Correspondence

Audit of deaths from cervical cancer

I read with interest the paper on audit of deaths from cervical cancer¹ and concur with the approach the authors have taken.

This district will shortly be holding the fourth annual review of invasive cervical cancers, and has found the information gained from a multidisciplinary audit to be invaluable in identifying the "holes in the net" of the screening programme through which women fall.

The details of our audit were described at the annual Scientific Meeting of the British

Society for Clinical Cytology at Leeds in September 1993.² Our review differs in several small but important ways from that described by Slater *et al.*

We chose to widen the audit to include not only deaths from cervical cancer, but also non-fatal cases of invasive disease. All these women bear the burden of illness caused by cancer and its treatment. Inaccuracies in death certification and consequent problems with OPCS mortality statistics are well described. We have found that computed laboratory records are a more accurate and easily accessible method

of identifying all cases. Moreover, only by reviewing all cases can one monitor one's performance against the *Health of the Nation* target, which calls for a reduction of 20% of cases of (not deaths from) invasive cervical cancer.

The method of reviewing previous smears and assigning cases to "true interval" or "false negative" categories is crucial and is obviously subject to enormous bias in the operation of the retrospectroscope. We have attempted to reduce any such bias by reviewing all smears reported as negative taken within five years of the onset of invasive disease and mixing them with a number (unknown to the reviewer) of true negative smears (reported as negative, with a subsequent normal smear at least three years later). It is vital that those reviewing smears should, as much as possible, be blind to the outcome following these smears. This manoeuvre encourages a more realistic approach to reviewing smears, so that any tendency to "overcalling" is minimised.

Slater *et al* do not describe the method used to assign deaths to each particular category. Our work in north Lincolnshire has led to the development of a simple algorithm (figure) by which all cases of cervical carcinoma are assigned to one (and only one) category. Although each centre could choose to perform its own particular form of audit, I believe a valuable opportunity will have been missed if differing forms of local audit proliferate. Valid comparisons between districts (and laboratories) will require standardised methods of defining these points of breakdown in the screening programme. The paper from Rotherham will, I hope, concentrate the minds of those responsible for national guidance in the operation of the cervical screening programme in setting up a useful system of audit throughout the country.

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- 1 Slater DN, Milner PC, Radley H. Audit of deaths from cervical cancer: Proposal for an essential component of the National Screening Programme. *J Clin Pathol* 1994; 47:27-8.
- 2 Hunt CM, Lamb MP, Breeson AJ, *et al.* Cervical screening: checking effectiveness by auditing "System Failures". *Cytopathology* 1993;4 Suppl 1:5.

Cervical screening

Two years ago a workshop of the National Co-ordinating Network (NCN) of the National Cervical Screening Programme issued guidelines for clinical practice which stated that, "smears showing viral changes but no nuclear change should be classified as normal."¹ Now a working party of the NCN has issued guidelines, stating "that no cell with HPV infection is normal and that no smear in which there is evidence of HPV infection should be reported as negative."² I would be grateful if those members that served on both committees could explain why they have changed their advice.

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Last smear before onset of symptoms no—clinical indication for smear.