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NEWS AND NOTES

SUPPLEMENT

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- *All letters must be typed with double spacing and signed by all authors.*
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- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Accuracy of cervical cytology screening

SIR,—Mr John A Giles and others (16 April, p 1099) discuss the accuracy of cervical cytology screening. Screening competes with the traditional "demand led" services of a chronically underfunded health service. It is essential, therefore, that screening programmes are effective lest resources become diverted from areas of proved need to schemes with populist appeal but little scientific basis.

Since the 1960s screening for cervical cancer has been based on the assumption that the disease has a long preinvasive phase, rendering it amenable to testing at regular intervals. The work of Mr Giles's team and others suggests that the clinical course of at least some cervical cancers is changing, with an earlier age of onset and more rapidly invasive behaviour.[1-3] The Intercollegiate Working Party on Cervical Cytology Screening has, therefore, recommended that screening should start at age 20 and continue at three yearly intervals.[4] The behaviour of cervical dysplasia is unpredictable, and there is little evidence that this policy will reduce deaths from cervical cancer. The rapidly invasive variant may not be amenable to any practical screening interval.[5] The only justification for screening is a proved reduction in mortality, not merely increased identification of abnormal cases.

Circumspection is required in interpreting cervical cancer statistics in Britain. Although deaths in women under 35 have increased from around 30 a year in the 1960s to about 110 a year in the 1980s, the mortality was as high as 70 a year in the 1950s (Office of Population Census and Surveys, personal communication). Comparing these small numbers with a total yearly mortality from all malignancies of about 150 000 puts the problem into perspective. The chances of screening significantly reducing such a low mortality must be small, especially when the poor compliance of some populations is considered.[6]

National statistics relating to "positive" smears should be interpreted with equal caution. Returns of form SBH 140 from pathology laboratories to the Department of Health and Social Security show an overall increase in the proportion of positive cases. In some regions, however, notably Wessex, there has been virtually no change in incidence in the past decade whereas other regions have shown a large increase. It is important to know whether these discrepancies reflect different disease patterns or merely differing pathological or gynaecological management. It is also impossible to be sure whether there is a true increase in positive cases in younger women as positivity in any age group can be "weighted" by an increased number of smears performed in that group and by repetition of positive smears (it is positive smears that are counted, not women with positive smears).

In Britain we have the advantages of a large population base and a nationally organised health service. It seems absurd to miss the opportunity to organise properly controlled clinical trials to establish the behaviour of cervical neoplasia and assess the effectiveness of screening in younger women. The alternative is to plunge hysterically into a hotch potch of district based schemes which will be enormously expensive and can never be proved to have saved lives.

JOHN R HUGHES

Havant Health Centre,
Hampshire PO9 2AQ

1 Macgregor JE. Rapid onset cancer of the cervix. *Br Med J* 1982;**284**:441-2.
2 Wolfendale MR, King S, Usherwood MM. Abnormal smears: are we in for an epidemic? *Br Med J* 1983;**287**:526-8.
3 Campion MJ, McCance DJ, Cuzick J, Singer A. Progressive potential of mild cervical atypia: prospective cytological, colposcopic, and virological studies. *Lancet* 1986;ii:237-40.
4 Sharp F, Duncan I, Evans DMD, *et al. Report of the intercollegiate working party on cervical cancer screening.* London: Royal College of Obstetricians and Gynaecologists, 1987.
5 Hakama M, Rasamen-Virtanen U. Effect of a mass screening programme on the risk of cervical cancer. *Am J Epidemiol* 1976;**103**:512-7.
6 Nathoo V. Investigation of non-responders at a cervical screening clinic in Manchester. *Br Med J* 1988;**296**:1041-2.

Vocational training in general practice

SIR,—Dr Marie Campkin and colleagues (7 May, p 1331) imply that the Joint Committee on Postgraduate Training for General Practice has based its decision to withdraw recognition of vocational training in the North East Thames region solely on the report of its visitors to the Bloomsbury scheme in June 1987. This is far from so.

The committee has national responsibility for maintaining standards for vocational training. It arranges for its visitors to review the arrangements in each region every other year. These visits are undertaken in different parts of a region on each occasion. Reports of the visits to the North East Thames region have highlighted a series of problems extending back to 1983.

In 1985 the visitors reported that the standards of medical records in a large proportion of training practices in the region did not match the standards required by the committee's minimum criteria. Following receipt of that report the committee arranged for its officers to meet representatives of the North East Thames region to discuss the matter further. The region gave assurances that in future its criteria for selecting trainers would be in