

Dr. J.H.F. Smith
Consultant Histopathologist & Cytopathologist
Royal Hallamshire Hospital
Sheffield S10 2JF
Tel: 0114 271 3728
Fax: 0114 271 2200
Email: John.H.Smith@sth.nhs.uk

2 July 2007

Mrs J Patnick
Director
NHS Cancer Screening Programmes
Don Valley House
Savile Street
SHEFFIELD
S4 7UQ

Dear Julietta

Audit of Invasive Cervical Cancer. NHSCSP Publication No 28.

I am writing on behalf of BSCC Council to appraise you of our response to this document and initial experience of implementation of the guidance contained therein.

BSCC Council welcome the publication of this document, especially alongside the publication earlier in the year of the document *Disclosure of Audit Results in Cancer Screening: Advice on Best Practice*, which should draw to a close a period of uncertainty about how to deal with these cases. There are, however, a number of practical problems raised by the documents, some of which were raised by the BSCC as comments to a previous draft of the guidelines in October 2003.

Role of Hospital-based Programme Co-ordinator (HBPC)

The HBPC will provide a central role in collecting the information about cancer histories from laboratory, Exeter records and GP records; providing data to Regional Quality Assurance Teams and Cancer Registries; communicating between gynaecological cancer centres and cancer unit HBPCs; attending colposcopy review meetings and gynaecological oncology meetings; organising slide reviews; and, ascertaining the clinical stage of the cancers. Although HBPCs should have been involved in cervical cancer audit since at

least 2001, the amount of documentation, co-ordination and communication of data required is far greater than previously carried out in most or probably any Trusts. HBPC posts have frequently been under-funded with insufficient administrative support. The NHSCSP explained at the recent Study Day that cervical cancer audit had been required since 2001 but it has never been adequately funded: with the current financial restrictions in PCTs and Trusts it is hard to see how the full duties of these posts can be fulfilled without additional central funding.

Cytology slide review

The slide review is said to have an educational purpose and “should be carried out only with staff with current knowledge of cervical cytology reporting and of its pitfalls”. This may provide a practical problem when conventional smears must be reviewed in laboratories converted to liquid-based cytology, with staff no longer, or never having been, familiar with such smears.

Regional slide review

Although the numbers of slides requiring regional review may not be great, there is likely to be a funding issue for QARCs and Trusts providing panels to carry out the reviews.

Histology review

The pathological diagnoses listed in Sections D and F in the Appendices are incomplete and do not address the type of problems that are likely to arise in a histological review, particularly in biopsies preceding a diagnosis of cancer. There is no mention of mixed CIN and CGIN lesions, of which one component could easily be missed, or of FIGO stage 1A carcinomas in a background of CIN and/or CGIN. Small foci of early stromal invasion may be over- or under-diagnosed in such a background. No consideration has been given to conditions that might be mistaken for CIN, CGIN or cancer. These early changes should be addressed in the classification and are more relevant than FIGO stage, which is largely based on radiological and clinical findings especially when more than stage 1.

Screen-detected cancers

While it is clearly important to identify screen-detected cancers, the criteria presented in the guidelines would exclude many cases. Apart from the sub-groups detected after previous treatment, screen-detected cancers would almost entirely be confined to cancers in women who had been previously screened (i.e. interval cancers). Screen-detected cancers should include sub-groups that are diagnosed in women who had previously never been screened, who had lapsed from routine screening, or who were diagnosed after a delay between an abnormal test recommending colposcopy and the diagnosis being made.

The designation “screen-detected” cancer should be informed by clinical information about route to diagnosis (through investigation of abnormal cytology rather than investigation of symptoms) and not simply on the date the next routine test is due.

Unlike breast cancer, cervical cytology tests may be carried out in asymptomatic women outside the three months before or after a screening

test is due. Conversely, tests in symptomatic women may be taken at the time when a routine test happens to be due.

Main reasons for cancers developing in well-screened populations

The guidelines have lost the main categories of “reasons” for cancers developing in screened populations, which form a useful basis for analysing both symptomatic and screen-detected cancers. It should be possible to record whether a woman has been regularly or infrequently screened; whether she had previous low-grade cytology that had not been investigated; whether there had been delay in referral for investigation; whether investigation had failed to detect a cancer or precancerous lesion thought to be present on cytology; whether previous treatment of CIN had been carried out and whether, in the latter case, follow-up had been negative or less frequent than recommended. These factors form a useful basis for analysing cancer histories, some of which seem to have been lost in the proposed classification.

Case control study

There are causes for concern in the “case control” aspect of the audit. It will not be possible to ascertain relevant screening history information from Exeter records alone because i) they do not store colposcopy or histology data and ii) they are incomplete prior to 1990, when recent results were transferred to the central system. Thus, it will not be possible to ascertain whether or when women with abnormal cytology had lesions confirmed on histology or were treated unless hospital and GP records were searched, which is unlikely to be possible without patients’ consent. Without this information case controls will be of limited value. Furthermore, for women born before 1965 there may be little or no information about cytological abnormalities when they were in their 20s and 30s, in which decades of life most CIN lesions are treated. These are limitations of previous NHSCSP case-control studies, which provided some useful information about screening intervals but little about the effectiveness of screening *per se*.

A case-control study could produce valuable information but only if the same clinical information were available for the cancer cases and controls. This is simply not the case with the information available in the UK on central records. A case-control study may also be less useful at a time when such a high proportion of the population has been screened at some time during their life, and when invasive cancer cases are concentrated in young women with early onset lesions, often screen-detected, which are known to be more difficult to prevent.

In summary, BSCC Council welcome the publication of this guidance and believe it will be a good starting point for auditing invasive cervical cancer and identifying areas where screening procedures could be improved. It may, for example, demonstrate the limitations of cytology to detect all high-grade abnormalities and the importance of their prompt investigation and treatment. It is doubtful whether the information centrally available will be sufficient for a truly informative case-control study to assess the effectiveness of screening. The amount of time taken in collecting, reviewing and analysing the data

should not be underestimated and will cost time and money whether or not it is centrally funded.

Yours sincerely

Dr J H F Smith
Chairman of Council