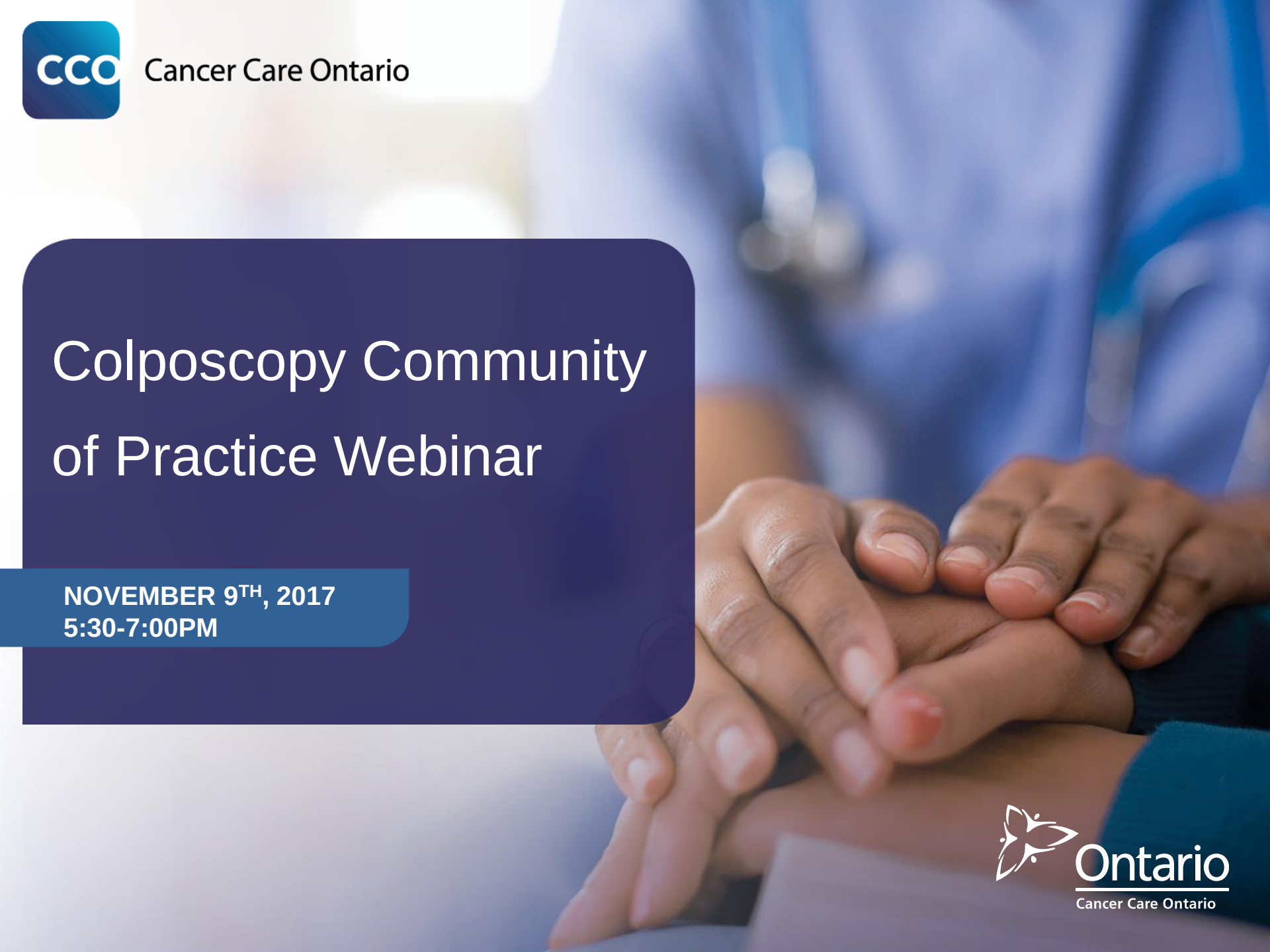
Cancer Care Ontario

Colposcopy Community of Practice Webinar

NOVEMBER 9TH, 2017
5:30-7:00PM



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Housekeeping Items

- If you a unable to hear us, please dial-in:
  - **416-620-7077 / 1-866-834-7685**
  - **Access code: 255 6848**
- Please use the chat box or the “Raise Hand” function in your window to alert us if you have a question or comment
- We have muted the line – if you have questions, press *7 to unmute yourself.
- 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 online

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

Welcome to the Colposcopy Community of Practice

About the Colposcopy CoP

- First webinar was held in September 2016, and the second was in June 2017

- 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 Royal College of Physicians and Surgeons Accredited Group learning Activity – we will issue you a letter of accreditation for 1.5 credit hours if you:
  1. Participate in today's event,
  2. Register as a member of the Colposcopy CoP, and
  3. Complete and submit the post-webinar evaluation survey.

Have questions? Email us!
ColposcopyCoP@cancercare.on.ca

Poll 1

1. I use the best practice pathways as recommended by the *Colposcopy Clinical Guidance Document* in my practice on a regular basis:

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly Agree

Poll 2

2. The Government of Ontario recently announced their intention to fund HPV testing. Do you know how HPV testing will affect your clinical practice?

a) I have a thorough understanding
b) I somewhat understand
c) I am unclear on how it will impact one of these criteria (entry or exit)
d) I am unclear on how it will impact my practice

Poll 3

3. I am aware of the indications for HPV testing in colposcopy as outlined in the *Colposcopy Clinical Guidance Document.*

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly Agree

Poll 4

4. Standardized terminology is important to me in interpreting and acting on cytology and histology reports.

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly Agree

Today's Agenda

Item	Presenter
Welcome and Introductions (Live web poll!)	Dr. Joan Murphy
Overview of Objectives and Agenda	
Cervical Screening Program Updates	
Appropriate Use of HPV Testing in Colposcopy + Q&A	
Case Studies (Live web poll!)	Dr. Julie Francis CSCL, South West LHIN
Standardized Terminology in Colposcopy + Q&A	Dr. Hector Li-Chang
Concluding remarks (Live web poll!)	Dr. Joan Murphy

Learning Objectives

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

- Appropriate use of HPV testing in colposcopy in Ontario
- Evidence-based management of patients in colposcopy as recommended in the *Colposcopy Clinical Guidance Document*
- Importance of using standardized cytology and histology terminology – for clinical communication and program management

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Cervical Screening and Colposcopy Updates

DR. JOAN MURPHY

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HPV Vaccination Update

HPV9 Vaccine Now Available

- Beginning in September 2017, all boys and girls in Grade 7 will be offered the HPV9 vaccine
- Students who were eligible for HPV vaccine prior to the 2017/2018 school year and have not started or completed their HPV immunization series will continue to be eligible for the HPV4 vaccine
- In June, Public Health Ontario released a school-based program update report, “Immunization Coverage Report for School Pupils in Ontario”, which can be found at www.publichealthontario.ca

HPV Testing in Ontario

In April 2017, the Government of Ontario announced its intention to fund HPV testing per program guidelines:

Modernizing and Enhancing Cancer Screening

Ontario continues to modernize and enhance cancer screening programs to enable early identification and treatment based on the latest evidence. Working with Cancer Care Ontario, the Province will modernize two primary cancer screening tests and develop a new screening program for those at high risk of developing lung cancer. These tests, based on the latest technology, include modernizing colorectal cancer screening from the existing fecal occult blood test (FOBT) to the fecal immunochemical test (FIT), and the primary screening test for cervical cancer from the existing Papanicolaou (Pap) test to the human papillomavirus (HPV) test for women aged 30 to 69. In addition, the Province will launch a lung cancer screening project for people at high risk at three pilot sites: The Ottawa Hospital, Health Sciences North and Lakeridge Health.

HPV testing in Ontario: The Future

- CCO is working closely with the Ministry of Health and Long-Term Care to plan for the implementation of HPV testing in the Ontario Cervical Screening Program
- Programmatic implementation of HPV testing is a complex, large-scale system level project
- CCO and the MOHLTC are currently in the planning stages of this multi-year project

Colposcopy Clinical Guidance Document: Feedback Received

Updates to the *Colposcopy Clinical Guidance Document* will be coming in 2018!

- Thank you for submitting feedback through your CSCL, our survey, or directly to the CoP inbox.

- OCSP met with the Clinical Expert Advisory Group (CEAG) over the summer to finalize changes

- To align the use of HPV testing in screening and colposcopy settings, the next version of the *Document* will be released in conjunction with updated cervical screening guidelines in 2018

CoP members will be the first to know!

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Appropriate Use of HPV Testing in Colposcopy*

DR. JOAN MURPHY

*Source: Colposcopy Clinical Guidance Document (2016)

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HPV Testing in Colposcopy

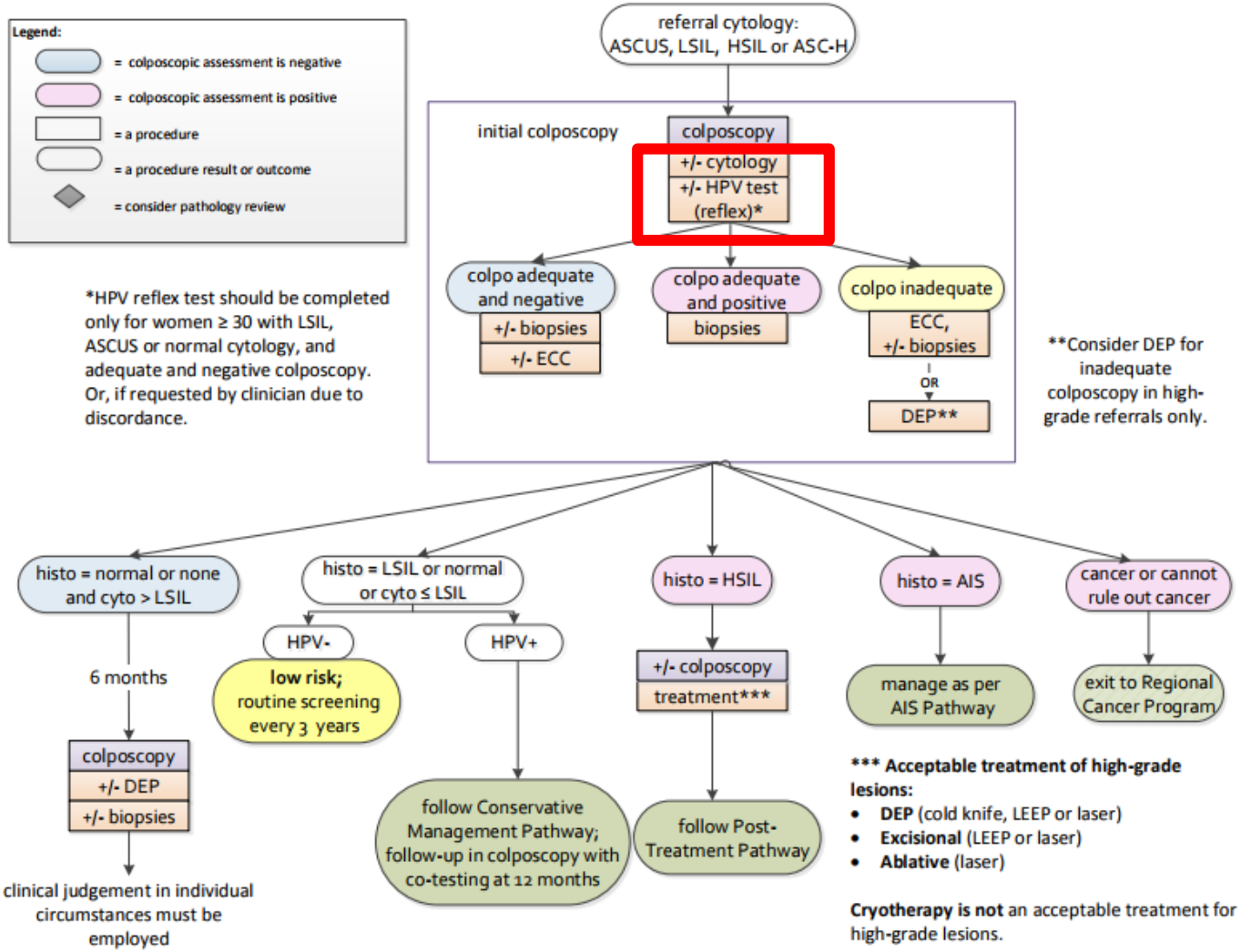
Referral Cytology

- HPV testing is not indicated for women with high-grade cytology
- HPV reflex test should be done only for women >30 with LSIL, ASCUS or normal cytology
- If cytology shows HSIL, hrHPV positivity should be assumed and HPV testing is not indicated.

HPV Status

- If HPV status unknown at time of referral, HPV reflex testing should be done where indicated (as above)
- If HPV status known, HPV testing should not routinely be repeated

Workup, Management and Treatment for SIL Referral



HPV Testing –Discharge from Colposcopy

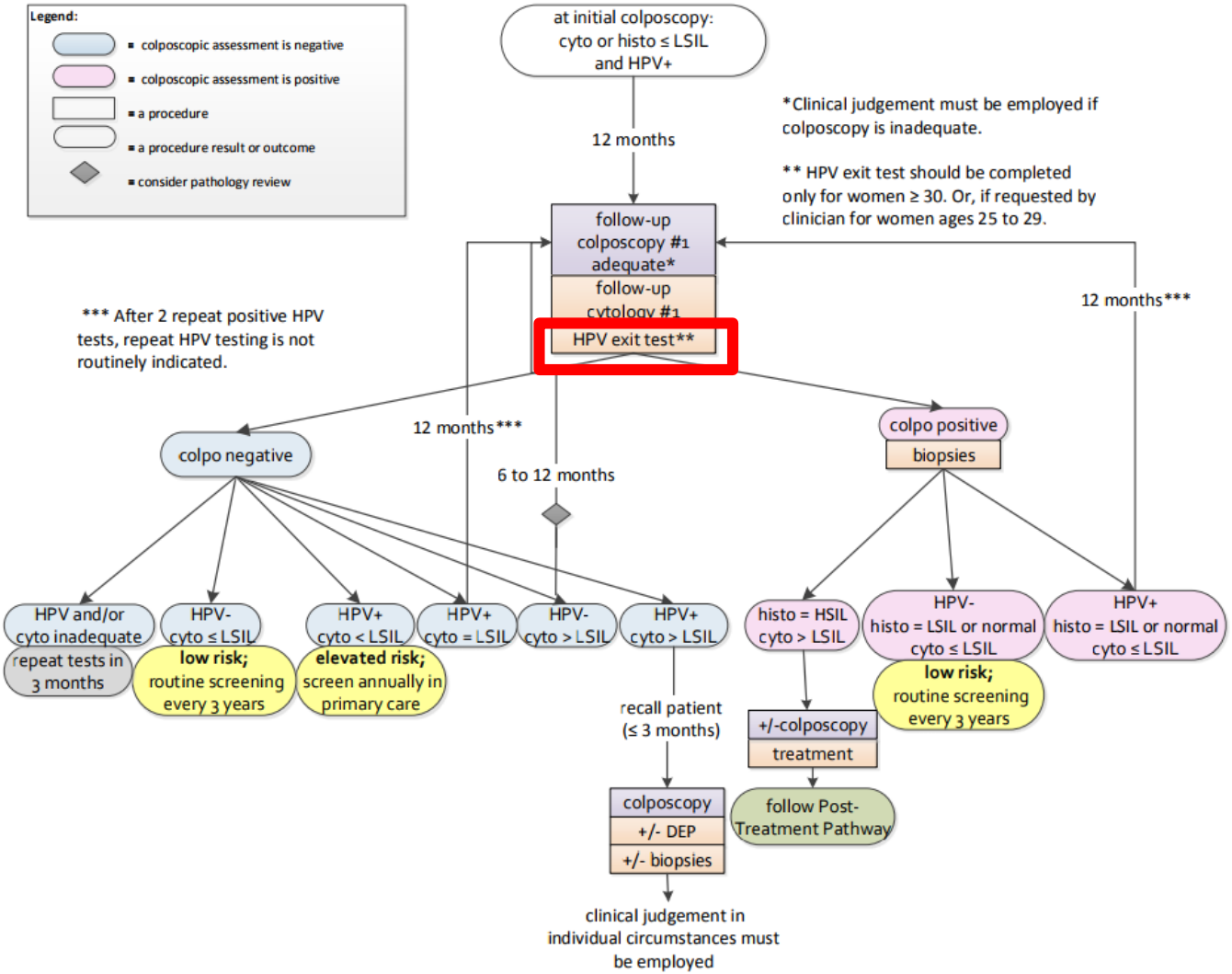
Conservative Management

- Exit testing can be performed in **conservative management** at the first follow-up visit at 12 months

Post-Treatment

- Exit testing can be performed at the second **post-treatment** follow-up visit (12-18 months post-treatment) to inform discharge and post-colposcopy management
- For women having 2 consecutive positive HPV tests (12 months apart), no further HPV testing should normally be done
- An HPV test should be completed for women post-treatment regardless of age

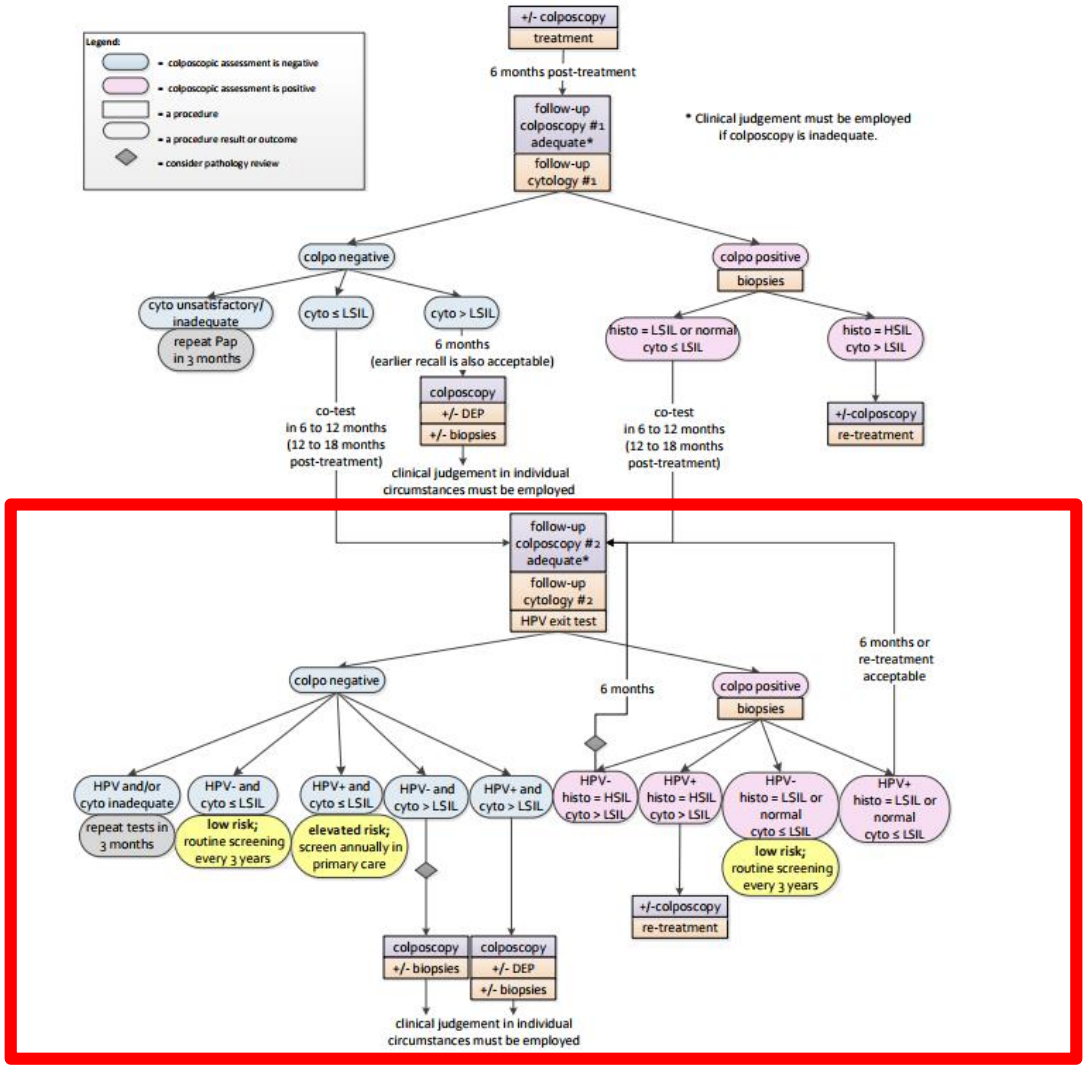
Conservative SIL Management



Post-Treatment SIL Management

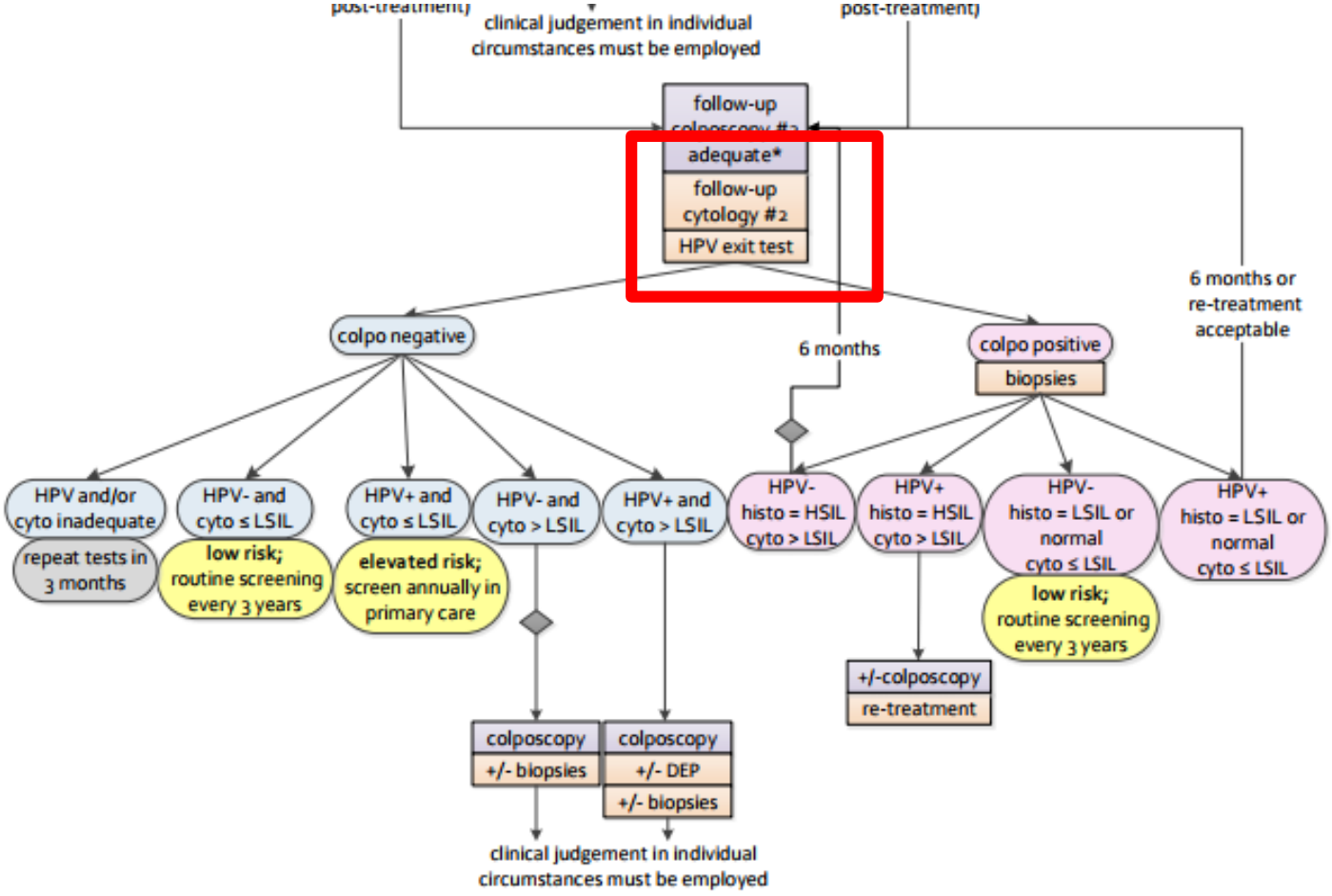
First follow-up visit

Second follow-up visit



Post-Treatment SIL Management

Second follow-up visit



Recommended Practice: Risk-Based Screening/Surveillance

At entry:

- Women over 30 with low-grade cytologic abnormalities who test **negative for HPV** can be discharged to primary care for **routine, triennial screening**

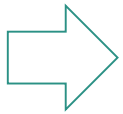
At discharge:

Treated women ages **21 – 69**:

- **HPV negative**, and
- cytology is normal, ASCUS, or LSIL.

Untreated women ages **30 – 69**:

- **HPV negative**, and
- cytology is normal, ASCUS, or LSIL.



Low Risk

Return to routine screening with triennial Pap

Recommended Practice: Risk-Based Screening/Surveillance

At discharge:

Treated women ages **21 – 69**:
- **HPV positive**,
- No visible lesion, and
- Cytology is normal, ASCUS, or LSIL.

Untreated women ages **30 – 69**:
- **HPV positive**,
- No visible lesion, and
- Cytology is normal, ASCUS.

Elevated Risk

Return to surveillance with annual Pap

Pop quiz!

A 31 year old woman is referred to colposcopy with LSIL cytology and has an HPV status known to be positive. The HPV test is from 2 years ago. What are your next steps?

Pop quiz!

A 32 y/o old referred to colpo: cyto = LSIL; HPV positive. HPV test is from 2 years ago. What are your next steps?

A) Repeat HPV testing

B) Colposcopy

C) Decline referral

D) A and B

Pop quiz!

Results: colpo negative, HPV negative, cyto = LSIL. What is your recommended next step?

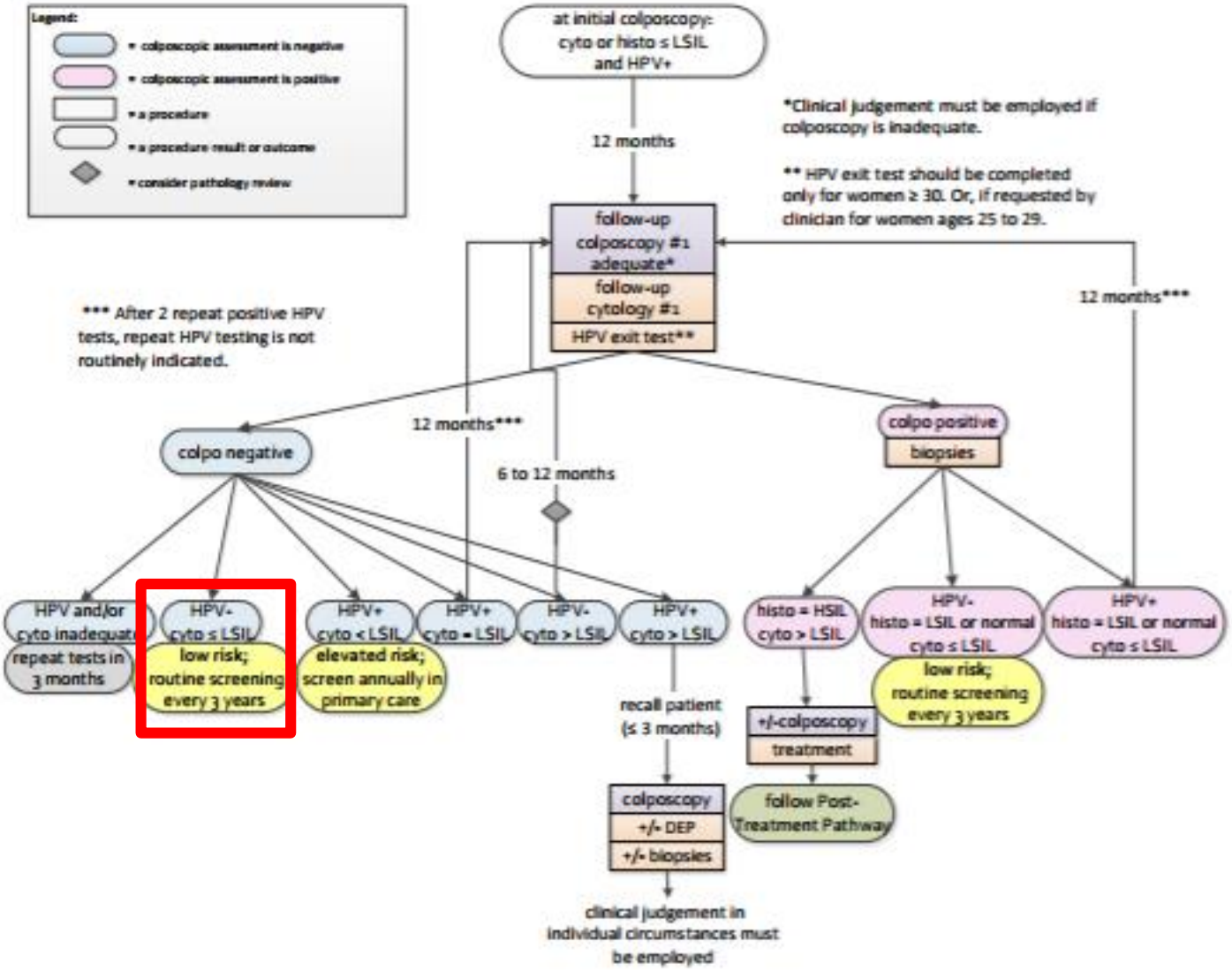
A) Return to annual surveillance

B) Return to routine screening

C) F/U colpo 6 months

D) F/U colpo in 12 months

Pop Quiz Answer



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Clinical Management in Colposcopy: Case Study #1

DR JULIE FRANCIS

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Case Study #1

Patient:

- 36 y/o G2P1A1
- IUS is present
- Patient due for cervical screening; Pap test done
- Patient has not completed childbearing and hopes for another pregnancy in 2-3 years
- BMI 40

Case Study #1

Q1: AGC-NOS on Pap test. What are the next clinical steps?

A) Repeat Pap in 3 months

B) HR HPV test

C) Colposcopy

D) Repeat Pap in 6 months

E) Hysterectomy

Case Study #1

Colposcopic exam shows:

- Vulva and vagina look normal
- Colposcopy with acetic acid performed
- She has a Type 2 transformation zone with part of the SCJ in canal
- There is an acetowhite lesion with punctation at 1 o'clock with the entire lesion visible
- Colposcopic impression is HSIL
- IUS strings are present

Case Study #1

Q2: At this visit, what tests do you order?

A) HR HPV Test & Repeat Pap

B) HR HPV Test, Colpo Biopsy, ECC

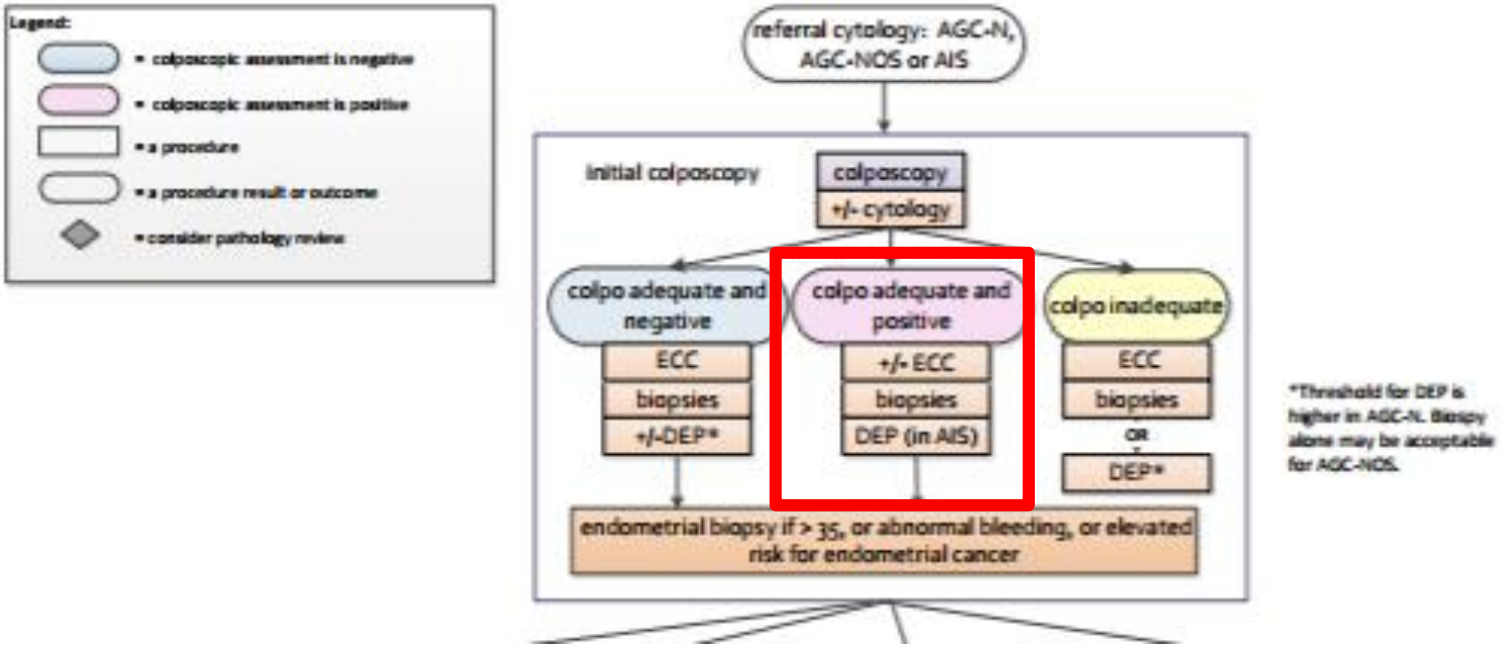
C) Pelvic U/S, Colpo Biopsy, ECC

D) Colpo Biopsy, +/-ECC, +/- Endometrial biopsy

E) Colpo Biopsy & ECC

Case Study #1

Answer: Colpo Biopsy, +/-ECC, +/-Endometrial biopsy



Case Study #1

Colpo Biopsy, ECC and Endometrial biopsy results:

- Biopsy shows LSIL
- ECC shows AIS
- Endometrial biopsy is normal

Case Study #1

Q3: What is the recommended next step (Biopsy=LSIL, ECC=AIS):

A) Repeat colpo in 6 months

B) DEP (LEEP)

C) DEP (cold knife cone)

D) Hysterectomy

E) B or C

Case Study #1

Answer: LEEP or Cold Knife

Considerations for Diagnostic Excisional Procedure:

- LEEP is an acceptable treatment if an intact specimen with interpretable margins can be provided
- Cold knife cone is an acceptable option
- Highest priority is an optimal specimen for pathologic assessment

Case Study #1

Q4: IUS removed. LEEP, histo = AIS, negative margins. What are your recommendations:

A) Hysterectomy

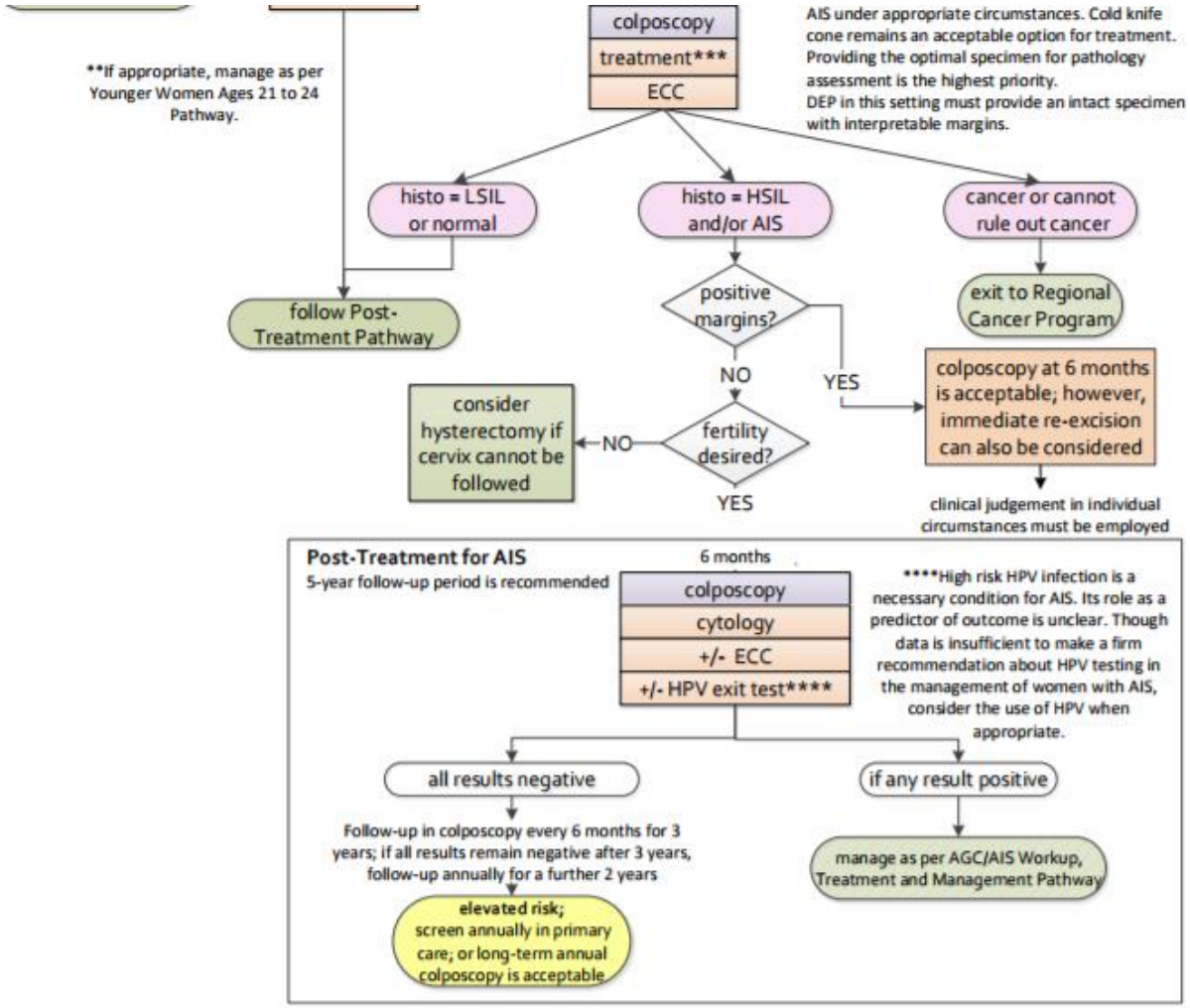
B) Colpo at 3 months

C) Colpo at 6 months

D) HR HPV test with next exam

Case Study #1

Answer: Colposcopy at 6 months



Case Study #1

Q5: 3 years later, childbearing complete. Type 3 t-zone. Next steps:

A) Colpo, cyto, ECC

B) Advise hysterectomy

C) Repeat LEEP/Cone

Case Study #1

What about the IUS strings?

Issues:

- Ability to provide intact specimen
- Concerns for infection
- Cutting strings and difficulty removing
- Unintended pregnancies if removed

Case Study #1

IUS and LEEP

- For glandular abnormality : consensus to remove and replace later because of need for deep enough specimen
- For squamous abnormalities that are visible:
- Remove and **offer alternative contraception** until replacement or
- Tuck strings in with Q tip
- Take specimen from two sides taking care to avoid cutting strings

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Terminology

HECTOR LI-CHANG MD FRCPC
PATHOLOGIST
ROYAL VICTORIA REGIONAL HEALTH CENTRE - BARRIE
DEPARTMENT OF PATHOLOGY AND LABORATORY
MEDICINE - UNIVERSITY OF BRITISH COLUMBIA

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Terminology - What's in a name?

Important that we all speak the same language

Clinicians are from Mars and pathologists are from Venus: Clinician interpretation of pathology reports

Seth M. Powsner, Jose Costa and Robert J. Homer

Archives of Pathology & Laboratory Medicine. 124.7 (July 2000): p1040.

- "language of pathologists is arguably furthest from daily medical discourse"
- Misunderstanding in 30% of reports

Terminology - What's in a name?

- The Bethesda System (TBS) and Lower Anogenital Squamous Tract (LAST) publications aim to standardize terminology

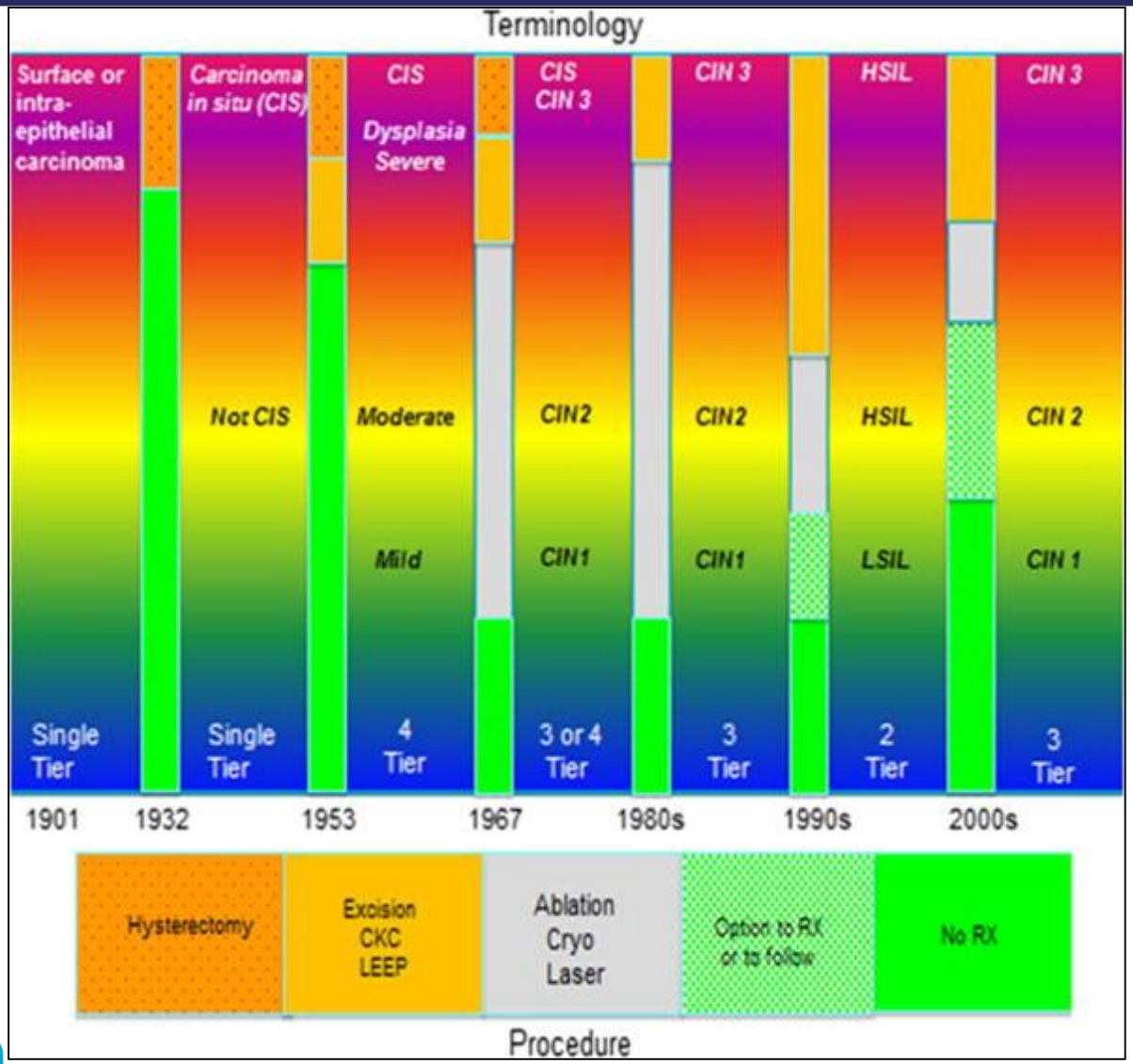
- Standardized terminology essential for:
  - Guiding clinical management

  - Preventing confusion among caregivers and patients
    "Mild to moderate dysplasia" - *??*
    "Carcinoma in situ" - *"Do I have cancer now?"*

  - Reliable results in epidemiologic studies

  - Programmatic considerations

Terminology - Evolution over Time



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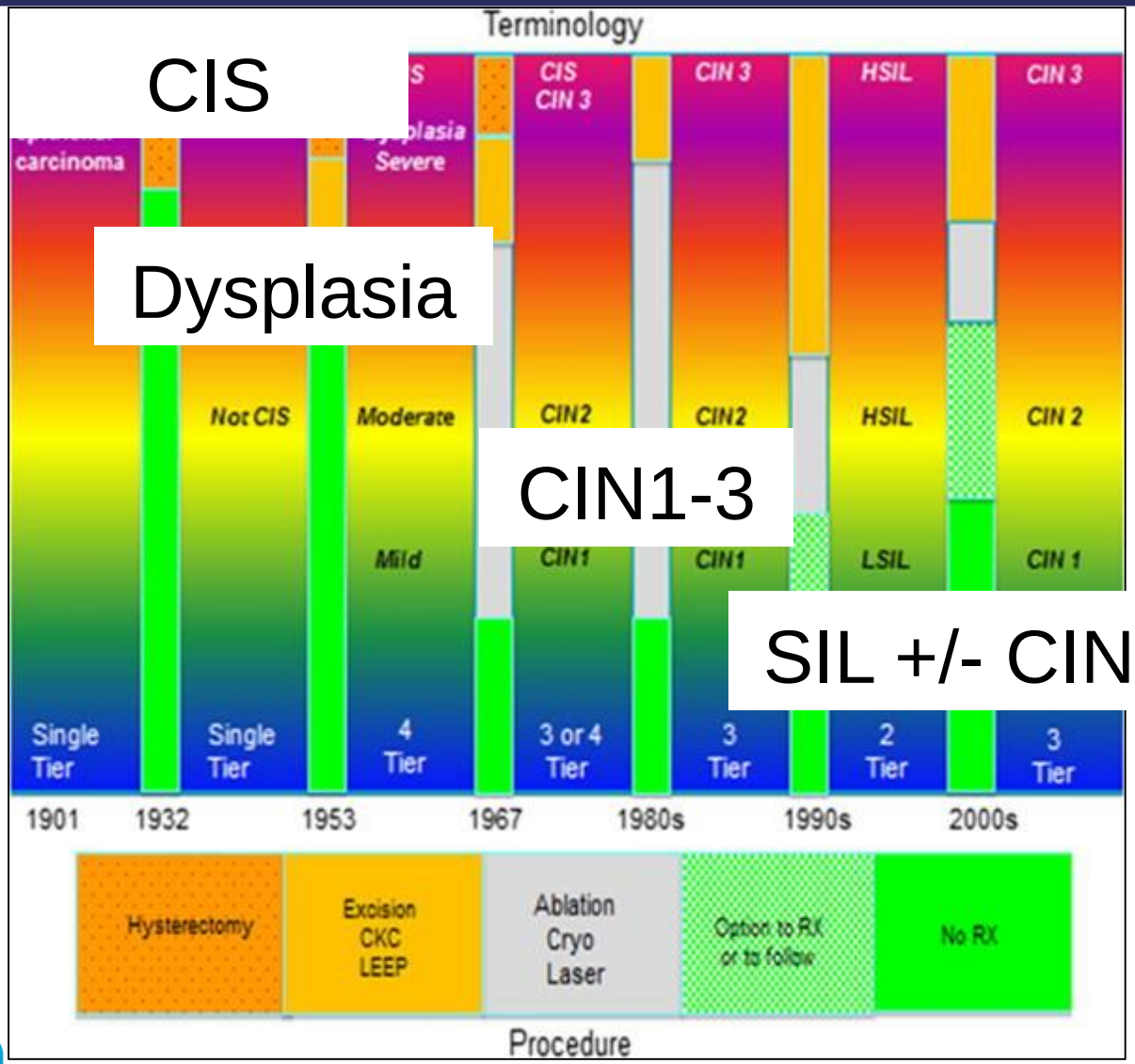
Darragh et al, *Int J Gynecol Pathol*. 2012

Terminology - Evolution over Time



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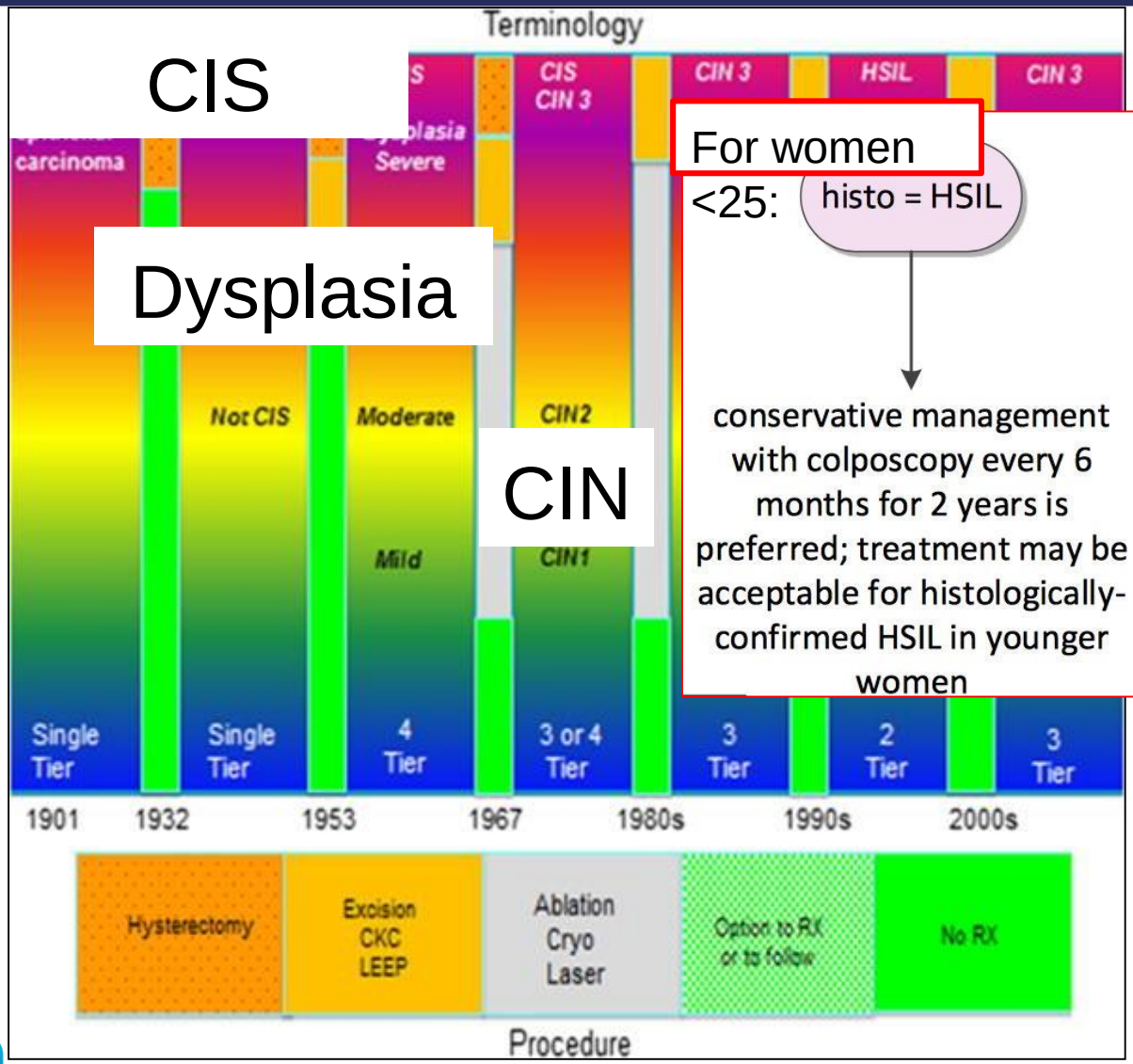
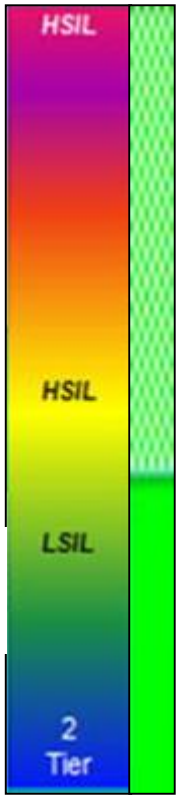
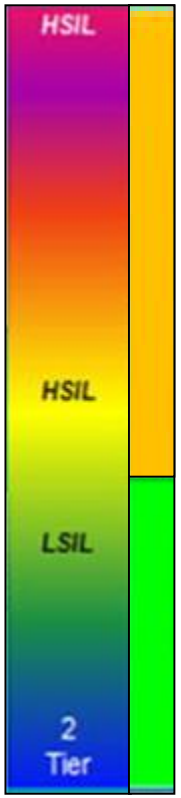
Terminology - Evolution over Time



For women <25: histo = HSIL

conservative management with colposcopy every 6 months for 2 years is preferred; treatment may be acceptable for histologically-confirmed HSIL in younger women





<25 >=25

Darragh et al, *Int J Gynecol Pathol*. 2012

Terminology - Current Best Practice

- Use two-tier SIL categorization as much as possible
  - Cyto: ASCUS and ASC-H where appropriate

- Avoid use of CIN2
  - Not reproducible
  - No longer relevant for clinical practice (not even in younger women)

- Avoid use of “carcinoma in situ”
  - Biologically equivalent to HSIL and not reproducible
  - Potential for misunderstanding

- Superficially invasive squamous cell carcinoma (SISCCA)
  - Preferred instead of “minimally invasive SCC”

A problematic case...

- 27 year old woman
- Cytology: HSIL
- Biopsy: “Mild to moderate dysplasia - CIN1-2”

A problematic case...

Patient: 27y/o; cyto=HSIL; biopsy = “mild to moderate dysplasia, CIN1-2”. How would you manage this patient?

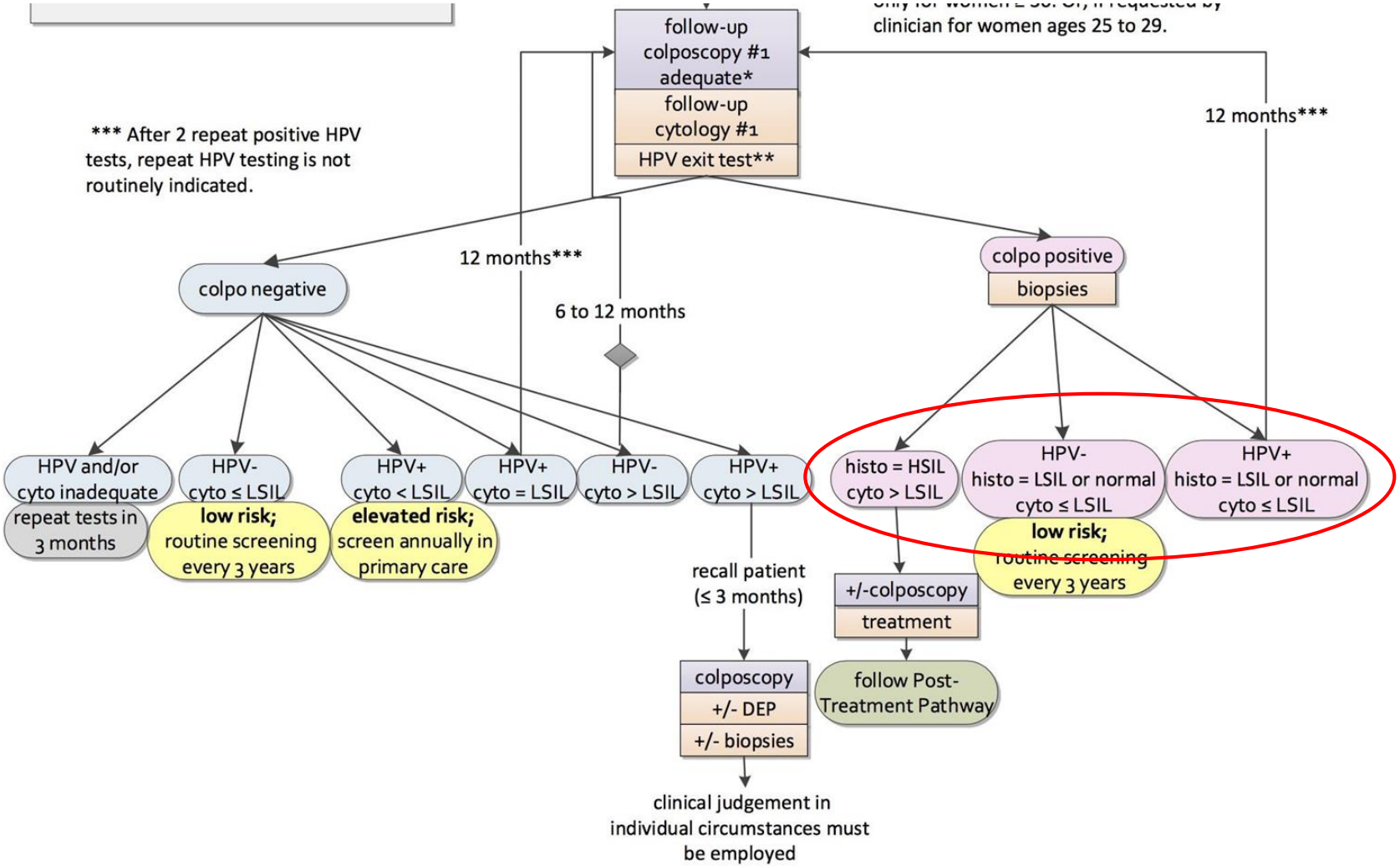
a) Manage as LSIL
b) Manage as HSIL
c) Call pathologist
d) Request review by expert
e) C or D

A problematic case...

ANSWER: Consider contacting pathologist and/or expert

- Pathologists are *usually* happy to learn and discuss cases
- Opportunity to bring colleagues up to speed on current best practices
- Occasional cases defy clear cut categorization, even after ancillary studies and expert consultation
  - Perhaps HR HPV testing helps adjudicate

A problematic case



Terminology - Problem Areas

1. **Adequate vs. Sufficient vs. Satisfactory**

2. **“LSIL cannot rule out HSIL”**

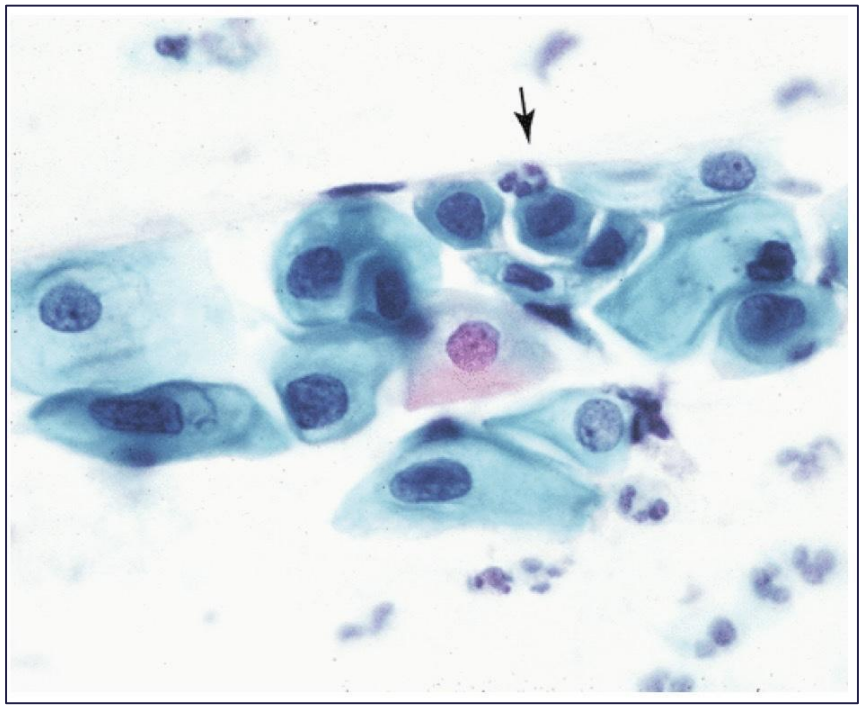
Adequacy

- Satisfactory/adequate vs sufficient
  - Other causes of unsatisfactory/inadequate specimen other than number of cells
  - Obscuring factors
  - Error/mislabelling

- Transformation zone/endocervix
  - May be absent (insufficient) but still satisfactory

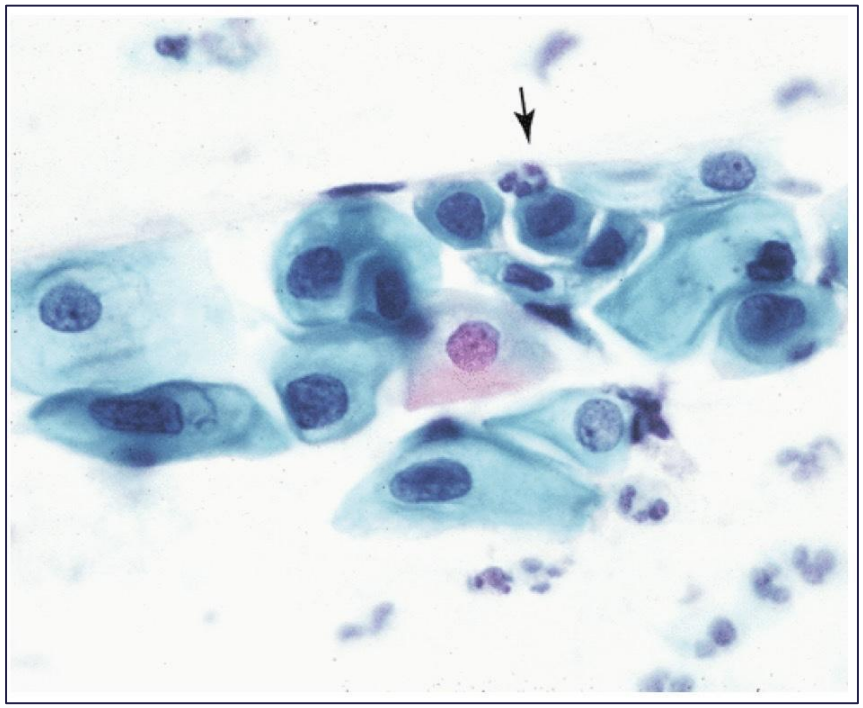
“LSIL cannot rule out HSIL”

- Intermediate diagnosis
  - Usually = LSIL + ASC-H
  - High-rates of subsequent HSIL on biopsy
- Avoid as much as possible → HSIL



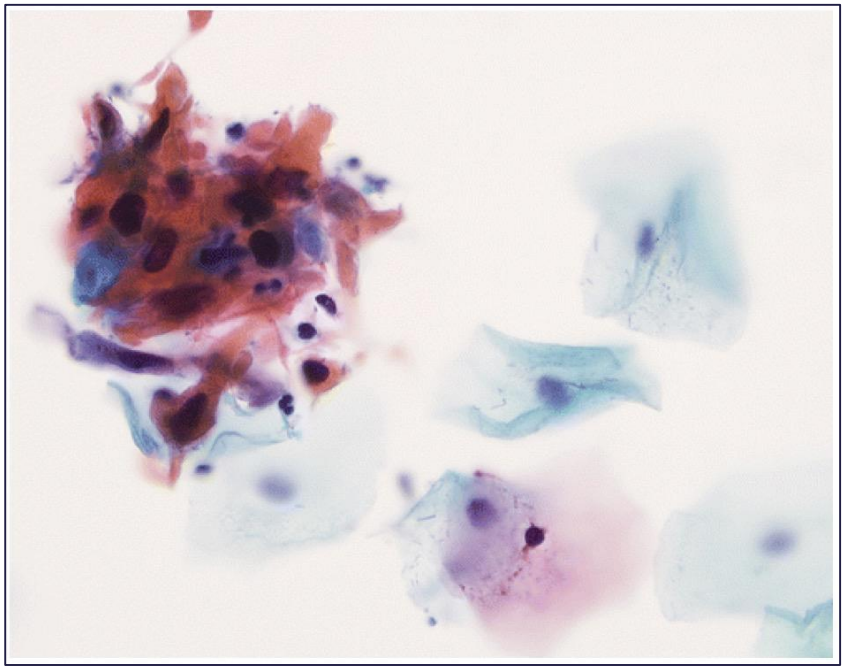
“LSIL cannot rule out HSIL”

- If necessary to use this term: add comment
  - Usually clarify that management should be as for HSIL/ASC-H



Another problematic case...

- 38 year old woman
- Colposcopy Negative
- Cytology: “LSIL, cannot rule out HSIL” - No further comment

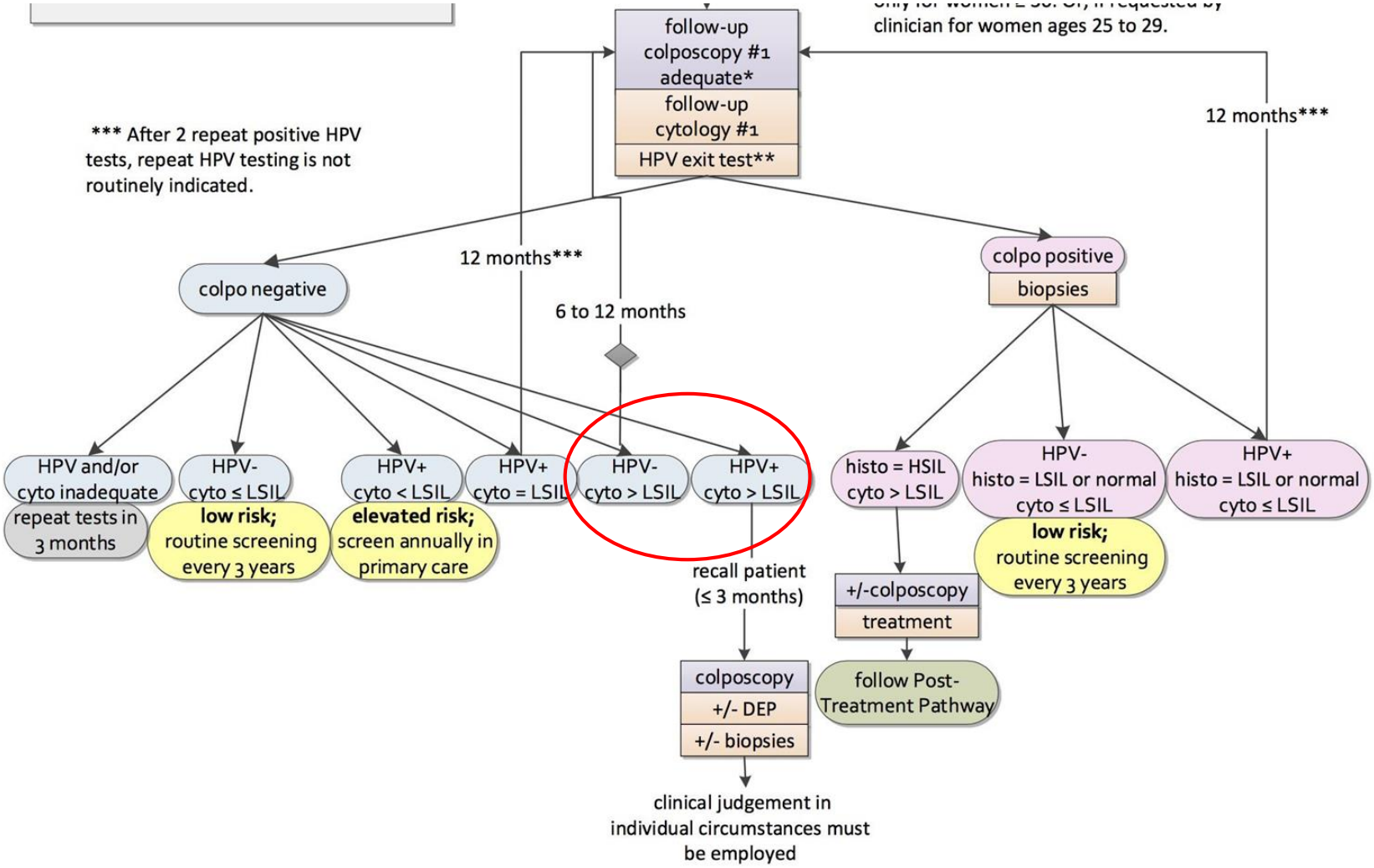


Another problematic case...

What are your recommended next steps? (38 y/o; colpo negative; cyto = LSIL cannot rule out HSIL)

a) Manage as LSIL
b) Manage as HSIL/ASC-H
c) HR HPV testing, if available
d) Call pathologist
e) Request review by expert
f) C, D and E

Another problematic case



Questions/Discussion

"I've narrowed the diagnosis down to 16 possibilities."

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Clinical Management in Colposcopy: Case Study #2

DR JULIE FRANCIS

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Case Study #2

Patient:

- 65 year old G2P2 woman
- Referred with LSIL cytology
- At first colpo visit, colpo satisfactory:
  - HR HPV positive
  - Histology is normal

Case Study #2

Q1: What are your recommendations? (LSIL referral; Histo = normal; HPV positive)

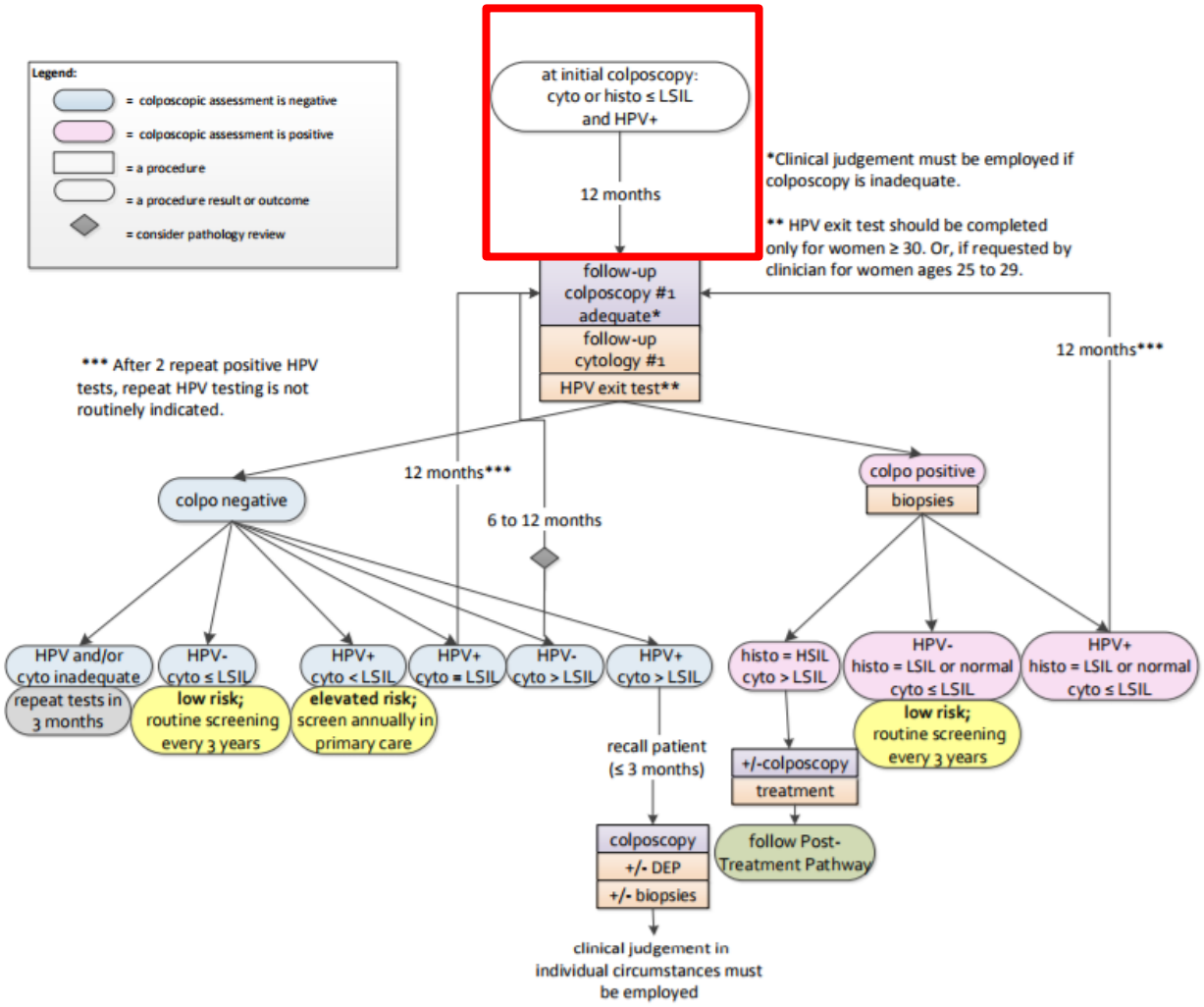
A) F/U colpo in 12 months

B) Discharge to annual surveillance

C) Treat

D) None of the above

Case Study #2


Legend:
= colposcopic assessment is negative
= colposcopic assessment is positive
= a procedure
= a procedure result or outcome
= consider pathology review
at initial colposcopy: cyto or histo ≤ LSIL and HPV+
12 months
*Clinical judgement must be employed if colposcopy is inadequate.
** HPV exit test should be completed only for women ≥ 30. Or, if requested by clinician for women ages 25 to 29.
follow-up colposcopy #1 adequate*
follow-up cytology #1
HPV exit test**
*** After 2 repeat positive HPV tests, repeat HPV testing is not routinely indicated.
12 months***
12 months***
6 to 12 months
colpo negative
colpo positive biopsies
HPV and/or cyto inadequate
repeat tests in 3 months
HPV- cyto ≤ LSIL
low risk; routine screening every 3 years
HPV+ cyto < LSIL
HPV+ cyto = LSIL
elevated risk; screen annually in primary care
HPV- cyto > LSIL
HPV+ cyto > LSIL
recall patient (≤ 3 months)
colposcopy
+/- DEP
+/- biopsies
clinical judgement in individual circumstances must be employed
histo = HSIL cyto > LSIL
+/-colposcopy
treatment
follow Post-Treatment Pathway
HPV- histo = LSIL or normal cyto ≤ LSIL
low risk; routine screening every 3 years
HPV+ histo = LSIL or normal cyto ≤ LSIL

Case Study #2

Q2: At 12-month follow-up, what do you recommend?

A) Cytology

B) HR HPV test

C) Biopsy, if lesion seen

D) A and C only

E) A, B and C

Case Study #2

Q3: Results: HPV positive, biopsy=HSIL. What would be your recommended next step?

A) F/U in colpo in 12 months

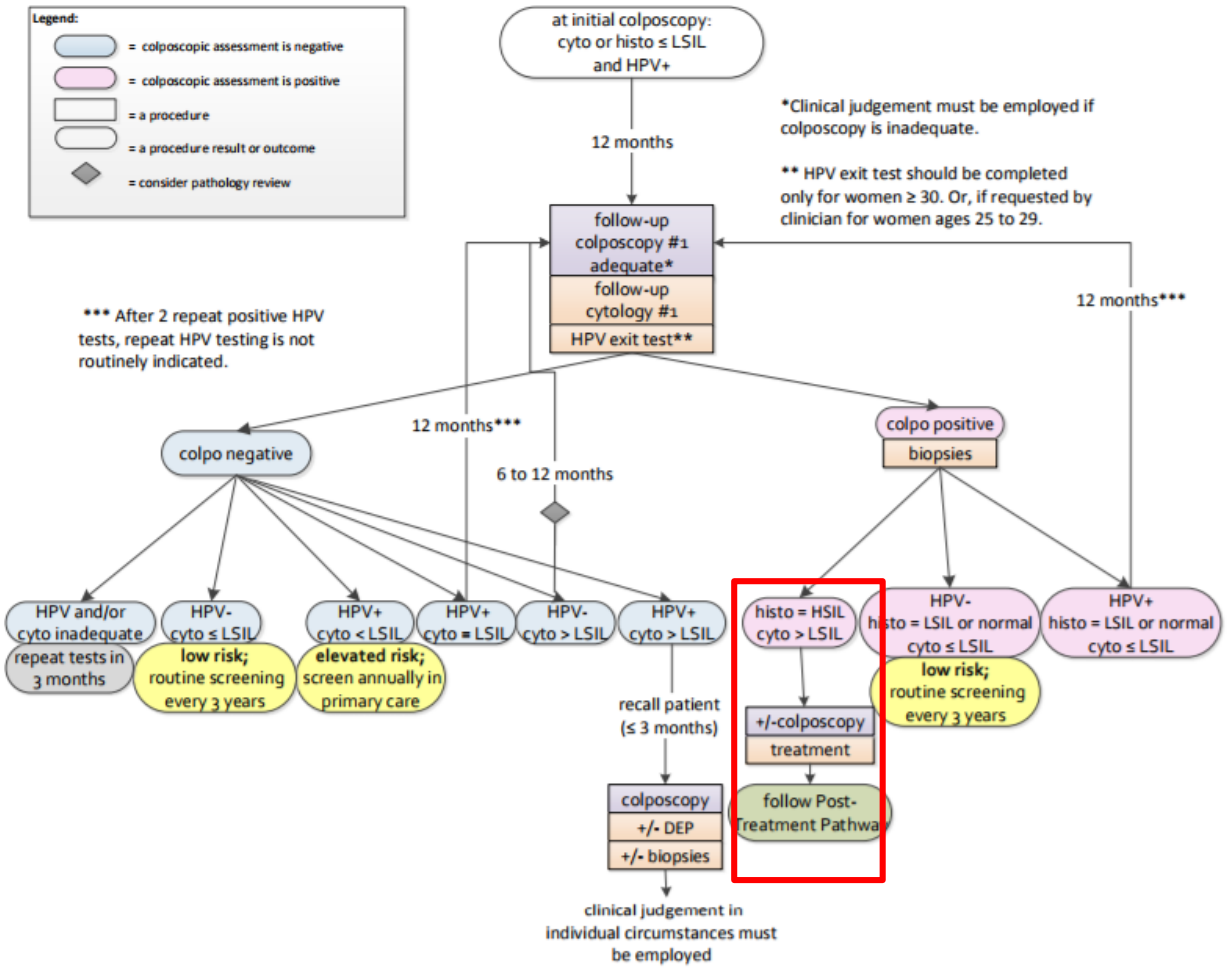
B) Discharge + annual surveillance

C) Discharge to routine screening

D) Treat (LEEP or laser)

E) None of the above

Case Study #2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colpo negative
12 months***
6 to 12 months
colpo positive biopsies
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HPV- cyto ≤ LSIL
low risk; routine screening every 3 years
HPV+ cyto < LSIL
HPV+ cyto = LSIL
elevated risk; screen annually in primary care
HPV- cyto > LSIL
HPV+ cyto > LSIL
recall patient (≤ 3 months)
colposcopy
+/- DEP
+/- biopsies
clinical judgement in individual circumstances must be employed
histo = HSIL cyto > LSIL
+/-colposcopy treatment
follow Post-Treatment Pathwa
HPV- histo = LSIL or normal cyto ≤ LSIL
low risk; routine screening every 3 years
HPV+ histo = LSIL or normal cyto ≤ LSIL

Case Study #2

Q4: With LEEP, a positive margin is seen. What is your recommended next step?

A) F/U at 6 months

B) Immediate re-treatment

C) F/U at 12 months

D) Discharge for annual surveillance

E) A or B

Cancer Care Ontario

Concluding Remarks

DR JOAN MURPHY

Ontario
Cancer Care Ontario

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 will use – or continue to use – the best practice pathways as recommended by the *Colposcopy Clinical Guidance Document* in my practice on a regular basis:

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly Agree

Poll 2

2. I understand how the introduction of HPV testing will affect my colposcopy practice, specifically regarding entry and exit from my practice.

a) Strongly disagree
b) Disagree (I still need some clarification)
c) Neutral
d) Agree
e) Strongly Agree

Poll 3

3. I am aware of the indications of HPV testing in colposcopy as outlined in the *Colposcopy Clinical Guidance Document*.

a) Strongly disagree
b) Disagree (I still need some clarification)
c) Neutral
d) Agree
e) Strongly Agree

Poll 4

4. I am familiar with standard cytology reporting terminology and I rely on it to inform clinical management:

a) Strongly disagree
b) Disagree
c) Neutral
d) Agree
e) Strongly Agree

- ✓ Annual membership fee of only $150 for Active members and of $70 for Associate members
- ✓ Quarterly issues of the Journal of Lower Genital Tract Disease
- ✓ Workshops in conjunction with the SOGC ACSC and CMEs
- ✓ Chance to remain in touch with and contribute to current Clinical Practice Guidelines as they pertain to cervical cancer screening, colposcopy and treatment

SCC

Society of Canadian Colposcopists

Société canadienne des colposcopistes

Membership BENEFITS

Apply today at https://www.research.net/r/SCC_new_member_app

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 for you to obtain your certificate of participation, you must fill out our survey that will be sent to your email address that you registered with.

What's Next

- Next meeting of the CoP will take place in **Spring 2018**
- Want to see something discussed? Let us know at ColposcopyCoP@cancercare.on.ca or speak to your CSCL
- Your regional Cervical Screening / Colposcopy Lead (CSCL) will be in contact with you for local events and the next CoP meeting

Ontario Cervical Screening / Colposcopy Leads

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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!