APPENDIX 11

CONSULTATION CLINIC NOTES, NATIONAL WOMEN'S HOSPITAL

PATIENT CODE 3X

This patient was originally seen at the Gynaecological Clinic in August 19 .., where she had been referred by Dr. .. with an A3 smear following recent miscarriage. Patient put on the waiting list for a cone biopsy. Admitted 4.10 for cone biopsy but it was decided to do a colposcopy and decision then regarding the cone biopsy.

Colposcopy Professor G Dr. M
Area thickened – squamous epithelium without any pattern.

5.10.64 Patient discharged to return to clinic in 6 weeks.

-.3.65 **Follow up Clinic.**
Colposcopy. Dr. M
Area of "Grund" anterior lip cervix unchanged – 12 to 2 o'clock. Punch biopsy from area. Repeat smear.

PATH REPORT: Punch biopsy cervix: Specimen consists of a fragment of pale tissue measuring 0.4 cms across. The section shows carcinoma in situ which extends into the superficial portions of some crypts.

Carcinoma in situ of the cervix.

SMEAR: Cells suggestive of but not conclusive for malignancy. We recommend a biopsy to exclude any possibility of malignancy. AC 23.4.65

2.4.65 Follow-up carcinoma in situ – so far diagnosed and treated by punch biopsy only. Same mild "erosion" surrounds a patulous external os. There is nothing on macroscopic appearance which is suspicious. Smear taken. To have further coposcopy and punch biopsy if necessary, in early July, unless the smear taken today is A5. Prof. G AC 1.7.65

SMEAR: Cells suggestive of but not conclusive for malignancy.

1.7.65 Follow-up carcinoma in situ – treated by Punch biopsy only. The area previously remarked is unchanged. No symptoms. Further smear taken. See in 6 months – for colposcopic and cytological examination. (pregnant 2/52) Prof. G AC 6.1.66

SMEAR: Cells strongly suggestive of malignancy.
LMP ... Due ...

Colposcopy – Dr M with Prof. G

Repeat Smear. Small amount of clear mucous present. Area of 'Grund' + +, On anterior lip of cervix from 11-2 o'clock, virtually identical to that previously seen. See in 6 months.

Opinion: Significant colposcopic appearances.

1.11.65 The uterus is somewhat hypertrophied because she is 5 months pregnant. She is booked for Waitakere Hospital under the care of Dr. C
Smear taken. See in Feb. Prof. G AC 10.2.66
The area on the anterior lip of the cervix has not enlarged.

SMEAR: Atypical cells but no evidence of malignancy. In view of smear 1.7.65 the present smear is probably not truly representative. 28.4.66
(8½ lb [baby] (12 days overdue, labour 5-6 hrs) 26.5.66

-.5.66 Follow-up carcinoma in situ – treated by Punch biopsy only. Had a normal confinement on (12 days overdue) labour lasting 5-6 hrs. 8½ lb ... infant. Has been well since and has breast fed. On examination there is marked eversion of the posterior lip of the cervix and to a lesser extent of the anterior lip of the cervix. There is a healing 'erosion' on the anterior lip. Rubbing the cervix vigorously produced some bleeding but nothing suspicious. See in 3 months. Prof. G AC 25.8.66

SMEAR: Atypical cells but no evidence of malignancy. Please repeat smear in 3 months.

25.8.66 Follow-up carcinoma in situ treated by Punch biopsy. Cervix unchanged in appearance. See in 6 months. Prof. G AC 9.2.67

SMEAR: Cells suggestive of but not conclusive for malignancy.

7.4.67 Follow-up carcinoma in situ – treated by Punch biopsy. This patient has been well. On examination there is still a considerable erosion and this bleeds easily to the touch. She has been referred to the Colposcopy Clinic (Dr. M) and will be seen again by Prof. G in 6 months. Dr. S AC -.5.67

SMEAR: Cells suggestive of but not conclusive for malignancy.

-.5.67 **Colposcopy Clinic:** LMP – ...
On Anovular since last babe. Obvious clinical PV discharge but no symptoms. Abnormal area 12-3 o'clock perhaps a little larger than when last seen nearly 2 years ago. Central part shows more obvious abnormal vessels with some elevation of surface epithelium. No ulceration or true tumour formation seen. Posterior lip transformation zone must be called abnormal. Dr. M AC 6.7.67

SMEAR: Cells suggestive of but not conclusive for malignancy. AC 5.-.67

2.11.67 Follow-up carcinoma in situ – Seen by Prof. G. Is symptom free. The cervix shows marked eversion of the columnar epithelium but there is nothing suspicious of malignancy. To be seen at Colposcopy Clinic in about 5 weeks. Smear taken. Dr. B AC 7.12.67

SMEAR: Cells conclusive for malignancy.

14.12.67 **Colposcopy Clinic:**
Anterior lip of cervix – the area earlier described between 11 and 2 o'clock now seems a little more obvious, particularly in

the 2 o'clock zone where the appearance is taking on more of a three dimensional appearance. There is a further small area on the anterior lip, about 10 o'clock with a 'Grund' appearance. Posterior lip – there is now a faint 'grund' appearance over most of the posterior lip of the cervix particularly towards the periphery or junction of the transformation zone with the native squamous epithelium beyond.
Summary: The changes are not very dramatic but there does seem to be some 'progression' both in extent and degree. Review in 6 months. If possible by both Prof. G and myself. Dr. M AC 6.68

SMEAR: Cells strongly suggestive of malignancy.

-.6.68 Mrs ... still continues to have positive smears and the cervix continues unchanged in appearance and there are no symptoms. The eversion of epithelium bleeds a little on scraping. Smear taken. She is a very sensible patient and knows all the ins and outs of the situation. See in four months for colposcopy. Prof. G AC 17.10.68

SMEAR: Cells conclusive for malignancy. 24.10.68

-.11.68 **Colposcopy Clinic:**
Area at the 12-2 o'clock region on anterior lip unchanged since examination 1 year ago, I could not make much of the posterior lip on this occasion. Suggest review in 1 year's time. Dr. M AC 30.10.69

SMEAR: Cells conclusive for malignancy. 6.11.69

6.11.69 Carcinoma in situ – appearance of cervix unchanged but the surface of the posterior transformation area bled on scraping, no bleeding from within the cervical canal on probing. Smear taken. To have colposcopic examination and patient will ring for the Thursday that suits her before Christmas. Otherwise regular appointment for 1 yr. I think she might have to be admitted for D&C and selective biopsy Prof. G

SMEAR: Cells conclusive for malignancy.

22.3.70 Re-admitted. Dr.

23.3.70 **COLPOSCOPY CLINIC:** Dr. M
No symptoms. Some bleeding caused posterior transformation zone with the insertion of speculum. Large multiparous cervix with now much more widespread changes than I have previously seen. On the anterior lip, the whole of the periphery of the transformation zone from 9 o'clock round to 3 o'clock is involved in a Coppleson two plus change. Posterior lip again almost the whole of the periphery of the transformation zone involved. It might be a good plan in this case to do four biopsies at 11 and 2 o'clock and again on the posterior lip at 4 and 8 o'clock.

SMEAR: Cells conclusive for malignancy.

24.3.70 **SELECTIVE BIOPSIES, ANTERIOR AND POSTERIOR LIPS OF CERVIX, EUA, D&C.** Prof. G

Indications: Positive cytology in 1965 with an earlier diagnosis of carcinoma in situ in the cervix and widespread colposcopic appearances.

Findings: Vaginal cysts as previously, cervix of moderate size with a large transformation zone in the gross. Uterus of normal size, in mid position, no adnexal pathology palpated.

Procedure: 1. Wedge biopsy. Anterior lip of cervix at 12 o'clock.

Procedure: 2. Second biopsy anterior lip of cervix at 3 o'clock.

Procedure: 3. Third biopsy posterior lip of cervix at 6 o'clock.

One suture in the anterior and posterior and two in the area at 3 o'clock. Dilatation to 8 Hegar, uterine cavity smooth, negligible curettings obtained. Dr. M

PATH REPORT: **Curettings:**
Sections show few fragments of Hypoplastic endometrium.

Biopsy Anterior lip cervix 3 o'clock.
Macroscopic: Specimen consists of a large wedge of cervix 2 cms in extent.
Histology: Sections show
Carcinoma in situ of the cervix.

Biopsy Post. lip cervix
Macroscopic: Specimen consists of wedge of cervix 1.9cms in extent. Histology: Sections show
Carcinoma in situ of the cervix.

Biopsy ant. lip cervix
Macroscopic: Specimen consists of a wedge of cervix 2.5cms. in extent.
Histology: Sections show **Carcinoma in situ with microinvasion of the cervix.** Dr. Mc

Condition satisfactory.

25.3.70 Discharged. To return to clinic in two months. AC 14.5.70

21.5.70 The biopsy sites have healed very well indeed. Smear taken. See in six months. No complaints. Prof. G AC 26.11.70
SMEAR: Cells strongly suggestive of malignancy.

10.12.70 A4 smear following the D&C and selective biopsy. On examination of the cervix shows a very large transformation zone on the anterior and posterior lips and this seems to be a small area independent to this on the right aspect of the anterior lip. She has now been on the pill for 5 to 6 years.The transformation zone bled quite readily on scraping. To have colposcopic examination next week. See in 6 months otherwise. Prof. G AC 17.12.70

SMEAR: Cells conclusive for malignancy.

7.1.71 **COLPOSCOPY CLINIC.** No symptoms. Again some bleeding on the posterior transformation caused with the insertion of the speculum. An area from 4 to 7 o'clock on the posterior lip shows abnormal changes. Anterior lip – the most dramatic changes are from 10 to 12 o'clock and extend out onto the right vaginal fornix of the most impressive Coppleson 3 area is confined to the portio of the cervix on the anterior lip in this area. In view of Professor G's, December comments and the extent of lesion, to come in in late February for further excision. Dr. M Admiss.

SMEAR: Cells conclusive for malignancy.

14.2.71 Re-admitted.

16.2.71 **E.U.A. CONE BIOPSY OF CERVIX.** Prof. G

Indications: Continuing positive smears and suggestive colposcopic appearances of cervix. Patient has been on the pill for about 7 years.

Findings: Very large transformation zone on the anterior and posterior lips. As previously described there is a 'tongue-shaped extension' out towards 10 o'clock. Uterus bulky and depth of uterine cavity 9½ cms. No adnexal abnormalities.

There is nothing really suspicious clinically about this patient's cervix, although the transformation zone bleeds easily on probing – as is usual in people who have been on the pill for a long time.

Procedure: Cervix infiltrated with Octapressin and 2cms deep cone biopsy taken. The epithelial aspect of the cone biopsy was extended in a triangular fashion, totally excising the previously mentioned area between 10 and 12 o'clock. The remainder of the canal then dilated and scanty, normal curettings obtained from the endometrial cavity. Cervix repaired with a continuous inverting suture, slight bleeding throughout. Prof. G

PATH REPORT: **Cone Biopsy Cervix**
Sections show carcinoma in situ of fairly considerate extent involving both anterior and posterior lip and displaying several small foci of microinvasion. As far as can be seen the abnormal area observed macroscopically is made up of rather exuberant thick almost papillomatous carcinoma in situ. Tumour is present at portioexcision margins.
Carcinoma in situ with microinvasion of the cervix. Dr. Mc

Curettings:
The endometrium shows the effect of prolonged hormone administration.
Hypoplastic hormone endometrium.

Condition satisfactory.

18.2.71 Discharged. To return to clinic in two months. AC 13.4.71

22.4.71 No symptoms. In the gross the cervix is somewhat distorted following the recent operative procedure. Two red linear areas which seem to be suture lines clinically within normal limits. Smear taken. Review at colposcopy in 6 months. Dr. M AC
SMEAR: Cells strongly suggestive of malignancy.

15.10.71 **COLPOSCOPY CLINIC:**
There is an irregular reddened area, butterfly in shape, extending from 3 o'clock on the cervix on to the vaginal wall a distance of approximately 1 cm. This red area shows a typical three dimentional change of Coppleson three plus, the total extent of this area would not exceed 2 sq.cms. Periods have been a little heavier also in the last few months. The colposcopic abnormality would account adequately for the reported abnormal cytology. I would be more satisfied clinically and scientifically since this should be possible quite safely and readily, to remove this small area which remains and extension to the vagina. To come in to have this area excised in the next few weeks, ie end of November. Dr. M Adm.
SMEAR: Cells strongly suggestive of malignancy.

23.11.71 Re-admitted.

23.11.71 **E.U.A. WEDGE BIOPSY OF CERVIX** Dr. M

Indications: Continuing positive cytology and colposcopic finding of an abnormal area at 3 o'clock.

Findings: Clinically the vagina and cervix healthy excepting that there is a red patch which can be seen macroscopically extending from the endocervical canal at 3 o'clock in an irregular fashion onto the left lateral fornix of the vagina, a distance of perhaps 1cm. The uterus was of normal size, anteverted, freely mobile, no adnexal pathology. The small vaginal cyst approximately 2 cms in diameter is apparent as on other occasions.

Procedure: Wedge excision of the area described at 3 o'clock onto the vagina fornix – area removed without difficulty then dilatation to 8 Hegar exploration with Vantz forceps of the smooth cavity. No polypi. Sharp curettage. A small amount of apparently normal curettings. The deficiency in the vaginal vault and cervix repaired with 3 interrupted sutures. Dr. M

PATH REPORT: Curettings:
Section shows **Hypoplastic hormone endometrium.**
Biopsy of cervix at 3 o'clock.
2x1.5x1cms. Sections show
Carcinoma in situ of the cervix
Condition satisfactory.

24.11.71 Discharged. To return to clinic in two months. AC 18.2.72

10.3.72 **COLPOSCOPY CLINIC:**
A small area of raised three dimentional "Grund" approx 2 mms in diameter can be seen at 6 o'clock. No other abnormality. Smear taken. Review by Prof. G in 6 months.
Dr. M AC 31.8.72
SMEAR: Atypical cells but no evidence of malignancy. 66.0kg
Please repeat smear next visit.

7.9.72 No complaints. I cannot see the raised three dimensional area previously mentioned on the cervix and the cervical epithelium looks quite normal around a very restricted external os. Smear taken. See in 1 year. Prof. G AC 6.9.73
SMEAR: Cells suggestive of but not conclusive for malignancy.

4.10.73 Patient follow-up for carcinoma in situ of the cervix. She is free of symptoms. Normal and regular periods. On vaginal examination the cervix is somewhat flush with the vaginal vault and scarred without any evidence of recurrent or persistent disease. Bimanual examination there were no abnormalities. Smear taken. See in 1 year. Dr. V AC 3.10.73
SMEAR: Cells suggestive of but not conclusive for malignancy.

14.11.74 Findings exactly as previously and no complaints. The face of the cervix is more or less flush with the vaginal vault and there are some epithelial irregularities around the external os due to the repeated biopsies but there is nothing abnormal about the actual epithelium itself. Smear taken. See in 1 year. Prof. G AC 30.11.75
SMEAR: Grade 3 66.5 kgs

11.12.75 No complaints and the findings are as previously ie some epithelial irregularity around the external os but nothing abnormal. Smear taken. See in 1 year. Prof. G AC 1.12.76
SMEAR: Grade 3.

26.1.76 Booked admission for cone biopsy.

27.1.76 **E.U.A. RING BIOPSY OF CERVIX. D&C.** Prof. G

Indications: Positive cervical smears – consistently since punch biopsy diagnosis of ca insitu in 1965.

History: Further biopsies in 1970 and 1971. A colposcopically significant area was excised in-toto in 1971, mainly in the left lateral fornix, made no difference to the smear reports. Nothing significant has been macroscopically visible on the cervix since then.

Findings: Cervix flush with vaginal vault with only the anterior lip clearly identifiable and the posterior lip is more or less contiguous with the vaginal epithelium of the vault. External os irregular but the epithelium looks substantially normal. There is a slight reddened area extending posteriorly from the edge of the external os onto the posterior fornix and vaginal epithelium for a distance of about 1cm. Colposcopically this showed a marked punctate appearance and is probably the source of the continuing positive smears. Uterus normal size and shape. No adnexal abnormalities.

Procedure: A ring of epithelium 1cm from the external os to the outside limits from all around the external os was taken down to and including the external os and extending a little further posteriorly than anteriorly. It was not really a cone biopsy as very little cervical substance was excised – only the epithelium covering the anterior lip of the cervix and the posterior lateral vaginal fornices was included in the biopsy. Cervix dilated in 9 Hegar and very scanty endometrial curettings obtained. Cervix repaired with 2 inverting sutures anterior and posterior. It is highly probable that this cervix will stenose quite markedly. Despite the consistently positive smears for 11 years there is still nothing suspicious of malignancy about this cervix. Prof. G

Path Report: **Curettings:**
Sections show fragments of endocervical tissue and a few portions of Carcinoma insitu of cervix without stroma.

Biopsy cervix opened at 3 o'clock:
Sections show Carcinoma insitu of cervix. The tumour reaches the upper cut edge in several slides.
Carcinoma insitu of cervix – Excision appears incomplete.

8.4.76 She is on pills and her periods have been normal. L.M.P. .... no post coital bleeding or intermenstrual bleeding. She has been very healthy. The ring biopsy on 27.1.76 showed carcinoma in situ of the cervix, excision appears incomplete. On examination there is white discharge, the cervix cannot be seen properly because of the shortening, no obvious lesion on the cervix. The uterus is normal in size, no adnexal mass. See in 3 months. AC 22.7.76

SMEAR: Grade 1. Dr. S 67.5kgs

22.7.76 Looks well. L.M.P. was somewhat painful something that she has been unaccustomed to for many years.On examination the explanation is fairly obvious – the vaginal cervix has now almost disappeared and the external os is so narrowed as to be very difficult to pick up. A No.2 dilator could not be introduced. If there is any further trouble with the next period, she may need admission for a dilatation. Otherwise see in December. AC 16.12.76

SMEAR: Grade 1. Prof. G 23.2.77
17.3.77

17.3.77 The cervix is very stenosed, in fact hardly visible and she is having some dysmenorrhoea. To be admitted for dilatation. Smear taken. 65.5kg

SMEAR: Grade 1. Prof. G Admss

4.4.77 Re-admitted.

5.4.77 **E.U.A. AND DILATATION OF CERVIX** Prof. G

Indications: Cervical stenosis following repeated ring biopsies of cervix. Previous history carcinoma-insitu first diagnosed in 1965. Last ring biopsy done January 1976. Smears negative since then. Some dysmenorrhoea over the last few months.

Findings: There is a natural vaginal cyst in the left side, probably mesometric in origin – it was about 1 x 2cm and was not removed. The cervix was flush with the vaginal vault and the external os was no more than a millimetre in diameter. The vault and vaginal cervix were very scarred. On drawing down the cervix, the cervical substance became more obvious. Cervix dilated easily the stenosis being mainly on the external aspect. Cervical os and canal dilated up to 12 Hegar and during this a tear was probably induced in the upper part of the cervical canal. Depth of uterine cavity about 8 cm. Uterus, normal size, retroverted and no adnexal abnormalities. Very scanty curettings obtained. Prof. G

Path Report: **Curettings:** L.M.P. ...
Sections show **Fragments of carcinoma devoid of underlying stroma, probably carcinoma insitu.**

6.4.77 Discharged to return to clinic in 3 months. AC 7.7.77

8.9.77 The cervix is still somewhat stenosed but looks rather better previously. The histological report is somewhat surprising. Smear taken. See in 1 year. AC 27.9.78

SMEAR: Grade 1 68 kg

27.9.79 Has been skipping a period or two recently. Findings as

before ie atrophic cervix although the epithelium looks well oestrogenised. Has been on the pill continuously now for 14 years. I do not think any further active follow-up is indicated. Write to pt. N.Sept 80

SMEAR: Grade 1 Prof. G

20.9.80 Note to Dr. A

Nov.80 Reply from Dr. A Alive without evidence of Ca.21.10.80. N.Sept 82

Sept.82 Reply from Dr. A Alive without evidence of Ca. N.Sept.84

14.9.84 Note to Dr. A

Sept. 84 REPLY: Alive without evidence of ca. 4.9.84. N.Sept 86

Sept. 85 Mr O has had this chart out – ?? attending him.

23.10.85 Referred and admitted thru Mr O for further treatment of carcinoma of the cervix.

29.10.85 **EXAMINATION UNDER ANAESTHESIS, BIOPSY OF CERVIX & INSERTION OF CAESIUM AFTER-LOADERS.**
Stage 1B Mr W Dr P

(See copy of operation findings)

Path Report: **Curettings:**
Section shows **Invasive squamous carcinoma of the cervix.**

Biopsy of cervix:
Sections show **Invasive immature squamous carcinoma of the cervix.**

31.10.85 Caesium removed.

1.11.85 Discharged. READMSS. 16/12

16.12.85 Re-admission

17.12.85 **WERTHEIM'S HYSTERECTOMY & PELVIC LYMPHADENECTOMY.**
Mr W

(See copy of operation findings).

PATH REPORT: **UTERUS, CERVIX, L) & R) TUBES & OVARIES:**
Section from vaginal cuff show radiation changes focal ulceration & foreign body reactions to suture material with giant cell systems. The cervix shows radiation changes with focal ulceration. No residual tumour is present. The myometrium is unremarkable and the endometrium is atrophic and shows radiation changes. The ovaries & fallopian tubes are unremarkable.
No residual tumour.

R) COMMON ILIAC:
Sections show **reactive lymph node hyperplasia.** There is no evidence of malignancy.

R) EXTERNAL ILIAC: Sections show fat lined by a rim of **lymphoid tissue.** There is no evidence of malignancy.

R) LATERAL ILIAC:
Section show **Reactive lymph nodes.** There is no evidence of malignancy.

R) OBTURATOR:
Sections show mainly fat with foci of **lymphoid tissue.** There is no evidence of malignancy.

OBLITERATED UMBILICAL ARTERY:
Sections show **Fibrofatty tissue** with some large vessels. No lymphoid tissue present.

R) PARAMETRIC TISSUE: Section show **Fibrofatty tissue**, No lymphoid tissue present.

L) EXTERNAL ILIAC:
Sections show **Reactive lymph nodes.** There is no evidence of malignancy.

L) OBTURATOR:
Sections show **Reactive lymph nodes.** There is no evidence of malignancy.

L) INTERNAL ILIAC:
Sections show **Fibro-fatty tissue.** No lymph nodes present.

L) OBLITERATED UMBILICAL ARTERY:
Sections show **Fibro-fatty tissue and a very small lymphoid follicle.** There is no evidence of malignancy.

3.1.86	Discharged.	AC 13.2.86 69ka
5.1.86	Re-admission with R) iliac fossa pain, all nursing, cares given.	
6.1.86	Discharged.	105/65
13.2.86	Mrs ... has made a good recovery from her Wertheim's hysterectomy in mid December. Apart from minor niggling lower abdo. pains she reports no symptoms, in particular no history of vaginal bleeding or discharge, no urinary symptoms, she has regained a good appetite and her bowels are working regularly. On exam; the wound is looking healthy the rest of the abdo. exam; was unremarkable. No obvious lesion in the vaginal vault was noted. No pelvic masses noted. She will be seen again in three months time. Dr H	AC 15.5.86
15.5.86	Seen today no bleeding or pain or urinary problems, no abdo; masses, no lymphadenopathy, vault well healed no pelvic masses. Smear taken. Tender lower region of suture	

	line. Continue to take ethinyloestradiol 20 micrograms, see in three months time.	Dr D	
	See copy of letter to Dr B from D		AC 28.8.86
	SMEAR: GRADE 1		
	See letter to Mr J from Dr A		67kg
28.8.86	Quite well, no symptoms, smear taken. Pelvic examination normal. See in six months.		
	SMEAR: Grade I	Mr J	AC 26.2.87 66.5
26.2.87	Fit and well. No problems. No bleeding, no pelvic pain, no urinary disturbance. On examination abdomen normal, pelvic examination normal, smear taken from vault. Review in one year.		AC 25.2.88

APPENDIX 12

SOME DEATHS IN PATIENTS WITH POSITIVE CYTOLOGY

Code	Outside 1966 Guidelines	Interval to onset of invasive disease	Cause of death	Year
1G	Age/Abnormal bleeding	2 years plus	Motor V. Accident	1973
2E	Age/Microinvasion	Initial microinvasion	Myocardial infarction	1985
2L1	Age/Microinvasion	Microinvasion 2 years plus	Myocardial infarction	1983
2L2	Age		Other Ca (2 sites)	1987
2N	Age/Probable invasion	Initial Microinvasion(hysterectomy)	Ca vagina	1978
2S	Age/Abnormal bleeding	7 years	Ca cervix	1987
3M	Age/Invasion edge of biopsy	5 years	Ca vagina	1981
3Y1	Positive cytology 1968-1973	Nil	Ca lung	1985
5K	Macroscopic abnormality	17 years	Ca vagina	1981
5W	Positive cytology 1968-1971	Nil	Asthma	1973
6U	Age/Abnormal bleeding	10 years	Ca vagina	1982
6W	Age/Abnormal bleeding	10 years	Ca cervix	1980
7F1	Age/Microinvasion	2 years	Myocardial infarction	1982
7L	Age	3 years	Ca vagina	1975
7R	Age/Abnormal bleeding	9 years	Ca vagina	1978
7W	Microinvasion	4 years	Ca cervix	1976
8B	Age	10 years	Ca cervix	1976
8L	Age/Abnormal bleeding	9 years	Ca cervix	1981
9A	Age/Abnormal bleeding	5 years	Ca vagina	1986
9D	Positive cytology 1972-1976	Nil	Ca cervix	1977
10K	Age/Microinvasion Abnormal bleeding	5 years	Ca cervix	1979
10P1	Age/Abnormal bleeding	–	Stroke	1984
10Q	Age/Microinvasion Abnormal bleeding	4 years	Ca vagina	1977
10U	Age/Microinvasion Abnormal bleeding	11 years plus	Ca cervix	1982

APPENDIX 13

SCHEDULE OF SUBMISSIONS RECEIVED

Professor A H Angelo
Law Faculty
Victoria University
WELLINGTON

Auckland Women's Health Collective
Ponsonby
AUCKLAND

Ms C Cameron
TVNZ Documentary Department
LOWER HUTT

Mrs P M Collings
St Johns
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Dr D H C Davidson
Specialist Obstetrician & Gynaecologist
HASTINGS

Department of Sociology & Social Work
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Mr A W Firth
A W Firth & Associates
PALMERSTON NORTH

Dr Kamayani
Eden Terrace
AUCKLAND

Mrs E Lovegrove
Epsom
AUCKLAND

Maternity Action
Mt Eden
AUCKLAND

Mental Health Foundation of New Zealand
AUCKLAND

National Council of Women of New Zealand (Inc)
WELLINGTON NORTH

New Zealand Women's Health Network
TAURANGA

Ms S Neal
Waterview
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Dr B Phillips
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Public Health Assoc. of Australia & NZ,
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Dr W J Ramsay
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Ms E Reid
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Dr R Reid
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Dr J E Simon
TAURANGA

Mrs V B Smith
Waterview
AUCKLAND

Social Workers in women's health
AUCKLAND

Trade Union Health & Safety Centre
AUCKLAND

Waikato Women's Health Action Centre
HAMILTON

Waiwharaiki Branch,
Maori Women's Welfare League
AUCKLAND

Wellington Patients Association
WELLINGTON

Wellington Women's Health Collective
WELLINGTON

West Auckland Women's Centre
HENDERSON

Women's Electoral Lobby
WEST AUCKLAND

Women's Health Research Caucus
(Wellington Branch)
WELLINGTON

Women's Resource Network
Devonport
AUCKLAND