For Debate

New cervical cytology request form is unusable

J V Clark, A J Sharp

In December 1988 the Department of Health circulated a letter (EL(88)P/206, FPCL142/88) to health service managers and administrators of family practitioner committees announcing the revised national request/report form HMR101/5 for cervical cytology screening, which is to be used from 1 April 1989. An example of the revised form was attached to the letter (fig 1). In our opinion this form has so many faults that it is unusable.

Confusion of colours and numbers

The top copy of the new form is green and beneath this are yellow, then pink, and then white copies. All of these are marked "GP's copy," which is wrong. A green top copy is unacceptable because green is used for industrial urine cytology screening. Yellow is recognised by all as for cervical cytology, and many hospitals have produced documentation based on yellow requests for cervical cytology.

A real danger posed by the revised form lies in the failure to stagger the numerical codings for reports of cytological pattern. These are now much closer together because extra categories have been introduced. The old form (fig 2) had report codings in boxes 23, 24, and 25 staggered so that if the copies underneath moved slightly there would be no danger of misinterpreting on these copies the numbers that had been ringed on the top copy. With the revised form there is considerable danger of such misinterpretation on lower copies in new boxes 09, 10, 17, 18, 19, 22, 23, and 24 (fig 1).

The letter from the Department of Health stated that all data not needed nation wide had been eliminated, but we question whether all the omitted items are unnecessary. Many women who have smears are taking oral contraceptives, but instead of ringing 4 in box 14 of the old form the smear taker will now have to ring 4 in box 19 ("taking hormones (specify in 20)") and then write "on oral contraceptives" in box 20. The extra hours taken by general practitioners to specify in box 20 will be considerable nation wide. "Symptoms" (the old box 19) is omitted completely, and this is a retrograde step, especially regarding "post-menopausal bleeding" because we do not believe that busy smear takers will always have time to write "post-menopausal bleeding" or "PMB" in the new box 20. The omission of the old box 20 ("appearance of cervix") is particularly serious because if there is no possibility of ringing 16 ("malignant") it will not be possible to collect accurate yearly returns required by the department. At present, cases which are clinically malignant are not recorded as cytological pick ups of malignancy under the screening programme. We do not consider that the new box 17 ("reason for smear") will adequately sift this out because smear takers may ring 3 ("clinically indicated") for anything from an opportunistic smear in a woman with a mild discharge to an obvious invasive carcinoma. The requirement on the old form to complete details on the appearance of the cervix ensured that the smear taker actually looked at the cervix, and in our opinion this increased the adequacy of smears. We appreciate that not all smear takers interpret the appearance of the cervix accurately, but laboratories soon learn which takers do interpret these appearances correctly and it is then helpful when screening for inflammatory and associated changes.

The omission of marital state would have been acceptable if "title" had been added to the patient details in new box 03. If the laboratory has to write or refer to a patient it will be impossible to address her correctly as either Mrs or Miss. The omission of separate suggestions of colposcopy, cervical biopsy, and curettage in the new box 24 ("management suggested") is not adequately replaced by the single new "gynaecological referral." Many hospitals have separate colposcopy and gynaecology clinics, and to simply refer a patient to a gynaecologist when colposcopy is indicated may cause delay for patients and irritation to general practitioners.

A disaster for computer systems

Those familiar with the old national request/report/recall form will realise from the foregoing that many

Cytology Laboratory, Department of Pathology, General Hospital, Northampton NN1 5BD
J V Clark, FRCPATH, *consultant histopathologist*
A J Sharp, FIMLS, *senior chief medical laboratory scientific officer*

Correspondence to:
Dr Clark.

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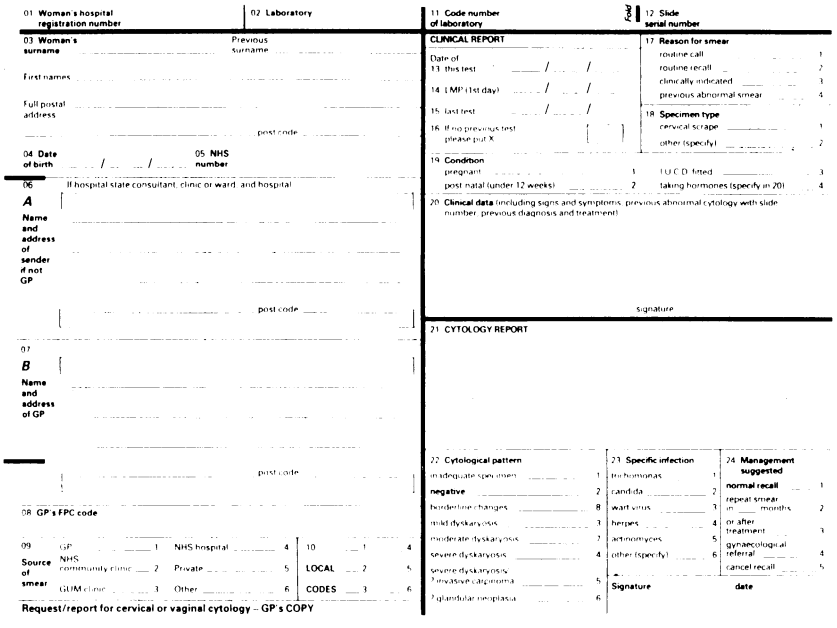

FIG 1—*Revised national request/report form for cervical cytology from Department of Health*

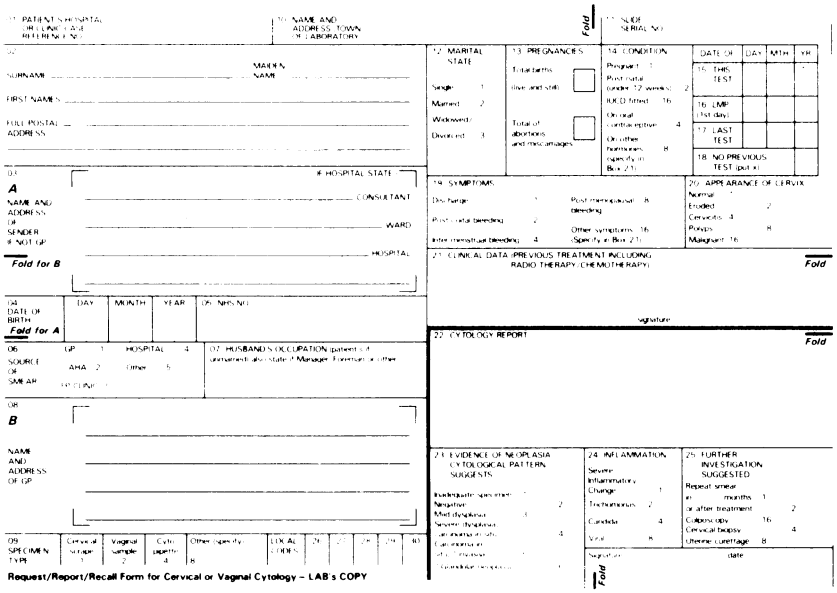

FIG 2—*Request form for cervical cytology currently in use*

boxes which are the same on the old and the revised forms have changed their numbers. In fact, 21 boxes have had changes of number, but, worse still, in many of the categories in the boxes the numbers have changed. These changes are disastrous for laboratories which use these numbers on computer systems. Fortunately, existing report codes of cytological pattern have been retained, but all the source codes except GP have been shuffled around and the codes under the new 19 ("condition"), 23 ("specific infection"), and 24 ("management suggested") boxes, which previously allowed summation entries, have been changed. In Northampton our cytology computer holds 181 000 test records and if data are now collected on the revised form they will be highly incompatible with our existing data. Reprogramming to recode our existing data would be expensive and might not work. Our data entry screens are set up in the order of the old form, but in the revised form some sequences have been changed. For instance, "source of smear" comes after, not before, the "name and address of GP," and for us this will slow down the entry of data.

On the reverse of every revised form will be printed details on taking a cervical smear. This is unnecessary and will cause difficulties to laboratories that use the blank reverse of the old form as a note pad for checking, rescreening, quality control, and general education in cytology.

Conclusion

We are firmly of the opinion that this revised request/report form must be amended before it can be regarded as acceptable for use. If the serious faults that we have pointed out are not corrected we think that many laboratories with a substantial investment in computerisation will be obliged to produce their own cytology request forms. This would be a retrograde step.

A mobile surgery for single homeless people in London

S S Ramsden, P Nyiri, J Bridgewater, D J El-Kabir

Abstract

Little is known about the social and medical characteristics of people who regularly sleep rough, or whether medical care can be targeted at these people. In 1987 a mobile surgery was used to provide primary health care at two sites in central London where many single homeless people sleep outdoors. One hundred and forty six patients were seen with illnesses ranging from scabies to osteomyelitis and tuberculosis. Sociodemographic data showed the patients to be generally an isolated group with deprived and unstable backgrounds, often compounded by alcohol abuse. Over a third of the patients from one site attended a drop in surgery for homeless people in Soho within a month after seeing a doctor in the mobile surgery. This suggests that the project can be a first step in integrating this isolated group with health care facilities.

Wytham Hall Sick Bay, London W9 2QJ
S S Ramsden, MRCP, *resident medical officer*
P Nyiri, BA, *medical student*
J Bridgewater, MB, *resident medical officer*

Great Chapel Street Medical Centre, London W1 7AL
D J El-Kabir, DM, *physician in charge*

Correspondence to: Dr Ramsden.

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Introduction

The term "single homeless" encompasses a large and diverse group of people, who suffer frequent and often serious ill health. Their lifestyles vary widely: some live in hostels and reception centres for long periods while some sleep in cardboard boxes in so called "cardboard cities." The health and social characteristics of the single homeless have most often been studied in those living in hostels and reception centres. Such studies have documented a high prevalence of physical and psychiatric illness, frequent prison sentences, and alcohol abuse as well as a high mortality.[1-5] Specialised medical centres and clinics held in hostels have brought health care to this deprived group.[3,6,7] Less is known about those who regularly "sleep rough" largely because they are so difficult to reach, but surveys suggest that these people suffer much physical and psychiatric illness as well as frequent alcohol abuse.[3,8,9]

In 1987, after a grant from the London-Edinburgh Trust, we bought a Renault Master van converted into a mobile surgery to provide primary health care at the sites where those sleeping rough congregate. The aims of this study were twofold: firstly, to investigate the social and medical characteristics of the patients sleeping rough in central London, and, secondly, to assess the acceptability and outcome of a mobile surgery for such patients.

Methods

The sites—We restricted ourselves to two sites in inner London where homeless people congregate: Lincoln's Inn Field and the Bullring. Lincoln's Inn Field is a small park in central London. Up to 50 single homeless people sleep there every night. The Bullring is a grim area of interconnecting concrete subways on the south bank of the Thames. Up to 150 people sleep there each night.

The mobile surgery and its operation—The mobile surgery was run by a doctor and two other people, either medical students or health workers for homeless people. Each site was visited once a week. We had to show respect and patience to be accepted. Some patients would take weeks before feeling that they could see the doctor. As far as possible most conditions