rescreening alone. This is not necessarily true; PAPNET cannot image up to the edges of the glass slides. Slide-by-side comparison of manual rescreening and PAPNET-assisted rescreening could only have made PAPNET look worse.

Koss, Mango and Radensky, and Schechter believe that our conclusions cannot be generalized because we are a “high-quality reference laboratory serving a low-risk population of women.” The percentage of abnormal Pap smears found in our laboratory is not unlike that of many health care systems. The careful definition of both our patient population and laboratory practices enables individual health care institutions to determine the applicability of our findings.

Seventy-five percent of invasive cervical cancers are diagnosed in women who have not had a Pap smear in the previous 5 years. Access to regular Pap screening, such as found in the military health system, is clearly a cost-effective method by which to reduce cervical cancer mortality. Health care dollars are scarce. The benefits and costs of new technological approaches for reducing cervical cancer deaths must be compared with those of effective “low-tech” methods when considering their widespread use.

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In Reply.—By assessing outcomes in life-years rather than the limited end point of cost per abnormality, the cited study by Dr Schechter follows the format of a conventional cost-effectiveness analysis. Nevertheless, it does not address the use of PAPNET considered by Dr O’Leary and colleagues. The comparison with 100% manual rescreening, frequently discussed as a method that might improve the accuracy of Pap smear testing, is of substantial interest. The finding that PAPNET identified fewer additional abnormalities, and at very high cost, suggests that it is not cost-effective when an excellent laboratory uses it this way. A more elaborate analysis is not needed to draw this conclusion.

As Drs Mango and Radensky note, the analysis by Schechter concluded that PAPNET-assisted rescreening was cost-effective in comparison with conventional Pap smear testing. However, Mango and Schechter had been informed months ago that Dr Adalstein Brown and I were not able to replicate Schechter’s results. Using a similar model and approximating his assumptions, we found that the cost-effectiveness ratio of PAPNET-enhanced rescreening was at least 5 times as great as the $48,000 per life-year figure that Schechter reported for incorporating PAPNET into biennial testing (unpublished data, 1997). His figures were close, however, to our estimates of the cost-effectiveness of PAPNET-enhanced testing compared with not screening at all. If the cost-effectiveness ratio reported by Schechter was actually based on a comparison with not screening at all, the consequences are substantial.

Given that conventional Pap smear testing is highly cost-effective, much of the effectiveness that his analysis attributes to PAPNET actually would be due to conventional Pap smear testing. When using Schechter’s assumptions, we found that PAPNET enhancement of conventional Pap smear testing has a cost-effectiveness ratio far above the range usually considered acceptable (unpublished data, 1997).

Schechter’s charges of conflict of interest are serious and based on false allegations. As I informed the editors of JAMA, I was assessing technologies to improve Pap smear testing for the national Blue Cross-Blue Shield Association’s Medical Advisory Panel. The Medical Advisory Panel is part of the Technology Evaluation Center, which is jointly sponsored by the Blue Cross-Blue Shield Association and Kaiser-Permanente. The Technology Evaluation Center, one of 12 organizations that the Agency for Health Care Policy and Research has designated as evidence-based practice centers, produces reports that analyze new medical technologies. The reports are respected for their accuracy and balance. Subscribers include health care providers, organizations, private payers, and government agencies such as the Health Care Financing Administration and CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). Organizations making reimbursement decisions might draw on Technology Evaluation Center reports for information, just as they might use the medical literature, consensus statements from specialty societies, expert opinion, and other sources of information. But contrary to Schechter’s allegations, I do not make coverage recommendations nor do I advise the Blue Cross-Blue Shield Association on reimbursement policy. In fact, neither the Medical Advisory Panel nor the Blue Cross-Blue Shield Association determines reimbursement policy (Blue Cross-Blue Shield Association is not an insurer). The claim that I am “the agent of an insurer” is false. Although I endorse full disclosure, my interest is in producing accurate and fair analyses, not in serving insurers or manufacturers. The editors had no reason to believe that my work on Pap smear testing constituted a conflict of interest.

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CORRECTIONS

Incorrect Axis Label.—In the article entitled “Allergic Reactions to Workplace Allergens,” published in the December 10, 1997, issue of THE JOURNAL (1997;278:1907-1913), a figure axis was labeled incorrectly. On page 1910, the vertical axis of Figure 12-3 should be labeled “PEFR, L/min.”

Incorrect Photo Credits.—In the Medical News & Perspectives article entitled “A Farewell to Harms: Experts Debate Global Disease Eradication Efforts,” published in the March 25, 1998, issue of THE JOURNAL (1998;279:897-899), credit lines were incorrect on 2 photographs. The photograph appearing on page 897 was taken by Robert Grossman, and both photographs appearing on page 899 were provided by The Carter Center.