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Carry on screening

The vogue for screening tests, driven by powerful commercial and political forces, is having an increasingly malign influence on our patients' health (as well as imposing a growing burden on our surgeries).

In recent weeks, two patients have presented me with the results of some of the latest screening initiatives in the private sector. One had paid around £3000 for the 'ultimate check-up'.[1] In addition to consultation and examination, the check-up included 'over 40' blood and urine tests, audiometry, ECG and spirometry, and ultrasound examinations of all internal organs. It culminated in a 'virtual tour' of the body using MRI images, and offered a DVD 'to take away, including a video of your beating heart', perhaps to enable the anxious patient to convince himself that he was still alive — or to show his significant other that the metaphoric source of romantic devotion was in good physiological order. At a special discount, MRI colonoscopy was available as an extra, although it was not clear whether the take-home DVD would include a tour up the customer's own rectum — an appropriate image of post-modern narcissism (and perhaps an entertaining addition to the family website).

Another patient had received a mail-shot from an enterprising company offering — at a mere £129 — ultrasound examinations of carotid arteries, the abdominal aorta, peripheral arteries and bones (for osteoporosis).[2] The letter invited customers to a local community centre, reassuring them that 'all four tests can be performed in less than an hour and you only have to take your shoes and socks off!'. While clients undergoing the 'ultimate check-up' are offered a 10% discount for bringing along a friend or relative, those at the lower end of the market are simply exhorted to 'tell a friend or loved one — you may just save a life'.

Although all these tests, with the exception of screening for abdominal aortic aneurysms in men over 65 years, have been rejected by national screening authorities, they are being informally 'rolled out' in this way around the country. While turning screening into a sort of recreational activity, these tests are likely to generate high levels of anxiety (especially from false-positive results) and further morbidity (from over-investigation and over-treatment). It is not at all reassuring to learn that the promoters 'always encourage you to discuss any findings with your GP'.

The popular appeal of screening tests in an anxious age results from the inflation to mythical status of the commonsensical notion that early detection leads to a more favourable outcome. But this is only true if early treatment is effective: this has not been demonstrated, for example, in relation to prostate cancer or in the case of atheromatous carotid arteries. There is a related presumption that late presentation is a common factor resulting in a rapid demise, particularly from cancer, but again, this has to be substantiated, especially when it may be the case that delays and inadequacies in treatment are a more important problem. Although it remains contentious, the popularity of the conviction that early diagnosis of cancer means better prognosis nurtures a climate of blame: patients blame themselves, family members blame patients, and everybody blames doctors for failing to recognise or diagnose malignancy before it becomes readily apparent.

The popularity of commercial scans and tests has increased the pressure on the NHS to provide similar procedures, resulting in the introduction of the 'MOT at 40' promised by the minister of health.[3] It is already clear that this will be considered a big disappointment. Patients whose friends and family members have had combined ultrasound scans or comprehensive Bupa medicals — never mind those who have had the 'ultimate check-up' — will feel grossly short-changed when they are offered meagre checks of height, weight and blood pressure and tests of blood glucose and cholesterol and sent on their way (perhaps without even seeing a doctor or nurse). The focus groups will soon relay popular dissatisfaction back to Westminster and it will be only a matter of time before extended surgery hours are devoted to providing MRI virtual body tours.

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Top Tips in 2 minutes

The Department of Health has chosen the bivalent vaccine Cervarix™ for its national vaccination programme in England. Although this will protect against human papilloma virus (HPV) 16 and 18, which cause 70% of cervical cancers, it will offer no protection against genital warts. In 2006, there were 83 745 new diagnoses of genital warts (first episode) and 44 655 recurrent episodes in patients attending departments of genitourinary medicine in England, Wales, and Scotland.[1] In addition to the financial implications of treating patients with ano-genital warts, estimated at £22.4 million in 2003, the psychological impact of the disease should not be underestimated.

HPV is the commonest sexually transmitted viral infection in the developed world and of the almost 200 types of HPV; about 40 infect the ano-genital tract.[2] 'Low risk' types, such as HPV 6 and 11, cause genital warts and minor cervical cellular abnormalities (for example, borderline changes or mild dyskaryosis on cytology) whereas 'high-risk' types, such as HPV 16 and 18, may cause high-grade dysplasia (intraepithelial neoplasia) and cancer of the cervix, vulva, vagina, penis, and anus. Approximately 80% of sexually active individuals will at some time become infected with HPV. Most HPV infection is subclinical, producing no signs or symptoms and studies of cervical infection show that about 80% of women clear the virus within 2 years of infection.[3]

Approximately two-thirds of people exposed to HPV 6 or 11 will develop genital warts, most commonly within a few months of exposure, although occasionally the incubation period can be much longer. The treatment of genital warts should be determined by taking into consideration wart type (keratinised/non-keratinised), site, number and patient preference. For example, multiple non-keratinised warts may be suitable for self-applied podophyllotoxin or imiquimod (the latter is more expensive — *British National Formulary* prices: approximately £15 & £51 respectively), whereas larger keratinised lesions are best approached by cryotherapy or excision/diathermy (requires local

Top Tips in 2 minutes: human papilloma virus (HPV) vaccines.

Why:	Cervical cancer kills just over 1000 women every year in the UK. It is the second most common cancer of women worldwide. • Infection with one of 15 high-risk human papilloma viruses (HPVs) is the main cause. Two types, HPV 16 and HPV 18, cause more than 70% of carcinoma of the cervix. HPV 6 and 11 cause genital warts, the commonest sexually transmitted viral infection in the UK. • HPV infection is extremely common in young sexually active women. One study showed that it affected 20% of 20–25 year old women.[4] Ninety-three per cent of women attending one STD clinic had at least one type of HPV antibody. • It has been estimated that 40% of 15 year olds in England have had sexual intercourse. For effective prophylaxis vaccination should occur before the onset of sexual activity.
How:	• Two HPV prophylactic vaccines have been developed. These are Cervarix™ a bivalent HPV 16/18 vaccine and Gardasil™ a quadrivalent HPV 16/18/6/11 vaccine. Three doses are needed over a 6-month period. The bivalent vaccine Cervarix has been chosen for the national vaccination programme. • It is VITAL that women appreciate that they must have cervical smears as part of the cervical cancer screening programme whether they have been immunised or not. This is because the vaccine will protect against the 70% of cancers caused by HPV 16 and 18 but not the 30% caused by other HPVs. UK Joint Committee on Vaccination and Immunisation (JCVI) recommended the routine vaccination of girls aged 12–13 years of age starting from September 2008: • there will be a 2-year catch-up programme starting Autumn 2009 for girls up to 18 years; • girls aged 16–18 years will be offered the vaccine from Autumn 2009; and • girls aged 15–17 years will be offered the vaccine from Autumn 2010.
What next and when:	Take home messages from the randomised controlled trials of HPV vaccines over 6 years: • They are effective in preventing HPV infection. • Protective antibodies are found in >98% of patients. • Antibody titres are greater than occur in natural infection. • They are safe with few side effects. Thirteen million doses have been administered worldwide. • The duration of protection is at least 6 years and there are indications that it is likely to be much longer. Follow-up studies are taking place to establish whether a booster dose will be needed • There is no data as yet on vaccine efficiency in women aged >26 years. • The Joint Committee on Vaccination and Immunisation acknowledge that a catch-up programme for all women aged 18–25 years is unlikely to be cost-effective but could benefit some individual women. The Department of Health is considering this further. • It has been recommended that vaccination should be given through schools. • No decision has yet been made as to which of the 2 vaccines will be used.
Patient information	http://www.patient.co.uk/showdoc/27001148/ on STIs and anogenital warts.
References/Web links:	http://www.immunisation.nhs.uk http://www.bashh.org British Association for Sexual Health and HIV (BASHH) More top tips can be found at http://www.addenbrookes-pgmc.org.uk/handouts.asp?title=Primary%20Care
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anaesthetic, preferably post-application of EMLA® cream). Perianal warts are not necessarily acquired by anal intercourse and are not infrequently misdiagnosed as hemorrhoids (usually in cases where an examination has not been performed). Women with genital warts do not require more frequent cervical cytology and colposcopy is only recommended in women with abnormal cytology (as per NHS Cervical Screening Programme) or with cervical lesions of diagnostic uncertainty or clinical concern.

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