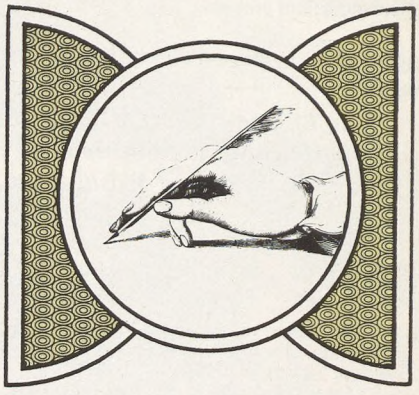
Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Use of Cervical Cytology

To the Editor:

Dr. Hurt, in "Cervical Cytology: Use and Follow-Up," presents an excellent discussion of cervical cytology *(J Fam Pract 7:579, 1978)*. However, I believe the endocervical aspiration technique of cytologic sampling, in spite of its proven efficacy, is just not going to be used by practicing physicians. Most will continue to use a "pancervical" Pap smear. Several studies[1-3] have evaluated the results of taking two "pancervical" Pap smears as a means of increasing the sensitivity of the procedure. Shulman et al[1] screened 2,823 patients and Sedlis et al[2] screened 17,737 patients by taking two "pancervical" smears *at the same sitting*. After removing excess mucus from the cervix with a cotton sponge, the pointed end of a spatula was inserted and rotated a full turn. The cellular material was then transferred to a slide and the same spatula was used to take the second specimen. Shulman's group increased the detection of abnormal cytology by 86 percent and Sedlis' by as much as 50 percent.

Further, a case can be made for using a cotton applicator for endocervical sampling in addition to the two pancervical smears. Garite and Feldman[4] found a significantly increased yield of abnormal cytology by adding a cotton applicator swab of the endocervix to an ectocervical sampling taken with a spatula. Interestingly, a third group was allowed to evaluate the cervix and select an "appropriate" method. If the cervix was everted (implying a visible squamocolumnar junction), only a spatula was used. If the cervix was not everted or the examiner was unsure, spatula and applicator were used. There was no significant improvement of this selective sampling group over those using the ectocervical technique alone. Thus, relying on the visualization of the squamocolumnar junction as an indication *not* to obtain an endocervical swab is probably not valid.

Thus, another reasonable cytologic sampling technique would be two "pancervical" smears, an endocervical swab as well as a vag-

Continued on next page

Continued from preceding page

inal pool system—all at the same sitting.

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2. Sedlis A, Watters AT, Balin H, et al: Evaluation of two simultaneously obtained cervical cytological smears. Acta Cytol 18:291, 1974
3. Luthy DA, Briggs RM, Buyco A: Cervical cytology: Increased sensitivity with a second cervical smear. Obstet Gynecol 51:713, 1978
4. Garite TJ, Feldman MJ: An evaluation of cytologic sampling techniques. Acta Cytol 22:83, 1978

To the Editor:

I would like to take issue with one major point in Dr. Hurt's otherwise excellent review of "Cervical Cytology: Use and Follow-Up" (*J Fam Pract 7:579, 1978*). He suggests annual routine screening Pap smears on most women and routine biannual screening Pap smears on women after hysterectomy for benign disease.

Frame, Rosser, and Gray, who have reviewed screening procedures, recommend less frequent Pap smears.[1-3] This recommendation is based on the prolonged course from dysplasia to invasive carcinoma of the cervix. Dr. Hurt states the mean age of presentation of carcinoma in situ and invasive carcinoma is 34 and 48 years, respectively. The Walton Study, to which he refers, also presents newer data based upon age specific incident peaks. These peaks are at age 25 to 29 for carcinoma in situ and age 60 to 64 for clinical invasive carcinoma.[4]

The Walton study does not address dysplasia, which is most prevalent in the 20 to 29-year age group.[5] Riehart found that the average progression time from dysplasia to carcinoma in situ was 44 months.[6]

Mathematical models using this information have recommended screening at set ages which vary from three to five years apart.[7,8]

Regarding females after hysterectomy, I see no reason to do Pap smears on them if the pathology report of the cervix was benign. Carcinoma of the cervix arises from the squamocolumnar junction and the transition zone, which is absent in these women.

It would appear that our energies are better directed to women who have had very infrequent or no Pap smears rather than simply repeating Pap smears on women who have had many consecutive years of negative results.

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3. Gray LA: The frequency of taking cervical smears. Obstet Gynecol Surv 24:909, 1969
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Continued on page 1124

Continued from page 1122

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The preceding letters were referred to Dr. Hurt who responds as follows:

The suggestions for cytologic screening included in the article "Cervical Cytology: Use and Follow-Up" (*Hurt WG: J Fam Pract 7:579, 1978*) are those of the American College of Obstetricians and Gynecologists. They were formulated for the screening of all women on an unselected basis and to satisfy the objectives of early detection and accuracy while compensating for errors inherent in sampling and interpretation. Now that consumerism has become an issue of top priority, I would concede that less frequent screening of selected groups of women at low risk is perhaps acceptable. I do not believe that any woman with a cervix should have routine screening any less frequently than every three years. Those considered to be at high risk for developing cervical neoplasia and carcinoma should continue to have annual cervical cytology. The decision to do less frequent smears must be made by a knowledgeable and responsible person on an individual basis. It is true that when taken as a whole cervical intraepithelial neoplasia runs a somewhat prolonged and orderly course prior to becoming invasive carcinoma. The rate of progression or arrest of any particular lesion, however, is less predictable. Time must be allowed for detection, documentation, eradication, follow-up, and possibly a repeat cycle of the same.

The mean ages of presentation of cervical intraepithelial neoplasia and invasive carcinoma may be shifting. This depends somewhat upon one's interpretation of microinvasive carcinoma. In our patient population, it appears that both the cervical intraepithelial neoplasias and invasive carcinoma are moving into the younger years and not undergoing a separation as suggested by the Walton Study. Perhaps the findings in the Walton Study are the result of years of systematic screening on a more homogenous and less mobile population (ie, British Columbia) with cytologic interpretation by a few centralized high quality laboratories. More studies will be needed to more accurately establish the trend.

We continue to perform vaginal cytology every two or three years on patients who have had a hysterectomy for benign disease. Occasionally, a dysplasia or carcinoma in situ of the cuff will be diagnosed. In addition, vaginal smears are routinely evaluated for evidence of infection and for hormonal status, and we have found the information which they provide to be of value in patient care.

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