

Saint M, Gildengorin G, Sawaya GF. Current cervical neoplasia screening practices of obstetrician/gynecologists in the US. *Am J Obstet Gynecol.* 2005;192:414-421.

Sirovich BE, Woloshin S, Schwartz LM. Screening for cervical cancer: will women accept less? *Am J Med.* 2005;118:151-158.

FAST TRACK

75% of women 40 or older prefer annual Pap test screening, and 69% maintain this preference even after learning longer intervals are safe

Q How many Ob/Gyns follow the new rules on Pap testing?

A A minority. Both Ob/Gyns and their patients prefer more frequent screening than the intervals advised by the American Cancer Society and other expert groups, 2 new studies found.

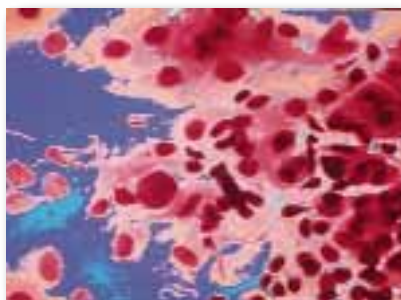
EXPERT COMMENTARY

Less-than-annual screening in women over the age of 30, with 3 or more normal Papanicolaou (Pap) tests, is recommended by 3 expert groups: the American Cancer Society (ACS), the American College of Obstetricians and Gynecologists, and the US Preventive Services Task Force. Other expert groups additionally recommend that we stop screening women who have undergone total hysterectomy for symptomatic fibroids with no history of dysplasia, low-risk women over the age of 70, and virgin girls before age 21.

Neither Ob/Gyns nor patients, however, are inclined to follow these recommendations.

What women want

Most women prefer annual screening, irrespective of evidence. Sirovich and colleagues found that 75% of women 40 or older—most of whom had been regularly screened—prefer annual testing. Once informed of the evidence, 69% said they will persist with annual screening. About half said they will continue being screened up to and after age 80 despite no evidence of benefit.



Cervical cells

Only 43% knew of the updated guidelines, and only 10% were being screened at the recommended intervals of 2 to 3 years.

These findings were via a survey conducted concomitant with the 2002 ACS guidelines, and published in February 2005. The nationally representative sample was questioned in a random-digit-dialing telephone survey with a response rate of 75%.

While 40% of the women understood that overscreening is wasteful and might lead to unnecessary further testing and treatment, 50% believed the primary motivation for recommending less frequent screening was cost.

What Ob/Gyns are doing

A majority of Ob/Gyns will screen women annually and indefinitely despite lack of evidence of benefit, Saint and colleagues found. They surveyed 355 randomly selected US Ob/Gyns, with a response rate of 60%.

More than 70% plan to continue screening in a 70-year-old woman with 30 years of negative Pap tests and no sexual intercourse for the past 10 years, and 60% of Ob/Gyns plan to carry on annual screening in a 35-year-old woman with 3 or more consecutive normal tests.

This is surprising, given that 82% of respondents use liquid-based Pap tests and 34% employ combined Pap-human papillomavirus (HPV) testing.

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A failure to ask the simple question: “Why?”

It would be fascinating to learn why physicians persist with annual screening. Unfortunately, Saint and colleagues did not ask this question. As is the case in much recent clinical research, we rarely ask the “why” questions that seek to make sense of outcomes analyses. A simple query at the end of the survey asking, “If you screen low-risk patients annually, what is your rationale?” would have helped clarify the issue. The answer probably has little to do with scientific evidence and much to do with tradition, meeting patient expectations, maintaining trust, and possibly fear of litigation from misdiagnosis.

A matter of time

Patients expect the best, and in this competitive era physicians will do what it takes to keep a patient satisfied. If that means annual cervical cancer screening, so be it.

Perhaps the issue boils down to a matter of time. After all, we spent 50 years teaching doctors and patients the importance of

annual screening, so it will be no surprise if it takes a long time for both Ob/Gyns and patients to trust that “less is more” in low-risk women.

Change may also hinge on the medical marketplace. Women who expect annual screening link it to more than cervical cancer prevention. They want their Ob/Gyns to focus on the entire health spectrum and will seek other physicians if their expectations are not met.

Despite breakthroughs in cervical cytologic sampling and DNA testing, the new technologies have not yet inspired broad confidence that less frequent screening is good health care.

And a matter of cost

Over the long term, however, paying for the more costly tools and interventions in screening and triage will be possible only with longer screening intervals for screen-negative women.

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Q Is screening all gravidas for genital herpes cost-effective?

A Yes. Until now, serologic screening of all gravidas unaware of their HSV-2 status was thought to be prohibitively expensive and not suitable for routine obstetric practice. This study indicates otherwise. Serologic screening of women in early pregnancy—with or without screening their partners—and treating those who test positive is the most efficient way to prevent neonatal herpes.

EXPERT COMMENTARY

In this carefully constructed decision analysis, Baker and colleagues compared 3 testing scenarios:

- **Standard care.** No herpes simplex virus type 2 (HSV-2) testing is performed and

antiviral therapy is offered only to women who know they have genital herpes.

- **Screening all gravidas.** All women unaware of their HSV-2 serologic status are screened at 15 weeks’ gestation. Those who test positive are offered antiviral suppressive therapy from 36 weeks’ gestation to the time of labor. Those who test negative are counseled about safe sex in the third trimester.
- **Screening all gravidas and their partners.** Gravidas unaware of their HSV-2 status are tested, and their partners are offered screening. Women who test positive are given antiviral therapy from 36 weeks to labor. If their partners test positive, they are offered antiviral therapy.

Baker D, Brown Z, Hollier LS, et al. Cost-effectiveness of herpes simplex virus type 2 serologic testing and antiviral therapy in pregnancy. Am J Obstet Gynecol. 2004;191:2074–2084.

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The second scenario had an incremental cost of \$18,680 per infant quality-adjusted life-year gained (QALY), while the third scenario cost \$48,956 per QALY gained. Since cost-effectiveness is usually defined as an incremental expense of less than \$50,000 per QALY gained, both scenarios met the criterion.

Most people don't know they're infected

About 25% of adults in the United States are infected with HSV-2.¹ Prevalence of genital herpes is even higher if HSV-1 infection is included. However, less than 10% of persons infected are aware they have the virus. The rest are mildly symptomatic, and usually are treated for recurrent genital complaints attributed to conditions other than genital herpes.²

Unfortunately, neonatal herpes is increasing with the rising prevalence among adults. Women at greatest risk of infecting their newborns are HSV-2

seronegative in early pregnancy, have an HSV-2 seropositive partner, and acquire new HSV-2 infection in the third trimester.

Since 75% to 90% of primary infections are unrecognized by patient and doctor, labor may begin without any external evidence of primary genital HSV infection and result in neonatal infection. ■

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