Re: An alternative cost-effectiveness analysis of ThinPrep in the Australian setting

I read with interest the article by Neville and Quinn[1] in the August edition of your journal, in which the authors raise legitimate concerns regarding the methodology used by the Medical Services Advisory Committee (MSAC) in its review of ThinPrep as an alternative to conventional Pap smear in cervical screening. I wish to place the deficiencies highlighted in this excellent article in a broader context and to make the authors of this article and your readership aware of similar concerns raised in a highly regarded meta-analysis titled 'Virologic versus Cytologic Triage of Women with Equavical Pap-Smears: A Meta-Analysis of the Accuracy to Detect High-Grade Intraepitelial Neoplasia'[2] published in the *Journal of the National Cancer Institute* regarding the scientific method utilised by a separate but related MSAC committee that rejected HPV testing for triage of abnormal smears in a screening setting.

I wish to draw the readers' attention to the first paragraph under the sub-heading 'Recent Reviews and Meta-analyses' of this article, which states:

> The Australian Medical Services Advisory Committee team reviewed literature regarding the management of women with low-grade epitelial abnormalities (LGEA) and concluded that there was insufficient evidence to support reimbursement for HPV triage of LGEA (93). The authors remarked that international data did not match the particular Australian cytologic reporting system and that throughout the cytologic literature different thresholds for triage tests and outcomes were used, which made pooling data difficult (93). However, no effort was made to pool data by separate test thresholds and histologic outcomes. The Australian LGEA category encompasses essentially low-grade squamos intraepithelial lesions. Our meta-analysis concerned the triage of women with ASCUS and not women with LSIL. However, in another systematic review (34) and also in the ALTS (33,94,95) it was found that HPV triage for LSIL had limited use because the test positivity rate was too high. Disparities between the Australian review and ours are likely the result of differences in the inclusion criteria for the index smear.

I will allow the reader to draw his own conclusions from this extract of the meta-analysis.

On the basis of these two flawed MSAC analyses, the Cervical Screening Program in Australia has been denied access to these important advances in screening methodology, which will save lives and have been adopted overseas. In particular, the UK National Health Service Cervical Screening Program, which shares many features in common with the Australian Cervical Screening Program, is in the process of implementing both liquid-based cytology and human papilloma virus (HPV) testing using HCII.

The Australian reader will doubtless be aware of the controversy regarding the recent National Health and Medical Research Council (NHMRC) sponsored review of guidelines. This controversy centres on the guidelines for management of smears reported as low-grade squamous intraepithelial lesion (LSIL) or atypical squamous cells of undetermined significance (ASCUS) (Chapter 6 of the NH & MRC document).

Aside from criticisms of scientific method of this latter document and the fact that a consensus with colposcopists, cytologists, and histopathologists has not been reached, the NH & MRC review committee used the flawed MSAC decision to dismiss any discussion of the use of HPV testing for triage of smears reported as ASCUS. The use of HPV testing represents an efficient and safe method of triage of women with smears reported as ASCUS. It represents a better alternative to the management recommended by the NH & MRC document.

The use of LBC as an alternative to conventional Pap smear goes hand in hand with HPV testing for triage of smears reported as ASCUS, since the residual LBC cell suspension is used for HPV testing without the requirement to recall the woman for a repeat sample. This allows women with smears reported as ASCUS to be presented with a management plan that is safe with prompt colposcopic management of significant precursor lesions in those that test positive for high risk HPV and prompt return to cytological screening in those who test negative. This, in itself, leads to cost savings if HPV testing were to be implemented.

It follows that the two defective MSAC reviews have contributed significantly to the difficulties that the Australian Cervical Screening Program faces with regard to the recently approved NH & MRC guidelines.

The timetable for review of all three documents is measured in years. The consequence of the foregoing is that deficient policy will take years to reverse.

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References

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2 Arbyn M, Buntinx F, Van Ranst M, Paraskevaidis E, Martin-Hirsch P, Dillner J. Virologic versus cytologic triage of women with equivocal Pap smears: a meta-analysis of the accuracy to detect high-grade intraepithelial neoplasia. *J Natl Cancer Inst.* 2004 February 18; **96**: 280–293.

