

NHS

Cancer Screening Programmes

Reducing the risk

Cervical Screening Programme 2000



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Foreword



The NHS Cervical Screening Programme (NHSCSP) continues to be a great success. More lives are being saved and it is estimated that the incidence of cervical cancer has fallen by 42% between 1988 and 1997. It is thought that this fall can be attributed to screening. These achievements are largely due to the dedication of the programme's staff throughout the country.

With the announcement of the NHS Plan and NHS Cancer Plan, this is an exciting time for all involved in the NHSCSP. The Programme is constantly striving to improve the service offered to women and monitoring the development of new technologies which could be used to achieve this. Liquid Based Cytology (LBC) could potentially improve the quality and readability of slides, which could reduce the number of false negatives and unsatisfactory smears. The Human Papilloma Virus (HPV) has been found to be present in nearly 100% of cervical cancers. It has been proposed that using HPV testing as triage in the management of women with mild or borderline smear results could improve the service offered to women. Both technologies will be evaluated together in a pilot starting in Spring 2001.

It is extremely important for women to receive accurate information about the programme so that they are aware of both the benefits and the limitations. New action to help inform the public and promote informed consent was announced in the NHS Cancer Plan. It was pledged that all women should receive with their invitation a

national information leaflet on cervical screening by 2001. All women should also receive results of their smear test in writing by 2001.

The Government would like to thank all the staff involved in the programme for their hard work. Without their effort and dedication, the programme would not have been the success that it is and I feel confident that they are capable of meeting the new challenges ahead. In the future, the combination of the expertise and commitment of staff, together with the harnessing of new technology, should ensure the programme continues to provide an excellent service and prevents more women developing and dying of cervical cancer.

A handwritten signature in blue ink, appearing to read 'Yvette Cooper'.

Yvette Cooper
Under-Secretary of State (Commons)

Saving 1,300 lives

The cervical screening programme is saving around 1,300 lives a year and preventing up to 3,900 cancers a year. It is a very successful programme. However, we are always striving to improve our services. This review paints a picture of the current state of activity in the cervical screening programme. The statistics section gives the number of women having smears and an overview of what the results of those smears are. In the text, we describe some of the issues which are current in the programme at the moment.

Since the tremendous expansion in the cervical screening programme a decade ago, coverage of the population by the programme has been relatively stable. However, there is some concern that the numbers of younger women having smears might be dropping slightly. We describe here an initiative in inner-city London specifically aimed at attracting women into the programme as they first become eligible. We also describe an initiative we have developed to enable women with learning disabilities to access the programme in an informed manner since previous research has shown that the programme has been very poor at reaching them.



The figures also show that the number of inadequate smears is growing. It has gone up every year since 1993. A new technique for obtaining cytology slides, liquid based cytology, is about to go to pilot as we go to press. Henry Kitchener from Manchester describes the potential advantages of liquid based cytology, one of which is that it may dramatically cut the number of inadequate smears so that fewer women have to come back for repeat smears.

One thing we are always concerned about is any anxiety created by cervical screening. By using the Human Papilloma Virus (HPV) test, we may be able to reduce the anxiety of an abnormal smear result by sorting out rapidly those women who are at higher risk from those who are, in fact, at very low risk. This will enable us quickly either to refer women for colposcopy or to return them back to routine screening. This will also be a subject of the pilot project.

Once women get to colposcopy, they are still very anxious. Raj Naik of Gateshead describes a scheme in operation in his hospital whereby women are getting the results of their colposcopy examination within hours, rather than days or weeks. This appears to reduce anxiety greatly since 75% of the women can be given the all clear and don't need treatment.

We all know that the health service is under pressure from shortage of staff and the colposcopy service is no exception. Gill Marsh describes her experience of training as a nurse to be a colposcopist. She finds that this offers her the opportunity to give a more complete service to women and often women find that having a nurse carry out their colposcopy rather than a doctor enables them to deal with their anxieties more easily.

Finally, the entire programme is underpinned by a vigorous quality assurance network. Karin Denton, regional quality assurance director from Bristol, describes how her team operates in support of individuals within the programme enabling them constantly to improve on their current service.

The cervical screening programme is very much looking forward to the future. We are piloting liquid based cytology and HPV testing. The picture in colposcopy clinics is also changing as new techniques and new staff grades become available. We are striving constantly to improve our service to women, although the ultimate aim of the service remains the prevention of cervical cancer in women.

A handwritten signature in blue ink that reads "Julietta Patnick".

Julietta Patnick
National Coordinator

Quality assurance helps reinforce high standards

The quality assurance programme for the cervical screening service is now one of the most rigorous in the world and new ways are constantly being looked at to improve its effectiveness.

Karin Denton, one of the senior consultants charged with running the programme, sees it very much as a support mechanism and a resource for the whole screening service, rather than some kind of inspectorate.

Dr Denton is Director of the South West Region Quality Assurance Team, which covers a geographical area stretching west from a line drawn through Cheltenham, Swindon and Bournemouth, right down to the Isles of Scilly. It covers some 1.3 million women in the screening age range.

The Quality Assurance (QA) teams were set up in 1996 to coordinate all aspects of the cervical screening programme – everything from taking the smear, calling and recalling women, the laboratory tests and colposcopy. The thinking was to tie the work together better, both within individual hospitals and areas and between areas, so that good practice could be shared.



Dr Karin Denton

The QA teams also work with cancer registries and health authorities. The core team in the South West consists of 12 people. A lead professional will coordinate with different groups, be it health authority screening commissioners or pathologists. In all over 100 people are linked to the QA team.

Said Dr Denton: "Since the national screening programme started there has been a constant evolution in standards, and each new revised edition of guidance that comes out is more demanding.

"I hope we are perceived as a resource by people at the coalface. Everything we do, we try to do in a supportive way. There's no point in simply rapping someone on the knuckles and saying you are doing this wrong. We want to be in a position to be able to offer help and advice as to how things could be improved."

Dr Denton points out that it is usually lack of resources, rather than any unwillingness to adhere to guidelines that can compromise standards, such as reporting times for results being missed because of staff shortages.

The very existence of QA standards can highlight a wider tension between wanting things done quickly and wanting them done to high standards. But the standards can help units argue for more resources.

Said Dr Denton: "In terms of financial resources the QA teams have been very useful because we have been able to highlight the need for additional resources. But the

biggest problem facing the pathology side of the service at the moment is a lack of manpower. This is a difficult area. "If you apply all the quality standards, it's going to take you longer and if you can't get additional staff, because there aren't any, you are not going to be able to continue doing the work as fast. We have taken the view that the other quality issues have to take precedence over speed."

Dr Denton believes evolving standards and a wider commitment to the ethos of quality assurance means some of the failings of the service in the past could not be repeated.

"The whole ethos has changed – we are looking at a lot more control measures before the smear has even been reported, and a lot more monitoring of the programme as it occurs, rather than retrospectively. With that more closely monitored set up, long-standing problems affecting lots of people shouldn't occur, because problems ought to be picked up much earlier."

One area where Dr Denton would like to see changes is in the public and media perceptions of the QA system, so that it is seen less as a policing service and more as a fire-sprinkler system, detecting and putting out very small fires before they grow.

"There should be praise for picking up small problems at an early stage, not blame. If a QA programme wasn't picking up problems, you would wonder if it was working properly."

"You can't have it both ways in encouraging health care providers to be open about errors and then jumping on them from a great height when they are. When there are very minor glitches, they should be publicised in a way that makes it clear that a problem has been identified and solved, and therefore the QA system is a good thing."

Dr Denton believes the service can be justifiably proud of its QA system. "The whole screening programme is far more vigorous here than in most other countries. I don't think there's any other country that has set up as comprehensive a quality assurance system as we have here, particularly in addressing the multi-disciplinary nature of cervical screening."

Early 20s targeted in inner-city poster campaign

Inner city areas face real difficulties in meeting cervical screening uptake targets. Multiple deprivation, extremely mobile populations and a high percentage of women for whom English is not their first language contribute to the challenge. Encouraging young women to come forward for screening in these areas can be hard.

In the Lambeth, Southwark and Lewisham district of south London, the most reluctant age group to come forward is women aged 20 to 24. So in May 2000, a campaign was launched employing some of the advertising approaches used in pubs and clubs, to encourage young women to come forward for cervical screening.

Dr Alan Maryon Davis, screening commissioner, explains that Lambeth, Southwark and Lewisham, with an overall cervical screening uptake rate of 76%, was one of the few districts in the country failing to meet the 80% guidelines.

A major problem is the very high population turnover, with some GP

registers changing by 40% each year, due to a large population of students and young people in first jobs. While the overall uptake in the district was 76%, the uptake rate in women aged 20-24 was just 50%.

Several initiatives were undertaken to help address the problem, including community development work, and working with GPs and practice nurses to alert them to the needs of the younger age group. A number of educational meetings were held with primary care staff, reminding them that although the chances of cancer in this age group were low, the risk factors, such as sexual activity and smoking, were high.



Second from left Irene Barlow, and fourth from left Dr Alan Maryon Davis.

A publicity campaign was devised, using posters and postcards, similar to those used to advertise in pubs and clubs. Some 6,000 posters and 100,000 postcards were produced at a cost of £25,000, and press and radio interviews were given. The posters and cards feature five young women from different ethnic backgrounds with the slogan "Just Say Yes – Have That Smear Test."

The postcards carried the slogan in 10 non-English languages used in the district, – Albanian, Bengali, Cantonese, French, Polish, Portuguese, Somali, Spanish, Turkish and Vietnamese. The cards were placed in pubs, clubs, restaurants, bars, hairdressers, colleges and other places where young people congregate. The posters were put up in GP surgeries and family planning clinics.

The campaign was carried out with the support and input of screening coordinator Irene Barlow, and the screening team is now analysing figures to get the results of the campaign.

Dr Maryon Davis says that although the hard data on uptake rates in the target age group are not yet in, he is optimistic that the posters and cards and the accompanying publicity have boosted attendance rates.

"We have had a lot of knock-on coverage in the press, not just local papers but in some of the national ethnic minority media. And we've had positive reactions from the professionals such as GPs and practice nurses too.

"A lot of people are interested in this campaign. We have had requests from other parts of the country for the posters, even though they carry the words Lambeth Southwark and Lewisham in small print at the bottom. I think it's encouraging that we've managed to export it so widely."

Dr Maryon Davis points out that an extra barrier to overcome in persuading young women to come forward for cervical screening was the general belief amongst the young in their own immortality, and the perceived long distance away from diseases such as cancer.

"There is evidence that young women tend to regard cervical cancer as someone else's disease. At that age, they don't see themselves as vulnerable. Some young women are quite embarrassed about this sort of thing and worry about whether there will be a female there to take the smear.

"In addition in recent years, there's been concern about whether the test actually works and whether you can rely on it. In telling people it isn't 100% accurate there is a risk that some will say 'why bother then?'"

Dr Maryon Davis adds: "We're confident that this publicity campaign has been worthwhile. It's had a feel good factor about it, which we believe has helped to energise primary care to make a little bit more effort with younger women."



Front of the postcard.

Tackling learning disability barriers to cervical screening

Persuading some groups of women to come forward for screening, for instance those with literacy problems or for whom English is not their first language, is a difficult task. But another group of women, who deserve screening as much as anyone else, but who are often overlooked – women with learning disabilities – can pose an even greater challenge.

Not only does the woman herself need to understand what is involved, but so do her relatives or carers, and often her GP. Through fears that women with learning disabilities will not be capable of making an informed decision for themselves, carers often deny such women the chance even to know about the screening programme.

Although this may be done with the best of intentions, the consequences can be grave. There have been a number of cases of advanced cervical cancer found in unscreened women with learning disabilities which might have been picked up at a treatable or even at the prevention stage if they had been included in the programmes.

There is a new initiative to try to help women with learning disabilities, and their relatives and carers, understand the importance of cervical screening and what it entails. It will also provide staff in the cervical screening programme with new material to help explain the procedures to women with learning disabilities.

Simple leaflets using clear pictures have been produced for the women themselves, together with longer pictorial guidebooks on having a smear for use by staff. The longer pictorial guidebooks can also help carers or relatives to understand and explain what is involved.



Professor Sheila Hollins and Wendy Perez

The leaflets and guidebooks have been drawn up by a multi-disciplinary working party, set up under the auspices of the screening programme to provide guidance on reaching women with learning disabilities. It has been chaired by Professor Sheila Hollins, Professor of Psychiatry of Learning Disability at St George's Hospital Medical School, London.

The working party consisted of smear-takers and colposcopists, radiographers and radiologists, GPs, public health specialists, managers, carers and people with learning disabilities. Two women with learning disabilities who work with Professor Hollins as teachers to medical students and patient advocates, Wendy Perez and Jackie Downer, served on the working party and helped write the leaflets and guidebooks.

The material has just been produced, and there are already suggestions that it could be used for the wider group of "hard to reach" women with poor literacy in English, not just those with learning disabilities.

Professor Hollins is convinced that with the help of the material, and sufficient time, women with learning disabilities can give genuinely informed consent to the procedures.

She said: "When we were first discussing this I felt we were being asked to promise a higher level of informed consent for this group than for the general population. I think if they use the material we have produced, they will be able to give their consent to the procedure.

"I think people with quite severe learning disabilities will be able to give their consent if they are properly prepared and informed – and I want them to be given that opportunity."

Part of the guidance for screening staff includes a description of "behavioural consent" which will help smear-takers to determine if at any time throughout the screening process the woman is withdrawing her consent by her behaviour.

The guidance also includes advice on how to prepare a woman for screening, including suggestions about preparatory visits, and different ways of explaining what is going to happen.

Adds Professor Hollins: "If our guidelines on behavioural consent are used, and people are given time and treated with respect and dignity, then actually they will be able to say if they do or do not want to participate in this."

Professor Hollins pointed out that 2% of all women have a learning disability sufficient that they need considerable support to lead an ordinary life.

"They are already disadvantaged in lots of ways and excluded from many aspects of ordinary life. I think it's quite tragic if a woman dies from untreated, undiagnosed, cancer; perhaps a cancer that is diagnosed at such a late stage that the symptoms are very distressing.

"I think people with learning disabilities have a right to equal access and to as good a health care as every other woman, and they are not going to get that unless they can access the same range of health provision."

Pilots on HPV and LBC could cut repeat smears and colposcopy

A pilot scheme is being set up to see if liquid based cytology and testing for the human papilloma virus can reduce the number of repeat smears, and the number of women with low grade abnormalities being referred on for colposcopy.

Three areas in England will be selected as the sites for this pilot scheme. Professor Henry Kitchener, chairman of the steering group organising the pilot, said both technologies held potential benefits for the screening service and for women themselves, but it was important to quantify the degree of improvement each could bring.

Professor Kitchener stressed that HPV testing was not looking at whether the technology should be used as a primary screening tool, but whether it should be added to the existing process to help reduce uncertainty over the best way to manage borderline and mild abnormal smears.

Professor Kitchener, head of gynaecological oncology at Manchester University, pointed out that in women with borderline and mild abnormal smears, a minority will have underlying high grade lesions which need to be diagnosed and treated. But the majority will have lesions of little significance that will not progress to potentially cancerous changes.

“If we could sort out the women who had high grade abnormalities that require treatment, from the women who could be managed in a much more conservative way, we could minimise unnecessary investigations in the colposcopy clinic.”

“One way in which we could do this would be through HPV testing. The virus is associated with higher grade abnormalities. When women with borderline or mild abnormal smears test negative for HPV there is only a very low risk that they will actually have a high grade abnormality.

“We could use the HPV test to rationalise the management by separating women who are higher risk from women who are at very low risk.

“If the pilots work it may change the policy on the management of women with borderline and mild abnormal smears – with fewer colposcopies needing to be done.”

The hope for liquid based cytology (LBC) is that it may result in fewer inadequate slides which require women to come back for repeat smears. Some studies have suggested that LBC could reduce the proportion of inadequate slides from over 9% to 1%, as well as producing slides which may be easier to read and quicker to process. It may also reduce the number of borderline smears.

In the pilot sites women will be screened by liquid based cytology instead of conventional smear cytology. One advantage of this will be they will not need to return for an HPV test if borderline or mild abnormalities are found, as the HPV analysis can be done using surplus material from the LBC test.

Said Professor Kitchener: “If the patient has a normal smear, she will just be re-screened at the normal time. If she has a high grade smear she will be referred for colposcopy as normal. It is only in the case of a borderline or mild abnormality that there will be a change in policy, which is that an HPV test will be done. If she tests positive, the patient will go for colposcopy immediately; if she tests negative the patient will go into a process of further surveillance.”

It is planned that each pilot site will screen a minimum of 25,000 women. It is hoped evaluation of the LBC results will start in October 2001, and the evaluation of HPV in October 2002, as the women have to be followed for longer. An independent group will evaluate the pilots.



Professor Henry Kitchener

Professor Kitchener said that although there are additional costs associated with LBC technology and HPV testing, particularly staff re-training implications, it is hoped the pilot sites will show that the technologies could be cost-neutral, through reducing colposcopies and the need for repeat smears.

Added Professor Kitchener: “We are not necessarily talking about reducing deaths from cervical cancer in this setting – but we are talking about improving the management of women with borderline and mild abnormal smears. If we can reduce the need for colposcopy, this will reduce the amount of anxiety women will experience. With inadequate smears, this can also lead to anxiety, and it is inconvenient having to return for a repeat smear.”

“A good outcome from the pilots would be a demonstration that LBC, combined with HPV in the event of a borderline or mild abnormality, could result in fewer inadequate smears, fewer borderline smears and fewer women going to colposcopy.”

One stop colposcopy cuts anxiety – and could save money

A one-stop colposcopy clinic can assess and carry out biopsies in a morning, give women the results of their biopsy in just two hours and offer treatment on the spot. Too good to be true? Such a project is up and running in the North East.

New technology means that staff at the Northern Gynaecological Oncology Centre at the Queen Elizabeth Hospital, Gateshead can give biopsy results within hours. And this one-stop approach can drastically reduce anxiety for women who no longer need to wait days or weeks for the results of their colposcopy examination. At the same time, this approach helps eliminate the risk of over-treating mild abnormalities.

Apart from the clear psychological benefits to women, the scheme hopes that by doing away with the need for

return visits for treatment it can eventually save money, although there is an initial outlay for the equipment.

The scheme is being pioneered by consultant gynaecological oncologist Mr Raj Naik, and his colleagues. Said Mr Naik: "We have known for a number of years that the present system for women who are referred with smear abnormalities creates a significant amount of anxiety and is associated with generally poor satisfaction rates with the whole process."

"The main problem with low grade smear abnormalities is having to take a diagnostic biopsy at the first appointment, and then having to wait for that before making a decision on treatment. This, under the normal NHS processing methods, can take three or four weeks and is an extremely worrying time for women.

Mr Naik explained that the one-stop scheme had become possible through the development of a new microwave processing technique, which can assess the small punch biopsies within 30 minutes.

Women are told in advance that there will be a two hour wait for the one-stop process, and advised to bring something to read while they wait. Some pop out to do some shopping, before returning for the results.

"Up to now, nearly every single patient has chosen to be managed by the one-stop process. We are auditing every patient we see. Women who have had to return to work have phoned two hours later for their results, or we have called them. It's tremendously reassuring to be able to give women their results on the same day."

The microwave machine costs £25,000, and the scheme is to be assessed by a health economist, commissioned by the national cervical screening programme to look at its cost-effectiveness.

"We hope the study will show that in the long-run, by eliminating the second appointment, it saves money, although this has not yet been proven.

The scheme has been in place for some 18 months, and around 300 patients have been through it. The audit of the patients has shown that about 25% of women with low grade smear changes have been found to have high grade CIN needing treatment.

"Those 25% of women are informed of the result after two hours, and the treatment can be carried out there and then, and it's over and done with. They don't need to attend the clinic again.

"The satisfaction is not just for the group that need treatment, but also for the larger group, that 75% who don't need treatment and can be told at that first appointment."



Mr Raj Naik

Initial costs aside, Mr Naik believes the scheme could be easily rolled out across the country, although clinics do have to be reorganised so women can be seen early in the morning, and much closer co-operation and liaison is needed with pathology departments. It was the pathology department at the Queen Elizabeth who first recognised the machine's potential and told Mr Naik about it.

"We believe there is just cause for the initial investment, and the reorganisation of clinics and pathology departments.

"Advantages for the patients are clear, and health professionals are reassured that we are not only treating pre-cancerous changes, but we are doing it in a manner that is more acceptable for the patient.

"A secondary advantage is that those clinicians who make a decision on treatment at first appointment without taking a diagnostic biopsy, are going to be over-treating women. They will be treating some women who don't need it, and there are cost and patient implications from this. This scheme should help to address this problem."

Mr Naik added: "We are quite convinced this new process is an advance, and we would like to see it being offered to women outside the Gateshead area."

Nurse colposcopy helps patients, doctors and the screening programme

When Gill Marsh was offered the chance to train as a nurse colposcopist four years ago, she jumped at it. As a colposcopy clinic nurse and manager of the unit, Gill had gained a considerable degree of knowledge about what abnormal smears look like on the cervix. And although she did a lot of counselling, she never did any hands-on colposcopy. "There were times" said Gill, "when I thought 'I could do that.'"

So she did. Gill, who works at the Women's Centre at the John Radcliffe Hospital, Oxford, now provides a full service for women including treatment. Gill took advantage of a scheme to train nurses as colposcopists, which local consultants and her Trust were keen to support. Although she doesn't run a regular session on her own, she provides locum cover for the other colposcopists if they are away on holiday, study or sick leave, or if extra clinics are needed.

The unit has six other male colposcopists, and it works out that Gill carries out more colposcopies than most of the doctors in the unit – around 200 a year. The only restriction on Gill's practice is that she can't refer on to other departments, and doesn't request ultra-sound scans. "If there's something outside normal colposcopy work I refer it on to the consultant, but otherwise I see and treat the patients in the same way as all the other colposcopists."



Gill Marsh

Gill points out that there can be psychological benefits to patients from having a nurse colposcopist, apart from specific requests from some women to see a female practitioner, perhaps for religious or ethnic reasons.

"Many women find it easier to talk to a nurse than a doctor. Some might even be reassured by having a nurse do the procedure – they think 'If a nurse can do it, it can't be serious.'"

"They tend to think of nurses as more approachable, more on their level, and they are not frightened to ask questions of a nurse, whereas sometimes they feel they are taking up a doctor's time with silly questions."

Although there was some initial trepidation about the concept of a nurse colposcopist, more from junior doctors than consultants, Gill explained that once she had demonstrated her abilities such attitudes quickly vanished. She has now been asked by specialist registrars if she will train them.

At times when Gill is not a hands on colposcopist she covers for the nurses as a clinic nurse, sometimes covers for the secretaries, carries out telephone counselling of patients, gives the results out to patients, audits the data, runs a smear clinic once a week, teaches and lectures.

"It's a smashing job! I can do anybody's job who works here, and I can see any patient who walks through the door. I can see them right through the process from start to finish."

"You can counsel them before they arrive, book them in, see them, treat them, follow them up and discharge them. It feels like providing a complete service. Taking on the colposcopy role has made the job richer."

One aspect that has struck Gill since becoming a colposcopist is that it has increased her respect for the work of the nurses.

"It increased my perception of how important the nurse is by the patient's side, because the colposcopist is concentrating on the view down the colposcope and doesn't see the woman's face when doing the job. You rely on that nurse to forewarn you of any problems or that the woman is not yet ready for the procedure. The extra training not only made me into a colposcopist, it made me much more understanding of the impact the nurse has."

Gill believes there is a wish amongst many nurses to take the extra training, although it can still be a struggle in some areas to persuade Trusts of the value of the post. "As more nurses have done it, and there are clear guidelines as to how nurses are trained, it has become easier. It's still fairly new, but it isn't innovative practice any more."

"From our point of view here in Oxford it has benefited the doctors, because they don't have to arrange their own locums; it's helped things like waiting times because clinics aren't cancelled if someone is sick; it's also meant that if a woman turns up and particularly wants to see a female we have an alternative. It's been very positive."

Statistics

These figures show a picture of a developing cervical screening programme over the last three years. Some figures are relatively stable, such as the number of women having smears with only a slight decrease in the numbers and in the percentage coverage of the population. The percentage of abnormal smears continues a slight trend upwards, while for the first time we see a decrease in those smears that indicate a potential glandular abnormality or a potential invasive cancer. This is a sign of the beginnings of maturity within the screening programme.

The percentage of inadequate smears has risen every year since 1993 and this year is no exception with a rise from 9.3% last year to 9.8% this year. While we see an increase in the number of inadequate smears in every age group, it is particularly pronounced in the younger women who also have a higher proportion of infections which is the major cause of an inadequate smear.

The trend in falling numbers of teenagers being screened is seen again and is most welcome. Since girls of this age are extremely unlikely to develop cervical cancer, the risk of complications from treatment outweighs any benefits of screening them.

For the first time this year we have included in this review some data about the outcome for women whom we refer for colposcopy. It also shows that the programme is diagnosing some cancers, although the objective of cervical screening is to prevent cancer developing, not to find it once it has already developed. However, most of the cancers found through the screening programme will be very early cancers which can be treated with relative ease for the woman and which have a very good outlook.

Thanks are due to all the health authority and laboratory staff who have input the data to generate the statistics. Thanks are also due to the statistics team at the Department of Health who undertake the analysis for the Programme. Finally thanks are given to all the regional quality assurance teams who have put a major effort into checking and validating all the returns.

Table 1

Coverage of screening: Women aged 25-64

The proportion of women, aged 25-64, who have been screened (coverage) has been relatively stable now for a number of years. Women in England should receive an invitation for screening every three to five years and coverage is calculated here at both the three year interval and at five years. The target is that at least 80% of women aged 25 to 64 should have had a smear within the previous five years.

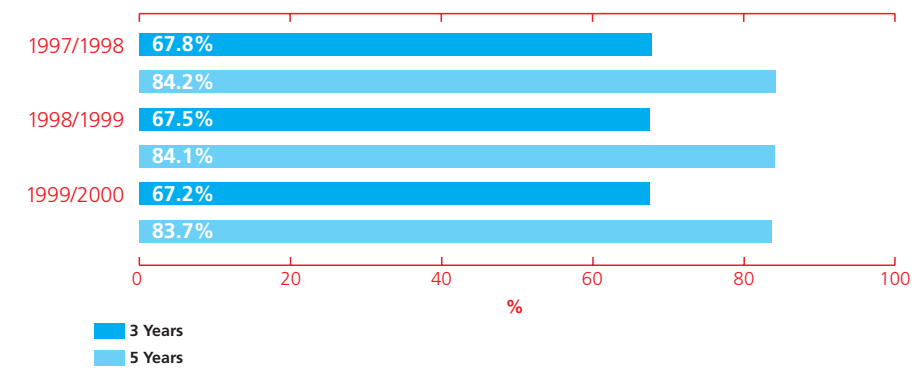


Table 2

Number of women screened: aged 25-64

The number of women screened has fallen slightly over the last three years in line with the slight drop in screening coverage. However, over three and a quarter million women are screened each year, and this represents more than four out of five of the eligible population.

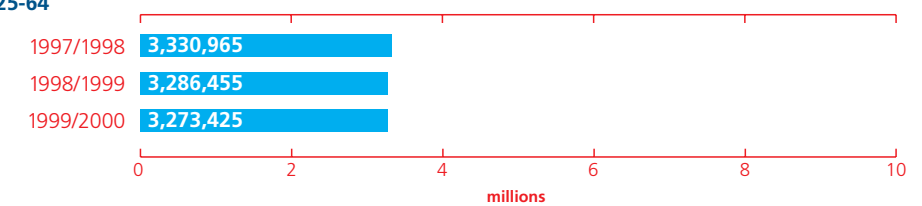


Table 3

Numbers of smears examined (all ages)

The number of smears examined fell slightly last year. This represents a continuation of the trend seen for a number of years since the huge expansion of the cervical screening programme in the early nineties. Many of the smears taken in the early days of the programme represented what we

would now call 'over screening' of women who were already adequately screened. The GP and community clinic smears represent smears taken largely from women without problems, whereas the 'all sources' figure includes smears taken from women already in hospital clinics.

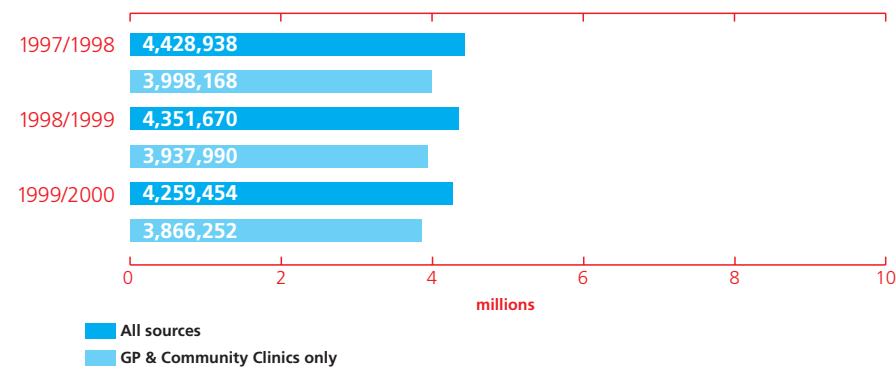


Table 4

Screening of teenagers: Women screened below 20

The screening of teenagers is continuing to show a welcome drop and has more than halved in the last three years alone. Women under 20 are extremely unlikely to develop cervical cancer and screening them finds a high proportion of apparent abnormalities when cell change is seen. This is often the result of developmental changes rather than any

problems in the cervix. Treating such young women can lead to problems for them in later life. Since their risk of developing cervical cancer is so low, the risk of harm from complications of treatment is far greater and can have serious consequences. The screening of teenagers is therefore discouraged by the screening programme.

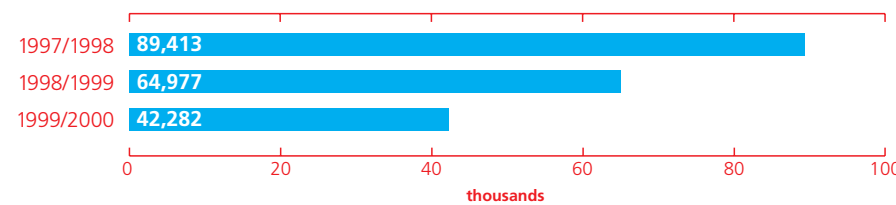


Table 5

Percentage of smears which are inadequate (women aged 20-64) GP & Community Clinics only

Every year since 1993, the percentage of smears classified as 'inadequate' has gone up. This year is no exception with a rise to almost one in ten smears being called inadequate. One of the reasons for looking at liquid based cytology is that this

technique may reduce the number of inadequate smears which are so classified due to infection obscuring the cells that the laboratories need to examine. The infection is filtered out in the preparation of a slide with the new technique.

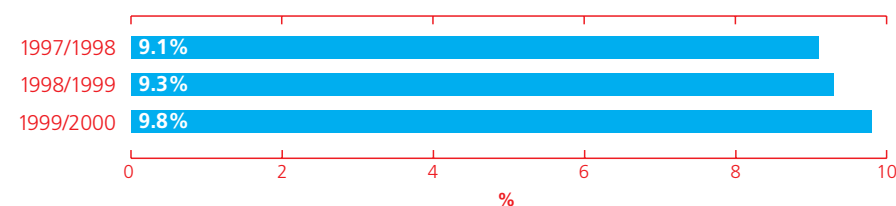


Table 6

Inadequate smears by age

This table shows that the inadequate smear rate is much higher in younger women than in older women. It can sometimes be difficult to get an adequate smear from a post menopausal woman due to the hormonally influenced changes to her

cervix. However, younger women have much higher rates of sexually transmitted disease and it is largely for this reason that their inadequate rates are higher even though their hormonal status should allow us to obtain a high quality smear more easily.

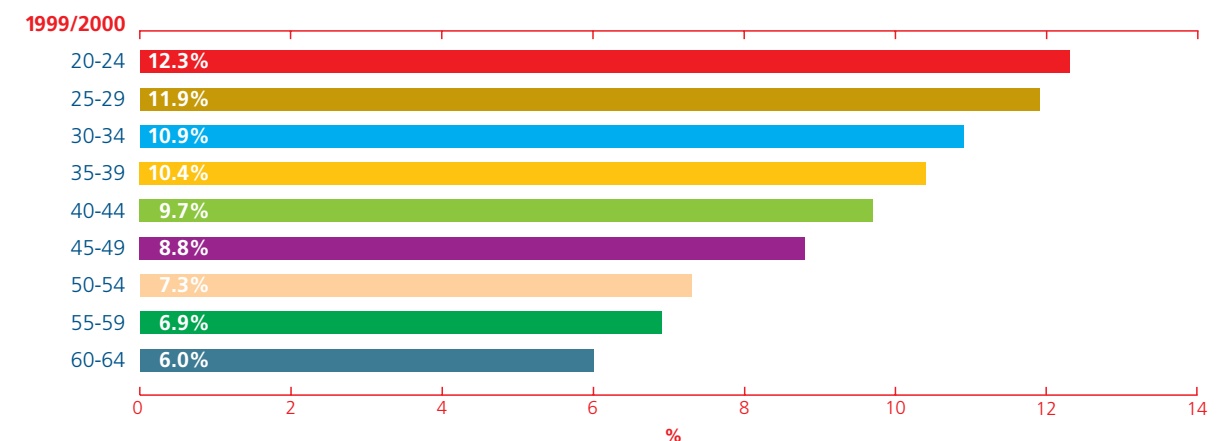
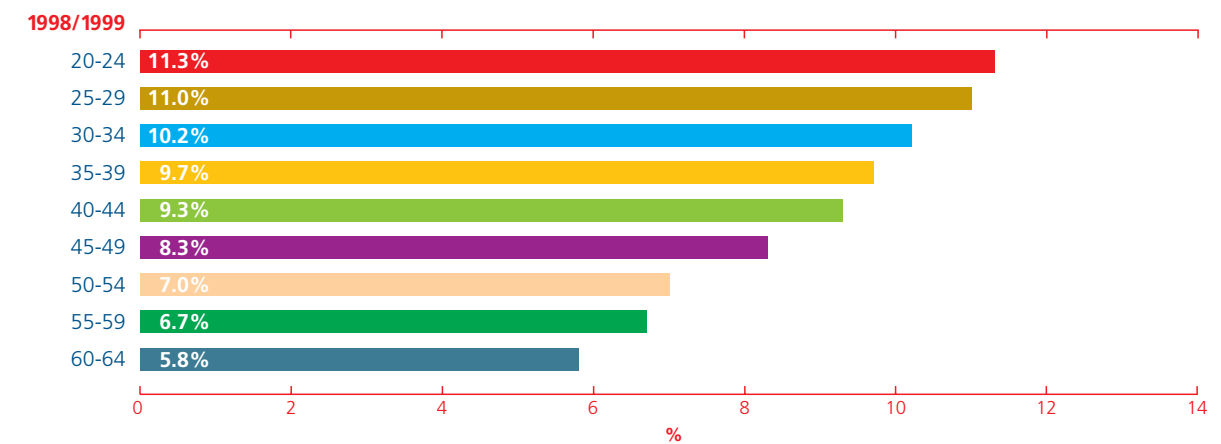
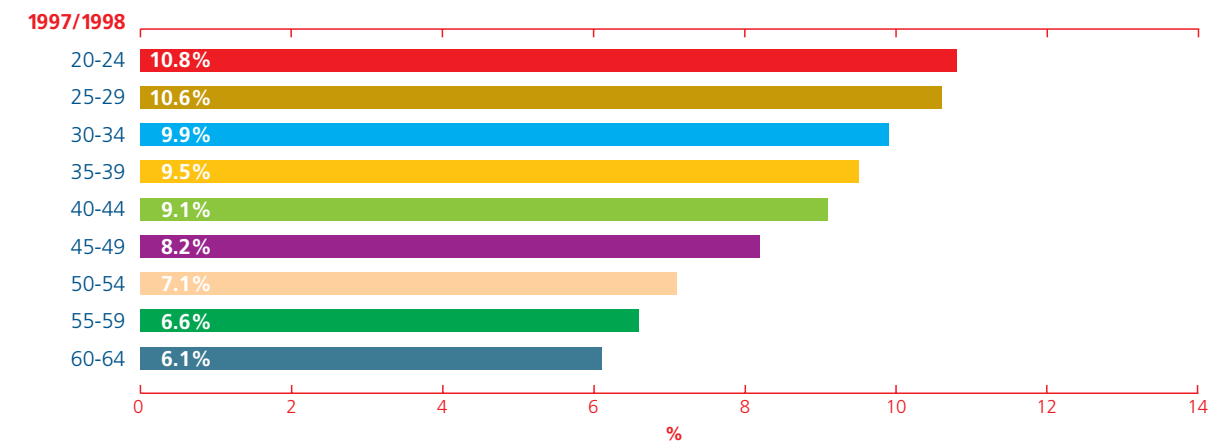


Table 7

Smears showing abnormality

The percentage of smears demonstrating some abnormality rose again slightly this year to 8.3%. However, the actual number of abnormal smears fell as the overall number of smears was less.

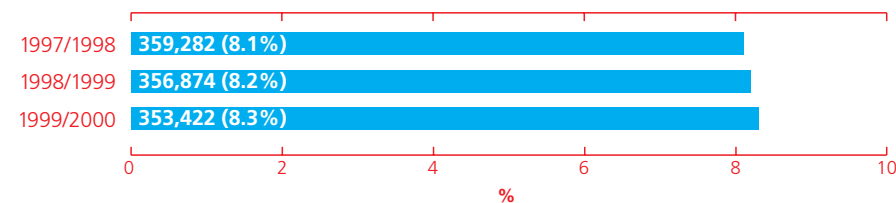


Table 8

Smears requiring immediate referral for colposcopy

Smears which are reported as showing moderate dyskaryosis, severe dyskaryosis or worse mean that the woman is immediately referred for colposcopy. The proportion of smears that these numbers represent is consistent. 0.9% of smears are reported

as moderate dyskaryosis and 0.7% of smears are reported as severe dyskaryosis or worse. In 1999/2000 66,437 women were referred immediately to colposcopy following an abnormal smear of this type.

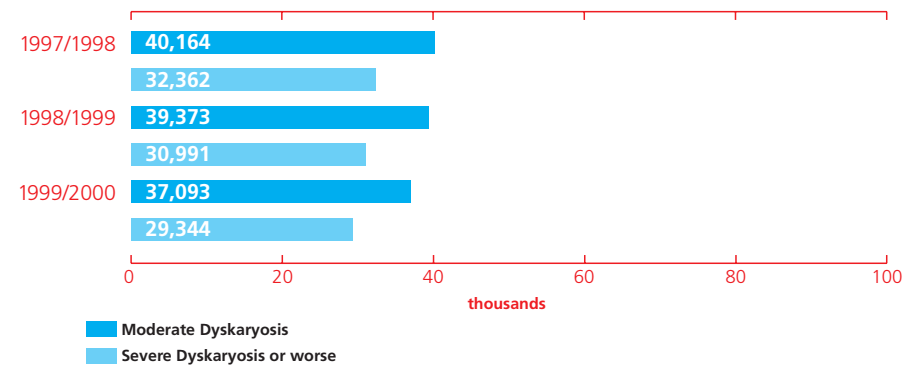


Table 9

Smears showing possible glandular abnormality or invasive cancer

Smears are best at detecting (potential) cervical intraepithelial neoplasia (CIN) which shows in a smear as dyskaryosis. However, sometimes a smear is found which is thought to come from a woman who potentially has either invasive cervical cancer or perhaps a glandular abnormality (adenocarcinoma) which is difficult to find on a smear. The proportions of women in these categories fell for the first time

this year which is to be expected as the programme matures since higher grade disease is prevented by earlier abnormalities being found and treated. By no means would all women with a smear report of this nature be found to have either a glandular abnormality or an invasive cancer, but we would expect them to be referred urgently for a gynaecological assessment.

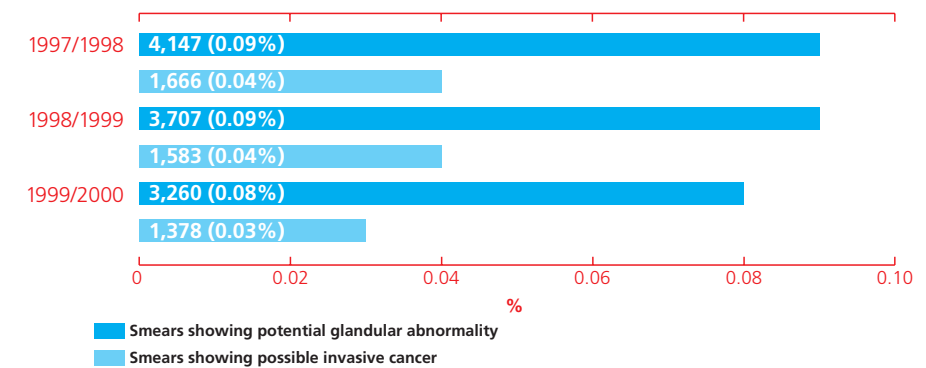


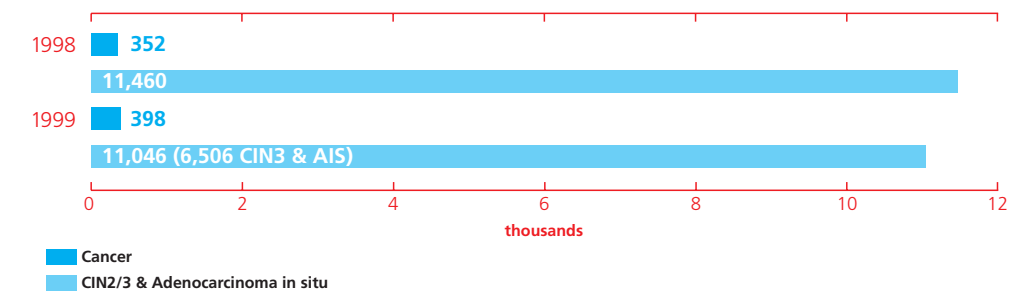
Table 10

Outcome of referral for colposcopy (April-June results only)

In 1998/99, for the first time we attempted to collect data on the outcome of a colposcopic referral. We have repeated the exercise this year. Since this information is currently difficult to collect, we collect it only for one quarter of the year which we believe to be representative of the full year. To get an estimate of annual figures, therefore, these numbers should be multiplied by four.

(AIS) from the totality of women who have CIN2, 3 or adenocarcinoma in situ. This is because CIN3 and AIS are registered with the cancer registry and recognised as lesions which are highly likely to become cancerous. However, they do not represent a cancer and will not necessarily develop into cancer in all cases. Nevertheless, all cases of CIN3 and adenocarcinoma in situ are treated since we cannot distinguish those which will progress from those which will not.

In 1999/2000, we have separated out those women found to have CIN3 and adenocarcinoma in situ





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