Age-restricted cervical screening

To the Editor:

The article by Cruickshank et al. points out that HPV testing could be valuable in identifying a small portion of women still at risk after 50 years for the developing of cervical cancer (1). The proposed changes for screening would serve the women more appropriately and use health care resources more efficiently. However, we propose a few suggestions.

There should not only be screened for HPV16, but also for other high-risk HPV types like 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, and 68. The latter types are also well known for their relationship with invasive carcinoma of the cervix (2). Between July 2000 and December 2002, the Laboratory of Clinical Pathology (Antwerp, Belgium) received 200,000 thin-layer cervical cytology preparations for cytologic evaluation from women in Flanders (Belgium). Using an algorithm for HPV testing based on MY9/11 consensus primers and type-specific PCRs (3), 4095 samples were tested for the presence of 14 different oncogenic HPV types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68).

The overall prevalence of the high risk HPV types for women under age 50 and for women older than 50 are shown in Table 1. Although in women older than 50 only half are HPV-positive, only one quarter of these are HPV-16 positive. From the seven Ca in-situ cases, four were HPV 16-positive, other cases were HPV 33-positive, HPV 45-positive and HPV 31,35-positive (Table 2). Also in cases with AGUS (n = 12), only three were HPV 16-positive, the two other HPV-positive cases were HPV 39-positive and HPV 56-positive. If one would only screen for HPV 16, 13 out of 20 cancer cases would have been missed (all in the 50 + group).

The study by Cruickshank et al. shows clearly that a risk population can be identified on the basis of positivity for HPV. Furthermore, it gives the impression that discontinuation for screening is possible in the majority of women over the age of 50 if they are not HPV 16 or 18 positive. However, giving high prevalence of other oncogenic HPV subtype types in Flanders, restricting HPV screening to HPV 16 or 18 testing alone would be not sufficient. An extension of the number of types to be screened for at the age of 50 is therefore necessary. A reduction in the number of women screened would not only mean a reduction in costs, but also a reduction in the induced psychological stress of the screening. This economic benefit would be warmly welcomed in the times of increased health costs and the decreased medical facilities.

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References


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| Table 1. The overall prevalence of high-risk HPV types for women younger and older than 50 years |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Age (year) | HPV tested (n) | HPV− (%) | HR+ (%) | HPV 16+ (%) | LR+ (%) |
|<50 | 3452 | 24.3 | 62.5 | 18.2 | 13.2 |
|≥50 | 643 | 47.4 | 38.4 | 10.0 | 14.2 |

*HR+ = high-risk HPV-positive, LR+ = low-risk HPV-positive (types different from HPV 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68).