Negative cytology preceding cervical cancer: causes and prevention

I read with interest the article of Robertson and Woodend. The authors reviewed 140 negative smears from 103 women who subsequently developed cervical cancer ("patients with microinvasive disease were excluded"). Forty eight smears (including one smear with severe inflammatory changes) were negative for abnormal cells (34.5%). As the authors consider of importance the "assessment of the quality of the smears received by a laboratory" it is surprising to read that the causes for true negative smears were not considered.

True false negative smears may result from a series of reasons. Some may be avoided, provided that the patient, and the persons in charge of the collection of the material and of the staining of the smears, are well aware of the pitfalls of the method. In fact, the instrument used for the collection of the smears may in itself entrap atypical cells (figure 1), thus contributing to a false negative smear, as the atypical cells collected from the area with cervical neoplasmia may never reach the slide. The type of instrument used is also important; a significantly lower number of atypical cells are transferred to the slides by cotton swab application (applicators and plastic spatulas than by cervical brushes. The method by which the smear is handled also has an important role, and variables such as (a) the technique used to deposit the material on to the slide, (b) the pressure exerted when smearing the material, and (c) the quality of the cervical mucus may also influence the presence of atypical cells in a cervical smear. Moreover, during staining procedures, detached material from the slides containing abnormal cells may render smears free from atypical cells, the vagina being a false negative region. Also, the detached material may become attached to other slides stained in the same batch (obtained from women without cervical neoplasias). The atypical cells attached to an "innocent" smear may yield a false positive smear.

One other important factor which was not mentioned by Robertson and Woodend is the patient herself. In earlier investigations we showed that smears taken immediately before conisation in cases showing histopathological dysplasia or carcinoma in situ were often negative for atypical cells. Shortly before taking the smear, the cervico-vaginal area had been thoroughly disinfected with a cotton swab. The vigorous rubbing of the cervix in order to disinfect the surgical area may have removed the superficial layer of atypical cells that are usually collected by conventional techniques of cell sampling. A Swedish gynaecologist found that about one third of his patients had used manual washing deep into the vagina a few hours before examination. Such a washing should have the same effect as the "exfoliation" caused by disinfection before conisation. In some countries the use of vaginal douches is widespread. Thus the patient must be instructed to come to the gynaecologist "unprepared" for a cytological test. One other common finding in smears is the presence of well preserved spermatocytes, suggesting trauma of the cervical mucus in the hours preceding cell collection (the absence of the spermatozoon, of course, does not rule out coitus). The effect of trauma in removing superficial layers of cervical epithelium has not been sufficiently emphasised.

It is obvious that factors other than the "screening fatigue" mentioned by Robertson and Woodend may be at stake, and that all participants in a cytological examination (the patient herself, midwives, staining technicians, screeners and (as) even doctors) should receive the proper information and education, so they are aware that each step in the procedure is important to achieve good results.

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Dr Robertson and Woodend comment: Dr Rubio draws attention to potential errors in the screening process that are related to the taking of smears in the clinic. Our purpose was to deal mainly with the laboratory examination of smears. Dr Rubio is quite correct, however, to emphasise the importance of a good smear-taking technique and other pitfalls described in his many studies.

Cytotoxic activity of Helicobacter pylori enhanced by acetohydroxamic acid

One of the major pathogenicity factors described for Helicobacter pylori is its strong urease activity, which enables it to survive in the acid environment of the stomach. It has therefore been suggested that acetohydroxamic acid (AHA), a potent inhibitor of various bacterial ureases including H pylori urease,1 be incorporated into therapy regimens aimed at eradicating H pylori. Synergistic effects between AHA and various antimicrobial agents against H pylori in vitro have recently been reported by Phillips et al in this journal, making this approach even more attractive.1 As we have observed that AHA enhances the cytotoxic effects produced by H pylori, we would like to add a cautionary note to the discussion on the possible use of AHA for treatment of H pylori infection as suggested by Mooney et al1 and again by Munster et al.4

We have been looking at the cytotoxic effects produced by supernatant fluids of H pylori sonicates on a quantitaive microtitre cytotoxicity assay, performed in a modification of a test described by Gentry et al.3 Briefly, sterile filtered (0.45

Section of a wooden spatula after collection of cervical material before conisation for carcinoma in situ. Note a large number of normal and atypical squamous cells trapped in the wooden fibres of the spatula (toluidine blue stain).


Dr Allardayre and Mr Bagshaw comment: We agree with Henrik von Wulffen and Thomas Marquardt that clinical trials should be undertaken with caution and in the light of all relevant in vitro and in vivo experimental evidence. It is also true that the publications on H pylori are littered with in vitro antibiotic data (including our own) that may have no bearing on the clinical outcome to the in vivo antibiotic functional efficacy in vivo. There are, however, a number of points regarding results obtained using H pylori sonicates that we believe differ in vivo. First, the results from Hamburg do not include dose or time response data. The synergistic antimicrobial effects reported by us were obtained using five to 10-fold less AHA! Also, the mean effects of continuous 48 hour exposure of HeLa cells to H pylori sonicate fractions and AHA in culture are not accompanied by any indication of the variability of the observation or the length of time required for the effect to become irreparable. The issues of dose and timing are germane to the clinical finding that a single 750 mg dose of AHA inhibits H pylori urease in infected patients by 86%. Second, there is a question relating to the practicality of the in vitro model using H pylori sonicates on HeLa cells as opposed to intact organisms on gastric epithelial cells (preferably mucus secreting) and the absence of control sonicate sephacryl fractions from organisms other than H pylori.

In the end, the clinical value of including urease inhibitors will rest on the balance between therapeutic efficacy and undesirable side effects of each experimental approach, such as our own and those of von Wulffen and Marquardt, have some value by indicating general therapeutic directions and constraints. But that is all they can do. At present, what is needed are in vivo Helicobacter pylori infection model experiments aimed at finding the most efficient means of eradicating H pylori at the least cost to the wellbeing of the host.


Alternative method for transport and storing gastric biopsy cultures of Helicobacter pylori

Veennadla et al reported the use of sterile saline as a transport medium for gastric biopsy specimens in order to obtain adequate culture results for Helicobacter pylori. Indeed, sterile saline is a simple and useful transport medium. Gastric biopsy specimens can, however, be put directly on to the surface of a suitable agar plate, thus obviating the need for transport medium. This reduces costs, handling, and risk of contamination, which is the main problem in culturing H pylori.

In our hospital the microbiology laboratory supplies the endoscopy unit with agar plates and transport medium. The biopsy samples are stored at 4°C in an ordinary freezer. Usually, our endoscopists take two gastric biopsy specimens with a sterilised forceps, and put them directly on to the surface of a suitable agar plate using a sterile needle, if necessary. The plate is subsequently stored in the freezer at 4°C until it is transferred to the microbiology laboratory. In our experience over 10 months, the biopsies are stored on agar plates which are considered suitable for culture for at least seven days at 4°C (from seven to 14 days), and for at least 25 hours at room temperature (from 25 to 25 hours). Samples can therefore be collected, even from distant endoscopy units once or twice a week.

According to Veennadla et al, one antral biopsy specimen is adequate for culture. In our experience this holds true except in the event of previous omeprazole therapy or where there is a strong reduction of parietal cells. In these circumstances H pylori may be present only in the oxyntic mucosa. This may be due to the change in antral pH to neutral, and as a result, local excetration of acid still present in the fundic area may permit H pylori survival in this zone. A false negative culture of a single antral specimen may also be due to an extensive intestinal metaplasia of the antral mucosa.

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