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Letter to the Editor

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Cervical Primary HPV Screening – what about the non-HPV disease?

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Dear Editor,

From 1 May 2017, 5-yearly primary HPV testing will replace the current Pap test in Australia as part of the new National Cervical Screening Program guidelines. Under the new scheme, reflex liquid based cytology (LBC) will only be initiated if high-risk HPV genotypes are detected.

One of the concerns occasionally voiced by doctors is that the opportunity to detect non-HPV related pathology is going to be lost. Although the present screening program is primarily aimed at identifying cervical disease, it is well known that Pap smears can serendipitously identify endometrial adenocarcinomas (and occasionally extra-uterine adenocarcinomas) in asymptomatic women. Endometrial cancers are unrelated to HPV infection and will not trigger further investigation under the new primary HPV testing protocol.

To determine whether this concern is valid or not, we collated all the cases of histologically confirmed endometrial adenocarcinoma over the previous two years (June 2014 to June 2016 inclusive) at our institution. We then retrospectively looked for cases of endometrial cancer that were incidentally detected in asymptomatic patients.

Our audit returned 77 cases of histologically confirmed endometrial adenocarcinoma. These were predominantly of endometrioid type (72/77, 93.5 per cent) and the remainder were of serous type (5/77, 6.5 per cent). The patients were aged from 41-94, with a mean age of 66 years. Of these cases, 40 patients (51.9 per cent) had also had a Pap smear at our institution in the previous two years. 18 of these (45 per cent) had endometrial cells present: Five cases (12.5 per cent) were reported as normal endometrial cells present. Thirteen cases (32.5 per cent) were noted to be abnormal (either '*atypical*', '*atypical glandular cells of uncertain significance*' or outright '*adenocarcinoma*'). Therefore, these 13 out of 40 cases represent the cases which would have had a theoretical chance of being incidentally detected by the smear.

We further analysed those 13 cases to determine if these were unexpected findings or whether there was a concurrent clinical history suggestive of underlying endometrial pathology. In total, 11 cases had clinical history available. All 11 cases had a clinical history which recorded symptoms which would have provoked further investigation to exclude endometrial pathology. The most common reported symptom was post-menopausal bleeding. Unfortunately, clinical history was missing from the remaining two cases. One of the cases without clinical history was in a 74-year-old patient, which is outside the current cervical screening age-range, suggesting that she presented with abnormal symptoms. The other case without recorded clinical history had a synchronous curette, again inferring the presence of abnormal symptoms.

These results, although a small sample, suggest that the rate of incidentally detected endometrial cancer on routine Pap smear on asymptomatic women is exceptionally low (none in our series). It also reiterates the point that Pap smears are a poor screening test for endometrial cancer. The sensitivity for a glandular abnormality in our audit was low (32.5 per cent), and other larger studies have confirmed similar findings. For example, Bansal et al. did a similar retrospective audit of 122 cases of histologically proven uterine adenocarcinomas, and demonstrated a sensitivity for glandular cell abnormality on Pap smear of 41.8 per cent.[1]

In conclusion, the move to 5-yearly primary HPV testing is not going to cause a significant increase in missed endometrial cancers which would have been incidentally detected by routine cervical smear of asymptomatic women. In addition, it is important to remember that the clinical symptom of post-menopausal bleeding should provoke appropriate referral and investigation to exclude underlying endometrial pathology.

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Web as a new shortcut in patient-doctor communication and medical care relationship

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Dear Editor,

Web communication has been described as a mean to empower patients to learn about their health and it may represent as a privileged way to favour a participatory medical model in healthcare. However, health-operators need to be aware of the power of internet and they need to recognize that it profoundly changed the relationship between patient and doctor. This letter wants to be a message for all health operators working with oncological patients in order to stimulate a critical thinking in their usual clinical practice.

In recent years, many web instruments such as blogs, forums, and chats have developed as a mean to empower patients to learn about their health through internet. This aspect is quite evident in rare conditions[1-2] where patients are often well-connected and updated by using internet as a source of information for their latest treatment, potential benefits or adverse events as well as patients' association activities. The web has contributed to develop a new model in medical care: the participatory medicine. Participatory Medicine is a model of health care that "seeks to achieve active involvement by patients, professionals, caregivers, and others across the continuum of care on all issues related to an individual's health".[3]

In our digital era, the development of particularly designed web systems such as blog, chat forums, as well as mobile applications for patients have allowed an increment of health literacy, sense of empowerment and they have improved the use of personal skills and medical knowledge. The interaction with the web have also determined cost and time savings, as well as error reduction, and efficiency.[4] However, not all health-operators working with patients have realized that the implementation of all these form of web interactions have seriously impacted patient-doctor communication. For example, the contemporary oncological patient has typically downloaded apps, googled the diagnosis, he has explored blogs and he has read forums about treatment possibilities much more before to receive the confirmation of his diagnosis or his treatment options in a medical room We need to recognize that internet has allowed patients to find information that would have been unthinkable in another era, and access to often high-specific knowledge impacting at the psycho-emotional and decision making level. In this perspective, it is crucial for doctors to consider what the patients know and how they built knowledge to share with them the comprehension of internet and/or app devices information, and to share with them the comprehension of emotional aspects that my impact on that knowledge (e.g., when information is perceived as difficult or frightening).[5] Patient involvement in healthcare management has rightly been defined the way to triumph of the contemporary healthcare management, and apps and web may exemplify the impeccable solution to reach this goal. However, all health-operators should be aware of this change and they should learn how to get patient more skilled and engaged in their healthcare through the web. In this perspective, we can promote a real and effective participatory medicine between patients and doctors.

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Gout Nodulosis: An Uncommon Presentation of Gout

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Dear Editor,

Gout is a disease which results from deposition of urate crystals either due to uric acid overproduction or underexcretion. Gout has four clinical stages of progression with variable presentation like asymptomatic hyperuricemia, acute intermittent arthritis or gout flares, intercritical periods and chronic tophaceous gout if left untreated.[1] Gouty tophi are seen in chronic disease due to deposition of monosodium urate (MSU) crystals in dermis and subcutaneous tissue but tophi may be the initial manifestation of gout.[2] Gout nodulosis is an uncommon presentation of gout and is characterized by subcutaneous tophi as the first presentation of gout in the absence of any gouty arthritis.[1]

We describe a case of gout nodulosis in a 40-year-old male, who presented with multiple soft tissue and periarticular swellings over bilateral upper and lower limbs over four years. There was no history of joint pain. Patient was non-alcoholic and non-diabetic with no history of intake of prescribed medications or substance misuse. Physical examination revealed subcutaneous swellings of size ranging from 1cm to 5cm in diameter, which were mobile and non-tender (Figure 1a and 1b). Plain radiograph did not reveal any evidence of erosive arthritis. His erythrocyte sedimentation rate was elevated (65mm at the end of first hour). Serum uric acid (4mg/dL) was normal and rheumatoid factor was negative. All other routine hematological and biochemical investigations including urine, renal function test, and lipid profile revealed no abnormality. His retroviral serology was negative. Fine needle aspiration cytology of the nodular swellings yielded thick chalky white particulate aspirate. The smears showed presence of fuzzy, crystalline structure along with neutrophils and lymphocytes in a proteinaceous background (Figure 1c). On polarizing microscopy, crystals were bright yellow, long, thin, needle-shaped and parallel to the line drawn on the compensating filter, strongly indicative of negative birefringence consistent with MSU crystals (Figure 1d). Based on clinico-pathological findings, final diagnosis of gout nodulosis was made. The patient was started on allopurinol. After 3 months of follow-up, the nodules had not regressed significantly and the patient refused any surgical interventions.

Iglesias and colleagues proposed the term ‘gout nodulosis’ in the year 1996.[3] A few case reports describing tophi as the first manifestation of gout have been reported.[1,2,4,5] Clinically gout nodulosis have a differential diagnosis, which includes tuberous xanthoma, rheumatoid nodules, ganglion cysts, fibromas, and Heberden's or Bouchard's nodes.[1] Considering that most of the cases of gouty nodulosis have normal serum uric acid level, a high index of suspicion followed by pathological investigations is required to arrive at a definitive diagnosis.[1,4]

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Figure 1a and 1b: Multiple subcutaneous, periarticular swelling in bilateral upper and lower limbs.
Figure 1c: Cytology smear shows presence of slender needle shaped crystals in a proteinaceous background. (Giemsa x 400)
Figure 1d: Polarizing microscopy shows negative birefringent crystals