



for Global Survival. It has been amazing to watch the evolution of public awareness and the development of a strong movement toward an international ban, which led more than 100 countries to sign a land-mine treaty in Ottawa last December.

Land-mines are brutal, indiscriminate weapons that continue to maim for years after conflicts end. Even if a mine doesn't kill, severe wounds usually result in traumatic or surgical amputations. For the wounded, there is often a need for antibiotics, blood, long hospital stays, costly prostheses and extensive rehabilitation. These are merely the medical consequences; the social and economic costs are also huge.

Canada is one of the few countries in which medical professional organizations such as the CMA have passed resolutions concerning land-mines. As we work toward the abolition of these weapons by the year 2000, physicians — and physicians-to-be — can be proud of the role their profession has played in building a more peaceful society and more peaceful world.

**Madeleine Cole**  
Medical student  
University of Calgary  
Received by email

## Screening for cervical cancer

Although we agree with many of the points raised in the editorial "Cervical cancer: screening hard-to-reach groups" (*Can Med Assoc J* 1997;157[5]:543-5), by Dr. Eva Grunfeld, the overall impression is that there is still some doubt about the success of Pap testing in reducing the incidence of and mortality rates associated with cervical cancer. The editorial emphasizes recruitment of underscreened and hard-to-reach groups, although Grunfeld acknowledges that 50% of women with inva-

sive cancer of the cervix have undergone Pap testing. In their article "Review of the screening history of Alberta women with invasive cervical cancer" (*Can Med Assoc J* 1997;157[5]:513-9), Dr. Gavin C.E. Stuart and colleagues document factors associated with the development of cervical cancer in such women. They stress the need for high-quality laboratory and information systems and a program to ensure that all women at risk undergo at least one Pap test and enter a cervical screening program.

After the last Canadian Workshop on Cervical Screening,<sup>1</sup> the Cervical Cancer Prevention Network (CCPN) was formed to facilitate the development of provincial screening programs for cervical cancer. Three working groups have been created, one each for information systems, quality management and recruitment. I am writing in my capacity as chair of the Recruitment Working Group.

With support from Health Canada, we commissioned a literature review to identify successful strategies that targeted women aged 15 to 69 years, hard-to-reach women and health care professionals. The review, which will be submitted for publication, demonstrated that a single strategy was unlikely to be effective, confirming results presented in the article "Effectiveness of a call/recall system in improving compliance with cervical cancer screening: a randomized controlled trial" (*Can Med Assoc J* 1997; 157[5]:521-6), by Drs. Sharon K. Buehler and Wanda L. Parsons. A combination of strategies and approaches is more likely to be effective,<sup>2</sup> although it is also expensive.<sup>3</sup> Because of the cost, it is vital that we in Canada take advantage of the networking opportunity offered at the national level through the CCPN and establish similar collaborative efforts at the provincial level, such as the Ontario Cervical Screening Collaborative Group.<sup>4</sup> The Recruitment Working Group has encouraged submissions of proposals to

the Federal Population Health Fund focusing on recruitment of 3 hard-to-reach groups: socially and economically disadvantaged women, immigrants and native women.

The statement in Grunfeld's editorial attributed to Hislop and associates<sup>5</sup> — that the rate among native women is 6 times that of the general population — is misleading. The "general population" in the cited article is that of British Columbia, which has the lowest rates of cervical cancer in Canada. According to a recent study, the incidence of cervical cancer among status Indians in Ontario was slightly less than twice that of the general population of Ontario, and between 1968 and 1991 the rates in both groups declined (Dr. L.D. Marrett, Cancer Care Ontario, Toronto: personal communication, 1997).

As the editorial stresses, cost-effective interventions are the order of the day. Those of us working to develop cervical screening programs know that if the incidence of cervical cancer is reduced, the savings in treatment and long-term care will quickly result in a net cost savings to the health care system, quite apart from preventing unnecessary suffering for hundreds of women and their families.

**E. Aileen Clarke, MB, MSc**  
Chair  
Recruitment Working Group  
Cervical Cancer Prevention Network  
Toronto, Ont.

## References

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### [One of the authors responds:]

I thank Dr. Clark for reiterating the points I made in the editorial:

- certain high-risk subgroups of women are underscreened;
- special strategies are needed to engage these women in screening;
- primary care practitioners are important for the success of a screening program; and
- formal screening programs provide quality assurance and efficient systems for gathering and collating data not possible with ad hoc screening.

It was encouraging to read of the work of the CCPN and the special efforts that will be made to screen hard-to-reach groups of women.

The suggestion that my reference to the article by Hislop and associates<sup>1</sup> is misleading is itself misleading. The points still stand that rates of death from cervical cancer are higher among native women and that culturally sensitive initiatives are needed to engage these women in cervical cancer screening programs.

**Eva Grunfeld, MD, DPhil**  
Ottawa Regional Cancer Centre  
Ottawa, Ont.

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## A measuring stick for health care

The article "Inappropriate hospital use by patients receiving care for medical conditions: targeting uti-

lization review" (*Can Med Assoc J* 1997;157[7]:889-96), by Carolyn DeCoster and colleagues, and the accompanying editorial, "Measuring the appropriateness of hospital use" (*Can Med Assoc J* 1997;157[7]:901-2), by Dr. Duncan J.W. Hunter, confirm many of the trends and practice patterns we have uncovered at our acute care facility.

Concurrent review of every patient admitted to hospital can be resource intensive when using previously described tools such as the appropriateness evaluation protocol<sup>1</sup> or the ISD-A review system.<sup>2</sup> At our hospital, a multidisciplinary team developed objective, accurate, easy-to-use criteria that were based on intensity of service and that could be applied quickly by the bedside nurse. Our "ACTIV index" allows concurrent assessment of the need for days of care in the hospital and barriers to care or discharge.<sup>3,4</sup> The database that has evolved over the past 4 years represents patient-specific data focusing on the patients' condition, not their diagnosis, acknowledges nonphysician elements and identifies interruptions to care plans.

We suggest that patients who have been "inactive" for 2 hospital days should be targeted for attention. Over 2 years, our own 2-day non-ACTIV project has reduced the number of never-ACTIV hospital days from 17.2% to 5.3% of total hospital days, for a saving in resources of \$2.43 million. We have linked our review data to records from the Canadian Institute for Health Information, which allows us to analyse the practice patterns of specific diagnostic groups as well as physician characteristics related to those groups. This information shows variations in care delivery and can be used for physician education.

We too experienced the unexpected phenomenon of reduced nonacute admissions on weekends and evenings. We feel that the emergency department screens these pa-

tients well and makes good use of our on-call home care.

The health care process *can* be measured and managed. Identifying inpatients who are receiving inappropriate levels of care has given us an opportunity to direct patient care processes in a manner that has improved quality and resource use. With the bedside nurse as the reviewer who identifies every patient, every day, many of the barriers to care are identified immediately and broken down almost as fast. We believe that our CONTINUUM project, which uses the "ACTIV index," is a simple, objective, reliable and inexpensive tool for utilization review and could be adapted to suit the needs of hospitals of any size.

**David I. Atkinson, MD**  
St. Thomas-Elgin General Hospital  
St. Thomas, Ont.

### References

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## BSE, variant CJD and infectious proteins

The Nov. 15, 1997, issue of *CMAJ* featured 4 articles on Creutzfeldt-Jakob disease (CJD), but none of the articles mentioned related work on "protein-like previral infectious particles." I would like to take this opportunity to correct that omission.

In 1982, at the same time that Dr. Stanley Prusiner published his paper on prions,<sup>1</sup> a similar mechanism for replication of the infectious proteins of scrapie was proposed,<sup>2</sup> and the