against the use of medication to treat depression in children. Children are less likely than adults to receive adequate analgesia for physical pain. There is a danger that, because of limited research and some antagonism to drug treatment, the same thing may happen with depression.

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1 Poznanski EO, Mokros HB. Children’s depression rating scale—revised. Los Angeles: Western Psychological Services, 1996.
how much stability there is in the ratings: less than half the acute trusts retained their 2001 ratings with 47 moving up and 37 moving down. Although differences in methodology may be partly responsible, this hardly suggests that the rating system provides a solid base for policy making.

Next year the Commission for Health Improvement takes over responsibility for the assessment system and faces the challenge of making it less opaque and more comprehensible. In doing so, it might usefully consult the original exponent of the star system: the Michelin guide. In classifying hotels Michelin does not just award stars for the cooking. Nor does it try to collapse all aspects of an institution into one metric. Instead, it has an elaborate battery of symbols for different aspects of the performance of the hotel. Something similar for trusts might be richer in information, provoke less anxiety or anger, and above all be more accurate because it is multidimensional.

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Continuous combined hormone replacement therapy and endometrial hyperplasia

The use of continuous combined hormone replacement therapy, consisting of an oestrogen and a progestogen taken daily by postmenopausal women, is increasing. Its possible benefits are the prevention of endometrial hyperplasia and reduction in the occurrence of endometrial bleeding with time. Daily exposure to oestrogen and progestin without a break may be more important than using oestrogen intermittently in prevention of disease. A major concern is the occurrence of endometrial cancer in women using cyclic or sequential hormone replacement with the progestin being given for either less than 10 days each month, 10-16 days each month, or every three months for 14 days. The case-control studies indicate a significant increased risk in endometrial cancer with a reduction in the number of days of exposure to progestin. The use of continuous combined hormone replacement therapy not only does not increase the incidence of endometrial cancer but could even be protective compared with non-use of hormone replacement.

Most clinical trials of continuous combined hormone replacement therapy have been for one year in order to obtain regulatory approval for the products. In some instances two and three years of use have been reported, but these data are limited. The end point in clinical trials is endometrial hyperplasia rather than endometrial cancer because of the low incidence of endometrial cancer in the general population. In clinical situations we assume that inhibition of endometrial hyperplasia implies endometrial protection. This assumption has been challenged recently, with a call for randomised prospective clinical trials to document the efficacy of progestins in preventing endometrial cancer.

To date, all clinical trials of unopposed oestrogen at moderate and high doses have shown an increase in the incidence of endometrial hyperplasia, which is related to dose and duration. The same is true for endometrial cancer after use of unopposed oestrogen. The rate of endometrial hyperplasia was no different for continuous combined hormone replacement and placebo in a Cochrane meta-analysis. With use of sequential hormone replacement, the rates of endometrial hyperplasia were no different from placebo, although there was an increase in the occurrence of hyperplasia after 24 months (odds ratio 4, 95% confidence interval 1.2 to 14.0).

Doctors are confronted with women who have taken continuous combined hormone replacement for several years and then experience endometrial bleeding and spotting. Assessment of these women has entailed ultrasound imaging of the endometrium, hysteroscopy, and endometrial assessment through biopsy. The accuracy of ultrasonography in diagnosing endometrial disease in these patients is open to question. The reason for this intensity of evaluation of the bleeding is that doctors have been trained to evaluate aggressively any endometrial bleeding in postmenopausal women. These investigations have usually failed to document any malignant cause of the bleeding in women taking continuous combined hormone replacement; rather, endometrial polyps or uterine fibroids seem to be the most common finding.

A paper in this issue (p 239) addresses the issue of limited published data in long term users of continuous combined hormone replacement by presenting a 5 year follow up of postmenopausal women taking a preparation of 2.0 mg oestradiol and 1.0 mg norethindrone acetate (Kliofem/Kliogest; Novo Nordisk, Denmark). The paper found no evidence of endometrial hyperplasia after five years of continuous combined hormone replacement therapy. Moreover, 75% of the women had a final endometrial assessment. This is noteworthy because the usual attrition rates in clinical trials are higher than that in this study.

These data are reassuring because they are in agreement with case-control studies that have documented a reduction in the incidence of endometrial cancer in women taking continuous combined hormone replacement therapy. These data should, however, be taken in context with the formulation of oestrogen and progestin used in the study—oestradiol-