CONSULTATION ON THE UK NSC POLICY ON CERVICAL CANCER SCREENING IN WOMEN

British Medical Association Cymru / Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation the UK NSC policy on Cervical Cancer screening in women.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of almost 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales welcomes the opportunity to respond to this consultation, which has major implications for the cervical screening programme in Wales and the balance between the good and the harm done by that programme as a consequence.

Overall, we believe that the evidence that inviting women aged 20-24 is, on balance, likely to do more harm than good is compelling.

In 2010/11 2,263 women aged 20-24 were referred to colposcopy by Cervical Screening Wales as a result of abnormal smears (30% of all colposcopy referrals). Of these, 1,895 (84%) subsequently had diagnostic or treatment biopsies. There is little, if any, evidence that this led to benefit either at an individual or population level.

Similarly, 20,493 Welsh women aged 20 were first invited for screening in 2006-7. By the time they were 25, they had a cumulative risk of 17% of at least one abnormal smear requiring repeat, and 7% of these being referred to colposcopy as a result of an abnormal smear. If this group of women had not been invited until age 25, this activity with its consequent anxiety and cervical damage would have been avoided. The table provided as appendix 2 of the NSC consultation suggests that if this group of women had not been invited until they were 25, there would have been no additional cancers diagnosed by age 29, although one cancer would have been diagnosed at stage 1b rather than 1a. The benefit of earlier invitation does not justify the harm done.

One comment often heard is that any change in age range should be delayed until the HPV vaccinated cohort enters the screening age (from 2014). As the evidence on the balance of benefit and harm has been collected from the experiences of unvaccinated women, it is clear that the change need not be delayed.
With advent of HPV vaccines there should be a lower risk of girls presenting with cervical cancer so again, there is a higher risk of harm from additional invasion in the event of an abnormal smear. As a related aside, it would be useful to consider here how the effectiveness of the vaccine will be measured.

There is a higher degree of inaccuracy in the smear results for those in age group 20-25 usually due to the use of hormonal treatment, sexual activity (partners, infections, not using condoms), smoking, etc which can lead to temporary changes in cell appearance. This means there is a significant risk of potential harm to patients requiring further investigations/treatment based on smear results which often resolve themselves without progressing to invasive disease. Additionally, there are consequences of treatment leading to harm in terms of significant increase of premature deliveries or other failed progression of pregnancies due to the removal of cervical tissue.

The proposed change in frequency of invitation for women aged 45+ from three to five years is similarly evidence based and should be supported. Cervical smear screening should not be used as a diagnostic tool – it is a screening tool and the incidence of cervical smears is significantly lower in this group. Evidence does not show any significant difference between screening every three or every five years. If women have any gynaecological symptoms (e.g. post-menopausal bleeding) then this should be investigated separately.

We believe that the document should detail how often a woman will be screened if an abnormality is picked up. We would also be interested to know the predicted cost savings from changing the age / frequency of screening as the document does not consider this.

In summary, BMA Cymru Wales supports the proposed changes to the age range and frequency of invitation for cervical screening, as the evidence is that the current regime is causing substantial avoidable harm for little, if any benefit. Also, anecdotally reported from a number of our members, many patients do not want or don’t seem to be in a rush to start programme.

Overall we believe that it makes sense to standardise the age groups across UK as currently it causes some confusion for patients from England when they register in Wales.