Schnatz PF, Guile M, O'Sullivan DM, Sorosky JI. Clinical significance of atypical glandular cells on cervical cytology. Obstet Gynecol. 2006;107:701–708.

Q Do atypical glandular cells on Pap test require aggressive follow-up?

A Yes. Perform colposcopy and directed biopsy, endocervical evaluation, and a pelvic examination in all women with atypical glandular cells on Pap test, and perform an endometrial biopsy in women with risk factors for endometrial cancer.

This analysis found that roughly 29% of women with atypical glandular cells had conditions that required follow-up or treatment, and 5.2% had a malignancy. Therefore, methodical follow-up is not only warranted, but necessary.

***FAST** TRACK*

- **In any woman with AGUS, do a colposcopy, endocervical evaluation, directed biopsy, and pelvic exam**
- **If she has risk factors, do endometrial biopsy**

Details of the study

Schnatz and colleagues reviewed 3,890 Pap tests that had a finding of atypical glandular cells of undetermined significance (AGUS), for which follow-up details were available.

They found these rates of pathology:

- 8.5% low-grade squamous intraepithelial lesions (LSIL)
- 11.1% high-grade squamous intraepithelial lesions (HSIL)
- 2.9% adenocarcinoma in situ
- 1.4% endometrial hyperplasia
- 5.2% malignancy

The distribution of cancers was:

- 57.6% endometrial adenocarcinoma
- 23.6% cervical adenocarcinoma
- 6.4% ovarian and fallopian tube carcinoma
- 5.4% squamous cell carcinoma of the cervix
- 6.9% other cancers

EXPERT COMMENTARY

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Several years ago I gave a talk entitled, "AGUS scares me." It still does.

For almost 2 decades I have been preaching that, except for a finding of invasive squamous cancer, the single most important cervical cytology report is one that confirms atypical glandular cells (now abbreviated as AGC under the Bethesda System). Virtually every paper written on the subject has shown that AGC are markers for cancer in a high proportion of cases, yet I continue to see clinicians react merely by repeating the sample, or quitting after a negative colposcopy.

Schnatz and colleagues confirmed that such action is insufficient. In their compilation of published research on the subject, 5.2% of all women with AGC and follow-up had invasive cancer, usually in the pelvis. That rate is many times higher than the cancer risk of HSIL, yet AGC often elicits a far less aggressive evaluation.

Does age matter?

I do wish the authors had done more to explore age as a variable. Most individual series are too small to establish guidelines based on age, but this review of the literature was an opportunity for meaningful observations.

Most of us are not as worried about a

report of AGC in a young woman, particularly if she is pregnant. However, that clinical impression is based on very scant data. This study would have been a good place to investigate whether we should pursue AGC differently in young women, and perhaps at what age we should begin to consider endometrial biopsy.

1 in 15 cancers nonpelvic

Of the 203 invasive cancers associated with atypical glandular cells, most originated in the pelvic organs. The authors present a reasonable sequence of evaluation, starting with colposcopy, endocervical evaluation, endometrial biopsy, conization, and pelvic ultrasound—more or less in that order. However, 14 (6.9%), or 1 in 15, of the cancers were located outside the reproductive organs. The authors did not emphasize this finding as much as I would have liked.

Consider colonoscopy, ultrasound, CT

If no source of the AGC is identified in the pelvis, particularly if the patient is older than 50, consider further tests (eg, colonoscopy, abdominal ultrasound, computed tomography). Although nonpelvic malignancies responsible for AGC are often already metastasized, a few cures have been achieved with careful, thorough investigation.

The author reports no financial relationships relevant to this article.

Q Does epidural early in labor lead to C-section?

Ohel G, Gonen R, Vaida S, Barak S, Gaitini L. Early versus late initiation of epidural analgesia in labor: Does it increase the risk of cesarean section? Am J Obstet Gynecol. 2006; 194:600–605.

FAST TRACK

This study should lay to rest concerns about alleged adverse effects of early regional anesthesia

A Not according to this study. When epidural analgesia was given at the patient's first request, it did not increase the risk of cesarean or instrumental delivery or adverse effects. It also shortened the first stage of labor.

Details of the study

Nulliparous women in early labor were randomized to receive epidural analgesia at the first request ("early" group, about 2.4 cm cervical dilation) or "late" (group in which the epidural was initiated at a mean dilation of 4.6 cm). Analgesia in the late group was provided by parenteral meperidine (Demerol) until cervical dilation increased.

There were no differences in:

- Cesarean delivery rates, either overall or for failure to progress
- Use of oxytocin
- Incidence of maternal fever
- Neonatal outcome as measured by Apgar score
- Presence of meconium

EXPERT COMMENTARY

William Camann, MD, Director, Obstetric Anesthesia Service, Brigham and Women's Hospital, Harvard Medical School, Boston

Why is this study important? There has always been, and continues to be, controversy about epidural analgesia during labor and alleged adverse effects on progress and outcome of labor. Ohel and colleagues have added to the growing body of evidence on these alleged effects—or lack thereof.

Although recent studies have virtually eliminated epidural analgesia per se as an important or causative factor for intrapartum cesarean delivery, there is still some concern that early initiation may have other adverse effects.

What about other adverse effects?

A recent study by Wong et al[1] drew the same conclusions as Ohel et al. However, the Wong study was criticized (a criticism

CONTINUED

with which I do not agree) for its use of a combined spinal-epidural technique, which was not thought to be representative of standard labor practice.

Ohel et al used a protocol that, by any definition, would be considered a typical epidural analgesia "cocktail." Thus, it should lay to rest any further concerns about alleged adverse effects of early regional analgesia.

Induced and spontaneous labors were included. One potential criticism of this trial is the inclusion of both induced and spontaneous labors. Ohel et al acknowledged and addressed this concern, and provided separate analysis, including power analysis, for these 2 groups. The results were consistent.

Comply with her request

This investigation report was accompanied by a superb editorial,[2] which concluded:

"… it is difficult to argue that epidural analgesia should be withheld from a woman who requests pain relief in labor. While such decisions should always be individualized, there should no longer be an arbitrary degree of cervical dilation before such a decision is considered.

"No longer should a patient be made to feel guilty about her wish for pain relief early in labor, powerless in her choices, or conflicted about the consequences of such a choice. Women should receive adequate pain relief when needed, as determined by the patient herself. What a concept—pain relief of real pain when requested."

Imagine that. ■

REFERENCES

1. Wong CA, Scavone BM, Peaceman AM, et al. The risk of cesarean delivery with neuraxial analgesia given early versus late in labor. N Engl J Med. 2005;352:655–665.
2. Nageotte M. Timing of conduction analgesia in labor. Am J Obstet Gynecol. 2006;104:598–599.

The author reports no financial relationships relevant to this article.