



The International Federation of Cervical Pathology and Colposcopy

HISTORY OF THE INTERNATIONAL FEDERATION OF CERVICAL PATHOLOGY AND COLPOSCOPY
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**“Memory is a curious mixture of
remembrances and forgetfulness”**

Jorge Luis Borges

Introduction

To address this Congress is a great honor that President Howard W. Jones III, has given to me, not because of my merits but because of my age.

In spite of being a member of the Argentinian Society since its foundation in 1964, my ties to the IFCPC started in 1984, with the invitation of President Kurihara to speak about “Diagnosis and treatment of VIN and VAIN” in the IFCPC Congress in Tokyo. Since then I was in the program of all the Federation congresses and became chairman of the IFCPC Education Committee for six years as well as chairman of the International Scientific Committee that culminated organizing the Buenos Aires Congress in 1999.

The history of institutions can be boring if only dates and names are quoted, but history can be a very attractive exercise if one intends to explore the ideas and controversies that were behind the foundation and development of the IFCPC. Apart from my age, because of my compromise with gynecology, I had the privilege of having been a very good friend and companion of many of the leaders that founded and ruled IFCPC over the last 50 years of the XX century.

So I will try to speak about the history of the Old Testament of the IFCPC, that is secondary prevention of cervical and lower genital tract cancer, and the impact of the announcement of the New Testament, that is primary prevention.

This difficult task is what I intend to do and I ask for your indulgence because I doubt that the challenge will be successful.

The IFCPC

The International Federation was founded on November the 6th, 1972, in Mar del Plata, Argentina. Today there are, here in this magnificent Congress in Auckland four “survivors” of the foundation days: Adolf Stafl, Joe Jordan, Fernando Guijón and myself.

Why in Argentina?

In the thirties Alfredo Jakob from Buenos Aires went to Altona in Hamburg Germany to learn with Hinselmann the method of colposcopy and after his return spread its use among gynecologists in



Buenos Aires at the same time facing great resistance from the academic establishment of the day. The pioneers were drs. Candia, Bibiloni, Roganti, Gori, Vazquez Ferro and Miguel Angel Tatti.

In 1956, in the First Gyn Chair of Buenos Aires University, chaired by my father Prof. G. di Paola, the alter two started routine use of cytology and colposcopy for the detection of cervical malignancy.

In 1958, G. di Paola and Vazquez Ferro published a very important paper on 2000 colposcopies. Together with R. Sammartino, the most important pathologist in Argentina, who trained in Germany, they published many other papers on intraepithelial carcinoma.

In August of 1964, they all were involved in founding the Argentinian Society of Cervical Pathology and Colposcopy.

There were 24 founding fellows, including myself following my return from Hopkins. In November of 1972, the Argentinian Society, under the Presidency of Dr. James Maclean and the General Secretary of Carlos Hermansson, organized the First World Congress of Cervical Pathology and Colposcopy in Mar del Plata and invited the most important world leaders of the subspecialty like:

Burghardt, Chanen, Coppleson, Staf., Hamperl, Jakob, Jordan, Wespi, McIndoe, Kolstad, Bonilla Musoles and many others.

On November the 6th the International Federation was founded and Eric Burghardt was nominated his first President.

The Argentinian Society the facilitating enzyme that produced the birth of the Federation has allways been very enthusiastic and protagonist.

Proof of that is the fact that it changed its name from the Argentinian Society of Cervical Pathology and Colposcopy to that of the Argentinian Society of the Lower Genital Tract and Colposcopy as early as 1989. The 1999 IFCPC Congress that was held in Buenos Aires and chaired by Roberto Testa was a great success with more than 2500 registrations. Now my disciple and friend Sivio Tatti will probably be, after the Thursday Assembly, the IFCPC President Elect.

The main objectives of the IFCPC, outlined in the Constitution and By-Laws were and still are:

- to stimulate basic and applied research and the difusión of knowledge in cervical pathology and colposcopy
- to stimulate the creation of national societies to contribute
- to the standardization of terminology and evaluation of diagnostic and therapeutic procedures in the field of cervical pathology, etc.

The membership of the Federation includes the Nacional Society of any country which will represent the specialists in uterine cervical pathology in that country.



Thirty two National Societies are represented in the IFCPC:

Argentina, Australia, Brazil, Canada, Chile, Colombia, Czech Republic, Croatia, France, Germany, Greece, Hungary, India, Indonesia, Israel, Italy, Japan, Korea, Mexico, Netherlands, New Zealand, Paraguay, Philippines, Poland, Portugal, Slovak Republic, Singapore, Spain, United Kingdom, United States, Uruguay and Yugoslavia.

Most recently, other five Societies have been admitted:

Bolivia, Costa Rica, Dominican Republic, Ecuador and Guatemala.

Since its beginning, thirty six years ago, the Federation has had 12 Presidents and has celebrated 14 Congresses.

Presidents have been as follows:

- 1972-1975: Eric Burghardt
- 1975-1978: Adolf StafI
- 1978-1981: Joseph Jordan
- 1981-1984: Carlos Salvatore
- 1984-1987: Malcolm Coppleson
- 1987-1990: George Wilbanks
- 1990-1993: Hans Stegner
- 1993-1996: Ian Duncan
- 1996-1999: Hajime Sugimori
- 1999-2002: Santiago Dexeus
- 2002-2005: Giuseppe De Palo
- 2005-2008: Howard W. Jones III

World Congresses of the IFCPC:

- 1st 1972 Mar del Plata (Argentina)
- 2nd 1975 Graz (Austria)
- 3rd 1978 Orlando (USA)
- 4th 1981 London (UK)
- 5th 1984 Tokyo (Japan)
- 6th 1987 Sao Paulo (Brazil)
- 7th 1990 Rome (Italy)
- 8th 1993 Chicago (USA)
- 9th 1996 Sidney (Australia)
- 10th 1999 Buenos Aires (Argentina)
- 11th 2002 Barcelona (Spain)
- 12th 2005 Cancún (Mexico)
- 13th 2008 Auckland (New Zealand)



The main objectives of the IFCPC have been that of cervical pathology and colposcopy, in particular primary and secondary prevention of cervical cancer.

I am tempted to say again, that we are speaking about the New and Old Testaments in the prevention of uterine cervical cancer.

I will try to dig along the path of the IFCPC in its 36 years of life trying to acknowledge the ideas and efforts of the main trailblazers throughout the world. What was the outstanding importance of colposcopy, which after all, is just an optical method of visualization of the uterine cervix, that developed initially in Europe and South America and yet, spread also to the English speaking countries inspiring the establishment of an international Federation?

The birth of colposcopy

In 1921 Hans Hinselmann while deputy professor at Hamburg University commenced his studies of methods that would more effectively observe the portio cervicalis. With the help of Leitz technicians, he devised the first working binocular colposcope. In 1925 Hinselmann published the first paper on colposcopy and in 1933 the book "Einführung in die Kolposcopie".

His aim was to the discovery of the primary focus of cervical cancer which he suspected would appear as a nodular lesion. Instead, he discovered and described a profusion of appearances of the cervix, both in health and disease.

Through painstaking documentation of colposcopic appearances of the cervix and histology correlation, Hinselmann demonstrated that that the origins of cervical cancer occur in a sheet of epithelium as opposed to a solitary focal lesion. Hinselmann's unconscionable wartime activities in WW II led to his ultimate disgrace and as a result delayed wider acceptance of his earlier research efforts. The use of the instrument however, spread quickly throughout Europe aided by such disciples as Mestwerd, Limburg, Wespi, Navratil, Ganze, Antoine, Coupez and Kolstad, all whom refined and modified Hinselmanns original concepts.

As optics and photographic equipment improved, so did the description, quantification and ocumentation of the cervical epithelium, in particular the description of capillary vascular bed of normal and neoplastic tissue.

For a long time colposcopy was restricted exclusively to Germany, central and southern Europe, Brazil and Argentina. This was due to the difficulties in understanding the original, somewhat cumbersome, German nomenclature and the barriers the WWII had created between Germany and the rest of the world.

In the English speaking world, such as the USA, colposcopy had been largely ignored. As reported by Di Saia and Creasman, initial efforts were made in the early 1930s to introduce it, but the method was ignored. The interest was renewed in the middle of the fifties although acceptance was low because of the competition with the Papanicolau test.



It was only after 1964, with the foundation of a specific society, that colposcopy gained some popularity and became recognized as an adjunctive technique to cytology.

In the 70's in the US and the UK the Papanicolaou smear was used exclusively for screening for cervical neoplasia. Minor abnormalities on the smear were "managed" by repeat cytology. Women with a pap smear suspicious of a high grade precursor lesions or positive for cancer were treated by cervical conization.

If subsequent histologic diagnosis proved to be "dysplasia" the conization was considered adequate treatment. This dated approach was irrational and resulted in high morbidity for the patient, in particular subsequent infertility or the increased risk of cervical incompetence and subsequent infant prematurity.

On the other hand, if "carcinoma in situ" was reported hysterectomy was performed. If invasive cancer was detected, the patient received radiation therapy or radical hysterectomy.

The evolution of modern dynamic anglo-american colposcopy is best attributed to the main pioneering efforts of Malcolm Coppleson in Australia, Joe Jordan in the UK and Adolf Stafl in the US.

Malcolm Coppleson was a gynecologist from Sydney that trained in Oxford with Prof. Stallworthy, who encourage him to get colposcopic training in Germany.

Back home in the fifties, Malcolm set up a colposcopy clinic at the Royal Prince Albert Hospital. He developed a very important Australian school with Bill Chanen, Rob Rome, Ellis Pixley and Andrew Ostor, who was also a great pathologist disciple of Burghardt. They founded the Australian Society in 1976. Albert Singer worked in colposcopy with Malcolm and Bevan Reid for five years before going to Oxford in 1970.

Malcolm Coppleson promoted colposcopy, not as a static source of magnified illumination, but as a clinical discipline in its own right independent of the associated disciplines of exfoliative cytology and histology. It is interesting to review Coppleson s reflections as to why such valuable technique was so slow to be accepted and introduced with such misgivings, in the English-speaking world. Stanley Way in 1968, condemned colposcopy as "the greatest hoax ever forced upon gynecologists". It was many years later that he publicly retracted this statement.

Malcolm had stated that the misgivings were:

- a. the universal misconception that colposcopy and exfoliative cytology were in conflict
- b. the criticism that " with the instrument, one cannot see the endocervical canal " and
- c. that colposcopy did not afford information that could not be resolved by the combination of cytology and biopsy. Bill Chanen and Malcolm received the Australia Order of Merit in recognition for their services to medicine and contributions to gynecologic oncology.

In the UK the story started in 1972 when Joe Jordan from Birmingham and Albert Singer from Oxford started the British Colposcopy Group. With Archie Crompton from Leeds who also has been trained in



colposcopy in Germany they founded with British Society in 1975. Joe Jordan as President of the IFCPC organized the famous London IFCPC 1982, the "Princess Ann Meeting".

The brits have worked very hard and well and the BSCCP has grown to a 2400 membership in 30 years. The most important example they gave to the other Societies of the Federation is to provide the British Government, guidelines to the diagnosis and management of cervical premalignancy and played a major role in the development of the Nacional Health Service Cervical Cancer Screening Programme.

Ian Duncan, more Scott than Robert Burns, Alan MacLean, my sucesor as President of the ISSVD, David Luesley, Patrick Walker have contributed enormously to the succes of the BSCCP and the IFCPC. Ron Jones, the Profesor of Auckland University, another outstanding member under the Southern Cross, keeps surprising the world with his excellent research on Vulvar Intraepithelial Neoplasia and the natural history of CIN3 Walter Prendiville from Dublin cannot be forgotten to be praised for all he has done for the ideals of the IFCPC.

In the United States of America the arrival of Adolf Stafl in 1968 was fundamental for the development of colposcopy and cervical pathology and he became a fundational icon of the IFCPC through these 32 years.

Other transcendental pioneers were Louis Burke, Ralph Richart, Duane Townsend Leo Twiggs, George Wilbanks,

I first met Adolf Stafl (born and educated in Prague, colposcopist and photographer) in September 1968 in the Mestwert Symposium "Die Cervix Uteri als lokale Praedilektion des Karzinoms" in Hamburg, Germany.

He has been having a grant in Johns Hopkins Womens Clinic, my Alma Mater, thanks to the Dubceck Prague Spring, and had been attending this important Hamburg meeting. These were ther days of September 1968 when the Russian tanks entered Prague and Adolf´s family left Czekooslovakia through the mountains and arrived safely at Hamburg, thank goodness to meet their husband and father. I had the privilege to be there and start a great friendship with Adolf. The Stafl family was received warmly by the JHHWC in Baltimore initially and subsequently in Milwaukee by Prof. Dick Mattingly, my past chief resident.

Adolf became assistant professor and contributed greatly to the development of cervical pathology and colposcopy in the USA.

I do not want to forget to mention the most valuable contributions of the non-English speaking Societies to the growth and development of the IFCPC.

The Italian Society produced great leaders as Giuseppe De Palo, Luigi Carezza, Mario Sideri, Luciano Marini to name the most remarkable.

Ninny De Palo from the Istituto di Tumori di Milano wrote many important books and is a tireless teacher of many generations of colposcopists in Europe and abroad. The Spanish Society of great



tradition in the field had Santiago Dexeus as one of his more elegant leaders and chief of one of the most important gynecological schools of Spain. Also what more can be said about the contributions of Xavier Bosch, Monserrat Cararach, Puig Tintoré and many other iberics.

The German speaking fellows as Hans Stegner, Olaf Reich, Raymond Winter, Helmuth Pickel and the French speaking like the incomparable Christine Bergeron cannot be forgotten in this history.

Last but no least Peter Bozse the distinguished gyn oncologist from Budapest is to be remembered for his dedication to the IFCPC.

The birth of cervical pathology

The first president of the IFCPC Prof. Eric Burghardt who in May 2006 died at the age of 85, was I think one of the most fundamental contributors to our knowledge of the cervical cancer pathology and carcinogenesis.

He was born in 1921 in Backa in the Balkans from a German family that had emigrated there, (those days part of the Austro-Hungarian Empire) in the XVIII century.

Very young served in the German army in the last years of the WWII, and was then was displaced by the Russians. He subsequently studied Medicine in Graz University influenced by the Axel Munthe "The Book of San Michele".

In 1950 he decided to dedicate himself to gynecology and started to work in Graz University, under the outstanding gyn pathologist Fritz Bajardi and the Profesor of Gynecology Prof.Ernst Navratil. The latter had recognized in the last 40ties the importance of gynecological cytology and had introduced the method into the Austrian clinics.

With Burghardt and Bajardi he developed a sophisticated system for the early diagnosis of cervical carcinoma, which they had called "cancer tracking", using cytology,colposcopy and biopsy.

In 1956 Burghardt and Bajardi had won recognition for their fundamental findings with respect to the morphogenesis of the early stages of cervical carcinoma, this at a time of great prejudices of general pathologists towards these new findings in cervical pathology Kaufmann, Ober and Hamperl from Cologne University, leading figures in German Gynecology and Pathology, and protagonists of the theory of the the migration of the transformation zone from the exocervix to the endocervix throughout a women´s life, all provided support and encouragement to E.B. in his career.

On the subject of the so called "microcarcinoma" introduced by Mestwerd in 1947, Eric Burghardt and Bajardi set about systematically examining the problem of the microcarcinoma from the morphological aspect ,based on their great wealth of histopathological material at the Graz Clinic. They postulated that it was not possible to define a microcarcinoma on the basis of the depth of invasion alone.

They set a tumor volume of 500 cm³ as the uppermost limit, which is equivalent to 5 mm (depth of growth) x 10 mm (length) x (10 mm (breadth). In 1973 Mestwerdt himself accepted these findings in a collaborative work together with E.B. and Karl G. Ober.



In between 1968 and 1972 E.B. compiled all that he knew about the precursors of cervical carcinoma and its early invasive stages and published its findings in a book, in 1972, entitled “Early Histological Diagnosis of Cervical Cancer”.

This was this “summae Theologicae” and coincided with his term of presidency of the I.F.C.P.C.

The book great success was guaranteed by the wealth of large-format histopathological illustrations with which the entire course of the development of cancer of the cervix uteri was meticulously illustrated for the very first time.

In 1984 E.B. published a second important book, entitled “Atlas der Kolposacopie” in which he put his wealth of knowledge of colposcopy and the histomorphology of the cervix uteri into a synoptic form. Eric Burghardt and his delightful wife Brigitte were outstanding people and their friendship was a gift we enjoyed together with my wife Irene for many years.

He organized numerous scientific events in Graz, such as the 2nd World Congress of the IFCPC in 1975 and the 125th Anniversary of the Chair of Obstetrics and Gynecology of the University of Graz, at which congregated the most important international specialists of Gynecology of the world and where I had the privilege of being invited.

He was very much admired by his disciples Raymond Winter and Hellmuth Pickel and was decorated with the Copernicus Medal of the University of Cracow, the Golden Medal of Honor of the Province of Styria, the Austrian Cross of Honor of Sciences of Austria and the Carl Kaufmann Medal in 1996, the highest award of the German Society of Obstetrics and Gynecology

God bless his memory – he was the undoubtedly father of cervical pathology!!!

Carcinoma in situ and dysplasia

The concept and term carcinoma in situ was introduced by Broders in 1932 and in 1953 the term dysplasia by Reagan. The International Committee on Histological Definitions acknowledges these two terms in 1962, dysplasia being defined as “all disturbances of differentiation of the squamous epithelium of lesser degree than carcinoma in situ”. Koss in 1963 published a paper in which he stated that regardless of morphologic appearance, all precancerous intraepithelial anomalies of the uterine cervix are capable of progression to invasive cancer, albeit with a lesser frequency for that of “mild dysplasia” and with a greater higher frequency for that of “severe dysplasia”.

Just as I have tried to portray Eric Burghardt as the father of the cervical pathology, inspired in the tradition of German Pathological scholarship, I would like to enhance the talented role of Ralph Richart in the interpretation of the natural history of cervical neoplasia.

In 1968, this New Yorker, Harvardian proponent the appropriate term of CIN, cervical intraepithelial neoplasia and this was universally acknowledged.



Richart encompassed in the term CIN all grades of dysplasia and carcinoma in situ, emphasizing dysplasia and carcinoma in situ as constituting an histological continuum. Ralph divided CIN into three grades:

- CIN 1 corresponding to mild dysplasia
- CIN 2 to moderate dysplasia and
- CIN 3 to both severe dysplasia and carcinoma in situ

In the 80's koilocytic atypia associated with HPV infection became a recognized entity. In 1990 Richart further proposed a new histopathological terminology based on only two grades of disease:

- Low grade CIN comprising the abnormalities consistent with koilocytotic atypia and CIN 1 lesions and
- High grade CIN comprising CIN 2 and 3. The high grade lesions were considered by Ralph to be the true precursors of invasive cancer.

The Richart terminology has survived until now and has applied to VIN VAIN and AIN and represents an enormous contribution in the management of precancerous lesions.

Apart from the question of diagnosis it is interesting to see how many members of the IFCPC have contributed to proposing methods of treatment for dysplasia and carcinoma in situ of the cervix. Traditionally for many years, treatment for carcinoma in situ had been cold knife conization, but with the realization of a significant rate of morbidity and in particular, complications related to subsequent infertility and cervical incompetent together with rising costs of hospital care, induced the search for other day-care or office practice facilities.

In 1974, Chanen and Hollyock in Australia, advocated ablation of the lesion by use of electrocoagulation diathermy.

In the USA, DiSaia and Creasman advocated cryosurgery, whilst Duncan in 1983 in the UK, employed a method of cold coagulation and Puig Tintoré and Gonzalez Merlo in Barcelona in 1988 ablated with CO2 Laser vaporization.

All these methods, although possible with or without local anesthesia providing the lesion could be seen or exposed in its entirety by a competent colposcopist, had the theoretical disadvantage that it was not possible to assess the depth of treatment and with the differing methods early and late complications could occur.

These were cited as reasons for renouncing destructive methods in favor of a return to modified excisional methods.

In 1979, Dorsey and Diggs in the USA, introduced new excisional methods for CIN treatment utilising carbon dioxide laser for conization.



In 1989, Prendiville in Ireland advocated electro large loop excision of the transformation zone (LLETZ), and Ferenczy in Canada in 1994, introduced electroconization using a fine-needle electrode.

At that time it was envisaged that a depth of no less than 4 mm would take care of the problem of safe margins.

All these strategies were rapidly disseminated thanks to the activity of the IFCPC meetings and various publications.

The IFCPC and the colposcopic classifications

One of the numerous objectives of the IFCPC was to contribute to the standardization of terminology and evaluation of diagnostic and therapeutic procedures in the field of cervical pathology.

In the Graz IFCPC 2nd Congress, terminology was standardized and an international nomenclature of colposcopic findings was introduced.

In this classification the term “atypical transformation zone” encompassed all suspicious patterns, and therefore required further histological evaluation.

In 1976, Stafl published the classification in “Obstetrics and Gynecology.”

Subsequently this terminology was questioned as being too imprecise and misleading and therefore at the 6th Congress held in Sao Paulo in 1987, a new committee was appointed to develop appropriate terminology to describe the colposcopic features, both before and after application of acetic acid and iodine solutions. After three years of deliberation, terminology was finally established at the 7th Congress in Rome in 1990 and published subsequently by Stafl and Wilbanks in “Obstetrics and Gynecology” in 1991.

The principal advantage of that classification was the introduction of a system of grading based on degree and severity of epithelial changes and vascular atypia, similar to the previous proposals of Copleson, Pixley and Reid in 1978 and by Mosetti and De Palo in 1987. Another advantage was the replacement of the word atypical pertaining to the transformation zone, by the term abnormal. However there were still objections to this IFCPC colposcopic classification and again a new committee was activated at the 10th IFCPC Congress in Buenos Aires in 1999 and the changes were presented in Barcelona in 2002.

The final result of such a prolonged search by an international collection of experts is as follows:

IFCPC colposcopic classification of 2002

1. Normal colposcopic findings
 - Original squamous epithelium
 - Columnar epithelium



Transformation zone

2. Abnormal colposcopic findings
 - Flat acetowhite epithelium
 - Dense acetowhite epithelium
 - Fine mosaic
 - Coarse mosaic
 - Fine Punctuation
 - Coarse Punctuation
 - Iodine Partial Positivity
 - Iodine negativity
 - Atypical vessels
3. Colposcopic features suggestive of invasive cancer
4. Unsatisfactory colposcopy
 - Squamous-columnar junction not visible
 - Severe inflammation, severe atrophy, trauma
 - Cervix not visible
5. Miscellaneous findings
 - Condylomata
 - Keratosis
 - Erosion
 - Inflammation
 - Atrophy
 - Deciduosis
 - Polyps

The miracle of primary prevention

In science miracles do not occur, but I cannot call it otherwise with the development for the first time in history of a vaccine that prevents cancer.

Beginning in the seventies, based on the fundamental works of Zur Hausen (recently receiver of the Nobel Prize in Medicine 2008) on the structure of the Human Papilloma Virus and its causal relationship with cervical cancer started the development of prophylactic vaccines.

As a result of the use of pseudoviral particles (VLPs) constituted by the major protein L1 of the virus capsid without any viral genetic material and with impressive clinical studies, a remarkable efficacy in preventing cervical precancers and cancers has been demonstrated and last year the vaccines were approved by the FDI. Their level of efficacy is unprecedented in history of vaccination: close to 100%. The high degree of efficacy is demonstrated in young women previously unexposed to the virus type associated with the vaccines. In practice, the effectiveness of HPV vaccines is limited by two factors: all genital cancers and precancerous lesions are not induced exclusively by the types 16 and 18, and that



the optimal benefit is demonstrated in adolescents and young women before they have encountered these viruses.

Practical questions will need to be addressed, such as the emergence of other viral types, the need to vaccinate boys, the duration of the vaccine protection, the extent of cross protection against other HPV types, and the access to vaccines in less wealthy countries.

If vaccination would be left to individual choice and initiative, the coverage will be low and the benefit in reducing the frequency of this cancer would be barely perceived. We need to keep in mind that in the context of public health, it may take several years to observe the benefits of prevention of cervical cancer with the need to follow a large number of vaccinated individuals, whereas, the impact of individual vaccination in reducing precancerous lesions will be significant within a cohort in a relatively short period of time following vaccination and this has been observed in clinical studies over two to four years.

But this miracle of primary prevention of lower genital tract cancer through vaccination will depend on its acceptability and the degree of engagement of health professionals.

The IFCPC, as an institution, has so far not demonstrated an enthusiastic engagement in this issue perhaps because that could be the end of its fundamental goal: to beat cervical cancer through secondary prevention.

But I think that the eradication of cervical cancer by vaccination would be a very prolonged process extending over almost thirty years and in the meantime the secondary prevention will be of utmost need.

Maybe this secondary prevention of the "nouvelle vague" will be different from the one the IFCPC has espoused since its foundation and new cost-benefits strategies such as low cost Hybrid capture II will replace cytology as an overall screening tool in developing countries.

This remain to be seen ,but the IFCPC which so far has demonstrated a great purpose in the search of excellence, as an internationally oriented group of societies will provide appropriate answers to the big challenges of our times.

The Program of this 13th Congress organized and chaired by Howard W. Jones III is the best proof that the New Testament has been endorsed and has become the new doctrine the IFCPC not forgetting the Old Testament to which loyalty is mandatory for many years to come.

Finally, my Fellow Friends, I cannot refrain my impulse to share with you a document that is a refreshing portrait of a humoristic view of how scientific societies can be observed.

It is an engraving of a "famous congress" illustrating a satirical poem of 1848 about pompous meetings in the middle of the XIX century that my dear friend Antonio Onnis found in an old curiosity shop in Venice many years ago.



I am sure that we can recognize in the drawing maybe ourselves and/or friends and by sure colleagues, because we all have our quota of self-sufficiency, pomp and circumstance due to our human condition but all these can be forgiven if it is accompanied by our Hippocratic concern for the service and custody of our patients that is and has been the fundamental goal of the IFCPC.

Before finishing I want to thank again President Willy Jones for his friendship through more than 50 years, and to my friends Bill Chanen, Ninny De Palo, Raymond Winter, Hellmuth Pickel and Silvio Tatti for the good help they gave me to face this endeavor.