Another diagnostic difficulty concerns infection with the human papillomavirus, which causes changes in cervical smears that may be indistinguishable from the mild dyskaryosis of CIN I.[3] Patients in whom the cervical smear shows human papillomavirus infection require careful surveillance because of its frequent association with cervical intraepithelial neoplasia.[4] These problems of interpretation, as well as sampling bias, account for the poorer specificity of cervical cytology reports at the lower end of the range of abnormality compared with the high specificity of reports of severe dyskaryosis.[5]

Any patient with signs or symptoms that raise suspicion of cervical cancer should be referred immediately for further investigation. In the absence of clinical suspicion one cytology report of borderline changes or mild dyskaryosis with or without infection with human papillomavirus should be followed up with another cervical smear test. A second such report is an indication for colposcopic examination.[2]

Recently a group of experts convened by the United States National Cancer Institute in Bethesda, Maryland, published recommendations on reporting cervical and vaginal cytology.[4] The Bethesda system has been advanced as a replacement of the outdated Papanicolaou classification. It introduces a new diagnostic term—squamous intraepithelial lesion—to encompass grades of cervical intraepithelial neoplasia (or dysplasia and carcinoma in situ). Squamous intraepithelial lesion (SIL) is subdivided into two categories—low grade SIL, which includes cellular changes associated with human papillomavirus infection and CIN I, and high grade SIL, which includes CIN II and CIN III. The Bethesda system has two other categories for abnormalities of squamous epithelial cells—squamous cell carcinoma and atypical squamous cells of indeterminate origin. The atypical cell category is equivalent to the British borderline report. Results in the British terminology can be transposed easily to the Bethesda system and vice versa if necessary, but there are conceptual and practical difficulties in the American recommendations. The Bethesda system for cytology reporting classifies squamous intraepithelial lesion separately from squamous cell carcinoma—implying that the distinction can be made accurately from a smear. Though the value of the smear test lies in its remarkably true reflection of the histological state of the epithelium, the use of histological terms suggests that a smear is equivalent to a tissue biopsy specimen. The British Society for Clinical Cytology working party rejected the use of histological terms for describing cells scraped from the surface of the epithelium as scientifically incorrect and potentially misleading.

The terminology introduced by the society in 1986 is widely used in Britain. It has proved workable in practice; and it provides a basis for quality assurance within laboratories and between centres. This terminology should be followed in cervical cytology until further knowledge of the precursors of cervical cancer invokes change.

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Allergy to peanuts

Reactions may be severe and patients should be prepared

The standard advice to patients who know they have developed an allergy to a food is to avoid it. This is easy with oysters or strawberries but more difficult with foods such as peanuts, which may be present in small amounts in anything from a Vegeburger to a Chinese satay sauce.

On pages 1377 and 1378 two short reports describe five young adults who became acutely ill after eating meals containing peanuts. Two died, and all five knew that they were allergic to peanuts. Three patients did not realise that the food they had chosen contained peanuts, one was told—incorrectly—that the food did not contain nuts, and one ate the food by mistake. Peanuts are legumes rather than true "nuts," and patients are more likely to be sensitive to related products such as peas, lentils, and soya bean than to other nuts. Despite this at least one of the patients reported or had had previous severe reactions to other nuts.

About one child in 100 has some form of food intolerance. Many grow out of it, but in others the intolerance persists into adult life and may worsen, with successive attacks being more severe. Serious reactions to foods such as eggs are well known, but the severity of reactions to peanuts seems to be less well recognised by the public and by doctors. Reactions to peanuts may be severe, usually occurring immediately after eating them. Urgent treatment may be needed if the patient's life is to be saved. The most important element of treatment in severe cases is subcutaneous or intramuscular adrenaline—0·5 ml of an 0·1% solution—which is repeated after 15-20 minutes if necessary. Corticosteroids and antihistamines may be added to this treatment.

Patients who have had severe episodes may need to carry parenteral adrenaline with them.[1] Although reactions are rare in those who try to avoid peanuts, the cases described show that inadvertent ingestion may occur even in those who are careful. Patients must be encouraged to carry the drug to deal with these unexpected emergencies. The importance of this precaution is shown by the first patient, in whom the delay in returning to a hotel for the syringe proved fatal.

The severity of peanut allergy makes trial by exposure hazardous. The results of radioallergosorbent tests and skin prick tests together with a careful history provide adequate information to recommend lifetime avoidance of peanuts and peanut based products in such patients.

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