Fall 2022 Provincial Colposcopy Community of Practice (CoP)

Webinar 2

November 10

Note: Do not distribute

Ontario Health
Cancer Care Ontario

With Thanks

Housekeeping items

- Please **mute** yourself when you are not speaking
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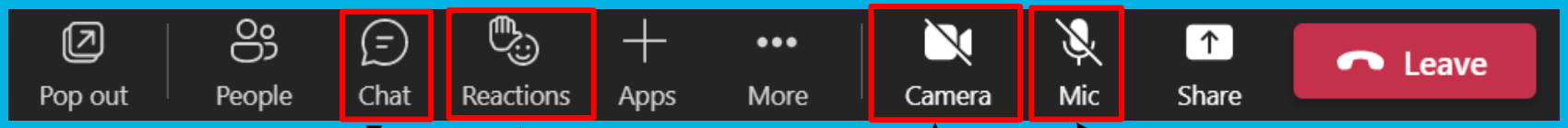
Open the task bar by hovering near the middle of the screen



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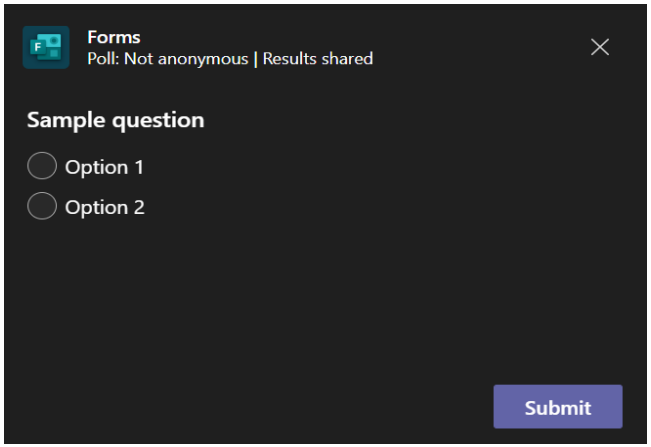
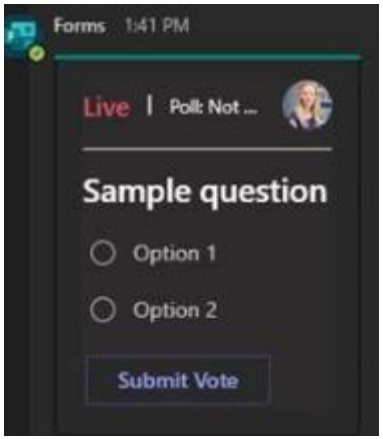


Poll in chat box



Accreditation

- Today's session is a Royal College of Physicians and Surgeons Accredited Group Learning Activity
- To receive a letter of accreditation for 1.5 credit hours, you must:
  - **Participate in today's event**
  - **Be registered as a member of the CoP**
  - **Complete and submit the post-webinar evaluation survey**

Thank you to our CoP Planning Committee

Dr. Robert Di Cecco

Dr. Hélène Gagné

Dr. Nadia Ismiil

Dr. Felice Lackman

Recording of CoP fall webinar is underway

Please note that this session will be recorded and will be available on the Colposcopy CoP Resources Hub in the coming weeks. You can access the hub here: www.cancercareontario.ca/en/colposcopy-resources-hub

Agenda: Webinar 2

Item	Presenter	Time
Welcome and introductions	Christine Stogios	5:30 – 5:35 pm
Ontario Cervical Screening Program (OCSP) updates: • Implementation of human papillomavirus (HPV) testing in Ontario • Impact of COVID-19 on cervical screening and colposcopy	Dr. Dustin Costescu	5:35 – 5:45 pm
Case study #1: Management of atypical glandular cells, favour neoplasia (AGC-N)	Dr. Dustin Costescu	5:45 – 6:05 pm
Cervical screening and colposcopy quality reporting: Facility reports	Dr. Rachel Kupets	6:05 – 6:20 pm
Questions from the field	Dr. Dustin Costescu	6:20 – 6:35 pm
Case study #2: Management of adenocarcinoma in-situ (AIS) with positive margins on loop electrosurgical excision procedure (LEEP)	Dr. Dustin Costescu	6:35 – 6:55 pm
Concluding remarks	Dr. Dustin Costescu	6:55 – 7:00 pm

Learning objectives

Following this meeting, participants will better understand:

- The impact of the COVID-19 pandemic on cervical screening and colposcopy services in Ontario
- Risk-based recommendations for patients who have a screening result of AGC-N
- What to expect for the 2022 quality reports and how to ensure colposcopists are able to benefit from quality reporting activities
- Risk-based recommendations for patients who have AIS with positive margins on LEEP

Ontario Cervical Screening Program (OCSP) updates

5:35 – 5:45 pm

Dr. Dustin Costescu

Reminder: Guidance for resumption of cervical screening

- The OCSP continues to encourage primary care providers (PCPs) to initiate cervical screening at **age 25** for people who are immunocompetent
  - People who are immunocompromised who are or have ever been sexually active should continue to be screened starting at age 21
- The OCSP will formally change the age of initiation for cervical screening from 21 to 25 with the implementation of HPV testing in the program

Reminder: Referral to colposcopy with first time low-grade result

- The OCSP recommends PCPs to extend the interval for repeating cytology after a low-grade result from 6 months to 12 months
  - Evidence-based and is considered is safe and acceptable
- Delaying repeat test allows more time for clearance of the HPV infection and avoids unnecessary interventions
- The risk of cervical cancer is very low for people with first time low-grade cytology results

Implementation of HPV testing in Ontario

Progress towards HPV testing implementation

- Evaluating submissions for both HPV Test System Vendor and HPV Laboratory Services Provider(s) Request for Proposals (RFPs)
- Finalizing program's updated cervical screening and colposcopy recommendations underway
- Drafting future state laboratory screening and colposcopy requisitions to request program-related HPV and cytology tests for eligible participants
- Executing on Stakeholder Engagement and Communications plan by engaging relevant stakeholders, including but not limited to regional physician leads, providers offering screening and colposcopy, etc.

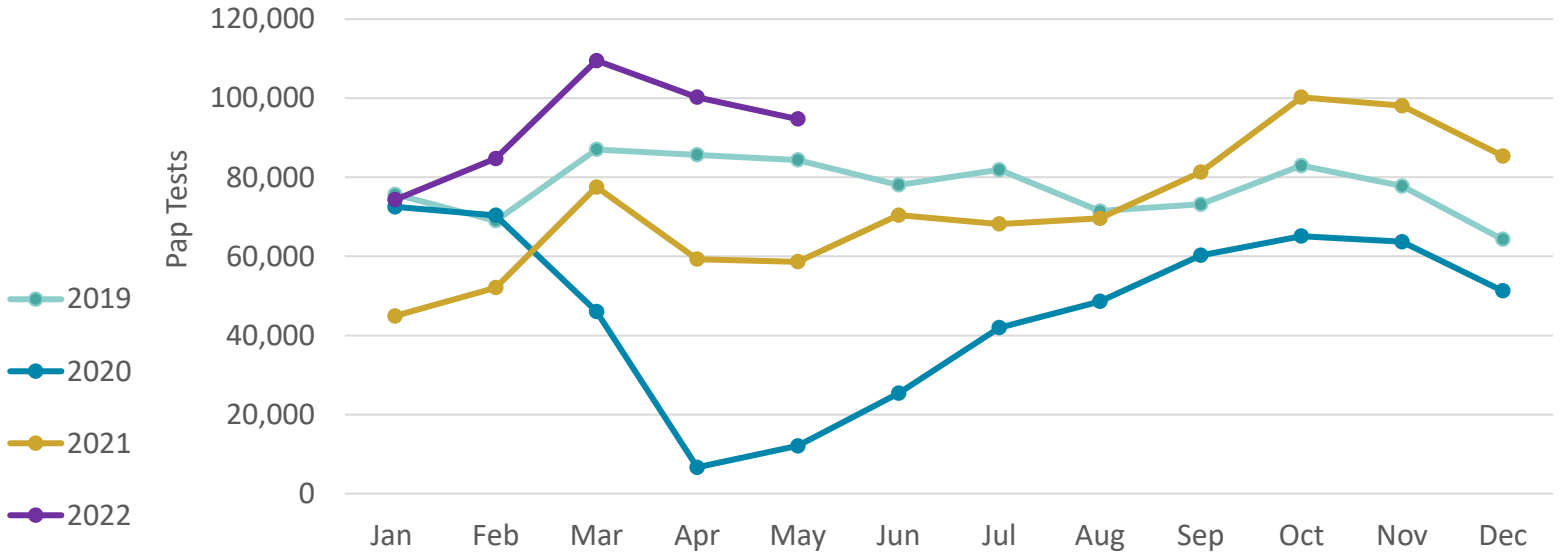
Impact of COVID-19 on cervical screening and colposcopy

Note: Do not distribute

Lab turn-around time delays in Ontario

- We are aware of delayed turn-around times to process cytology at some labs across the province
- We are continuing to monitor the issue and are working with the Ministry of Health to resolve this issue
- For future CoPs, the wait time data for people with high-grade results will be presented in a way that accounts for the lab delays

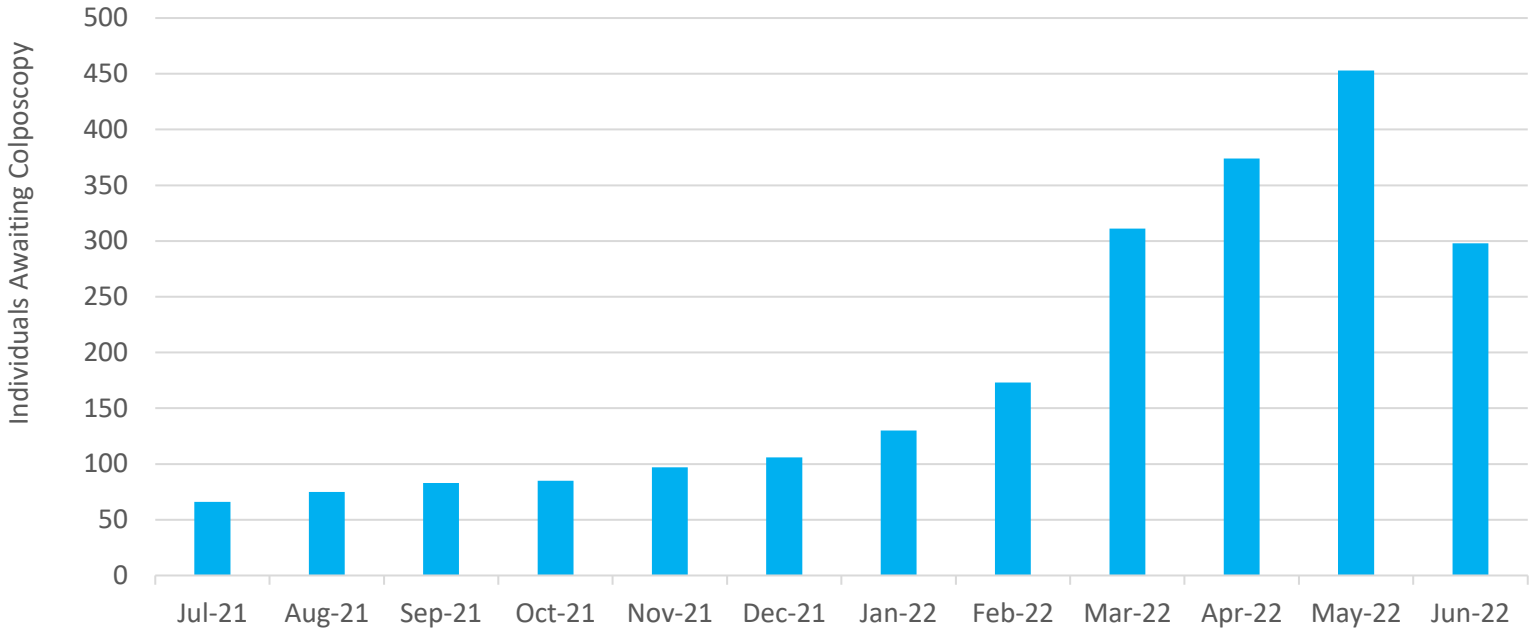
Pap tests volumes by month



*Due to the extended lab turnaround time to process Pap tests, volumes are only available up to May 2022

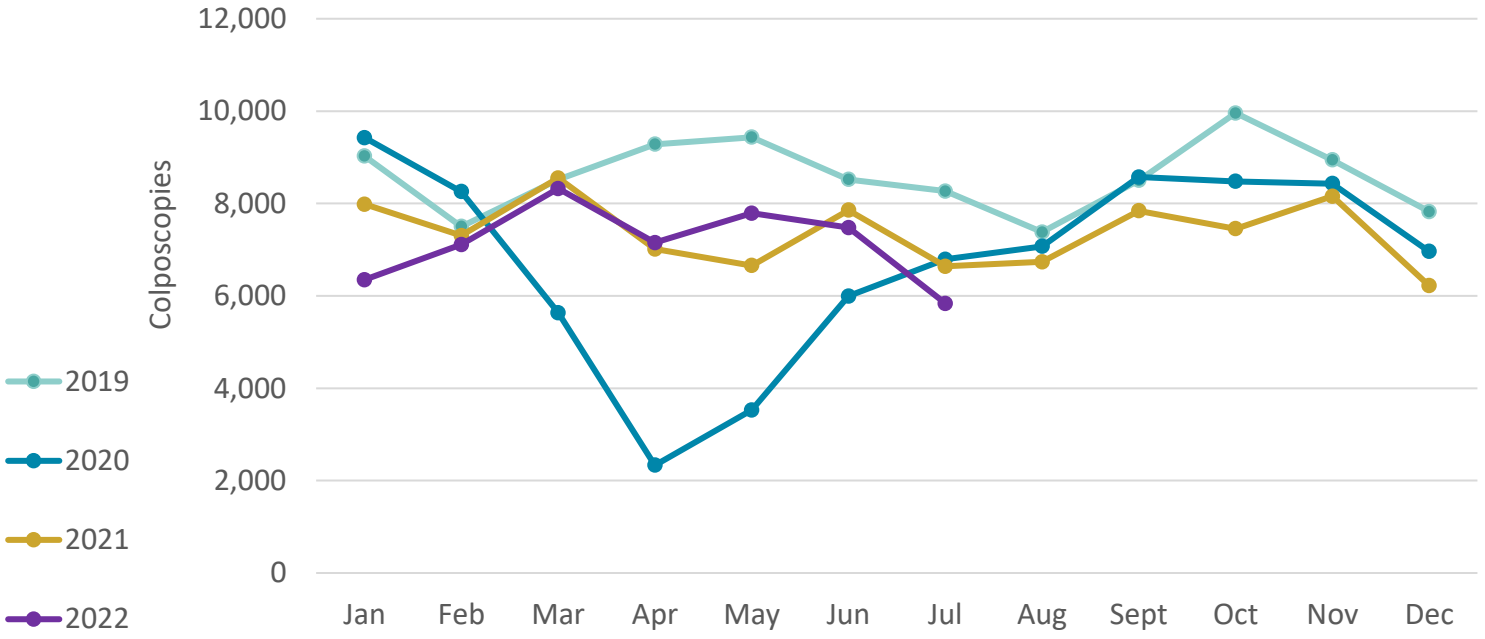
- In May 2022, Pap tests done as part of the OCSP were 112% of 2019 volumes
- Participation rate in 2022/23 Q1 is 52%, up from 51.3% in 2021/2022 Q1, although still below the pre-pandemic participation (58.7% in 2019/20 Q1)

People with high-grade Pap test results without follow up within 6 months



Lab delays may be impacting wait times for participants with high-grade results awaiting colposcopy

Colposcopy volumes by month



Colposcopy data for Aug – Oct 2022 is incomplete due to OHIP lag

2022 volumes are currently following the trends of 2021 volumes

Opportunities to reduce unnecessary cytology testing

- Consider declining referrals for people referred with first time low-grade cytology results to align with updated guidance
- Encourage PCPs to delay initiation of cervical screening until age 25 for people who are immunocompetent
- Do not repeat cytology at first colposcopy visit if seen within 3 to 6 months of referral cytology

Case study #1: Management of AGC-N

5:45 – 6:05 pm

Dr. Dustin Costescu

Case study 1: Patient history

- Age 40
- Seen by PCP for an intra-uterine device placement
- Last Pap was 5 years ago; patient is due for cervical screening so a Pap is performed
- **Result**: AGC-N; patient is referred to colposcopy

Answer poll in chat or via pop-up

Upon receipt of referral, how would you triage this patient?

a) Highest priority
b) Not required to prioritize at top of list; book once time is available
c) Decline referral to colposcopy and refer to a gyne-oncologist

Immediate and 5-year risk for CIN3+ for people with AGC cytology

Current HPV	Current cytology	n[a]	%[b]	CIN3+ cases	CIN3+ immediate risk, %	CIN3+ 5-y risk, %	Recommended management	Recommendation confidence score %
HC2	**AGC**	977		254	**26**	35	Colpo./treat	80
HPV 16		49	0.41%	27	**36**	43	Colpo./treat	92
HPV 18		34	0.30%	21	**33**	41	Colpo./treat	83
HR 12 (HPV other)		68	0.90%	9	**5.4**	5.4	Colposcopy	78

High immediate and 5-year risk for CIN3+ with index AGC cytology

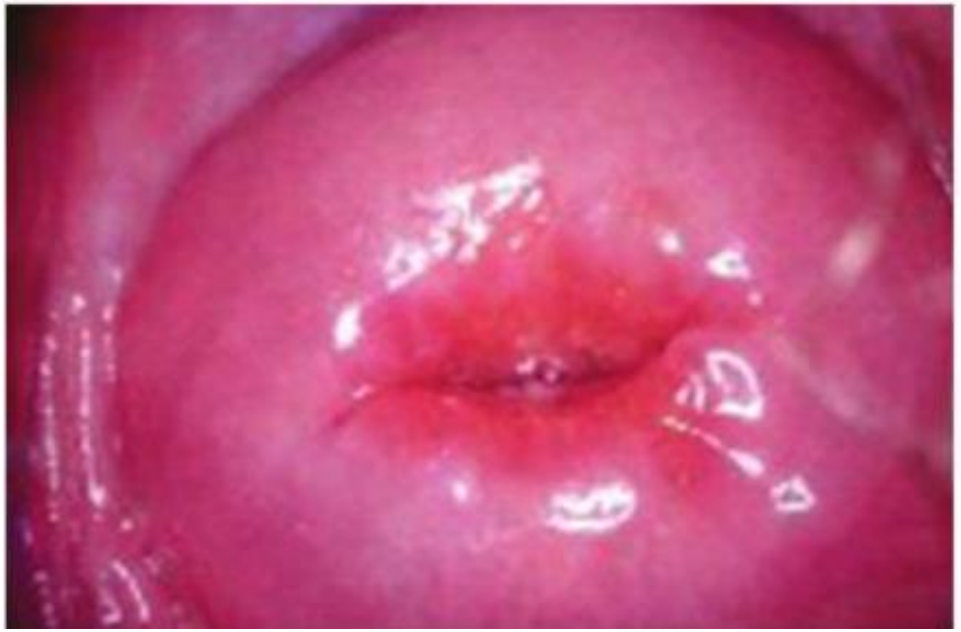
Reference: Demarco M, Egemen D, Raine-Bennett TR, et al. A Study of Partial Human Papillomavirus Genotyping in Support of the 2019 ASCCP Risk-Based Management Consensus Guidelines. J Low Genit Tract Dis. 2020; 24:144-147.

Visit #1

- The patient is seen in colposcopy and notes that their family is complete. The colposcopy findings are:
  - Type 1 transformation zone
  - Colposcopy is adequate and negative

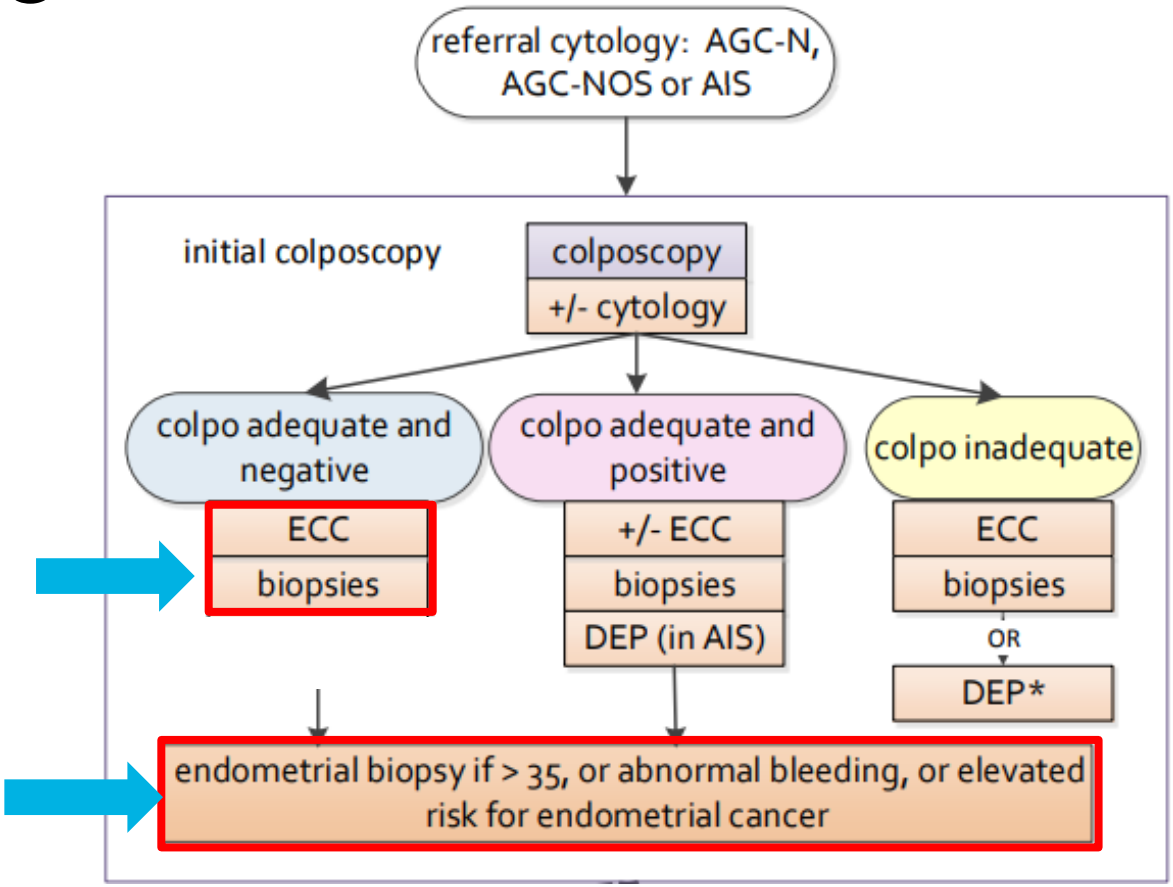
Answer poll in chat or via pop-up

- Based on the colposcopy findings you decide to:
  a) Repeat Pap
  b) Endocervical curettage (ECC)
  c) Biopsies (including endometrial biopsy)
  d) B & C



Shafi M, Nazeer S. The normal cervix and colposcopic appearance (chapter 2) - colposcopy [Internet]. Cambridge Core. Cambridge University Press; [cited 2022Oct14]. Available from: https://www.cambridge.org/core/books/abs/colposcopy/normal-cervix-and-colposcopic-appearance/6A10C0909907BD3F502C4D18AAE460FF

Colposcopy Pathway #5: Management of AGC



*Threshold for DEP is higher in AGC-N. Biospy alone may be acceptable for AGC-NOS.

Visit #2

- The findings from visit #1 show:
  - ECC: Negative
  - Cervical biopsy: Negative
  - Endometrial biopsy: Negative

Answer poll in chat or via pop-up

- Based on the colposcopy findings you decide to:
  a) Perform cytology
  b) Perform deep excisional procedure (DEP)
  c) Repeat endometrial biopsy and ECC
  d) Discharge to primary care

Correlation of glandular Pap test abnormalities to AIS and carcinoma

Cytology diagnosis	Likelihood of invasive cancer, AIS or CIN 2,3
AGC-NOS	9-41%
AGC-N	27-96%

High likelihood of significant findings for those with AGC cytology

Reference: Wright, et al. 2001 consensus guidelines for the management of women with cervical cytologic abnormalities JAMA; Apr 24, 2002; 287: 2120- 2129

CIN3+ risk for people referred with AGC after one negative colposcopy

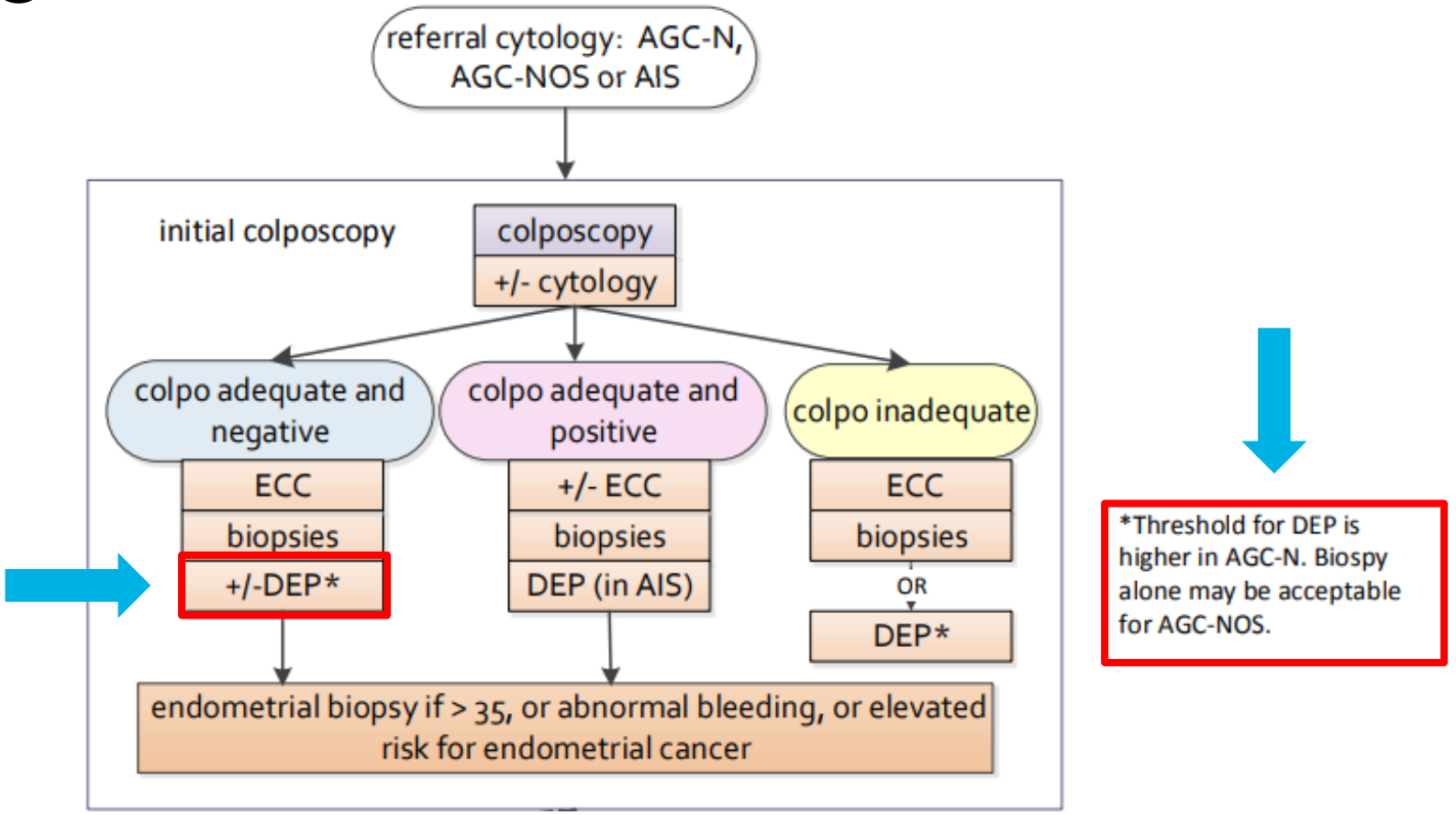
TABLE 2. Risk of CIN 3+ by Reason for Colposcopy Referral and HPV Status for Women in the Precolposcopy and Postcolposcopy Groups

		1 year risk of CIN 3+		3 years risk of CIN 3+	
		Precolposcopy[c]	Postcolposcopy[d]	Precolposcopy[b]	Postcolposcopy[d]
Reason for colposcopy referral[a,b]		Risk[e]	Risk[e]	Risk[e]	Risk[e]
HPV+	HSIL+	44.4 (42.6, 46.2)	7.69 (0.29, 15.0)	45.4 (43.6, 47.3)	9.3 (0.27, 18.3)
	ASC-H	22.2 (20.8, 23.6)	4.7 (1.7, 7.7)	23.9 (22.4, 25.4)	6.5 (2.2, 10.8)
	AGC	23.6 (21.0, 26.4)	5.6 (1.3, 9.9)	26.0 (23.3, 28.9)	8.0 (1.5, 14.5)
	LSIL	3.9 (3.6, 4.2)	1.1 (0.71, 1.5)	4.6 (4.3, 5.0)	1.8 (1.1, 2.6)

1- and 3-year risks of CIN3+ after one negative colposcopy are not low enough to discharge people referred with AGC cytology

Reference: Demarco M, Cheung LC, Kinney WK, et al. Low risk of cervical cancer/precancer among most women under surveillance postcolposcopy. J Low Genit Tract Dis 2018;22:97–103.

Colposcopy Pathway #5: Management of AGC



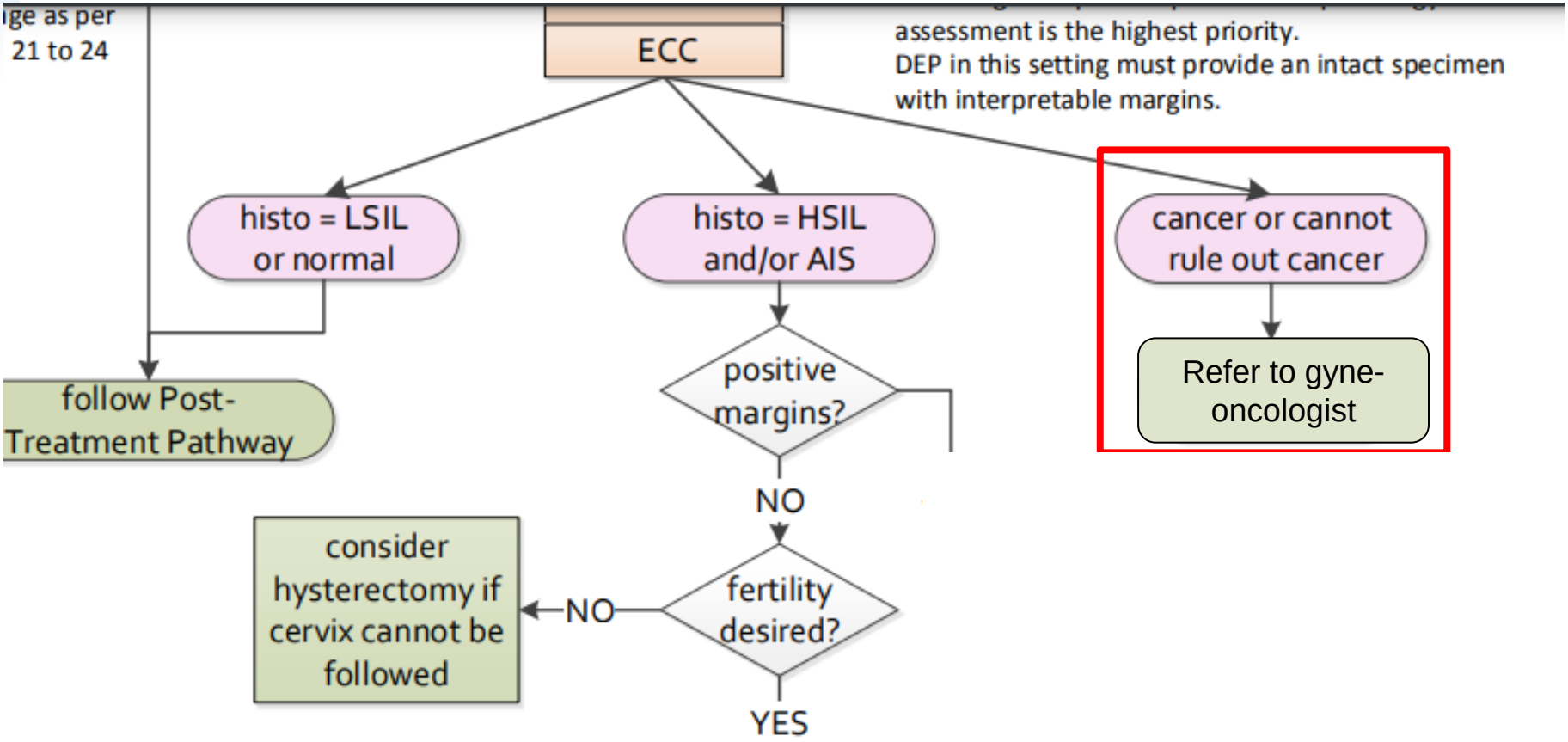
Visit #3

- The DEP is performed and shows cervical cancer. What is your next step?

Answer poll in chat or via pop-up

a) LEEP
b) Pathology review
c) Refer to gyne-oncologist
d) Hysterectomy

Pathway #5: Management of AGC



Diagnosis of malignant disease

Diagnosis on Pap (DX)	% with final diagnosis of cervical cancer	% with final diagnosis of endometrial cancer	% with final diagnosis of ovarian cancer
AGC	1.05%	1.8%	0.14%

KEY TAKEAWAY

People referred with AGC cytology may be at risk for gynecological malignancy. In certain clinical circumstances, people referred AGC cytology may need additional investigations during diagnostic work up

Kupets R, Paszat L. How are women with high grade Pap smear abnormalities managed? A population based study. Gynecol Oncol. 2011 Jun 1;121(3):499-504.

Cervical screening and colposcopy quality reporting

6:05 – 6:20 pm

Dr. Rachel Kupets

2022 Quality report overview

- 122 facility reports were sent to facility contacts and their respective regional Cervical Screening Colposcopy Leads (CSCLs) on September 29th
  - Successfully onboarded 34 additional facilities (3 hospitals, 31 non-hospitals)
- Reminder:
  - There is support at the regional level from regional cancer program leadership to help you achieve good quality and implement change
  - The facility lead can offer support at a local level

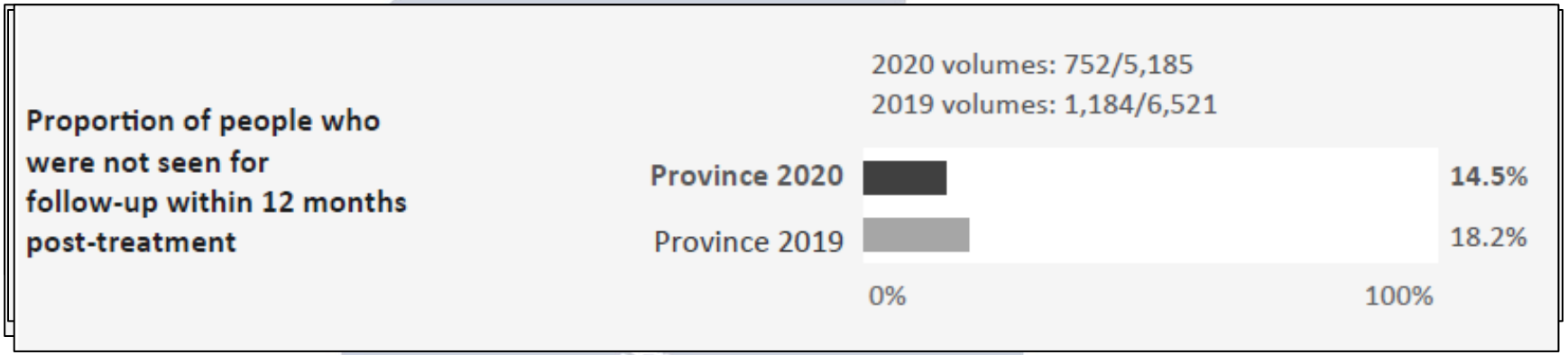
2022 quality report overview

- Colposcopy quality facility survey response rate

Release Year	Response rate
2021	66 out of 88 (75%)
2022	81 out of 118 (69%)

- Purpose of the survey:
  - Allow facility and regional leadership to identify opportunities for quality improvement
  - Inform Ontario Health on where to focus efforts on developing tools and resources
- Each facility's survey responses are included in their facility report

Key provincial highlights



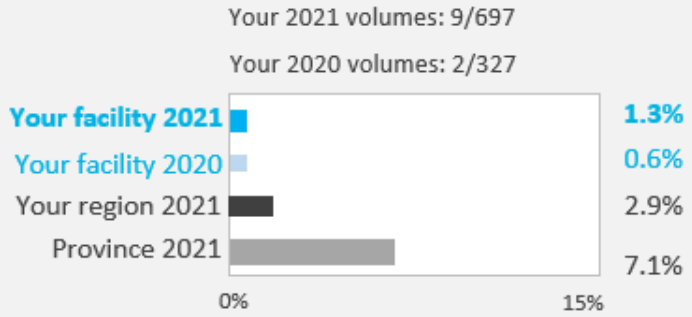
How to use your facility's report

- Conduct a review to understand the data
  - How your facility fits in relation to your region and the province
  - How your outcomes compare year over year
- Identify areas to make improvements that are relevant and impactful to patients
- The reports are intended to support quality, not performance management
  - Ontario Health is available to provide support with quality improvement efforts but will not actively follow-up or track progress

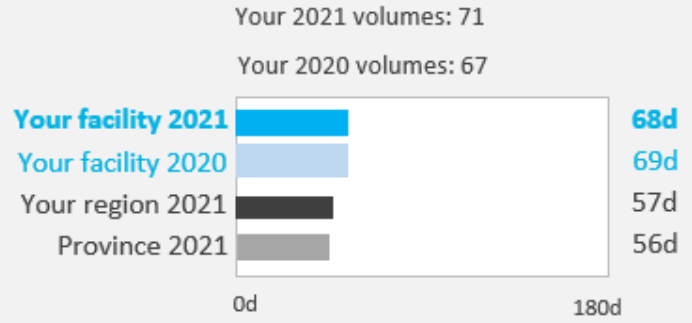
If you have not seen your facility's report, please connect with your Facility Lead or Regional Cervical Screening and Colposcopy Lead

Example – Facility report review

Proportion of people seen for colposcopy following their first ASCUS result

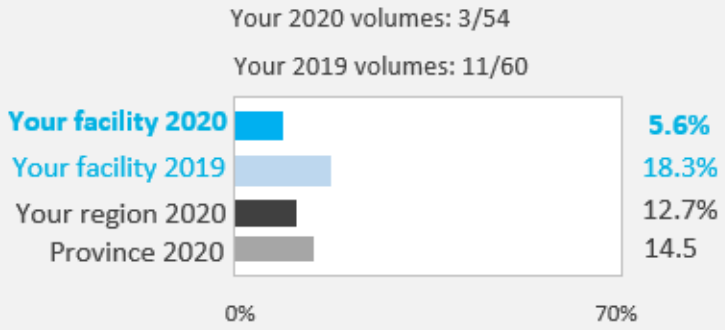


Median wait time (in days) from high-grade cytology test to colposcopy (total)



Candidate for a facility-level quality improvement initiative

Proportion of people who were not seen for follow-up within 12 months post-treatment



Example: Facility improvement plan

Guiding questions	Action plan
Where will your QI efforts be focused?	Lowering the median wait time (in days) from high-grade cytology test to colposcopy
What steps will you take to achieve the change?	• Review process to review triage of new referrals to ensure appropriate prioritization of people with high-grade cytology results. • Collaborate with your network of colposcopists to identify those with capacity for more timely colposcopy visits
What resources do you need?	• OCSP screening recommendations • Access to local community of practice • Opportunity to seek guidance from regional CSCL

Questions

- Do you have any questions or feedback on the reports?
- If you have any questions or need support, please contact your regional CSCL or Ontario Health at cancerscreening@ontariohealth.ca

Questions from the field

6:20 – 6:35 pm

Dr. Dustin Costescu

Question from the field

Question:

- What is the recommended management of a patient with LSIL cytology in primary care after discharge from colposcopy?

Answer:

- First time LSIL cytology → repeat cytology in 12 months

Question from the field

Question:

- What is the recommended approach to HPV testing once patient is discharged to annual screening?

Answer:

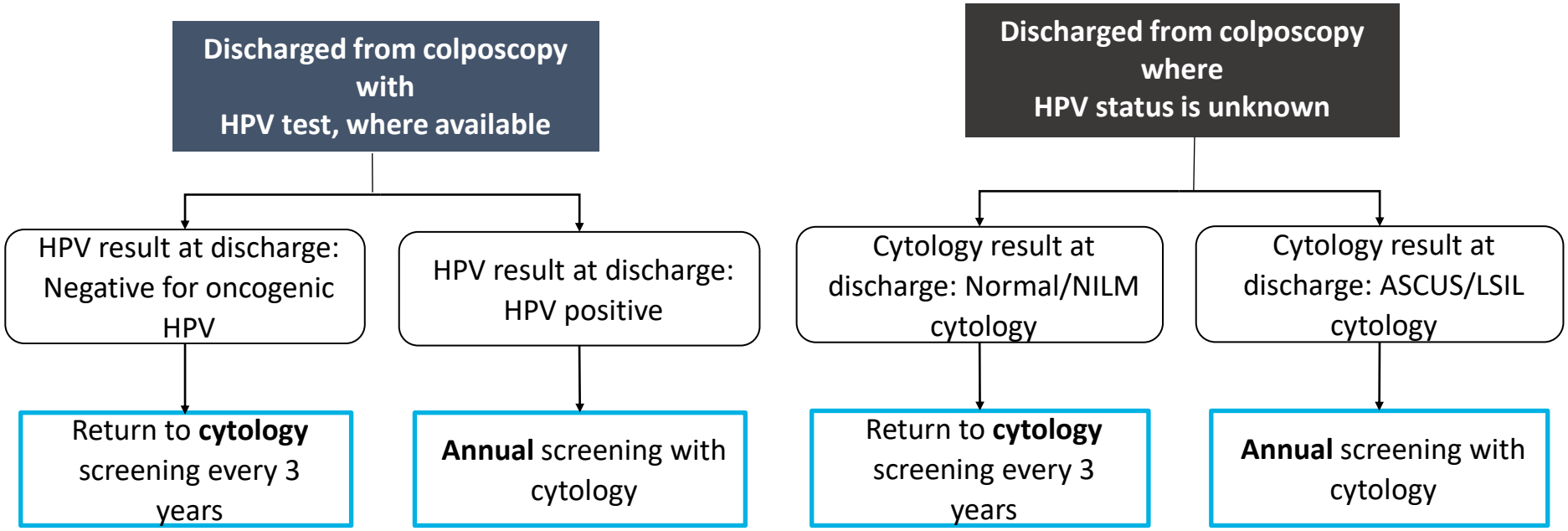
- Reminder: HPV testing is currently only available in some hospital settings or on a patient-pay basis
- HPV testing is not required for low-grade results; repeating cytology in 12 months is safe and acceptable

Question from the field

Answer (cont'd):

- If patient makes an informed decision to obtain HPV testing, the following management recommendations can be followed:
  - People who are HPV 16/18 positive can be referred directly to colposcopy
  - People who are HPV non-16/18 positive should repeat their cytology in 12 months
  - People who are HPV negative should return to routine screening with cytology in 3 years

Reminder: Screening in primary care after discharge from colposcopy



Question from the field

Question:

- What are the recommended next steps if the HPV exit test from colposcopy is negative, but cytology is HSIL?

Answer:

- If cytology result is HSIL, the patient is not eligible for discharge from colposcopy
  - If the patient has been treated for a high-grade lesion → refer to Colposcopy Clinical Guidance Recommended Best Practices Pathway #4 (post-treatment)
  - If the patient has been managed conservatively → refer to Colposcopy Clinical Guidance Recommended Best Practices Pathway #2 (conservative management)

Case study #2: Management of AIS with positive margins on LEEP

6:35 – 6:55 pm

Dr. Dustin Costescu

Case study 2: Patient history

- Age 35
- Seen in primary care for a routine visit
- Patient due for cervical screening so a Pap is performed
- **Result**: AIS; patient is referred to colposcopy

Answer poll in chat or via pop-up

Upon receipt of referral, how would you triage this patient?

a) Highest priority
b) Not required to prioritize at top of list; book once time is available
c) Decline referral to colposcopy and refer to a gyne-oncologist

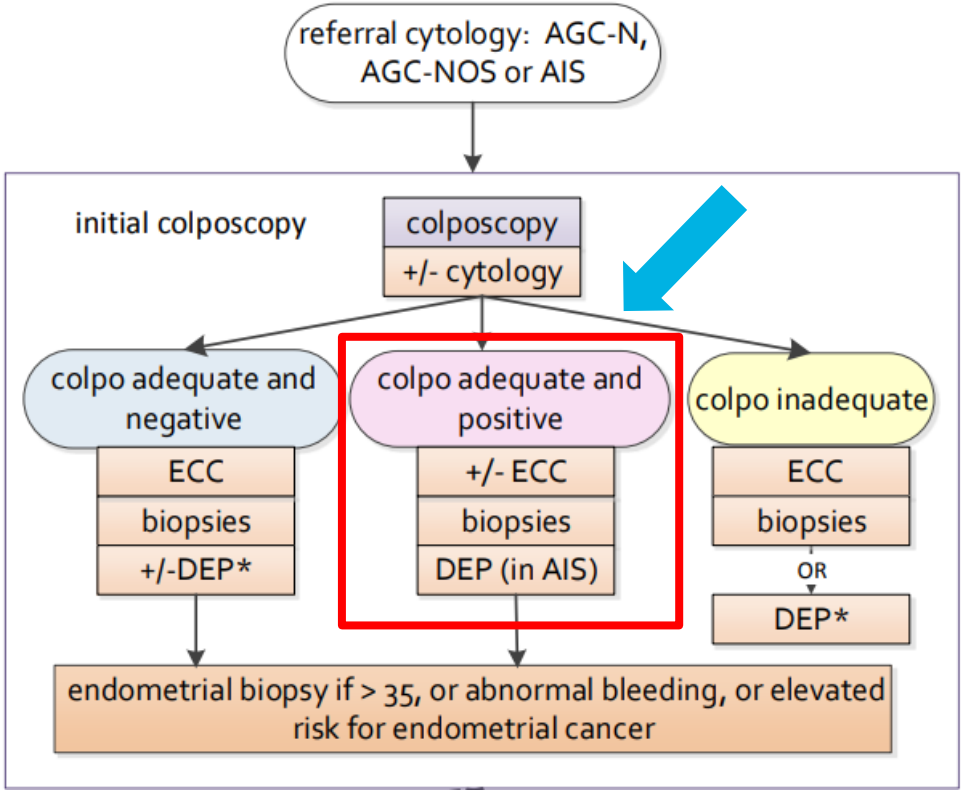
Visit #1

- The patient is seen in colposcopy. The colposcopy findings are: Adequate and positive

- Based on the colposcopy findings you decide to:
  a) Repeat Pap test
  b) ECC
  c) DEP
  d) Endometrial biopsy and biopsy of the lesion
  e) B, C & D

Answer poll in chat or via pop-up

Pathway #5: Management of AGC/AIS



*Threshold for DEP is higher in AGC-N. Biospy alone may be acceptable for AGC-NOS.

AIS referral cytology accurately predicts histologically confirmed AIS

Table 2. PPVs for Cytologic Reports of AIS, ?AIS, and AEC

Cytoprediction	PPV (high-grade disease)	PPV (high-grade glandular disease)
AIS	91%[a]	88%[c]
?AIS	75%[a]	72%[c]
AEC	9%[b]	7%[b]

PPV, positive predictive value; AIS, adenocarcinoma in situ; ?AIS, possible AIS; and AEC, atypical endocervical cells.
[a]AIS vs. ?AIS: $p = .032$.
[b]These PPVs represent the lower limit of possible actual values, due to the low proportion with histologic follow-up.
[c]AIS vs. ?AIS: $p = 0.046$.

KEY TAKEAWAY

DEP highly likely to be required even if colposcopic impression is negative

Reference: Roberts, JM., Thurloe, JK., Biro, C., Hyne, SG., Williams, KE. et al. Follow-up of Cytologic Predictions of Endocervical Glandular Abnormalities: Histologic Outcomes in 123 Cases. Journal of Lower Genital Tract Disease. 2005;9(2):71–77

Adenocarcinoma: Pap smear

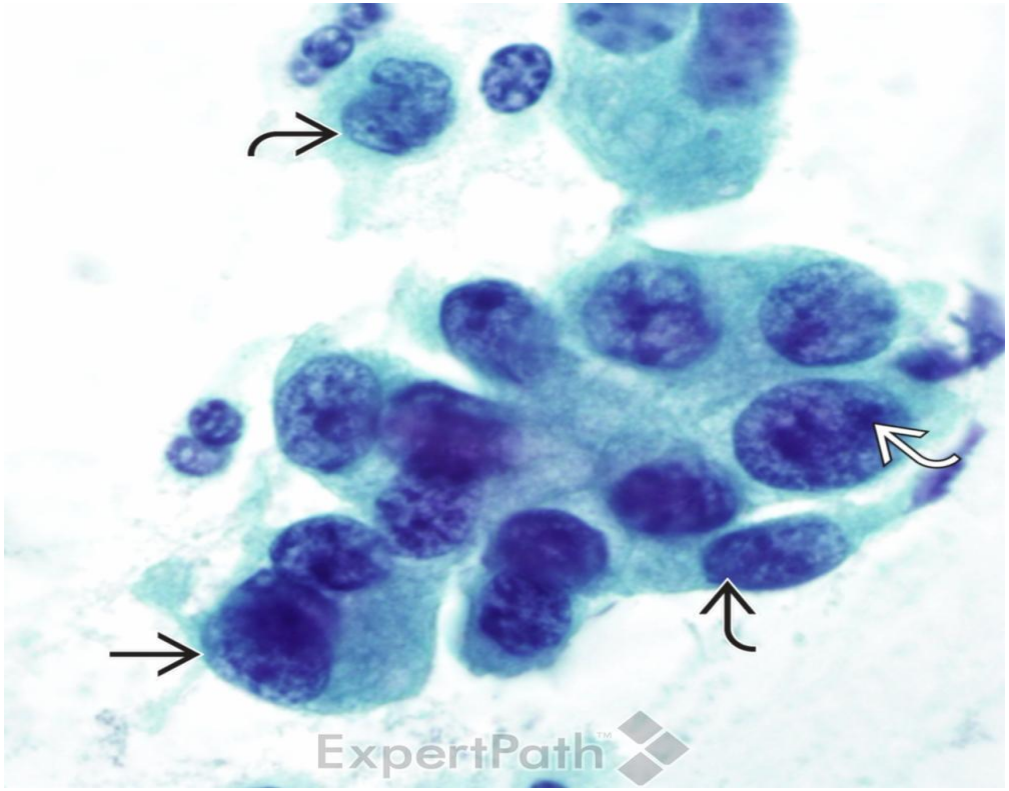


Image provided by Dr. Nadia Ismiil

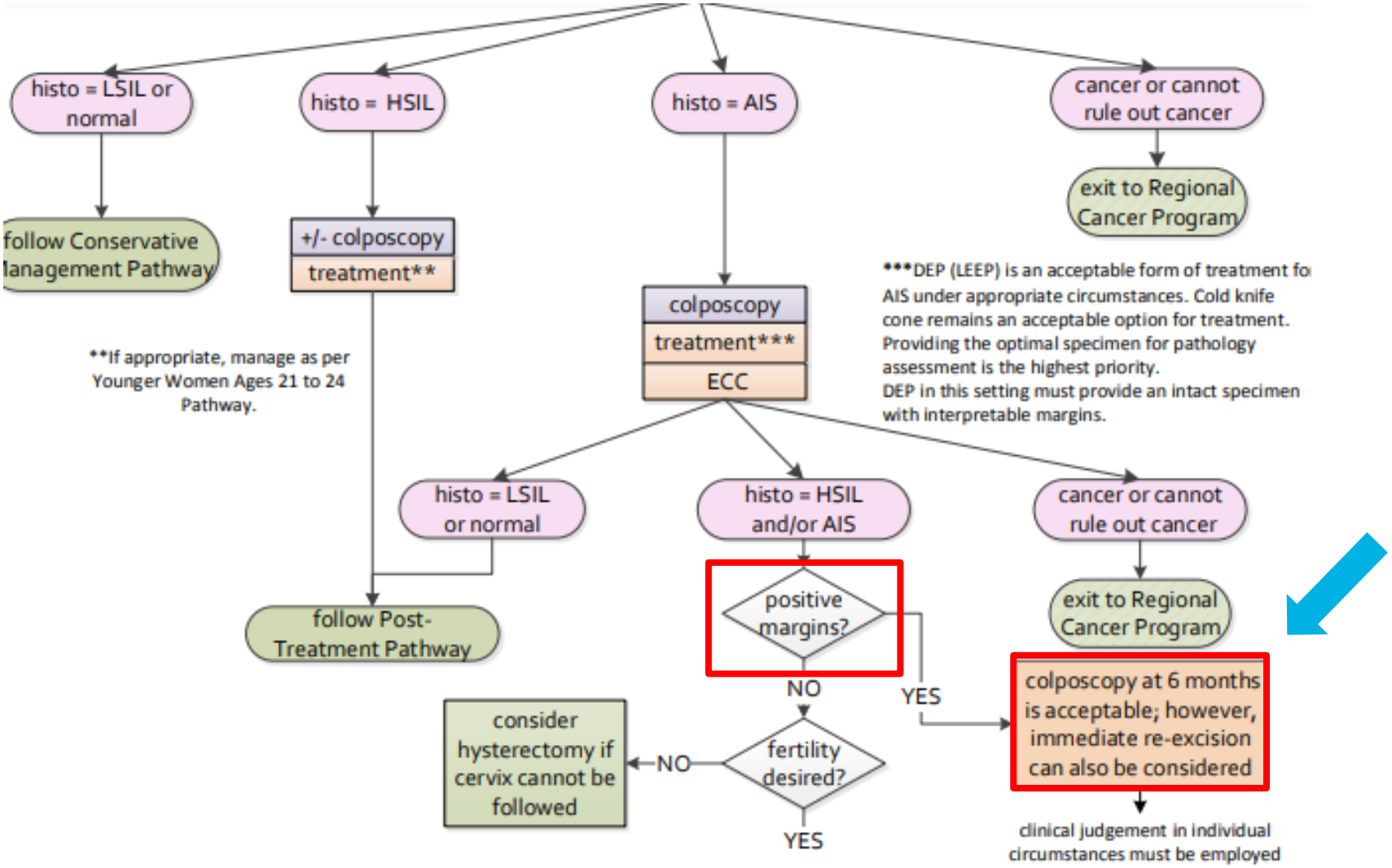
Visit #2

- A DEP (e.g. LEEP) is performed followed by an ECC. The margins of the LEEP are positive for AIS as is the post-LEEP ECC

Answer poll in chat or via pop-up

- Based on the findings you decide to:
  a) Repeat colposcopy in 6 months
  b) Repeat LEEP
  c) Perform ablative treatment
  d) Perform Pap test

Pathway #5: Management of AGC/AIS



Positive margins are a risk factor for AIS recurrence and persistence

TABLE 2. Loop Electrosurgical Excision Procedure/Cone Biopsy Margin Status and Follow-up Results (Including 8 Pap Only)

	AIS or adenocarcinoma, *n* (%)	Negative, *n* (%)	Total, *n* (%)	κ
Margin positive	25 (47.2)	28 (52.8)	53 (32.7)	
Margin negative	10 (9.3)[a]	97 (90.7)	107 (67.3)	
Total	35 (21.9)	125 (78.1)	160 (100.0)	0.45

[a] $p < .001$.

Persistent/recurrent AIS was substantially higher in the patients with positive margins vs. negative margins

Reference: Upadhyay Baskota S, Wang T, Zhao C. Follow-up findings in post-conservative treatment surveillance for women with cervical adenocarcinoma in situ. J Low Genit Tract Dis. 2020;25(1):38–42.

AIS and stratified mucin-producing intraepithelial lesion (SMILE)

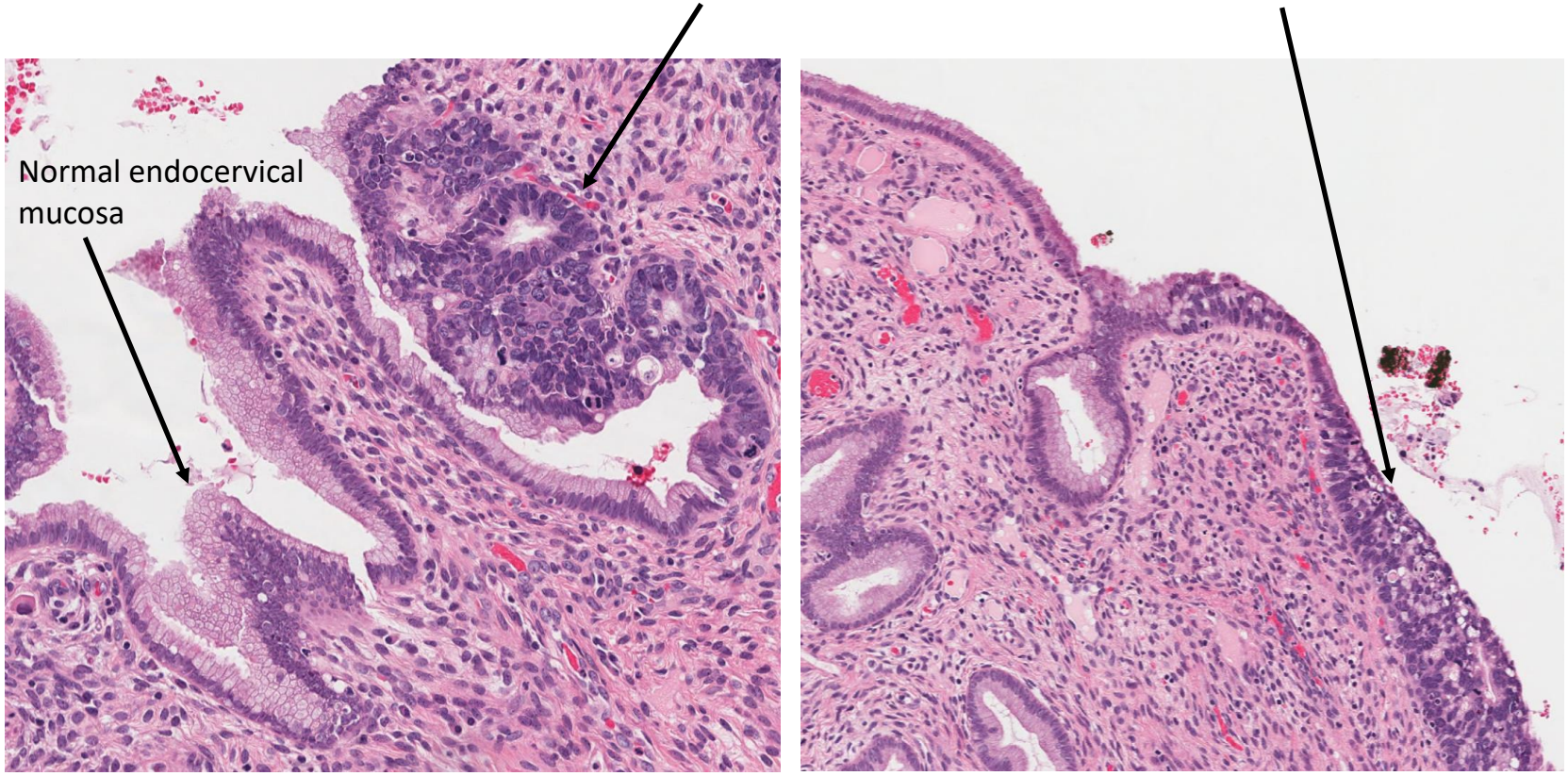


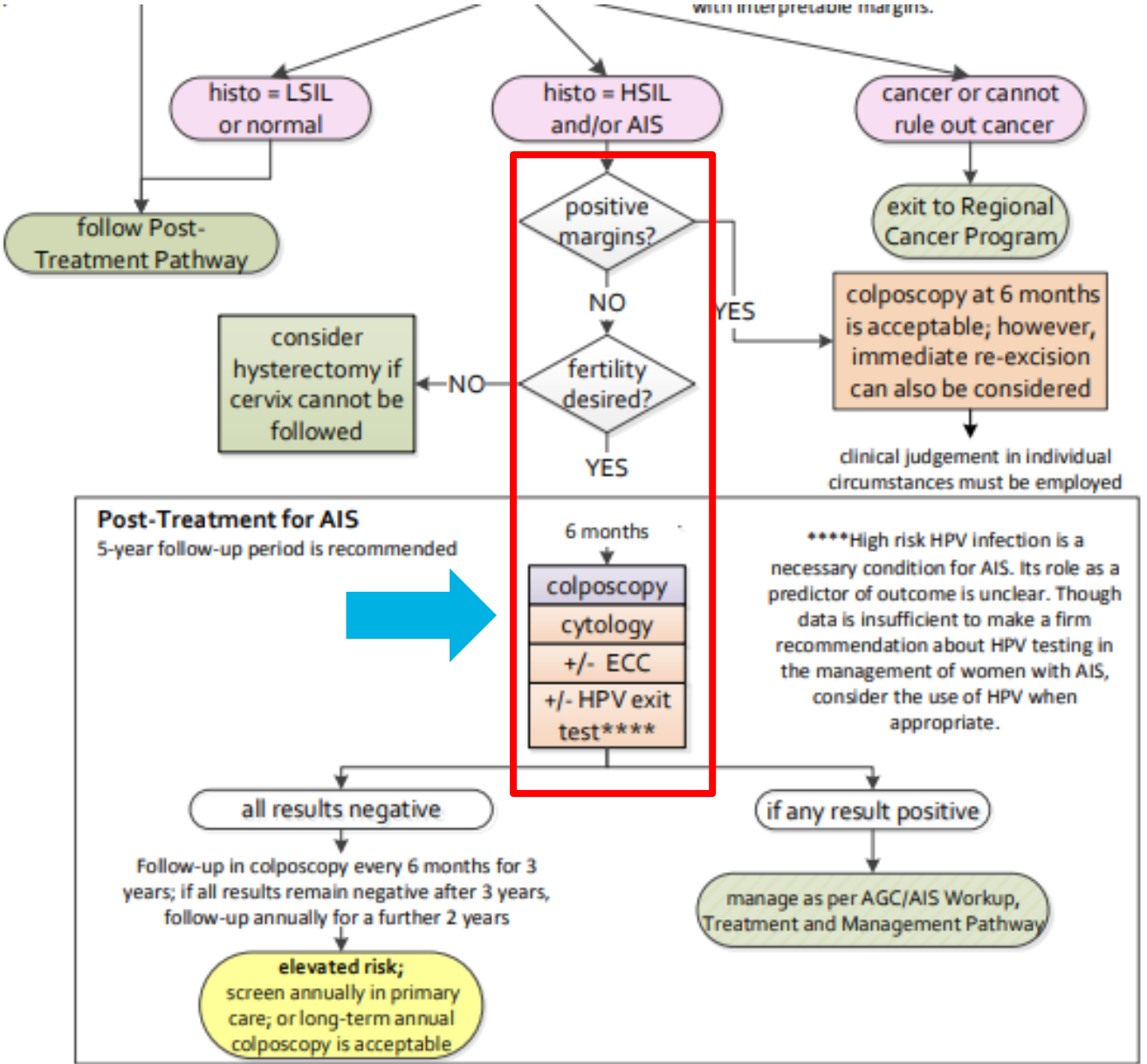
Image provided by Dr. Nadia Ismiil

Visit #3

- A repeat LEEP shows AIS with negative margins. The patient expresses that future fertility is desired. What is your next step?
  a) Hysterectomy
  b) Repeat colposcopy in 6 months
  c) Repeat colposcopy in 3 months
  d) LEEP

Answer poll in chat or via pop-up

Pathway #5: Management of AGC/AIS



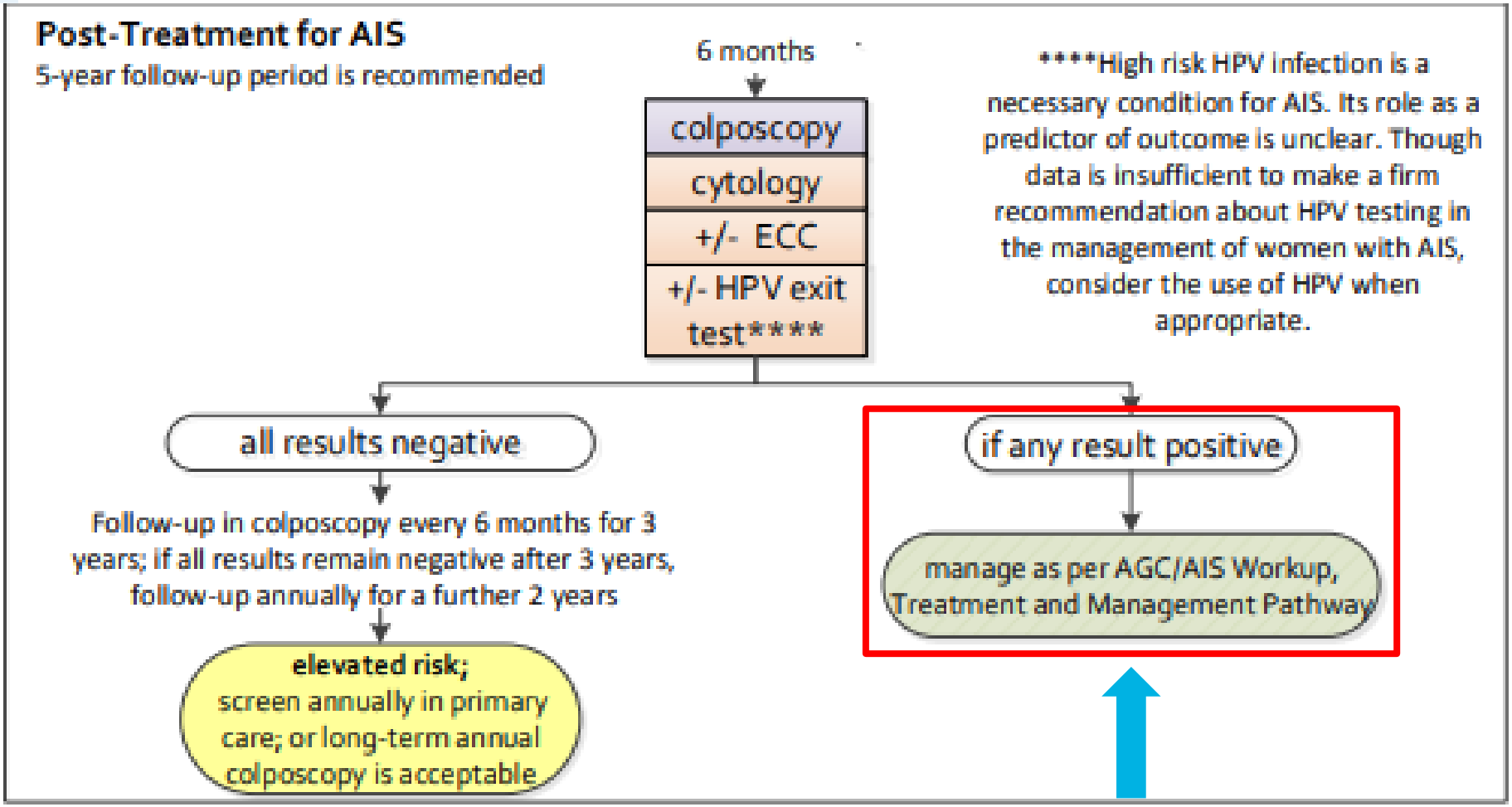
Visit #4

- A colposcopy repeated at 6 months shows:
  - AIS cytology
  - Positive ECC

Answer poll in chat or via pop-up

- What is your next step?
  a) Repeat LEEP
  b) Hysterectomy
  c) Discharge to primary care

Pathway #5: Management of AGC/AIS



Invasive adenocarcinoma, conventional type

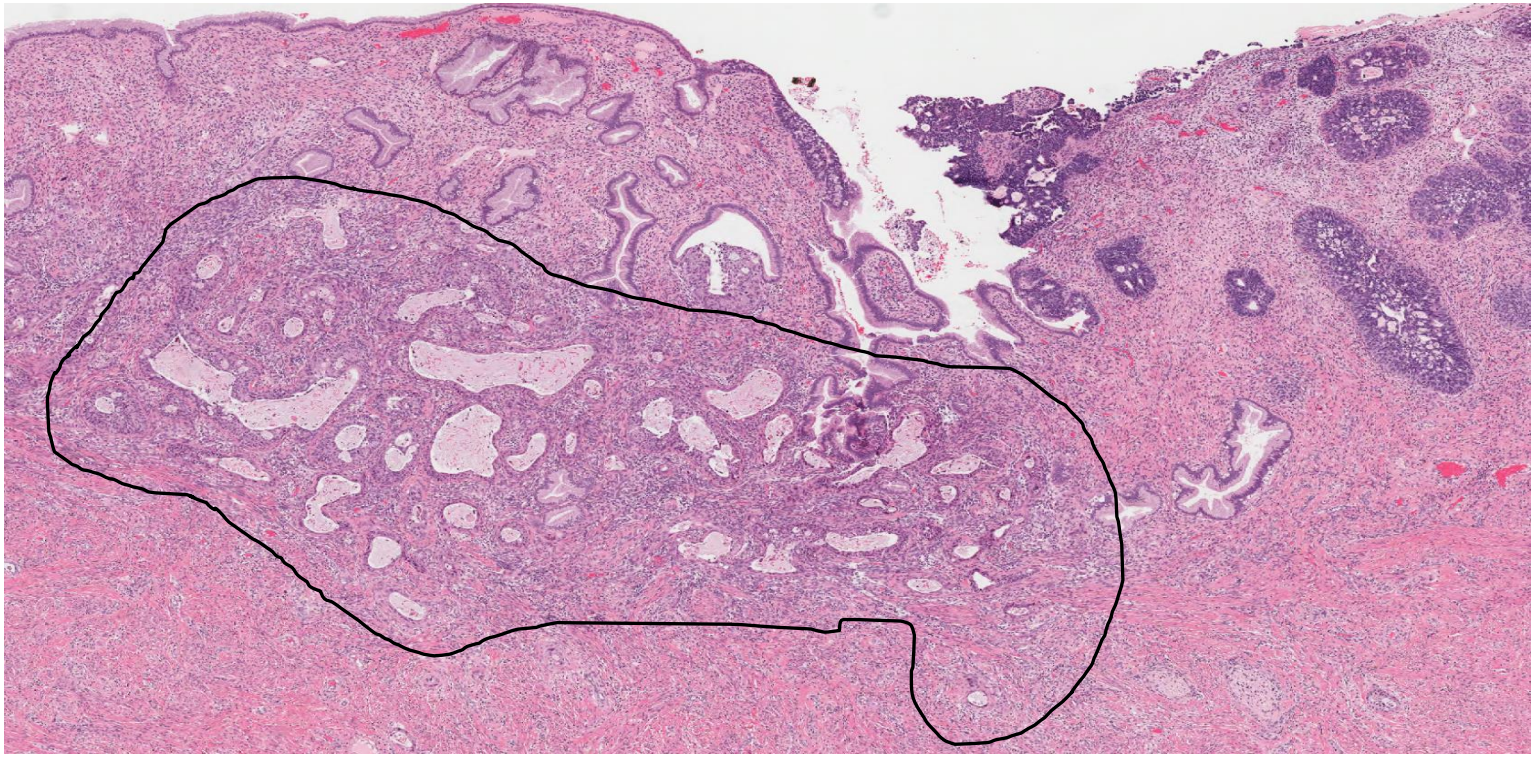


Image provided by Dr. Nadia Ismiil

Final remarks

6:55 – 7:00 pm

Dr. Dustin Costescu

Accreditation

Royal College of Physicians and Surgeons of Canada – Section 1:

This event is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada, approved by Continuing Professional Development, Faculty of Medicine, University of Toronto. You may claim up to a maximum of 1.5 hours (credits are automatically calculated).

In order to obtain your certificate of participation, you must fill out our survey that will be emailed to you following this meeting.

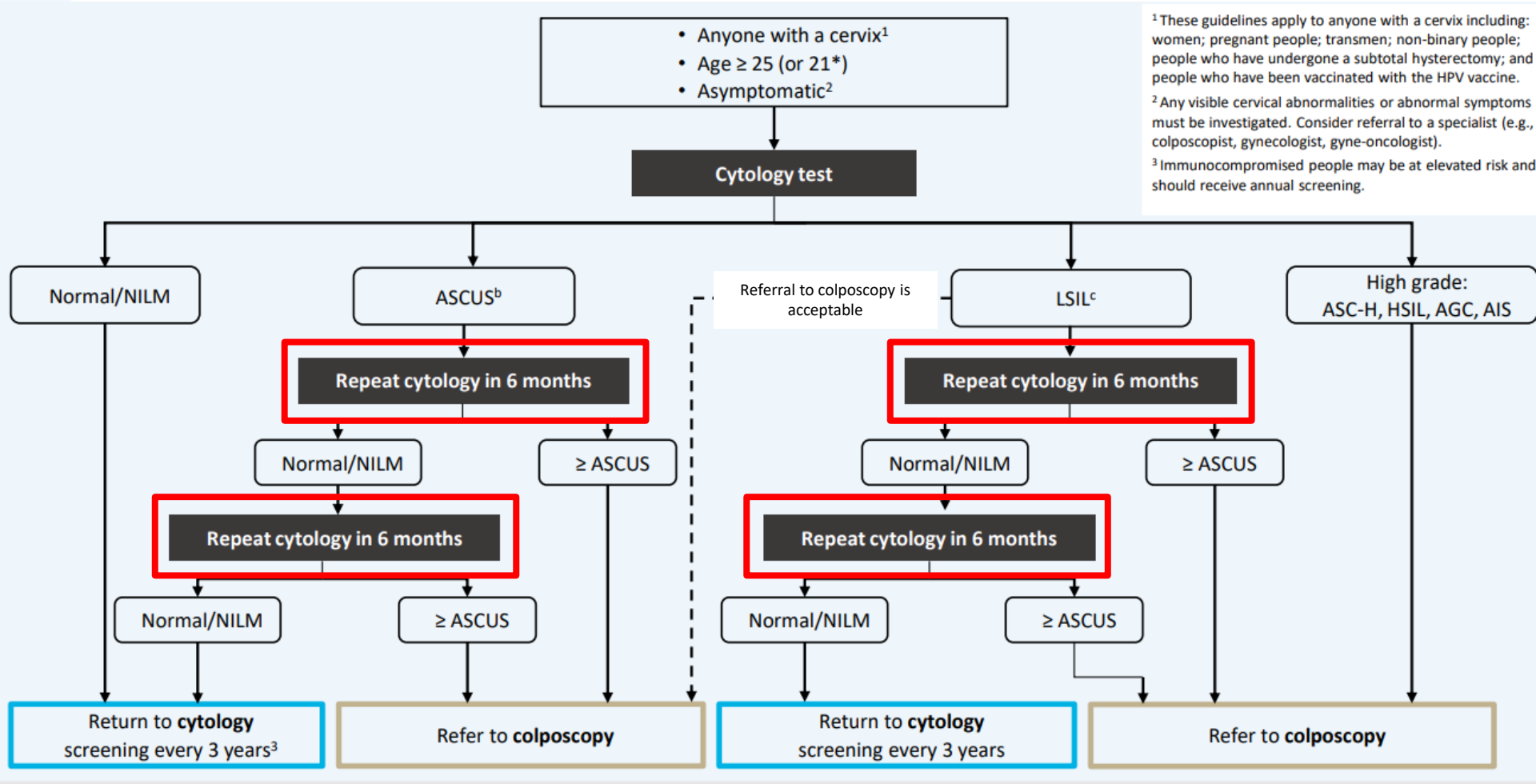
What's next?

- Please ensure you fill out the post-webinar survey – survey link will be emailed to CoP webinar attendees
- Next CoP webinar: Spring 2023 (dates TBD)
- Share your feedback and questions with us at ColposcopyCoP@ontariohealth.ca


Thank
You!

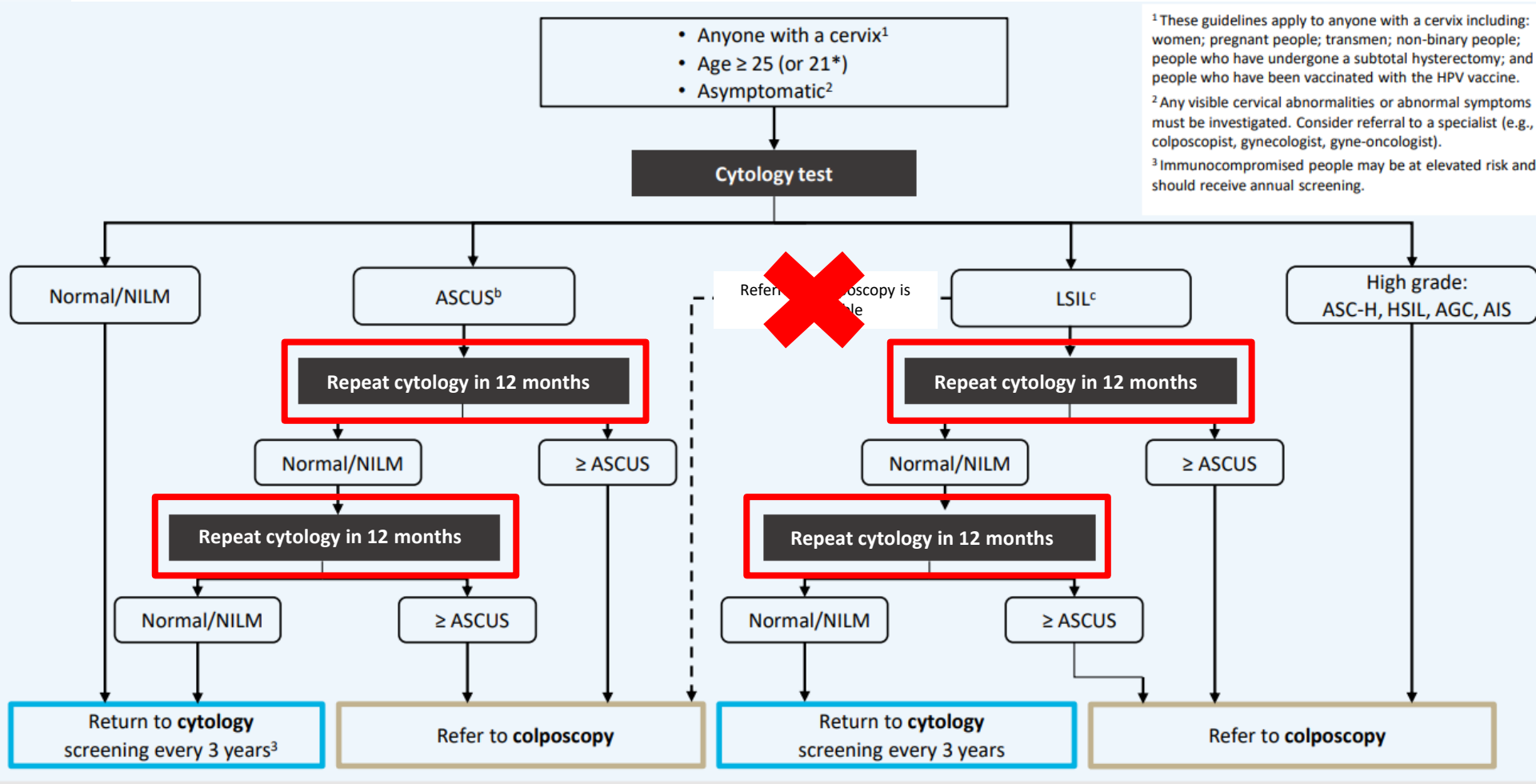
Appendix

OCSP's previous screening pathway



Definitions: NILM (normal) – no intraepithelial lesion or malignancy seen; ASCUS – atypical squamous cells of undetermined significance; LSIL – low-grade squamous epithelial lesion; ASC-H – atypical squamous cells, cannot rule out high-grade; HSIL – high-grade squamous intraepithelial lesion; AGC – atypical glandular cells; AIS – adenocarcinoma in-situ

OCSP's updated screening pathway



[1] These guidelines apply to anyone with a cervix including: women; pregnant people; transmen; non-binary people; people who have undergone a subtotal hysterectomy; and people who have been vaccinated with the HPV vaccine.

[2] Any visible cervical abnormalities or abnormal symptoms must be investigated. Consider referral to a specialist (e.g., colposcopist, gynecologist, gyne-oncologist).

[3] Immunocompromised people may be at elevated risk and should receive annual screening.

Positive margins are a risk factor for AIS recurrence/persistence and progression to cancer

Author, Year	Excision Margin Status	Cumulative risk			
		1 year	2 year	7 year	9 year
Booth, 2014	Negative			4.6 (NR*)	
	Positive			6y =17.2 (NR)	
Li, 2013	Negative	7.2 (NR)			
	Positive	2.5 (NR)			
Powell, 2019	Negative		6.1 (NR)		
	Positive		30.2 (NR)		
Tan, 2020	Negative	2.8 (NR)			4.3 (NR)
	Positive	26.4 (NR)			28.7 (NR)

*confidence interval not reported in study (NR)

Booth BB, Petersen LK. Can adenocarcinoma in situ of the uterine cervix be treated safely by conisation in combination with endocervical curettage?. European Journal of Gynaecological Oncology. 2014 Dec 10;35(6):683-7.

Li Z, Zhao C. Long-term follow-up results from women with cervical adenocarcinoma in situ treated by conization: an experience from a large academic women's hospital. Journal of lower genital tract disease. 2013 Oct 1;17(4):452-8.

Powell A, Cohen PA, Spilsbury K, Steel N, Blomfield P. RANZCOG Fellows' adherence to guidelines following cytological prediction of cervical adenocarcinoma-in-situ: Cause for concern?. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2019 Apr;59(2):294-300.

Tan JH, Malloy MJ, Thangamani R, Gertig D, Drennan KT, Wrede CD, Saville M, Quinn M. Management and long-term outcomes of women with adenocarcinoma in situ of the cervix: A retrospective study. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2020 Feb;60(1):123-9.