



Misinformation and lack of knowledge hinder cervical cancer prevention

To the Editor: Cervical cancer is the second most common cancer, with an age-standardised incidence rate of 30 per 100 000 per year, and is the leading cause of cancer mortality among South African women.¹ The National Department of Health (NDOH) national screening policy entitles every woman attending public sector services to 3 free Papanicolaou (Pap) smears in her lifetime at 10-year intervals, starting at the age of 30 years. Properly implemented, this policy could decrease the incidence of cervical cancer by more than 50%. Community awareness is the key to achieving optimal coverage and participation in the screening programme.

The causative link between high-risk human papillomavirus (HPV) and cervical cancer has been established.² HPV vaccine offers great potential for primary prevention of cervical cancer in South Africa. Two prophylactic vaccines, with a good safety profile and sustained efficacy after 5 years,^{3,4} have been licensed for use in South Africa but are not yet available in the public health sector. Secondary prevention of cervical cancer through Pap smears remains vitally important as all women will not be vaccinated, some cervical cancers are caused by HPV types not included in the current HPV vaccines, and the vaccines are not effective in women who already have HPV infection.

We conducted a qualitative study between February 2007 and March 2008 that explored key challenges and opinions towards HPV vaccination introduction in South Africa in three diverse areas in the Western Cape province. Health care providers, policy makers and key policy influentials at national and provincial levels were interviewed, and focus group discussions were carried out with women aged 21 - 57 years who had children who would be eligible for the HPV vaccine.⁵ Knowledge and perceptions on cervical cancer and prevention were also explored.

Women's levels of knowledge and understanding of cervical cancer, the causative relationship between HPV and cervical cancer, and the purpose and preventive nature of Pap smears was poor. Many knew of the availability of cervical screening services but did not fully understand the purpose of Pap smears. Some associated Pap smears with 'cleansing or scraping the womb', after possible exposure to a sexually transmitted infection, after having been raped or, in other instances, to ensure fertility. Health care providers confirmed some of these beliefs.

Health care providers displayed differing levels of knowledge of the current cervical screening policy, the rationale for the policy, and the links between HPV and cervical cancer. Some providers were misinformed about the South African cervical screening policy.

Lack of knowledge of cervical cancer is a prime barrier to preventing cervical cancer.⁶ We need to develop and evaluate

innovative strategies to raise awareness about cervical cancer and the importance of screening as a preventive measure. For successful screening programmes, health care providers must understand the rationale of policy and the causative relationship between HPV and cervical cancer, and be cognisant of community misconceptions and beliefs.

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Complaints against doctors

To the Editor: The 'patients corner' in the South African Medical Association website prominently displays the following:

COMPLAINTS AGAINST DOCTORS:

The Health Professions Council of South Africa (HPCSA) investigates complaints against medical practitioners on behalf of the public.

Complaints must be lodged in writing to:

The Registrar
Health Professions Council of SA
PO Box 205
PRETORIA
0001

or on their website: www.hpcs.co.za.

Of course the HPCSA accepts complaints. So do litigation lawyers, medical aid societies, fraud lines, consumer columns and the South African Police Services. The South African Medical Association at branch level also has an established structure to deal with complaints.

What possible reason has SAMA to prompt complainants to 'mainline' to the HPCSA, knowing full well the time lags, complexities and costs of defending at HPCSA level, imposing (as it does) considerable duress upon SAMA's members? The foundation principle in resolving a dispute is to attempt



resolution at the lowest level. If this fails at the level of the individual doctor, the next lowest level to attempt resolution would be within the doctors' association, namely SAMA. Why, then, does SAMA not say this to enquiring laymen?

Perhaps SAMA also plans to advertise litigation lawyers on their website as a fund generator.

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Knees, Comrades and sample size

To the Editor: We wish to raise concerns with regard to the study published by Hagemann *et al.* ('Do knees survive the Comrades Marathon?').¹ The design of the study is purported to be a prospective study of 10 randomly selected participants. Closer reading shows the sampling to be that of a convenience sample in which participants volunteered for the study. No mention is made of how potential participants were approached or, later, how many patients were excluded from the study owing to pre-existing injury. This sampling technique is not statistically random and introduces serious selection bias. Factors such as age, weight or whether it was an uphill or downhill race are also not considered.

The second point of concern is the very small sample size used in this study. Small sample sizes in medical studies are often a result of necessity, but there are inherent dangers in making use of them. Over the 6-year period (1997 - 2002), there were over 90 000 entrants in the Comrades Marathon.² Using an alpha value of 0.05 and a 95% confidence level, based on a population of 90 000 entrants, the recommended sample size is 383. A sample size of only 10 introduces a 30.99% margin of error. This study then becomes an example of a type II error where finding that there is no difference between the two groups is primarily a factor of the small sample size rather than a reflection of an actual lack of difference.

Owing to its methodology and sample size, it would be ill-advised to draw any valid conclusions from this study. These data might have been better suited to use as a case series from which a larger confirmatory study could be designed.

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Drs Hagemann, Rijke and Corr reply: We thank Drs Rodseth and Geddes for their comments on our study. They focus on two aspects of the study: (i) its design – specifically on how the participants were selected in this prospective study; and (ii) the small sample size, which would introduce a margin of error contravening the conclusion that there was no difference between the two groups.

The study was designed to determine the effect of ultra-marathon running on the structures of the normal knee and any unknown pre-existing abnormalities of the knee. In selecting participants, knees that had previous surgery or documented injuries were excluded and, therefore, none were excluded later on the basis of any such pre-existing injury. No other qualifications (such as age, weight or gender) were considered as conditions for eligibility. As part of the recruiting protocol, all participants were volunteers. We disagree that this selection of knees is non-random or introduces a selection bias. We did not provide information on the specifics of the race as this is readily available.¹

As is often the case with prospective MRI studies, the small sample size was the result of necessity. However, in designing this study, we purposely restricted our aims to avoid the dangers inherent to this small size by limiting the study to normal knees (including by necessity those with unknown abnormalities) and by only registering changes on follow-up scans. Specifically, we disagree with the view that 383 participants would be required for this study to meet the conditions of alpha equal to 0.05 and a 95% confidence level, based on 90 000 entrants. Such numbers of participants would have to be recruited if the purpose of this study were a complete inventory of all injuries, new and pre-existing, collected and followed up over the course of the three sequential MRI studies. However, by limiting the aims of this study, we have been able to demonstrate convincingly that there was no difference between the two groups. Researchers of similar prospective MRI studies on the knees of runners (references 5, 6, 7, 10, 11) had enrolled between 5 and 10 participants to arrive at their conclusions.

1. <http://results.comrades.com>

1. Hagemann GJ, Rijke AM, Corr RD. Do knees survive the Comrades Marathon? *S Afr Med J* 2008; 98: 873-876.

2. <http://results.comrades.com> (accessed 1 December 2008).