



## COVID-19 Tip Sheet for Facilities Performing Colposcopy

### 12 – Guidance for Increasing Colposcopy Services – 2020-06-19

---

**To:** RVPs and Directors

**From:** Ontario Cervical Screening Program, Ontario Health (Cancer Care Ontario)

**Re:** Guidance for increasing colposcopy during COVID-19

---

#### Preamble

In May 2020, *A Measured Approach to Planning for Surgeries and Procedures during the COVID-19 Pandemic* and *COVID-19 Operational Requirements: Health Sector Restart* were released by Ontario Health and the Ontario government, respectively. These documents identify requirements to allow for the gradual reintroduction of deferred non-essential medical services during the COVID-19 pandemic. In June 2020, *Recommendations for Regional Health Care Delivery During the COVID-19 Pandemic: Outpatient Care, Primary Care, and Home and Community Care* was released by Ontario Health. This document outlines principles to support planning and decision-making related to gradually increasing care delivery during the pandemic. This tip sheet is intended to supplement the provincial guidance with specific considerations for increasing colposcopy services. It is not intended to replace or supersede any other provincial guidance, government directives or public health measures.

#### Issue Summary

As the COVID-19 pandemic evolves, it is important to consider the impact of deferred care and develop a plan to resume services while maintaining COVID-19 preparedness. Regional Cancer Programs (RCPs) and the broader colposcopy community have requested support in developing a priority classification framework to help guide the use of colposcopy services during COVID-19.

#### Background

A priority classification framework has been developed to support decision making for increasing colposcopy services.

#### Approach

Data on immediate risk of developing cervical intraepithelial neoplasia 3+ (CIN3+) based on recent cervical screening history (i.e., cytology and/or human papillomavirus [HPV] results) were obtained from Ontario data and the published literature (referenced in the Additional Resources section below) and used to define risk-based

thresholds. The risk-based thresholds were then applied to the priority classification framework described in this document, which was modelled on the framework in the Ontario Health (Cancer Care Ontario) *Pandemic Planning Clinical Guideline for Patients with Cancer* document. To meet the needs of patients who require colposcopy, the priority classification framework was expanded to define four priority levels (A, B1, B2, C). Finally, each potential cervical screening result was assigned to one of the four priority levels based on the immediate risk of CIN3+.

The OCSP Clinical Lead and Lead Scientist developed this framework with input from Regional Cervical Screening/Colposcopy Leads and a subset of Regional Primary Care Leads.

## Priority classification framework for colposcopy services

- Definitions for each priority level are outlined in Table 1.
- Table 2 summarizes the priority level of potential cervical screening results (i.e., referral cytology and HPV status).
- Currently, HPV testing is not part of the OCSP or an insured test in Ontario<sup>1</sup>. However, HPV testing is available in some places in Ontario through patient-pay or in some hospitals. Therefore, since some people in Ontario receive HPV testing, HPV test results have also been included in the priority classification framework.

### Implementation considerations

- As per the documents released by the Ministry of Health and Ontario Health (listed in the Preamble), healthcare system capacity is expected to be restricted for an extended period of time.
- To use healthcare system capacity without impacting readiness to respond to a surge in COVID-19 cases, facilities and regions should use a **staged or stepwise approach for resuming services**.
- Maximum delays or wait times for each priority level are **not** included in this framework because when and how procedures are resumed at each priority level will depend on local factors, such as:
  - Availability and impact on resources (e.g., PPE, staffing and physical space); and
  - Local trends of COVID-19 infection.
- The priority classification framework is intended to allow for flexibility based on physician discretion and clinical circumstance.
- Consideration should be given to time on waitlists and prior delays related to COVID-19 (i.e., patients in each priority level who have been waiting the longest should be given access first).

---

<sup>1</sup> Ontario Health (Cancer Care Ontario) is working with the Ministry of Health to plan the implementation of HPV testing in cervical screening and colposcopy. Until then, cytology remains the recommended test for screening.

**Table 1: Priority classification definitions**

Priority	Definition	Recommendation
<b>A</b>	Patients who are deemed critical and require colposcopy because their situation is unstable, is causing unbearable suffering and/or is immediately life threatening	<b>N/A (no cervical screening abnormalities meet the criteria for priority A)</b>
<b>B1</b>	Non-critical patients who require services or treatment for conditions that may cause an early negative impact on quality of life or functional status – colposcopy will alter management or outcome	<b>While colposcopy services are restricted, patients in this category are the highest priority</b>
<b>B2</b>	Non-critical patients who require services or treatments with conditions for which a delay of several weeks will not likely alter quality of life or prognosis	<b>While colposcopy services are restricted, patients in this category are moderate to high priority</b>
<b>C</b>	These patients should not be referred to colposcopy. <b>Referrals received by colposcopists for these patients should be declined</b> to facilitate repeat screening in primary care with cytology within approximately twelve months*	<b>Do not perform colposcopy on these patients during the pandemic</b>

\* This recommendation is based on the anticipation of cervical screening services resuming. If cervical screening services are not available when these patients are due for repeat cytology, appropriate management should be determined using clinical judgment.

**Table 2: Prioritization of cervical screening abnormalities in colposcopy during COVID-19**

Priority	Risk-based threshold	Referral cytology	HPV status
<b>A</b> Patients who are deemed critical and require colposcopy because their situation is unstable, is causing unbearable suffering and/or is immediately life threatening	No cervical screening abnormalities meet the criteria for priority A	N/A	N/A
<b>B1</b> Non-critical patients who require services or treatment for conditions that may cause an early negative impact on quality of life or functional status – colposcopy will alter management or outcome	<b>Immediate risk of CIN3+ is &gt;15%</b>  (any high-risk cytology result)	<ul style="list-style-type: none"> <li>• AIS</li> <li>• HSIL+</li> <li>• AGC</li> <li>• ASC-H</li> </ul>	Regardless of HPV status
<b>B2</b> Non-critical patients who require services or treatments with conditions for which a delay of several weeks will not likely alter quality of life or prognosis	<b>Immediate risk of CIN3+ is 7% to 15%</b> Single (HPV 16/18 positive) or consecutive (HPV status unknown) low risk cytology results	<ul style="list-style-type: none"> <li>• LSIL x2</li> <li>• LSIL x3</li> <li>• LSIL, ASCUS x2</li> <li>• LSIL, ASCUS</li> <li>• ASCUS, LSIL</li> <li>• ASCUS x2</li> <li>• ASCUS x3</li> </ul>	HPV status unknown
		<ul style="list-style-type: none"> <li>• ASCUS</li> <li>• LSIL</li> </ul>	HPV 16/18 positive

Priority	Risk-based threshold	Referral cytology	HPV status
<b>C</b> These patients should not be referred to colposcopy. Referrals received by colposcopists for these patients should be declined to facilitate repeat screening in primary care with cytology within approximately twelve months*	<b>Immediate risk of CIN3+ is &lt; 7%</b>	<ul style="list-style-type: none"> <li>• ASCUS*</li> <li>• LSIL*</li> </ul>	HPV status unknown or HPV positive for non 16/18

\*The five-year risk of CIN3+ for patients with a first time LSIL or ASCUS who are positive for non 16/18 HPV or who have an unknown HPV status is sufficiently low that repeat cytology within approximately twelve months is an acceptable management option.

**Acronyms:** adenocarcinoma in-situ (AIS), high-grade squamous intraepithelial lesion (HSIL), atypical squamous cells; cannot exclude high-grade squamous intraepithelial lesion (ASC-H), atypical glandular cells (AGC), low-grade squamous intraepithelial lesion (LSIL), atypical squamous cells of undetermined significance (ASCUS), cervical intraepithelial neoplasia (CIN) and human papillomavirus (HPV).

Table 3 outlines other important considerations for the use of colposcopy services during COVID-19.

**Table 3: Other considerations for colposcopy care during COVID-19**

Area of colposcopy care	Guidance
<b>Symptoms or suspicious clinical lesions</b>	<ul style="list-style-type: none"> <li>• Advice for patients referred to colposcopy for reasons other than screening abnormalities (e.g., symptoms or lesions suspicious for malignancy) is beyond the scope of the OCSF. Management of these patients should be determined using clinical judgement.</li> <li>• Symptoms suspicious for cervical cancer and lesions require urgent attention and may require direct referral to gynecologic oncology.</li> </ul>
<b>Treatment</b>	<ul style="list-style-type: none"> <li>• Follow best practices for treatment as per <a href="#">Clinical Guidance: Recommended Best Practices for Delivery of Colposcopy Services in Ontario</a>. <ul style="list-style-type: none"> <li>○ Patients with high-grade dysplasia require treatment.</li> <li>○ Patients with low-grade dysplasia do not require urgent treatment (see Table 2).</li> </ul> </li> </ul>
<b>Post-treatment surveillance</b>	<ul style="list-style-type: none"> <li>• To prioritize visits for surveillance after treatment, consider risk factors for persistence of disease or recurrence. For example, patients with negative loop electrosurgical excision procedure (LEEP) margins and no invasion are at low risk; therefore, these patients are not high priority.</li> </ul>
<b>Discharge from colposcopy</b>	<ul style="list-style-type: none"> <li>• To maximize capacity for high priority procedures, follow the OCSF best practices for discharge to screening in primary care as per <a href="#">Clinical Guidance: Recommended Best Practices for Delivery of Colposcopy Services in Ontario</a>. <ul style="list-style-type: none"> <li>○ Most people with negative colposcopy and normal or low-grade cytology are at sufficiently low risk of CIN3+ that ongoing colposcopy is not beneficial.</li> <li>○ Tables 4a and 4b outline the discharge criteria for patients in colposcopy who have received treatment and are in colposcopy for post-treatment follow-up.</li> <li>○ Figure 1 outlines the <b>most common</b> pathways to discharge patients in colposcopy for post-treatment management, with or without HPV testing.</li> </ul> </li> </ul>

Patients can be discharged to screening in primary care if they have the combined results outlined in Table 4a at their second (or subsequent) visit at least 12-18 months post-treatment\*.

**Table 4a: Discharge criteria for patients in colposcopy for post-treatment follow-up (HPV testing available)**

Results: Colposcopy	Results: Histology	Results: Cytology	Results: HPV status
negative	N/A	normal, ASCUS or LSIL	HPV negative
negative	N/A	normal or ASCUS	HPV positive
positive	normal or LSIL	normal, ASCUS or LSIL	HPV negative

Patients with results outlined in Table 4b over a 24-month period may be discharged to screening in primary care.

**Table 4b: Discharge criteria for patients in colposcopy for post-treatment follow-up (HPV testing not available)**

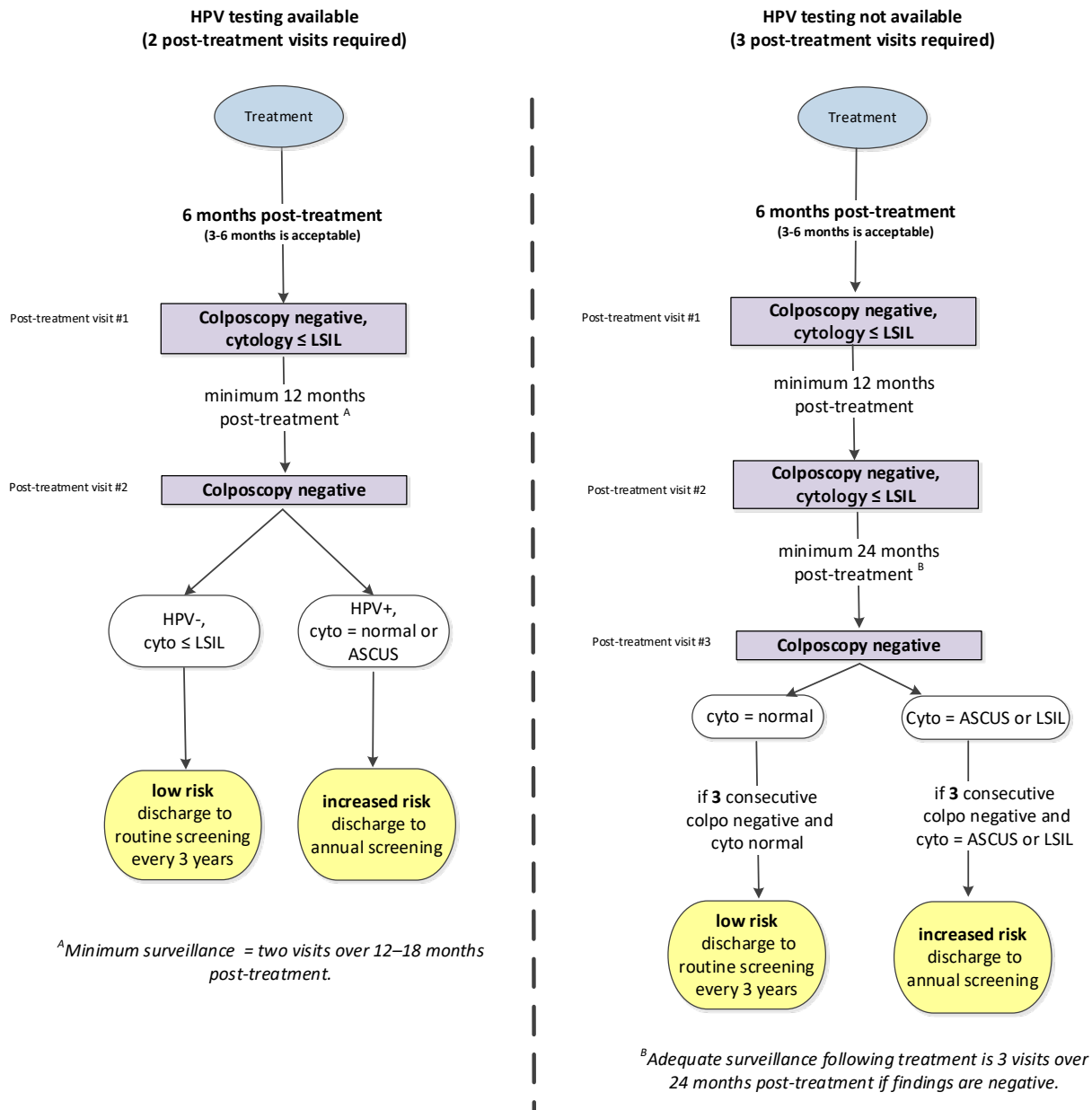
Results: Colposcopy	Results: Histology	Results: Cytology	Results: HPV status
3x negative	N/A	3x normal, ASCUS or LSIL	--

**Acronyms (Table 4a and 4b):** adenocarcinoma in-situ (AIS), low-grade squamous intraepithelial lesion (LSIL), atypical squamous cells of undetermined significance (ASCUS), cervical intraepithelial neoplasia (CIN) and human papillomavirus (HPV).

**\*Post treatment for AIS:**

- Follow-up in colposcopy every 6 months for 3 years
- If all results remain negative after 3 years, follow-up annually in colposcopy for 2 more years

**Figure 1: Most common pathways to discharge colposcopy patients who have completed post-treatment follow-up**



Note: Figure 1 was adapted from pathways #5 and #8 in [Clinical Guidance: Recommended Best Practices for Delivery of Colposcopy Services in Ontario](#). For a detailed overview of all the colposcopy management pathways, please refer to the clinical guidance. For a text description of Figure 1, please refer to Tables 4a and 4b.

## Opportunities to improve the delivery of colposcopy care

- It is anticipated that the impact of COVID-19 on the healthcare system, including constraints on healthcare capacity and PPE resources, may be prolonged.
- As per the documents released by the Ministry of Health and Ontario Health (listed in the Preamble), regions and facilities should consider opportunities for improving the delivery of colposcopy care, during the COVID-19 pandemic.
- Throughout the pandemic, regions should collaborate to provide appropriate and equitable access to care (e.g., transfer of referrals between facilities based on capacity). Regional collaboration to ensure timely access to treatment for patients with high risk screening abnormalities is particularly important.
- RCPs and facilities are also encouraged to track and monitor the backlog of referrals and procedures to inform wait time strategies (e.g., centralized referral, extending schedules).

### Optimizing use of resources during management of colposcopy backlog

- As Ontario moves through the full course of the COVID-19 pandemic, colposcopy volumes and waitlists will vary based on the availability of resources and screening.
- Individual consideration and risk-based management of patients being considered for colposcopy is encouraged to maximize capacity for high-priority procedures and minimize risk to patients and staff. An important strategy for optimizing the use of colposcopy resources is to ensure that colposcopy services are provided to all newly and previously referred patients in alignment with recommendations from Ontario Health (Cancer Care Ontario) (see Table 1), including adherence to appropriate referral criteria, surveillance algorithms in colposcopy, and discharge to primary care.

### Centralized referral intake, triage guidelines and colposcopy waitlists

- Facilities and RCPs should consider implementing processes for **centralized referral intake** (i.e., coordinated points of entry for receiving referrals) and **centralized colposcopy waitlists** (i.e., patients are booked for the next available appointment with an appropriate provider). Centralized models are beneficial because they:
  - Support the ethical prioritization of patients at hospital and regional levels;
  - Facilitate the identification of duplicate referrals (i.e., referrals that may have been sent to more than one facility or provider for the same indication);
  - Facilitate consistent use of **evidence-based referral triage criteria** for the population – the classification framework described in this tip sheet provides a starting point that may be tailored to local context;
  - Facilitate tracking and monitoring of the procedure backlog to inform wait time strategies (e.g., extending schedules); and
  - Reduce wait times for patients who need colposcopy care.

## Cervical screening prior to age 25

- There is strong evidence, including recommendations from the Canadian Task Force on Preventive Health Care, to support a higher age of initiation for cervical screening (1). **Primary care providers are encouraged to initiate cervical screening at age 25.**
- Patients younger than 25 who have initiated screening and are referred to colposcopy for screen-related abnormalities should be accepted or declined in alignment with priority B1, B2 or C.

## Additional Resources

### Literature on the immediate risk of CIN3+ for different screening abnormalities

- Cheung LC, Egemen D, Chen X, Katki HA, Demarco M, Wisner AL et al. 2019 ASCCP Risk-based management consensus guidelines: methods for risk estimation, recommended management, and validation. J Low Genit Tract Dis .2020 Apr;24(2):90.
- Demarco M, Carter-Pokras O, Hyun N, Castle PE, He X, Dallal CM, et al. Validation of a human papillomavirus (hpv) dna cervical screening test that provides expanded hpv typing. J Clin Microbiol. 2018 May 1;56(5):e01910-17.
- 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.

### References

1. Canadian Task Force on Preventive Health Care. Recommendations on screening for cervical cancer. CMAJ 2013;185(1):35-45.

## Recommended Next Steps

Please feel free to share this guidance as you feel appropriate.

## For More Information

While we are unable to provide advice on individual cases, should you have any question regarding this guidance, please feel free to contact the Ontario Cervical Screening Program at [screening@cancercare.on.ca](mailto:screening@cancercare.on.ca).