Correspondence

Cytological changes preceding cervical cancer

Dr Robertson and colleagues must be con-
gratulated for holding up the "red flag of classification" to the "bulls of gynaecologi-
cal cytology". If the data and conclusions are correct, it is disturbing that the frailty of the current reporting system becomes increasingly evi-
dent.

A basic premise in the currently recom-
mended terminology and management of cervical smears is that the degree of dyskaryosis correlates with the grade of cervical intraepithelial neoplasia (CIN).1,2

However, published information3 and the Robertson letter indicate that this is far from the case. Reasonable correlation occurs between severe dyskaryosis and CIN3, but consider-
ably more variation is observed as the degree of dyskaryosis diminishes. Whether or not dyskaryosis and CIN should be correlated is debatable, as the definitions involved are purely arbitrary. However, a principal reason why they do not must be the variability of smear repeat variation and the histopathological diagnosis of CIN.4

Health Service guidelines emphasise the important requirement to compare cytology and biopsy results.5 However, the crucial audit in whether cytological findings identify clinically relevant histopathological abnormalities and whether the false positive rate is accurately kept to a minimum.

Surprisingly, with only one or two excep-
tions,6,7 there has been little discussion with regard to the possible introduction of the American Bethesda system for reporting cervical smears. Indeed, some cynics believe that this was all part of a major introduction was doomed following the timing of the publication, which coincided with the printing of several million new HMR forms. However, although the Bethesda system uses the terminology that may squelch dyskaryosis, its overall complexity and content is analogous to that of the cur-
rent British system. Accordingly, unlike Dr Robertson, I share previous authors' views8 that the Bethesda system has little to commend it.

I suspect that many gynaecological cytopathologists already perceive nuclear changes as either low or high grade abnor-
malities. It is therefore reassuring to see that Dr Robertson's scientific conclusion supports this view. With little difficulty, cur-
rent national recommendations for termin-
ology 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 unbounded 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 gynae-
ocological cytology is currently in a state of high grade dyskaryosis.

Which cytopathologist, with their hands on their hearts, can deny that accurate distinc-
tion between borderline changes, wart virus, and mild dyskaryosis is difficult, 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 exist-
ence 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 the result of a streak of "to save money". Such reports requested annually and the requirement for these subtle distinctions to be assessed in quality assurance schemes. It is also questionable as to whether this complicated system should continue to be the staple of cytology training schools.

My proposition is simple: back to cy-
tological basics, before it is too late.

D. SLATER
Department of Histopathology,
Rotherham Hospital, NHS Trust,
Morpurgo Road,
Rotherham S60 2UD

cal grading of cervical intra-

Dr Robertson, Woodend, and Elliott comment: We agree with most of Dr Slater's com-
ments, but would never have dared mention them. They draw attention to the Emperor's new clothes and suggest rebellion 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.

In advocating a low and high grade method of reporting, the Bethesda system is cited by us only as an example. We accept that it is rather too elaborate. However, unlike Dr Slater, we hesitate to include "borderline changes", with wart virus and mild dyskaryosis as a low grade abnor-
mality. Among cytopathologists "border-
line" seems almost to have achieved the status of a diagnostic entity. Our experience is that in practice it merely reflects uncer-
tainty in interpretation of a smear. Reparative changes in the cervix, papillo-
ma virus infection, or atypical cells due to inflammation can all present difficulties. The latter may occasionally be confused with invasive cancer, and a six month repeat smear would be inappropriate. We feel that such reports should describe the diagnostic difficulty, advise on further action, and be summarised as "no diagnosis".

To the lay person the term "borderline" is unsatisfactory. It could be quite frightening for some women, giving the impression of a limbo bordering on (?) the abyss. It is not a diagnostic entity and, like the unicorn which had similar problems of identity, should be allowed to pass into mythology.

Pregnancy in von Willebrand's disease

The guidelines on the investigation and management of haemorrhagic disorders in pregnancy are welcome.1 With reference to the management of such a patient with von Willebrand's disease, we have recently studied 23 pregnancies managed at a single centre,2 and add the following comments.

We believe that there is a tendency towards complacency in the management of pregnant women with von Willebrand's disease due to an excessive reliance on improvement in the coagulation defect. The coagulation parameters improve in many instances, but we also noted some 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.3,4 In addition, our observations support the view that type II patients carry a higher risk of primary post-
partum haemorrhage (four cases; 3/11 type II & 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 adequately. 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 Willebrand's disease in pregnancy. We would suggest that with reference to secondary PPH, while the administration of prophylactic von Willebrand factor (vWF) containing...