ical profession and the public. It should be judged as a scientific document, but its recommendations should be judged for what they are: reasonable statements made by competent Canadian physicians for the preservation of the health of Canadian women.

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References

1. MACGREGOR JE, TEPER S: Screening for cervical cancer. *Lancet* 1: 1221, 1974
2. Official notice (E). *Can Med Assoc J* 1: 57, 1911

The task force on cervical cancer screening programs

The decision to establish a task force on cervical cancer screening programs was made by the Conference of Deputy Ministers of Health in December 1973. It was intended to be the first of a series of task forces that would produce "state of the art" reports on certain programs and health care activities whose effectiveness was in doubt. At the first meeting of the task force in June 1974 it was apparent that there was some disagreement among the members concerning the value of cervical cancer screening programs, but such disagreement was resolved by much hard work and many hours of deliberation. The final report represents the unanimous views of the members.

The recommendations of the task force deal with such matters as frequency of screening, quality control and follow-up mechanisms. It is the view of the task force that much of the repetitive annual screening of women whose previous smears have been normal is unnecessary. Reduction in the frequency of examination of such women and deployment of resources to concentrate on women at risk who presently are not being screened at all will permit Canadian cervical cancer screening programs to become more effective without utilizing more resources than they do at present.

Certain recommendations, such as those dealing with the development of large laboratories and central registries, require implementation by governments. However, the decision to change the frequency of examination will be implemented only if the health professions and, even more important, the public at large are persuaded that this is a reasonable thing to do. With this in mind, the task force has recommended that the report be widely distributed and publicized and that it be explained to journalists and broadcasters concerned with medical matters. Publication of this report in the Journal is one step in making known the reasoning that has led the task force to make its several conclusions and recommendations on screening programs for cervical cancer.

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Cervical cancer screening programs: a pathologist's viewpoint

In the 25 years that screening programs for the detection of precancerous and early malignant lesions of the cervix have been developing in the West, there has been controversy regarding the efficacy of the Pap test in reducing mortality from cancer of the cervix. Although it seems likely that the discussion will continue, a reasonable consensus has been reached, which was concisely expressed in 1972 at a symposium held by the International Union Against Cancer in Sheffield, England.[1] At the conclusion of the session on screening for cancer of the cervix agreement was unanimous that "(1) exfoliative cytology of the cervix provides a test of value both in gynecological diagnosis and in screening apparently healthy women, and that a laboratory facility, under a trained cytologist, should be supplied wherever consultative medicine is available; (2) the use of this test as a population screening procedure promises useful yields of pre-invasive or early cancer and potential reduction in mortality. However, to realize this potential and to achieve substantial control of cervical cancer mortality, there must be a well organized service backed by a research and development effort so that progress can be measured and the service adapted to the needs and circumstances of the particular population."

Spriggs[2] came to a similar conclusion, adding a special plea that the test should be brought to those women at greatest risk — older women in the lowest social classes — who at present are largely bypassed by screening programs.

The comprehensive Walton report that is published in this issue of the Journal summarizes current knowledge and concepts of the epidemiology and natural history of cancer of the cervix. Up-to-date information on screening programs and their effects on the incidence and mortality of carcinoma of the cervix in Canada are reported. Of great interest are the conclusions and recommendations. If implemented, they may lead to a continuing reduction in the mortality from this disease.

The recommendation that the low-risk group of women — the majority of the female population — should be screened once in 3 years, rather than annually, seems sensible and logical in view of the extremely low detection rate of abnormalities in this group once a patient has had two negative smears. It has obvious economic advantages, which will no doubt be noted by those agencies responsible for funding health-care programs. However, it is important to realize that reducing the frequency of testing among women who now attend annually does not solve the problem of women who do not get a Pap test because of fear, ignorance or modesty. It has been well established[3-5] that these patients are likely to be older, usually over the age of 45, and in the lower socioeconomic groups. New and effective means must be developed to reach this important segment of the population, in which the majority of new cases of invasive squamous carcinoma of the cervix appear. Part of the solution may lie in the better use of community health resources such as family-planning, well-women, prenatal and venereal disease clinics. Medical students, the family physicians of the future, must be taught the value of the Pap test and when it should be used.

If the 3-year screening interval for the low-risk group is accepted, it is