PRACTICE OBSERVED

Essays on Practice

Cervical screening: a do it yourself job for general practice

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Cancer of the lung and of the cervix are the only common malignancies that are amenable to preventive measures on a large scale. Whereas lung cancer is prevented by stopping smoking (primary prevention), the progression of premalignant cervical neoplasia can be arrested by screening (secondary prevention). Primary prevention is preferable to secondary, but in cervical cancer it is hampered by uncertainty as to the exact cause. Cervical cancer is known to be commoner in heavy smokers.[1] More importantly, it is known to be associated with the use of oral contraceptives,[2] multiple sexual relationships, and pregnancy outside marriage.[3] The confidence with which doctors discourage smoking and advise reducing the consumption of animal fat evaporates when confronted by these uncomfortable associations. Sexual mores are a no go area into which educational, medical, and governmental intervention is difficult and largely unacceptable. Consequently, secondary prevention by screening is likely to remain the chief means of fighting cervical cancer.

The screening programme in north east Scotland has shown that results matching those in Iceland, Finland, parts of the United States, Canada, and Denmark can be achieved in Britain.[4-6] But it is disappointing that in Britain mortality from cancer of the cervix has only dropped from 2434 deaths in 1968 to 2068 in 1980.[7,8] The reason is not that too few smears are being done. In fact the number rose from 687 000 in 1965 to 2 982 000 in 1980, and general practitioners increased their contribution 20-fold during this period.[9] That all this industry has not resulted in a substantial reduction in mortality is not due to a failure to provide facilities but to a failure to promote them among groups most at risk, particularly women aged over 40.[10] An audit of my own patients showed that 6·8% of eligible women over 35 have never had a smear, and 24·5% have not had one for over five years.

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Whose responsibility?

There is no shortage of policy making and recommendations on cervical screening.[11-13] But now that the recall system that was operated through the National Health Service Central Register has been abandoned there is no national system for implementing comprehensive screening. A working model exists in the form of the Exeter Family Practitioner Committee Computer Unit, which is funded by the Department of Health and Social Security, but it may take up to 10 years for all family practitioner committee databases to become computerised and provide a national recall system. Until then the initiative lies largely with general practices. As a high proportion of patients with invasive cervical cancer have never had a smear[11,14] the immediate priority is recruiting women into a screening programme, especially those between 35 and 65 who have never been screened.[15]

How to do it

In *Cervical Screening: a Practical Guide* Ann McPherson describes clearly how a recruitment and recall system may be organised in general practice.[16] Reluctant general practitioners cannot plead expense and lack of a computer as reasons for continuing to screen haphazardly. Neither can they plead lack of time. The 70% reimbursement for employees and the present fee system for quinquennial smears should more than cover the cost of identifying women who have not been screened from the age-sex register and setting up a nurse's clinic, where not only smears may be done but other preventive measures undertaken, such as detecting hypertension, teaching breast self examination and giving advice on smoking and weight. A substantial minority of patients prefer a nurse or midwife to do their smears.[17-19]

The practice, however, needs to be flexible, and doctors should be willing to accommodate women, for whom it is more convenient to attend an ordinary surgery. Dr McPherson gives practical suggestions for ensuring proper communication of results to patients and operating a reliable recall system. These are vital to avoid the inadequate follow up, which has been implicated in many cases of invasive cancer of the cervix.[11,20] She also suggests how to invite patients for screening and how to explain abnormal results. Carrying out a similar programme, Standing and Mercer achieved a 96% screening rate for all eligible women.[21]

An epidemic of smears in younger women?

In 1980 the rate of "positive" smears (severe dysplasia/carcinoma in situ) was 6·8 per 1000 smears examined; there was a maximum rate of 11·4 for women in the age group 30 to 34 years. The rates in 1973 were 4·3 and 4·5 respectively.[11] In 1985 seven out of the 258 women on my practice list aged between 20 and 35 had smears showing "severe dysplasia/carcinoma in situ" and required either laser treatment or cone biopsy. It is of doubtful statistical value to extrapolate from such a small number and claim a positive smear rate of 24 per 1000 women under 35. But these figures echo the worrying evidence that women who were born around 1951 and later are prone to a considerably higher frequency of disease than those born earlier.[20,22] Perhaps more disturbing is the possibility that the preinvasive stage may be shorter in some younger women.[11,23] It may be that the "excessive" screening of younger women has resulted in the observed increase in the incidence of clinical cancer in women under 35 being much less than it might have been.[24] The question arises whether screening should be carried out more often than every five years, particularly as it is likely that the cohort of women who were born after 1951 will continue to have high positive rates throughout their life.

The fact remains that in the immediate future the greatest gains in preventing cervical cancer will come from recruiting eligible women over 35 who have never been screened. In absolute numbers these women still have the greatest incidence of invasive cancer and the greatest mortality. But policies of cervical screening will need to be reviewed constantly and may need to be altered as the 21st century approaches. Establishing a comprehensive and reliable system of recruitment and recall in general practice will provide the essential framework to cope with increased demands.

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100 YEARS AGO

Seldom has it been given to any officer by his death to bequeath a larger legacy of honour to the corps to which he belonged, than in the case of the lamented Surgeon Heath, who fell by the Burmese dacoits in carrying his wounded comrade from the field. He has shown that to every military surgeon is open the triple path of duty, attendance on the sick, succour of the wounded, and rescue of the wounded; and he has added another name to the long roll which has already proved that in the day of battle the military surgeon has not been found wanting. A more honourable or more interesting career can scarcely be offered by any other branch of the national service, than can be embodied in the duties of the military surgeon. That the rewards for these duties are becoming every day more adequate and more liberal is a matter for sincere congratulation; since, although there are many ready to perform these services, there are few out of whom humanity has been so far spiritualised as to render them indifferent to the public and substantial recognition of them. Under these circumstances, the moment may not be inappropriate to again bring forward the question, whether it is just that military surgeons should continue to be regarded and rewarded as "non-combatants." The serious hardship that results from the existing distinction between combatant and non-combatant cannot be better illustrated than by supposing that Surgeon Heath and Lieut. Armstrong had both survived their wounds, and that a year hence, both being unfit for service, were placed on temporary half-pay. In accordance with the Army Circular, March 1st, 1880, the "officer placed on half-pay on account of ill-health, incurred in and by the service, may reckon time on half-pay, not exceeding one year, towards full-pay retirement," whereas the medical officer, who received his wound on the same battlefield who risked his life to save a comrade, and who qualified for the highest reward of valour which his Sovereign can bestow, could reckon nothing towards retirement, because in official designation he is only a "non-combatant." The absurdity still remains, that the man whose duty calls upon him to lay down his life under the fire of the enemy is a non-combatant. (*British Medical Journal* 1886;i:166.)

In a paper read at a recent meeting of the Liverpool Chemists' Association, Mr. R. M. Sumner related some personal experiences as to the use of cucaine, both as a preventive against pain, and a remedy for, sea-sickness. Mr. Sumner professes to have had considerable acquaintance with cuca leaves for many years, both in business and in personal use, and to have believed strongly in the exhilarating and stimulating effect which they have upon the nerves. Owing, however, to the nauseous character of the pharmaceutical preparations of the leaves, he had personally been in the habit of chewing the leaves without alkali. The report of the trials made last autumn by Professor Manassein, of St. Petersburg, with a solution of cucaine, induced him, being very subject to sea-sickness, to test its efficacy on himself, during some cross channel passages he made. Having dissolved 3 grains of cucaine hydrochlorate in 1½ ounces of water, he took one-third of this solution before starting, and another third soon after leaving land; and, although the weather was boisterous, he declares that he not only felt no inconvenience from the trip, but even enjoyed the motion of the vessel. Satisfied with the results obtained, and wishing to find a more permanent solution, he next used a solution of cucaine, in camphor water, with which, after being kept four weeks, he obtained like good results with a smaller dose than formerly. But, though the camphor-water proved an excellent preservative for the cucaine, it was not pleasant to the taste, besides which a solution was somewhat inconvenient. He therefore had some cucaine lozenges made, each containing one-twelfth grain of cucaine hydrochlorate. These he describes as at once active, palatable, portable and permanent. With four of these lozenges, taken at intervals, he, in another trip, was enabled to defy sea-sickness. Since then, the author has severely tested the powers of cucaine with unvarying good results, but thinks that, in the majority of cases at least, one-third of a grain would be required, although Professor Manassein only prescribed one drachm of a solution of cucaine, of the strength of one in a thousand to be administered every two or three hours. (*British Medical Journal* 1886;i:411.)

Practice Research

Changes in the population aged over 75 of an urban general practice: implications for screening

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Abstract

In an urban group practice of six principals 545 (4·2%) of 13 100 patients were over 75 years of age. Although 54 of these patients died during one year, there were 72 "urban migrants" (42 removed from the district and were replaced by 30 new registrations) and 58 age transfers within the age-sex register. Although urban migrants who were aged over 75 and over 85 represented only a small percentage (0·6% and 0·1% respectively) of the total practice population, they accounted for 12·8% and 14·9% of their respective age groups. There may be delays of up to three months before such patients are routinely registered with new practices. Thus a potentially hidden and appreciably vulnerable section of the aged population who are likely to require crisis intervention has been identified. This may explain previous conflicting views about the value of health screening programmes in the elderly.

Introduction

The results of previous studies have shown a high prevalence of unmet need in the population aged over 75 years.[1] To minimise the demand for crisis intervention in this age group an anticipatory approach to medical care is desirable.[2] This requires a clear definition of the population to be screened. It is well recognised that mobility of the younger, more economically active age groups results in a high turnover of patients in general practice.[3] Apart from having a higher mortality rate, however, people over 75 have not been recognised previously as producing similar demographic changes. Although it is well known that the younger elderly retire to coastal areas, the effects of intraurban migration by those who are over 75 have not been appreciated. Such migration is often the result of the need for more appropriate housing, the uptake of local rehousing schemes, and the desire for closer contact with family carers. To determine the extent to which migration and mortality might affect a health care screening programme for people over 75 in an urban general practice we monitored their demographic changes during a 12 month period using the practice age-sex register.

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Methods and results

An age-sex register was constructed in an urban group practice of six principals in 1982 by checking the family practitioner committee register against the available case notes. The age-sex register was updated using the quarterly returns of patient registrations and removals. On 1 July 1983 there were 13 100 patients, of whom 545 (4·2%) were aged over 75, and of these, 114 (representing less than 1% of patients in all age groups but 20·9% of those over 75) were over 85. A duplicate age-sex register was made for all patients who were then over 75.

Updating of the original register was continued and was supplemented from hospital discharge summaries, personal information from practice staff about deaths of patients and removals, and registrations of new patients. The age distribution of these patients was checked and compared with the total numbers of patients listed and aged between 75 and 84 and over 85.

One year later this updated register was compared with the duplicate that had been made on 1 July 1983. The number of patients who were known to have died, removed out of the area or in to residential homes, registered with other practices, or were no longer included on the register and were untraceable was noted. Additional information about removals from the register was obtained from the family practitioner committee, records of deaths from local hospitals, and by telephoning relatives or neighbours of the remaining patients. These results were compared with similar information collected for those aged 0 to 75.

During the 12 months from 1 July 1983 96 of the 545 patients aged over 75 were removed from the age-sex register because of urban migration (42) or death (54), representing 17·6% of the patients who had initially been recorded as over 75 but only 0·7% of the total number of patients on the practice age-sex register. Of the 42 patients over 75 who removed from the area, 23 had moved to another district (most to be closer to their family), nine had entered residential homes, four had transferred to the lists of local general practitioners for convenience, and six were untraceable but known not to be living at their recorded addresses. Although 88 new patients over 75 were entered in the age-sex register (30 as urban migrants and 58 as age transfers) there was an overall loss of eight patients during the year (table).

During the 12 months of the study in the population aged 0-75 on the age-sex register there were 1826 new registrations and 1512 removals—a patient turnover of 11·5% and an overall gain of 314 (2·5%) patients.

Removals and registrations on age-sex register of patients aged over 75 during 12 months

Age (years)	Total No of patients	No of deaths	No removed from area (%)	No of new registrations (%)	Total No of patient moves (+ or −)	Age transfers
75-84	431	31	29	26	55	58
Over 85	114	23	13	4	17	18*
Total No	545	54	42	30	72	58

* These patients remained on the over 75 age group

Discussion

The role of screening programmes for the elderly in general practice remains controversial. Indeed, recommendations have included: simple screening by "case finding" among consulters (on the basis of apparent low levels of ill health among elderly non-consulters[4,5]), screening elderly groups who are "at risk",[6] and screening the whole practice population[7,8] (since over half of non-consulters over 75 needed treatment or other action[9]). One reason for such conflicting views might be that the extent of the turnover of the population both by migration and mortality has not been considered.

During the one year of our study 7·7% of the original group of patients over 75 became urban migrants, and this was greater than the 5·8% migration within and out of Southwark (the London borough where the practice is situated) that had been recorded in the 1981 census.[10,11] When patients move they do not usually notify the practice that they leave, and there is an average delay of three months between the date of migration and the new practice being notified by the family practitioner committee.[12] This period is a substantial part of the lifetime remaining to patients over 75. Moreover, the results of other studies have shown that the elderly who have recently changed their dwellings are at a greater risk of needing medical care and require priority on any screening programme.[13-15] In our study there were 72 such patients of 130 live patients over 75 who were put on to or taken off the over 75 register—a group of new and potentially hidden elderly patients at risk in the community. Indeed, although the turnover of live patients by urban migration was only 0·6% of the total population of patients, it was equivalent to 13·2% of the original group over 75. Similar figures for the group over 85 were 0·1% and 14·9% respectively.

Failure to seek out such obviously vulnerable patients may account for previous disparate recommendations about the value of screening programmes for the elderly. Furthermore, there are implications for a screening programme for elderly patients in an inner city practice. Reliance cannot be placed solely on the returns from the family practitioner committee for an updated age-sex register for the elderly. These need to be supplemented often by additional sources of information on removals and deaths, and here local knowledge is valuable. In practical terms the most frustrating aspect of any screening programme is the time wasted in trying to contact patients who no longer seem to exist, and as our results show such patients were a large proportion of all those over 75.

The observed mortality rate for patients over 75 (99·3 per 1000) is close to the average in the London borough of Southwark (97 per 1000 for 1983).[16,17] Widowhood, however, is associated with increased morbidity and mortality, and there is no doubt that prompt notification of death to the practice would facilitate finding and managing a further group at risk—namely, bereaved elderly spouses[18] and carers.

The high turnover of live patients over 75 in the practice population (13·2%), a group well known to have concealed medical problems, underlines the importance of regular and conscientious updating of the age-sex register for patients of that age group. Each practice should be acquainted with the demographic characteristics of its own area and determine whether it has a high proportion of patients at risk. This would be helped if new patients were entered into the age-sex register and assessed on their initial application to register rather than the practice waiting for their case notes to be transferred.

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100 YEARS AGO

It has become a matter of common observation and remark that the out-patient department of general hospitals no longer offers the same scope for clinical research either for the physician or the student, as it did some years ago, when "specialisation" was less marked, and a man was permitted to deal with the organism as a whole, instead of restricting his field of vision to one particular organ or part of one. At present, the bulk of the patients coming under the care of the out-patient physician are dyspeptic or hypochondriacal, and, under these circumstances, it is not to be wondered at if the work becomes in the long run well nigh unsupportable from its monotony. The throat-specialist seizes hold of the cases of throat-disease, and, under that heading, retains the treatment of patients suffering from diphtheria, aortic aneurysm, syphilis, and even phthisis, when accompanied by laryngeal symptoms. That "gentle-fingered genius, the gynaecologist," purloins another portion, which comprises almost every disease occurring in females; the aurist, the dermatologist, the oculist, the dentist, etc., each and all withdraw their quota from the crowd of patients, until only those whose ailment admits of no precise definition are left for the physician to examine and prescribe for. The evil is aggravated by a tendency to specialisation even among the physicians themselves—one gentleman acquires a preference for "nervous" cases, and forthwith all such cases gravitate to him, and so on, until by successive siftings nothing but the most uninviting cases remain to be adjudicated. The surgeons are a trifle better off, although even here the special hospitals have had a deleterious influence on the number and quality of the cases. Still, he gets an opportunity now and again of passing a catheter, and incising a boil, and he is, moreover, very careful to keep what cases do turn up under his own care.

Certain advantages doubtless attend the creation of special departments, but the result is ultimately to impair the value of the education given to students, who are very unlikely to attend all the branches with equal assiduity. Moreover, the physician himself is apt to lose the faculty of taking a broad grasp of his patient's ailments, and may come to treat Menière's disease with topical applications, and aphonia from aneurysmal pressure by means of laryngeal insufflations.

It is difficult to see what remedy can be brought to bear for a state of things for which, after all, the profession itself is responsible. There can probably be little doubt that the prestige of the profession has not been enhanced by this extreme specialisation, which is conducive to rivalry of such intensity, that the finer feelings become blunted. It is, however, a movement of evolution which it is useless to resist, and idle to deplore. We can only hope that the period of transition which accentuates its more disagreeable features, may soon give place to a more harmonious blending of the discordant atoms. (*British Medical Journal* 1886;ii:73.)