A CERVICAL CYTOLOGY SURVEY IN GENERAL PRACTICE

V. F. COLLINSON, M.B., B.S., M.R.C.G.P.
Bedford

WHEN a cervical cytologist was appointed for the Bedford area at the end of 1966, a local liaison committee was established to determine how to use her services. The demand for cytology had come predominantly from women in the upper social classes and, if the service was offered to all, it would be those women most at risk amongst the lower social classes who would be missed. As a pilot scheme, two general practitioners were selected to conduct a survey of their own patients who fell into 'at risk' categories. The following is an account of the survey carried out by one of these doctors.

Method

The original suggestion of the liaison committee was that the general practitioner should select, from amongst his female patients over the age of 35, those falling into social classes IV and V, and those with large families. The patients so identified were to be visited by a health visitor who would explain what cytology was and make an appointment for the patient to attend a special surgery session to have a smear taken. This appeared to be a relatively straightforward procedure but it quickly became clear that in practice the doctor's knowledge of his patients was too inexact to ensure satisfactory selection. It was thought to be unjust to deny the service to patients in other social classes who would accept the offer of cytology but who might not request it spontaneously.

Accordingly a letter was sent to all female patients in the practice between the ages of 35 and 60 inclusive, advising them of the cytology service. Those who failed to reply within a month were sent a second letter and if there was no response a visit was made by the health visitor, and a marker was placed in the patient's record so that the service could be discussed with her at her next surgery attendance.

The practice age-sex register listed 566 women in the age group described, and it was decided to take ten smears each week in a session of about 1½ hours. Beginning with the youngest, 20 'first

letters' were sent out each week. The survey commenced in February 1967 and was completed in just under a year. Smears were also taken from women of any age on request and at all postnatal examinations; the results of these were incorporated in the final analysis.

Response

Of the total, 56 (10 per cent) had left the practice or moved without trace, 24 (4.2 per cent) had had total hysterectomy and three (0.5 per cent) were pregnant. Of the remaining 483 there were 50 (10.3 per cent) who had had smears taken elsewhere within the previous two years, at family planning clinics or at the hospital when attending for gynaecological complaints or elsewhere, and 24 (5 per cent) had had smears taken in the practice before the survey. Sixteen (3.3 per cent) were excluded for medical or psychiatric reasons.

Of the remaining 393 patients, 179 (45 per cent) had smears taken in response to the first letter, 83 (21 per cent) after the second letter and 49 (12 per cent) after visits by the health visitor. Forty-four women (11 per cent) objected to having a smear taken even after the procedure had been explained to them. A further 33 (8.3 per cent) failed to reply and contact with these could not be made. Thus there were 76 (19.3 per cent) failures; some of these no doubt were patients who had moved away. Most of the failures were older women; their refusal was not apparently connected with social class (figures 1 and 2).

In six (1.5 per cent) patients who attended, it was impossible to

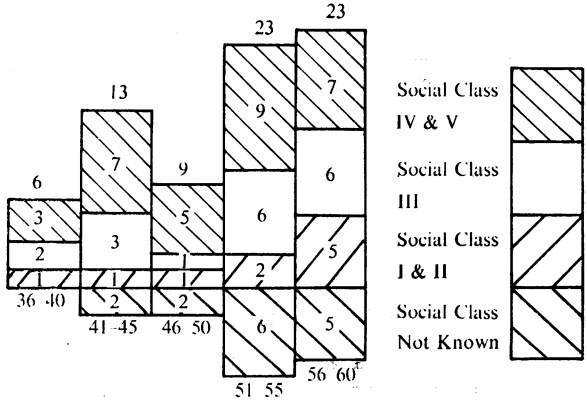

Figure 1.

Distribution of failures by age and social class
Ages at foot of columns, totals at top.

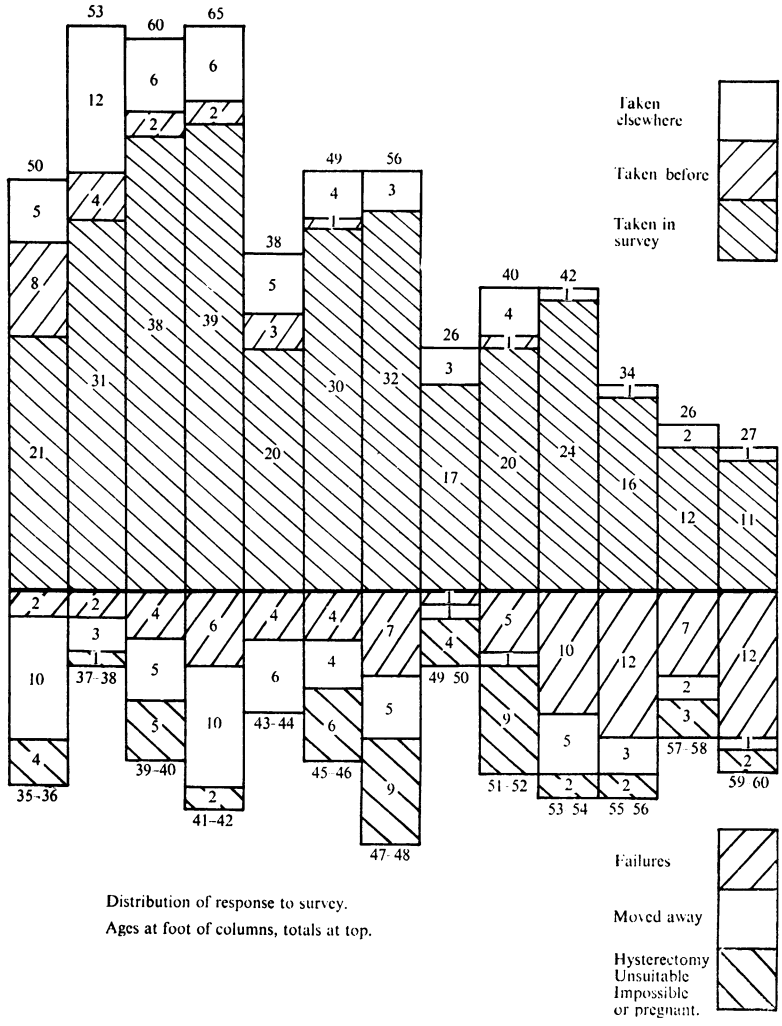

Figure 2.

take a smear either because they were virgo intacta or because the examination caused them too much distress.

Results

In all 354 results were analysed. Of these 311 were from the survey, 23 were postnatal and 20 from patients below the age of 35 who had requested cytology.

In 237 (66 per cent) patients the cervices were clinically normal, but in 95 (26 per cent) erosions were present; polyps of the cervix

were found in 18 (5 per cent), cervicitis in four (1.1 per cent) and cervical cysts in four (1.1 per cent), either alone or in combination.

The cytologist reported normal cells only in 236 (66 per cent) smears, the presence of inflammation in 112 (32 per cent), an excess of leucocytes in 82 (23 per cent) and histiocytes in 16 (4.5 per cent). Many of the reports contained more than one of these items.

Four (1.1 per cent) smears were technically unsatisfactory but were reported as normal when repeated. Nine (2.8 per cent) were suspicious but were all found normal, sometimes after several repeats. Only two (0.56 per cent) positive smears were found and both these were confirmed as carcinoma *in situ* after cone biopsy of the cervix. One of these patients was in early pregnancy: the pregnancy progressed normally in spite of cone biopsy.

Incidental findings

Trichomonas vaginalis was found in 20 (5.6 per cent) smears and moniliasis in three (0.84 per cent). In none of these did the patient complain of symptoms but all were given and responded to treatment. Other gynaecological abnormalities detected were four prolapses, two fibroids, one previous repair which was too tight and required further surgery, and one case of postmenopausal bleeding. None of these eight (2.2 per cent) was known before.

The breasts of each patient were examined. One benign cyst was found. No other abnormalities were detected. This suggests that in this practice, where carcinoma of the breast is not uncommon, patients do present themselves early.

Discussion

The failure rate of 19.3 per cent was disappointingly high, but it is difficult to suggest any other approach which would achieve a success rate greater than 80 per cent, and the failure rate may have been inflated by patients who had moved away. Thirty-three of the 76 failures were amongst patients in the 55 to 60 age group. Amongst the younger patients the success rate was considerably better than the overall average. Failure appeared to be more related to age than social class, though this cannot be conclusively demonstrated.

The only expense incurred in conducting this survey was for postage and stationery, as the practice ancillary staff was used. The health visitor, however, spent considerable time in visiting patients and attended each session when smears were taken. A major benefit resulting from the survey was that liaison between the health visitor and the doctor improved considerably and ultimately she was attached to the practice.

Many of the patients came reluctantly and probably would not have done so if they had been unfamiliar with the doctor and the

practice arrangements. This familiarity gives the general practitioner an advantage over others in conducting this kind of survey and renders the management of abnormalities less complicated.

The survey made no excessive demands upon the practitioner's time and the relatively leisurely atmosphere of the smear sessions encouraged patients to bring up unrelated medical problems which they might otherwise have refrained from doing. A further advantage is that once the machinery has been organized it lends itself readily to conducting other similar surveys.

The results themselves are not remarkable except, perhaps, in the high incidence of cervical erosion and polyps and the presence of symptomless trichomonas infection. The number of incidental findings of other remediable abnormalities is a further indication of the value of a cervical survey.

Summary

The method of conducting a cervical survey of the female population in one general practice between the ages of 35 and 60 is described. The distribution of failures is discussed in respect of social class and age, and the results are analysed. It is suggested that there are economic and other advantages in conducting such a survey from general practice.

Acknowledgements

I am deeply indebted to my secretarial staff for conducting the survey and keeping the necessary records, to Miss S. Moore, the health visitor, for her most valuable suggestions and assistance throughout and to the cytologist at Bedford General Hospital, who readily accepted the additional load.

Use by general practitioners of obstetric beds in a consultant unit: Report of first 500 cases. K. L. OLDERSHAW, M.B., B.S., D.Obst.R.C.O.G., and J. M. BRUDENELL, M.B., B.S., F.R.C.S., M.R.C.O.G. *Brit. med. J.* 1968. **3**, 112.

This is a report on the first 500 deliveries supervised by general practitioners in the consultant obstetric units of Dulwich and St. Giles hospitals in S.E. London.

The perinatal mortality was 12 per 1,000 and there were no maternal deaths. There was close consultation between general practitioners and hospital staff over any abnormalities although clinical responsibility was often retained by the general practitioners. Forty per cent of deliveries were actually attended by the general practitioner but he was present at 63 per cent of primigravida deliveries. The working of the scheme appeared satisfactory to the patients, general practitioners and hospital staff. It is seen as one solution, in urban areas at least, to the problem of maintaining the general practitioners' interest and skill with a diminishing number of domiciliary confinements.