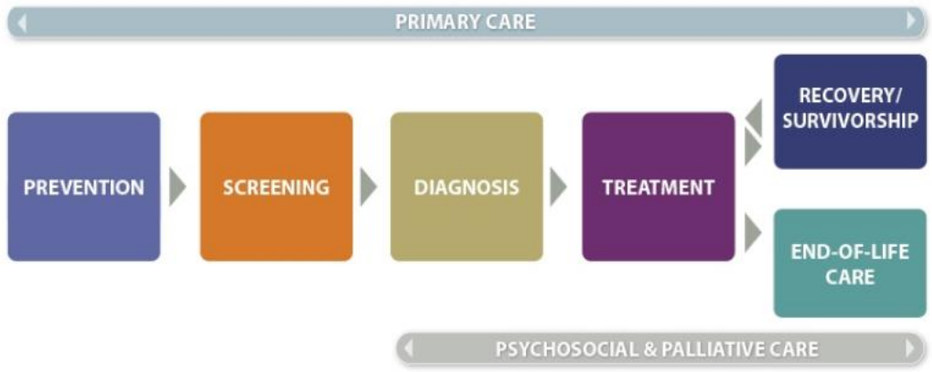
Cancer Care Ontario

Cervical Cancer Diagnosis Pathway Map

Disease Pathway Management

Version 2018.03



Disclaimer

The pathway map is intended to be used for informational purposes only. The pathway map is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathway maps are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway map. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway map. The information in the pathway map does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

Ontario
Cancer Care Ontario

Target Population

- This pathway map reflects the clinical management of women with abnormal screen tests, or signs or symptoms that are concerning for lower genital tract neoplasia, who are in need of diagnostic intervention.
- This pathway map does not address the primary screening tests. For primary screening, please see the Cervical Cancer Screening Pathway Map.

Pathway Considerations

- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, **Health Care Connect,** is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see **Person-Centered Care Guideline** and **EBS #19-2 Provider-Patient Communication***
- Hyperlinks are used throughout the pathway map to provide information about relevant CCO tools, resources and guidance documents.
- The term 'healthcare provider', used throughout the pathway map, includes primary care providers and specialists, e.g. family doctors, nurse practitioners, gynecologists, midwives and emergency physicians
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit **EBS #19-3**

* **Note.** **EBS #19-2** and **EBS #19-3** are older than 3 years and is currently listed as 'For Education and Information Purposes'. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

Pathway Map Legend

Colour Guide

- Primary Care
- Palliative Care
- Pathology
- Surgery
- Radiation Oncology
- Medical Oncology
- Radiology
- Gynecology
- Multidisciplinary Cancer Conference (MCC)
- Psychosocial Oncology (PSO) & Supportive Care

Shape Guide

- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- Off-page reference
- Patient/Provider interaction
- Referral
- Wait time indicator time point

Line Guide

- Required
- Possible

Pathway Map Disclaimer

This pathway map is a resource that provides an overview of the treatment that an individual in the Ontario cancer system may receive.

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This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. CCO and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant scientific findings may have been reported since completion of this pathway map. This pathway map may be superseded by an updated pathway map on the same topic.

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Cytology Results

ASCUS (Atypical Squamous Cells of Uncertain Significance)
ASC-H (Atypical Squamous Cells, cannot exclude HSIL)
AGC[1] (Atypical Glandular Cells)
Atypical Endocervical Cells
Atypical Endometrial Cells
HSIL (High-Grade Squamous Intraepithelial Lesion)
LSIL[2] (Low-Grade Squamous Intraepithelial Lesion)
NILM (Negative for Intraepithelial Lesion or Malignancy)
Squamous Carcinoma
Adenosquamous Carcinoma
Adenocarcinoma
Other Malignant Neoplasms

From Screening Pathway Map (Page 4)

Visit to Healthcare Provider

Patient presents with one or more of the following:
- Intermenstrual, postcoital or postmenopausal bleeding
- Vaginal discharge (blood stained and/or watery)
- Pelvic pain when associated with one or more of the above

Signs may include:
- Abnormal inspection and/or palpation of the cervix or lower genital tract

Focused History to include:
- History of previous pap tests, including abnormal pap tests and/or treatment[3]
- HPV status (if known) including: history of genital warts, immunization and HPV testing
- HIV/AIDS status

Pelvic Examination
Including speculum and bimanual/ pelvirectal exams and examination of external genitalia

Directed Physical Examination

Suspicious Finding(s)

Visible lesion(s) → R → Gynecologist Or Gynecologic Oncologist → Biopsy → Pathology → Results

No visible lesion(s) → Cytology (Papanicolaou Test) → Cytology → Results

Results:
- Inconclusive[4] → Proceed to Page 4 (A)
- Negative for Malignancy → Proceed to Page 4 (A); Further investigation and/ or management as indicated → Status
  - Ongoing non malignant abnormaility → Treatment and follow up as appropriate
  - No ongoing treatment or treatment complete → Return to primary care provider
- Positive for Malignancy → Proceed to Page 5 (B)
- Any abnormalities → Proceed to Page 4 (C)
- Normal/ NILM → Further Investigation and/ or Management as indicated → Refer to Appropriate Specialist; Return to primary care provider

[1] AGC may be sent for a colposcopy and endometrial sampling
[2] Evidence suggests that either repeat cytology or colposcopy are acceptable management options after the first LSIL result. Though colposcopy may be useful to rule out high-grade lesions, low-grade abnormalities, particularly in young women, often regress and as such may be best managed by surveillance
[3] In a setting of an uncertain or unknown screening histology results, CytoBase and/or the Primary Care-Screening Activity Report (PC-SAR) may be helpful. CytoBase is a database of results of cervical screening tests processed at community laboratories in Ontario. Specimens processed through hospital labs are usually not available in CytoBase. For more information, refer to Overview of the CytoBase System . For more information about PC-SAR, refer to Screening Activity Report
[4] If biopsy results are inconclusive, direct communication between the clinician and the pathologist may be required to determine next steps (e.g. repeat biopsy or observation)
For additional information about the optimal organization of gynecologic oncology services in Ontario refer to EBS #4-11
For additional information about the optimal organization of colposcopy services in Ontario refer to EBS #15-12

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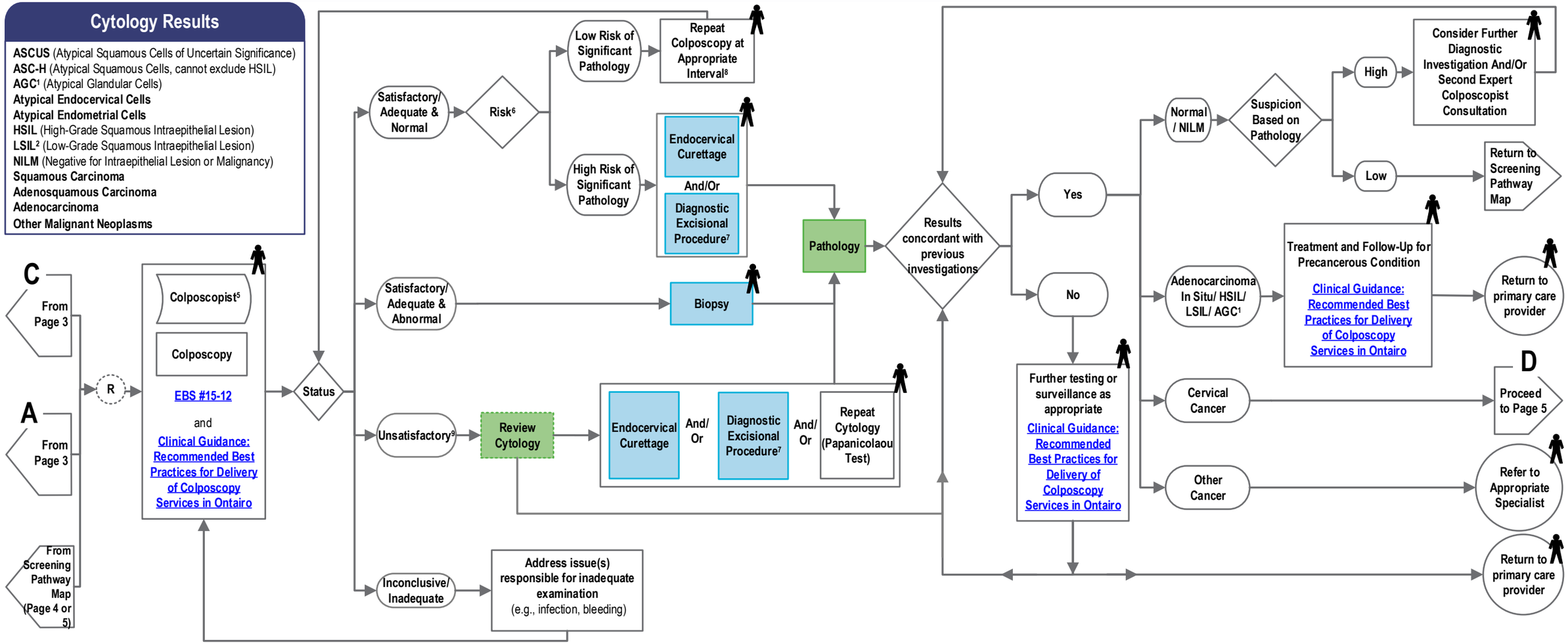

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[5] A colposcopist may be a gynecologist, gynecologic oncologists, pathologists and primary care physicians trained in colposcopy. For more information about training requirements, refer to EBS #15-12
[6] Risk factors to be considered include: age, cytology, histology, degrees of discordance, presence of visible lesions, duration of abnormality, immunocompromised individuals, fertility preservation, and loss to follow-up
[7] A conservative approach is preferred for women with low grade abnormalities who are young (e.g. under 30 years old) and/or who wish to preserve fertility options
[8] Repeat colposcopy as needed based on clinical discretion
[9] Squamo-columnar junction or the entire lesion cannot be seen

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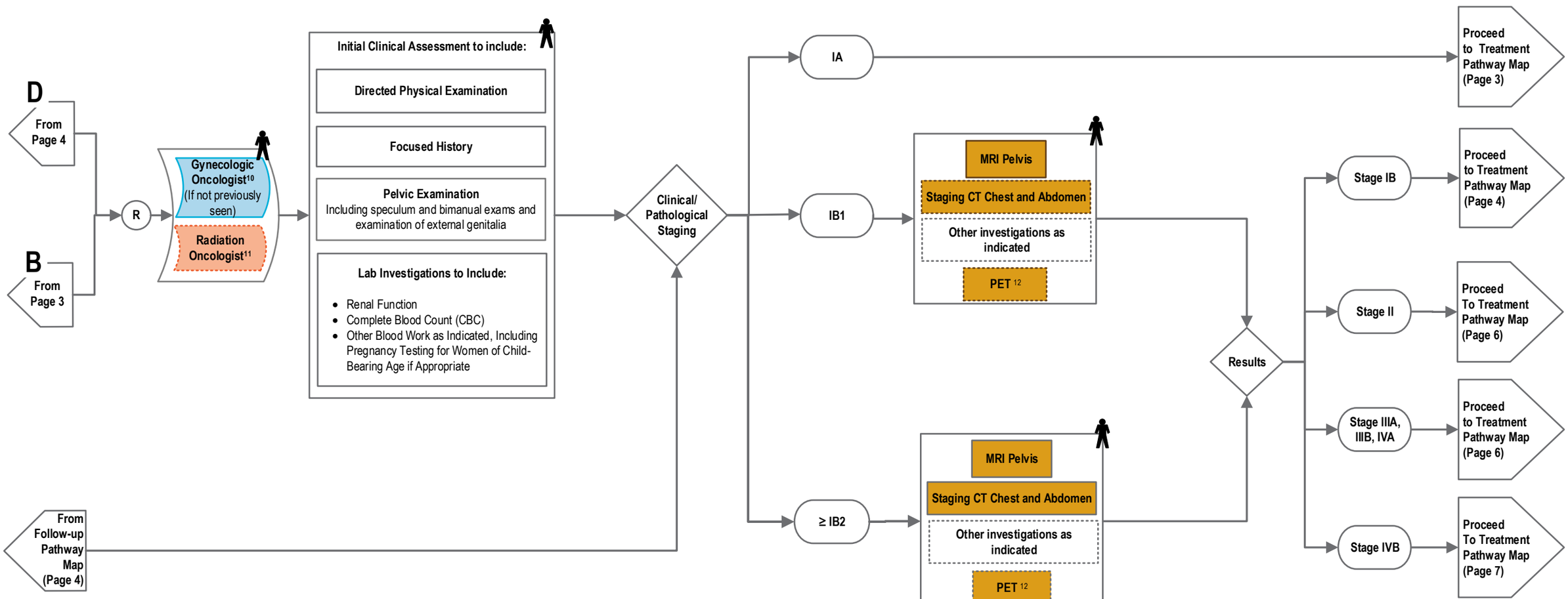

[10] In cases where timely referral to a gynecologic oncologist is not possible, referral to a radiation oncologist or medical oncologist, with expertise in gynecologic oncology, may be considered

[11] Consider referral for urgent radiotherapy to control severe bleeding. Radiotherapy should be planned and delivered with consideration for potential future curative treatment.

[12] PET scan should be ordered if the following is found on CT/MRI: a) A positive or indeterminate pelvic lymph node, b) An indeterminate or suspicious para-aortic lymph node (with or without pelvic lymphadenopathy)