DISCUSSION

Dr Colville (*Leeds*): May I state a case against cervical cytology? I think we have not heard enough about the case against, I do not think it is really fair to put this forward as my personal opinion, but I think it is worth discussing. First of all, natural history: Dr Lissmore who was a pathologist at the Women's Hospital in Leeds until recently says that epithelia grow outwards, or towards their cavity away from the basement membrane. Now carcinoma *in situ* lies outside the basement membrane and it will therefore grow outwards and not inwards. If it is not a carcinoma *in situ*, namely, if the basement membrane is broken, then it is a different condition. Why do carcinoma *in situ* and other carcinomas occur in this region? If their cell divisions are occurring outside the basement membrane they are doing so in an area of relative ischaemia, so things may not go as normally as they otherwise would; also they are bombarded by spermatozoa which bring nuclear substance and food. Both carcinoma *in situ* and carcinoma proper occur mostly in married women, more often in the lower social classes, which I think is significant. Dr Lissmore says that this normal epithelium is extremely thin and if you use an Ayre speculum it may break, turning a carcinoma that cannot possibly be malignant into one that can, because cells are possibly introduced to an area where there is both blood and lymphatic supply.

Professor Scott did some work on this at Leeds, trying atraumatic methods of taking cervical smears, with which he found much fewer positive results so it was not so effective in finding carcinoma *in situ*. As for the irrigation method I think that was worse still, but it did at least pick up cases of vaginitis due to monilia and Trichomonas. I am not against screening by looking at the cervix but I am against traumatic scraping of the cervix. I think that it is ethically wrong for us to do this until it is proved that we are not doing our patients a disservice.

Dr Wilson: I do not think I am qualified to argue about the pathology of carcinoma *in situ*. Quite recently there has been an excellent presentation of the evidence and weakness in the evidence for the value of screening as a technique in carcinoma of the cervix, written by Dr Knox of the social medicine department in Birmingham. The case is not proven ultimately to the satisfaction of all by the one criterion of—Does it lower the mortality from cancer of the cervix? The practice of cervical cytology has been growing in all western countries, and direct evidence has been in favour of its effectiveness rather than mortality. It would have seemed unfair to set up further experiments and wait 20 years before providing a service. This is the kind of thing that has to be decided pragmatically. Fifteen to 20 years ago, methods of randomizing trials were hardly generally known and if you look back at the evidence of those years certainly some of it is rather thin.

Chairman: Dr Donaldson, what is to be done with the people who have been through this mental health screening exercise?

Dr Donaldson: We really have not quite finished this mental health test and diagnostic procedure which was suggested to us by the local

consultant psychiatrist who was very keen on preventive psychiatry. What we did was to take the group with scores of 19 plus, which was a very high score, and found that 80 per cent of these were abnormal. There were of course amongst them, people who were getting treatment—the refugees come rushing from doctors' surgeries and hospital outpatients to check up whether they are getting the right treatment, this is inevitable —but some of the conditions such as depression are certainly amenable to treatment. We are now looking at the lower scorers, the ones scoring less than 19, we have not had the results of those through yet, but we hope that it is not going to show 80 per cent needing treatment as well, otherwise there will be no need for a questionnaire at all. We will just need a sign saying 'Mental Health', and take their names as they come along. We are trying to isolate these people, then consult with the general practitioner to see if treatment can be given to them.

Chairman: There are of course other ways of screening for mental health. The story is an old one about the man who went to the psychiatric clinic in New York; he went in the first room and there were two doors, one 'men' and one 'women', so he went in the one for men and again there were two doors, one 'over 40 years of age' and the other one 'under 40 years of age'; he went in the 'over 40' and again he came to two doors, one 'income over 10,000 dollars', and the other 'income under 10,000 dollars'; he went through the 'under 10,000 dollars' door and found himself in the street.

Professor Scarborough: I was examining for the London M.B. just the other day and I asked the students in the oral examination their attitude to this subject of presymptomatic diagnosis. All those that I asked thought it was a good thing, obviously not having thought much about it. I tackled one of them with some of the considerations that have been mentioned this afternoon, and he said, 'Oh yes, I quite accept what you say, I quite see that you would not be able to do anything about a great deal of what you found', and here I must quote him correctly, 'but', he said, 'I think nowadays almost anything that engenders optimism in the practice of medicine is justifiable'. Now that is a good point. I think a lot of us rather unconsciously and certainly without formulating our ideas in the clear way that he did, think about this subject in that frame of mind. This is very dangerous, for it is a subject which requires the maximum amount of objectivity.

Dr Harvard Davis: I think Professor Scarborough is quite right, but in deference to the profession it must be said that in many cases we are being pushed by politicians and the public, faster than we want to go. If it was left to us we would not go as fast as we are doing.

Dr Wade (*Monmouthshire*): This is really a supplement to the first question. Although it has not been proved that cervical smear tests reduce mortality, what is the ethical position when one feels convinced that the individual is benefitting? Although I have not done many of them I have already picked up one positive in the very early stages, and I feel sure that this case would not have been detected for a considerable time, as she was not a regular attender. She just came up for postnatal examination, and I feel that by the time she would have complained of

symptoms she would have been in a fairly advanced state of carcinoma of the cervix. I would like to ask male doctors whether they would have their wives screened. I feel that they probably would. Even if they are not convinced that the population as a whole would benefit, they would probably feel that the individual patient would benefit.

Dr Colville: My wife is secretary of the Yorkshire Medical Women's Federation; they have discussed this and a majority say that they would not have it. You are assuming that it is a pre-invasive condition and this is what we have no proof about, if you had followed the case up by colposcopy and not by scraping which is dangerous, I suggest you would have seen it disappear.

Dr G. W. Clarke (*Glamorgan*): Whilst we are on the subject of cervical screening, has anyone ever considered the possible dangers of therapy? I am painfully aware of a case where a very minor blemish was found on cervical screening which resulted in death following radiotherapy. This is a thing to consider. There is no doubt at all that the case was gone into perfectly and on the strength of a possible carcinoma *in situ* a life was lost. This is something we must consider.

Dr Levitt (*Marylebone*): We have 12 patients under the age of 21 in Marylebone with carcinoma of the cervix; this has been confirmed at the Samaritan Hospital. The fact that the Yorkshire Women's Federation have turned down something is interesting but not relevant; the fact that somebody might have died after cervical scraping is tragic but not relevant, crossing the road is just as dangerous, and you might even swallow a fish bone.

Dr Wilson: I think that cervical cytology will go very much in the direction that Dr Wade was indicating, that as we learn more and as the services for it develop, we must try and concentrate on populations at the very highest risk. This also partly answers the question of the individual tragedy of a person who dies under anaesthetic or whatever it is, under some diagnostic or therapeutic procedure. One of our problems at the Ministry is that we must try and find the means of approaching the population at highest risk which, as has already been pointed out, are women of high multiparity and certainly older women, though quite a lot of cases occur in younger women of lower social class at an early age of marriage. It seems that general practice with attached ancillary workers is the ideal way of approaching this population; as this type of practice grows and group practices and health centre practices increase, it would be much more feasible to provide a really hard hitting service.

Dr Donaldson: We have used such tests for diabetes and we estimate that something like half of the packets taken were used. In a town not so very far from us the medical officer of health put clinistix in the public conveniences. I think this is going a bit too far and my own opinion is that self-testing is of limited value. I believe that we should try to introduce screening into health centres; too much time has been spent in planning the size of rooms, rents, and so on, with not enough time for the type of activity that can go on in health centres. This I think is what we are trying to do.