CERVICAL CANCER PREVENTION

KHOQ EE MING

Cervical cancer is the second commonest female cancer on a worldwide basis after breast cancer. In developing countries, it is the most frequent female neoplasm. In developed countries such as the USA, invasive cervical cancer is the eighth leading cancer cause of death in women with approximately 13,000 new cases diagnosed and about 7,000 women die from this annually. In UK, the incidence is approximately 15 to 16 per 100,000. In Malaysia, the statistics are not much different to the Western figures. From the records of government hospitals, cervical cancer is the commonest female malignancy with an incidence rate of 12.7 per 100,000. The Chinese seem to have the highest incidence among the races. The peak incidence of cancer occurs in women aged 35 to 45 and 55 to 65. Premalignant conditions occur 10 years earlier i.e. at age 25 to 35 and 45 to 55.

The exact aetiology of the cancer of the cervix remains uncertain. However, research continues to suggest that Human Papillomavirus be the most likely culprit.

The risk factors for cervical cancer include early onset of sexual intercourse, low socioeconomic status, history of multiple sexual partners, genital Human Papillomavirus infection, smoking, immunosuppression, HIV positive and possibly long term oral contraceptive users and those with a history of sexually transmitted diseases.

EFFICACY OF SCREENING

The principal screening test for cervical cancer is the Pap smear. It has widely been accepted that screening has been effective in reducing the incidence and mortality rate for cervical cancer from historical surveys, cross cultural correlational studies, case control studies and data analysis from large scale screening programmes. This has not been proven by randomised controlled trials but at this time it would be precluded by ethical consideration. Most cases of death had occurred in unscreened women or in those who had had few smears at long intervals. Several case control studies have found a 2.7 to 4 fold increase and even up to 9 fold increase in the risk of invasive cervical cancer in a women who has never received cervical screening.

Pap smear has a sensitivity of 50% to 90% and a specificity of 90% to 99% depending on the techniques used. Most of the false negative smear can be attributed to laboratory errors and poor technique in performance. Therefore accurate technique is crucial in reducing the false negative results.

About 4.5 million smears were taken in 1991-2 in England and 77.6% of it was done in a primary care setting. In Malaysia, 34,627 women had smear done in 1985 and in 1987 it had increased to 73,868. Primary care providers have been shown to be able to persuade up to 96% of women in their practices to undergo testing and therefore they are in an optimal position to have a significant impact in eliminating avoidable death from cervical cancer. The incorporation of smear into routine primary care screening is the most promising in increasing Pap smear coverage in at risk women. An effective call recall system for cervical screening programme can also increase the uptake of the test. In 1988, a systemic call recall system for cervical screening programme was set up in England and the coverage of the target population has increased from 61% to 83% between 1989-90 and 1992-3.

METHODS OF SCREENING

Prior to having the Pap smear, it is important that the procedures for the test be explained to the patient and an information leaflet on cervical cancer and the smear test be given to educate the patient and to allay patient’s anxiety.

Patient should be instructed to avoid douching or having coitus in the 24 hours prior to the