

COMMENTARY

No More Routine Pap Tests for Adolescents

At first glance, this latest American College of Obstetricians and Gynecologists' opinion on cervical cancer in adolescents is yet another reason for "guideline shock." The symptoms are familiar: New national guidelines are released before older ones are fully implemented, and as in this case, the recommendations appear to be the opposite of traditional practice.

In reality, this guideline is the result of an evolutionary process that has been in play since 2002, one in which the management of adolescent women, defined as those under age 21 years, has become much more conservative. Before then, a national consensus guideline issued in 1989 recommended that women initiate cervical cancer screening with the onset of sexual activity, or by age 18 years even if a woman was a virgin.

In 2002, the American Cancer Society, relying on new studies of the natural history of human papillomavirus infections and consequent preinvasive cervical lesions, recommended that a woman delay her first screen until 3 years after her first episode of vaginal intercourse or to start screening at age 21 years, given the possibility that some women would not disclose their sexual history.

In the following year, ACOG and the U.S. Preventive Services Task Force issued similar guidelines.

In 2006, the American Society for Colposcopy and Cervical Pathology (AS-

CP) took the next step by recommending that women under age 21 years not receive HPV-DNA testing under any circumstances and also sharply differentiated the management of abnormal cytology and histology results in adolescents, compared with adult women.

More recently in December 2009, the ACOG Practice Bulletin "Cervical Cytology Screening" flatly recommended that cervical cancer screening begin at age 21 years, regardless of the age of onset of sexual activity (Obstet. Gynecol. 2009;114:1409-20).

The newest ACOG guideline on this topic adds further advice for the management of adolescents who had abnormal Pap screening results in the "old system" and how they should be transitioned to the new.

The reason for this evolution in thinking is clearly stated in each of the guidelines. In younger women, most HPV infections are transient and not dangerous at the time of infection. If persistent infection with a high-risk type of HPV does result in the development of a high-grade lesion, it typically does so over a period of years or even decades, allowing ample time for the discovery of a preinvasive lesion once a woman starts screening at age 21 years.

In addition, invasive cervical cancer is exceedingly rare in adolescents, occurring at a rate of 1-2 cases per million women per year, and even some of these

cases do not appear to have been preventable by screening.

Beyond the fact that screening of adolescents has no apparent benefit, the harms of screening are becoming better understood. Numerous studies have shown the negative psychological effects of screening, disclosure of abnormal results, and treatment, including effects on sexual function. Even more concerning are the findings that pregnancy outcomes following loop electrosurgical excision procedure show a significant increase in the rate of preterm birth.

Regrettably, there is no reason for optimism that this set of recommendations will be embraced quickly. As a number of studies have shown, clinicians have been slow to adopt the 2002 cervical cancer screening guidelines and consumers either don't know about the guidelines or believe that they are financially motivated. Providers are fearful of encountering a patient with an interval cancer and being sued for a missed diagnosis and also concerned that well-woman visits will be skipped if they are not tied to the need for a Pap test.

There is also concern that sexually active adolescents will not receive annual Chlamydia screening and targeted screening for other sexually transmitted infections once they are informed that annual screening pelvic exams and Pap tests are no longer recommended. While these are legitimate concerns, they must be addressed in ways other than requiring a young woman to receive a test that is unnecessary and potentially harmful

For this guideline to be successfully implemented, a number of interventions are necessary. Most importantly, consumers must be educated and persuaded that the public health message of the last 60 years regarding the need for annual Pap screening in all women has been significantly modified for the purpose of improving quality of care and not just to save money. Second, providers must be convinced that the guideline is based on the best available evidence and are somehow motivated to follow it. Third, once these measures have been achieved, health plans should stop paying for cervical cytology in women under age 21 years, as many have done already for HPV-DNA tests.

While some clinicians will prefer to wait for updated guidelines produced by the USPSTF or the American Cancer Society before changing their practices, it is clear that the momentum of the evolutionary changes will continue in the direction that ACOG has taken. By continuing to screen adolescents for cervical cancer, including those who are pregnant, we risk harming our patients rather than helping them. It's time to abandon this unnecessary practice. ■

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LETTERS FROM MAINE

Pertinent Negatives

Hx: runny nose x 3 d—fever 101 ax yest afternoon—very fussy last night—some cough—no Breakfast—no V or D

PE: Well—N.A.D. sl fussy—orients to Mom—Chest clear—Rt TM honey colored opaque bulging—Lt creamy fluid level 2/3 immobile

Dx: B.O.M.

Plan: Amox 250 tid x 10 d/Ret 3 wks

Does this look familiar? It's a typical note that has been scanned into a patient's electronic medical record. It was originally handwritten and includes a small schematic diagram of a tympanic membrane. But it could have been typed or dictated with a system such as Dragonspeak.

Does it seem skimpy? How does it compare to your own office records or those you receive from an emergency room? Is the format familiar?

You may wonder why I don't use the SOAP format (subjective, objective, assessment, plan). I was already a few steps into my training when SOAP was introduced and promoted. One of those old dog/new tricks deals. But a more philosophic answer is that I have some real reservations about the objectivity of most physical exams, my own included.

Look at our poor track record in observing and

recording the appearance of tympanic membranes or heart murmurs or lung sounds. How many of us are disciplined enough to describe a skin eruption beyond reporting it as "maculopapular"? If we were to change the "O" in SOAP to "observation" instead of "objective," I could buy it. Otherwise a physical exam is in the eye of the beholder. The only objective portions are the vital signs and the lab work. And I have my doubts about the accuracy of weights and BPs coming out of many offices and emergency rooms. My notes are divided into history, physical exam, diagnosis (or assessment), and plan. If the child has multiple problems, I number them and match them with similarly numbered plans.

If you can accept my old-school format, can you accept my note's skimpiness? You may ask, "Where are the pertinent negatives?" Good question. But here's a better question: What is the value of listing pertinent negatives?

When we were medical students, a list of pertinent negatives proved that we had taken a thorough history and done a complete exam. My colleagues who cover for me know how thoroughly I interview and examine patients. I owe them a thumbnail sketch of how sick the child looked and a description of the positives in case it's helpful for comparison at a subsequent vis-

it. I include "chest clear" out of habit, but otherwise I try to spare my busy brother and sister pediatricians the tedium of a laundry list of negatives.

Two groups retain a perverse curiosity about what I haven't seen or heard: the lawyers and the third-party bean counters. They remain zealous believers in the myth that, "if you didn't document it, it did not happen." Obviously this is rubbish, but they wield power (mostly financial), and unfortunately that power has influenced, and I fear will continue to influence, the format and style of electronic medical records. Templates, drop-down lists, and preprogrammed phrases will become the norm. The busy physician will click or tap with a stylus to create a voluminous list of negatives, pertinent and otherwise, that only a medical school instructor would care about.

Navigating these electronic shortcuts is not as easy as it sounds. The extensive lists they generate mean more wasted time for a covering physician. The finished note's spell-checked and laser-printed clarity doesn't guarantee that the right questions have been asked or that the exam was expertly done. ■



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