# Spring 2022 Provincial Colposcopy Community of Practice (CoP)

Webinar 1

MAY 26, 2022, 5:30 – 7:00 P.M.

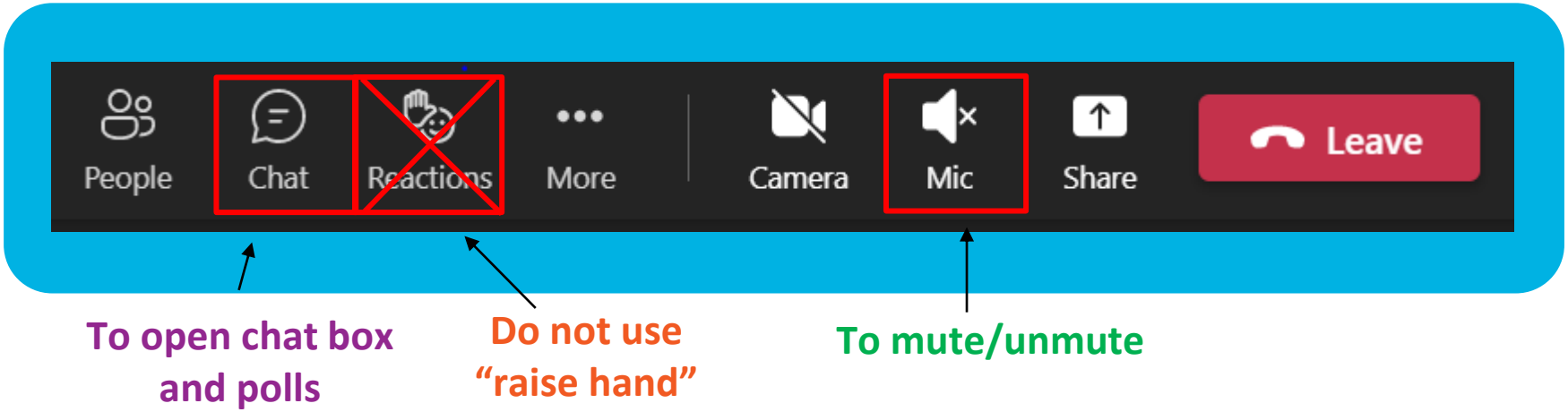
**Recommended browser for Microsoft Teams: Google Chrome**

Ontario Health
Cancer Care Ontario

# With Thanks

# Housekeeping items

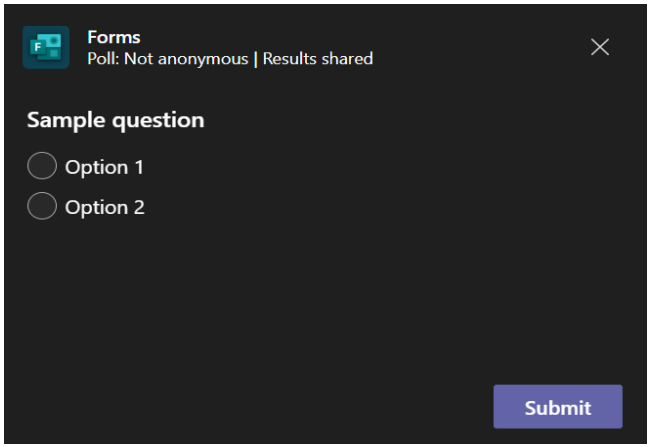
- Please **mute** yourself when you are not speaking
- Please turn off your webcam to minimize connection issues
- Please use the **chat box** to ask questions or share comments; do not use the "**raise hand**" option
- During the case studies, polls will appear on your screen or in the **chat box**



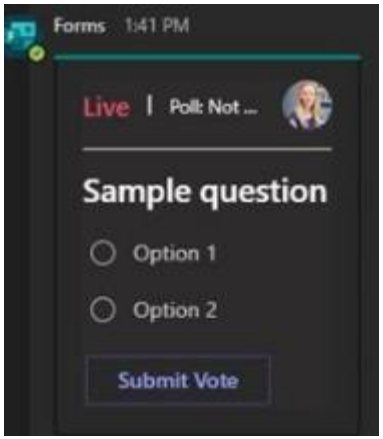
# Poll options

- Polls will either pop up on your screen, appear in the chat box, or both
- You can respond in either location

**Poll pop-up**




**Poll in chat box**



# Accreditation

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

# Thank you to our CoP Planning Committee

Dr. Robert DiCecco

Dr. Hélène Gagne

Dr. Nadia Ismiil

Dr. Felice Lackman

# Recording of CoP spring webinar is underway

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

# New Provincial Clinical Lead for the OCSP: Dr. Dustin Costescu

# Agenda

| Item | Presenter | Time |
|---|---|---|
| • Welcome and Introductions<br>• Update on HPV testing implementation | Bronwen McCurdy | 5:30-5:37 pm |
| Ontario Cervical Screening Program (OCSP) update:<br>• Update on impact of COVID-19<br>• Interval for repeat cytology after low-grade result | Dr. Dustin Costescu | 5:37-5:55 pm |
| Case studies:<br>• Follow-up of HPV+ patient and low-grade cytology<br>• Post-treatment management | Dr. Rachel Kupets | 5:55-6:25 pm |
| Cervical screening and colposcopy quality reporting | Dr. Rachel Kupets | 6:25-6:45 pm |
| Questions from the field | Dr. Dustin Costescu | 6:45-6:55 pm |
| Concluding remarks | Dr. Dustin Costescu | 6:55-7:00 pm |

# Learning objectives

Following this meeting, participants will better understand:

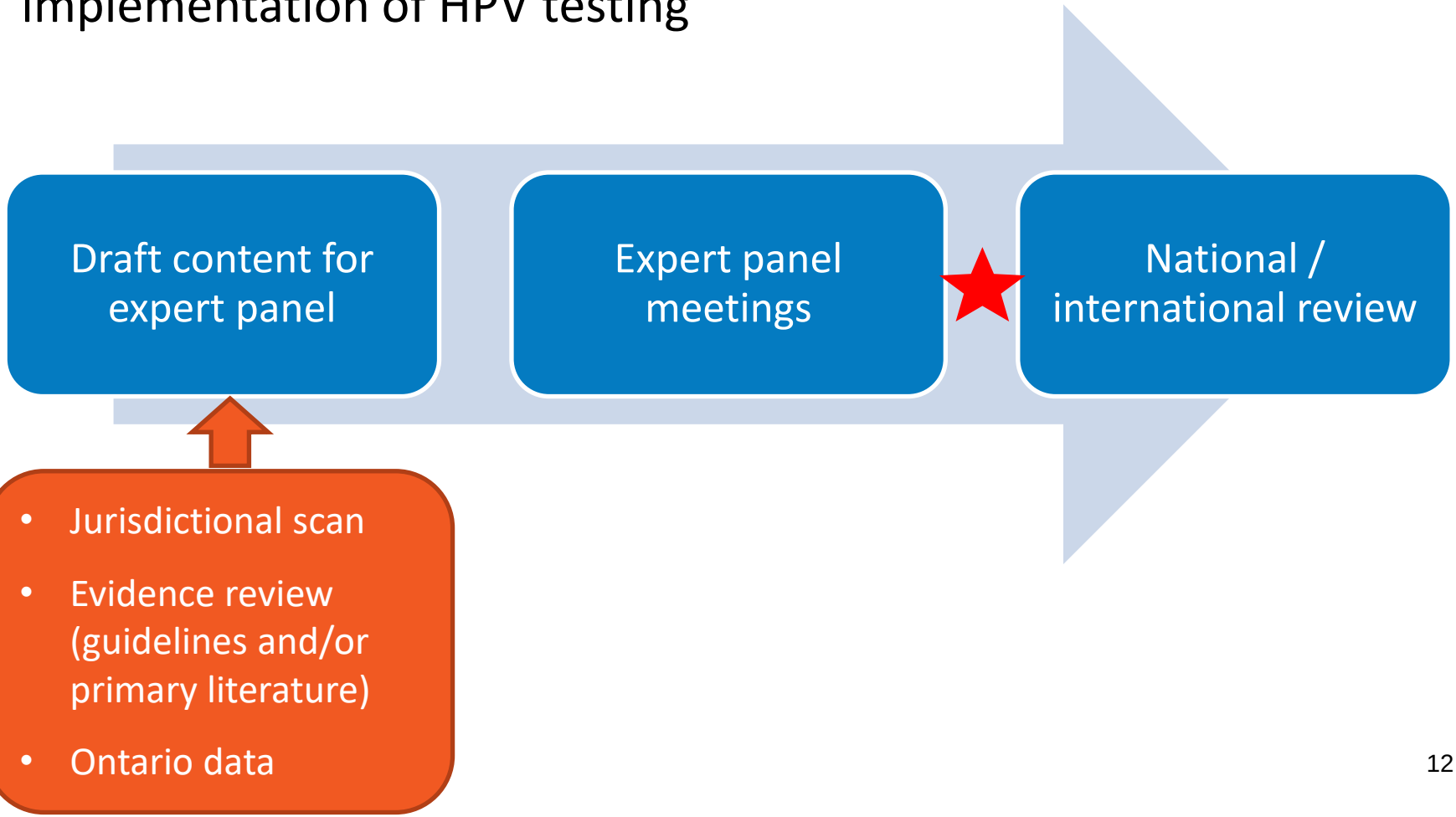
- The impact of the COVID-19 pandemic on cervical screening and colposcopy services in Ontario
- Risk-based recommendations for discharge from colposcopy for treated and untreated patients
- What to communicate to primary care providers when discharging people from colposcopy
- The impact of endocervical gland extension on persistence/ recurrence of cervical dysplasia
- What to expect for the 2022 quality reports and how to ensure they are able to benefit from quality reporting activities

# Update on HPV testing implementation

**Bronwen McCurdy**

# Approach to updating OCSP's cervical screening and colposcopy recommendations

Recommendations are being updated to support future implementation of HPV testing



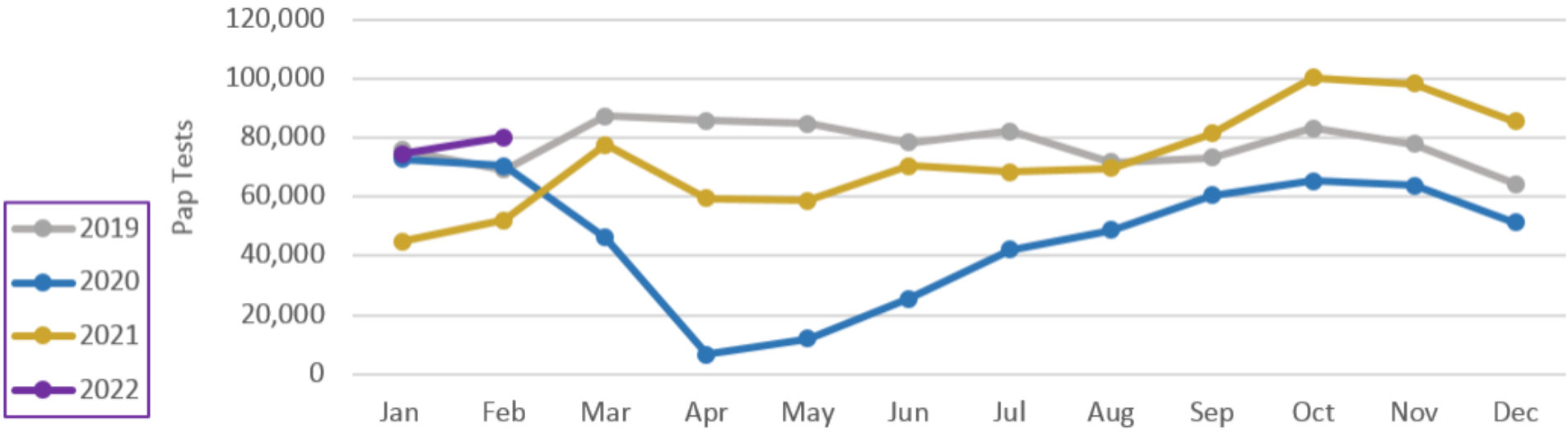
# Key areas under review

- ✓ HPV-based algorithms for screening and colposcopy
  - People at average risk
  - People at elevated risk (e.g., immunocompromised, some people post-discharge from colposcopy)
- ✓ Screening cessation
- ✓ Management of people under age 25 in screening and colposcopy
- ✓ Repeat testing post-unsatisfactory cytology and/or invalid HPV test result
- ✓ Vaginal vault testing for patients with total or radical hysterectomy

# Ontario Cervical Screening Program updates: Cervical screening during COVID-19

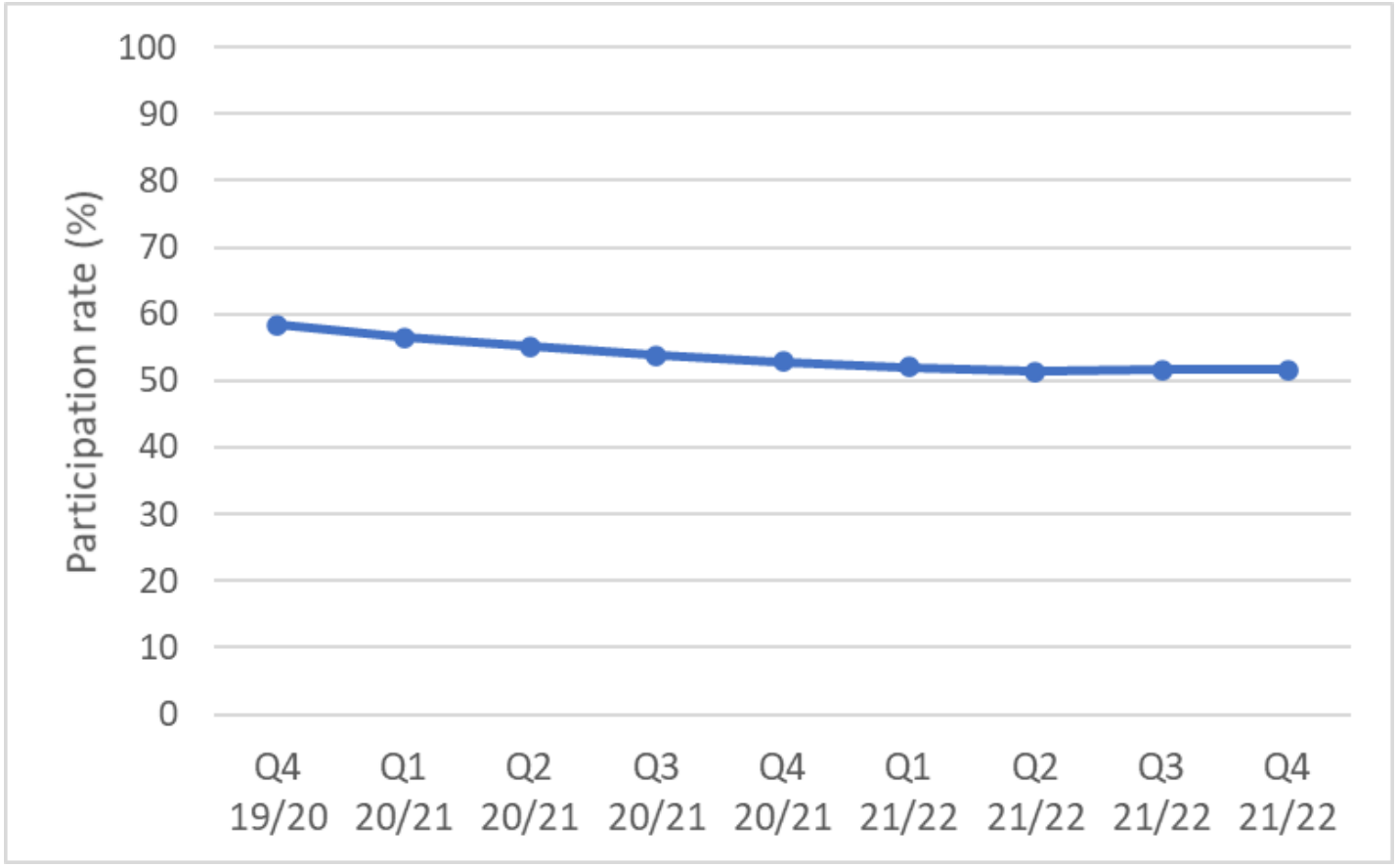
Dr. Dustin Costescu

# Pap tests volumes by month and year



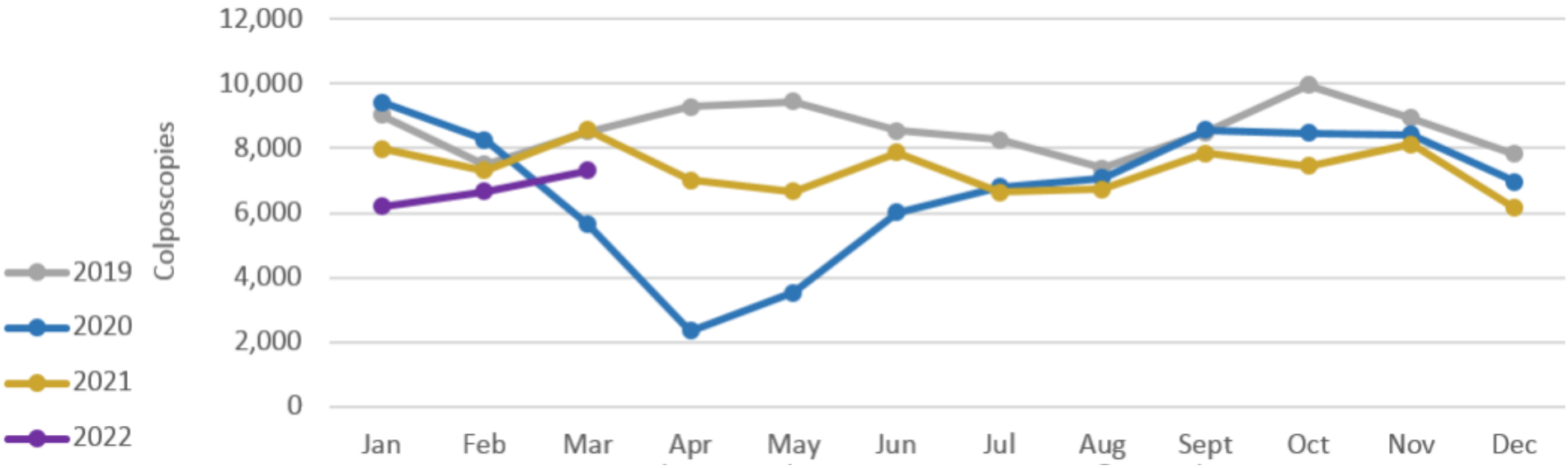

Pap tests volumes have been at (or exceeded) pre-pandemic volumes since September 2021

# Cervical screening participation rate by quarter




- Cervical screening participation rates declined in the early-mid stages of the pandemic
- Since Q2 21/22, rates have stabilized around 51%

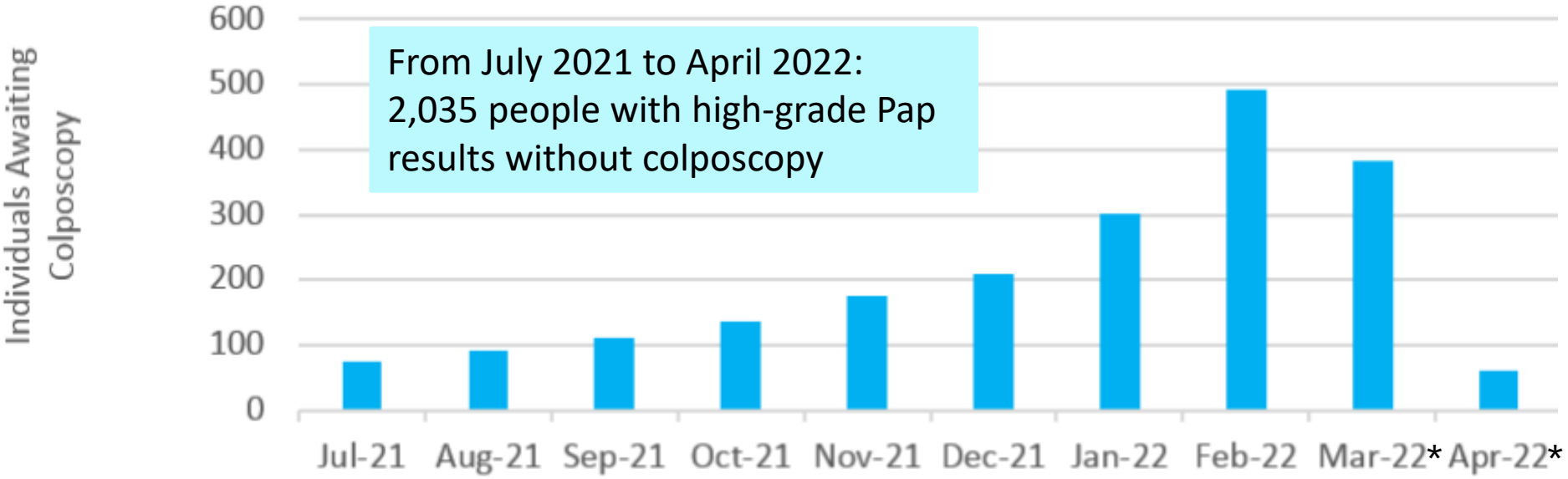
# Colposcopy volumes by month and year




**The latest month of colposcopy data is incomplete due to OHIP lag**

Generally, colposcopy volumes have not yet recovered to pre-pandemic volumes

# Cumulative number of individuals with high-grade Pap results without colposcopy



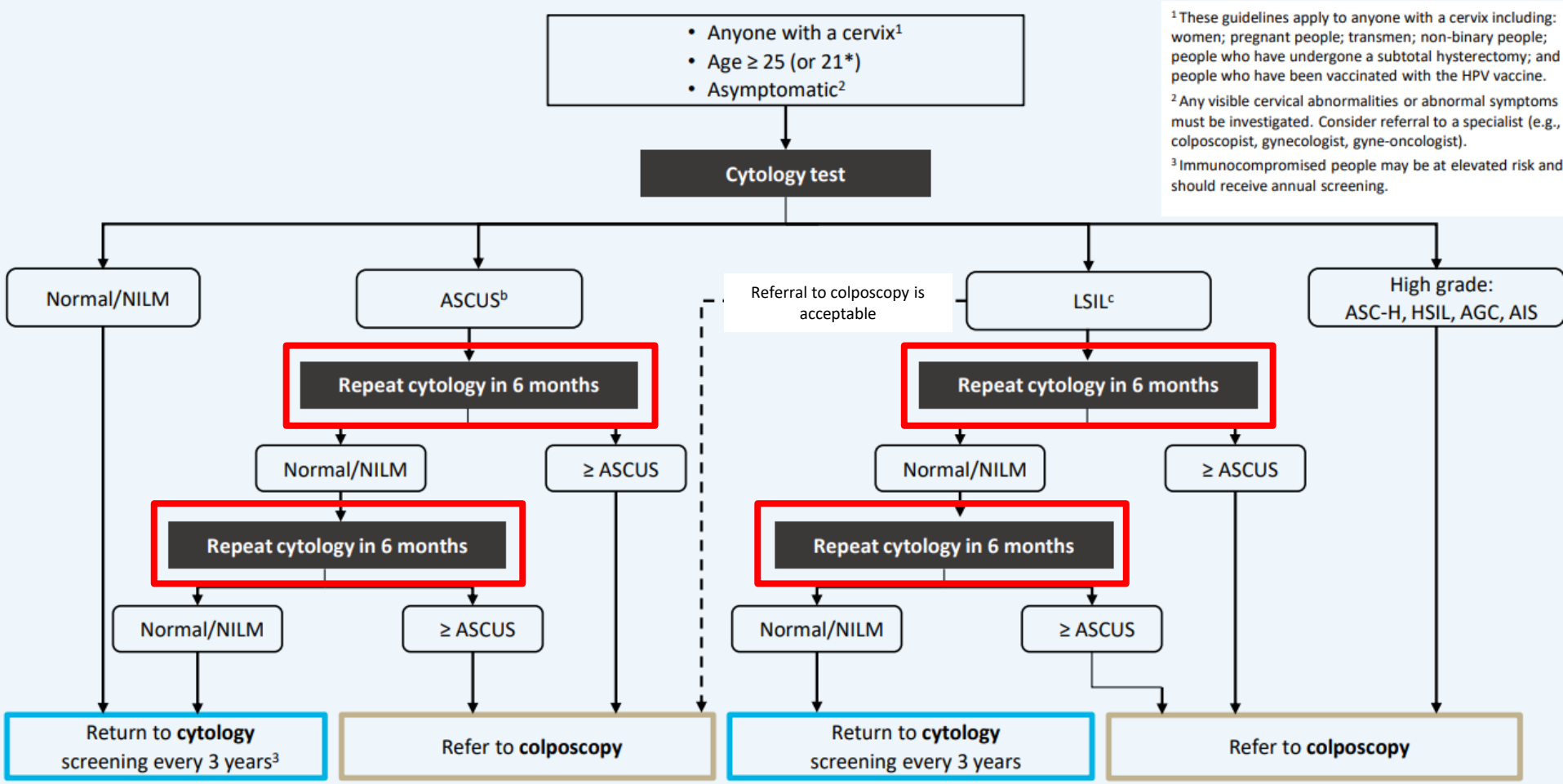

* Most recent two months of data may be incomplete due to data lag

Colposcopists and primary care providers should continue to collaborate to ensure that people with high grade results have a follow-up colposcopy

# Interval for repeat cytology after low-grade result

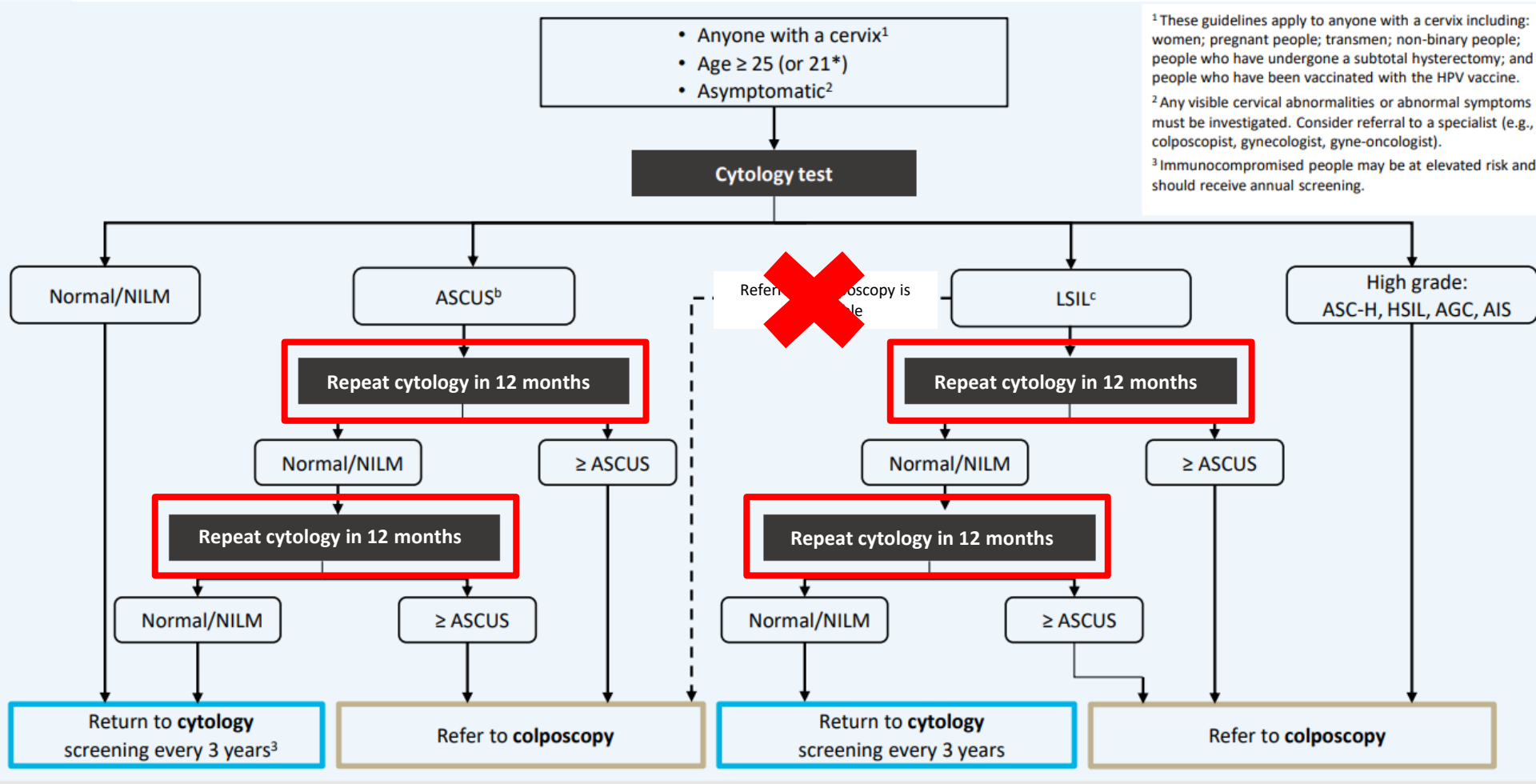
**Dr. Dustin Costescu**

# OCSP's previous screening pathway



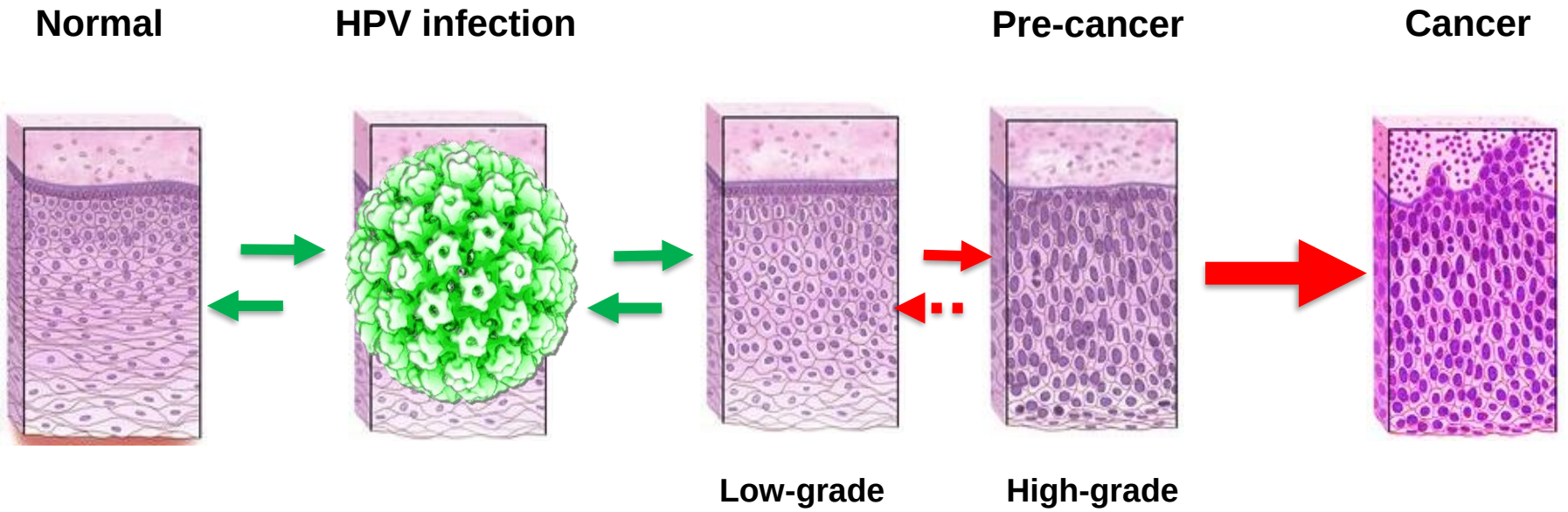

**Definitions**: NILM (normal) – no intraepithelial lesion or malignancy seen; ASCUS – atypical squamous cells of undetermined significance; LSIL – low-grade squamous epithelial lesion; ASC-H – atypical squamous cells, cannot rule out high-grade; HSIL – high-grade squamous intraepithelial lesion; AGC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

# OCSP's updated screening pathway

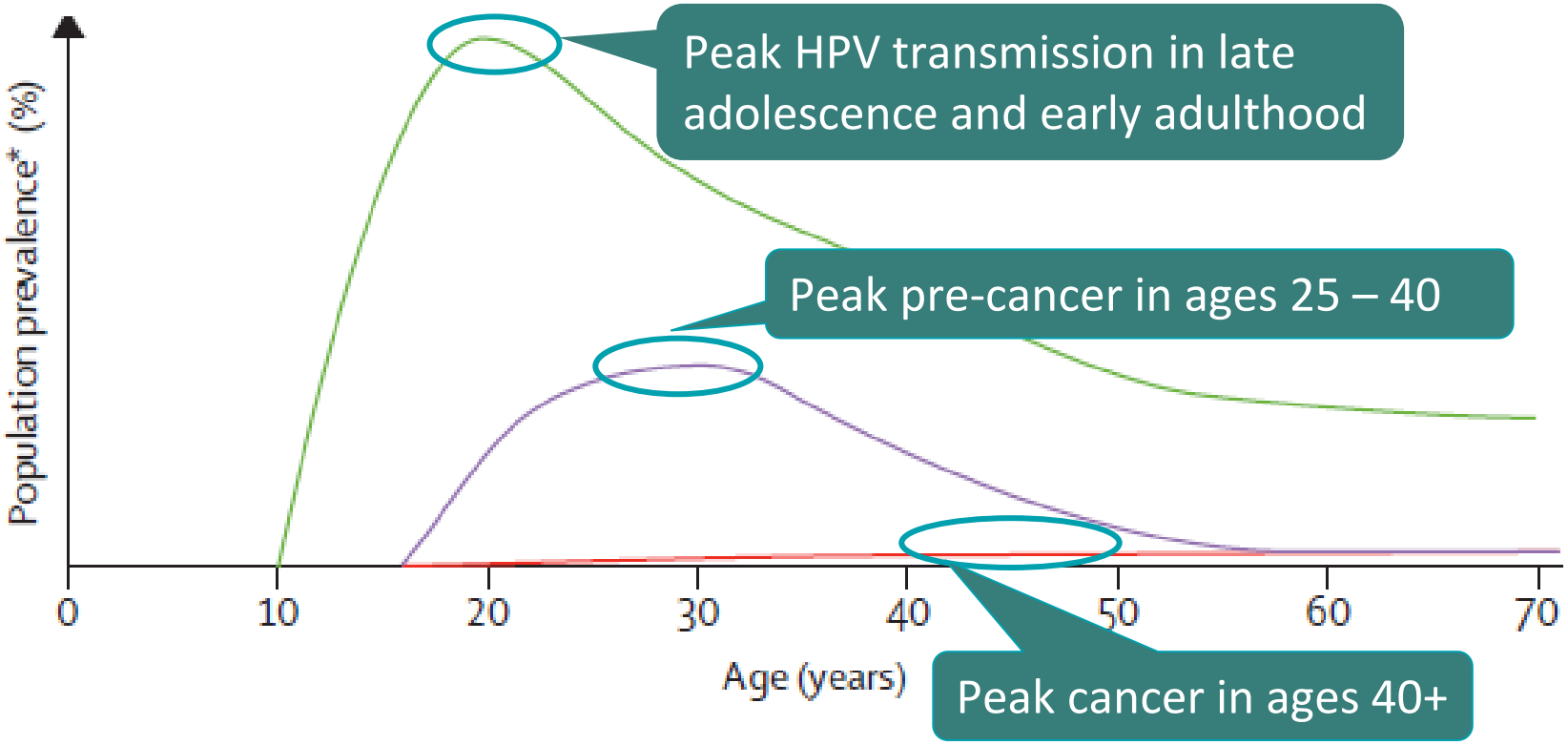


# Natural history of cervical cancer

- Almost all cervical cancer cases are caused by persistent infection with high-risk types of HPV
  - Majority of these pre-cancers can be detected through screening
- Cervical pre-cancer progresses slowly
  - 15 - 20 years in immunocompetent people



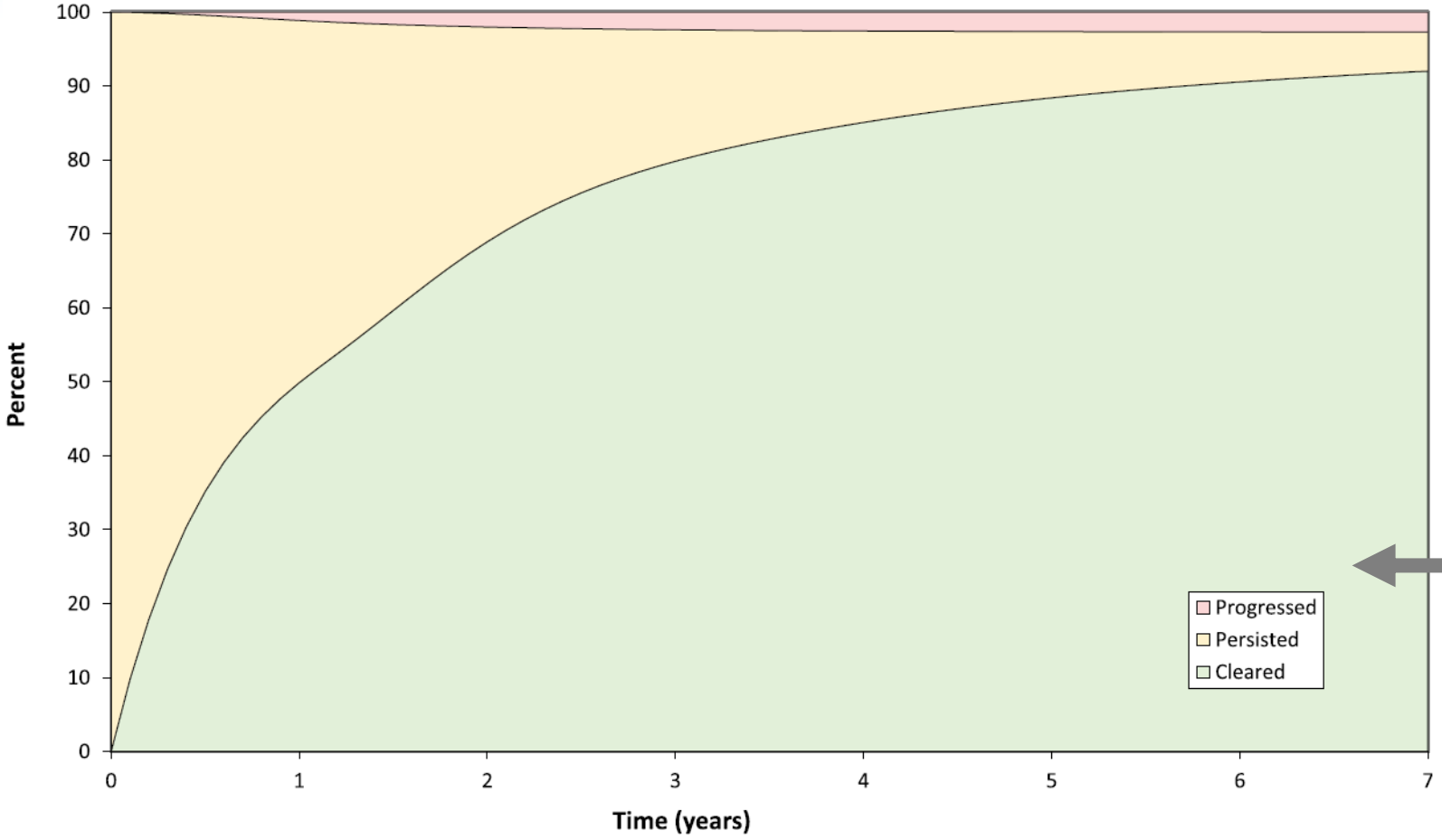
# Progression to cervical cancer: Long natural history




Ontario Health
Cancer Care Ontario

Reference: Wentzensen N ,Schiffman M. Accelerating cervical cancer control and prevention. Lancet Public Health 2018;3:e6-e7

# Natural history of HPV progression




More than 90% infections clear

Reference: Demarco M, Hyun N, Carter-Pokras O, et al. A study of type-specific HPV natural history and implications for contemporary cervical cancer screening programs. EClinicalMedicine. 2020;22:100293.

# Ontario data: 5-year incidence rates of pre-cancers by referral profile

| Profile** | N (%) | # of in-situ cases | SIR All ages (%) | 95% CI | SIR <30 years (%) | SIR >30 years (%) |
|---|---|---|---|---|---|---|
| A | 2105 (16.9) | 51 | 2.2 | [1.5-2.8] | 2.9 | 2.0 |
| AN | 1961 (15.7) | 7 | 0.3 | [0.1-0.5] | 0.6 | 0.2 |
| L | 2499 (26.2) | 177 | 7.3 | [6.0-8.6] | 5.6 | 7.7 |
| LN | 1099 (11.5) | <5 | 0.4 | [0-0.8] | 0.1 | 0.4 |



SIR: standardized incidence rate; standardized according to the age distribution of the whole cohort
CI: confidence interval
**A: ASCUS, N: Normal, L: LSIL

# Regression after an initial low grade cytology result

**Table 4. Cytologic diagnosis on repeat cytology of initial low-grade dysplasia and colposcopic referral pattern**

| Follow-up cytology diagnosis | Repeat cervical cytology followed by colposcopy | Repeat cervical cytology No colposcopy | Total |
|---|---|---|---|
| Initial = ASCUS | n = 8810<br>n (%) | n = 22 063<br>n (%) | 30 873<br>n (%) |
| Normal | 1162 (13.2) | 19 885 (90.0) | 21 047 (68.2) |
| ASCUS | 4481 (51.0) | 1478 (7.0) | 5959 (19.3) |
| LSIL | 2704 (31.0) | 571 (2.6) | 3275 (10.6) |
| HSIL | 383 (4.3) | 46 (0.2) | 429 (1.4) |
| Other | 77 (0.9) | 83 (0.4) | 160 (0.5) |
| Initial = LSIL | n = 8404 | n = 9979 | 18 383 |
| Normal | 712 (8.5) | 8169 (82.0) | 8881 (48.3) |
| ASCUS | 2456 (29.2) | 859 (9.0) | 3315 (18.0) |
| LSIL | 4775 (56.8) | 884 (8.0) | 5659 (30.8) |
| HSIL | 436 (5.3) | 39 (0.4) | 475 (2.6) |
| Other | 25 (0.3) | 28 (0.3) | 53 (0.03) |

Early cervical cell changes (i.e., LSIL or ASCUS results) are likely to resolve within 24 months

Reference: Kupets R, Lu Y, Vicus D, Paszat L. Are There Flaws in the Follow-Up of Women With Low-Grade Cervical Dysplasia in Ontario? Journal of Obstetrics and Gynaecology Canada. 2014;36(10):892-9. doi:10.1016/S1701-2163(15)30438-2

# Impact of extending the interval for cervical screening

- In 2012, the OCSP switched to a 3-year screening interval from a 1-year screening interval
- Extending the screening interval did not have a significant impact on cervical cancer incidence or mortality in Ontario

| Indicator | Year | Rates per 100,000 (95% CI) |
|---|---|---|
| Cervical cancer incidence | 2010 | 9.2 (8.3 – 9.8) |
| | 2018 | 8.4 (7.8 – 9.1) |
| Cervical cancer mortality | 2007 – 09 | 2.2 (2.0 – 2.4) |
| | 2016 –18 | 2. 0 (1.8 – 2.2) |

Data source: Ontario Cancer Profiles: https://cancercareontario.ca/ontariocancerprofiles

# Take home messages

- Repeating the cytology test after 12 months allows more time for clearance of the HPV infection and avoids unnecessary interventions
  - Approximately 48% of HPV infections will resolve in 12 months and 70% of HPV infections will resolve in 24 months
- The risk of cervical cancer is very low for people with first time low-grade cytology results
- Extending the interval for repeating cytology after a low-grade result is safe and acceptable

# Considerations for people with a known HPV status

- Currently, HPV testing is not an insured test in Ontario. However, HPV testing is available in Ontario though patient-pay or in some hospitals
- HPV testing for someone with a first time ASCUS or LSIL is not required (repeat cytology in 12 months is safe and acceptable)
- However, those who make an informed decision to have an HPV test after a low-grade cytology result can follow these management recommendations:
  - People who are HPV 16/18 positive can be referred directly to colposcopy
  - People who are HPV non-16/18 positive should repeat their cytology in 12 months
  - People who are HPV negative should return to routine screening with cytology in 3 years

# Communications

- A communication sharing this update has been sent been sent to:
  - Regional Cancer Programs
  - Colposcopy associations, primary care associations and the Association of Ontario Midwives
- Ontario Health (Cancer Care Ontario) is working with Ontario labs that provide cervical screening testing to update cytology result reports so they reflect this recommendation change

# Case study 1: Follow-up of HPV+ patient with low-grade cytology

Dr. Rachel Kupets

# Reminder: HPV testing in Ontario

- OCSP will continue to recommend cytology testing for cervical screening until HPV testing is implemented as part of the program
  - Providers and participants should be assured that cytology alone is a safe and effective test for cervical screening
- Recognizing that HPV testing may be available for some participants, the OCSP provides some guidance on HPV testing and managing people with HPV test results on our website

# Case study 1

- A 35-year-old patient is referred to colposcopy after 2 LSILs one year apart
- Patient is seen in colposcopy 8 weeks later

Should a repeat cytology test be performed in colposcopy?

A. Yes

B. No

# ON data: Cytology results for participants who had a repeat test

| Repeat cytology result | Time from index cytology test | % (n) agreement with index cytology result by index cytology result | | | | | |
|---|---|---|---|---|---|---|---|
| | | ASCUS | LSIL | ASC-H | HSIL | AGC | AIS |
| Low-grade / normal cytology | <90 days | 95.0% (614) | 94.1% (593) | 47.5% (104) | 29.1% (72) | 70.1% (61) | 50.0% (<5) |
| | 3 – 6 months | 97.6% (4040) | 96.7% (2375) | 62.3% (91) | 47.4% (83) | 84.5% (71) | 0% (0) |
| High-grade cytology | <90 days | 5.0% (32) | 5.9% (37) | 52.5% (115) | 70.9% (175) | 29.9% (26) | 50.0% (<5) |
| | 3 – 6 months | 2.4% (98) | 3.3% (87) | 37.7% (55) | 52.6% (92) | 15.5% (13) | 0% (0) |

**Key takeaways**

- High agreement for low-grade/normal result
- Despite lower agreement for high-grade results, management should be based on the higher risk result for patient safety



Reference: Ontario Health data analysis

# Case study 1

- Colposcopy is performed and patient pays for HPV test

Result: **colposcopy did not detect a high-grade lesion (i.e., HSIL), HPV 16/18+**

What is the appropriate next step?

A. Follow-up in colposcopy in 6 months

B. Follow-up in colposcopy in 12 months

C. The next visit should be in primary care

# Case study 1

- 12-month colposcopy visit
  - Result: **colposcopy did not detect a high-grade lesion (i.e., HSIL), cytology ASCUS, HPV+**

# ON data: Risk for HSIL/invasive cancer for people referred with normal/low grade cytology, ≤LSIL in colposcopy

| | HSIL incidence rate | | Invasive cancer incidence rate | |
|---|---|---|---|---|
| **By index cytology** | 3-year rate (%) | 5-year rate (%) | 3-year rate (%) | 5-year rate (%) |
| Normal | 0.69 | 0.93 | 0 | 0.02 |
| ASCUS | 4.31 | 5.60 | 0.08 | 0.11 |
| LSIL | 5.85 | 7.23 | 0.04 | 0.07 |
| **By index biopsy** | 3-year rate (%) | 5-year rate (%) | 3-year rate (%) | 5-year rate (%) |
| No Biopsy | 4.11 | 5.20 | 0.05 | 0.08 |
| Negative | 2.85 | 3.81 | Negative* 0 | 0.05 |
| LSIL | 7.09 | 8.32 | LSIL^ 0 | 0 |

*There were <5 cases of invasive cervical cancer (ICC) during 5-year follow-up of negative biopsy

^There were zero cases of ICC during 5-year follow-up of biopsy confirmed LSIL

Reference: Ontario Health data analysis

# Case study 1



**TABLE 4A.** Immediate and 5-Year Risks of CIN 3+ Postcolposcopy at Which CIN 2+ Was Not Found, After Referral for Low-Grade Results

| History: precolposcopy test result | History: colposcopy result | Current HPV result | Current cytology result | *n* | % | CIN 3+ cases | CIN 3+ immediate risk, % | CIN 3 + 5-y risk, % | Recommended management | Recommendation confidence score, % |
|---|---|---|---|---|---|---|---|---|---|---|
| Low grade[a] | <CIN 2 | HPV-negative | NILM | 32,361 | 55 | 56 | 0.00 | **0.42** | 3-y follow-up | 99 |
| Low grade[a] | <CIN 2 | HPV-negative | ASC-US/LSIL | 2,937 | 5.0 | 14 | 0.05 | **0.92** | 1-y follow-up | 93 |
| Low grade[a] | <CIN 2 | HPV-negative | High grade[b] | 149 | 0.25 | 4 | 1.6 | 4.1 | Colposcopy | Special situation |
| Low grade[a] | <CIN 2 | HPV-negative | ALL[c] | 35,603 | 60 | 74 | 0.01 | **0.51** | 3-y follow-up | 73 |
| Low grade[a] | <CIN 2 | HPV-positive | NILM | 9,352 | 16 | 272 | **2.1** | **5.2** | 1-y follow-up | 100 |
| Low grade[a] | <CIN 2 | HPV-positive | ASC-US/LSIL | 12,843 | 22 | 445 | **3.1** | **6.0** | 1-y follow-up | 100 |
| Low grade[a] | <CIN 2 | HPV-positive | High grade[b] | 1,294 | 2.2 | 276 | **23** | 31 | Colposcopy | 94 |
| | | | Total[d] | 58,936 | 100 | 1,067 | | | | |

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Cancer Care Ontario

Reference: Egeman D, Cheung L, Chen X, Demarco M, Perkins R, Kinney W, et al. Risk Estimates Supporting the 2019 ASCCP Risk-Based Management Consensus Guidelines. J Low Genit Tract Dis 2020;24: 132–143.

# Case study 1

Is the risk of HSIL sufficiently low for discharge from colposcopy?

A. **Yes**, their risk for HSIL is low, therefore safe to discharge

B. **No**, their risk for HSIL is not low enough to discharge

Yes, risk is low enough to discharge but given HPV+ result, discharge to **annual cytology screening** in primary care

# Case study 1

- When discharging patients from colposcopy to primary care, we encourage colposcopists to indicate appropriate screening intervals in the discharge letter

# Discharge letter

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.<br><br>*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.<br><br>*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.<br><br>*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.<br><br>*These patients are at **slightly elevated risk** for high-grade dysplasia or cervical cancer and should be **screened annually**.* |

# Case study 1

- Current pathways, discharge letters and other resources for colposcopists are available on the OH (CCO) website: Toolkit for Ontario Colposcopists - Cancer Care Ontario
- Future state pathways will be risk-based, incorporating HPV and cytology testing

# Case study 2: Post-treatment management

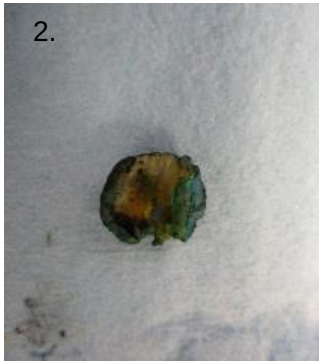
Dr. Rachel Kupets &
Dr. Nadia Ismiil

# Case study 2

- A 38-year-old patient is referred for colposcopy
  - Biopsy result: **HSIL**

- Loop electrosurgical excision procedure (LEEP) is performed
  - Result: **HSIL with extensive involvement of endocervical glands, negative margins**

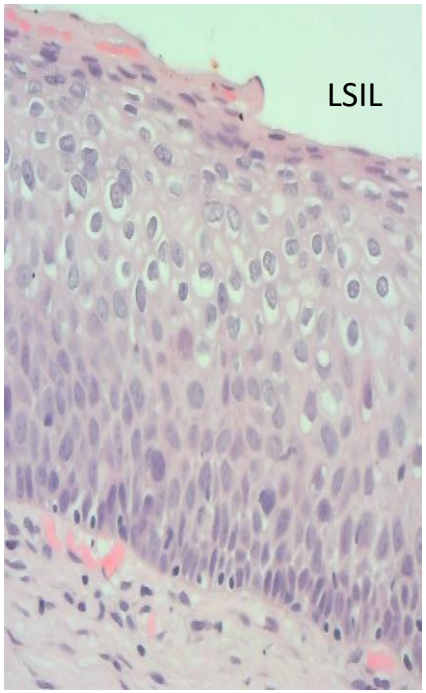
# Grossing and Description LEEP

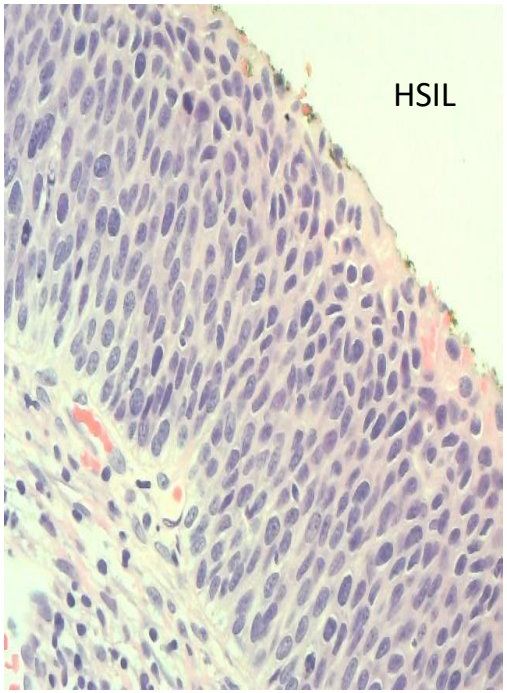



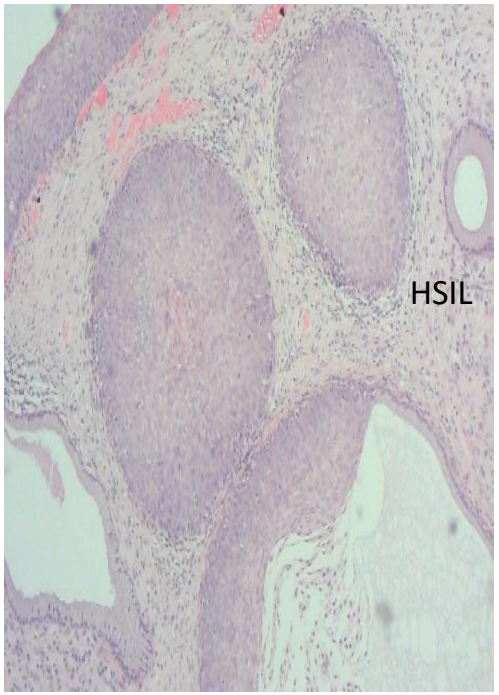


1. Identify, orient and measure
2. Ink margins 1) endocervix, 2) deep, 3) ectocervix
3. Serially section radially and submit

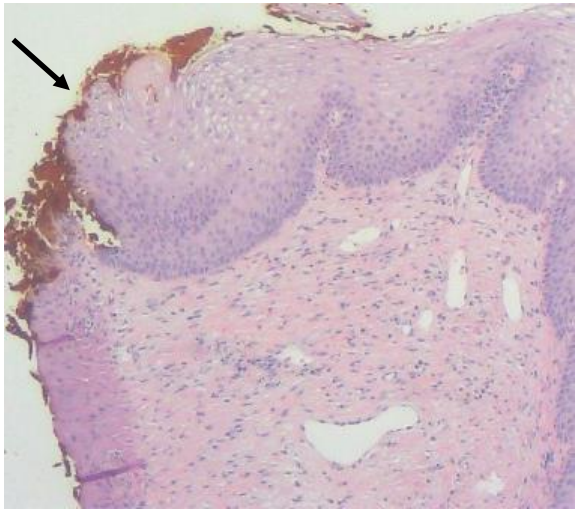
# Cervical dysplasia



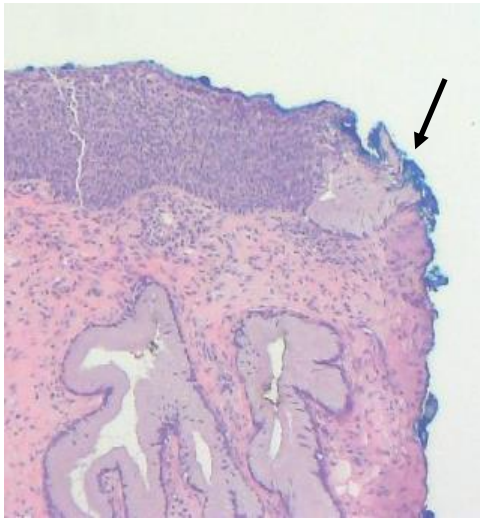



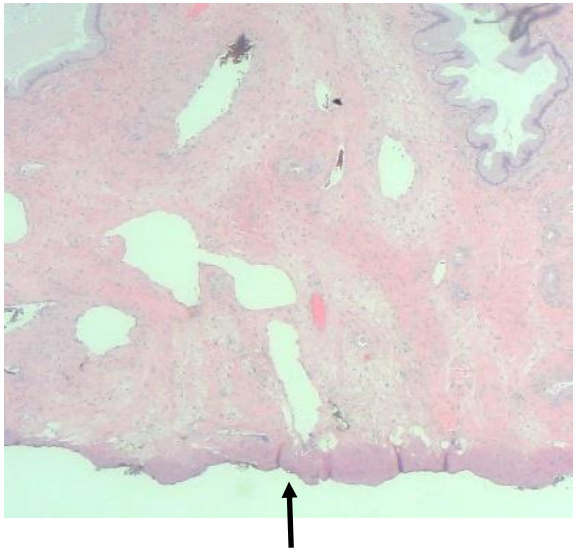
# LEEP margin evaluation



Ectocervix

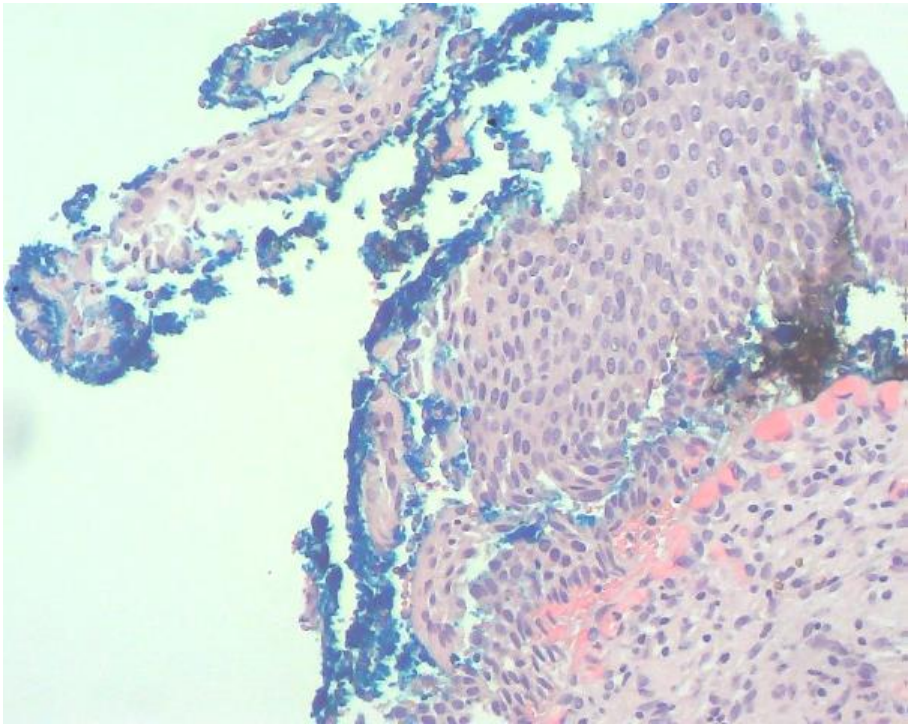


Endocervix



Deep

# Positive margin



# Case study 2

If your facility does not have access to HPV testing, how many post-treatment visits are required, assuming colposcopies do not detect high-grade lesions (i.e., HSIL) and all cytology results ≤ LSIL?

A. 1

B. 2

C. 3

D. 4

If HPV testing is available: only 2 post-treatment visits are required, assuming histo/cyto results ≤ LSIL at both and an HPV test at visit #2 is negative

# Case study 2

If your facility does not have access to HPV testing and all 3 post-treatment colposcopies do not detect a high-grade lesion (i.e., HSIL) and cytology results ≤ LSIL, **what is the appropriate screening interval when discharging to primary care?**

A. Every 6 months

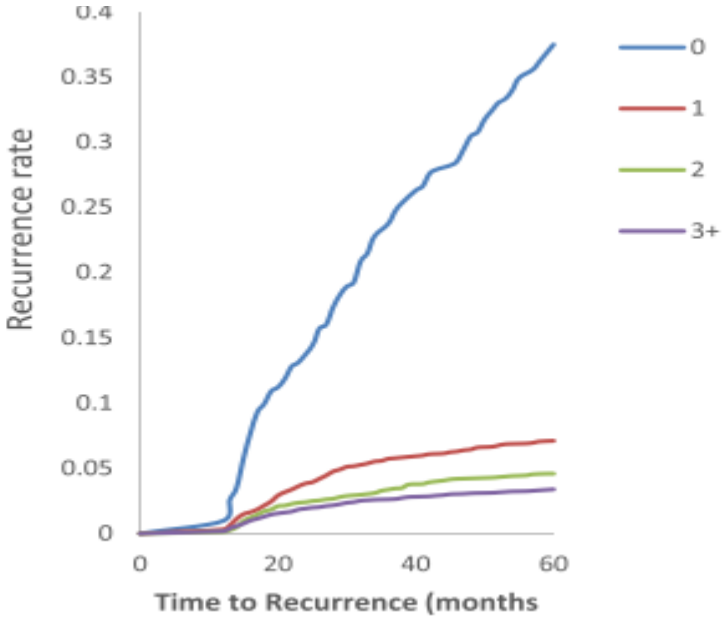
B. Annual screening

C. Routine screening every 3 years

If HPV testing is available: same recommendation applies (assuming histo/cyto results ≤LSIL at both post-treatment visits and negative HPV test at visit #2)

# ON data on recurrence by # of normal cytology tests after treatment for CIN3/AIS

**Recurrence by # of normal cytology tests after treatment**




5 Year Recurrence

0.....37.5%
1.....7.1%
2.....4.6%
3+.....3.4%
p=0.0001

**KEY TAKEWAYS**

- A normal cytology result after treatment reduces the risk of recurrence
- The more normal cytology results a person has, the lower their risk of recurrence
- There is still a risk of recurrence after 3+ normal cytology results, but risk is low enough to safely return to routine screening every 3 years



Reference: Swift BE, Wang L, Jembere N, Kupets R. Risk of recurrence after treatment for cervical intraepithelial neoplasia 3 and adenocarcinoma in situ of the cervix: recurrence of CIN 3 and AIS of cervix. J Low Genit Tract Dis. 2020;24(3):252–8

# Cervical screening and colposcopy quality reporting

Dr. Rachel Kupets

# Recap: 2021 quality reporting activities

- Reports sent by email on September 21, 2021
- Quality report overview and Q&A teleconference (October 21, 2021) facilitated by Provincial Clinical Lead and Lead Scientist
- Regional Cervical Screening and Colposcopy Leads available to answer questions, discuss reports and provide quality improvement guidance
- Evaluation of 2021 reports indicate most recipients:
  - Read all or part of the report.
  - Understood the standards and indicators
  - Believe the report accurately represents their facility's performance

# 2022 quality reports: what to expect

- Facility, regional and provincial quality reports will continue to be released annually
  - Target release: September 2022
- No significant updates to the report design, standards, indicators or reporting processes

Is there additional support the Ontario Cervical Screening Program or Regional Cervical Screening and Colposcopy Leads can provide to help you interpret the reports and identify quality improvement opportunities?

# Current activities: facility onboarding*

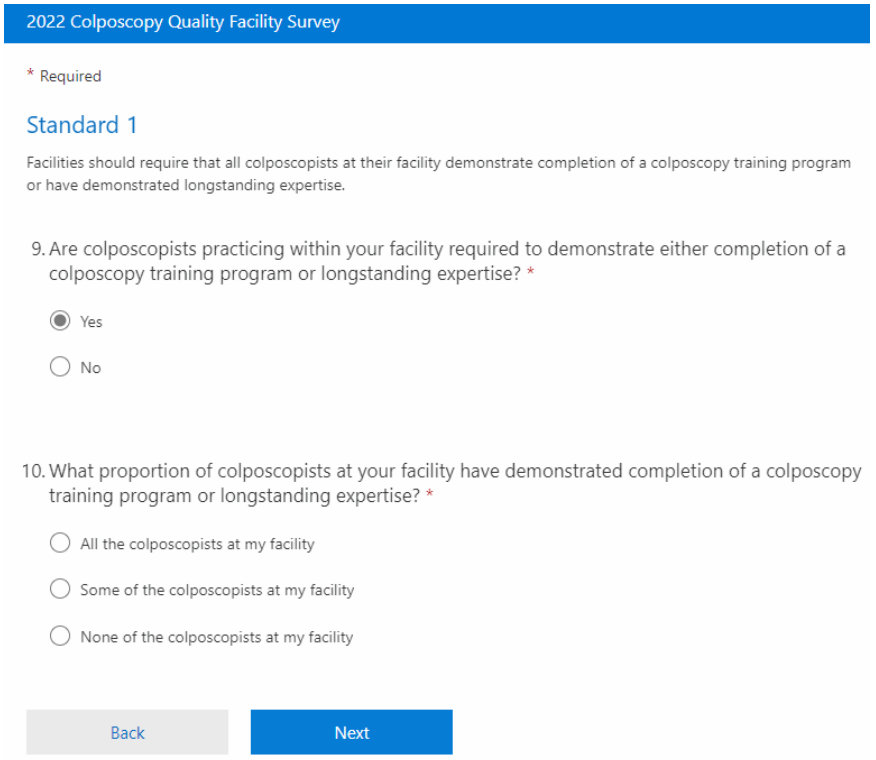
- Continuing to onboard non-hospital colposcopy facilities
- OCSP thresholds for considering an individual or group practice to be a separate facility are:
  - ≥ 50 colposcopy or treatment volumes that occur in a non-hospital setting; or
  - ≥ 30% of colposcopy or treatment volumes that occur in a non-hospital setting

| | Total number of eligible facilities | Number of onboarded facilities | Percentage of onboarded facilities that will receive quality reports |
|---|---|---|---|
| Hospitals | 57 | 57 | 100% |
| Non-hospitals | 83 | 53 | 64% |

*As of April 18, 2021

# Current activities: facility survey

- 2022 colposcopy quality facility survey is live!
  - Focused on adherence to nine quality standards
  - Survey link emailed to Facility Quality Leads on April 20, 2022
  - **Reminder!** Improvements to the implementation of standards will be reflected in your 2022 reports
  - **Deadline: June 10, 2022**



# How can you get involved?

- Connect with your Facility Quality Lead to understand your facility's report!
  - Engaging in conversations now about quality reporting and improvement will help prepare you for the release of physician-level reports
- Attend regional events hosted by your Regional Cervical Screening and Colposcopy Lead

Are there any approaches or resources your facility has found helpful with your report review and quality improvement activities?

# Next steps

- Email us at cancerscreening@ontariohealth.ca if you are:
  - A Facility Quality Lead and have not received a link to the survey
  - Unclear whether your facility has been onboarded and will be receiving a quality report this year
- Advance communication in August
  - Communicate report release date
  - Update contacts/report recipients, if required
- Report release in September
- Planning for physician-level reporting

# Questions from the field

**Dr. Dustin Costescu**

# Questions from the field

**Question:**

- Are there recommendations for vaginal vault testing?

**Answer:**

- Currently out of scope for the OCSP
- We understand that this is of interest and concern to clinicians
- The OCSP will be providing guidance on vaginal vault testing in primary care in our future state HPV testing recommendations

# Questions from the field

**Question:**

- What is the recommended approach to colposcopy in pregnancy?

**Answer:**

- Pregnant people with any high-grade lesions should be seen by a colposcopist who is experienced with colposcopy and management of lower genital tract abnormalities during pregnancy
- Aim is to exclude invasive disease
- If possible, defer biopsy or treatment until the pregnancy has concluded
- Pregnant people with apparent low-grade lesions should have repeat assessment with colposcopy and cytology testing at 12 weeks postpartum
- For additional details see OH (CCO) Clinical Guidance: Recommended Best Practices for Delivery of Colposcopy Services in Ontario (Section 2.3)

# Questions from the field

**Question:**

- What is the false negative rate associated with HPV testing in cervical screening?

**Key definitions:**

- **False negative:** a negative HPV test result when a lesion is present
- **Sensitivity**: the effectiveness of a test to correctly identify people with a disease
- **Specificity**: the effectiveness of a test to correctly identify people without a disease
- **Negative predictive value (NPV):** the probability that people with a negative screening test truly don't have the disease

# Questions from the field

**Answer:**

- High sensitivity is the most important element of a screening test
  - Specificity needs to be high enough to minimize falsely identifying participants with insignificant abnormalities
- Overall, HPV testing with reflex cytology offers greater sensitivity while reducing unnecessary colposcopy referrals[1]
- NPV of HPV testing for detecting HSIL or worse is very high (over 99% over 10 years[2]), therefore the protective value of a negative HPV test is very reassuring

References: 1. Grimes D, Corry E, Malagon T, O'Riain C, Franco E, & Brennan D. Modeling Cervical Cancer Screening Strategies With Varying Levels of Human Papillomavirus Vaccination. JAMA Network Open. 2021;4(6):e2115321 2. Elfstrom M, Smelov V, Johansson A, Eklund C, Naucler P, Arnheim-Dahlström L, et al. Long term duration of protective effect for HPV negative women: follow-up of primary HPV screening randomised controlled trial. BMJ 2014 Jan 16.

# Questions from the field

**Question:**

- What is the recommended approach to discharging unattached patients from colposcopy?

**Answer:**

- Access to primary care is an important issue that has been exacerbated by the pandemic
- However, this is a system-level challenge
- Ongoing colposcopy should not be performed on discharged patients
- If no primary care provider is available, consider seeing the patient in a gynecology practice (yours or an amenable colleague)
- You may also refer the patient to Health Care Connect

# Concluding remarks

Dr. Dustin Costescu

# Accreditation

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

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

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

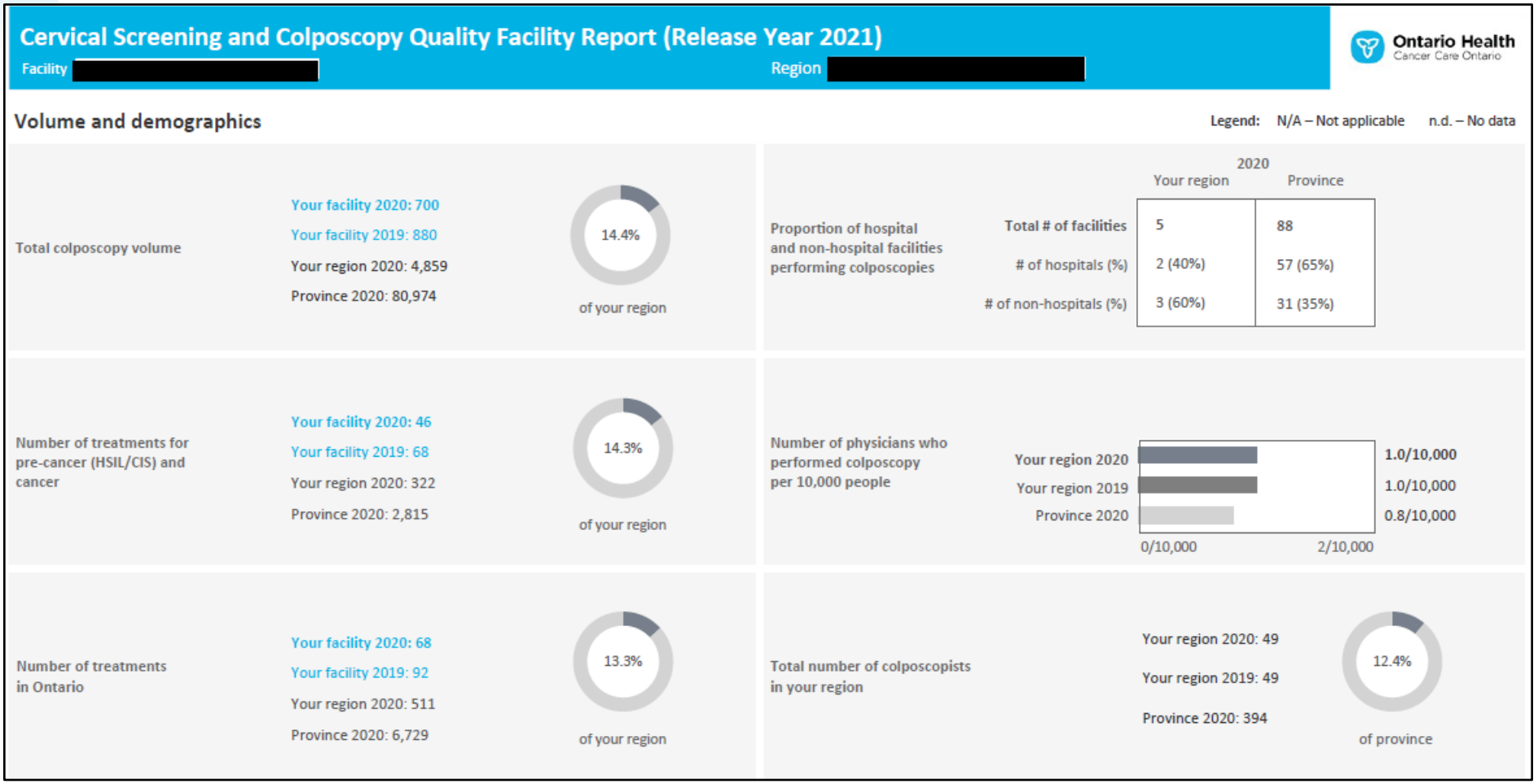
# What's next?

- Please ensure you fill out the post-webinar survey – survey link will be emailed to CoP webinar attendees
- Next CoP webinar: Fall 2022 (dates TBD)
- Share your feedback and questions with us at ColposcopyCoP@ontariohealth.ca


Thank
You!

# Appendix: Cervical screening and colposcopy quality reporting

# Facility report: volume and demographics



Cervical Screening and Colposcopy Quality Facility Report (Release Year 2021)

Facility [redacted] Region [redacted]

Ontario Health
Cancer Care Ontario

Volume and demographics

Legend: N/A – Not applicable n.d. – No data

**Total colposcopy volume**

Your facility 2020: 700
Your facility 2019: 880
Your region 2020: 4,859
Province 2020: 80,974

14.4% of your region

**Proportion of hospital and non-hospital facilities performing colposcopies**

2020

| | Your region | Province |
|---|---|---|
| Total # of facilities | 5 | 88 |
| # of hospitals (%) | 2 (40%) | 57 (65%) |
| # of non-hospitals (%) | 3 (60%) | 31 (35%) |

**Number of treatments for pre-cancer (HSIL/CIS) and cancer**

Your facility 2020: 46
Your facility 2019: 68
Your region 2020: 322
Province 2020: 2,815

14.3% of your region

**Number of physicians who performed colposcopy per 10,000 people**

Your region 2020 1.0/10,000
Your region 2019 1.0/10,000
Province 2020 0.8/10,000

0/10,000 2/10,000

**Number of treatments in Ontario**

Your facility 2020: 68
Your facility 2019: 92
Your region 2020: 511
Province 2020: 6,729

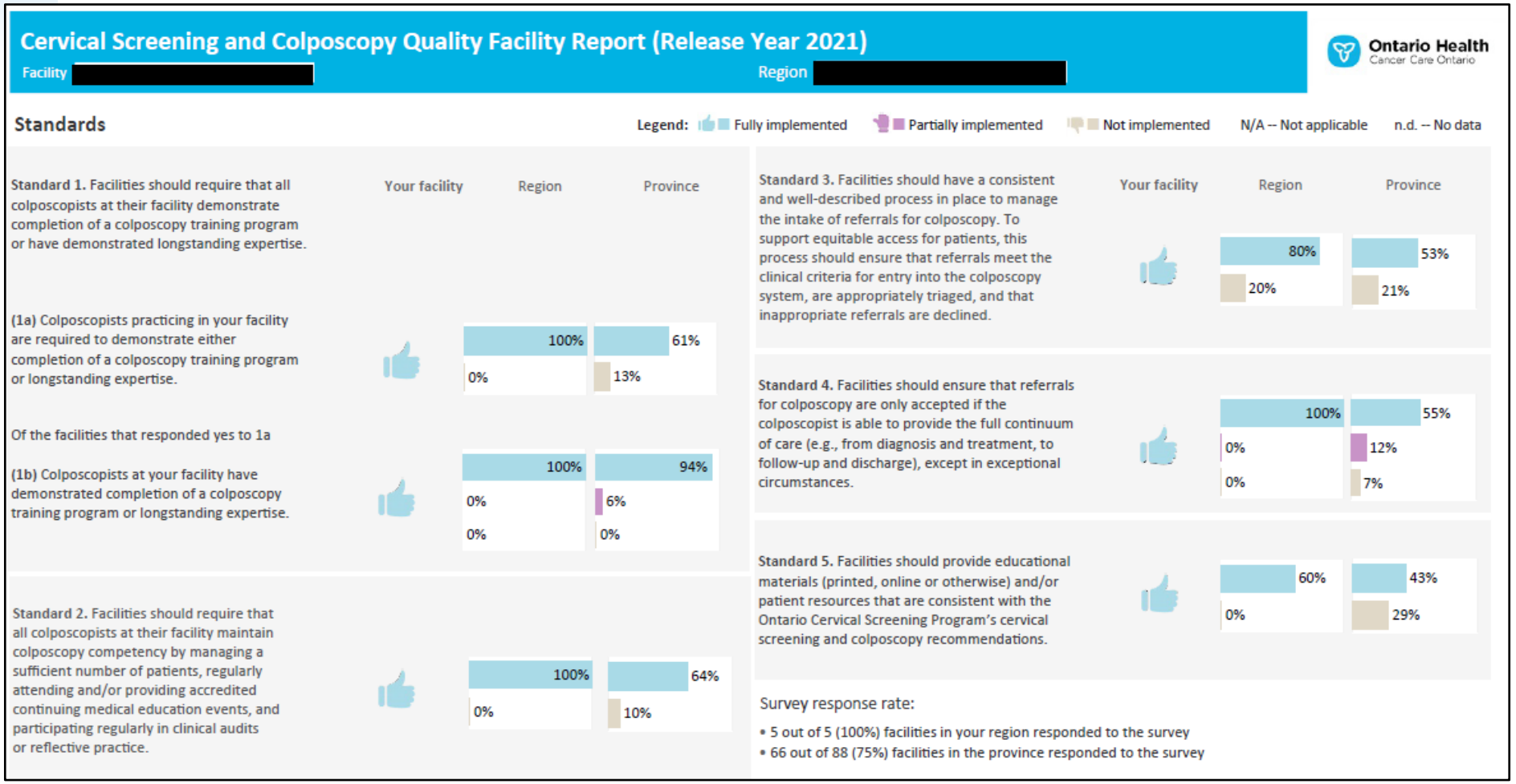
13.3% of your region

**Total number of colposcopists in your region**

Your region 2020: 49
Your region 2019: 49
Province 2020: 394

12.4% of province

# Facility report: standards



## Cervical Screening and Colposcopy Quality Facility Report (Release Year 2021)

Facility [redacted] Region [redacted]

Ontario Health
Cancer Care Ontario

### Standards

Legend: Fully implemented | Partially implemented | Not implemented | N/A -- Not applicable | n.d. -- No data

**Standard 1.** Facilities should require that all colposcopists at their facility demonstrate completion of a colposcopy training program or have demonstrated longstanding expertise.

| | Your facility | Region | Province |
|---|---|---|---|
| (1a) Colposcopists practicing in your facility are required to demonstrate either completion of a colposcopy training program or longstanding expertise. | | 100% | 61% |
| | | 0% | 13% |
| Of the facilities that responded yes to 1a | | | |
| (1b) Colposcopists at your facility have demonstrated completion of a colposcopy training program or longstanding expertise. | | 100% | 94% |
| | | 0% | 6% |
| | | 0% | 0% |

**Standard 2.** Facilities should require that all colposcopists at their facility maintain colposcopy competency by managing a sufficient number of patients, regularly attending and/or providing accredited continuing medical education events, and participating regularly in clinical audits or reflective practice.

| | Your facility | Region | Province |
|---|---|---|---|
| | | 100% | 64% |
| | | 0% | 10% |

**Standard 3.** Facilities should have a consistent and well-described process in place to manage the intake of referrals for colposcopy. To support equitable access for patients, this process should ensure that referrals meet the clinical criteria for entry into the colposcopy system, are appropriately triaged, and that inappropriate referrals are declined.

| | Your facility | Region | Province |
|---|---|---|---|
| | | 80% | 53% |
| | | 20% | 21% |

**Standard 4.** Facilities should ensure that referrals for colposcopy are only accepted if the colposcopist is able to provide the full continuum of care (e.g., from diagnosis and treatment, to follow-up and discharge), except in exceptional circumstances.

| | Your facility | Region | Province |
|---|---|---|---|
| | | 100% | 55% |
| | | 0% | 12% |
| | | 0% | 7% |

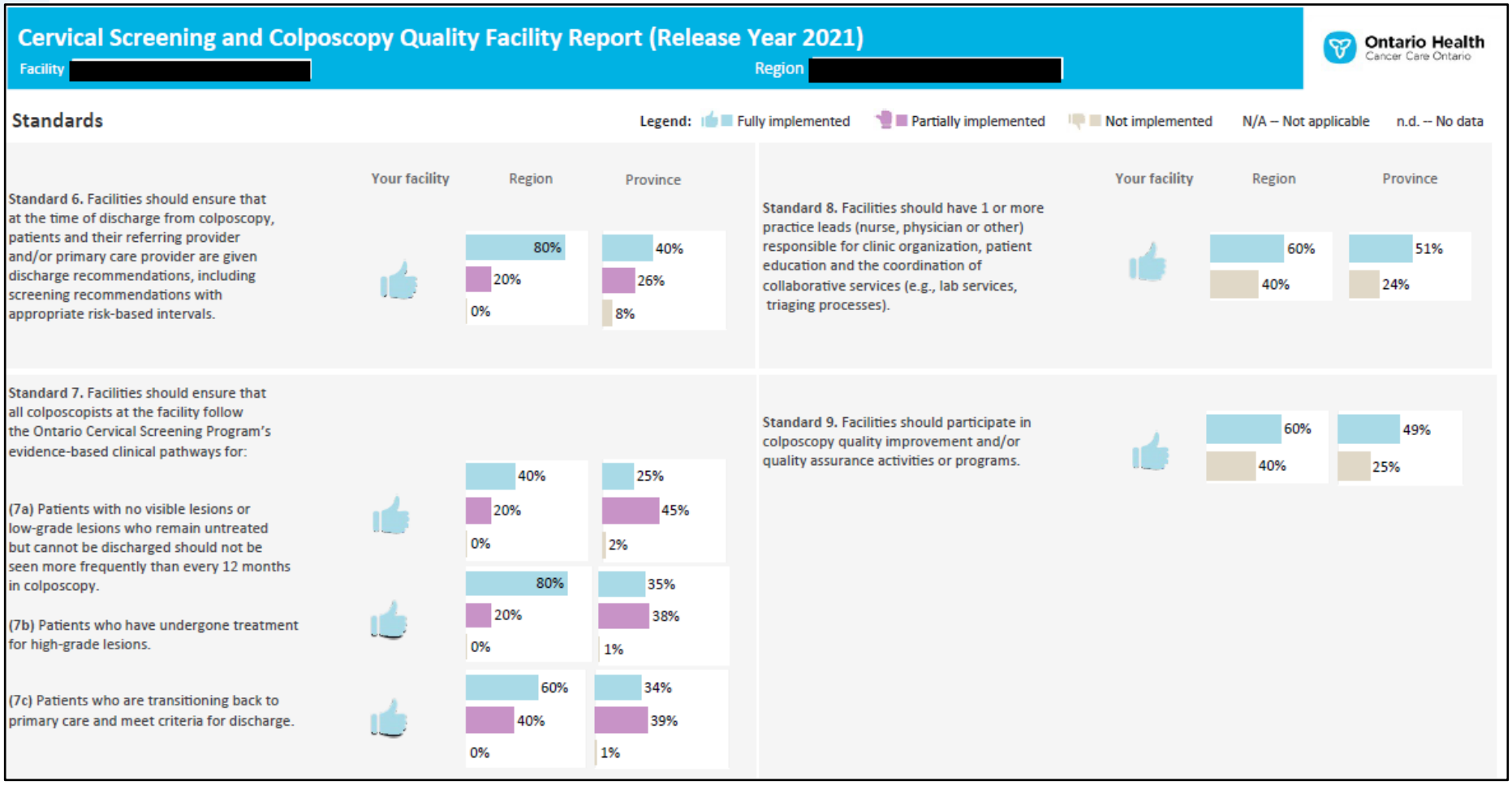
**Standard 5.** Facilities should provide educational materials (printed, online or otherwise) and/or patient resources that are consistent with the Ontario Cervical Screening Program's cervical screening and colposcopy recommendations.

| | Your facility | Region | Province |
|---|---|---|---|
| | | 60% | 43% |
| | | 0% | 29% |

Survey response rate:

- 5 out of 5 (100%) facilities in your region responded to the survey
- 66 out of 88 (75%) facilities in the province responded to the survey

# Facility report: standards con't



Cervical Screening and Colposcopy Quality Facility Report (Release Year 2021)

Facility [redacted] Region [redacted]

Ontario Health
Cancer Care Ontario

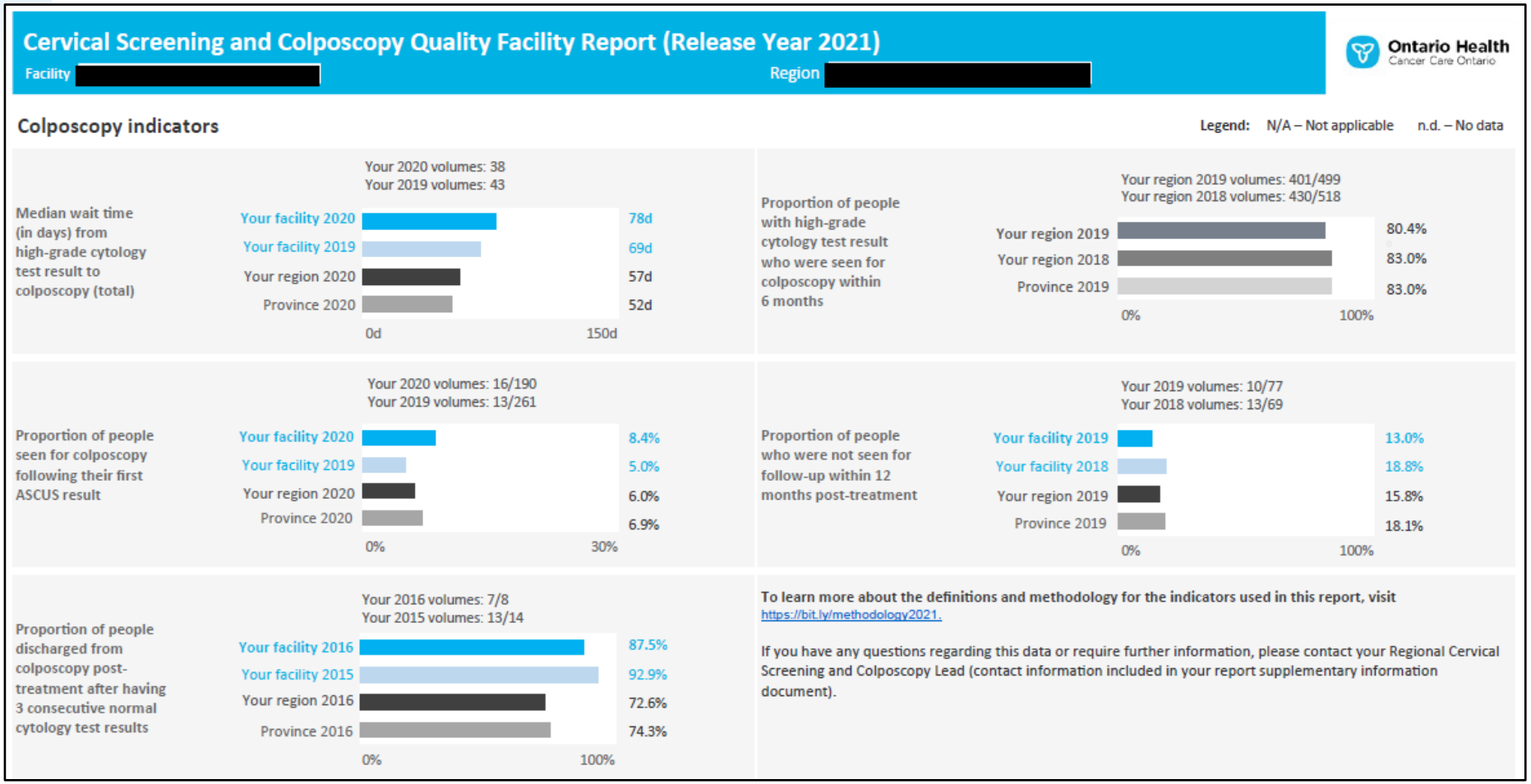
Standards

Legend: Fully implemented | Partially implemented | Not implemented | N/A – Not applicable | n.d. -- No data

| | Your facility | Region | Province |
|---|---|---|---|
| **Standard 6.** Facilities should ensure that at the time of discharge from colposcopy, patients and their referring provider and/or primary care provider are given discharge recommendations, including screening recommendations with appropriate risk-based intervals. | | 80% / 20% / 0% | 40% / 26% / 8% |
| **Standard 7.** Facilities should ensure that all colposcopists at the facility follow the Ontario Cervical Screening Program's evidence-based clinical pathways for: | | | |
| (7a) Patients with no visible lesions or low-grade lesions who remain untreated but cannot be discharged should not be seen more frequently than every 12 months in colposcopy. | | 40% / 20% / 0% | 25% / 45% / 2% |
| (7b) Patients who have undergone treatment for high-grade lesions. | | 80% / 20% / 0% | 35% / 38% / 1% |
| (7c) Patients who are transitioning back to primary care and meet criteria for discharge. | | 60% / 40% / 0% | 34% / 39% / 1% |

| | Your facility | Region | Province |
|---|---|---|---|
| **Standard 8.** Facilities should have 1 or more practice leads (nurse, physician or other) responsible for clinic organization, patient education and the coordination of collaborative services (e.g., lab services, triaging processes). | | 60% / 40% | 51% / 24% |
| **Standard 9.** Facilities should participate in colposcopy quality improvement and/or quality assurance activities or programs. | | 60% / 40% | 49% / 25% |

# Facility report: colposcopy indicators



# Facility report: cervical screening indicators

## Cervical Screening and Colposcopy Quality Facility Report (Release Year 2021)

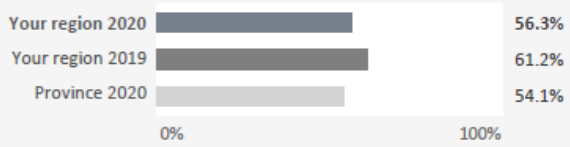
Facility [redacted] Region [redacted]

Ontario Health
Cancer Care Ontario

### Cervical screening indicators

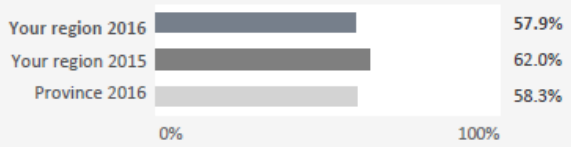
**Cervical screening (cytology test) participation**

Your region 2020 volumes: 251,535/447,168
Your region 2019 volumes: 269,733/441,081




**Cervical screening (cytology test) retention**

Your region 2016 volumes: 44,995/77,767
Your region 2015 volumes: 56,651/91,394




**Positive predictive value (pre-cancer and cancer)**

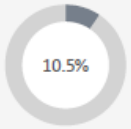
| | Your region | Province |
|---|---|---|
| Pre-cancer 2019 | 224 (5.0%) | 1,882 (4.5%) |
| Cancer 2019 | 13 (0.30%) | 122 (0.30%) |
| Pre-Cancer 2018 | 291 (6.1%) | 2,546 (5.9%) |
| Cancer 2018 | 18 (0.40%) | 135 (0.30%) |

**Detection rate (pre-cancer and cancer)**

| | Your region | Province |
|---|---|---|
| Pre-cancer 2019 | 224 (2.5/1,000) | 1,882 (2.2/1,000) |
| Cancer 2019 | 13 (0.15/1,000) | 122 (0.14/1,000) |
| Pre-cancer 2018 | 291 (3.1/1,000) | 2,546 (2.9/1,000) |
| Cancer 2018 | 18 (0.19/1,000) | 135 (0.15/1,000) |

**Total number of cytology tests in Ontario**

Your region 2020: 67,640
Your region 2019: 110,275
Province 2020: 645,085




of province

Cervical screening performance, as measured by these indicators, cannot be reported at the facility level. Regional and provincial-level performance data for these indicators have been included for information and to inform quality improvement initiatives.