Correspondence

Cytological changes preceding cervical cancer

Dr Robertson and colleagues must be con-
gratulated for holding up the "red flag of classi-
fication" to the "bulls of gynaecological-
cytology", and it is reassuring that this is as-
far as the rarity of the current reporting sys-
stem becomes increasingly evi-
dent.

A basic premise in the currently recom-
manded terminology and management of cer-
vical smears is that the degree of dyskaryosis correlates with the grade of cervical intraepithelial neoplasia (CIN). However, published information and clinical observations, particularly as the rarity of the current reporting system becomes increasingly evi-
dent.

Whether or not dyskaryosis and CIN should correlate is debatable, as the definitions involved are purely arbitrary. However, a principal reason why they do not must be the failure of many observer variations and the histories of the diagnosis of CIN. Health Service guidelines emphasise the important requirement to compare cytol-
y and biopsy results. However, the cru-
cial audit is whether cytological findings identify clinically relevant histopathological abnormalities and whether the false positive rate is accordingly kept to a minimum.

Surprisingly, with only one or two excep-
tions, the authors have little discussion with regard to the possible introduction of the
to the Bethesda system for reporting cervical smears. Indeed, some cynics believe that if the Bethesda introduction was doomed following the timing of the publica-
tion, which coincided with the printing of several million new HMR forms. However, although the Bethesda system uses the terms low grade squamous intraepithelial lesions, its overall complexity and content is analogous to that of the cur-
rent British system. Accordingly, unlike Dr Robertson, I share previous authors' views that the Bethesda system has little to com-
ment on.

I suspect that many gynaecological cytopathologists already perceive nuclear changes as either low or high grade abnor-
malities. It is, however, the observer cytologist to see that Dr Robertson's scientific conclusion supports this view. With little difficulty, cur-
nent national recommendations for termi-

tology and management of cervical smears could be amalgamated along the following lines:

- Borderline changes, wart virus, and mild dyskaryosis could be grouped together as low grade abnormalities. These would necessitate a six month repeat smear and, if persistent, require referral for colposcopy.
- Moderate and severe dyskaryosis could be grouped together as high grade abnormalities with the necessity for immediate referral for colposcopy.
- Gynaecological cytology has now become a nationalised industry with a propagated aura of sophisticated diagnostic accuracy. This has resulted in undoubted success in the field of "cytology job and working party creation schemes". However, as the diag-
nostic gold standard of CIN has partially collapsed, it is hard to believe that gynaecol-

gical cytology remains as relevant and unscathed. Which cytopathologist, with their hands on their hearts, can deny that accurate distinct-
tion between borderline changes, wart virus, and mild dyskaryosis is difficult, often impossible, time consuming, and a largely pointless pursuit? These changes are all far more realistically grouped together as low grade abnormalities, requiring the same clinical management. The hours saved by avoiding such mental contemplation would be enormous.

We should not lose sight of the fact that the basic function of gynaecological cytology is merely to screen for relevant disease that will require subsequent histopathological diagnosis and clinical management. It must be seriously questioned whether the exis-
tence of multiple, closely related, diagnostic categories is warranted. Furthermore, it is rumoured that this problem is about to be compounded by division of the category of borderline changes. Superficially, credibility for the existence of the current terminology seems to be justified by a mass of statisti-

cal returns requested annually and the requirement for these subtle distinctions to be assessed in quality assurance schemes. It is also questionable as to whether this multitude of coupled abnormalities should continue to be the staple of cytology training schools.

My proposition is simple: back to cyto-

galogical basics, before it is too late.

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Pregnancy in von Willebrand's disease

The guidelines on the investigation and management of haemorrhagic disorders in pregnancy are welcome. With reference to the management of von Willebrand's disease, we have recently studied 23 pregnancies managed at a single centre, and add the following comments.

We believe there is a tendency towards complacency in the management of pregnant women with von Willebrands disease due to an excessive reliance on improvement in the coagulation defect. The coagulation parameters improve in many instances, but we also have a number of exceptions, particularly in those more severely affected with low factor VIII (VIII:C)) before conception. In our series, those patients with low baseline VIII:C values (<15 IU/dl; four cases) had only limited improvement in VIII:C by the third trimester, the maximum attained being 54 IU/dl in the group. Bleeding times shortened significantly in only one of seven cases studied, and similar findings have been noted by others. In addition, our observations support the view that type II patients carry a higher risk of primary post-
partum haemorrhage in first pregnancies (3/11 type II or 0/12 type I). This seems to be independent of the value of VIII-C in the third trimester, and presum-
ably is explained by a failure of the primary haemostatic defect to improve in pregnancy. Importantly, secondary PPH occurred to a similar extent in both groups (2/12 type I and 3/11 type II—22% overall) and may be more dangerous as it often occurs after discharge from hospital.

The guidelines should serve to raise awareness and maintain vigilance in the management of von Willbrand's disease in pregnancy. We would add that with reference to secondary PPH, while the administration of prophylactic von Willebrand factor (vWF) containing


Dr Robertson, Woodend, and Elliott comment: We agree with most of Dr Slater's com-

ments, but would never have dared make

them. They draw attention to the Emperor's new clothes and suggest rebel-

lion in the ranks. We also have long regarded cervical cytology as a screening procedure with little diagnostic precision, apart from its detection of severe dyskaryosis.
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