Matters arising

There are a number of small points in respect of the data they present which require clarification: the indications for taking a cervical smear are actually not given and it is not clear whether the 185 patients represent the total number smeared over the 5 month period of study. It is really quite impractical to know who was invited to participate and who declined.

The proportion of abnormal smears was much lower in the non-wart group (7 of 53) than in the wart group (52 of 117). However, the wart group is twice the size of the non-wart group, which may not be representative of women patients as a whole.

Although it is clearly stated that 59 patients had a cervical biopsy, it is less clear how many were colposcopied. Surely some patients with abnormal smears showed no abnormality on colposcopy and therefore did not have a biopsy. If these patients are included in table 3, it is not clear from the legend, but 65 (117–52) patients seem to have gone missing.

While the authors' conclusions appear valid from the data presented, the relevance of mildly abnormal smears is called into question. Their biopsy results show that cervical intra-epithelial neoplasia (CIN) was present in 30% (13 of 43) of patients with warts. However, in 11% (1 of 9) of patients in contact with warts, but in 43% (3 of 7) of patients without warts or wart contact. From this it could well be concluded that genital warts are not related to CIN.

With regard to the points raised by Drs Evans and Kell. 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 offered the colposcopy appointment 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, were definitely colposcoped, as were all, except 3 from the warts/warts contact group who had normal smears.

Increased incidence of cervical cytological abnormalities in women with genital warts

I was interested to read the study by Rowen et al 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 who were in contact and only 9% of controls. Both studies effectively repeat the findings of Franceschi and colleagues 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, 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 relatively 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 the clinician’s preference. The study 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 the cytologist in this particular study 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 Kell 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 screen an abnormal report without the smear being reviewed by a senior screener. Secondly, a screams 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' 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.

Increased evidence of cervical cytological abnormalities in women with genital warts

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 authors conclusion. We present data 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 122 who were attending the genitourinary medicine out-patient clinic, Royal Liverpool University Hospital...
had negative cervical cytology. At colposcopic examination, 122 of these women had abnormal cervical histology (table).

Overall, there was a 23.6% false negative cytology rate, with 34 (13.3%) women having major cervical pathology (CIN 2 + 3). These women’s pathology would have gone undetected if colposcopy had not been performed.

We feel that our results strengthen the argument for colposcopic examination of women with genital warts. Within the 60 genitourinary medicine clinics who have colposcopy facilities in England and Wales, 31 clinics routinely colscope women with genital warts, four those with only cervical warts and 21 those women who have been in contact with genital warts, irrespective of their cervical cytology. A recent survey of colposcopy services in the UK, carried out by the British Society of Colposcopy and Cervical Pathology, did not mention genital warts as being an indication for colposcopy.

Summary

If national guidelines are to be established for colposcopy within both genitourinary medicine and gynaecology, then there must be discussion and co-operation between the two disciplines. The national co-ordination network has held workshops addressing these issues, and guidelines may be issued in the near future.

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1. Rowen D, Carne CA, Sonnek C, Cooper P. "Increased evidence of cervical cytological abnormalities in women with genital warts or contact with genital warts: the need for increased vigilance?" Genitourin Med 1991; 67: 460-3.

Anglo-French MSUVD Autumn Meeting

Strasbourg 2-4 October 1992

Themes: HIV, HPV, Male and Female Genital Tract Infection, New Diagnostics.

Information: Dr M A Waugh, General Infirmary, Leeds, LS1 3EX, UK

Secretariat: Tel: 0532 437162
Fax: 0532 441165

Dermatology Course 1992 for trainees/consultants in Genitourinary Medicine & Allied Specialties. Approved by the British Postgraduate Medical Federation under section HM 67/27. A full day lecture course to be held at The Royal London Hospital, Whitechapel, London E1 1BB on 8 May 1992

From 1992 in order to comply with existing EEC training programmes for Dermatovenereologists, and the EC directive 75/363 EEC, Genitourinary Physicians in the UK require adequate training in dermatology. This course will provide an up-to-date overview of common general and genital dermatoses.

Topics include: Erythrasmaqous & Follicular Disorders, Cutaneous Infections, Pigmented Lesions, Non-Pigmented Skin Cancers, Genital Dermatoses, Pre-malignant & Malignant Lesions of the Genitalia, Skin Manifestations of HIV/AIDS, Skin Manifestations of Systemic Diseases, Practical Techniques in Dermatology.

Speakers include: Professor E Wilson-Jones (Emeritus Professor in Dermatology, University of London), Dr C M Ridley (Royal Northern & Whittington Hospitals), Dr G Levene (Middlesex & University College Hospitals & St John’s Hospital for