ABNORMAL CYTOLOGY REPORT AND FURTHER MANAGEMENT OF PRECANCEROUS LESION : EFFECT OF CHANGE TO TBS

Dear Editor,

We read with interest the article on The Bethesda System (TBS) of reporting by Chatterjee et al [1]. The authors have drawn attention to the important area of cytology reporting. The system aims at standardization of lexicon and clear some grey zone. Undoubtedly, diagnosis and management of the precancerous lesions forms the corner stone of the preventive strategy against carcinoma cervix. Hence it will be pertinent to see if the management strategy for this group is affected by the change in nomenclature from CIN I,II,III to LSIL and HSIL.

The apprehension that the use of the term neoplasia in CIN might be a green signal to perform radical surgery may not be correct. The implication of cervical intraepithelial neoplasia is understood by it's being in use for a long time since introduction by Richards [2]. However, over treatment or rather overzealous treatment of precancerous lesions without being radical is a fact to reckon with which is not likely to be affected by the change in nomenclature.

The problem actually is a lack of logistics to implement a rigorous screening and follow up programme. It was estimated in 1986 that with an increase in resources by 12 times, even 25% of the eligible population cannot be covered by the end of the century [3]. Today the situation is even worse than that estimate. Hence there is a tendency to over treat once an abnormal cytology is reported in the very few who have been able to undergo a screening at some time. 60% of CIN I (now LSIL) are likely to regress and can be managed

by a cytological follow up but the preference will remain to biopsy and go in for local ablation. Similarly HSIL (previously CIN II & III) can be managed by local ablation or conization, but the tendency in our country will be to accept it as an indication of hysterectomy, if the age and parity so permits. Though prevalent approach entails some surgical morbidity, it is unlikely to change under the existing condition with change over to TBS.

The stepping up of the treatment strategy may be a necessary evil to partially compensate for the logistic limitations of implementing a cytology follow up coupled with the problem of loss to follow up in a floating population in our setup.

References

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2. Richart RM. Influence of diagnostic and therapeutic procedures on the distribution of cervical intra epithelial neoplasia. *Cancer* 1966;19:1635-8.
3. The WHO Bulletin 211 Geneva Switzerland. 1986;64:607.

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Reply

Dear Editor,

I am grateful to Professor and his team of senior Doctors for having taken a keen interest in the article. I agree with the views of the authors that the main problem is a lack of logistics to implement a rigorous screening and followup programme. However we still feel that overtreatment of precancerous lesions particularly LSIL cases (CIN I) should be avoided.

We recommend a practical follow-up schedule for CIN (cervical intraepithelial neoplasia) cases as being followed in the Institute of Cytology and Preventive Oncology, New Delhi.

1. For control subjects -yearly.
2. For CIN I & CIN II cases - 6 monthly for 4 years.
3. For CIN III/invasive carcinomas - 6 weeks after treatment and then 6 monthly for 3 years.

4. Follow up of treated cases are undertaken for assessing
 - a. Recurrence
 - b. Disease free survival
 - c. Death
 - d. Side effects of management
 - e. Latest HPV status

Cervical smear examination, colposcopy and cervical biopsy are done during follow-up whenever required.

Reference

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TROPICAL PULMONARY EOSINOPHILIA : NOCTURNAL SYMPTOMS

Dear Editor,

This 24 year old serving soldier presented with dry cough, breathlessness, mild grade fever and generalised bodyaches for the last 15 days. On examination he was moderately built, temperature - 37.8°C, Pulse- 90/min regular, BP - 110/70 mm of Hg and throat was normal. Chest did not reveal any wheeze or crackles. Abdomen/CVS/CNS/ - Normal. Next morning patient complained that he was unable to sleep because of dry cough and breathlessness through out the night. Chest did not reveal any wheeze or crackles.

Systemic examination was again normal.

On next day patient had similar complaints and was not able to sleep through out the night. Again clinical examination did not reveal any abnormal finding. On subsequent night, patient was examined : chest had extensive bilateral wheeze mainly in infrascapular and interscapular areas. Bronchodilators were given and investigated further. Haemogram : Hb. 14.0 gm/dl, TLC-8000 per cmm with 18% eosinophils on differential count. Absolute eosinophil count was 1440 per cmm. Blood slide for MF was negative