practitioners of narrative therapy and the theorists of narrative medicine. But there is so much to do!

—Rita Charon, MD Phd
New York, NY
by e-mail

Reference
1. Charon R. What to do with stories. The sciences of narrative medicine. *Can Fam Physician* 2007;53:1265-7.

Strep steps

There have been excellent points touched upon in the articles published in *Canadian Family Physician* regarding strep throat. The recent letter by Dr Pol Morton[1] sparked my interest. One way to help decide the best management for patients with symptomatic throat complaints is to engage patients (or guardians) in discussions about the risks and benefits of therapy and to conclude with informed decision making regarding therapeutic options (analgesics, antibiotics, etc).

One way to do this is to discuss the number needed to treat and the number needed to harm. Treatment with antibiotics has not been shown to affect the rate of poststreptococcal glomerulonephritis, neither has it been shown to reduce the incidence of rheumatic fever. Rheumatic fever is related to a strain of *Streptococcus* having the "m" gene. The prevalence of that gene in the community might assist clinicians in deciding whether there is a need for antibiotics.

If we look at patients with uncomplicated pharyngitis and have ruled out serious disease, then the number needed to treat for prevention of rheumatic fever has been estimated at more than 1 million. The question is, how many will be harmed by prescribing antibiotics more than 1 million times when they do not appreciably change patient-oriented outcomes?

—Mark Mensour MD
Huntsville, Ont
by e-mail

Reference
1. Morton P. Should we treat strep throat with antibiotics? [Letters]. *Can Fam Physician* 2007;53:1299.

Rules of engagement

The Practice Tip article about using lubricant for Papanicolaou tests[1] was very reassuring, as one of us (Dr Lofsky) has used small amounts of lubricant with plastic disposable specula without difficulty. He has had few problems with water-moistened metal specula and, like many others, has used specula warmed with water and temperature-tested on patients' upper legs as a further comfort measure. Plastic specula seem to have much more drag on insertion. Additionally, small specula are quite adequate and more comfortable for many first-time Pap tests and for sexually inactive menopausal women.

Perhaps the liquid-based cytology method used in most Ontario laboratories is another factor that facilitates quality assurance, as the specimen is placed in a centrifuge and separated from other extraneous material such as mucous and secretions. Also, cytotechnologists prepare the slide as a monolayer, which improves specimen adequacy for interpretation and quality.

The screening recommendations noted in Tsang and Osmun's first paragraph differ slightly from the 2005 evidence-based Ontario recommendations for cervical cancer screening. After initiation of sexual activity, 3 annual Pap tests are recommended. If the first 3 Pap tests are normal, ongoing screening is recommended every 2 to 3 years. A 3-year screening interval is recommended only if there is a recall system in place (either a provincial system or within a physician's office). There are ongoing efforts and recommendations for provincial recall systems to ensure regular screening for *all* eligible women.

Further, the authors' suggestion to stop screening after menopause (with only 3 additional Pap tests) diverges substantially from Ontario's (and other provincial) cervical screening guidelines, which recommend continuing regular Pap tests until age 70. Since there is no reference provided for their statement, this is likely their own personal opinion, which does not coincide with existing provincial guidelines. Given that incidence and mortality rates for cervical cancer are the highest for women older than 50 years in Ontario[2] and other provinces, the suggestion to discontinue screening by age 60 is alarming and should not be adopted as preferred practice.

—Stan Lofsky MD CCFP FCFP
—Robbi Howlett PhD
North York, Ont
by e-mail

References

1. Tsang N, Osmun WE. Smear tactics. A more comfortable Papanicolaou test. *Can Fam Physician* 2007;53:835.
2. Ontario Cervical Screening Program. *Selected extracts from the OCSP Program Report 2001–2005.* Toronto, ON: Ontario Cervical Screening Program; 2005. Available from: **www.cancercare.on.ca/documents/OCSPProgramReport2001-2005.pdf**. Accessed 2007 October 9.

Competing interests

Dr Lofsky *is a member of the Section on General and Family Practice of the Ontario Medical Association and represents the Section at the Cervical Cancer Screening Collaborative Group of Cancer Care Ontario. He receives honoraria from the Section for attending meetings. In the past year he received honoraria for attending the Ontario Cervical Screening Collaborative Group biannual meeting and for attending the Ontario Colposcopy Standards Review Panel under the auspices of Cancer Care Ontario.*

β-Agonists: all the facts please

I would like to share my comments about the recent debate titled "Should we avoid β-agonists for moderate and severe chronic obstructive pulmonary disease?" (COPD) between Drs Salpeter and Aaron (*Can Fam Physician* 2007;53:1290-3 [Eng], 1294-7 [Fr]).

In support of the argument not to use β-agonists in the management of COPD, Salpeter leads the reader to believe that tolerance to β-agonists

Ontario cervical screening practice guidelines

English
www.cancercare.on.ca/documents/CervicalScreeningGuidelines.pdf

French
www.cancercare.on.ca/documents/CervicalScreeningGuidelines-French.pdf

Full report
www.cancercare.on.ca/pdf/pebc_cervical_screen.pdf