Screening for cervical cancer

Your leading article on this subject (18 September, p 659) and Dr R A A R Lawrence's letter (25 September, p 754) both point the way to better screening systems which do not depend solely upon action taken by women. However, neither spelt out the simple system already available in many general practices for such screening. I refer to age-sex registers.

An age-sex register provides a simple method of identifying groups of patients and can be used to note screening (and other) procedures. A thin coloured tag can be applied to denote a cervical smear and different colours may be used for different years. Responsibility for marking the cards can be delegated to a practice ancillary. Family doctors should receive reports of smears carried out in hospital or family planning clinics and these may be recorded as well as those done by the practice. At any one time those women who have not been screened may be identified and either the doctor or the health visitor can follow them up.

Clearly there are many refinements which may be built into such a system. Four are obvious: it is possible for the doctor and his health visitor to identify the "at risk" women and direct a screening programme towards these; the intensity of individual screening can be better controlled and limited resources made available to all at risk; recall systems can be simply devised; and the record cards can be code-marked when a cervical cytology fee is claimed.

If money were to be spent in providing all practices with age-sex registers and with staff to help maintain them Britain might have one of the most comprehensive cervical cancer screening programmes in the world.

MICHAEL HALL

Department of General Practice,
Exeter Postgraduate Medical
Centre,
Exeter

SIR,—Your leading article on screening for cervical cancer (18 September, p 659) was constructive, balanced, and encouraging.

I write to make a plea for continued screening for breast cancer. The fact that the group that avails itself of present cervical screening is not that at high risk for cervical cancer but that at high risk for breast cancer means that the failure to palpate the breasts at the time a cervical smear is taken is a mockery of good preventive medicine.

GILLIAN TURNER

University Department of
Obstetrics and Gynaecology,
Bristol Maternity Hospital,
Bristol

Prostatic cancer

SIR,—In your leading article on this subject (28 August, p 490) you did not mention the place of external irradiation in the treatment of the localised form of this disease.

In view of the high accuracy of lymphography¹ and bone scanning² in detecting tumour spread to lymph nodes and bones it seems unjustified to treat patients with disease confined to the prostatic region and/or the regional lymph nodes by transurethral resection and wait-and-see policy only.

Although the reported experience of

treating such cases by external irradiation from Britain is limited,³ others have shown its effectiveness.^{4,5} So far I am unaware of a controlled clinical trial to evaluate this method, and the need for a national or regional controlled clinical trial to assess it is obvious.

A ROSTOM

Department of Radiotherapy,
Radiotherapy Research Unit,
Institute of Cancer Research,
Royal Marsden Hospital,
Sutton, Surrey

¹ Paxton, R M, *et al*, *British Medical Journal*, 1975, **1**, 120.

² Buck, A C, *et al*, *British Journal of Urology*, 1975, **47**, 287.

³ Morgan, R J, *et al*, *British Journal of Urology*, 1974, **46**, 677.

⁴ Bagshaw, M A, *et al*, *Cancer*, 1975, **36**, 723.

⁵ Del Regato, J A, *Radiology*, 1967, **88**, 761.

Pathogenesis and epidemiology of schizophrenia

SIR,—Your leading article on this subject (8 September, p 662) well illustrates some of the pitfalls awaiting commentators on current psychiatric research. May I comment briefly on some of the unconscious assumptions contained in the article since they contribute to that most energetic of enterprises—psychiatric myth-making.

(1) Because aspects of human behaviour are observed as common to all cultures the assumption cannot be made that the behaviour is a "disease," however bizarre or "abnormal" the phenomenon is considered. Individuals in all societies experience nightmares and excessively excitable behaviour occurs in non-human primate cultures, domestic animals such as the dog or cat, and in young children of many cultures. Such behaviour, however, does not necessarily constitute a "disease" requiring "diagnosis" and "treatment."

(2) Many of the assumptions made in psychiatry on the basis of epidemiological research are invalid since they do not take into account changes in time. The relatively simple mathematics required for such transformations seems to escape the grasp of most epidemiologists. Thus human beings evolve, cultures evolve, symptoms evolve, observers evolve, and categories evolve. It is not just that the symptoms of "masturbatory insanity" are subsumed under another category—that indeed may be so—but also that the static entity "masturbatory insanity" no longer exists for the counters to count. Some anthropological researchers of high repute failed to find "psychosis" in certain "underdeveloped" cultures years ago. A few decades later they found it. Later still the traditional categories of "mental illness" seemed to have declined. Some anthropologists have considered the possibility from observations of developed societies that "psychosis" peaks and then declines as a society develops. They may or may not be correct. It is too early to make assumptions. However, such facts do underline the difficulty of making assumptions from current epidemiological research.

(3) It is both dangerous and invalid to equate "genetic" (a biological category) with "medical" (a matter of professional interests and having arbitrary limits).

(4) One can "treat" almost any human behaviour, from outbursts against State tyranny to middle-aged loneliness, from evangelical religion to agoraphobia, with drugs

or any other methods. However, the assumption that it is always of "value" so to do is obviously a matter for debate.

(5) The myth that a "drug revolution" has altered the quality or quantity of a particular arbitrary category of "mental illness" in a society is not consistent with the facts. The available evidence is quite to the contrary and points to an evolutionary process.

The result of a beginning in research is a middle in which new hypotheses are necessary, and if there is to be an end it will be as indeterminate as the point of departure. Thus research on "schizophrenia" may become an investigation of the biochemistry of the central nervous system, or of human evolution, normal and abnormal, but certainly it will produce answers not to the original question but to new and as yet unasked questions. Unless psychiatric researchers realise that it is almost impossible for them to research stasis they will never join other disciplines and be eligible for the membership of the college of modern science.

PETER KELLETT

Ipswich Hospital,
Ipswich

Pelvic infection and intrauterine devices

SIR,—Your leading article (25 September, p 717) correctly emphasises that pelvic infection is a complication of the intrauterine contraceptive device (IUD) but its precise incidence remains undetermined. However, it is notoriously difficult to diagnose pelvic sepsis on clinical grounds alone. Jacobson and Westrom,¹ in a laparoscopic study of 814 cases of clinical pelvic sepsis, confirmed the diagnosis in only 65% of cases studied. Other pathology was found in 12% and the pelvis had a normal appearance in 23%. Some doubt must therefore be cast on the many surveys relying on clinical findings alone.

A subsequent laparoscopic study from the same department by Westrom² shows the effect of pelvic sepsis on fertility. There were 415 women who had developed pelvic sepsis 6-14 years earlier. Of these, 12.2% were involuntarily childless and 63.4% had become pregnant. In a further study Westrom *et al*³ showed that the overall risk of developing salpingitis in women using IUDs was increased three times compared with matched women who were using other methods of contraception. The risk was even greater for nulliparous women. Many of the patients studied were using copper-containing devices, yet our investigations currently in progress have shown a lower incidence of bacterial contamination of the uterine cavities with copper devices compared with others.⁴

The likelihood that the cervical appendage is a significant factor, as indicated earlier by one of us,⁵ remains an open question and needs to be investigated. Indeed, the nature of the cervical appendage might be a significant factor in the ascent of organisms up the genital tract.⁶ However, clinical studies are required and such studies are in progress.

Finally, the implication that copper offers protection against gonorrhoea may well have been over-emphasised. Although it may play some role, a recent report by Johannisson *et al*⁷ showed no difference between copper IUD and oral contraceptive users in relation to the incidence of gonorrhoea. They demonstrated no in-vitro inhibition of gonococci by copper in the presence of serum proteins.