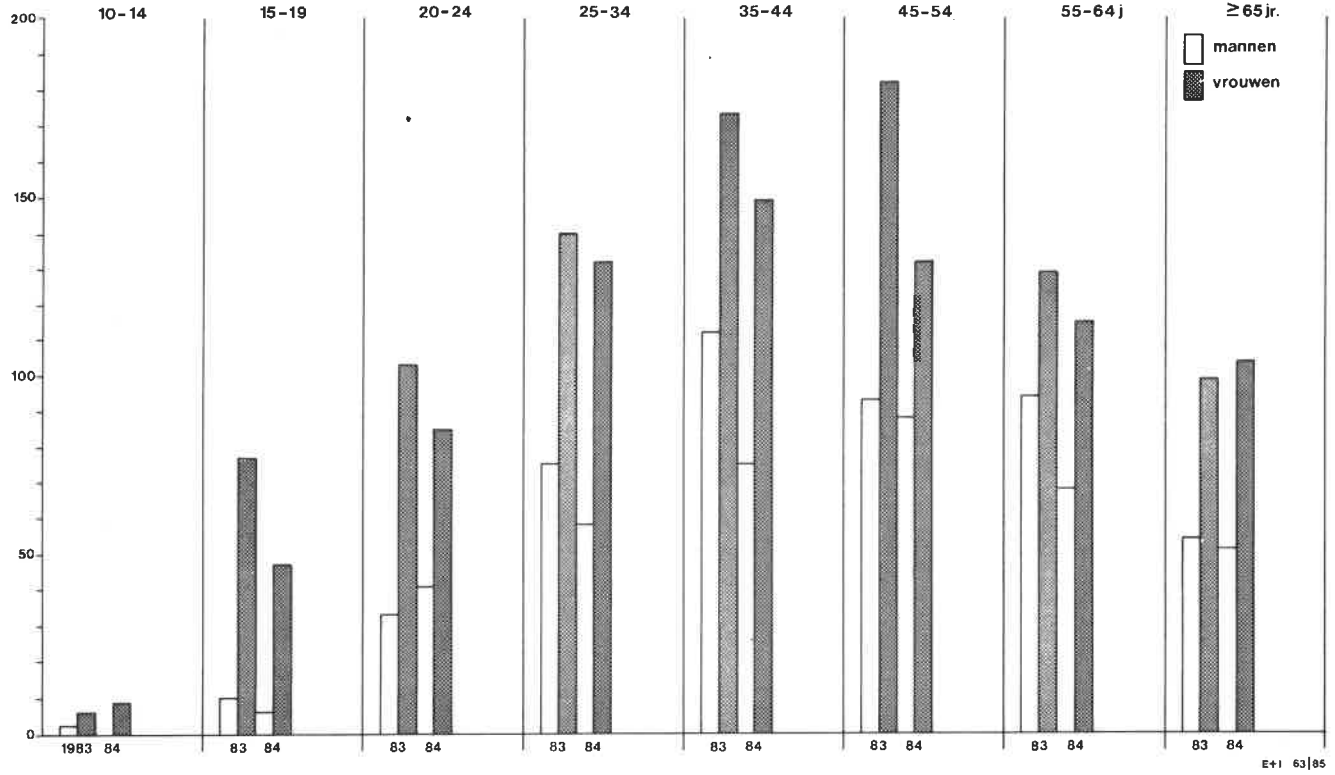
Figuur 16
Absoluut en relatief aantal door peilstationartsen gerapporteerde (nieuwe) patiënten met (vermoedelijk) een maligniteit en aantal mannen en vrouwen naar leeftijdsgroep, 1982 - 1984



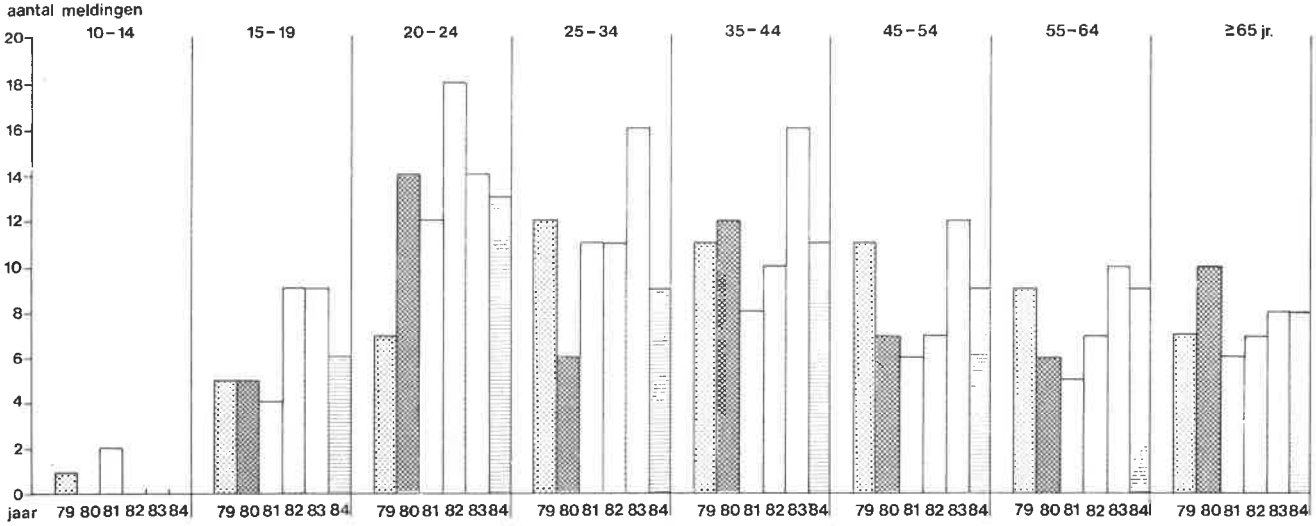
Figuur 17
Aantal nieuwe patiënten "in behandeling" voor een depressief syndroom, per provincie- en urbanisatiegroep, per 10.000 mannen resp. vrouwen, 1984



Figuur 18
Aantal nieuwe patiënten "in behandeling" voor een depressief syndroom naar leeftijdsgroep, per 10.000 mannen resp. vrouwen, 1984

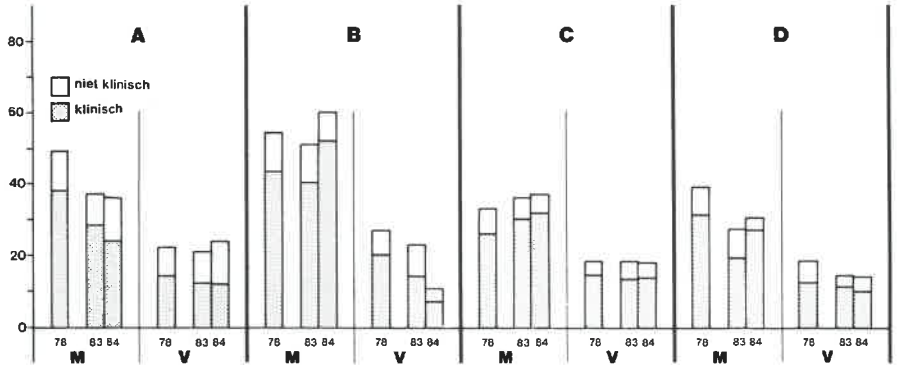


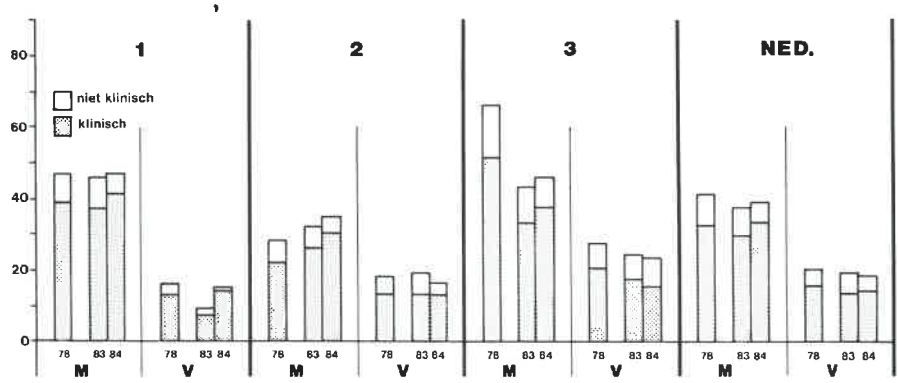
Figuur 19
Aantal meldingen van een suicide(poging) naar leeftijdsgroep, per 10.000 inwoners, 1979 - 1984



E+I 64/85

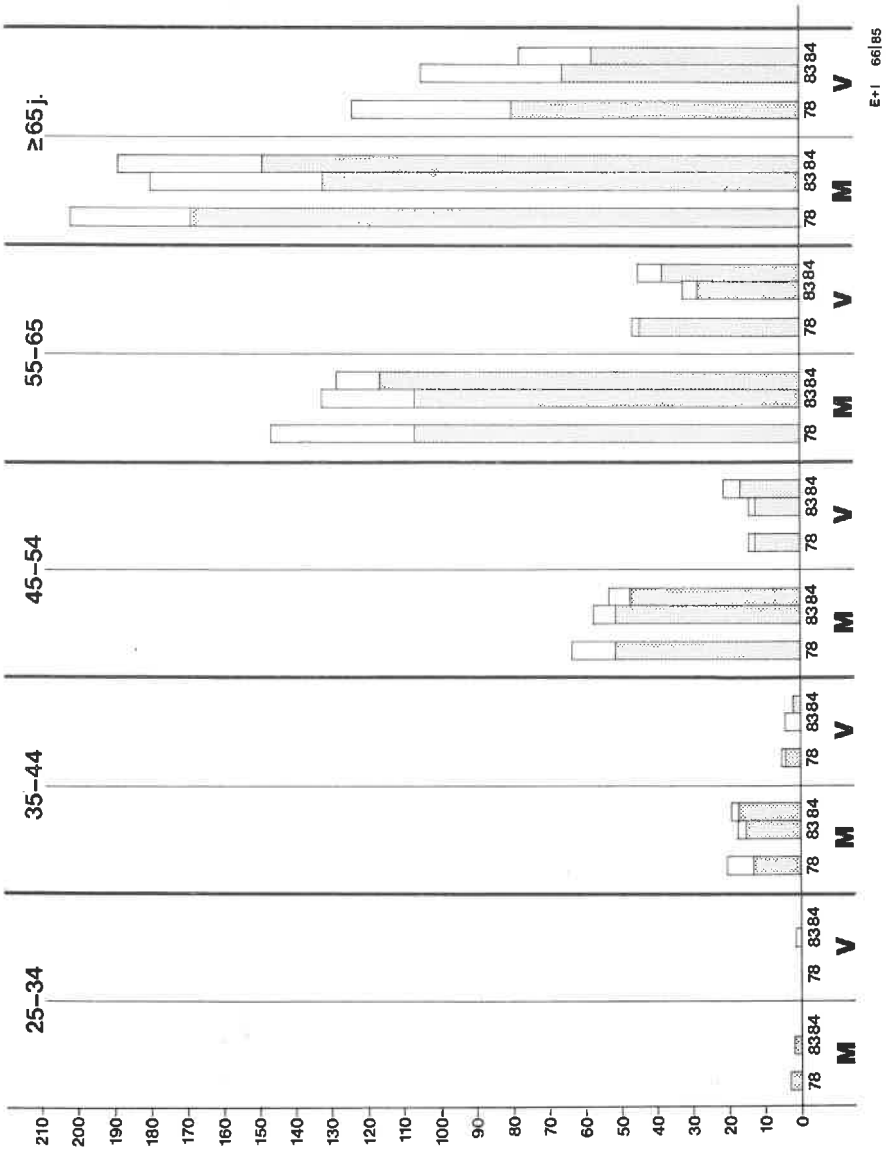
Figuur 20 en 21
Aantal gevallen waarbij de peilstationarts handelt alsof het een acuut hartinfarct betreft, per provincie- en urbanisatiegroep, per 10.000 mannen resp. vrouwen en naar al of geen opname in een ziekenhuis binnen 48 uur, 1978, 1983 en 1984



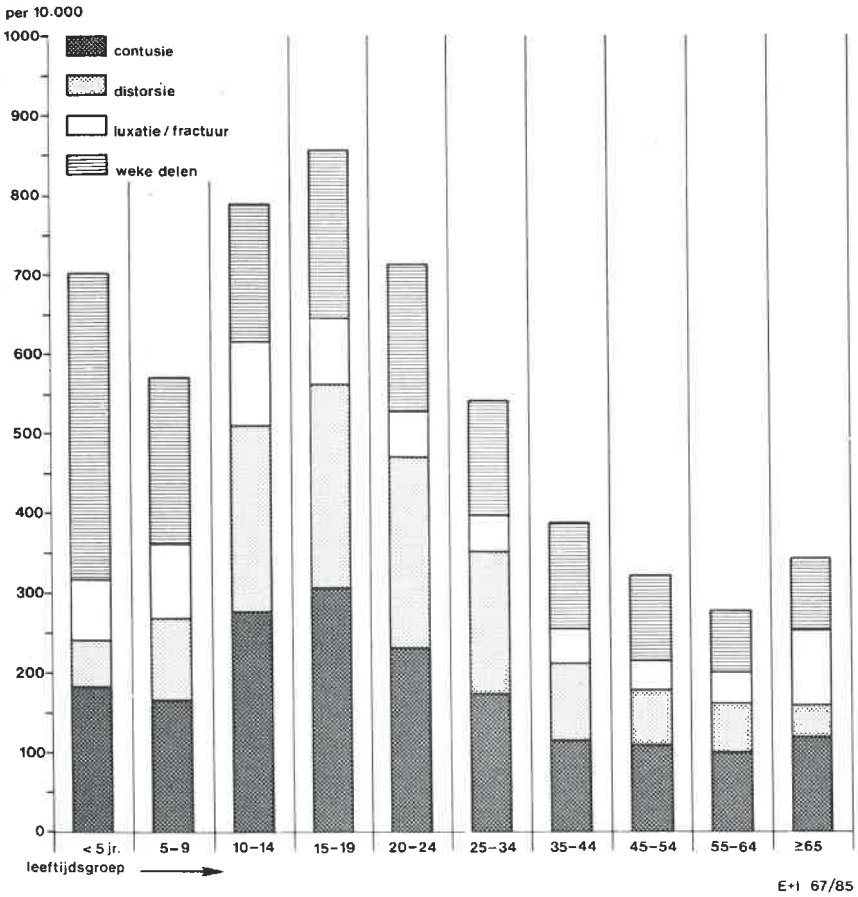


E+I 65/85

Figuur 22 en 23
Aantal gevallen waarbij de peilstationarts handelt alsof het een acuut hartinfarct betreft naar leeftijdsgroep, per 10.000 mannen resp. vrouwen en naar al of geen opname in een ziekenhuis binnen 48 uur, 1978, 1983 en 1984



Figuur 24
Aantal eerste contacten wegens letsels aan het steun- en bewegingsapparaat naar leeftijdsgroep per 10.000 inwoners, 1984



FOOTNOTES

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

2) Figures from the registration of professions in primary health care, Jan. 1984, p. 29, table 13. Published by NIVEL, Utrecht.

3) Idem, p. 27, table 11.

4) 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.

5) In these tables and the tables in the text derived from them frequencies are given in all cases per 10 000 men, women or inhabitants, unless stated otherwise.

6) This must satisfy the following criteria (Pel, 1965):
   a. An acute beginning, i.e. at most a prodromal stage of three to four days (including pre-existent infections of the respiratory organs at a non-pathogenic level);
   b. The infection must be accompanied by a rise in rectal temperature to at least 38°;
   c. At least one of the following symptoms must be present: cough, coryza, sore throat, frontal headache, retrosternal pain, myalgia.
   Pel, J.Z.S. (1965) Proefonderzoek naar de frequentie en de aetiologie van griepachtige ziekten in de winter 1963-1964 (Experimental investigation of the frequency and aetiology of influenza-like illness in the winter 1963-1964). Huisarts en wetenschap 8, 321.

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

8) Letter from the Minister of Public Health and Environment to the

President of the Second Chamber of the States-General. Second Chamber, 1981-1982 session, 17 100 Chapter XVII, No. 63.

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

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

11) Ministry of Public Health and Environment, 1982.

12) Recent demographic developments in the member states of the council of Europe (CDDE (83)26).

13) Schadé, F. and IJzermans, C.J. (1985). Over de volledigheid van de voorgestelde Landelijke Kankerregistratie, Huisarts en Wetenschap, 28, p. 171-173.

14) Atlas van kankersterfte 1969-1978, Central Bureau of Statistics, p. 8.

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

16) Myocardial infarction: a comparison between home and hospital care for patients. H.G. Mather c.s., British Medical Journal, 17 April 1976, p. 925-929.
A randomised trial of home-versus-hospital management for patients with suspected myocardial infarction. J.D. Hill c.s., The Lancet, 22 April 1978, Vol. 1 p. 837-841.

17) F. Meyman, book review of Letsels van het steun- en bewegingsapparaat, Huisarts en Wetenschap (1983) 26, p. 275.

18) The currency of a referral card.

19) Data on the make-up of the health insurance fund practice are still being collected.

20) All physicians less one who was not authorized by the Netherlands Institute for General Practice to request the LISZ figures.

21) "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.

22) An euthanasia declaration is a written request for euthanasia on certain conditions.

23) Kenter, E.G.H. Euthanasie is een huisartspraktijk, Medisch Contact: 1938, 38, p. 1179.

Explanatory notes pertaining to:

Bijlage 1

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

Bijlage 2

Bijlage	- Appendix
Weekstaat t.b.v. centrale registratie	- Weekly return for central registration
Continue morbiditeitsregistratie, peilstations	- Continuous morbidity registration, sentinel stations
Proj. no.	- Project number
Verslagjaar	- Year under review
Week no.	- Number of the week
Code peilstations	- Code number sentinel stations
Rapport. dagen	- Number of days over which reporting took place
Regel no.	- Line number
Leeftijdsgroep	- Age group
Influenza (-achtig ziektebeeld)	- Influenza (-like illness)
Diabetes mellitus	- Diabetes mellitus
Cervixuitstrijkje	- Cervical smear
Na 1-1-1981 voor de eerste maal afgenomen op grond van	- Taken for the first time after 1-1-1981 on the ground of
Klachten/symptomen	- Complaints/symptoms
Louter preventieve overwegingen	- Pureley preventive considerations
Initiatief huisarts	- General practitioner's initiative
Verzoek van de vrouw	- Woman's request
Ziekte van Parkinson	- Parkinson's disease
Sterilisatie verricht	- Sterilization performed

Morning-after-pill voorgeschreven	- Prescription of morning-after-pill
Behandeld wegens depressie	- Treated for depression
Suicide(poging)	- (Attempted)suicide
Hartinfarct	- Myocardial infarction
klinisch	- clinical
niet-klinisch	- non-clinical
M	- Male
V	- Female
Weeknummer	- Number of the week
Opgemaakt d.d.	- Completed on
Aantal dagen gerapporteerd	- Number of days over which reporting took place
(Zie voetnoot[1])	- (See footnote number[1])
Zie ommezijde voor voetnoot	- For footnotes see reverse

1. Door vakantie, ziekte en andere oorzaken zal deze rapportage zich echter ook over minder dan 5 dagen kunnen uitstrekken. Het wordt van belang geacht om, zo mogelijk, ook tijdens het weekeinde waargenomen patiënten te rapporteren. (M.u.v. influenzapatiënten.)
2. Betreft uitsluitend nieuwe patiënten, ook telefonisch consult melden.
3. Betreft rapportering van vrouwen bij wie na 1-1-1982 om welke reden dan ook een cervixuitstrijkje heeft plaatsgevonden. Indien bij een vrouw na 1-1-1982 opnieuw een cervixuitstrijkje wordt gemaakt, dient dit altijd onder de subrubriek 'herhalingsonderzoek' geboekt te worden (zie ook voetnoot 7).
4. Bijvoorbeeld in het kader van pilcontrole.

1. As a result of vacation, sickness and other causes this reporting may extend over fewer than 5 days. It is considered to be of importance to report, if possible, patients observed during the weekend as well. (Influenza patients excluded.)
2. Relates solely to new patients. Report telephone calls as well.
3. Concerns reporting of women on whom a cervical smear was taken after 1-1-1982 for whatsoever reason. If a cervical smear was taken again a woman after 1-1-1982 this should always be entered under the subheading 'Repeat examination' (see also footnote 7).
4. For example as part of check-up for the pill.

5. Bijvoorbeeld wegens verdacht preparaat of wegens technische onvolkomenheden bij onderzoek vorig preparaat.

6. Betreft alleen **nieuwe** patiënten met de **echte** ziekte van Parkinson (zie ook de toelichting).
Geslacht:.....

7. Indien het een patiënt(e) betreft uit een van de leeftijdsgroepen, waarvan het vak gerasterd is, dan tevens exacte leeftijd hierachter vermelden.
Leeftijd:.....

8. Uitsluitend indien er een directe indicatie is. Indien een recept voor de morning-after-pill wordt afgegeven omdat de betrokkene bijvoorbeeld met vakantie naar het buitenland gaat, dient dit niet te worden gerapporteerd. (Zie ook voetnoot 8).
Naam van de pil.....

9. Betreft uitsluitend nieuwe patiënten. Voor de aanvullende gegevens s.v.p. apart formulier invullen en bij de weekstaat voegen.

10. Alle eerste contacten, waarbij de huisarts wegens een depressie actie (medicatie, terugbestelling, gesprekscontact, verwijzing) onderneemt. Zie ook de toelichting op de weekstaat.
Risico op suicide (poging): n.v.t./geen/laag/middelmatig/hoog.

5. For example on account of suspect preparation or technical imperfections in the examination of the preparation.

6. Concerns only **new** patients with **genuine** Parkinson's disease (see also the explanation).
Sex:.....

7. If a patient is concerned in one of the age groups whose box is filled in, also give the exact age here.
Age:.....

8. Solely if there is a direct indication. If a prescription for the morning-after-pill is issued because the patient is for instance going on holiday abroad, this should not be reported. (See also footnote 8).
Name of the pill:.....

9. Relates solely to new patients. For the supplementary data please complete a separate form and attach in to the weekly return.

10. All first contacts in which the general practitioner takes action on account of a depression (medication, repeat consultation, discussion with the patient, referral). See also the explanation on the weekly return. Danger of (attempted) suicide: n.a./none /slight/moderate/great.

11. Voor de aanvullende gegevens s.v.p. een apart formuliertje invullen en bij de weekstaat voegen.
12. Betreft een vermoeden op een (primair of recidief) hartinfarct, met dien verstande dat een of meer van de gebruikelijke maatregelen zijn genomen (zie ook de toelichting op de weekstaat).
13. Onder een niet-klinische patiënt wordt in dit verband verstaan een patiënt, die niet binnen 48 uur wordt opgenomen.
14. Betreft alleen letsels t.g.v. een ongeval. Zie ook de toelichting op de weekstaat.
15. Verwijzingen naar een specialist. Betreft alleen ziekenfondspatienten. Zie ook de toelichting op de weekstaat.

11. For the supplementary data please complete a separate form and attach it to the weekly return.
12. Concerns suspicion of a primary or recurrent cardiac infarction, with the proviso that one or more of the usual measures have been taken (see also the explanation on the weekly return).
13. In this context a non-clinical patient is one who is not admitted to hospital within 48 hours.
14. Relates only to traumas as the results of an accident. See also the explanation on the weekly return.
15. Refferal to a specialist relates only to health insurrance fund. Members see also the explanation on the weekly return.

Tables 1a-3e

Continue morbiditeits-registratie peilstations	Continuous morbidity registration sentinel stations
Kwartaal	- Quarter
Leeftijdsgroep	- Age group
Influenza (-achtig ziektebeeld)	- Influenza (-like illness)
Cervixuitstrijkje	- Cervical smear
Klacht/symptoom	- Complaint/symptom
Initiatief huisarts	- General practitioner's initiative
Verzoek vrouw	- Woman's request
herhalingsonderzoek	- Repeat smear
Ziekte van Parkinson	- Parkinson's disease

Sterilisatie verricht	- Sterilization performed
Morning-after pill voorgeschreven	- Morning-after pill prescribed
Maligniteiten	- Malignancies
Depressie	- Depression
Suicide(poging)	- (Attempted)suicide
Hartinfarct	- Myocardial infarction
klinisch	- clinical
niet-klinisch	- non-clinical
Letsels van steun- en bewegingsapparaat	- Trauma of the musculoskeletal system
Contusie	Contusion
Distorsie	Distortion
Luxatie/fractuur	Luxation/fracture
Weke delen	Soft tissue
Verwijzingen	- Referrals
Actief	Active
Geruststelling	Reassurance
Diagnose	Diagnosis
Behandeling	Treatment
Combinaties	Combinations
Passief	Passive
Refractie-afwijkingen	Refractive disorders
Overige	Others
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 100000 or more

Voetnoot	- Footnote
N.B. Als gevolg van het afronden bij het berekenen van de relatieve frequenties kunnen kleine verschillen in de totalen zijn ontstaan.	N.B. As a result of the rounding-off when calculating relative frequencies, small differences in the totals may have occurred.

Table 4a

Aantal patiënten met influenza (-achtig ziektebeeld) per week en per 10,000 inwoners, 1983 en 1984 (t/m 17e week)	- Number of patients with influenza (-like illness) per week and per 10,000, 1983 and 1984 (up to and including the 17th 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	
Continue morbiditeitsregistratie	- Sentinel stations - Continuous morbidity registration
Grenslijn provinciegroep	- Boundary of province group

Figure 2

Het percentage dagen dat in 1983 per week is gerapporteerd	- Percentage of days weekly reported in 1983
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 10000 inwoners, 1983-1984 (t/m 17e week)	- Number of patients with influenza (-like illness) per week, per 10 000 inhabitants, 1983-1984 (up to and including the 17th week)
Provinciegroep	- Province group
Urbanisatiegroep	- Urbanization group
Naar leeftijdsgroep en geslacht	- By age group and sex

Figure 4

Hoogste en laagste weekincidenties van influenza (-achtig ziektebeeld) per 10000 inwoners voor de jaren 1970-1982 en weekincidenties van 1983-1984 (t/m 17e week)	- Highest and lowest weekly incidences of influenza (-like illness) for 1970-1982 and weekly incidences for 1983-1984 (until the 17th week).

Figures 5 - 8

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 9 and 11

Aantal bij mannen verrichte sterilisaties	- Number of sterilizations performed on

Figures 10 and 12

Aantal bij vrouwen verrichte sterilisaties	- Number of sterilizations performed on

Figures 13 and 14

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 15 and 16

Aantal nieuwe kankerpatiënten	- Number of new cancer patients

Figures 17 and 18

Aantal nieuwe patiënten 'in behandeling' voor een depressief syndroom	- Number of new patients treated for depressive syndrome

Figure 19

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

Figures 20, 21, 22 and 23

Aantal patiënten waarbij de peilstationarts handelt alsof het een acuut hartinfarct betreft, per..... en naar al of geen opname in	- Number of cases in which the physician acts as if an acute myocardial infarction is concerned, per..... ..... and by admission or

een ziekenhuis binnen 48 uur.

non-admission to hospital within 48 hours.

Figures 24

Aantal eerste contacten wegens letsels aan het steun- en bewegingsapparaat.

- Number of first contacts on account of traumas of the musculo-skeletal system.