BRITISH MEDICAL JOURNAL

SATURDAY 13 JUNE 1987

ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO 6586 BRITISH MEDICAL JOURNAL 1987 VOLUME 294 1501-1564
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 294 (6586) 1501-1564 (1987)

CORRESPONDENCE

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- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
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Colposcopy and cytology

SIR,—The edition of 23 May highlighted the current dilemma in colposcopy and cytology with four articles approaching the subject from different angles: Professor H Fox's leading article (p 1307), the article by Dr H C Kitchener and others (p 1313), Dr Jane Chomet's Practice Research article (p 1326), and the Lesson of the Week by Dr M J Campion and colleagues (p 1337). As a cytologist, I would endorse Professor Fox's opinion that standardisation of terminology in cytology is important, but this would do little to alter the basic problem, which is the borderline ("atypical") smear in patients with preneoplastic lesions (cervical intraepithelial neoplasia grade 2 or 3).

Few would disagree that colposcopy should be more widely available, but surely no one can envisage its use as a screening test. The provision of training for new colposcopists, whether in general practice, family planning clinics, or genitourinary medicine clinics, will, at least initially, increase demands on colposcopy centres. In addition, the spin off effects of expansion will increase the workload of cytology and histopathology laboratories as well as that of primary care doctors responsible for follow up.

A cytological report recommends a course of action in local conditions. If the colposcopy clinic has a four month waiting list (which may be undesirable but is not unknown) or there is no local colposcopy service a repeat smear may be a more reasonable course of action than referral in the first instance for borderline changes.

The present state of disarray can be resolved only by closer links between colposcopy and cytology, with the colposcopist indicating to the cytologist what advice he considers to be most appropriate (partly depending on what numbers the colposcopy service can cope with). Various other factors, including correlation of cytological and histological findings, are necessary to determine the optimum advice so that patients may not develop invasion lesions. In view of the apparent trend towards "false negative" cytology — that is, borderline changes — in cervical intraepithelial neoplasia grade 2 or 3 such advice cannot be a static decision but must constantly be reviewed.

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SIR,—Dr Jane Chomet and Dr H C Kitchener and colleagues each report a year's experience of colposcopy in general practice and family planning clinic settings, respectively. In the same issue Dr M J Campion and colleagues emphasise the increased risk of invasive cervical cancer associated with human papillomavirus infection and suggest that such disease may be the earliest stage of cervical intraepithelial neoplasia.

Genital wart virus infection is the third commonest sexually transmitted disease in the United Kingdom after non-specific genital infection and candidal infection, yet in neither of these colposcopic studies did the authors assess the history or prevalence of wart virus infection. If this aspect of cytological changes in the cervix is not appreciated and appropriate action taken the burgeoning threat of cervical cancer will continue to grow.

The increasing prevalence of precancer in young women is faced principally by departments of genitourinary medicine, where training in colposcopy has been an integral part of higher specialist training for the past two years, and clinics have been operating in several centres for much longer. Our waiting list for colposcopy at the West London Hospital, where we run three clinics a week, is now six months. More resources are needed urgently.

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Early onset pre-eclampsia: recognition of underlying renal disease

SIR,—Dr B U Ihle and coworkers (10 January, p 79), described 84 women with pre-eclampsia before 37 weeks' gestation, noting a high degree of recurrent hypertension in subsequent pregnancies and, surprisingly, the presence of chronic renal disease or essential hypertension in 90% of the subjects. In two thirds of these patients the lesion was glomerulonephritis, usually of the IgA variety. We wonder whether these data represent a selected population, perhaps relating to the referral pattern of the University of Melbourne renal department.

One of us (LCC) followed the clinical course of 270 women surviving eclampsia (the convulsive phase of the disorder) between 1931 and 1951, and most of these women were re-examined periodically for almost 40 years.[1,2] Unfortunately, the prenatal records did not always reflect when the disease started, but we ascertained that it was before 36 weeks' gestation in at least 42% of the women. (As eclampsia represents a severe stage of the disorder it is reasonable to assume that many more had had hypertension for some weeks before the putative convulsion.)

When urine samples from 174 of these women, still alive 23-43 years after the eclamptic gestation, were examined for protein only four yielded positive results. Of the 96 who died, 17 had a