## Managing low-grade cervical lesions

The optimal management of patients with low-grade squamous intraepithelial lesions (LSIL), many of whom have transient human papillomavirus (HPV) infections, is controversial. We applaud Susie Lau and Eduardo Franco for tackling this difficult issue.[1] However, we are concerned that Canadian practitioners will interpret their commentary and its algorithm as an endorsed guideline. Clinical practice guidelines should be based on thorough review of the evidence, expert review by a wide variety of stakeholders and practitioner feedback. Furthermore, recommendations should be clear, straightforward and clinically applicable. We believe their algorithm is unlikely to be accepted into clinical practice because of its complexity and its reliance on obtaining an accurate date of sexual debut.

The authors quote US guidelines[2] for cervical abnormalities but fail to recognize other consensus guidelines in Canada and abroad. The report of the Pan-Canadian Forum on Cervical Cancer Prevention and Control[3] was based on a consensus process that included a wide variety of stakeholders. That report did not provide specific guidelines for the management of LSIL, but recommended that a national consensus management algorithm be developed. Currently, the Cervical Cancer Prevention and Control Network, supported by the Public Health Agency of Canada, is developing strategies to achieve those recommendations.

A revised set of Ontario-based guidelines was recently released;[4] optimal management of women with LSIL was one of the most contentious issues. In the end, the review panel concluded that for the present there is insufficient evidence to recommend different management strategies for LSIL based on a specific patient age.

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In their article on management of LSIL in young women, Susie Lau and Eduardo Franco have provided an algorithm that if implemented would reduce unnecessary intervention and anxiety in women aged 24 years or less.[1] However, as they state, the incidence of invasive cervical cancer in women aged 20–24 years is 1.7 per 100 000 annually, far below the incidence of HIV seropositivity (16–34 per 100 000 in young women[2]) and diseases such as lymphoma (12.5 per 100 000 in people of all ages[3]), for which we do not routinely screen. Is there evidence that detection of cervical cytological abnormalities in this group reduces the risk of developing cervical cancer later? If not, it is illogical to recommend screening for women younger than 24 years of age.

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### [The authors respond:]

We wish to respond to the thoughtful comments by Howlett and colleagues and Burn to our commentary.[1] We agree with Burn that cervical cancer risk among young women is very low. However, the finding of an LSIL smear in a young woman is a very common byproduct of existing cervical cancer screening guidelines. What we proposed is in line with the new knowledge concerning the relative performance of Pap cytology and oncogenic HPV testing and, contrary to what Howlett and colleagues suggest, it is based on a thorough review of the evidence by the American Society for Colposcopy and Cervical Pathology that included Canadian experts.[2] HPV testing has substantially greater sensitivity than cytology and it targets a period in the natural history of cervical neoplasia that is "upstream" from the appearance of cytological abnormalities, which provides a better margin of safety if the result is negative. Cytological follow-up every 6 months has been the management standard in Canada, but immediate colposcopy also occurs frequently. We rec-

ommended using HPV testing because it would lead to fewer visits to the primary care provider. We further reasoned that with less than three years since first vaginal intercourse it would be highly unlikely that an HPV infection once established would have led to a high grade lesion.

There are no Canadian guidelines yet that appropriately take into account HPV testing. The Pan-Canadian Forum on Cervical Cancer Prevention and Control[3] has provided a fast-track opportunity to generate such evidence in the context of our country's screening programmes. In the meantime, however, we believe that the algorithms we proposed are a scientifically and clinically cogent management option.

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# Not all guidelines are created equal

I have read with interest the recent editorial criticizing the Canadian Diabetes Association (CDA) Clinical Practice Guidelines (CPGs).[1] I am one of the few physicians who have served on both clinical practice guideline groups and drug review panels (in my case the CDA and Canadian Hypertension Education Program [CHEP] guideline groups and the Ontario Drug Programs Branch Pharmacoeconomic Review Committee respectively). The mandate of guideline groups and drug review panels differ so extensively that one should expect that their respective conclusions will often differ. Guideline groups advocate use of the most effective therapies as suggested by the medical literature, and typically do not perform economic analyses when generating guidelines. Drug review panels determine whether a new therapeutic is sufficiently cost-effective and has an acceptable budget impact within the context of their jurisdiction. There are 4 primary reasons why guideline groups do not (and in my opinion should not) perform economic analyses when generating guidelines. First, guideline groups do not have a mandate from any provincial or federal agency to make decisions about what therapies will be publicly funded. Equally important, they have no mandate to recommend removal of currently funded therapeutics when the cost-effectiveness of care would benefit from such an action. Second, guideline groups are not provided projected budget information that would help inform an economic assessment. Third, one could consider an assessment of effectiveness to be somewhat "universal." In contrast, the determination of whether a therapy is acceptably cost-effective can certainly vary between jurisdictions. Finally, an economics based approach would place guideline groups in a true conflict of interest between their patient advocacy role and their obligations to the health care payors. It is important to recognize that the quality of the health economics section of a company's approval application could be lower than the clinical section, which could affect the subsequent conclusions about the drug.

The roles of guideline groups and drug review panels are both necessary and complimentary. Recognizing that the most effective therapies will not always be the most cost-effective leads to the appropriate expectation that guideline groups and drug review panels may reach opposite conclusions. The potential for dualities of interest is real, and guideline groups have processes in place to allow for declarations of potential conflicts. Making these declarations accessible to reviewers is a reasonable request. I would also suggest that making available the guideline's technical documents would be helpful in explaining how a literature review led to a specific guideline, and would mitigate criticism that self-interest motivated particular recommendations. CPGs are an essential resource for clinicians. Allowing reviewers to be aware of potential conflicts of interest is reasonable. Excluding publication of guidelines because potential conflicts of interest may exist is not.

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**Competing interests:** Dr. McFarlane has been involved in continuing medical education events and/or advisory boards that have been sponsored by companies that sell insulins in their product lines, including Sanofi-Aventis, the maker of insulin glargine.

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A recent *CMAJ* editorial drew attention to the potential for conflicts of interest to influence the development of clinical guidelines.[1] While we share your concerns, we wanted to register our disagreement with the *CMAJ* editorialist's conclusion that the only way to reduce potential conflicts of interest is to mandate that guideline panels consist only of non-experts. We believe strongly that clinical expertise in a particular area is necessary to properly interpret evidence related to that area.

We believe that the best solution to the dilemma raised by your editorialist is to ensure that guideline panels develop a transparent system of checks and balances that ensures both the integrity of the process and the quality of the recommendations made. To that end, we would like to point out that the hypertension recommendations produced by the CHEP are developed annually by experts from a variety of disciplines, none of whom are paid for their CHEP activities, and the following steps are taken to minimize potential biases:

1. An independent steering committee (consisting of representatives of the