Comment on ‘Characteristics and screening history of women diagnosed with cervical cancer aged 20–29’

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Sir,

We agree with Castanon and her colleagues (Castanon et al, 2013a) that the more than two-fold increase in cervical cancers registered in women aged 25–29 years in England in the last decade cannot entirely be explained by the cessation of screening women aged 20–24 years, which was first recommended in 2003. Nevertheless, we cannot believe that policy has not had some effect on the increase. Incidence of invasive cervical cancer per 100 000 women aged 25–29 years was higher in 2011 than the previous highest level in that age group: 19.3 compared with 14.8 in 1986 (Office for National Statistics).

Since 1992, registrations in England as a whole of invasive carcinoma of the uterine cervix in women aged 25–29 years have consistently represented 3% of total registrations of invasive and in situ cancer combined (cervical intraepithelial neoplasia grade 3, CIN3, is registered as carcinoma in situ), and the two diagnoses have increased in parallel, including during the so-called ‘Jade Goody effect’ in 2009, which is consistent with most of these cancers being screen-detected (Figure 1). The number of increased registrations of CIN3 since 2004 in women aged 25–29 years (the peak age group for CIN3 since the late 1990s) is greater than the simultaneous decrease in women aged 20–24 years, suggesting an increased risk in women born between about 1977 and 1983 (marked ‘+’ in Figure 1), which was before the effect of the new inflammatory infiltrates in patients with colorectal cancer. Eur J Cancer 50(3): 544–552.

Forrest, Richards et al, 2010a, b;); Vayrynen et al, 2013, 2012 a, b).

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Response to comment on ‘Characteristics and screening history of women diagnosed with cervical cancer aged 20–29’

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Sir,

Dr Herbert et al (2014, this issue) suggest that women in England born between 1985 and 1995 have been ‘let down’ by the National Health Service. It is true that most would neither have been vaccinated against HPV types 16 and 18 nor have been invited to screening between age 20–24. However, we reject the notion that they have been let down. We have estimated elsewhere (Landy et al, 2014) that the change in policy (inviting women for screening from age 25 instead of from age 20) will have resulted in about 2800 fewer women aged 20–24 being screened each year. This may be balanced by the additional women who will be screened at age 25, but it is unlikely to make much difference overall.

We agree with Dr Herbert et al that 1A1 cancers may sometimes be treated with a knife cone under a general anesthetic rather than by loop excision under a local anesthetic, but we suggest that the audit data they present are out of date and not representative of England today. In our audit, 92% (887 of 965) women aged 20–29 with stage IA1 cancer diagnosed since April 2007 had a cone excision. It is difficult to believe that it is desirable to treat over 100 women with high-grade cervical intraepithelial neoplasia by a cone excision in order to prevent one case of IA1 cervical cancer that will also be treated by cone excision (albeit possibly a more invasive one).

The decision to only invite women for cervical screening from age 25 is clearly emotive, but it is not helpful to refer to it as an unfortunate experiment. It was based on an independent committee’s unanimous view that screening women aged 20–24 was likely to cause more harm than benefit. It was not the same as that of CIN3 as suggested by Castanon et al (2013a, and the effect of a ‘cancer diagnosis’ on a woman as young as 25–29 years may be devastating. During the period of our audit, only 3 of 41 IA1 cancers had a single large loop excision of the transformation zone (LLETZ), compared with 85 of 100 cases of CIN3 (Table 1). The most frequent treatment of IA1 cancer was LLETZ followed by knife cone biopsy, because many of these cancers arise in widespread CIN3 that may be difficult to excise completely on a LLETZ; 5 had trachelectomy and 15 had hysterectomies. Most women with CIN3 had a single LLETZ, those who had further treatment tended to be slightly older. LLETZ is less likely to cause premature rupture of membranes than repeated or larger excisional biopsies (Castanon et al, 2013b).

Disallowing screening for women aged 20–24 years, whatever their clinical history of sexual activity, is an experiment that is unfortunately taking place during a period of time when there are birth cohorts at increased risk and screening coverage is falling in younger women. In our opinion, the view that screening women under age 25 years causes ‘more harm than good’ is letting down a generation of women who are above the ages of those who will benefit from vaccination in the future.

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