Cervix Service

New screening tool may boost your odds for preventing cervical cancer

June 1, 1998 By Lark Lands, PhD

Spread 'em. A cop's command when you're in the wrong place at the wrong time? Nope, just what gynecologists might as well say when you're lying on an exam table—legs in the air, feet in metal stirrups—shivering at the prospect of that cold metal speculum's insertion. For many women, the cervical exam is a double whammy of anxiety and discomfort.

But look at it this way: While there's no sure way to prevent most other cancers, there is for the cervical variety. And that's using appropriate screening to ensure early detection of cell chan-ges. The screening tools are Pap smears—cells swabbed from the cervix, the opening between the vagina and the uterus—and, if necessary, colposcopy with biopsy—the collection of tissue samples using a low-power microscope. After either procedure, cells are microscopically examined for precancerous abnormalities. If abnormal cells—variously called dysplasia, cervical intraepithelial neoplasia (CIN) or squamous intraepithelial lesions (SIL)—are found, treatments can stop what might otherwise become invasive cancer.

"This is a disease that's almost totally preventable," says gynecologist Helen Sejtin, MD, of Cook County Hospital in Chicago. In fact, since routine Pap smears were first recommended in 1943, there has been a 70 percent decrease in deaths from cervical cancer. Since HIV positive women are four to 10 times more likely than their HIV negative sisters to have abnormal cells, regular testing is a must.

Yet this is a case in which the old-fashioned way is definitely not better. Although simple to do, a standard Pap misses precancerous cell changes as much as 30 percent of the time. The standard alternative—colposcopy with biopsy—is more sensitive (90 percent accuracy) but also more invasive (after all, part of your cervix is snipped off), with some risk of infection and bleeding. Since diagnostic accuracy is tied to the examiner's expertise, only someone highly trained is acceptable. Unfortunately, they're often in short supply, so the waiting list might be months long. And it's way more expensive than a Pap smear.

The average total for getting Pap smear results is $90 ($65 for the exam and procedure; $25 for lab costs). The colposcopic exam will run you $400 to $500, plus $110 for lab fees. And since there is no standard that recommends colposcopy for initial screening, insurance coverage may be tough to get.

Which might seem to weight the scales against colposcopy, until you consider the large State University of New York study that found a significant number of women with HIV whose diagnoses came back as false negatives with Pap smears alone. The colposcopy with biopsy identified abnormalities far more often, prompting the immediate treatment that's very much needed—especially since cervical cancer may progress much more rapidly in PWAs than in HIV negative women. So what's a poz gal to do?

Start your own "smear campaign" by demanding the latest from your doc: A new FDA-approved screening procedure is almost as sensitive as the colposcopy plus biopsy and only slightly pricier than the standard Pap. Pap Plus Speculoscopy (PPS) starts with a standard smear. Then a chemical light—the Speculite—is used to illuminate the cervical area after a vinegar wash. With a handheld scope, the clinician inspects the cervix. Using the Speculite, normal tissue will appear dark blue or purple and abnormal areas white. So the clinician looks for islands of white in the purple-blue field. Pap results combined with these observations significantly increase the accuracy of diagnosis.

If the Pap is positive and abnormal white areas are also noted, there's a high likelihood of disease and an urgent need to follow up. If both findings are normal, it's very likely that you're truly disease-free. And if white areas are seen but the Pap is negative—especially common in women who don't shed cells even when abnormalities are present—retesting is advisable.

Already available in many Planned Parenthood clinics, the PPS is inexpensive (besides the Pap itself, $20 for the visual exam plus $6 for the Speculite). Docs can get a scope for only $50. Since the exam is simpler than the standard colposcopy, nurse practitioners and physician's assistants can do it, increasing the availability and helping keep costs down.

But what about the discomfort of all these tests? Experts say that using the appropriate-size speculum (for example, smaller ones for women who rarely have sex with men), warming it before using it and carefully explaining the procedure to the patient in advance should minimize the unpleasantness. In any case, Philadelphia PWA Vanessa Strothers, a peer educator with the Jonathan Lax Treatment Center, is of the grin-and-bear-it school. Given that cervical cancer may have no symptoms until it's well advanced and likely to be fatal, she bites the bullet. "You can count on it," she says. "I get my Pap smear right on schedule."

And how often is that? Although federal guidelines are contradictory, a review of clinical literature by Risa Denenberg, a New York City nurse-colposcopist and longtime advocate for women with HIV, found a consensus on these points:

1. All women with HIV should receive gynecologic screening (exam with Pap) in their primary-care setting every six months for as long as no abnormalities are found.
2. If inflammation is seen, treat and repeat: Treat infections and repeat the exam in three months. Some clinicians prefer an immediate colposcopy with biopsy, since a small percentage of women with inflammation have cancer or severe dysplasia.
3. If abnormal cells are found whether it's any level of dysplasia or just atypical cells (mild cytologic atypia)—a colposcopy with biopsy is a must.
4. If moderate to severe dysplasia is found, aggressive treatment—usually cryotherapy, surgery, laser or electrocautery ("freeze, cut or burn," in gynecologist lingo)—is required. Then it's Paps every three months until you get four negatives in a row, when it's back to one every six

months.

5. For mild dysplasia, opinion is divided as to aggressive treatment vs. careful monitoring. Doctors who favor the latter cite the risks of treatment (bleeding and infection) and note that low-grade lesions are rarely precancerous, and even with treatment are likely to recur in HIV positive women.

In addition to regular screening, consider a few other preventive measures. According to the American Cancer Society, a low-fat diet loaded with fresh fruits and vegetables helps ward off cancer, so that's a good start. And a number of studies in HIV negative women have linked deficiencies of certain nutrients—beta-carotene, folic acid and vitamins E and C—to increased risk of cervical cancer, so taking a mixed carotenoid supplement, plenty of folic acid, 800 IUs of E and 500 to 2,000 mg of C could help. One study showed reversal of mild dysplasia with 10 mg of folic acid daily. (Studies using only 5 mg didn't find benefits.) Always accompany folic acid with B-12, preferably via injection or nasal gel. And, finally, quit the cancer sticks. Smoking is strongly tied to cervical cancer risk.

Is all this trouble worth it? Statistics are persuasive: Cervical cancer is the most common cancer in women worldwide, is likely to be fatal if diagnosed late and is 95 percent preventable with early detection. Spread 'em.

Project Inform (800.822.7422) offers a free discussion paper on gynecological and treatment issues for HIV positive women. The WORLD newsletter (510.658.6930; Box 111535, Oakland, CA 94611) responds to health questions from women with HIV. Two helpful resources are Gynecological Care Manual for HIV Positive Women, by Risa Denenberg (EMIS/Durant, OK), available at 800.225.0694, and the Center for Cervical Health (732.255.1132; www.cervicalhealth.org).

For information or to order equipment or supplies for PPS, call Trylon Corporation (800.486.8979). Its website, www.tryloncorp.com, lists studies done to validate PPS.

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Pap/Colp Prep

Musts for accurate cervical exams

Both Pap smears and colposcopies must be done very carefully to improve accuracy. Nurse-colposcopist Risa Denenberg suggests the following practices. Some you can do yourself; others you can watch for or ask about to make sure the practitioners are following acceptable guidelines. Forewarned is forearmed.

1. Try to have Pap smears or colpscopies done in the middle of the menstrual cycle.
2. Do not douche, use tampons or have sexual intercourse for 48 hours prior to the Pap smear exam.
3. Lubricants should not be used in preparation for doing Paps; they interfere with getting good samples.
4. The Pap examiner should take two samples, first tracing the squamo-columnar junction (where the inner and outer cervical linings meet) and sampling it with a cervical spatula; then obtaining an inner-cervix sample with a cotton swab or narrow cytobrush.

5. Pap smears that contain blood are unacceptable and must be repeated. Fixative must be applied within 10 seconds after spreading the cervical samples on the slides in order to preserve them.
6. Slides should be carefully labeled. Only labs that employ the standardized Bethesda system to report results should be used for Pap smear analysis.
7. Prior to a colposcopy, always treat any infections or conditions that could make diagnosis difficult, including yeast infections, bacterial infections, herpes outbreaks and atrophic vaginitis.

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