Correspondence

Multifactorial audit of invasive cervical cancer

We read with interest the article by Dr Slater,1 in which he makes recommendations for the Cervical Screening Programme based on an audit of invasive cervical cancer occurring in the Rotherham district.

We have several comments. The cases were selected from cytology records and this might be found to underestimate the number of patients who develop cervical carcinoma and who have never had a smear (six patients in this study). These patients are very hard to follow up, the Avon Cervical Screening Programme Cancer Registry records and mortality data from the Office of Population Census and Surveys (OPCS), as well as histology records. In our experience none of these sources successfully identifies all cases.

Another factor discussed is the issuing of an inappropriate laboratory report. The table quotes this as occurring in 16 of 20 cases (80%) which appears to be mathematically incorrect. It is worth noting that of these (presumably six) cases only four involved missed dyskaryosis and this was of the “easily missed” variety. As stated, there is as yet no definition of an acceptable false negative rate in the Cervical Screening Programme and we look forward to forthcoming guidelines on this important matter.

Dr Slater also comments on the lack of failsafe procedures for inadequate smears. While it is true that the national guidelines refer “gaps in women with abnormal smears”, there is no reason why laboratories or FHSAs should not also include follow up of inadequate smears in their failsafe systems. Indeed, the Avon Cervical Screening Programme has incorporated such a mechanism.

A further point of interest is Dr Slater’s suggestion that opportunistic smear should be performed during hospital visits. We commend that this is impractical and potentially dangerous. Most hospital wards and non-gynaecological outpatient departments do not have the equipment or trained personnel to perform cervical smears and the resulting specimens are likely to be of poor quality, which may well lead to a false sense of security, or inadequacy, leading to increased workload and patient anxiety because the smears need repeating.

Finally, we would like to point out how small the numbers in this audit are. Expressing the results in terms of percentages seems rather meaningless and no values for statistical significance are included. While this audit makes interesting anecdotal reading, we feel that the results derived are of limited value in assessing the effectiveness and quality of the National Screening Programme.

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Dr Slater comments:
I thank Drs Denton and Brett for their interest in my recent article.

I wholeheartedly agree that there are numerous sources from which to obtain such patient information. My study merely highlighted that derived from the Rotherham Hospital records. In fact, as they suggested, the results were derived from both the cytopathology and histopathology records. The identification of all cases of cervical cancer, along the lines recommended by the authors, will be an important aspect of the work of the proposed “Regional” Quality Assurance Teams (QATs).1

I apologise for any confusion conveyed with the mathematics in my report. The figure in brackets represents the percentage number of times the factor occurred in the patients. The reason for the apparent discrepancy is that some factors occurred more than once in one specific patient. Retrospectively, this should have been emphasised by a gap between the two columns.

I am pleased to hear that the Avon Cervical Screening Programme has incorporated inadequate smears into their failsafe procedures. Unfortunately, the same cannot be said for most of the remainder of the UK. Sadly, fundamentals such as failsafe procedures will not be made available until this aspect is specifically incorporated into national guidelines.

I fully acknowledge that it is usually inappropriate for cervical smears to be undertaken during “non-gynaecological” hospital attendances. As highlighted in my discussion section, it is clearly desirable to incorporate cervical smear history into the routine past medical history. Appropriate advice and referral could then be given.

I am appreciative that numbers in my audit were small. The reason for the article was merely to generate national discussion, as evidenced by the current correspondence.

I was also hoping to highlight factors that could be used regionally on a unified basis in the new QATs. It would appear highly desirable that all QATs approach this important area of audit in a similar way so that there can be national amalgamation and comparison of data.

I NHS Cervical Screening Programme, Assuring the Quality and Measuring the Effectiveness of Cervical Screening. National Co-ordinating Network, Hall The Printer, 25

Dr Slater comments:
I am appreciative of Dr Rubin for his interest in my article. Although not specifically itemised, my previous audit of deaths from cervical cancer also identified occasional cases where inadequate smears had not been repeated.1 Furthermore, I hope that my article will encourage larger regional audits that will more accurately ascertain the size of the problem.

To date, however, inadequate smears have been undoubtedly the “poor relative” of cytopathology reports. For example, there is still no national recommendation with regard to the time within which an inadequate smear should be repeated. Similarly, the potential clinical importance of inadequate smears is not recognised, as negative remains poorly emphasised. Indeed, there are no specific guidelines, in my opinion unreasonably, to exclude inadequate smears from the national proficiency testing scheme. I agree wholeheartedly that failsafe mechanisms were investigated for the follow up of abnormal smears and that the primary responsibility for follow up still remains with the smear taker. In these days of laboratory computerisation, however, it would not appear totally unreasonable that there must be secondary check. With inadequate smears have indeed been repeated within, say, three months.


Detection of autoantibodies to neutrophil cytoplasmatic antigens

ACG Broadsheet No. 143 has recently been distributed to Australian pathologists.1 It states that indirect immunofluorescence (IIF) is the technique of choice in testing serum samples for antineutrophil cytoplasmatic antibodies (ANCA), but that ELISAs should be confirmed using formalin fixed neutrophils and that antibody levels determined by titration of fluorescence. Most laboratories would use IIF to screen for ANCA, but would confirm positive serum samples, determine antigen specificity and antibody titre using enzyme linked immunosorbent assays (ELISAs) for proteinase 3 and myeloperoxidase antibodies, rather than the techniques described in the Broadsheet.

Antigen specific ELISAs have a number of advantages over the other techniques. These ELISAs will confirm the presence of ANCA that have been detected by IIF; non-specific binding can occur with IIF, but is unlikely to occur with both methods. In addition, ELISAs will confirm the presence of ANCA in serum samples with a coincidental antinuclear antibody (ANA). An ANA may obscure perinuclear fluorescence, and ANA occur in up to 40% of some series of patients with Wegener’s granulomatosis or microscopic polyarteritis.2

The most important advantage, however, is that the ELISAs will determine antigen
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