Opportunistic cervical cytology screening in a genitourinary medicine department: is it worthwhile?

It is generally agreed that the patient population attending genitourinary medicine (GUM) clinics are more active sexually and are more mobile than the general population. As most GUM clinics perform opportunistic cervical screening, this study was carried out to establish whether screening in our clinic would significantly increase the detection rate of dyskaryosis and also to establish the need for a prospective study to justify the financial and manpower implications of an opportunistic screening programme.

Case notes of 200 new clinic attenders were reviewed for details of cervical cytology at our clinic and these were compared with previous cytology, if any, taken elsewhere. Each patient was screened for other sexually transmitted diseases. The following details were also noted on a proforma: age of the patient, smoking habit, method of contraception practiced, coitarche, and previous history of sexually transmitted diseases.

The average age of the patients was 26 years (range 14–62) and the average age of coitarche was 17 years (range 13–23). No statistically significant differences could be detected between the various kinds of contraception used, smoking or coitarche and the result of the smears.

Of the 200 patients screened in our clinic, 75 (37.5%) showed cytological abnormalities: inflammatory lesions in 21, borderline changes in 10, mild dyskaryosis in 32, moderate dyskaryosis in six and severe dyskaryosis in six patients. Sixteen patients (8%) with mild to moderate dyskaryosis were less than 20 years of age. Two further patients (14 years and 16 years of age) in this age group showed evidence of severe dyskaryosis with the GUM cytology being their index cytological examination. Sixty one (81%) patients with abnormal cytology had an associated STD. HPV infection was seen in more than 50% (32) patients. Of the 152 (76%) patients who had cytology done elsewhere previous to GUM attendance, 112 (73.7%) had cytology reported as normal, 15 as abnormal and in 25 patients the results were unavailable. The abnormalities encountered were inflammatory changes in six, borderline changes in two, mild dyskaryosis in six and herpes virus in one patient. Of the 112 patients, 39 with normal previous cytology had abnormal GUM cytology. Seven patients with abnormal previous cytology continued to have abnormalities when tested again. The cytological conversion took less than six months in 10 patients, between one and two years in 22 patients and over three years in four patients.

Forty eight patients had never had a cervical smear before this attendance. GUM cytology was normal in 16 of these, abnormal in 29 and inadequate in three patients. The abnormalities were inflammatory lesions in three, borderline changes in five, mild dyskaryosis in 16, moderate dyskaryosis in one and severe dyskaryosis in four patients.

Our study shows the high incidence of cervical cytological abnormalities encountered during opportunistic screening in a GUM clinic. This is most likely a true representation of the incidence of dyskaryosis in GUM clinics rather than a cytological diagnostic bias and therefore underlines the need for screening. Since the introduction of cervical screening in the UK, various strategies have been implemented to achieve a coordinated and standardised programme. One study in the Paddington and North Kensington districts published in 1987 evaluated the outcome of three yearly screening as opposed to five yearly screening recommended by the Department of Health and discouraged opportunistic screening except where there was a clinical indication for doing so. Whilst this improved their CIN detection rate, and reduced the number of cytology/smears screened, this did not include opportunistic screening in GUM clinics.

In 1988 the Department of Health and Social Security (UK) instructed all health authorities to introduce a computerised call and recall system into the existing cervical cytology screening programme based on the existing computerised database held by the Family Practitioners Committee (now known as the FHSA). Eighty eight percent of the health authorities had implemented a scheme by the target date of April 1988. However, it was as early as 1989 that non-attendance was being reported as a problem by 44% of districts. Well documented deficiencies have been displayed nationally in the system by Holland et al calling for a reorientation of the service and in a recent study by Amery et al the problems districts face in managing an effective call/recall system have been aptly described.

As the present system does not differentiate between various risk levels, we still have to achieve an effective screening service that is, an accurate, continually updated computerised database which will enable the right target population to be invited for screening and follow-up. The department of GUM has a unique opportunity to screen what is considered an "at risk" population who are
usually not on the national recall system and who appear to be at increased risk of cervical abnormalities due to the presence of sexually transmitted infections such as genital warts which are known to be linked with cervical dysplasia. A large age matched, controlled, prospective study is, however, needed to validate the impression that women attending STD clinics are a “high risk” group for cervical cytological abnormalities and that the abnormalities detected are clinically significant to warrant a policy of opportunistic screening.

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Establishing a satellite genitourinary medicine clinic

In urban areas a single genitourinary medicine (GUM) clinic may serve a large population. In rural areas with a low population density, smaller local clinics may be required because otherwise patients may be unable to attend an appropriate clinic. In April 1992 we set up a satellite clinic at a health centre in the centre of the English Lake District as an adjunct to a larger clinic located at a hospital 15 miles away. Travel between these locations by public transport is very difficult, and many young people do not have a car. The locality includes many hotels and restaurants and an establishment for higher education. The local general practitioners (GPs) supported the initiative.

Two good clinical rooms and a suitable patient waiting area were available at the health centre for a clinic session of an hour’s duration once every two weeks. The clinic was discretely signposted. The clinic times were advertised to local GPs and at selected sites such as the educational establishment and at staff residences in the hospital. GUM consultant and health adviser from the hospital were assisted by the surgery practice nurse and one of the local GPs who provided much helpful local knowledge. No receptionist was necessary. Case notes were stored at the hospital clinic and current notes were transported to the satellite clinic.

We aimed to keep tests and treatment simple because patients requiring complicated tests and treatments could be referred easily to the hospital clinic. Wet microscopy of vaginal preparations was performed using a portable microscope taken to the clinic but we managed without gram-staining slides. Identification of gonorrhoea, chlamydia and herpes virus was undertaken using suitable transport media. Serological tests for syphilis, hepatitis B and HIV were available. All specimens were taken to the hospital laboratory immediately after the clinic, and results were directed to the hospital clinic to ensure that confidential reports did not get lost in the surgery’s mail. A small stock of standard medicines was taken to the the clinic. Genital warts were treated with applications of TCA and podophyllum.

In the first year, 28 clinics of one hour were held and there were 123 attendances, including 63 new patients. No cases of syphilis, gonorrhoea or HIV infection were detected. There were six cases of chlamydia and eight patients were treated for non-specific urethritis or epidemiologically for non-specific urethritis or chlamydia. There were 23 cases of genital warts, three cases of primary genital herpes, 12 of candida and seven of bacterial vaginosis. After pre-test discussion with the health adviser 50 patients were tested for HIV. Almost all patients belonged to the target population of young sexually active people, and several commented on the convenience of attending a local clinic. One patient attending regularly for wart treatment pointed out that she could tell her employer that she was popping out to the doctors for ten minutes, whereas a trip to the hospital clinic would have required an explanation for a half-day absence. No problems were encountered in providing a GUM service within a GP surgery setting. Attendance for follow-up visits was good and contact tracing success was excellent. Towards the end of the year a further satellite clinic was established at another location and we now provide a satellite clinic session each week, alternating between the two sites.

In conclusion, the satellite clinic provided an effective low-cost addition to the main hospital clinic in controlling sexually transmitted diseases. The success depended upon favourable features of the locality, including the support of staff at the only major health centre in the area, and the involvement of an experienced GUM doctor and health adviser who were able to maintain standards of practice similar to those at a hospital department of GUM. Without these features, a GUM clinic in a GP surgery might not exert a beneficial effect on public health.

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