Hannan, which concluded that estrogen should be taken for more than 7 to 10 years after menopause to achieve a measurable benefit after age 75. The authors' main conclusions were based on studying only 24 women 75 years of age or older who took estrogen longer than 7 years. Only 3 of the 24 were still taking estrogen when the data were analysed. We cited the article by Cauley and associates, which found that the major benefits in fracture prevention were seen only in women currently taking estrogen (both short- and long-term users), although the most benefit was seen in the subjects who started taking estrogen within 5 years of menopause. Neither of these studies addressed the issue of fracture prevention before the age of 65.

The problem with these studies is that they were not interventional, and the use of hormone therapy by the subjects was influenced by a wide variety of variables that were not under the control of the investigators. As we pointed out, there is a paucity of prospective randomized controlled trials of hormone therapy. We applaud the long-term prospective randomized controlled trial being undertaken in the Women's Health Initiative under the auspices of the US National Institutes of Health. This study will address the safety of longer-term hormone therapy, and the results should be available in about 7 years.

The initiation of hormone therapy long after menopause is still likely to have significant benefits, and physicians should not be pessimistic about this issue in discussing therapy with their patients.[1] The double-blind, randomized, placebo-controlled clinical trial that showed benefits of estrogen therapy in fracture prevention as well as bone density was carried out in postmenopausal women whose average age was 65 years.[2]

It is important to note that our article was a consensus statement agreed to and written by the members of the Scientific Advisory Board of the Osteoporosis Society of Canada. Consensus statements are always a compromise, and our plan is to continue to revise our position as more evidence becomes available. The publication of our article is simply one stop along the road.

We do not see any major discrepancies between our conclusions and those of the articles cited by Marshall. As we stated, ovarian hormone therapy "should be continued for a minimum of 10 years beyond menopause for maximum bone protection." However, one should not infer from this statement that these are the only conditions under which estrogen has a preventive or therapeutic effect.

**David A. Hanley, MD**
Professor of Medicine
University of Calgary
Chair
Consensus Conferences
Osteoporosis Society of Canada
Calgary, Alta.
**Robert G. Josse, MD**
Professor of Medicine
University of Toronto
Chair
Scientific Advisory Board
Osteoporosis Society of Canada
Toronto, Ont.

**References**

1. Schneider DL, Barrett-Connor EL, Morton DJ. Timing of postmenopausal estrogen for optimal bone mineral density: the Rancho Bernardo Study. *JAMA* 1997; 277:507-602.
2. Lufkin EG, Wahner HW, O'Fallon WM, et al. Treatment of postmenopausal osteoporosis with transdermal estrogen. *Ann Intern Med* 1992;117:1-9.

I read the recent guidelines for management of osteoporosis and recommendations for ovarian hormone therapy with great interest; these will be of immediate use in my practice.

I have some questions concerning the recommendations on follow-up surveillance. The incidence of endometrial cancer is not increased if a progestin is used in addition to the estrogen, yet the incidence of postmenopausal bleeding would be considerably higher. The authors recommend vaginal ultrasonography, then uterine sampling if needed. Hospital-based dilatation and curettage is expensive and involves the use of general anesthetic. Office sampling is not yet common in family practices. Is the sensitivity and safety of this procedure great enough to justify its wider use in primary care?

The Ontario Breast Screening Program offers women screening mammography every 2 years from the age of 50. Surveillance recommendations are for a mammogram every 1 to 2 years, yet breast-cancer rates are not increased during the first 5 years of estrogen therapy.[1] Should a woman 45 years of age be counselled to undergo mammography when hormone therapy is initiated, or would it be reasonable to wait until she is 50?

The author recommends that annual pelvic examinations be arranged. The recent guidelines for Papanicolaou smears in Ontario recommend that samples be taken yearly for 3 years, then every 2 years if results are normal until age 69.[2] If there is no history of fibroids or endometriosis, could the same guidelines be used for Papanicolaou smears and pelvic examinations once hormone therapy is initiated? There would be no increased risk of cervical cancer, and rapid growth of fibroids could be detected at the 1-year follow-up. The pelvic examination would be done sooner if there was any abnormal bleeding. Perhaps the reminders for Papanicoloau smears could be included in the letters sent by the Breast Screening Program, since the target populations dovetail.

With the increasing use of hormone therapy, follow-up surveillance and its associated costs are likely to become more important. I would like to be reassured that the guidelines are based on sound evidence.

**Michelle Greiver, MD**
Willowdale, Ont.
Received via e-mail

**References**

1. Steinberg KK, Thacker SB, Smith J. A meta-analysis of the effect of estrogen replacement therapy on the risk of breast cancer. *JAMA* 1991;265;1985-90.
2. Clarke EA. Cervical screening in Ontario. *Ont Med Rev* 1996;63(8):40-1.

The consensus statements from the Scientific Advisory Board of the Canadian Osteoporosis Society are, in general, a welcome update for the primary care physician. However, the rather sparse comments on the management of steroid-induced osteoporosis were rather disappointing. In "The use of bone density measurement in the diagnosis and management of osteoporosis" (*Can Med Assoc J* 1996;155[suppl]:924-9), Dr. William Sturtridge and colleagues recommend that "if significant bone loss has occurred, a bone density measurement may aid in the decision to intervene with calcium and vitamin D supplementation." Several studies have now shown that significant bone loss (in the order of 10% to 20%) occurs within 6 to 12 months of starting treatment with supraphysiologic doses of glucocorticoids (greater than 10 mg) in approximately 60% of patients,[1] and a portion of this loss is irreversible. Therefore, it is appropriate to recommend a bone density assessment at baseline and appropriate intervention if there is evidence of osteopenia. Furthermore, there is little evidence that either calcium or vitamin D supplementation constitutes effective prophylaxis against steroid-induced osteoporosis.[2] Although recommending supplementation is standard practice among many physicians when steroid therapy is initiated, it is arguably more cost-effective to initiate bisphosphonate therapy in all patients receiving supraphysiologic doses of steroids.[3]

A separate consensus statement on steroid-induced osteoporosis would have been more appropriate than this article's unnecessarily conservative statements, which do not reflect currently available evidence or modern standards of practice.

**Walter P. Maksymowych, MD**
Consultant Rheumatologist
Associate Professor of Medicine
University of Alberta
Edmonton, Alta.

**References**

1. Gennari C, Civitelli R. Glucocorticoid-induced osteoporosis. *Clin Rheum Dis* 1986;12:637-54.
2. Adachi J, Bensen W, Bianchi F, et al. Vitamin D and calcium in the prevention of corticosteroid-induced osteoporosis: a three year follow-up study. *J Rheumatol* 1996;23:995-1000.
3. Mulder H, Struys A. Intermittent cyclical etidronate in the prevention of corticosteroid induced bone loss. *Br J Rheumatol* 1994;33:348-50.

## Keeping kids away from guns

I applaud Drs. Antoine Chapdelaine and Pierre Maurice's excellent article "Firearms injury prevention and gun control in Canada" (*Can Med Assoc J* 1996;155:1285-9). It is particularly timely because, in late November 1996, federal Justice Minister Allan Rock tabled proposed regulations that will define important areas of the law, such as the screening of applicants for firearm ownership and the requirements for locking and storing firearms.[1]

Reducing access to firearms is particularly relevant to preventing injuries to children and adolescents. Developmental characteristics of children and adolescents make them particularly vulnerable to the risks of an improperly stored firearm. Young children may have a poor under-