Management of cervical dyskaryosis

National guidelines are not followed

EDITOR,—We hope that the work of G Flannelly and colleagues will help bring uniformity to the management of different grades of dyskaryosis in cervical smears.¹ The management of mildly dyskaryotic smears is not uniform throughout Britain. Kitchener observed in 1991 that 37% of the 210 health districts investigated had a policy of referring patients for colposcopy if a single mildly dyskaryotic smear was obtained.² The guidelines on cervical screening produced under the auspices of the national coordinating network provide a clear strategy for the management of different grades of dyskaryosis.³

Although the national guidelines on cervical screening were widely distributed among gynaecologists, the extent to which they are followed is unknown. To investigate compliance with the national guidelines among the consultants in gynaecology and obstetrics in the north west of England a postal questionnaire survey was carried out in October 1992 by a regional working party of the Royal College of Obstetricians and Gynaecologists' audit unit. The response rate was 100%. Although, according to the national guidelines, referral for colposcopy is advisable only after two consecutive mildly dyskaryotic smears have been obtained, 13 of the 69 consultants surveyed considered a single mildly dyskaryotic smear to be an appropriate criterion for referral. Consultants who performed colposcopy themselves were more likely to consider the procedure for a single mildly dyskaryotic smear than consultants who did not perform colposcopy (11/45 (24%) v 2/24 (8%)).

A uniform strategy of referral for colposcopy for all grades of dyskaryosis would probably be welcomed by doctors working in both primary and secondary care. An easier protocol is more likely to be remembered and adhered to, but two potential problems exist. Firstly, without further allocation of resources the delay between referral and appointment to a colposcopy clinic will worsen. Secondly, with the present popularity of immediate treatment with diathermy loop excision, many women will be treated unnecessarily. For example, of 158 women with a mildly dyskaryotic smear, 40 had no further dyskaryosis after 24 months' surveillance.¹

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1 Flannelly G, Anderson D, Kitchener HC, Mann EMF, Campbell M, Fisher P, *et al.* Management of women with mild and

moderate cervical dyskaryosis. *BMJ* 1994;308:1399-403. (28 May.)

2 Kitchener HC. United Kingdom colposcopy survey, British Society for Colposcopy and Cervical Pathology. *Br J Obstet Gynaecol* 1991;98:1112-6.

3 Duncan ID. *NHS cervical screening programme: guidelines for clinical practice and programme management*. Oxford: National Coordinating Network, 1992.

Immediate colposcopy is necessary

EDITOR,—In 1993 a review of cervical smears previously reported at Inverclyde Royal Hospital, Greenock, as showing no abnormality resulted in the reclassification of the smears of 1954 women to various categories of abnormality. Because of the original misclassification further gynaecological assessment was delayed by at least one year. All women who were still resident locally and whose smear had been reclassified as showing mild dyskaryosis or worse were offered a fast track colposcopy appointment, while women whose smear had been reclassified as unsatisfactory or "borderline" were offered a fast track repeat smear test. Women no longer resident locally were contacted, usually by their current general practitioner; their current situation was determined and follow up recommended when appropriate.

The smear was reclassified as borderline in 614 women, as showing mild dyskaryosis in 268, and as showing moderate dyskaryosis in 78. These women were followed up, and, when available, the findings on cervical biopsy were obtained (table). Our findings support those of the prospective study reported by G Flannelly and colleagues.¹ We agree that women with any degree of dyskaryosis should be referred for colposcopy.

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Colposcopy is not cost effective

EDITOR,—We welcome G Flannelly and colleagues' finding that cytological surveillance is safe, particularly as this agrees with our report on women who have mild dyskaryosis.² The authors' conclusion that cytological surveillance is not efficient, however, warrants further discussion. Their published data do not provide evidence of safety; presumably none of the 40 women with normal smears (in their figure) had cervical intraepithelial neoplasia grade III, although an estimated 40 of the 82 women with persistent dyskaryosis requiring

colposcopy were found to have cervical intraepithelial neoplasia grade III. The estimate is based on the 187 women with cervical intraepithelial neoplasia grade III among the 538 with mild dyskaryosis (their table IV).

Efficiency should imply a lower cost for each case of cervical intraepithelial neoplasia grade III detected. No evidence for this is provided in the paper, and the comment seems to be based on the small proportion of women (40/158) who completed the 24 month surveillance programme.

We have reported previously, on the basis of audit of our practice, that the marginal cost of detecting additional cases of cervical intraepithelial neoplasia grade II or III by using immediate colposcopy rather than cytological surveillance may be as high as £1200.³ This applies specifically to women showing good compliance during cytological surveillance after a first mildly dyskaryotic smear has been obtained. Clearly, cytological surveillance is more efficient for women who do not default. The problem of defaulting can be tackled in several ways, but, most importantly, education of patients must be improved.

An alarming proportion of women with an abnormal smear still think that they have cancer. Many methods of improving communication have been advocated and shown to be successful. For example, explanatory leaflets describing the nature of the abnormality and subsequent management are effective. Personal communication, rather than a letter from the general practitioner or practice nurse, has been recommended. If the patient continues to default then she should be referred immediately for colposcopy.

Surely a policy of blanket referral for a potentially unpleasant examination that provokes anxiety (colposcopy) is no substitute for better education of patients.

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1 Flannelly G, Anderson D, Kitchener HC, Mann EMF, Campbell M, Fisher P, *et al.* Management of women with mild and moderate cervical dyskaryosis. *BMJ* 1994;308:1399-403. (28 May.)

2 Jones MH, Jenkins D, Cuzick J, Wolfendale MR, Jones JJ, Balogun-Lynch C, *et al.* Mild cervical dyskaryosis—safety of cytological surveillance. *Lancet* 1992;339:1440-3.

3 Jones MH, Jones JJ. Management of mildly abnormal smears. *Lancet* 1993;342:813.

Accurate diagnosis is essential

EDITOR,—G Flannelly and colleagues recommend that mild dyskaryosis should be managed by immediate colposcopy rather than cytological surveillance.¹ Their conclusion is logical, but is it practical outside a specialised unit?

The problem lies in the lack of accuracy in the diagnosis of low grade lesions. This has been well documented for histological diagnosis.² Many would agree that neither cytopathologists nor histopathologists can distinguish mild dyskaryosis from human papillomavirus infection, which is extremely prevalent.³ The selection of dyskaryotic smears for external quality assurance schemes

Findings on cervical biopsy in women whose smears had been reclassified. Figures are numbers (percentages) of women

Reclassified result of smear test	No of women	Women in whom findings on biopsy were obtained	Finding on biopsy	
			CIN grade II	CIN grade III
Borderline	615	91 (15)	7 (1)	28 (5)
Mild dyskaryosis	268	189 (71)	11 (4)	32 (12)
Moderate dyskaryosis	78	57 (73)	7 (9)	15 (19)

CIN=Cervical intraepithelial neoplasia.