Increased incidence of cervical cytological abnormalities in women with genital warts

I was interested to read the study by Rowen et al1 showing a higher rate of smear abnormalities in women with or contacts of genital warts. Their observations agree with my own (Griffiths M, MD thesis, University of London), where I found abnormal smears in 28% of women with warts and only 9% of controls. Both studies effectively repeat the findings of Franceschi and colleagues2 who found an excess of abnormal smears (largely of "superficial dyskaryosis") in women with warts compared with other STD clinic attenders, though a review of their paper demonstrates that high grade abnormalities were more common in controls.

However, we have shown no difference in the risk of cervical epithelial disease between the two groups,3 when judged by colposcopy and histology. We hypothesised that the reason for this apparent discrepancy might, at least in part, be due to more cautious examination and reporting of smears coming from women known to have warts, resulting in a relative over-reporting of (particularly minor) abnormalities by cytologists. This hypothesis was supported by the findings of a pilot study in which smears from women with warts were sent to cytology with clinical details of either "warts" or "routine" according to whether one or the other had been recorded. The specimens showed an excess of "abnormal" smears among "warts" patients but this difference just failed to reach statistical significance owing to sample size.

I believe that cytologists are more likely to report abnormal smears if the clinical information given refers to a history of warts, and therefore would be interested to know whether this was the case in this particular study which was blind to clinical information concerning the patients' history of warts.

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Rowen et al reply:
The letters from Drs Griffiths, Evans and Bell concerning our recent paper are read with interest and raise some points which merit discussion. In our study the screeners were aware of clinical details. It is of course possible to over-report smears. However, we do not feel that significant numbers are over reported as several safeguards are in place to prevent this. Firstly, a relatively junior screener cannot sign a smear report without the smear being reviewed by a senior screener. Secondly, a senior deemed to show mild dyskaryosis must be reviewed by a pathologist. Thirdly, follow-up smears from women with borderline abnormalities on previous smears are screened by a senior MLSO. If any abnormality is found on that smear, it and the previous smear are then reviewed by the cytopathologist. Furthermore, if there were significant over reporting one might suspect that the "current smear normal, previous smear abnormal" group in our study would be larger than we found. Dr Griffiths's results from his pilot study in which screeners were blinded to the real clinical details are of interest. There may or may not be an excess of smears reported as abnormal in the "warts" group. However, his conclusion that the failure to demonstrate a statistically significant difference in rates of smears reported as abnormal in the two groups was simply due to sample size cannot be justified at this stage. If a full scale study, with sufficient numbers in each group subsequently demonstrates a significant difference in rates, then one may draw the conclusion that the pilot study failed to demonstrate significant differences because of sample sizes.


With regard to the points raised by Drs Evans and Bell, patients attending our clinic are offered cervical cytology if (a) they have not had a smear within the last 3 years or (b) they or their sexual partners have genital warts and they have not had a smear within one year. The 185 women in the study were drawn from 191 women having smears during the study period. No patients declined to answer the life-style questions, but six patients, all from the warts/warts contact group, were not available for colposcopy appointments as they were about to leave the area and thus were not included in the study.

All patients in the study with abnormal smears, except two, who defaulted from follow up, were colposcopied, as were all, except 3 from the warts/warts contact group who had normal smears.

Table 3 in the paper should have been headed "Abnormal cytology results compared with colposcopy results" and "Biopsy proven CIN". Thus the NO CIN column represents those whose biopsies were negative and those who had a normal colposcopy. We therefore have attempted to resolve the confusion this may have caused.

The small number of women with abnormal smears but no history of genital warts or contact with warts, we would agree that there was a high rate of CI N. They did however differ from other groups by virtue of having significantly more sexual partners and it is possible some may have been infected with HIV without developing warts. What is not known is the natural history of sub-clinical HIV infection and whether such lesions ultimately develop into frank warts. The lesions are not then considered to be sub-clinical lesions as are also associated with abnormal cytology in the absence of warts.

We also agree that we did not find a significant incidence of CIN in the warts/warts contact groups, a point alluded to in the discussion. We did find differences in rates of cytological abnormalities between the warts/warts contact group and the non warts/warts group, and forward the notion that these abnormalities may be the result of an acute reaction to HIV infection which had settled by the time colposcopy was performed.

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We read with great interest Dr Rowen et al's paper examining the need for increased cytological vigilance in women with genital warts or contact with genital warts, and agree that this group should also be offered colposcopic examination of the cervix irrespective of their cervical cytology result. Our results and experience are in agreement with the conclusions. We present figures from our department on women with genital warts and negative cytology. In the period May 1987 to June 1988, 248 women with genital warts and 14% were attending the genitourinary medicine out-patient clinic, Royal Liverpool University Hospital