THE UNIVERSITY OF MELBOURNE

A. E. Rowden White and
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Department of Obstetrics
and Gynaecology

Parkville, Victoria 3052
Australia

7 JUN 1991

5th June, 1991.

Dr. J. Cattanach,
37 Vista Street,
BULLEEN, 3105.

Dear Dr. Cattanach, Nigel,

Dr. Gray has forwarded to me a copy of your letter of 31st May. I write as Chairman of the Gynaecological Oncology Group of Victoria, the body to which your original letter was sent. Your letter was reviewed by an expert panel and as you are aware the findings were that there was no causal link identified between intercourse at the time of menstruation nor was there any solid scientific information to suggest that products such as Gynaeseal would reduce the incidence of cervical cancer. These comments are purely on a scientific basis and a review of the literature.

As you point out in your letter, the evidence you quote is "circumstantial" and I do not believe it is up to the centres to prove or disprove your hypothesis. I believe it is up to yourself.

I am unsure as to your reason for writing to Dr. Gray. You state in the last paragraph that "My purpose in writing is to clarify these matters with you in the hope that the manuscript will be accepted for publication". I am unsure as to which manuscript you mean and I also feel that it is not worthwhile pursuing this correspondence with the Gynaecological Oncology Group since I feel that they have spent enough time and effort in replying to your original letter.

Yours sincerely,

Michael A. Quinn
Chairman
Gynaecological Oncology Group
of Victoria

cc. Dr. N. Gray

MAQ/LB

OK
Can add any letter

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Director: Dr Nigel Gray A.M. MB. BS. Hon. LL.D. FRACP. FRACMA

Anti-Cancer Council of Victoria

4 June 1991

4-1107

Associate Professor Michael A. Quinn
Professorial Unit
Royal Women's Hospital
Grattan Street
Carlton Vic 3053

Dear Michael,

My secretary told me that you're going to write back to this character. It may well be that your letter obviates the need for mine - however, I've drafted a response which is relatively temperate and is an attempt not to more deeply involve myself in what is obviously an incredibly tortuous grant for intellectual debate.

Let me know whether you think I should tear mine up and leave the field to you, or whether I should send it or something like it.

Cheers -

Yours sincerely,

Nigel Gray
Director

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4 June 1991 **DRAFT** 4-1106

Dr. J.F. Cattanach
Natural Family Planning & Fertility Clinic
37 Vista Street
Bulleen Vic 3105

Dear Dr. Cattanach,

I've read your letter dated 30 May and am responding as best I can.

As I understand the situation you sent us your hypothesis, via Robin Marks, for comment. Your 30 May letter suggests it was forwarded for possible publication - I don't imagine you were expecting us to publish it because we are not a medical journal. i.e. I'm assuming that you were seeking an opinion.

Our VCOG responded to your request by inviting an assessment and forwarding that assessment to you.

Your response is to write and critique the assessment (which is your sovereign right) but I'm in a position where I don't understand what you are now expecting me to do.

If you want the work published then you are welcome to send it to any of the medical journals. If you want the opinion of the VCOG you are certainly entitled to ask us for it and we've given it to you. I understand that you don't agree with the assessment and you are, of course, welcome to debate scientific issues as much as you like with any of the members of the VCOG. Nevertheless I'm still unable to see what role the Anti-Cancer Council, as a body, has in relation to the publication of your work. We've offered you the friendly comment and critique that you sought and I don't see that we can do much more.

Your letter to me also raises a second issue i.e. the fact that your research on Gynaeseal was blocked because the ACCV did not fund your research. My response to this is straightforward - our funding is competitive, based on peer review and external assessment, and we are only able to fund the most highly refereed grants.

You further suggest that a subsequent line of research was also blocked because Vic Health failed to fund it and that Bob Porter, Judith Lumley and myself are on the subcommittee that recommended against the funding - again my response is that funding from Vic Health is competitive and the fact that your funding application was not successful is not necessarily a reflection on the quality of the work - it is merely a reflection that there were more competitive research opportunities offered by other projects before the Foundation.

I hope this letter clarifies the situation. I can't see any reason why you shouldn't forward your paper to a journal for publication nor why you shouldn't continue to apply for funding of your research grant proposals. Obviously in both cases you are in a competitive environment and subject to peer review, like everybody else.

Best wishes.

Yours sincerely,

Nigel Gray
Director

Natural Family Planning and
Fertility Clinic

30th May, 1991

Dr Nigel Gray A.M.,M.B.B.S.,LL.D.,FRACP,FRACMA
Director
Anti-Cancer Council of Victoria
1 Rathdowne Street
CARLTON 3053

31 MAY 1991

Dear Dr Gray,

Recently I recieved a letter from the Secretary of the Council's Gynaecology Oncology Group, Ms Susan Fitzpatrick, regarding the writer's hypothesis on the aetiology of cervical cancer. This includes what appears to be a referee/commentor assessment of a paper forwarded for possible publication.

Respectfully, I believe the commentator's understanding of this hypothesis is incomplete. This person states:

> The critical factor for risk of cervical cancer is participation in intercourse at an early age. This can be partially explained by intercourse during menstruation.

In fact, the hypothesised critical factor is intercourse at times of low oestrogen production, this risk being accentuated if cervical eversion/metaplasia is present. To summarize, oestrogen levels are low from immediatly before the onset of menstruation until the onset of the fertile pase (the menstruation-fertile phase interphase) as well as during lactation and in the post-menopause. Cervical eversion/metaplasia is normally present in late adolescence, it is more likely during late pregnancy, in the puerperium, and during lactation. During full lactation oestrogen levels are particularly low, while during pregnancy oestrogen levels high - therefore cervical mucus is scant during full lactation and abundent during pregnancy, especially late pregnancy. Cervical eversion/metaplasia is more likely to be present in women on oral contraceptives. These set of circumstances and risk factors are uniquely consistent with the vast bulk of epidemiological data on cervical cancer aetiology. Following the predicted demise of the papilloma virus aetiology theory as the critical factor in cervical cancer risk, in the absence of a competing hypothesis that comparably fits the criteria and the circumstantial evidence, the writer's hypothesis must be pre-eminent - certainly it remains formally unchallenged since the time it was first published in 1980. An unsolicited entry referable to this hypothesis has appeared in every issue of the Directory of On-Going Research in Cancer Epidemiology sice it was first published.

..2/

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The commentator draws attention to the limited nature of the writer´s published statistical data. This data is a key piece in what was can be likened to a jigsaw puzzle. With validation that there is a behavioral change with regard to intercourse during menstruation versus age, came realization of the most critically important aspect - the precision with which the basic hypothesis integrates with all available first class research data. The data were obtained in a truely random manner that was acceptable to the statisticians at the Computer Centre Monash University. It has not been quashed by the research findings of others. Certainly, the evidence was strong enough for a formal ministerial enquiry (Consumer Affaris Tasmania) to acknowledge the claim that Gynaeseal promises to reduce the risk of cervical cancer by allowing the claim it to appear on the instructiton sheet.d

The direction of further research, as outlined in the writers Doctorate Thesis 1986 (copy retained by Monash University), outlines proposed definitive research that the writer would have actioned around 1978 had he been able to obtain funding. Funding was sought unsuccessfully from the Anti-Cancer Concil of Victoria. In a letter (dated 10th November, 1977) your own comment at the time was this :

> The general feeling in the Council is that our own processing facilities are overstrained and we are not able to find funds to help wyou with your project as it is not directly enough relevant to cancer.

A peer reviewed research report on the clinical trial conducted by the writer has now been accepted for publication in an international OBGYN journal of high repute. A large part of the Discussion is devoted to this hypothesis and the corresponding promise of a cervical cancer protective effect brought by Gynaeseal if used at times of low oestrogen production, as described in the paper forwarded to the Anti-Cancer Council of Victoria. The commentator raised no objection to this material. The writer´s presention of the cervical cancer aetiology hypothesis in relation to the promise Gynaeseal offers, at an international cancer conference was received without challenge. An established authority on cervical cancer, Dr Leopold Koss, strongly encouraged the writer persue this avenue of research, stating that he had always been particularly impressed by a research finding, published in Nature during the sixties, that demonstrated malignant change in fibroblast after the addition of sperm.

As a result of funding certain funding applications being rejected, I cannot present your commentator with further definitive supporting data. However, I suggest that the circumstantial evidence is so strong the onus of proof now resides with those who would dissent. I was unable to persue this line of research at that time and was obliged in 1977 to open-up another line of research. The result may have been loss of leadership, in an international sense, for Australia. The subsequent line of research opened-up, which was into the late sequelae of tubal sterilization, has considerable relevance to the hypothesis in question. It too has been effectivly blocked recently by the writers failure to gain funding from Vic Health. I understand that Professor Robert Porter, Dr Judith Lumley and yourself

made up the majority of the sub-committee that recommeded against funding of this research project, despite Professor Carl Wood agreeing to be a co-worker, and Professor Norman Beischer agreeing that this research should be actioned.

My purpose in writing is to clarify these matters with you in the hope that the manuscript will be accepted for publication. I would be most grateful if you would comment upon these matters, and delighted to discuss these matters at your convenience.

Yours sincerely,

(Dr) John F Cattanach
OBGYN Physician

PRESENTATION AT 7TH INTERNATIONAL SYMPOSIUM
ON PREVENTION AND DETECTION OF CANCER (Nice, 1989)
BY DR JOHN F. CATTANACH

The hypothesized carcinogenic action of sperm (and carcinogenic viruses) encompasses the following:

i/ basic protein released from sperm degraded during its stay on the cervix comes into contact with new epithelial cells activated during the process of metaplasia;
ii/ the resulting permanent endowment with excessive DNA deflects these cells towards neoplasia;
iii/ the basic structure of cervical mucus (a system of filament bundles) is arranged in more orderly fashion under oestrogenic stimulation;
iv/ and mucus does not remain over cervical eversion (present at menarche and after childbirth) as it does over the normal squamous epithelium of the cervix (Coppleson, 1975; Reid, 1985).

Epidemiological evidence indicates that the critical factor for cervical cancer risk is primarily the participation in intercourse at an early age. This may be explained, at least in part, by a correlation between intercourse during menstruation and the age at which intercourse is commenced (Cattanach, 1980). Because oestrogen levels are minimal during menstruation, and cervical mucus is produced by the endo-cervical cells of the cervix as a direct response to oestrogen stimulation, the amount, and therefore the protective effect, of cervical mucus would be reduced or absent during menstruation. Similarly, the observed increased risk of cervical cancer following tubal ligation (Powell, 1962; Haynes, 1970; Muldoon, 1972), as well as oral contraceptive use (Melamed, 1969; Brinton, 1986; Ebeling, 1987), may be due to reduced naturally metabolised oestrogen levels (mucus produced under ethinyl oestradiol stimulation is known to be altered and reduced). Mid-luteal phase total urinary oestrogen excretion was found to be significantly lower in women who had previously undergone tubal sterilization at least two years before assay, and pregnanediol levels at or below 2.0mg/24hrs - indicative of anovulation - were significantly more frequent. The bio-engineering phenomenon - intracapillary hypertension localised to the ovary (Cattanach, 1985 & 1988) - results in tissue damage and reduced ovarian function.

The observed association between post-tubal sterilization oestrogen deficiency syndrome with physical problems (including osteochondritis, tenosynovitis, obesity, irritable bowel syndrome as well as problems normally linked to oestrogen deficiency) suggest that oestrogen and possibly progesterone is important in the maintenance/protection of endothelium, ligaments and tendons. The association of psychological problems with abnormal lipids - elevation in LDL-cholesterol and triglycerides (which was exacerbated by cigarette smoking) - is further evidence of the importance of oestrogen in brain function and maintenance.

A new type of (patented) sanitary tampon (that has a secondary function as a alternative diaphragm) is expected to reduce the risk of cervical cancer in those women who have been sterilized, take oral contraceptives or engage in sexual activity during menstruation.

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GYNAESEAL AND OTHER VAGINAL BARRIERS

John Cattanach

Natural Family Planning and Fertility Clinic, Hawthorn, Victoria

Gynaeseal was developed by the writer both to improve the performance of ovulation identification methods of birth control and to protect women from an increased cervical cancer risk associated with intercourse at times of low oestrogen production (eg during menstruation and lactation).[1,2,3] Gynaeseal emerged from the failure of the conventional diaphragm to function as a tampon.[4,5] The result was a 'diaphragm tampon,' a product that is both a superior tampon and a better diaphragm by virtue of the pragmatic realities of design: a true seal because it generates a physiologically acceptable suction pressure over the cervix. Clearly, Gynaeseal would function as a better diaphragm if properly placed over the cervix. Thus, the substantial diaphragm-related evidence is applicable in support the claim that Gynaeseal would reduce the risk of sexually transmitted diseases.[6-18]

There has been some confusion of Gynaeseal with an overseas product called Femshield which, according to press reports, was developed specifically to control heterosexual spread of HIV. Gynaeseal has a number of apparent advantages over this 'female condom,' designated WCP-333: normal physiological sensation for the male; easier and more acceptable insertion (the latter doesn't have an applicator); similar STD protection if combined with douching (as long as the vaginal/vulval epithelium is intact); more comfort for both wearer and her sexual partner; and it is aesthetically more acceptable.

May I walk the reader through the likely genital route in heterosexual transmission of STDs (including AIDS), assuming integrity of normal, oestrogenic vaginal epithelium. The thick, spongy multi-layered squamous epithelium of the vagina doesn't transmit HIV and other STD agents, apart from syphilis,[15] as long as it is intact and there are no lesions or lacerations present. The lining of the vagina *per se* is very similar to normal skin except that it doesn't have a layer of keratin (compressed dead squamous cells) on the surface, but then it is much thicker, assuming natural oestrogen levels are adequate. The oestrogen-dependent acidic environment within the vagina would provide added protection. As with other viruses (and bacteria, including chlamydia), entry is apparently via the cervix. For about 7 days from the onset of menstruation, and during full lactation, oestrogen production is low. Theoretically, whenever oestrogen production is low, and especially when the endometrium is shedding, women are prone to transmission of infectious agents and other forms of foreign DNA/RNA. Oestrogen production is directly linked to endocervical mucus production, the key to cervical defences.

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Hawthorn Victoria 3122

This formed the basis of the writers presentation at a recent WHO sponsored international cancer conference,[19] which in turn was based on his hypothesis, first published in 1980[20] regarding the pathogenesis of another sexually transmitted disease, cervical carcinoma. Foreign DNA/RNA gains access to the columnar cell via known mechanisms (partly a phenomenon initiated by the basic protein, protamine that encapsulates the chromosomes within the sperm head, and probably an amoebic-like function of the columnar cell as well). In the proceedings of the above conference,[19] the inference can be drawn that sperm is the initiator of cervical cancer while certain sub-groups of papillomavirus may be promoters of the carcinogenic process. At the junctional zone (just inside the cervix under normal circumstances, and on the surface when eversion/ectopy is present), the external squamous epithelial protective lining changes to the true lining of the inside of the body - the endothelium, a single layer of secretory/absorption columnar endothelium commences. Unlike squamous cells which repel foreign DNA, columnar cells actually absorb foreign DNA/RNA (eg viruses and fragments of the chromosomes of degrading sperm) unless protected by the thick, viscous mucus that is present at times of adequate natural oestrogen production. It should be noted that oral contraceptives result in the production of a thin, watery mucus, as well as a tendency to eversion (ectropy), thus increasing the risk of dysplasia, as evidenced by several research publications.[21-24] For anatomical and physiological reasons, urethral transmission is far less likely than cervical. This view is supported by epidemiological data. Early douching with soapy water before Gynaeseal is removed should provide substantial protection against transmission of the virus.

When Gynaeseal is available for use as a tampon during menstruation and as a diaphragm in association with douching at the extremes of the fertile phase, or whenever there is doubt about fertility status, women in fact have an advanced and healthy form of birth control that both minimizes the risk of cervical cancer in women who are sexually active during menstruation and the risk of other STD transmission. At a time when there is a crisis in menstruation control, STD prevention and birth control technique, the availability of Gynaeseal is indeed timely. A recent review article on adolescent contraception[25] ranks intravaginal barriers pre-eminently. A large survey published in the August 1982 issue of a reputable consumer magazine (Choice) reported the unexpected finding that the happiest users were those who had combined the ovulation method with barriers. It makes good sense to combine Gynaeseal with ovulation identification methods, as explained in the booklet 'Gynaeseal Applied to Natural Family Planning - the Healthiest, Most Acceptable Method' (Commodore Press, Melbourne ISBN 0 7316 5640 7).

Though the diaphragm has been shown to have health advantages that make it theoretically preferable to oral contraceptive and the IUD,[26] it has failed to become a popular method of birth control. In comparison, Gynaeseal doesn't significantly

distort female anatomy and shouldn't be linked to urinary tract infection, especially as it is intended to be disposable, minimizing the risk of colonization by gram negative organisms. Because there is no heavy spring to distort gynaecological anatomy, the urethra in particular, the increased risk of urinary tract infection associated with the conventional diaphragm[26-32] will be significantly reduced.

Gynaeseal is easier to insert because of the unique spiral-curved applicator and the male partner can more easily be involved, potentially a major advantage when intercourse occurs in the early morning. Though inexpensive (approximately $2 each when the 6-pack is purchased). Gynaeseal is re-usable. If it is to be re-used, care must be taken to observe how the two latex parts are assembled securely in a particular way around the 'O' ring, and regular sterilization of the disassembled parts is recommended. In comparison to readily available antiseptics, including 1% hypochlorite solution, laboratory tests that involved latex experts at the UK headquarters of a major latex supplier indicate that a solution of melaluca oil least affects the suction generated by the ultra-pure latex used in the fabrication of Gynaeseal. Properly maintained, Gynaeseal appears to last indefinitely.

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Misconceptions?

In his article, 'Oral Contraceptives: Past, Present and Future', [Patient Management 13 (11): 75, 1989], Dr Gabor Kovacs makes fleeting mention only of the cardiovascular and lipid abnormality problems known to be associated with oral contraceptives. As well as asking my colleagues not to refer to the synthetic non-naturally metabolised pseudo-oestrogens in oral contraceptives as 'oestrogen' – a more accurate term such as 'oestranoid' should be coined and used – I wish to take this opportunity to point out some of the oral contraceptive-related problems that have been of particular concern to me.

I have come to believe that the long term health risks associated with oral contraception, particularly those of breast and cervical cancer, are serious – far more serious than the risks associated with pregnancy. This belief has been reinforced as a result of being invited to present my research findings [1,2,3] at the recent 7th International Symposium on Cancer Detection and Prevention, held in Nice [4].

Some prominent doctors involved in family planning still defend the combined oral contraceptive. Dr Edith Weisberg, Medical Superintendent of the Family Planning Association of New South Wales, for instance, seems to concede the serious long term sequelae of the original high dose oral contraceptives, but states that the considerable reduction in the dose of non-naturally metabolised pseudo-progesterone ('progestogen') in the current low dose pills means those sequelae will not occur now [5]. I'm very concerned that it is the ethinyl oestradiol, the unnatural pseudo-oestrogen, that is the real culprit, and the dose of that hormone has been reduced by only 30 to 50%.

A Swedish oncology group from Lund, headed by Dr H. Olsson, told the above conference that women who took oral contraceptives in Sweden as teenagers during the 1960s have a 5-fold increased risk of premenopausal breast cancer [6]. In the future we are likely to find that young women currently taking the low dose oral contraceptives have a breast cancer rate at least double or treble the normal rate. The fact that a university-based research group has found a 5-fold incidence in association with the original combined oral contraceptive, that similar findings of lesser magnitude have been found in a UK study [7], and that the basic mode of action of oral contraceptives hasn't changed, means warning bells should be ringing loudly. It is simply too serious a human experiment to impose upon unsuspecting and trusting young women.

The rate of cervical cancer has been increasing, and there is a certain synchronicity with this and the hormone content of oral contraceptives. The cervical deficiencies resulting from a reduction and thinning in consistency/viscosity of the mucus produced by the endocervical glands is, I believe, the key. All the evidence points to the essential nature of mucus of normal consistency as a protection of the vulnerable junctional zone of the squamo-columnar junction at the cervix [4,8].

Many have wished oral contraception to be the answer. In fact, the comparatively high percentage of women who discontinue [9] are probably the lucky ones in the longer term.

The wise and effective alternative, I believe, is the combination of ovulation identification with vagino-cervical dual-function barriers. It is significant that a recent review of birth control options for young women [10] has given pre-eminent ranking to intravaginal barriers.

John F. Cattanach
Medical Director
Natural Family Planning and Fertility Clinic
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AUSTRALIA

Incidence, Prevalence and Characteristics of MDS in a Defined Population

The MDS are a group of common, pre-malignant conditions that have been very little studied epidemiologically. A comprehensive population-based survey of patients with MDS is being carried out, and their disorders studied by a panel of laboratory tests. In this way it is hoped to define their prevalence and incidence, taking the group of disorders as a whole and by laboratory sub-categorisation, and to make a contribution to identifying aetiological factors. This will be a joint study combining laboratory and epidemiological aspects. A prevalence study of all cases of MDS known in the Australian island state of Tasmania was performed on January, 1st 1989. Subsequently, all cases newly diagnosed in the years 1989-1990 are being identified and data on age, sex, ethnic background, area of residence, education, occupation, family disease history as well as a clinical history of the presenting episode collected in order to generate hypotheses which could be tested. Laboratory tests will be performed to define characteristics of the cases diagnosed. They will include: routine morphology and cytochemistry, cell marker studies, natural killer cell activity assay, cytogenetics, and haemopoietic progenitor cell cultures. A comprehensive history of exposure to possible aetiological environmental agents is being obtained, with controls.

TYPE: Cross-Sectional; Incidence
TERM: Environmental Factors; Occupation; Premalignant Lesion; Registry; Socio-Economic Factors
SITE: Myelodysplastic Syndrome
REGI: Tasmania (Aus)
TIME: 1988 - 1991

Melbourne

17 **Cattanach, J.F.** **03889**
Monash Univ., Dept. of Obstetrics and Gynaecology, 140 Power St., Hawthorn, Melbourne, Vict. 3122, Australia (Tel.: 818 0271)
COLL: Brown, J.B.; Walters, W.W.

Relationship between Post Tubal Ligation Oestrogen Deficiency State and Neoplasia, Particularly of the Uterine Cervix

A number of researchers have observed a small but apparently real increased risk of uterine cancer following tubal ligation. It is widely thought that oestrogen protects women from many neoplasias prior to the menopause. Oestrogen production may be intrinsic to the protective mucous coat on bronchial epithelium, gastrointestinal epithelium, as well as cervical epithelium. It could well be that women with low oestrogen levels who smoke are more vulnerable to the plant RNA in bronchi and break down products of sperm or viruses (such as wart virus) in the case of cervical epithelium. For instance, low oestrogen levels at the menses may increase general risk of carcinogenesis. A non-randomised group of 66 women have been found to have a significantly increased incidence of abnormally low luteal phase urinary excretion of total oestrogen; all were younger than age 45, and had undergone tubal ligation at least two years before the assays were taken. This cohort, together with future volunteers, will be monitored for bronchial carcinoma and cervical neoplasia, as well as disorders of other secretory epithelia (e.g., stomach and large bowel). A paper appeared in Contraception 38:541-550, 1988

TYPE: Cohort
TERM: Drugs; Monitoring; Oestrogen Deficiency; Tobacco (Smoking); Tubal Ligation; Urine
SITE: Colon; Lung; Stomach; Uterus (Cervix)
TIME: 1985 -

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WORLD HEALTH ORGANIZATION

INTERNATIONAL AGENCY FOR RESEARCH ON CANCER

DEUTSCHE KREBSFORSCHUNGSZENTRUM

DIRECTORY OF ON-GOING RESEARCH IN CANCER EPIDEMIOLOGY 1991

EDITORS
M. COLEMAN J. WAHRENDORF

file in Cervical Cancer

(9 Better Health Committee)

Director's Office

MEMORANDUM

DATE: 30 July 1991 4-2062

TO: Dorothy Reading

FROM: Nigel Gray

Apropos the HDV State Plan for Cervical Screening.

My initial reaction was mild irritation that somebody had gone to such a lot of trouble to rewrite what is already standard stuff.

However, it's placed in HDV format (although not on letterhead). The fact that there is an overall strategy with clearcut goals in Victoria for cervical cancer.

Given that the Health Department is delegating responsibility for implementation of health promotion etc. to agencies outside the Department, they nevertheless **ought** to have and **wish** to have some place in the sun and also perhaps the overarching responsibility for making certain that the right things happen.

The above paragraph would more or less summarise a number of discussions I've had with Hayden Raysmith.

Thus, whereas we could see this as a bid by the government to establish its place in the system in which it plays a relatively small role in policy development; we could also perceive it quite reasonably as their statement that things are OK and on track and adequately delegated to adequate organisations. They probably ought to have the right to bring the whole thing together in this way since in practice the government pays the actual bills for screening and investigation.

There is one point arising from the document which clearly needs attention and that's the potential over-intervention rate. The government very reasonably has an interest in this.

If this paper is to be a model for a string of 19 others reflecting the priority areas of the Better Health Committee, I would be fairly content. It represents a sharp departure from the Health Plan written by Shane Solomon a few years ago in which the Department abrogated to itself the role of lead agency in every program in the State.

Thus we appear to have reached an age of enlightenment.

Nigel

ANTI-CANCER COUNCIL OF VICTORIA

EDUCATION UNIT

M E M O R A N D U M

FROM: Dorothy Reading

TO: Nigel Gray

DATE: 22 July, 1991

SUBJECT: HDV State Plan for Cervical Screening

==========

Attached is a copy of a document commissioned by Vivian Lin. I'm sure you need to know what's in it for background for the Better Health Committee.

Sheila and I have made lots of critical comments along the way, most of which have been accepted. I don't know what the purpose of the document is.

Dorothy

cxcdr05r

THE VICTORIAN CERVICAL CANCER SCREENING PROGRAM:

A STATE PLAN

Women's Health Policy and Programs Unit
Health Department Victoria, June 1991

ACKNOWLEDGEMENTS

Health Department Victoria is indebted to Ms Heather Mitchell, the Victorian Cervical Cytology Registry; Ms Sheila Hirst and Ms Dorothy Reading, Anti Cancer Council Victoria, for their assistance in drafting this document.

For further Comment

This document has been drafted by the Women's Health Policy and Programs Unit, Health Department Victoria for consultation with relevant individuals and organisations in the Victorian Cervical Cancer Screening Program. Comments should be forwarded to:

Ms Gaby Marcus
Acting Manager
Women's Health Policy and Programs Unit
Health Department Victoria
20th Floor
555 Collins Street
Melbourne 3000

by .....

DRAFT ONLY

STATE CERVICAL CANCER PLAN

CONTENTS

Please Note:

The development of cervical screening policies involves a number of complex issues. Since investigation and discussion of these issues has been the subject of a recent Commonwealth Government report, they are not addressed in detail in this plan. Readers are referred to the report of the Cervical Cancer Screening Evaluation Steering Committee (CCSESC), August 1990, for a more complete discussion of the issues and presentation of relevant evidence.

1. BACKGROUND

This document outlines progress toward and plans for the implementation of an organised approach to cervical screening in Victoria.

It has now been demonstrated internationally that 90% of squamous cell carcinoma of the cervix can be prevented given the existence of an organised system of cervical screening (CCSESC, 1990 p1). Australia, through its participation in the World Health Organisation's Health for All initiative has a commitment to reduce deaths from cervical cancer by 30% by the year 2000. This will require a reduction in the death rate from 4.1 to 2.9 per 100,000 population (ACCV, 1991 pp2-3).

In 1988-89 the Commonwealth, State and Territory health authorities established the National Cervical Cancer Screening Evaluation under the auspices of the Australian Health Ministers' Advisory Council (AHMAC). The impetus for the evaluation was concern that after twenty five years of experience of cervical screening there were a number of problems associated with what was essentially a passive opportunistic approach including:

. large numbers of women remained unscreened or under screened while other groups were over screened;

. variation in the quality of Pap smear taking and reporting;

. the lack of a method for ensuring that women with abnormal Pap smears received appropriate follow up; and

. the high financial cost of cervical cancer screening (CCSESC, 1990 pp 1-5).

The report of the Cervical Cancer Screening Evaluation Steering Committee (CCSESC), which drew upon both the Australian and international experience of cervical screening as well as a number of pilot programs commissioned as part of the evaluation, was presented to AHMAC in August 1990. In April 1991 the Australian Health Ministers Council (AHMC) endorsed the report.

In particular, the Health Ministers:

(i) agreed in principle to an organised approach to cervical screening;

(ii) endorsed a National Cervical Screening Policy:

. initially with a minimum two year interval for routine screening supported by reminder systems based on three years;

. following an assessment of the impact of the policy in 1993, introduction of a three year screening interval when recall systems, reliable cytology and adequate epidemiological data collections are in place;

. screening to commence between 18-20 years and cease at 70 years, noting that practitioners may recommend earlier commencement where coitus has already occurred; and

(iii) approved further development of this approach by the Commonwealth, including funding arrangements, a communication strategy, and improvement of quality assurance in cervical smears and management of abnormalities.

Acceptance of this National Screening Policy is of particular significance given that policies have been an area of considerable debate and discussion among professional and community groups. In the absence of a consensus in relation to screening intervals and age of commencement and cessation of screening, women have been given conflicting advice by practitioners. Typically this has been based on a shorter screening interval than that endorsed by AHMC.

The new National Screening Policy is broadly based on the outcomes of a consensus conference convened in 1988 by the Australian Cancer Society.

2. THE VICTORIAN CERVICAL CANCER SCREENING PROGRAM

While cervical screening was introduced in Victoria in the 1960s, prior to 1989 as was the case in other Australian States and Territories, the Victorian approach was passive and opportunistic. In 1989, following an amendment to the Cancer (Central Registers) Act, the Victorian Cervical Cytology Registry (VCCR) was established to provide the structural framework for an organised approach to cervical cancer screening in Victoria. Given the successful establishment of the Registry and the commitment to the development of cervical screening policies and programs at the National level, it is both appropriate and timely that a plan be developed to ensure that all components of an organised approach are implemented in the Victorian context.

There are a range of institutions and services in both the public and private sectors which together comprise the Victorian Cervical Cancer Screening Program. They include:

. **Pap smear taking services.** Most Pap smear tests in Victoria are taken by general medical practitioners in private practices and community health centres. Other providers include obstetricians and gynaecologists; practitioners in public hospitals and nurses.

. **Cytology Laboratories.** Cervical cytology in Victoria is provided through a network of private laboratories and

the publicly funded Victorian Cytology Service (VCS). The VCS undertakes approximately 50% of all cervical cytology in Victoria.

. **Follow up and investigation of abnormalities.** General practitioners, gynaecologists and colposcopists play a major role in the follow up and investigation of women with screen detected abnormalities.

. **The Victorian Cervical Cytology Registry.** The Registry has monitoring and reminder functions; provides a fail safe method of ensuring that women with significant abnormalities are followed up and has the capacity to assist in the quality assurance process in respect of laboratories[1];

. **Community and Professional Education.** The Anti Cancer Council Victoria, the VCS and the VCCR play a role in the development of educational programs aimed at communicating to both women and health professionals the purposes and benefits of cervical screening and the activities and philosophies of the Victorian program. Responsibility for professional education also lies with the relevant tertiary institutions and professional associations.

The significant challenges which remain in the Victorian context involve developing strategies to ensure that:

. mechanisms exist to efficiently and effectively monitor, coordinate and evaluate the program;

. there is consistency in reporting on cervical cytology between laboratories;

. agreement is achieved among relevant health professionals concerning the management of screen detected abnormalities in Victorian women;

. screening and management policies are communicated and adhered to by relevant health professionals;

. unscreened and under screened women participate in an organised approach to cervical screening program - namely in cervical screening and in the Registry;

. mechanisms exist to ensure that women who 'age' into the Victorian program do participate in screening; and

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[1]At present the Management Committee of the Registry is a Sub-Committee of the Board of the Victorian Cytology Service (VCS). The VCS is in the process of becoming incorporated, after which the Registry will continue to be a program of the VCS. The Laboratory and Registry share premises.

. appropriate and sensitive services for Pap smear taking and recruitment are available in Victoria.

3. COORDINATION, MONITORING AND EVALUATION

As indicated above the Victorian Cervical Cancer Screening Program comprises a number of components. Its successful implementation will depend upon there being effective communication, coordination and cooperative working relationships between relevant groups and organisations. Further, Victoria's participation in efforts to monitor and evaluate the National Screening Policy will depend upon there being some mechanism for program wide coordination in the Victorian context.

At present there is no organisation with a specific charter to oversee coordination, monitoring, evaluation and ongoing planning of the cervical screening program in Victoria. From time to time, however, the Board of the Victorian Cytology Service has assumed responsibility for some of these tasks.

It is proposed in this plan that there is a need for a mechanism to ensure that the program is effectively coordinated, monitored and evaluated. There are two possible options for developing such a mechanism. A separate unit could be established to be overseen by a group representing relevant areas of professional and community expertise - including gynaecologists, general practitioners, pathologists, colposcopists, Anti Cancer Council Victoria, Health Department Victoria, nurses, women's groups; the VCCR and the VCS. The Unit would be auspiced by one of the major agencies in the Victorian Cervical Cancer Screening Program. Alternatively, the functions of monitoring, coordination and evaluation could be assigned to an existing organisation in the Program. The latter option has advantages in terms of efficiency and cost effectiveness and is a viable one given that the Victorian Cervical Cancer Screening Program is well established and is operating effectively. It is proposed that a decision regarding the most appropriate mechanism be decided following further consultation.

OBJECTIVE	KEY RESPONSIBILITY	TIME LINES
To develop a mechanism to ensure program wide coordination, monitoring, planning and evaluation.	Interim: The Board Victorian Cytology Service.	Progressive implementation commencing 1991-92.

3. THE MANAGEMENT AND FOLLOW UP OF ABNORMALITIES

The CCSESC report identified a number of problems associated with the management of screen detected abnormalities:

. some women with abnormalities are not being followed up;

. at present there is no standardised reporting requirements within laboratories with the result that there are wide variations in what is reported by laboratories, particularly in relation to minor abnormalities and in recommendations to practitioners on the management of such abnormalities;

. at present there is wide variation between practitioners in the management of abnormalities - namely in determining whether further investigation is necessary and what form of treatment is required. Recent research suggests that this may be leading to some women being referred for unnecessary treatment (CCSESC,1990 p5). This may occur at the expense of efforts being placed into ensuring that those requiring treatment are being followed up.

The acceptability of a screening program to Victorian women will depend on this problem being addressed. So too will its cost effectiveness - it is estimated that 50% of the current cost of the Cervical Screening Program nationally is incurred in the investigation and treatment of screen detected abnormalities (ibid).

In Victoria the Registry provides a 'safety net' for participating women to ensure that those with significant abnormalities are followed up.

At the National level, the issue of the management of abnormalities has been referred to the Health Care Committee of the National Health and Medical Research Council for consideration.

It is proposed that in the Victorian context the focus should be on developing greater consensus, understanding and skills around appropriate reporting and management with a view to significantly reducing unwarranted investigation and treatment. This will involve a number of initiatives including:

. analysis of data from the Victorian Cervical Cytology Registry to provide an indication of current management practices and a more accurate understanding of the screening histories of women who develop invasive cancer of the cervix. It is proposed that funds be sought for the implementation of this component of the plan.

. the conduct of a series of workshops involving pathologists, colposcopists, obstetricians and gynaecologists, women's health groups and general medical practitioners. The aim of the workshops should be to involve relevant parties in the development of a consensus around appropriate protocols and procedures for the reporting and management of screen detected abnormalities; and

. the development of pre-service and in service education and training for relevant health professionals regarding the reporting and management of screen detected abnormalities (see Section 5.2, Professional Education, below). Professional education programs would be based upon the research findings and policies and protocols outlined above.

OBJECTIVE	PRIMARY RESPONSIBILITY	TIME LINES
To gain an indication of the screening histories and management of women with screen detected abnormalities using data from the Victorian Cervical Cytology Registry.	The Victorian Cervical Cytology Registry.	To commence 1991-92 with progressive implementation to 1993-4.
To convene a series of workshops involving relevant health professionals and community interests for the purposes of developing agreed policies and protocols for the reporting and management of screen detected abnormalities.	To be initiated by Anti Cancer Council Victoria.	

5. EDUCATION AND RECRUITMENT

Education and recruitment involves women themselves as well as the range of health professionals involved in the delivery of the Victorian Program. Strategies need to be developed with a view to:

. promoting the purposes and benefits of cervical screening to health professionals and to women;

. promoting the philosophies, policies and activities of an organised approach to health professionals and to women (eg screening intervals; the Registry);

. encouraging women to participate in screening in the first instance and to ensure their ongoing participation according to recommended intervals.

. enhancing the capacity of relevant health professionals to effectively deliver the range of components of the program from education and recruitment and Pap taking services to the management and follow up of abnormalities.

Attention to education and recruitment strategies in the Victorian Program is particularly important for a number of reasons:

. in the absence of a consensus in relation to screening policies, women have been given conflicting advice by practitioners. Typically this has been based on a shorter screening interval than that proposed in the National Screening Policy. The cost effectiveness of the Cervical Cancer Screening Program will depend upon practitioners and women being aware of and adhering to the National Screening Policy.

. as noted above, there are concerns about unwarranted investigation of screen detected abnormalities. This has consequences both for the individual women concerned; the acceptability of the program to women and its cost effectiveness.

. while in general in Victoria rates of participation in cervical screening have increased steadily over the last twenty years, data suggests that among particular groups of women there remains a significant proportion who have either never been screened (the unscreened) or who have been screened at intervals greater than three years (the under screened). There are a number of barriers to screening including:

- forgetting;
- lack of understanding of the role and value of cervical screening;

- embarrassment or discomfort associated with smear taking; and
- limited access to services which are sensitive and appropriate to the needs of specific groups of women (eg services specifically targeted to Koori and non-English speaking women; separate clinics for rural women; choice of gender of service provider) (ibid pp47-49).

The majority of women who develop invasive cancer of the cervix have never been screened (ibid p35). Those groups identified as both unscreened and under screened include older, low income and Koori women and women of non-English speaking background. Without effective strategies in place to ensure the recruitment of these women to screening, medical practitioners may be reluctant to implement the new screening policies.

In addition to professional education offered through relevant tertiary institutions there has been a number of specific community and professional education initiatives within the Victorian Cervical Screening Program. These are as follows:

. The Anti Cancer Council of Victoria (ACCV) has developed and continues to implement a range of activities to promote the purposes and benefits of cervical screening to women and health professionals. These include:

- an information pamphlet on cervical cancer and cervical screening in multi lingual form;

- the initiation and support of specific campaigns in the community;

- support to health and community workers through the provision of advice and resources;

- in service education for health professionals;

- a poster encouraging women to participate in screening; and

- a resource library for use by community groups and services running programs to promote the purposes and benefits of cervical screening. The library holds up to date written and audiovisual material.

. In 1990 the Management Committee of the Registry convened an education sub committee to, among other tasks, develop a community education program to promote the Victorian Cervical Cytology Registry to women and health professionals. The Registry was successful in securing funds through the Health Promotion Foundation for funds for this purpose. Two community education workers employed as part of the project have played a

role in promoting the Registry through women's groups and networks and among community health and development workers. A multilingual pamphlet and poster has also been produced.

. The VCS offers a professional education program coordinated by a part time general medical practitioner. The program includes an information service and the production and distribution of a regular newsletter.

. In 1989-91 the Health Promotion Foundation funded the 'Victorian Community Based Cervical Screening Project' - a project aimed at recruiting unscreened and under screened women to cervical screening. The Project was implemented by community health nurses employed in selected community health centres across Victoria. It is currently being evaluated.

In the context of this project a three week training course was developed at Latrobe University (Abbotsford Campus). The course was undertaken by nurses participating in the project on an in service basis. Course material focused on issues regarding the taking of Pap smears. A broad range of women's health, recruitment and program administration and development were also addressed.

5.1 **Women**

In Australia two approaches to the development of education and recruitment strategies aimed at women can be discerned. The first involves broad scale activities aimed at women in general. The second is a targeted approach involving communicating with particular groups of women known to be unscreened or under screened. While many of the activities and resources developed in the context of the Victorian education program to date have been accessible to a wider audience, the focus has been increasingly towards a targeted approach.

It is proposed that in Victoria current activities applicable to a wider audience of women be maintained at a low level but that a targeted approach be further developed. The reasons for this are as follows:

. evidence suggests that broad campaigns are not a particularly effective way of reaching women who are unscreened or under screened and that indeed they may foster over screening among some groups of women with rates of screening which are already satisfactory (Mitchell, Hurst and Cockburn et al, 1991, In Press);

. existing initiatives have been based on screening policies consistent with those recommended in the National Screening Policy. Hence there is no need to

revise information which has to date been communicated to Victorian women; and

. it is believed that at this stage in Victoria, given the tendency for many practitioners to recommend a shorter screening interval than that identified in the National Policy, that resources would be more effectively used in communicating the new screening policies to practitioners.

The establishment of the Registry helps to ensure that women are reminded when their tests are over due. However in order to benefit from the reminder function of the Registry, women have to have had a Pap smear since its establishment.

The ACCV, in conjunction with the VCCR have been successful in securing funds from the Better Health Commission to develop strategies to recruit under and unscreened women. Through their participation in the Registry, women recruited throughout the life of the project will be regularly reminded if and when they become overdue for subsequent Pap smear tests.

At the successful completion of this project the Victorian Cervical Screening Program will enter into a maintenance phase. Any future initiatives will be relatively small and focused on specific areas of need.

The Program will be state wide and its primary target group will be older women as this group experiences the highest rates of cervical cancer but participates least in screening. However emphasis will also be placed on Koori, rural, isolated, low income and disabled women and women of non-English speaking background. The project will employ three major strategies:

(i) personalised invitations to women in the 50-69 year age group using the electoral register;

(ii) implementing innovative strategies for recruiting women to screening and delivering Pap smear services (eg work based programs) The emphasis in this second component of the program will be on supporting existing local workers through the provision of resources, information and activity guidelines; and

(iii) working with health and community workers to increase their knowledge and awareness of and capacity to respond to cervical cancer and screening issues.

This project was developed on the basis of a pilot project undertaken by the ACCV in 1989. Experience from the pilot suggests that a combination of strategies (namely personalised invitations and a community campaign) had a greater impact on recruitment than either strategy implemented in isolation (ACCV, 1991 p3).

The project will achieve state wide coverage progressively over a three year period, working region by region.

It is anticipated that special services for Koori women will be a need which may require attention and resources beyond those sought in the joint submission. This will be assessed as part of the evaluation of the joint project.

While the Victorian program involves a reminder system for women who have participated in cervical screening, it does not have a call system; ie. a system using a population register such as the electoral roll to invite women in relevant age groups to participate in screening in the first instance. A call system, while a feature of a comprehensive organised approach has attracted only limited support in Australia to date. This is because it is thought to be costly and vulnerable to being construed as a threat to privacy.

Consideration of a call system is crucial as it is an important strategy for ensuring that those women who 'age' into the Victorian program do participate in screening. The joint VCCR/ACCV submission (see above) proposes a limited 'once only' call system using the electoral register for women in the 50-69 age group.

It is proposed that further consideration be given to such a system for those women who 'age' into the program as part of the evaluation of the Victorian program in general and of the joint project in particular.

OBJECTIVE	KEY RESPONSIBILITY	TIME LINES
To increase the participation of those groups of women who are unscreened or under screened in an organised approach to cervical screening.	The Victorian Cervical Cytology Registry and Anti Cancer Council Victoria.	Implementation over three years commencing 1991-92.
To consider the need for a call system for women who 'age' into the Victorian Cervical Cancer Screening Program in the context of the evaluation of the Program.	The body responsible for monitoring, evaluation and coordination of the program.	Ongoing, to be completed 1994-5.

5.2 Health professionals

There is a need for education aimed at a range of professionals involved in the Victorian Program including:

5.2 (a) **Community Development and Community Health Workers.**

Social workers, Koori health workers; ethnic health workers; youth workers; community nurses and women's health workers often have good links and skills in working with those groups of women who have to date been under screened or unscreened. They are therefore well placed to play a role in community education and recruitment. Workers at this level require information regarding screening policies and philosophies; effective recruitment strategies; and referral services. At present support of this nature is available through ACCV and the VCCR and is also an important component of the joint ACCV\VCCR submission to the Better Health Commission (see above).

5.2 (b) **Nurses**

The CCSESC report indicates that most women will continue to have their Pap smears taken by general practitioners. However, there is some evidence to suggest that services delivered by Nurses have considerable capacity to address some of the problems associated with recruiting unscreened and under screened women. There are a number of reasons for this:

- nurses are often employed in settings (eg community health services) where they are able to provide Pap smears in the context of other women's health issues;

- the use of nurses (a profession comprised predominantly of women) increases the possibilities of women having choice of gender of service provider. This may be particularly important in rural and isolated communities; and

- the CCSESC report found that women themselves find the service provided by nurses acceptable and sensitive to their needs.

Pilot programs conducted in the course of the evaluation found that nurses were able to take smears of a desirable quality (CCSESC, 1990 p61-65).

Accordingly it is proposed that nurse practitioner courses be developed and offered in tertiary institutions providing education to nurses as well as in other relevant organisations (eg; the Family Planning Association).

OBJECTIVE	KEY RESPONSIBILITY	TIME LINES
To develop post graduate education programs to enable nurses to participate in the delivery of the education, recruitment, counselling and Pap test taking aspects of the Victorian Cervical Cancer Screening Program.	To be initiated by the College of Nursing, Australia.	To commence 1991-92

5.2 (c) **Medical practitioners**

There are a number of medical practitioners involved in the implementation of the cervical screening program. These include:

. General Medical Practitioners. General Practitioners have an important role to play in encouraging women to participate in screening; in Pap smear taking and in the follow up of screen detected abnormalities. The focus in education for general practitioners should be on both the technical and interpersonal skills required to execute these roles effectively and sensitively.

. Pathologists. Pathologists are responsible for the analysis and reporting of cervical cytology. The emphasis in training needs to be on the technical aspects of these tasks.

. Obstetricians, gynaecologists and colposcopists. These professionals play a significant role in the follow up and investigation of screen detected abnormalities. The emphasis in training needs to be on both the technical aspects of investigation as well as the interpersonal and counselling skills required for the sensitive management of women with screen detected abnormalities.

To date significant efforts have been placed into communicating the purposes, benefits and activities involved in cervical screening to women (see section 5.1 above). The

success of the National Program, however will depend upon practitioners providing advice to women which is consistent with program screening policies; the content of education programs aimed at women and acceptable management practices. It is proposed that:

. education and training modules be developed for inclusion in the undergraduate and post graduate medical curriculum;

. in-service education programs be developed targeted to pathologists, general practitioners and obstetricians/gynaecologists, with particular emphasis being placed on information relating to screening policies and the management of abnormalities; and

. a campaign be developed aimed at communicating to relevant health professionals the screening policies of the National Program and issues relating to the appropriate management of abnormalities.

Both the education and training modules and the campaign will be based on the policies and protocols outlined above (see Management of Abnormalities, Section 3).

OBJECTIVES	KEY RESPONSIBILITY	TIME LINES
To communicate the National Screening Policy to relevant health professionals with a view to ensuring its application.	To be initiated by Anti Cancer Council Victoria in cooperation with the Royal Colleges of Pathologists, Obstetricians and Gynaecologists and General Practitioners and the Victorian Cooperative Oncology Group.	To commence 1991-92 with progressive implementation to 1993-4.
To ensure there exists among relevant health professionals an adequate skill and knowledge base with regard to cervical screening, screening policies and philosophies and the management of screen detected abnormalities.		

5.2 (d) **Cytologists**

Cytology is one of the course components of the basic qualification for most laboratory scientists (B App Sc Lab Sci). Specific job training is provided by employing institutions. The VCS runs an organised training program for new staff. Other institutions which train staff provide more informal 'on-the-job' training. Continuing education activities are mainly provided by meetings and workshops organised by the Australian Society of Cytology.

OBJECTIVE	KEY RESPONSIBILITY	TIME LINES
To ensure that adequate training is provided for appropriately qualified Cytologists.	Pathology laboratories in both the public and private sectors. Royal Melbourne Institute of Technology Australian Society of Cytology	Ongoing
To ensure that continuing education is available to Cytologists.		

6. CERVICAL CYTOLOGY REGISTRY

The CCSESC report proposed that cervical cytology registries be developed in each of the states. The Cervical Cytology Registry was established in Victoria in 1989 following an amendment to the Cancer (Central Registers) Act. Women participate in the Registry on a voluntary basis, with consent being sought by the smear taker. It is the responsibility of the laboratory to lodge relevant details with the Registry.

The Registry has a number of functions including:

. Monitoring of recruitment, participation in screening, management practices, and screening histories.

. Reminder and recall. While in general it is accepted in Victoria that the VCCR reminder function should complement practice based reminder systems, a significant proportion of medical practices do not have these systems (Bowman et al, 1990). Further, studies show that many women change their practitioner within recommended Pap smear intervals and so do not necessarily benefit from practice based reminder systems (Mitchell, 1990 pp126-131);

. providing a fail safe method for ensuring that women with significant abnormalities are followed up. This is particularly important since abnormal results are sometimes overlooked by a practice.

. quality assurance in respect of laboratories.

It is estimated that 98% of the results of Pap tests taken in Victoria are registered with the VCCR. The vast majority of private laboratories as well as those attached to large public hospitals are participating. At present steps are being taken to involve the laboratories of smaller hospitals. It is hoped that by December 1991 virtually 100% of Pap tests taken in Victoria will be registered with the Registry, with all laboratories participating.

The Registry commenced its recall functions in 1990 for those women who have not returned for a Pap smear within the time lines of the agreed protocol. To date approximately 10% of the full effect of the Registry's recall function has been implemented. A pamphlet providing general information about the Registry and the purposes and benefits of cervical screening is included with all reminder letters. At present steps are also being taken to develop an insert instructing women unable to read the English version of the pamphlet on where they are able to get further information in their own language.

The VCCR is located at the Prince Henry's Hospital as part of the VCS. It is anticipated that the VCS (including the VCCR) will be relocated to the Royal Women's Hospital in December 1991.

OBJECTIVE	KEY RESPONSIBILITY	TIME LINE.
To maintain and further develop systems for monitoring, quality assurance and for reminding women when their next test is over due.	The Management Committee, Victorian Cervical Cytology Registry.	Ongoing.

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Centre for Behavioural Research in Cancer

MEMORANDUM

TO: **Participants at the ACCV "Cervical screening campaign future directions" meeting.**
Nigel Gray, Robin Marks, Dorothy Reading, David Hill, Sandra McLure, Sue Noy, Heather Mitchell, Onella Stagoll, Michael Quinn, Vicki White, Sheila Hurst, Marco Cappiello, Jeanette Ward, Louise Johnson, Graham Giles.

FROM: **Jill Cockburn**

DATE: **19 April, 1990**

Subject: **Proportions of women who report never having had a Pap test.**

Dear Participant,

At our recent meeting I presented data from a survey we conducted on cervical screening behaviour of randomly selected women from the Ballarat region. There was some surprise expressed at the proportion of women from our study who reported never having had a Pap test. We have therefore contacted researchers from other centres around Australia who have conducted comparable surveys, to obtain some other estimates. This information is attached. You will see that our figures agree with those reported by others. All studies give estimates of around 10% of women reporting they have never had a Pap test.

Jill Cockburn

Jill Cockburn

61CJC01:sn2

Researchers	Centre	Age group survey	N	Percentage of women reporting never had Pap
Cockburn et al	CBRC, Vic	40-70	time 1: 347 time 2: 309	8.9% 10.4%
David Hill	CBRC, Vic	40-70	5220	9.0%
Damien Jolly (for ACCV case-Control study)	CEC, Vic	40-69	729	11.5%
Jennifer Bowman	University of Newcastle, NSW	18-70	757	8.8%
Jennifer Muller	Epidemiology & Cancer prevention Unit, QLD	20-69	1925	11.8%
Les Irwig	University of Sydney, NSW	20-70	not given	10%

A member of the Australian Cancer Society
Director Dr Nigel Gray A.M. MB BS Hon. LL.D. FRACP FRACMA

VICTORIAN
COOPERATIVE
ONCOLOGY GROUP

Anti-Cancer Council of Victoria

GYNAECOLOGICAL ONCOLOGY GROUP OF VICTORIA

gogov/lr-1

May 4, 1989

Dr R Marks
Director
Programs & Management
Anti-Cancer Council of Victoria

Dear Robin

Re: **ACCV Policy on Cervical Screening Interval**

The report of the working party convened to consider Council policy on cervical screening interval was discussed by GOGOV at its meeting on March 16 and also by VCOG on March 22.

I am pleased to advised that both GOGOV and VCOG agreed with the recommendations of the working party and recommended that it be adopted as ACCV policy.

GOGOV also supported research being undertaken to determine whether there is an increased incidence of invasive cancer of the cervix in young women and whether there is a new disease of rapidly invasive cancer of the cervix in young women.

Reports of the progress of these research projects would be greatly appreciated.

Yours sincerely

Susan Fitzpatrick

Administrative Secretary

KEOGH HOUSE, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053 ☎ (03) 662 3300
Facsimile: (03) 663 3412 Telex: ACCV AA 34158

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB BS Hon. LL.D. FRACP FRACMA

VICTORIAN
COOPERATIVE
ONCOLOGY GROUP

Anti-Cancer Council of Victoria

Executive Secretary : Professor Emeritus RRH Lovell

vcog/mm-1

29 August, 1989

Memorandum to: Dr N Gray, Dr D Hill, Ms D Reading
Dr G Giles, Ms S Baxandall, Ms A Holzer
Mrs B Lovegrove, Ms S Noy

From: Mrs S Fitzpatrick

Subject: **ACCV Policy on Cervical Screening Interval**

The attached letter refers to the endorsement by VCOG (March 22) of the recommendations of the Council's working party on policy for cervical screening interval.

The working party recommended:

1. Cervical screening is recommended only for women who have had sexual intercourse. The screening should start within three years of first intercourse.

2. Screening can cease at the age of 65 years if previous regular smears up until this age have been normal. This does not imply that women should not continue to be seen regularly by a doctor after the age of 65 years to exclude other gynaecological disorders.

3. The screening interval for all women with normal smears should remain at **two years** for the time being.

4. Research should be undertaken to determine whether or not there is (1) an increased incidence of invasive carcinoma of the cervix in young women; (2) there is a new disease of rapidly invasive carcinoma of the cervix in young women.

5. The recommendations on the screening interval should be reassessed, and altered if necessary, when the results of the research recommended in 4. are available.

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1 copy NG ✓

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB. BS. Hon. LL.D. FRACP. FRACMA

Anti-Cancer Council of Victoria

31st May, 1989

Dr. P.S. Bunn,
Eildon Clinic,
EILDON. 3713.

Dear Dr. Bunn,

In his telephone conversation with you, Dr. Nigel Gray mentioned the final report of our cervical screening campaign in the Mallee/Loddon/Campaspe region in August 1988. I am forwarding a copy of this report to you for your information, as promised by Nigel.

It was the information gleaned from the survey results of this campaign that showed us the importance of anonymity and a female practitioner to roughly 40% of women who participated in that campaign. Accordingly we went to some lengths to encourage the provision of screening clinics in our subsequent campaign in April this year.

After some delay I have managed to get in touch with the locum who staffed the clinic in your area and she has agreed to sent out results to the women concerned. Her letter to the vast majority of them whose smears were normal will advise them to seek a repeat smear in two years' time from their own medical practitioner. One or two of the smears, I understand, showed benign abnormalities and she will attempt to make arrangements to contact the women involved. I am happy to let you know of the outcome of these attempts should you wish me to do so.

Yours sincerely,

Dorothy Reading

Dorothy Reading
Director of Education

cxcdro3r

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A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB. BS. Hon. LL.D. FRACP. FRACMA

Anti-Cancer Council of Victoria

11 May 1989

49-1053

Dr. P.S. Bunn
Eildon Clinic
Eildon Vic 3713

Dear Dr. Bunn,

I'm writing a personal note to explain a bit about the rationale for the Anti-Cancer Council's recent campaign to encourage people to have Pap smears. Donna Reed has passed on your concerns to us and naturally I am anxious to make sure that we haven't put a foot wrong.

Our starting point is the fact that there is a significant number of Victorian women (about quarter of a million) in the at risk age group for cervical cancer who have **never** had a smear. The other way of phrasing this is that 1.15 million out of the at risk 1.4 million have had a smear. About three quarters of the cancer occurring in Victoria at the moment occurs in women who have never had a smear.

Our response to this has been, region by region, to run campaigns trying to encourage the never smeared population to have one. As a part (but only a part) we have encouraged local hospitals to run special clinics staffed by women to take smears during the campaign. Our reason for this is that our Behavioural Science Unit indicates that there is a significant proportion of the never smeared population who give as a reason for not having a smear, the fact that they would only wish to have such a procedure from a woman.

We are very much **not** attempting to steal people's patients as we are a charity which doesn't have any service delivery function. We are in fact encouraging women to have a smear and hope that having had one they will continue to have smears from the doctor of their choice.

The patients who gave your name as the person to whom the results should be sent, obviously chose to have the follow-up service rendered by you and it seems to me that this indicates that they probably are members of that population group who prefer to have a woman take their smear but prefer to have their own doctor handle any outcomes.

The Anti-Cancer Council is anxious that the smear campaign succeeds in contacting more and more of the never smeared population and will greatly appreciate anything you can do to help encourage this group.

This letter really is an explanation, although I hope it might also influence your decision.

Yours sincerely,

Nigel Gray
Director

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URGENT URGENT URGENT

ANTI-CANCER COUNCIL OF VICTORIA

EDUCATION UNIT

M E M O R A N D U M

FROM: Dorothy Reading

TO: Nigel Gray

DATE: 8th May, 1989

SUBJECT: Problem arising from recent pap smear campaign

Attached is a letter from Dr. Bunn of Eildon, refusing to handle results of pap smears taken in a screening clinic. The Director of Nursing has not been able to change his mind.

I have drafted a letter which I think you should sign - I hope you agree. David Hill even suggested you should offer to talk to him on the phone so I have included that in the last line.

The only issue not addressed is the quality of the smears. We could offer a VCGS report on whether they were OK, but that would be a problem if they were not. I'm in all day if you want to discuss this.

Dorothy

Dorothy

cxcdr03r

Sheila Hurst is
v. concerned.
Women are ringing
+ can't get their results

J

KARLIK

EILDON CLINIC
EILDON, 3713
TEL. (057) 74 2009

Director of Nursing,
Eildon & District Community Hospital,
EILDON 3713

May 2nd 1989,

Dear Donna,

After due consideration, I feel that I cannot be responsible in releasing results to the people concerned in the recent Pap Smear Clinic.
In all conscience I cannot charge to give results of a service I did not render and further, if the results are abnormal, I am in no position to advise the people as I have no clinical notes. The patients have tacitly indicated the service that I give at this clinic does not meet their requirements.
Furthermore, I will restate that the ever increasing government services may result in this practice becoming non-viable.

free

Yours sincerely,

P.S. Bunn.

No-one

Chief Executive Officer - Bruce Giovaretti

Ms Bunn

and District Community Hospital

HIGH STREET, EILDON, Vic. 3713
PHONE EILDON 74 2609, 74 2404

FACSIMILE NO. 057 74 2169

- FACSIMILE TRANSMISSION -

DATE : 4/5/1989

TO : Sheila Hirst

FROM : Donna Reed Director of Nursing, Eildon Hospital, 057. 742. 404.

SUBJECT : Pap Smear Clinic.

COMMENTS : Good luck.
Awaiting your prompt reply.

NO. OF PAGES : 2.

SIGNATURE : .....Reed.....

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB, BS, Hon. LL.D, FRACP, FRACMA

Anti-Cancer Council of Victoria

23 May 1989

49-1080

Professor N. Beischer
Australian and New Zealand Journal of
Obstetrics and Gynaecology
University Department of Obstetrics
and Gynaecology
Mercy Maternity Hospital
Clarendon Street
East Melbourne Vic 3002

Dear Norman,

Thanks for your note about the lack of clarity which applies to publication of cervical cancer information.

I've sent a copy to Graham Giles who will respond to you directly. He may or may not choose to co-author something with Heather Mitchell.

Yours sincerely,

Nigel Gray
Director

cc A - GG+

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Australian and New Zealand Journal of

OBSTETRICS AND GYNAECOLOGY

Official publication of the Royal Australian College of Obstetricians and Gynaecologists and the Arthur Wilson Memorial Foundation

Editor: PROFESSOR NORMAN BEISCHER
UNIVERSITY DEPARTMENT OF
OBSTETRICS AND GYNAECOLOGY,
MERCY MATERNITY HOSPITAL,
CLARENDON STREET,
EAST MELBOURNE,3002,
VICTORIA

Sub-Editor: DR JAMES EVANS
DEPARTMENT OF OBSTETRICS
AND GYNAECOLOGY,
ROYAL WOMEN'S HOSPITAL,
CARLTON, 3053,
VICTORIA

16th May, 1989

Dr Nigel Grey
Anti-Cancer Council
1 Rathdowne Street
CARLTON SOUTH 3053

16 MAY 1989

Dear Nigel,

Recently the Australian and New Zealand Journal of Obstetrics and Gynaecology has accepted papers from New South Wales and South Australia on the incidence and mortality of carcinoma of the cervix and the 2 States report different figures. For argument's sake, New South Wales reports that when allowance was made for the number of women having hysterectomy, cancer of the cervix has decreased significantly in incidence from 1973 - 1982 and in the mortality rate. A report from South Australia however, states that there has been an increase in the cervical cancer incidence of 80% in women under the age of 50 years in the 9-year period to 1986, but a decrease of about 25% in older women. The purpose of this letter is to ask whether you or one of your officers would be prepared to write an editorial for the Australian and New Zealand Journal of Obstetrics and Gynaecology on the Australian situation regarding the incidence of genital tract carcinoma and whether it is changing. It would probably be wise to make separate statements for invasive cancer of the cervix, uterine body, ovary and vulva. **I think it is important that such an editorial sets out the time at which the various States and Territories in Australia introduced notification of cancer, because statistical comparisons should be interpreted in light of this.** For example, since 1972 the New South Wales Central Cancer Registry has received statutory notification of all cases of cancer in New South Wales residents admitted to hospital or attending radiotherapy departments, and abstracts of Death Certificates in which cancer was mentioned. Similar data has also been collected from the Australian Captial Territory. I am sure our readers would be interested, as would I, to know the comparable notification situation for the other States and Territories. I know there have been 2 recent bulletins from the Anti-Cancer Council regarding endometrial and cervical cancer but from memory they do not address themselves to the problem of certification and whether the incidence in the community of these diseases has changed either in separate age groups and in the population as a whole.

With kind regards,

Yours sincerely,

Norman

NORMAN A BEISCHER

cc: Dr Barry Kneale
c/- Mrs Susan Fitzgerald

1875

DRAFT

ANTI-CANCER COUNCIL OF VICTORIA

EDUCATION UNIT

MEMORANDUM

FROM: Sheila Hirst

TO: Nigel Gray, Robin Marks

DATE: 10th May, 1989

SUBJECT: Complaints to Medicare about legality of Pap Test Clinics of Goulburn North-East Region

==========

A number of complaints have been received by Dr. Bernie Zerman, Medicare Advisor, re the legality of the Pap Test Clinics, held in the last campaign region.

The clinics have been held in a variety of settings:

a. hospitals
b. community health centres/community houses
c. GP practices

The holding of special clinics in the GP practices is a new development in this campaign.

The clinics have either been held as free clinics or the women have been bulk-billed. The bulk-billing aspect has been negotiated at a local level. While many doctors were happy to participate, they felt that it was really important that they offered a broader service i.e. breast checks, blood pressure, etc. In this context they selected to bulk-bill.

The complaints received by Dr. Zerman have covered two main points

a. The clinics have been promoted as "free" clinics. Obviously where there is a bulk billing arrangement, this is not the case. In reviewing media publicity received to date, this has not occurred; rather the clinics have been promoted as "special" but not free.

b. The legality of advertising clinics in specific GP practices. This has been seen to be unfair advertising resulting in "poaching" from other practitioners.

Wherever possible, women have been encouraged to go to their own doctor and the advertising (both in print and on radio) has promoted both the usual medical channels as well as special clinics (see attached sample press coverage and advertisement).

Dr. Zerman would like to discuss these issues with us particularly with the medical practitioner within the Council responsible for the program. He is keen to ensure that future clinics do not breach the appropriate laws.

Can we arrange to discuss this matter?

Sheila Hirst

Sheila Hirst

I have organized a provisional meeting for Thursday 15.5.89 at 12 midday with NG, DR. RM and SH.

c.c. Dorothy Reading

11/4/86

Pap Test Month launched this week

Pap test month was launched this week in the Goulburn North East Region.

As a joint venture of the Anti-cancer Council of Victoria and local health workers, the campaign aims to help reduce the toll of cancer of the cervix in women.

Cancer of the cervix (the neck of the womb) is the most preventable cancer in women if only all women knew about having a Pap test at least every two years.

The Pap test detects early changes in the cervix which may lead to cancer if not treated.

Of the 270 women who develop this cancer annually, nearly three quarters of them will have never had a Pap test.

Seventy per cent of cancer of the cervix occurs ion the over 40's but the vast minority of Pap tests are performed in younger women.

The Anti-cancer Council's education officer, Sheila Hirst, said: "These startling figures linking not having Pap tests with cancer of the cervix have been the driving force behind the Council's Pap test campaign.

"In the Goulburn region it is estimated there are about 11 800 women aged between 45 and 69 out of a total of 19 385 who haven't had a Pap test for at least three years.

In Kyabram and district it is estimated over 1300 women out of a total of 2253 women in this age group haven't had a Pap test for at least three years.

Many of these women haven't had one for years.

"It is these older women that we particularly want to reach with the important Pap test message," said Ms Hirst.

"But we also want to encourage all women with an outdated Pap test record to take advantage of Pap Test Month and have a Pap test during the next four weeks."

Local community health workers, gynaecologists and general practioners have been putting their weight behind this important campaign and encouraging women to have a Pap test.

Women are advised to go to their family doctor for a Pap test.

Some women prefer to choose another doctor and for some a woman doctor is preferable.

As a part of the campaign special Pap test clinics are being held at the West Goulburn Community Care Centre in Stanhope.

The clinic is staffed by local doctors and are especially for women of 40 who have not had regular Pap tests.

The clinics will be operating between 9.15 am and 11.15 am today (Tuesday), Tuesday April 18, Thursday April 27 and Tuesday May 2.

Appointments can be made by contacting the centre on 57 2400.

PAP TEST CAMPAIGN

WHERE TO GET A PAP TEST

1. Make an appointment with your local doctor.
2. SPECIAL PAP TEST CLINICS

VENUE: West Goulburn Community Care Centre, Stanhope.

DATES: Tuesday, April 11, 9.15-11.15
Tuesday, April 18, 9.15-11.15
Thursday, April 27, 9.15-11.15
Tuesday, May 2, 9.15-11.15

Telephone (058) 57 2400 for an appointment

The Pap Test Campaign is supported by your local community and the Anti-Cancer Council of Victoria.

Cervical

21 March 1989

49-871

MEMORANDUM TO: D. Reading/R. Marks/D. Hill/H. Mitchell

FROM: Nigel Gray

==========

Last year the press picked up pap as a label for for the papilloma virus. This is entirely appropriate except that it causes confusion with Pap as short for Papanicolaou. I think we should give serious consideration to the shorthand jargon we use with the press. It may be wise for us to consider establishing something other than pap as a label for our cervical cytology smear.

This is just to trigger your thinking patterns. We ought to talk about it sometime.

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB. BS. Hon. LL.D. FRACP. FRACMA

Anti-Cancer Council of Victoria

2 December 1988

49-721

Mrs C. Evely
75 Ruskin Street
Elwood 3184

Dear Mrs Evely,

Sue Noy has passed across your letter of November 8 and I'm writing to reply. I'm sorry to be a little late.

There's quite a lot of background which I would need to give you to answer the questions you have raised.

First of all that meeting was intended to be a Consensus Conference. The Australian Cancer Society organised the meeting but the initiative to try and achieve the consensus came from this organisation.

The reason for needing a Consensus Conference is that various groups of interests have different views of what needs to be done. As a cancer society we are very anxious to see the disease eradicated. In practice, however, there are a lot of other groups with an interest in the management of disease and there are at least two bodies of technical opinion, quite apart from a variety of bodies of consumer opinion.

In effect, the attempt to achieve consensus failed. The recommendations which were announced at the end of the day and which were published by the Australian Cancer Society to those present at the conference, in fact fell apart quite quickly. The gynaecologists are firmly wedded to the idea of annual screening and the same can be said for the College of General Practitioners. The epidemiologists take the view that screening every three years is adequate to control most of the disease.

As a cancer society who has the responsibility for (a) running the education programs which support cervical screening; and (b) pushing the government into providing adequate services we have a different view again. Our view is based on the practical problems associated with organising such a screening program.

In all of this it's important to concede that everybody has the best intentions but there are genuine differences between the technical opinions involved.

There is, of course, no doubt that the gynaecologists are correct in saying that, if we seriously want to eradicate the disease, then we have to screen everyone annually. The reason for this is (I suspect) exemplified by your own cases mentioned in your letter. There is a small number of patients who develop rapid onset cervical cancers and these are **not** picked up by screening every two or three years. These are fortunately a small percentage, it's not known what percentage they constitute - it's probably of the order of 10% of all patients.

KEOGH HOUSE, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053 ☎ (03) 662 3300
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In practical terms, no-one in anywhere of the world has ever been able to screen all women in a population. Victoria has been relatively successful by world standards. I can summarise this:

> There are 1.4 million women at risk in Victoria and of these only 250,000 have **never** had a smear. 85% of the cancer occurs in the population who have never had a smear. 15% of the cancer occurs in the population which has had one or more smears.

Obviously the most important thing we can do to eradicate the disease is attempt to screen the 250,000 women who have never been screened. As a cancer society we see this as our prime target and are working on it both in terms of research to identify ways of reaching these women and through the Health Department with the objective of seeing that a register is established of all pap smears in Victoria. Once such a register is established it will be possible to issue invitations to people who have never had a smear and to encourage them enthusiastically to have one. Funding for the register is available from the Commonwealth Government and the Victorian Cytology Service is able to run the register and to extend its existing services. The Minister for Health is currently looking at the budget of the service.

In summary, we are fairly close to being able to run a relatively well organised screening service which will make sure that most people in the population have at least one or two smears during their lifetime. The better educated and willing people, of course, will have many more smears than this. About 20% of the population is likely to have bi-annual or tri-annual smears and a smaller percentage will have them every year. So far the Federal Government has shown no inclination to object to funding the service at this level.

To return to the Consensus Conference I don't think we have a consensus and therefore there's probably not much need to comment in detail on the points of disagreement between yourself and the recommendations. I also had points of disagreement. However, if you have any specific questions you'd like me to address I'd be very happy to do it in a later letter. I hope these comments are helpful.

Best wishes.

Yours sincerely,

Nigel Gray
Director

Anti-Cancer Council of Victoria

Education Unit

Memorandum

Date: 16 November 1988

From: Sheila Hirst

To: Dr Nigel Gray

Subject: Cervical Screening Consensus Recommendation

Attached is a letter from Mrs Christine Evely regarding the consensus recommendation. Although not recently, I have talked with Christine in the past as she is an active member of the Cervical Cancer Support Group. My perception is that the Group sees education and advocacy as an important component of its activities and as such were extremely distressed at the consensus recommendation.

Please could you either

a. respond directly
b. forward to the appropriate person
c. return to me to respond with some general guidelines.

I have ~~written~~ drafted a brief letter of acknowledgement but it needs more!

Thanks

Sheila

Sheila Hirst

cxcsh02e

Ms S Noy,
Anti-Cancer Council of Victoria,
1 Rathdowne St,
Carlton South, 3053

Mrs Christine Evely
75 Ruskin St,
Elwood, 3184
8/11/1988

Dear Ms Noy,

I received a letter and report, in August, from L.A. Wright of the Australian Cancer Society regarding the Consensus Conference on cervical cancer. In his letter he stated that you would be able to inform me of progress in this area. Could you please send me details of any progress which has been made since this conference.

I would like to express some of my thoughts regarding the conference. To put it mildly I am shocked and angered by some of the recommendations of this conference.

Firstly, that screening of women should commence at the age of 18 and stop at age 65. Do women outside these age groups have a guarantee that they will not develop cervical cancer or other related conditions which are often detected when a smear test and accompanying medical examination take place? How can the target group for cervical cancer screening be <u>all</u> women when the above ages are mentioned? This does not appear to be logical.

Secondly, there appears to have been general acceptance that 3 yearly screening be recommended, providing 2 annual smears are normal. It appears to me that this conference based this recommendation upon the research and opinions of very few people who have only a limited view of the disease. It does not seem to me that the true views of those consumers who have had direct experience with this disease or the doctors who treat them were canvassed adequately, if at all. I and many women I know would be facing even more drastic treatments (as if radical hysterectomy and lymphadenectomy aren't bad enough) had we been following recommendations such as these. In my case I have had normal smears every 2 years since 1981. However, this was not often enough to prevent me, at age 28, from developing <u>invasive cancer</u> between smears. Away from the microscopes you find

that there are real women developing cervical cancer, who do not always fit the picture portrayed by research statistics.

There are several points to be made about cervical screening. Obviously a great deal of money is required to develop, co-ordinate and implement a community awareness program informing about the need for all women to have annual smear tests and pelvic examinations.

However, if such a program were to be undertaken there are a number of benefits for women and the community in general. Firstly, almost NO-ONE would die from cancer of the cervix. Since this is the only PREVENTABLE cancer, surely there would be enormous benefits to the community if the medical profession was able to say that one form of cancer, which kills, has been eliminated.

The economists have paid lip service to the economics involved in life versus death. However, there is a lot to be said for being alive. Even if you are only one person in a very large population. The economic considerations tabled did not seem to adequately consider the following:
The costs to the community of the 1,000 women who have been diagnosed as having cervical cancer and who live! These women require various costly treatments involving hospitalisation, including radical surgery, radiotherapy, chemotherapy, followed by life-long follow-up health checks. The disruption to lives that this involves is not confined to the patient but also to their families, extended families and friends, often involving extensive time away from employment, much travel not to mention emotional upheaval.

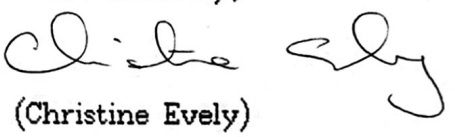
The other issue is quality of life. While many women would still be saved from death due to cervical cancer under the suggested guidelines, this would be at the expense of reproductive function. In a growing number of cases this involves women who have not yet begun a family. The emotional trauma that these women and their families then go through, which incidently is also costly both in human and economic terms, could be avoided.

It is a cop-out to say that existing cytological services could not cope with the increased demand of annual

smear tests. If this is true, then a long-term (not too long) plan needs to begin now. The necessary resources must be put into place over as short a time as possible while community awareness programs are developing. By the time the awareness programs have become comprehensive the resources must all be in place.

This is the perfect opportunity for the medical profession to begin to educate the community about the need for preventive health care. The dental profession has succeeded marvellously in this regard and don't appear to have suffered financially. Given that women are in many cases primary care givers, if they were encouraged to have annual health checks, including smear tests and pelvic examinations, this would be an excellent model for their families. Perhaps many more diseases or illnesses could be detected early giving patients increased chances of living longer, healthier lives.

Yours sincerely,



(Christine Evely)