Cervical screening moves to call, recall

CervicalCheck is now focusing on motivating women who have not proactively attended for screening to date

IN THE ABSENCE OF a national organised population-based screening programme in Ireland, deaths from cervical cancer have been increasing by an average of 1.5% per year since 1978. Ireland is the only region of the British Isles where the mortality rate from cervical cancer has risen in the last 30 years (see Figure 1). This has occurred despite significant numbers of smears being done on an opportunistic individual basis by health professionals. In 2002 a total of 230,000 conventional smears were processed in Irish laboratories.

The effect of population screening programmes on the incidence and mortality from cervical cancer has varied among different countries, primarily because of differences in the implementation of organised screening and coverage of the target population. International evidence is clear and compliance with screening interval recommendations and high population coverage of screening are vital for the success of a population screening programme.

In Sweden, the overall incidence of cervical cancer declined by 67% over a 40-year period between 1965 and 2005. In England and Wales, the mortality rate has halved since 1988 with mortality falling by 7% per year at the start of this decade. These impressive impacts on morbidity and mortality have been achieved because these national programmes are structured, organised and quality-assured. A critical component of a structured organised programme is the implementation of what is known as call, recall.

Case study: the effect of call, recall in the UK

During the 1960s, 1970s and early 1980s, cervical screening in the UK was plagued with difficulties, resulting in minimal impact on the incidence and mortality from cervical cancer. The numbers of smear tests and interventions at colposcopy grew massively but without any obvious impact on death rates. Young, low-risk women were having annual tests; older women were developing cancer and had never heard of the screening service. Some women had abnormal results but received no investigation, treatment or follow-up.

It was clear that these problems had to be addressed and in 1988 the National Health Service Cervical Screening Programme (NHSCSP) was established. A well-structured, organised population screening programme was the result. Call, recall was a key element of this reorganisation. The rate of reduction in deaths from cervical cancer in the UK was seen to accelerate when a stringent call and recall system was introduced. Population coverage also increased, achieving the coverage target of 80% (see Figure 2).

CervicalCheck – implementing call, recall

Since the launch of CervicalCheck on September 1, 2008, the programme has proven very successful with uptake rates exceeding expectations. The programme must now focus on motivating those women who have not proactively attended for screening to date. From September 1, 2009 CervicalCheck will move from an open opportunistic access system to an organised call, recall method of invitation (see Table 1) with the aim of maximising uptake among all eligible women. This is proven best international practice and will strengthen the national programme.

More than 1.1 million women are in the age range for cervical screening in Ireland and the coverage target is 80% of these eligible women. This is a significant challenge for the programme and for all registered smearsakers. It is clear from international experience and published data that this target will not be achieved without a formal call, recall method of invitation. CervicalCheck is aiming to ensure that the number of smears taken in the second and subsequent years of the programme will match the number of smears taken in year one.

Over the course of the three- to five-year screening intervals, CervicalCheck will issue personalised letters of invitations to all women in Ireland aged 25-60 who have not yet participated in the programme. There is no change in relation to women who have already had one or more CervicalCheck smear tests – the repeat or recall recommendations that accompany the smear test results determine when their next programme smear is due.
CervicalCheck – disadvantaged populations

Cervical cancer screening utilisation is influenced by socio-demographic factors. Women from disadvantaged backgrounds are generally more likely to see the screening procedure as unpleasant, unnecessary and feel less obliged to attend than their more well-off neighbours. In the UK, cervical screening coverage has consistently been higher in affluent areas, although this disparity is declining.

There is a distinct lack of evidence in Ireland and elsewhere to support the case that opportunistic screening alone will result in additional cancer prevention benefit for disadvantaged populations. Screening programmes must always be designed, delivered and evaluated from the target population perspective, be that the total national population or a specific subgroup. Without evidence-based planning, any lack of compliance at a population level with opportunistic screening is likely to result in greater costs with little or no additional cancer prevention.

The National Cancer Screening Service (NCSS) has a statutory remit to implement special measures to promote participation in its screening programmes by disadvantaged populations.

CervicalCheck is fully committed to maximising uptake in all populations of women in Ireland, but it first requires evidence and validated national screening data to enable it to identify the most appropriate enhanced screening models that will undoubtedly need to be deployed over the coming years to target ‘hard to reach’ populations. CervicalCheck screening services will continue to evolve but will only do so on the basis of evidence-based medicine to guide its development.

Preparing your GP practice for call, recall (by Dr Criona Burns)

As a working GP and regular smeartaker in the midwest, there are a number of practical steps that can be taken in a practice to incorporate the move to organised call, recall method of invitation:

- I have encouraged my reception and nursing staff to use the website www.cervicalcheck.ie to ensure that all staff members are competent in dealing with women’s enquiries
- Women who contact the surgery to request a free smear test will be facilitated when they are eligible. Eligibility is summarised in Table 1
- Eligibility of a woman for a programme smear can be checked by ringing CervicalCheck on 1800 45 45 55
- The Cervical Screening Register (CSR) is a national register of women in the screening age range and is maintained and continuously updated by CervicalCheck

Table 1

1. Women presenting to their smeartaker with a CervicalCheck invitation letter
   - Women who receive a CervicalCheck invitation or recall letter
   - Women aged 25-60 who have not had a smear test in the previous three years but who have opted in to the programme and received an invitation letter. Women can opt in either through online registration on www.cervicalcheck.ie, by completing and returning a freepost form, or by calling CervicalCheck on Freephone 1800 45 45 55

2. Women presenting to their smeartaker without a CervicalCheck invitation or recall letter and who are eligible under one of the following criteria:
   - Women over 60 who have never had a smear test
   - Women of any age post-colposcopy
   - Women post-hysterectomy in certain circumstances
   - Women aged 20 and over on renal dialysis
   - Women aged 20 and over with HIV infection
   - Women aged 20 and over with post-organ transplant

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For all women within the target age group of 25-60 years, I know that they will be called through the CervicalCheck programme and I will encourage women to engage with it. In my practice I look at the past year to ensure that all women in the screening age range and is maintained and continuously updated by CervicalCheck

- Women can self-register online at www.cervicalcheck.ie, in writing or by calling CervicalCheck on 1800 45 45 55. This ensures that their details are present and correct and that a letter of invitation will be issued to every woman that has not already had a programme smear test. To ensure that they will receive the letter of invitation they will be reminded to notify the programme of any change of address
- If a new (to CervicalCheck) woman aged 25-60 has not received a letter of invitation she will be advised to check that she is registered and to make an appointment once she has received an invitation letter
- I will continue to ensure that as much screening history as possible is recorded on the Cytology Referral Form to assist the cytologist in making a follow-up recommendation
- For post-colposcopy smears, my smeartakers are instructed to identify the number of the smear in that woman’s follow-up, eg. third of 10 recommended post-treatment smear tests
- If women have concerns relating to their screening health, every effort will be made by my practice to allay their fears and ensure ongoing confidence in CervicalCheck.

At a practical level I have confidence in the CervicalCheck screening programme and I will encourage women to engage with it. In my practice I look at the past year as an opportunity to get women involved in the screening programme.

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References on request
Changes in uptake of cervical screening

Caroline Williams and Eimear McCarthy compared uptake of screening in practice pre- and post-introduction of CervicalCheck

FOLLOWING THE SUCCESS of the Irish Cervical Screening Programme in the Mid-Western Health Board Region in 2000, and the subsequent development of the 2007 National Cancer Screening Service, the NCSS CervicalCheck got underway on September 1, 2008. Around 1.1 million women in Ireland are aged between 25-60 and deemed eligible for screening. CervicalCheck’s target coverage is a minimum of 80% of the eligible population. If these rates are achieved, a reduction in death rates from cervical cancer of almost 95% is achievable in the long-term.

In Ireland, an average 180 new cases of cervical cancer are diagnosed each year, the average age is 46 years, and average age at death is 56 years. Current screening intervals are three yearly at age 25-44 and five yearly at age 45-60 with two previously normal smears.

Methods

Using the practice clinical database, all patients who received cervical screening in May 2008 and May 2009 were included in the study. Free screening for all women aged between 25 and 60 years commenced in September 2008. A total of 70 women were included. This retrospective audit compared the following differences between the two groups:

• Numbers screened
• Average age
• Numbers of GMS card holder or private patients
• Length of time to obtain results
• Numbers actively recalled for screening.

Of note, this practice had been offering cervical screening free of charge to GMS card-holding patients prior to the introduction of the NCSS.

Currently, the practice has 5,918 patients deemed as ‘active’, i.e. attending the practice within the last two years. Of these, 3,405 (57.5%) are female, of which 2,004 women are aged between 25 and 60 years old and suitable for screening. Therefore 34% of all patients attending the practice are eligible for a free cervical smear. This figure does not take into account women aged under 25 who are sexually active and request a smear, or those aged over 60 who are either having follow-up smears or request a smear as they have not been previously screened.

Results

A cohort of 70 women was included, of which 29 presented in May 2008 compared with 41 in May 2009. The average age presenting for a screen in May 2008 was 36.2 years compared to 38.0 years in the later group.

The audit results demonstrated differences between numbers of women who were GMS cardholders and those who were private patients, with an increase in private patients presenting for screening in May 2009 (see Table 1). Average time to result following screening in May 2008 was 66.6 days, compared to 20.8 days in May 2009 following introduction of the screening programme.

In the May 2008 group, 19 women (65.5%) were actively recalled for a smear compared to 19 (46.3%) in May 2009. Numbers self-presenting increased between the two groups: 10 (34.5%) in May 2008 compared to 22 (53.7%) in May 2009 (see Table 2).

The May 2008 group had 23 (79.3%) smears reported as normal. Three (10.3%) were classified as mild dyskaryosis, one (3.4%) was moderate dyskaryosis and two (7%) were severely dyskaryotic. In the May 2009 group, 40 (98.0%) were reported as normal, none were classified as mild, moderate or severe dyskaryosis. One (2%) was classified as query squamous cell carcinoma. The results were followed up appropriately as per management recommendations by the NCSS.

Discussion

Overall, there has been an encouraging increase in the numbers of women screened in this practice since the introduction of free smears in September 2008.

The audit demonstrates a small increase in age of women presenting for screening since introduction of a free service. There are 974 women attending this practice aged 25-37 years old, 726 aged 37.1-49 years and 304 aged 49.1-60 years old. In both sample groups the greatest proportion attending were aged between 25-37 years (19 women in each group). This reflects not only the majority age range of
women attending the practice but also suggests popular culture such as the recent death of Jade Goody, aged 27, from cervical cancer increased awareness and uptake of screening in the younger age group. This audit highlights women aged 37-60 years need to be targeted in this practice for screening, as they are less likely to present. The introduction of the national call/recall system to screen this month should result in an increase in older women being screened.

The numbers of private patients availing of a screen once it became free increased. This confirms that provision of this service by the HSE has encouraged women to partake in screening, and suggests economic factors were previously inhibiting uptake. The number of GMS cardholders screened did however decrease. We can remove cost as a factor here, as these women were being screened by the practice free of charge previous to the introduction of Government free screening in September 2008. This is a worrying result as the association between socio-economic status and development of human papilloma virus-associated cancers has previously been documented. Again, the introduction of NCSS call/recall may improve this figure for the practice.

The audit confirms that length of time waiting for results has decreased considerably, by some 45.8 days in the reviewed months. This benefits both GP and patient, aiding prompt management plans as required. A woman who has had a positive experience when attending for a smear, for example obtaining a rapid result, is more likely to participate in the screening programme.

The audit supports the planned roll-out of automatic call/recall of women for smears by NCSS. Up to September 2009, the practice attempted to periodically recall patients for screening. In the two sample months, the percentage recalled by the practice declined. However, encouragingly, the percentage of women self-presenting did increase. Without a standardised recall system, uptake may become erratic. It would be of interest to the practice to review uptake following national call/recall and review the need for the practice to have a computerised recall system as a ‘safety net’ system.

Finally, although not an initial point of interest to this audit, we were interested to see differences in the rates of abnormality detected during the two chosen months. With such a limited study it would be inaccurate to further comment on differences in cytological outcome between the two groups. However, this audit has initiated a further audit within the practice to assess this variation.

**Conclusion**

This audit has highlighted to the practice that the introduction of the NCSS has increased uptake in cervical screening in their population group. It has suggested the need to target older women for screening as well as GMS card holders to improve uptake. The practice periodic recall has proved inadequate to reliably maintain uptake. It is hoped that NCSS automatic call/recall will improve uptake. A follow-up audit would be recommended once call/recall is in full operation to review uptake and allow the practice to decide whether it also needs its own automated system.

The audit is limited by its retrospective nature, in so far as it only provided a ‘snap-shot’ review of two months chosen at random before and after the implementation of free screening. Validity of the audit would be improved if all data regarding screening had been reviewed.

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References on request