happening in the United States. Pellegrino's assertion that generalist's functions will be seriously threatened by "commercial and economic pressures" seems doubly ironic in view of North American research on the importance of primary care to effectiveness and efficiency of a healthy system.[4] The evidence seems yet to reach those administering managed care organizations in the United States. Sadly, the editorial appears substantially, but uniquely, relevant within the borders of a one-time health superpower.

Grant Russell, MB, BS, DRANZCOG, FRAPCG, MFM
The University of Western Ontario
London, Ontario, Canada

References

1. Pellegrino ED. Can the generalist survive the 21st century? J Am Board Fam Pract 2000;13:312–4.
2. General Practice Branch, Commonwealth Department of Health and Family Services. General Practice in Australia: 1996. Commonwealth Department of Health and Family Services, 1996.
3. Magarey A, Rogers W, Veale B, Weller D, Sibthorpe B. Dynamic divisions. A report of the 1997–98 Annual Survey of Divisions. Commonwealth Department of Health and Aged Care, National Information Service, 1999.
4. Starfield B. Primary care: balancing health needs, services, and technology. Revised edition. New York: Oxford University Press, 1998.

Vaginal Cuff Testing

To the Editor: Videlefsky et al[1] address a common clinical question confronting primary care providers and their female patients: is routine vaginal cuff sampling indicated in a woman who has undergone a hysterectomy for a benign condition? As the authors note, there is lack of consensus from specialty organizations and guideline panels regarding the answer to this question, though retrospective analyses such as their own[1,2] show a limited yield to this clinical practice.

To determine how common vaginal cuff sampling is within the authors' study population, it would be instructive to perform a chart review of patients who had undergone hysterectomy for benign reasons but had not obtained follow-up vaginal cuff sampling during the same study period (April 1987 – July 1996). One could then randomly select and review the same number of patient charts (n = 220) to determine whether vaginal cuff sampling had not been performed because of physician recommendation, patient preference, or lack of follow-up. By examining both patient cohorts (those receiving and those not receiving vaginal cuff sampling), one could compare practice patterns among obstetrician-gynecologists, family physicians, and mid-level providers. It is worth noting that the necessary exclusion of women who have not undergone vaginal cuff sampling introduces an inherent selection bias into such a retrospective analysis. If it were to be discovered that a substantial number of women had not obtained vaginal cuff sampling because of a lack of follow-up, as is the case for cervical dysplasia, might this be a marker for increased risk for vaginal dysplasia? Although Videlefsky et al did not find women with pre-hysterectomy cervical dysplasia in their study to be at increased risk for post-hysterectomy vaginal dysplasia, one should examine those women who had not undergone vaginal cuff sampling and determine whether there was a higher prevalence of pre-hysterectomy cervical cytologic abnormalities.

To add to the seven cases of patients who had positive findings on vaginal cuff sampling in the authors' study, I report on a case of vaginal dysplasia that was detected following routine vaginal cuff sampling. The patient was a 45-year-old gravida 4, para 4 woman who underwent vaginal hysterectomy in 1991 secondary to uterine prolapse. Cervical histologic findings at the time of her hysterectomy showed focal squamous metaplasia. She had two episodes of "cellular atypia" 4 years before her hysterectomy, after which she had four normal Papanicolaou smears. Her baseline health was good. She had three lifetime sexual partners. She had a family history of ovarian cancer involving her paternal grandmother, and she was without a history of sexually transmitted disease or tobacco use. After her hysterectomy the patient was lost to follow-up for 4 years, at which time she had a normal findings from a gynecological examination and vaginal cuff sampling. She was subsequently lost to gynecological care for an additional 4 years, at which time I saw her, 9 years after her hysterectomy. She had no genitourinary complaints. She had grossly normal findings on a gynecological examination, but her vaginal cuff sample was remarkable for a high-grade squamous intraepithelial lesion-moderate dysplasia. She was subsequently referred to a gynecologic dysplasia clinic for biopsy of an acetic-acid positive section in the mid vagina, which showed moderate dysplasia with koilocytosis. The patient subsequently underwent laser vaporization of the involved area and has subsequently had uneventful recovery. There has not been a sufficient time lapse at present for follow-up examination and vaginal cuff sampling.

Such a case causes me to agree with the authors. Although there is limited yield of vaginal cuff sampling within the stated study population, further investigation should be performed in an effort to determine risk factors for vaginal dysplasia after a hysterectomy for benign conditions so that the patient reported here will not have undetected lesions. Currently, my own practice pattern is to counsel patients who have had pre-hysterectomy cervical abnormalities, who have had multiple sexual partners, who are immunocompromised, or who have a family history of cancer to undergo periodic vaginal cuff sampling.

Peter Lewis, MD
Hershey, Pa

References

1. Videlefsky A, Grossl N, Denniston M, Sehgal R, Lane JM, Goodenough G.. Routine vaginal cuff smear testing in post-hysterectomy patients with benign uterine conditions: when is it indicated? J Am Board Fam Pract 2000;13:233–8.
2. Pearce KF. Cytopathological findings on vaginal papanicolaou smears after hysterectomy for benign gynecologic disease. N Engl J Med 1996;335:1559–62.