Cancer Care Ontario

Colposcopy Community of Practice Webinar

JUNE 2/8, 2017

Ontario
Cancer Care Ontario

Housekeeping Items

- If you a unable to hear us, please dial-in:
  - **416-620-7077 / 1-866-834-7685**
  - **Access code: 255 6848**
- We have muted the line, but will open the line for discussion throughout the webinar
  - When the line is open for discussion, please do not put us on hold – we can hear your beeps!
- Please use the chat box or the “Raise Hand” function in your window to alert us if you have a question or comment
- For technical difficulties, dial “0” to speak to an operator
- Please note that this session is being recorded and will be available for a period of time

For reference, the Colposcopy Clinical Guidance document and the related colposcopy toolkit documents are provided in your calendar invitations

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Welcome to the Colposcopy Community of Practice

About the Colposcopy CoP

- First webinar was held in September 2016

- Today's webinar will be interactive
  - ✓ Live polls before and after presentations
  - ✓ Q&A periods after each agenda item
  - ✓ Participation is encouraged

- Today's session is a CPSO Accredited Group learning Activity – we will issue you a letter of accreditation for 1.5 credit hours if you:
  1. Participated in today's event,
  2. Registered as a member of the Colposcopy CoP, and
  3. Will complete and submit the post-webinar evaluation survey.

Poll 1

1. I know where to and/or have accessed current colposcopy guidelines on the CCO website.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Poll 2

2. I have altered my practice to align with current CCO colposcopy guidelines.

- ○ Strongly disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Poll 3

3. I know where to and/or have accessed the online colposcopy toolkit from the CCO website.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Poll 4

4. In my practice, I have used resources for colposcopy providers from CCO's online colposcopy toolkit.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Today's Agenda

Item	Presenter
Welcome & Introductions • Live Web Poll – Pre-session	Dr. Joan Murphy Dr. Rachel Kupets
Overview of Objectives and Agenda	Dr. Joan Murphy
Colposcopy Clinical Guidance & Toolkit + Q&A	
Clinical Guidance: Case Studies	Regional Cancer Screening Colposcopy Leads
Are some women discharged from colposcopy too soon? (Study) + Q&A	Dr. Rachel Kupets
Concluding Remarks • Live Web Poll – Post-session	Dr. Joan Murphy
Accreditation	

Learning Objectives

We hope that by the end of this meeting, you will better understand:

- Referrals to colposcopy – and declined referrals – and clinical scenarios in colposcopy
- Criteria for appropriate discharge from colposcopy
  - OCSP's recommendations for appropriate screening intervals following discharge from colposcopy
- Evidence-based patient management as recommended in the Colposcopy Clinical Guidance Document

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Colposcopy Clinical Guidance Document & Toolkit

DR. JOAN MURPHY

Ontario

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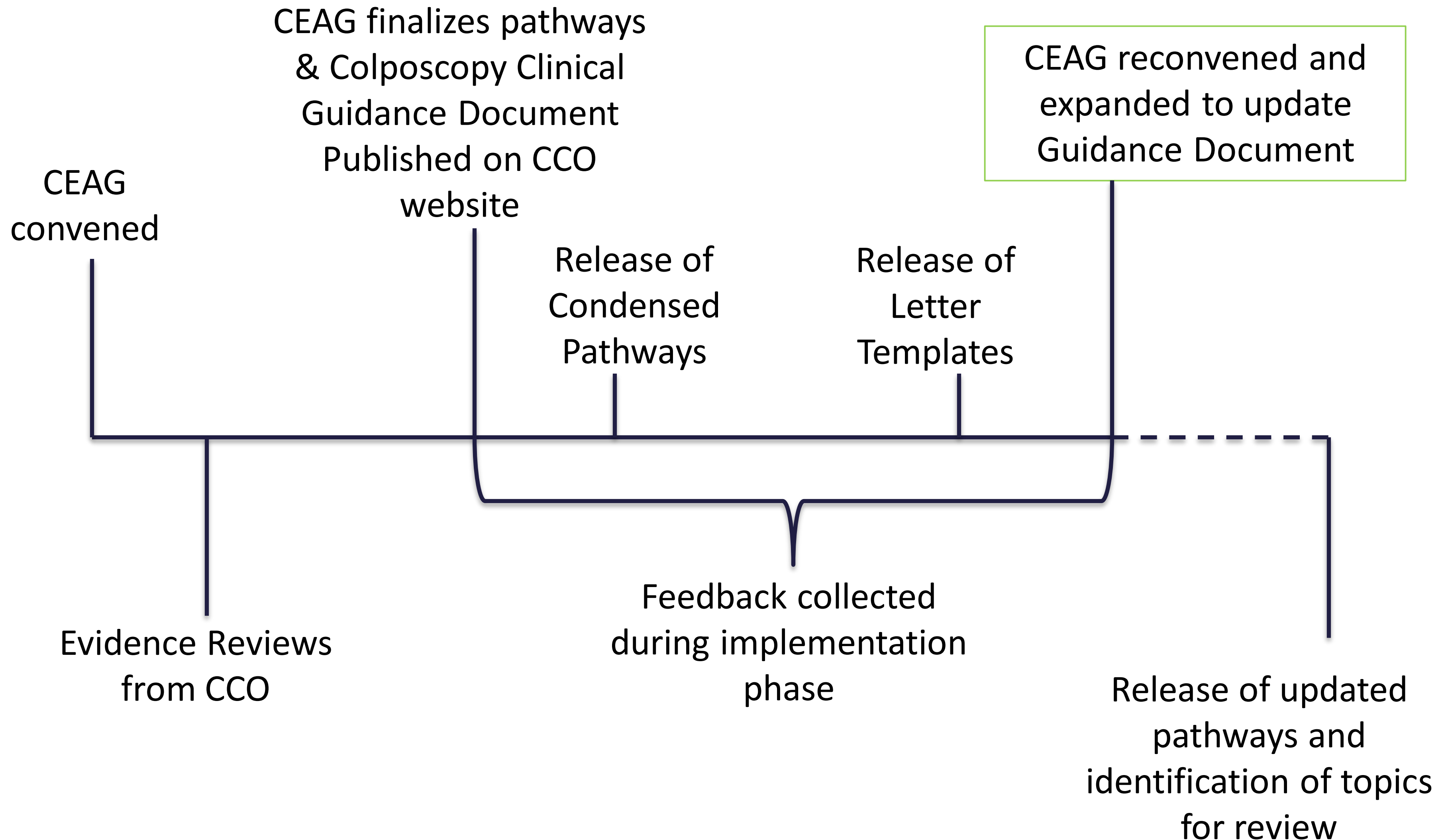
Colposcopy Clinical Guidance Document: Evolution Sequence



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Colposcopy Clinical Guidance Document: Accessing the Document & Toolkit

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Prevention & Care

- Cancer Care Overview
- Types of Cancer
- Primary Care Program
- Person-Centred Care
- Prevention
- Screening
  - Letters to the Public about Cancer Screening
  - Breast Cancer Screening
  - Cervical Cancer Screening
    - About the Ontario Cervical Screening Program
    - Cervical Cancer Facts
    - Pap Test
    - Human Papillomavirus (HPV)
    - Resources for the Public

Healthcare Provider Resources - Cervical Screening

We are offering certified courses online to better serve the healthcare community – all of which are free and accessible anytime, anywhere. This site offers credits for courses on Cancer Screening, as well as Aboriginal Relationship and Cultural Competency.

Please visit the e-learning site.

- **Ontario Cervical Screening Cytology (Pap Test) Guidelines**
- **Regional Cervical Screening/Colposcopy Leads**
- **Ontario Colposcopy Clinical Guidance**
- **Cervical Screening Evidence-Based Series**
- **Screening Activity Report**

https://www.cancercare.on.ca/pcs/screening/cervscreening/hcpresources/

Colposcopy Clinical Guidance Document: Accessing the Document & Toolkit

https://www.cancercare.on.ca/pcs/screening/cervscreening/hcpresources/

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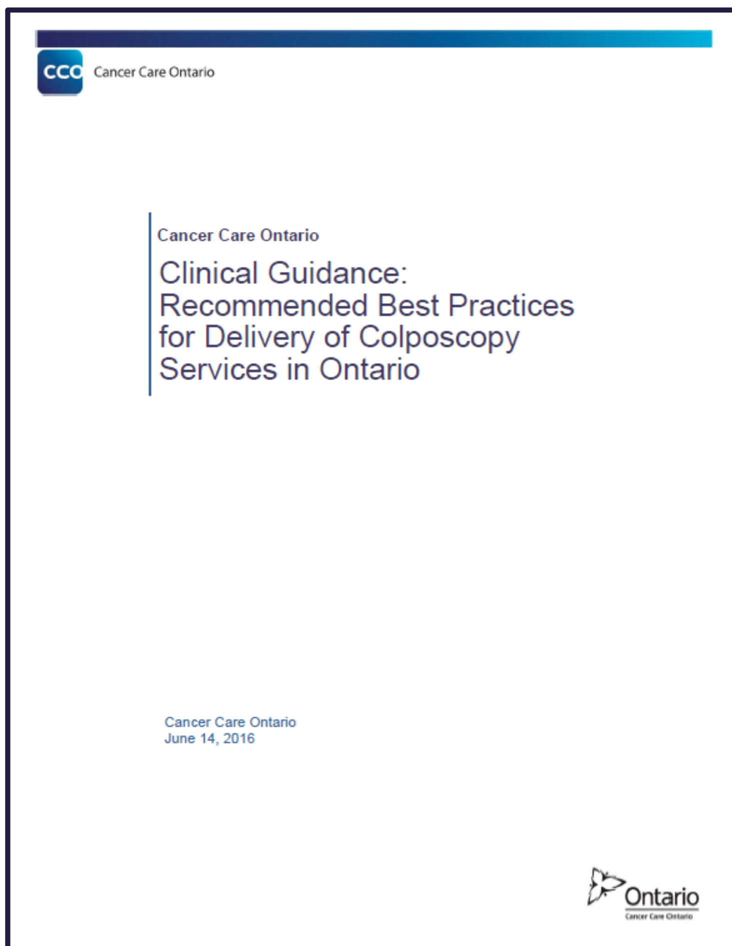
Colposcopy Clinical Guidance Document: Accessing the Document

Guidance Document



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Clinical Guidance: Recommended Best Practices for Delivery of Colposcopy Services in Ontario

Cancer Care Ontario
June 14, 2016

Ontario

Pathway Summary

Clinical Guidance: Recommended Best Practices for Delivery of Colposcopy Services in Ontario
Best Practice Pathway Summary

June 14, 2016

Glossary of Terms

- **Colposcopy** is the examination of the cervix, vagina and, in some instances, the vulva, with the colposcope after the application of a three to five percent acetic acid solution coupled with obtaining colposcopically-directed biopsies of all lesions suspected of representing neoplasia.
- **Colposcopic impression** documents the visual inspection of blood vessel configurations, surface contour, colour tone and lesion demarcation before and after the application of acetic acid and/or Lugol's iodine.
- A colposcopic impression is considered "satisfactory" or "adequate" if the entire squamocolumnar junction and the margin of any visible lesion can be visualized with the colposcope.
- A colposcopic impression is considered "normal" if there is no visible abnormality on the cervix.
- **Endocervical curettage (ECC)** uses a spoon-shaped instrument, or curette, to scrape the mucous membrane of the endocervical canal (the passageway between cervix and uterus) to obtain a small tissue sample.
- **Diagnostic excisional procedure (DEP)** is the process of obtaining a specimen from the transformation zone and endocervical canal for histological evaluation and includes laser conization, cold-knife conization, loop electrosurgical excision (LEEP), and loop electrosurgical conization. DEPs can act as both diagnostic and therapeutic tools.
- **Cytopathology** is a branch of pathology that studies and diagnoses diseases on the cellular level; cervical smear tests screen for abnormal cytology.
- **Histopathology** is the microscopic study of diseased tissue.

Abbreviations and Acronyms

AC: adenocarcinoma
AGC-N: atypical glandular cells, favor neoplastic
AGC-NOS: atypical glandular cells, not otherwise specified
AIS: adenocarcinoma in situ
ASC-H: atypical squamous cells, cannot exclude high-grade squamous intraepithelial lesion
ASCUS: atypical squamous cells of undetermined significance
CIN: cervical intraepithelial neoplasia
colpo: colposcopy
cyto: cytology
DEP: diagnostic excisional procedure (both a diagnostic and therapeutic tool)
ECC: endocervical curettage
histo: histology
HPV: human papillomavirus
HSIL: high-grade squamous intraepithelial lesion
LEEP/LLETZ: loop electrosurgical excision procedure/large loop excision of the transformation zone
LSIL: low-grade squamous intraepithelial lesion
TZ: transformation zone (area of the cervix where abnormal cells and dysplasia occur); the location of the transformation zone on the cervix varies from woman to woman

Legend

Symbol	Definition
+/-	optional
cyto > LSIL	HSIL and ASC-H
cyto ≤ LSIL	LSIL, ASCUS or normal
cyto < LSIL	ASCUS or normal
histo ≤ LSIL	LSIL or normal
	colposcopic assessment is negative
	colposcopic assessment is positive
	a procedure
	a procedure result or outcome
	consider pathology review

Toolkit for Ontario Colposcopists:
Colposcopy Clinical Guidance Condensed Pathways

HPV testing available in colposcopy
Work up, conservative management and treatment

women referred to colposcopy with screen-detected abnormality as per current referral guidelines

ASCUS, LSIL, HSIL, ASC-H

AGC-N, AGC-NOS, AIS

Visit #1

colposcopy
+/- repeat cytology***
+/- biopsies
+/- ECC
+ reflex HPV test for ≤ LSIL in 30+ ONLY

colposcopy
+ biopsies
+/- repeat cytology***
+/- DEP, +/- ECC

colposcopy finding: no or squamous lesion

colposcopy finding: histo = AIS

21–24

>25

25–29

≥30

≥30

colpo/histo/cyto ≤ LSIL

no lesion seen or histo ≤ LSIL BUT cyto > LSIL

histo = HSIL

colpo/histo/cyto ≤ LSIL

HPV- histo/cyto ≤ LSIL

HPV+ histo/cyto ≤ LSIL

no lesion seen or histo negative BUT cyto > LSIL

histo = HSIL

discharge to primary care

ELEVATED RISK: annual surveillance**

≤ 6 months

12 months

discharge to primary care

LOW RISK: routine screening every 3 years

12 months

≤ 6 months

Visit #2

colposcopy + cytology*

colposcopy every 6 months with treatment at 2 years if HSIL persists or immediate treatment if clinically appropriate

colposcopy + cytology

colposcopy + cytology + HPV exit test

colposcopy +/- DEP +/- biopsies*

treatment

treatment + ECC

follow visit #2 for ≥25 in non-HPV pathway

follow post-treatment pathway

HPV- histo/cyto ≤ LSIL

HPV+ no lesion seen cyto ≤ ASCUS

HPV+ and histo ≤ LSIL, HPV+ and cyto = LSIL OR HPV- and cyto > LSIL

HPV+ no lesion seen cyto > LSIL

histo = HSIL

discharge to primary care

discharge to primary care

LOW RISK: routine screening every 3 years

ELEVATED RISK: annual surveillance**

12 months

≤ 6 months

colposcopy + cytology +/- HPV exit test****

colposcopy +/- DEP +/- biopsies*

treatment

follow post-treatment pathway

NOTE:
The simplified pathways have been streamlined; detailed guidance for specific points in care can be found in the full Clinical Guidance document.
These pathways are meant to provide guidance, but should be applied with the unique needs of each patient and specific resource considerations in mind. Clinical judgement must be employed in individual circumstances.
*Annual assessment in colposcopy may be appropriate.
**Refer to current screening guidelines for additional guidance on screening or surveillance post-discharge.
***Cervical cytology may be repeated at the initial colposcopy if indicated, as long as it has been three months since the last cytology result.
****After two consecutive positive HPV tests a year apart in colposcopy, further HPV testing is NOT routinely indicated. HPV test should only be performed if previous HPV result was negative.

HPV testing available in colposcopy
Post-treatment management

women in colposcopy

treated for histo = squamous lesion

treated for histo = AIS

6 months

histo = LSIL or normal

histo = HSIL and/or AIS

Post-treatment visit #1

colposcopy + cytology

positive margins?

YES

colposcopy at 6 months is acceptable; however, in some cases immediate re-excision may be considered

NO

colpo/histo/cyto ≤ LSIL

no lesion seen BUT cyto > LSIL

histo = HSIL

if cervix cannot be followed, hysterectomy may be considered

NO

fertility desired?

6–12 months

≤ 6 months

6 months

Post-treatment visit #2

colposcopy + cytology + HPV exit test

colposcopy +/- DEP +/- biopsies*

re-treatment

follow post-treatment pathway

colposcopy + cytology +/- ECC +/- HPV exit test

HPV- histo/cyto ≤ LSIL

HPV+ no lesion seen cyto ≤ LSIL

HPV-, histo = HSIL OR HPV+, histo ≤ LSIL

no lesion seen BUT cyto > LSIL

HPV+ histo = HSIL

all results negative

any result positive

discharge to primary care

discharge to primary care

LOW RISK: routine screening every 3 years

ELEVATED RISK: annual surveillance**

6–12 months

HPV- 6 months

HPV+ ≤ 6 months

repeat visit every 6 months for 3 years; if all results remain negative after 3 years, follow up annually for a further 2 years

colposcopy + cytology or re-treatment acceptable if HPV+

colposcopy +/- biopsies

colposcopy +/- DEP +/- biopsies*

re-treatment

follow post-treatment pathway

discharge to primary care for annual surveillance or long-term annual colposcopy is acceptable*

follow pathway for AGC/AIS referrals

NOTE:
The simplified pathways have been streamlined; detailed guidance for specific points in care can be found in the full Clinical Guidance document.
These pathways are meant to provide guidance, but should be applied with the unique needs of each patient and specific resource considerations in mind. Clinical judgement must be employed in individual circumstances.
*Annual assessment in colposcopy may be appropriate.
**Refer to current screening guidelines for additional guidance on screening or surveillance post-discharge.

Toolkit for Ontario Colposcopists: Declined Referral Template

DECLINED REFERRAL FORM

NOTICE: COLPOSCOPY NOT REQUIRED

Colposcopist name:

Contact information:

Date:

Patient identifier:

Based on this woman's referral cytology and/or HPV test result, she is at low risk for high-grade dysplasia or cervical cancer.

It does **not** appear that she requires a colposcopic assessment. Colposcopy has **not** been scheduled. If this referral has been based on additional information, please advise and we will re-evaluate.

Any visible cervical abnormalities or abnormal symptoms must be investigated by a specialist (e.g., colposcopist, gyne-oncologist, gynecologist) regardless of cytology findings.

As per the Ontario Cervical Screening Program's cervical screening guidelines, the criteria for referral to colposcopy for screening detected cervical cytologic abnormalities are as follows:

Age group	Screening Results
Women of any age	**High-grade abnormal cytology**, including ASC-H, HSIL, AGC or greater
Women age 30 and older	Low-grade cytology: • One LSIL; • ASCUS + consecutive low-grade abnormal (ASCUS + ASCUS or ASCUS + LSIL); • LSIL + consecutive low-grade abnormal (LSIL + LSIL or LSIL + ASCUS); • One ASCUS + HPV-positive; or • One LSIL + HPV-positive.
Women age 29 and younger	Low-grade cytology: • One LSIL; • ASCUS + consecutive low-grade abnormal (ASCUS + ASCUS or ASCUS + LSIL); or • LSIL + consecutive low-grade abnormal (LSIL + LSIL or LSIL + ASCUS). **Note: current evidence does not support HPV testing for women under 30 because the rate of transient (clinical inconsequential) infections is higher younger women.[1]**

AGC = atypical glandular cells
ASC-H = atypical squamous cells – cannot exclude HSIL
ASCUS = atypical squamous cells of undetermined significance
HPV = human papillomavirus
HSIL = high-grade squamous intraepithelial lesion
LSIL = low-grade squamous intraepithelial lesion

Women over 30 with LSIL or ASCUS Pap, who are HPV negative, do not require colposcopy and should be screened triennially. These women are at or below population risk for high-grade dysplasia or cervical cancer.

For further information on screening and colposcopy recommendations for Ontario see cancercare.on.ca/pcs/screening/cervscreening/hcpresources.

, MD, Colposcopist

[1] Murphy J, Kennedy E, Dunn S, Fung Kee Fung M, Gzik D, McLachlin CM, et al. Cervical Screening. Toronto (ON): Cancer Care Ontario; 2011 Oct 5 [In Review 2016 Apr.] Program in Evidence-based Care Evidence-based Series No.: 15-9 IN REVIEW. Available online: cancercare.on.ca/common/pages/UserFile.aspx?fileId=124513

Version 1.0
Date Released: February 2, 2017
Available Online: cancercare.on.ca/pcs/screening/cervscreening/hcpresources

Toolkit for Ontario Colposcopists: Discharge Recommendations Template

DISCHARGE RECOMMENDATIONS
COLPOSCOPY SERVICES

Colposcopist name:

Contact information:

Date:

Patient identifier:

This patient is now discharged from colposcopy. She requires Pap screening by a primary care provider:

- ☐ Every three years (routine cervical screening)
- ☐ Every year (surveillance)

Re-referral to colposcopy in the future should be guided by her screening results.

According to the Ontario Cervical Screening Program's recommendations, whether or not a woman has been treated, further colposcopic examinations are not required and she can be discharged to primary care if:

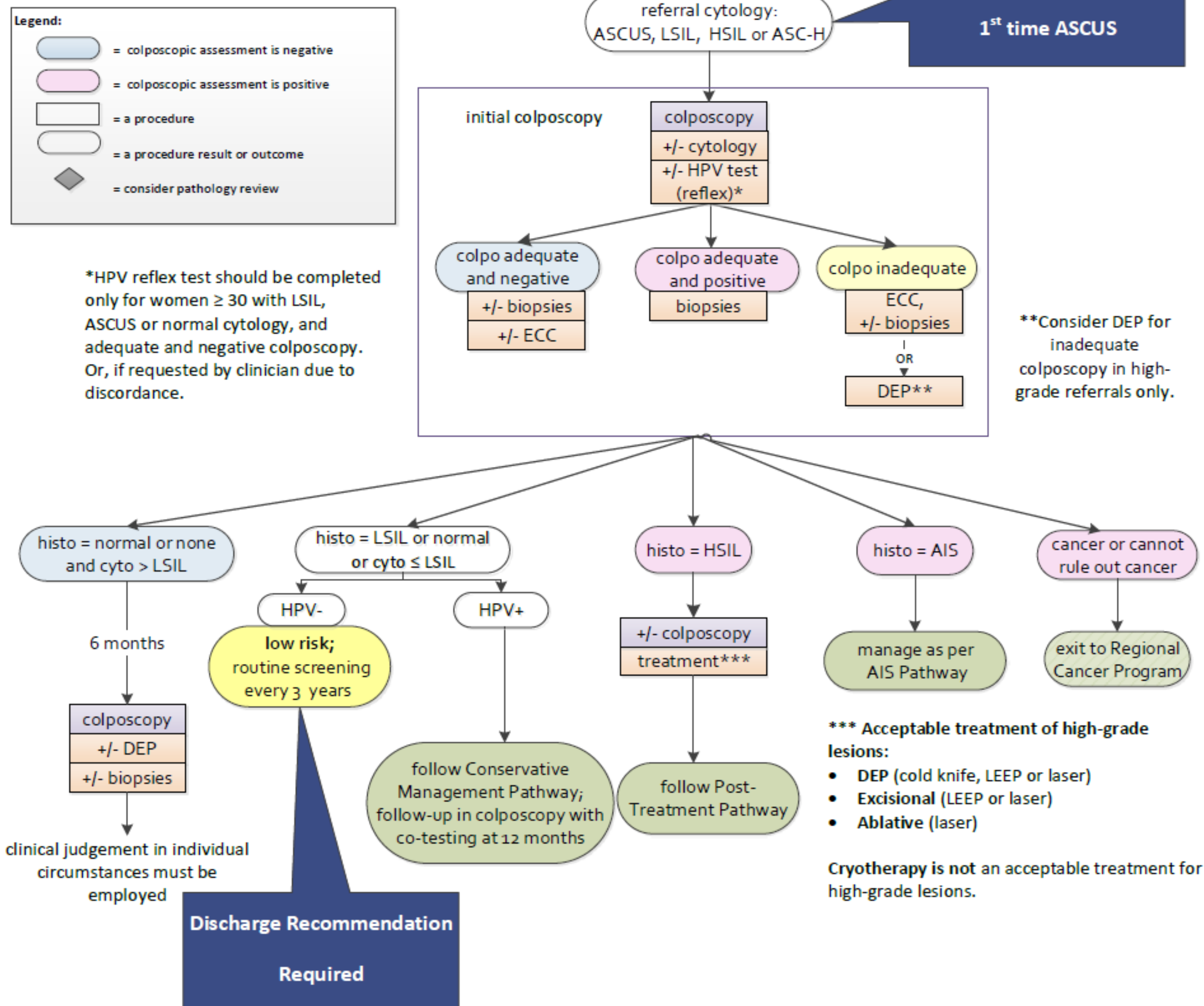
HPV testing was **not** done	HPV testing was done
☐ Colposcopy negative AND negative cytology on 3 consecutive visits. Pap screening every 3 years by a primary care provider. *These patients are at very **low risk** for high-grade dysplasia or cervical cancer.*	☐ HPV test is negative AND normal or low-grade cytology. Pap screening every 3 years by a primary care provider. *These patients are at very **low risk** for high-grade dysplasia or cervical cancer.*
☐ Colposcopy negative AND any combination of normal or low-grade cytology on 3 consecutive visits. Pap screening every year by a primary care provider. *These patients are at **slightly elevated risk** for high-grade dysplasia or cervical cancer and should be **screened annually**.*	☐ HPV test is positive AND normal or low-grade cytology. Pap screening every year by a primary care provider. *These patients are at **slightly elevated risk** for high-grade dysplasia or cervical cancer and should be **screened annually**.*

For further information on screening and colposcopy recommendations for Ontario see cancercare.on.ca/pcs/screening/cervscreening/hcpresources.

________, MD, Colposcopist

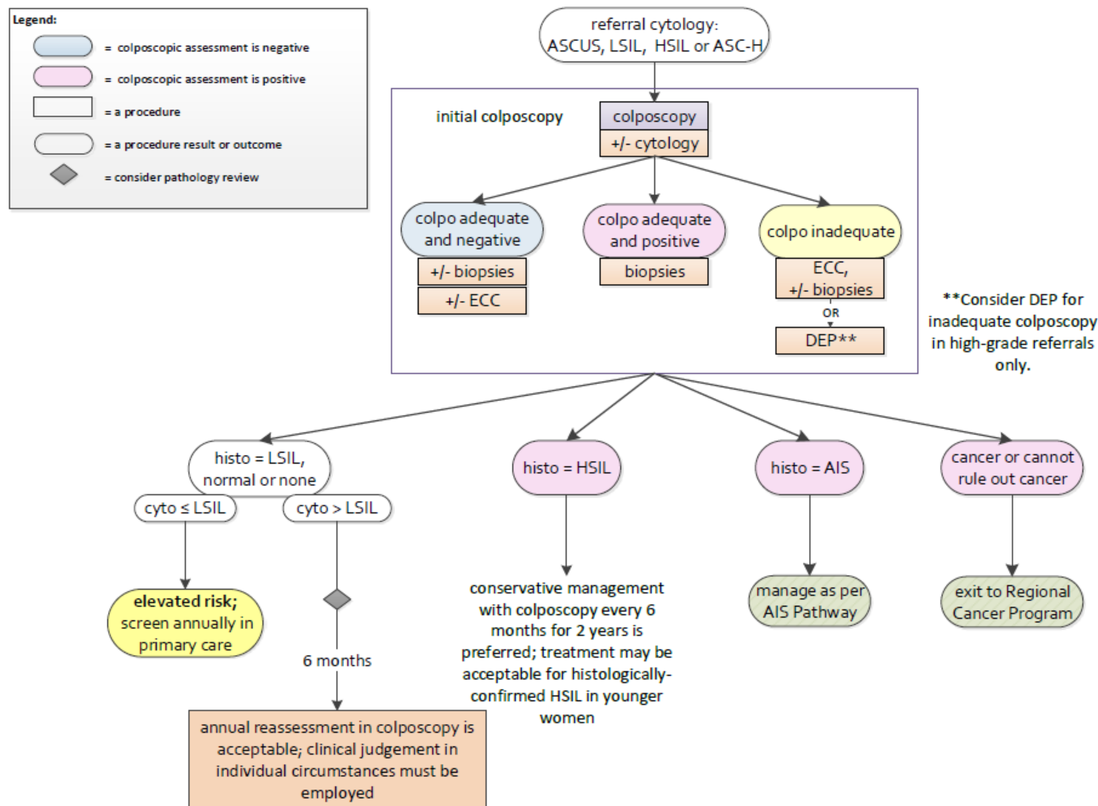
Version 1.0
Date Released: February 2, 2017
Available Online: cancercare.on.ca/pcs/screening/cervscreening/hcpresources

Colposcopy Clinical Guidance Document: When is it appropriate to use letter templates?



Colposcopy Clinical Guidance Document: Featured Pathway

Management of Younger Women Ages 21 to 24



Colposcopy Clinical Guidance Document: Primary Care Tool

Ontario Cervical Screening Guidelines Summary

Revised October 2016—based on current (2012) screening guidelines

Ontario Cervical Screening Program

Screening initiation

Women should begin screening for cervical cancer at **age 21** if they are or have ever been sexually active. Women who are not sexually active by age 21 should delay cervical cancer screening until they are sexually active. Sexual activity includes intercourse, as well as digital or oral sexual activity involving the genital area with a partner of either sex.

Screening interval

If a woman's cytology is normal, she should be screened **every three years.** The absence of transformation zone is not a reason to repeat a Pap test earlier than the recommended interval. See reverse for management of abnormal cytology.

Screening cessation

A woman may discontinue screening **at age 70** if she has an adequate and negative cytology screening history in the previous 10 years (i.e., three or more negative cytology tests).

Notes:

- Any visible cervical abnormalities or abnormal symptoms must be investigated by a specialist (e.g., colposcopist, gyne-oncologist, gynecologist) regardless of cytology findings.
- Cancer Care Ontario is working with the Ministry of Health and Long-Term Care to implement HPV testing in the Ontario Cervical Screening Program.

Special screening circumstances

- **Women who have sex with women** should follow the same cervical screening regimen as women who have sex with men.
- **Pregnant women** should be screened according to the guidelines. Pregnancy does not alter the recommended screening interval. Only conduct Pap tests during pre- and post-natal care if a woman is due for regular screening.
- Women who have undergone **subtotal hysterectomy** and retained their cervix should continue screening according to the guidelines.
- Women who are **immunocompromised** (e.g., HIV-positive or on long-term immunosuppressants) should receive annual screening.
- **Transgender men** who have retained their cervix should be screened according to the guidelines.

For more information and resources
Visit: cancercare.on.ca/pcresources | Call: 1-866-662-9233
Email: screenforlife@cancercare.on.ca

Ontario Guidelines for Follow-Up of Abnormal Cytology

Revised October 2016—recommendations for referral to colposcopy unchanged from May 2012 guidelines summary

Refer directly to colposcopy for the following cytology report:

- High-grade squamous intraepithelial lesion (HSIL)
- Atypical squamous cells, cannot exclude HSIL (ASC-H)
- Atypical glandular cells (AGC), atypical endocervical cells, atypical endometrial cells (also consider endometrial sampling)
- Squamous carcinoma, adenocarcinoma, other malignant neoplasms.

Any visible cervical abnormalities or abnormal symptoms must be investigated by a specialist (e.g. colposcopist, gyne-oncologist, gynecologist) regardless of cytology findings.

Diagnosis	Recommended management				
Atypical squamous cells of undetermined significance (ASCUS)	**For women <30 years old (HPV triage is not recommended)**				
	Repeat cytology in 6 months	Result: Normal	Repeat cytology in 6 months	Result: Normal	Routine screening in 3 years
				Result: ≥ASCUS	Colposcopy
		Result: ≥ASCUS	Colposcopy		
	For women ≥30 years old				
	HPV testing for oncogenic strains*	Result: Negative	Routine screening in 3 years		
		Result: Positive	Colposcopy		
	If HPV status is not known				
	Repeat cytology in 6 months	Result: Normal	Repeat cytology in 6 months	Result: Normal	Routine screening in 3 years
				Result: ≥ASCUS	Colposcopy
		Result: ≥ASCUS	Colposcopy		
Low-grade squamous intraepithelial lesion (LSIL) †	Repeat cytology in 6 months	Result: Normal	Repeat cytology in 6 months	Result: Normal	Routine screening in 3 years
				Result: ≥ASCUS	Colposcopy
		Result: ≥ASCUS	Colposcopy		
	Or refer to colposcopy				
Unsatisfactory for evaluation	Repeat cytology in 3 months				
Benign endometrial cells on Pap tests	• Pre-menopausal women who are asymptomatic require no action (continue to follow usual screening guidelines) • Post-menopausal women require investigation, including adequate endometrial tissue sampling • Abnormal vaginal bleeding in any woman requires investigation, which should include adequate endometrial tissue sampling				

* HPV testing is not currently funded by the Ministry of Health and Long-Term Care.
† Evidence suggests that either repeat cytology or colposcopy are acceptable management options after the first LSIL result. Although colposcopy may be useful for ruling out high-grade lesions, low-grade abnormalities, particularly in young women, often regress on their own and may therefore be best managed by surveillance.

Screening/surveillance in primary care after discharge from colposcopy

The colposcopist should provide specific and individualized screening recommendations when a woman is discharged from colposcopy:

- Women eligible for discharge from colposcopy who have normal, ASCUS or LSIL cytology and a **negative HPV test are at average risk** and should be screened every three years.
- Women eligible for discharge from colposcopy who have normal, ASCUS or LSIL cytology and a **positive HPV test are at elevated risk** and should have annual surveillance.
- Women eligible for discharge from colposcopy, **whose HPV status is not known,** should be screened according to risk-based recommendations made by the colposcopist.

Re-referral to colposcopy should be based on screening results (cytology), as per current guidelines.

For further information on coloposcopy, visit **cancercare.on.ca/ocspresources**

Screening/surveillance intervals after discharge from colposcopy

HPV status	Recommended interval
Negative	3 years
Positive	Annual
Unknown	Follow recommendations from colposcopist

Need this information in an accessible format? 1-855-460-2647, TTY (416) 217-1815 publicaffairs@cancercare.on.ca

PCC2024

https://www.cancercare.on.ca/pcs/screening/cervscreening/hcpresources/

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Colposcopy Clinical Guidance Document: Primary Care Tool

Screening/surveillance in primary care after discharge from colposcopy

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Screening/surveillance intervals after discharge from colposcopy

HPV status	Recommended interval
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Positive	Annual
Unknown	Follow recommendations from colposcopist

Need this information in an accessible format? 1-855-460-2647, TTY (416) 217-1815 publicaffairs@cancercare.on.ca

PCC2024

Colposcopy Clinical Guidance Document: Feedback Received

Emerging Themes:

- Usefulness of the non-HPV pathways
- Colposcopy in addition to cytology at follow-up visits
- Time interval recommendations
- Terminology use
- Role of conservative management
- Consideration for bimodal distribution when ceasing screening at age 70
- Vaccination
- Data collection mechanisms

Colposcopy Clinical Guidance Document: Feedback Received

Emerging Themes:

- Pregnancy and Postpartum
  - When should a screening Pap test be done for a postpartum woman?
  - If a pregnant woman was seen for colposcopy during her pregnancy, Pap test +/- biopsy, & colposcopic finding suggest ≤ LSIL / ASCUS, when should she be seen for follow-up colposcopy postpartum?
  - If the pregnant woman was found to have HSIL during pregnancy (but no cancer), when should she have follow-up colposcopy postpartum?

Comments and Questions

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Clinical Management in Colposcopy: Case Studies

REGIONAL CERVICAL SCREENING COLPOSCOPY LEADS

Ontario

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Case Study #1

Case Study #1

A 29 year old G3P3 patient is referred to colposcopy

- First Pap: First-time ASCUS
- Heavy smoker

You recommend:

a) Repeat Pap and HPV testing with colposcopy
b) HPV testing only
c) Decline referral; recommend repeat Pap in 6 months.
d) Treatment

Case Study #1

This woman returns 6 weeks after a follow-up Pap which showed LSIL. HPV status unknown.

You recommend:

a) Colposcopy with biopsy if lesion(s) identified

b) Repeat Pap and recommend HPV testing

c) Decline referral

d) Treatment

Case Study #1

From Visit #1

Results for this woman are:
Pap LSIL, histology LSIL, colposcopy adequate, reflex HPV testing not performed.

You recommend:

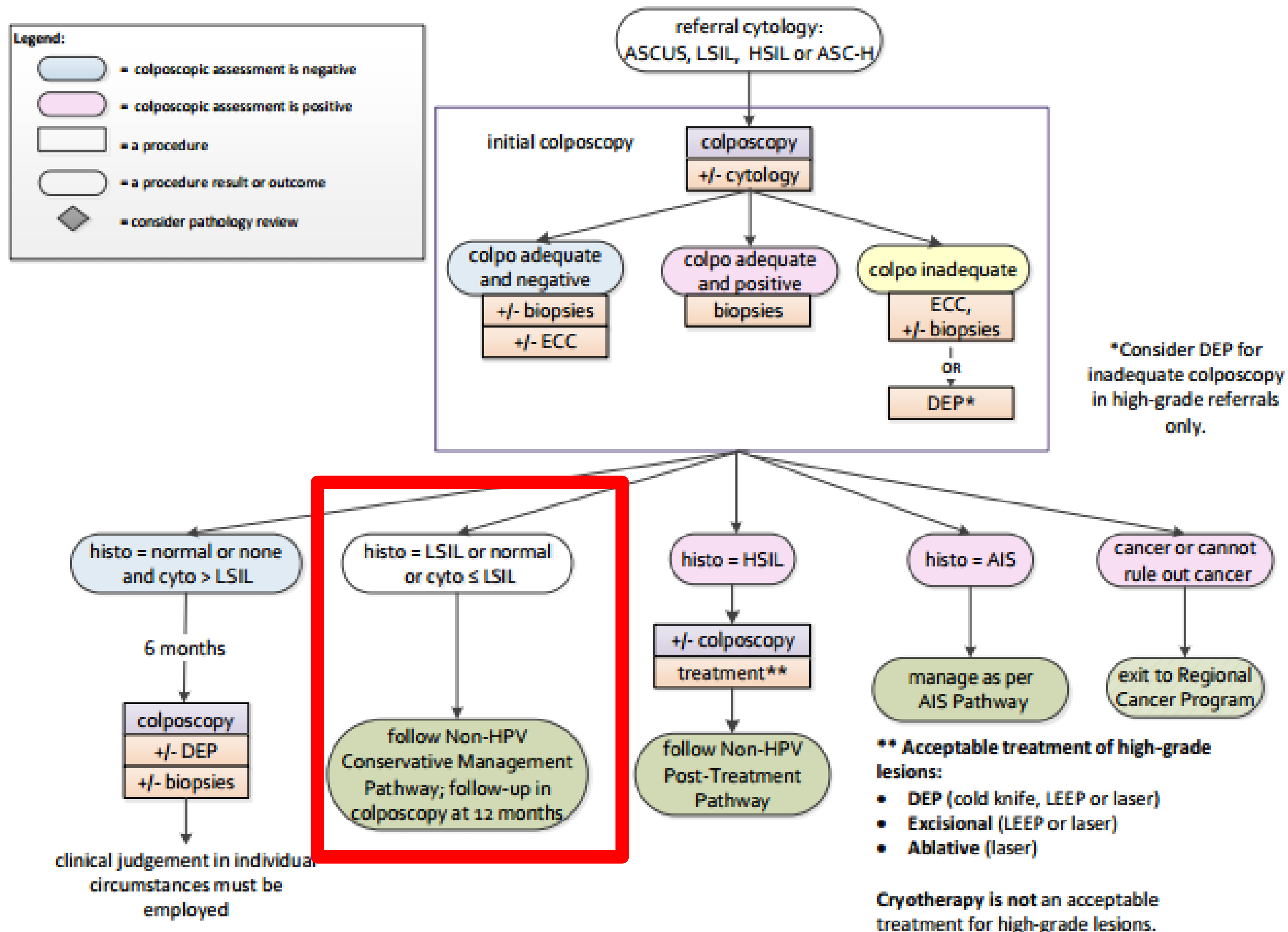
a) Follow-up colposcopy in 6 months, consider HPV testing

b) Follow-up colposcopy in 12 months, consider HPV testing

c) Treatment

d) Discharge to annual surveillance in primary care

Case Study #1



Case Study #1

From Visit #2

Results at 12 month follow-up (she is now 30 years old):
Pap LSIL, colposcopy negative, HPV testing unavailable (patient cannot pay)

You recommend:

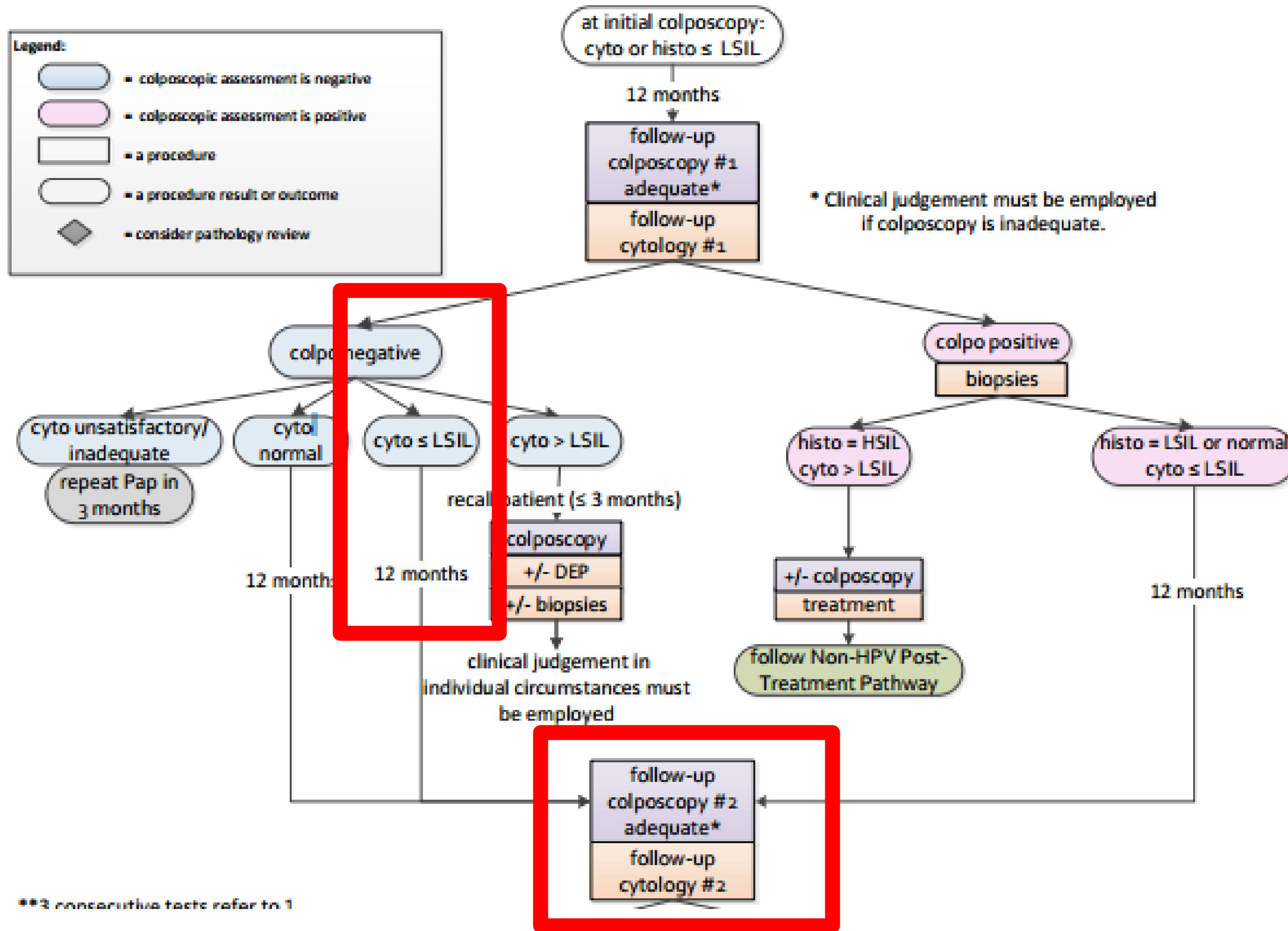
a) Repeat follow-up colposcopy in 3 months or less

b) Repeat follow-up colposcopy in 12 months

c) Discharge to annual screening in primary care

d) Treatment

Case Study #1



Case Study #1

From Visit #3

At next 12 month follow-up:

Pap LSIL, colposcopy positive, histology LSIL, HPV status unavailable

You recommend:

a) Consider HPV testing

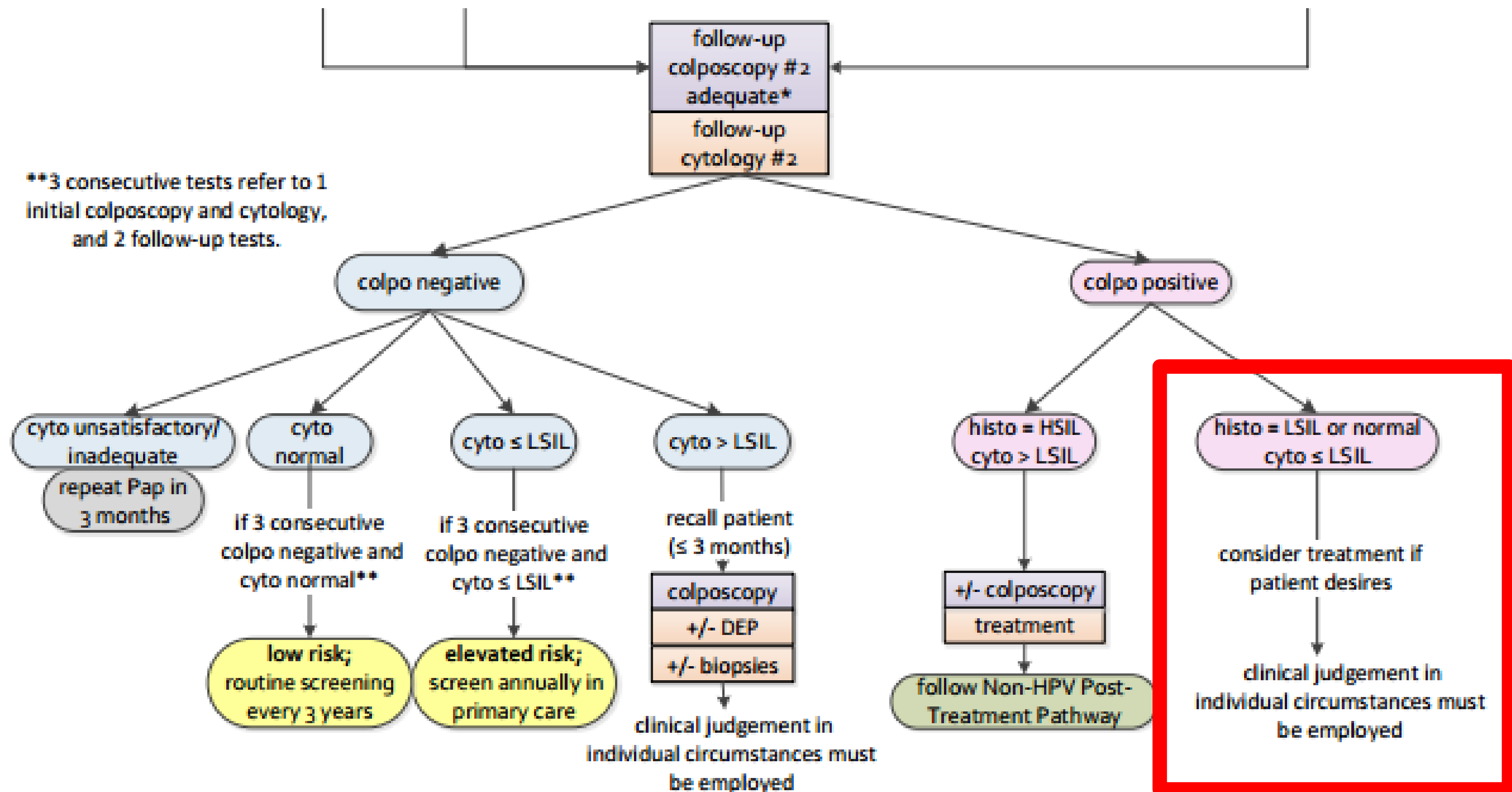
b) Discharge to annual screening in primary care

c) Repeat follow-up in 12 months

d) Treatment, then follow post-treatment pathway

e) A and C

Case Study #1



Case Study #2

Case Study #2

A 32 year old G1P1 is referred to colposcopy 4 weeks after a routine Pap showing HSIL; regular screening; no previous abnormalities. You recommend:

a) Treatment with LEEP, DEP or laser

b) Perform colposcopy and biopsy if lesion identified

c) Perform colposcopy and repeat cytology

d) Perform HPV test if available

e) C and D

f) B and D

Case Study #2

Her colposcopy is adequate, impression is HSIL and confirmed by histology. What would you recommend for the next steps?

a) Immediate recall to colpo and treatment with LEEP or laser

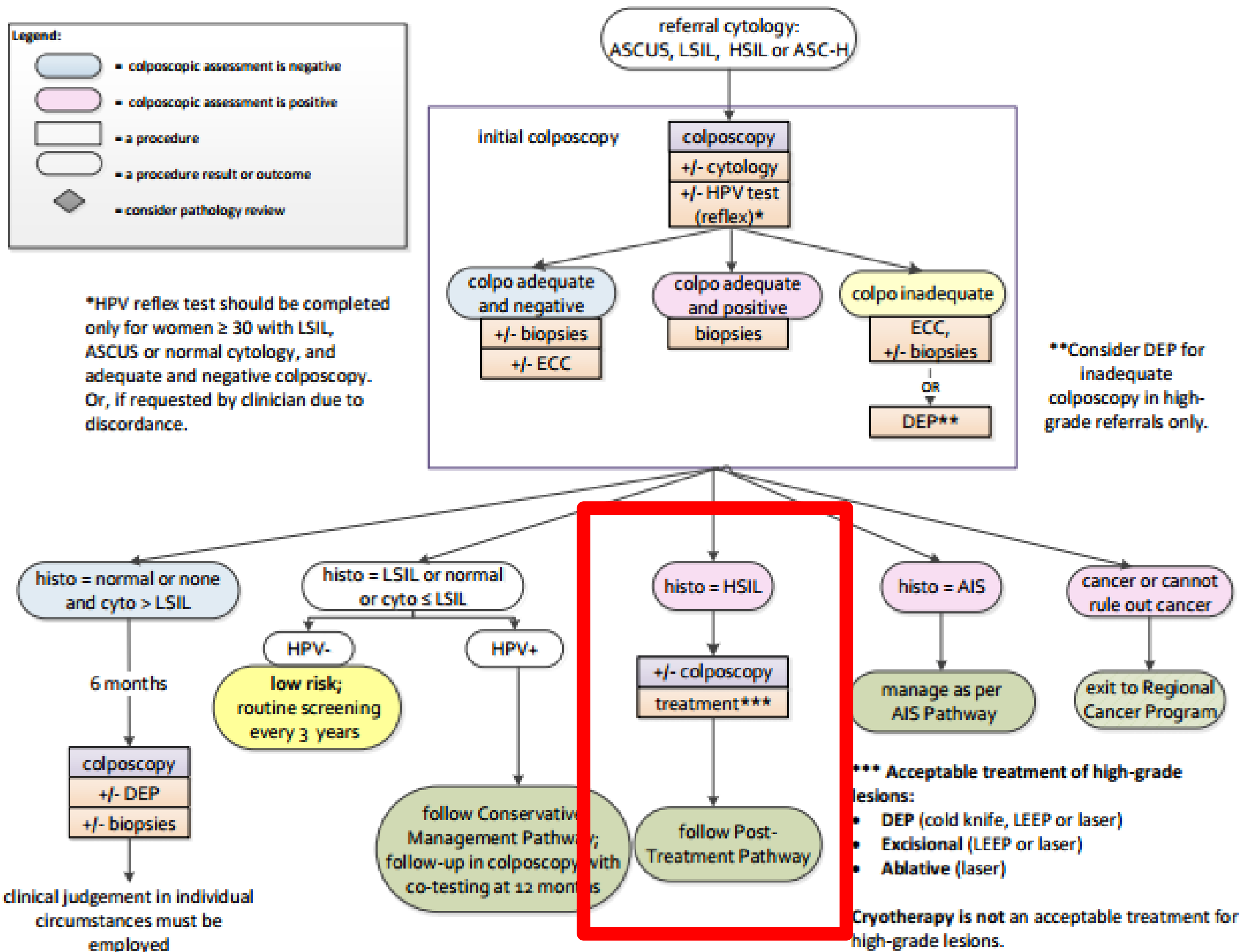
b) Discuss harms and benefits of treatment with patient

c) Perform HPV test and treat if HPV positive

d) Follow-up in 12 months with colposcopy and treatment

e) A and B

Case Study #2



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Case Study #2

If the woman's initial colposcopy was LSIL confirmed by histology (instead of HSIL), what would be your next recommended steps:

a) Recommend HPV testing

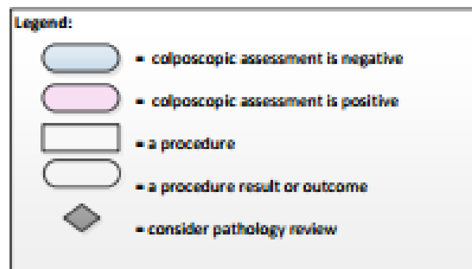
b) Discharge woman to routine screening (every 3 years) in primary care

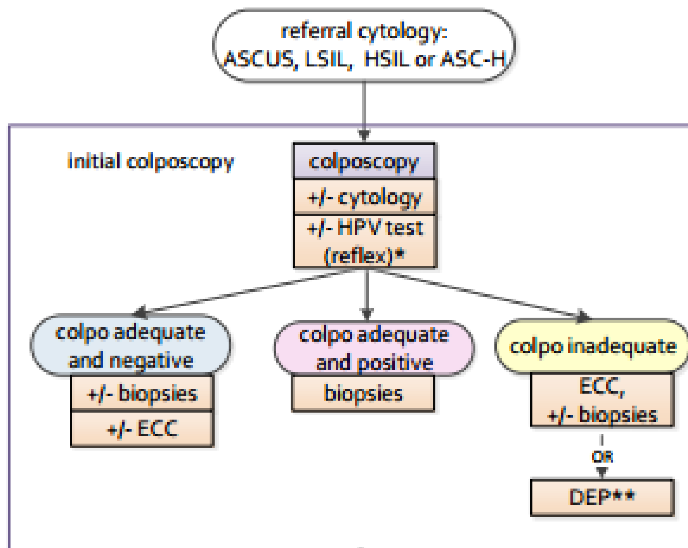
c) Discharge woman to screening annually in primary care

d) Follow-up in colposcopy in 12 months

e) DEP

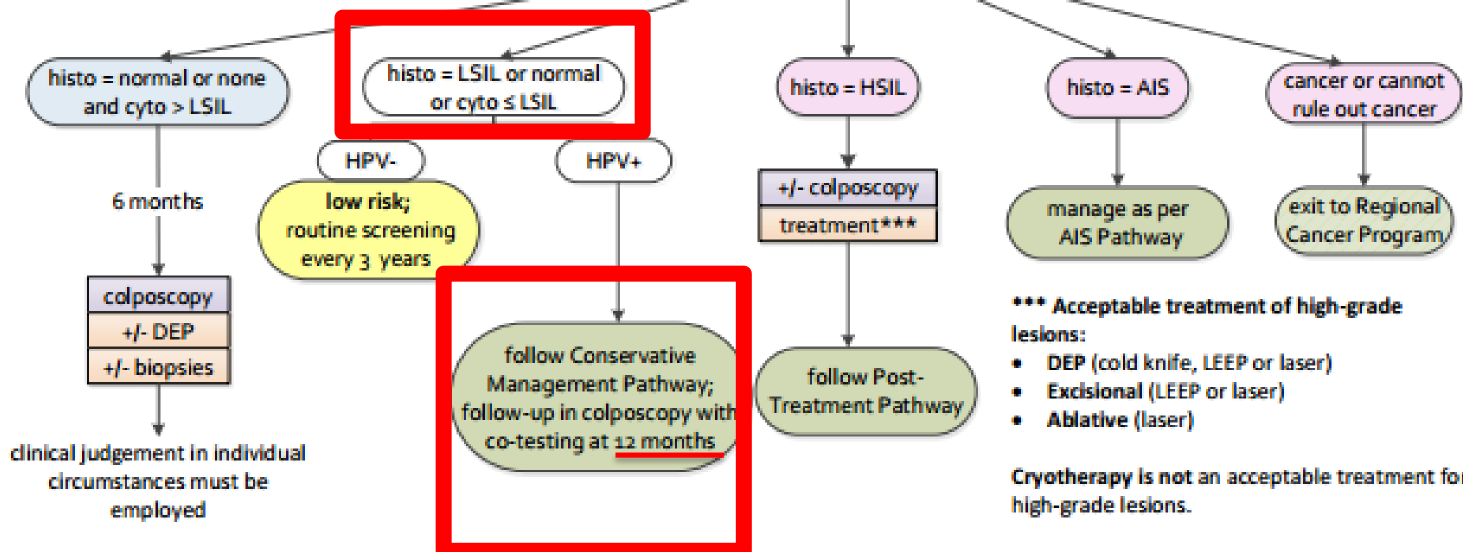
Case Study #2





*HPV reflex test should be completed only for women ≥ 30 with LSIL, ASCUS or normal cytology, and adequate and negative colposcopy. Or, if requested by clinician due to discordance.

**Consider DEP for inadequate colposcopy in high-grade referrals only.



*** **Acceptable treatment of high-grade lesions:**

- **DEP** (cold knife, LEEP or laser)
- **Excisional** (LEEP or laser)
- **Ablative** (laser)

Cryotherapy is not an acceptable treatment for high-grade lesions.

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Are some women discharged from colposcopy too soon?

DR. RACHEL KUPETS

Ontario

Cancer Care Ontario

Are Women Who Exit Colposcopy Without Treatment at Elevated Risk for Cervical Cancer?

Anna J. Koné Péfoyo, BEng, MSc, PhD,[1] Li Wang, MD, MSc,[2] Julia Gao, MSc,[2] and Rachel Kupets, MD, MSc[3]

Objective: This study aims to estimate the risk of cervical cancer and impact of treatment and other factors in women referred for high-grade (HG) and low-grade (LG) cytologic changes and discharged from colposcopy.
Materials and Methods: A retrospective cohort study identified 14,787 and 41,916 women with a first-time HG and LG cytologic abnormality between 2007 and 2010 and underwent colposcopy within 1 year. Treatment status was determined within the episode of care. Incidence of cervical cancer postcolposcopy was determined up to March 2015. Logistic regression assessed impact of colposcopic care and patient factors on cancer risk.

were respectively 8.1 per 100,000 and 2.2 per 100,000 in Canada.[3] The purposes of cervical cancer screening programs are to detect and to eliminate high-grade (HG) dysplastic changes on the cervix, thereby reducing invasive cervical cancer incidence.

The current process is to screen women with cytologic testing and refer those thought to be at elevated risk for severe dysplastic lesions to colposcopy for further evaluation. The risk of HG abnormalities varies with the index cytology result.[4]

The success of the screening process in reducing cancer risk resides in an appropriate management and treatment of the women within colposcopy. However, research has found some variations

Published in the Journal of Lower Genital Tract Disorders
January 2017

Introduction

- More than half of women are exited from colposcopy without undergoing treatment

- There are concerns that lesions may have been missed in untreated women who may continue to be at elevated risk of developing cervical cancer

Setting and Design

- This study is carried out in Ontario, which has 4.3 million screen eligible women aged 21-69
- Given our universal health care, all Ontario residents have a unique health care number which allows for linkage of multiple data bases which reflect health care utilization and cervical smear results
- This study is a population based retrospective cohort design carried out with the use of administrative data

Methods

- Study Cohort: women with a first time cytologic abnormality between 2007-2010 who were referred to colposcopy with one year of pap. No prior history of abnormal Pap results, colposcopy or treatment for dysplasia or cancer in 3 years prior
- Colposcopic episode end: no activity for 14 months
- Cohort followed until 2015
- Treatment status was determined with in colposcopic episode and cancer incidence was determined post episode

Characteristics of Women in the Cohort, by Initial Cytology

		High grade n (%)	Low grade n (%)
All women		14,787 (100)	41,916 (100)
Age groups			
	21-29	4346 (29.4)	17137 (40.9)
	30-39	4679 (31.6)	10645 (25.4)
	40-49	3276 (22.2)	8669 (20.7)
	50-59	1778 (12)	4160 (9.9)
	60-69	708 (4.8)	1305 (3.1)
Treatment within episode			
	Yes	9180 (62.1)	11949 (28.5)
	No	5607 (37.9)	29967 (71.5)
Number of colposcopies within episode			
	Initial only without treatment	2735 (18.5)	13848 (33.0)
	Initial only with treatment at some point	1449 (9.8)	1634 (3.9)
	Initial + 1 colposcopy with or without treatment	2917 (19.7)	9156 (21.8)
	Initial + 2 colposcopies with or without treatment	2391 (16.2)	5989 (14.3)
	Initial + 3 colposcopies with or without treatment	2016 (13.6)	4385 (10.5)
	Initial + 4 or more colposcopies with or without treatment	3279 (22.2)	6904 (16.5)
Occurrence of cancer			
	No	14170 (95.8)	41796 (99.7)
	Yes, within episode	527 (3.6)	86 (0.2)
	Yes, after episode	90 (0.6)	34 (0.1)

% of Women Exiting After an Initial Colposcopy and No Treatment, by Initial Cytology and Women's Characteristics

	Women with High grade (n=2735)	Women with Low grade (n=13,848)
All women	18.5	33.0
Age groups		
21-29	15.4	30.1
30-39	13.9	32.3
40-49	20.0	35.5
50-59	28.5	39.6
60-69	32.6	37.9
Residency		
Urban	18.2	33.0
Rural	20.5	33.1
Rural-remote or very remote	19.0	32.3
Area level income quintile		
1- highest income	19.2	35.1
2	19.0	32.7
3	18.7	32.2
4	17.7	33.1
5- lowest income	17.4	32.1

Percentage of Women with Treatment During Episode, by Characteristics

Characteristics	High grade	Low grade
Age groups	**(p<.0001)**	**(p<.0001)**
21-29	65.2	31.0
30-39	70.2	30.1
40-49	60.4	26.6
50-59	44.2	21.0
60-69	42.1	18.8
Residency	**p<.0001**	**p=.003**
Urban	62.9	28.7
Rural	56.9	27.9
Rural-remote or very remote (including territories)	57.5	25.6
Area level income quintile	p=0.253	**P<.0001**
1- highest income	63.0	28.7
2	62.8	29.8
3	61.6	29.9
4	62.7	27.5
5- lowest income	60.6	27.0
Number of colposcopies within episode	**(p<.0001)**	**(p<.0001)**
Initial only with or without treatment	34.6	10.6
Initial + 1 colposcopy with or without treatment	55.4	22.1
Initial + 2 colposcopies with or without treatment	70.1	32.9
Initial + 3 colposcopies with or without treatment	81.0	45.0
Initial + 4 or more colposcopies with or without treatment	85.5	62.9

Percentage of Women with Cancer After Episode, by Characteristics

Characteristics		High grade	Low grade
Age groups		**(p <.0001)**	(p=0.199)
	21-29	0.2	0.05
	30-39	0.6	0.08
	40-49	0.7	0.1
	50-59	1.0	0.1
	60-69	1.7	0.2
Residency		p=0.288	p=0.718**
	Urban	0.6	0.08
	Rural	0.9	0.1
	Rural-remote or very remote (including territories)	0.4	0.12
Area level income quintile		p=0.693	p=0.806
	1- highest income	0.7	0.06
	2	0.7	0.1
	3	0.7	0.08
	4	0.5	0.07
	5- lowest income	0.6	0.1
Number of colposcopies within episode		**(p<.0001)**	**(p=0.04)**
	Initial only without treatment	2.0	0.14
	Initial only with treatment at some point	0.4	0.12
	Initial + 1 colposcopy with or without treatment	0.4	0.04
	Initial + 2 colposcopies with or without treatment	0.2	0.07
	Initial + 3 colposcopies with or without treatment	0.4	0.02
	Initial + 4 or more colposcopies with or without treatment	0.1	0.04
Treatment within episode		**(p<.0001)**	(p=0.895)
	No	1.1	0.08
	Yes	0.3	0.08

What impacts Risk of Cervical Cancer After Exit? High grade Initial Cytology

	OR	95% CI
Treatment (crude OR)		
No	3.8	(2.4; 6.0)
Treatment by number of colposcopies (adjusted OR)*		
No treatment and Initial colpo only	6.6	(3.9; 11.0)
Treatment and Initial colpo only	1.5	(0.6; 3.7)
No treatment and initial + one or more follow-up colpo	1.1	(0.5; 2.4)
Treatment and initial + one or more follow-up colpo	1	
Age		
21-29	1	
30-39	2.9	1.4; 6.0
40-49	2.6	1.2; 5.6
50-59	3.1	1.4; 6.8
60-69	4.7	2.0; 11.2
Income quintiles		
1- highest income	1	(0.5; 1.9)
2-	0.9	(0.5; 1.8)
3-	0.6	(0.3; 1.3)
4-	0.8	(0.4; 1.6)
5- lowest income	1.0	(0.5; 1.9)
Residency		
Urban	1	
Rural	1.4	(0.7; 2.9)
Rural-remote	0.6	(0.2; 1.5)
Pap after colposcopy**		
No	2.0	(1.2; 3.2)

What impacts Risk of Cervical Cancer After Exit? Low grade Initial Cytology

	OR	95% CI
Treatment (crude OR)		
No	0.9	(0.5; 2.0)
Treatment by number of colposcopies (adjusted OR)*		
no treatment and Initial colpo only	1.8	(0.8; 4.1)
Treatment and Initial colpo only	1.6	(0.3; 7.6)
No treatment and initial + one or more follow-up colpo	0.3	(0.1; 1)
Treatment and initial + one or more follow-up colpo	1	
Age		
21-29	1	
30-39	1.6	0.6; 4.0
40-49	1.9	0.7; 4.8
50-59	1.7	0.5; 5.5
60-69	3.9	1.0; 14.6
Income quintiles		
1- highest income	1	
2-	1.9	(0.6; 6.4)
3-	1.6	(0.5; 5.5)
4-	1.3	(0.4; 4.6)
5- lowest income	2.0	(0.6; 6.4)
Residency		
Urban	1	
Rural	1.3	(0.3; 5.3)
Rural-remote	1.6	(0.5; 5.4)
Pap after colposcopy		
No	1.8	0.7; 4.7

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Study Conclusions

- This study represents a cohort of 56 703 women who initiated a colposcopic episode of care between 2007-2010
- Women referred to colposcopy for a high grade Pap smear and are discharged without treatment are at elevated risk of cervical cancer; 1.1% vs. 0.3% for those who undergo treatment
- Women referred for a low grade dysplasia who are discharged without treatment are NOT at elevated risk

Study Conclusions

- Currently due to the fragmented screening program in many jurisdictions in Canada, there is not an integrated cervical cancer screening program which allows women to transition easily between screening, colposcopy, surveillance and back to screening again
- Proper exit strategies from colposcopy need to be established for treated and untreated women
- Appropriate recommendations need to be provided by colposcopists regarding follow-up, frequency of screening post-colposcopy to primary care physicians, and women

Questions and Comments

Exit Poll – 4 questions

- Please respond to the following questions
- You will have 1 minute per question

Please do not log off after the exit poll – stay tuned for important information on upcoming Colposcopy CoP events!

Poll 1

1. I know where to and/or have accessed current colposcopy guidelines on the CCO website.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Poll 2

2. I will alter my practice to align with current CCO colposcopy guidelines.

- ○ Strongly disagree
- ○ Disagree
- ○ Neutral
- ○ Agree
- ○ Strongly Agree

Poll 3

3. I know where to and/or have accessed the online colposcopy toolkit on the CCO website.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Poll 4

4. In my practice, I will use resources for colposcopy providers from CCO's online colposcopy toolkit.

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

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 ?? hours (credits are automatically calculated).

What’s Next

- Next meeting of the CoP will take place in **November/December 2017**
- Proposed topics include:
  - HPV testing
  - Colposcopy quality indicators
  - Benchmarks and organizational standards
- Your regional Cervical Screening / Colposcopy Lead (CSCL) will be in contact with you

Ontario Cervical Screening / Colposcopy Leads

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Scientific Lead	Rachel Kupets	Rachel.kupets@cancercare.on.ca
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LHIN 4 - Hamilton Niagara Haldimand Brant	Dustin Costescu	costescu@hhsc.ca
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LHIN 13 – North East	Jennifer Jocko	jennjocko@gmail.com
LHIN 14 - North West	Naana Jumah	njumah@nosm.ca

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What's Next

We welcome your feedback!
Please fill out the online evaluation that will be emailed to you.

You can always reach us through email at ColposcopyCoP@cancercare.on.ca.

Thank you!

Thank you!