

preferable to synthetic ones, but do not explain the reason for the statement. I find that many women object to natural oestrogens on the grounds that they are obtained from horses' urine and that there is some controversy about the horses' welfare, a viewpoint I tend to share.

According to the manufacturers' information most other brands of hormone replacement therapy (HRT) are synthesised from plant material and I have had no problems in prescribing them.

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Raymond G Walker

To the Editor:

The articles by Professor Cooper and Dr Dennison, and by Dr Compston fail to address a rational plan for management in postmenopausal women. I recommend to Professor Cooper a DEXA bone scan for all women at the time of their first mammogram at the age of about 50 years, avoiding the problems of population strategy and high-risk target strategy based on clinical factors. This approach would identify the population at risk and also enable physicians to encourage long-term HRT treatment with general improvement in bone mass and other beneficial effects. In the current osteoporosis epidemic which has been apparent for at least 10 if not 20 years, I am not aware of any public health measures making an impact on this rise.

Only by measuring the 9.6 million women aged over 45 years in this country can implementation of sensible treatment, based on the scan results, be planned. Postmenopausal women are fully aware of it and it has not been explained to me how rationally to counsel this population without a DEXA bone scan.

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Authors' response:

Regarding the point made by Dr Walker, the *British National Formulary* suggests that the profile of natural oestrogens (oestradiol, oestrone and conjugated equine oestrogens) is more appropriate for hormone replacement therapy than that of the synthetic oestrogens (ethinyloestradiol, mestranol and stilboestrol) and it has also been suggested that synthetic hormones may carry a greater risk of adverse events, although both these points remain controversial. Conjugated equine oestrogens ('Prempak C' and 'Premarin') are obtained from pregnant mares' urine, but the Medical Information Department at the manufacturer (Wyeth Laboratories) have given an assurance that the process is carefully controlled and they placed a statement in a number of medical journals to this effect in 1995. It appears that most other brands of oestrogen are derived from plant material and the products mentioned above are the only ones derived from equine urine.

Dr Perry advocates performing bone densitometry on all women at the time of their first mammogram at the age of 50 years, his rationale being that this enables the supervising physician to encourage long-term HRT treatment. We are not aware of any studies showing that knowledge of one's bone density reduces fracture rate through improved compliance. In addition, the cardiovascular protection afforded by HRT is important and may be the main indication for starting treatment regardless of bone mass considerations. It might therefore be argued that a stronger case could be made for screening at the age of 65 years when alternative drug therapies might usefully be employed.

Health economic analyses for osteoporosis are driven by hip fracture, the most serious consequence of low bone density. Screening by bone mineral density alone provides a tool of high specificity and low sensitivity. This may be improved by adding independent risk factors such as previous fragility fracture or neuromuscular function to the model, but these are less common at menopause than later in life.

Finally, we wish to emphasise the difference between screening those who have not sought medical advice and clinical practice in which