Spring Provincial Colposcopy Community of Practice (CoP)

Webinar 2

JUNE 18, 2021, 7:30 – 9:00 A.M.

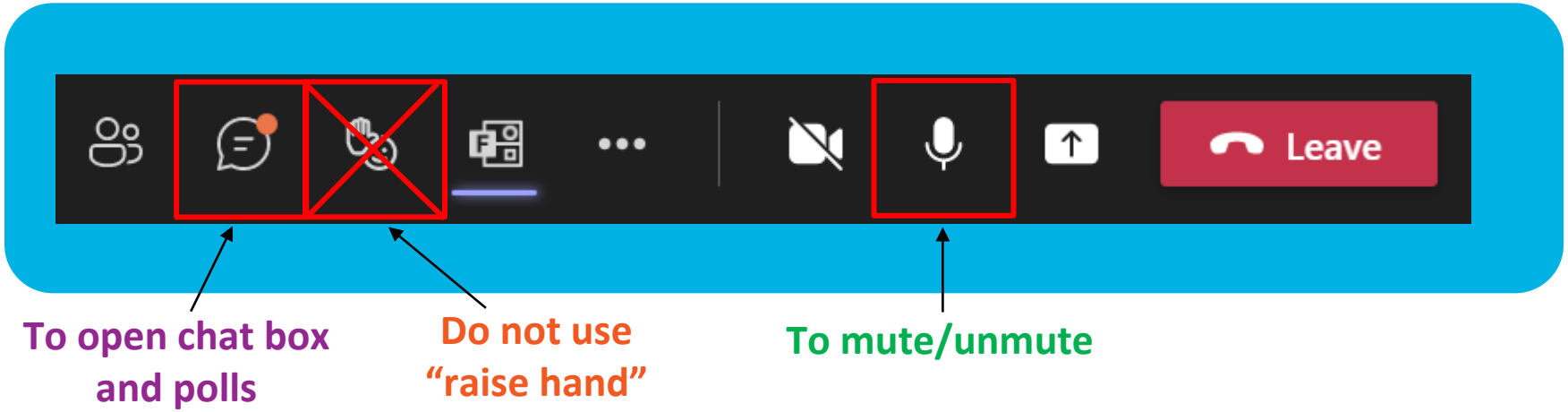
Recommended browser for Microsoft Teams: Google Chrome

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**



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. Paul Gurland

Dr. Felice Lackman

Dr. Keiyan Sy

Dr. Laura White

Welcome to the Colposcopy Community of Practice (CoP) spring webinar

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

Agenda

Item	Presenter	Time
Welcome and introductions	Dr. Joan Murphy	7:30-7:35 am
Ontario Cervical Screening Program (OCSP) updates	Dr. Joan Murphy	7:35-7:45 am
Cervical screening and colposcopy during COVID-19: What we are seeing at the provincial level	Dr. Joan Murphy and Dr. Rachel Kupets	7:45-7:50 am
Cervical screening and colposcopy quality reporting	Dr. Rachel Kupets	7:50-8:00 am
Case studies: • Discharge from colposcopy post-treatment • Discharge from colposcopy for untreated patients	Dr. Joan Murphy and Dr. Rachel Kupets	8:00-8:40 am
Questions from the field	Dr. Joan Murphy	8:40-8:55 am
Concluding remarks	Dr. Joan Murphy	8:55-9:00 am

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 assessment for discharge from colposcopy for treated and untreated patients
- What to communicate to primary care providers when discharging people from colposcopy
- Appropriate use of human papillomavirus (HPV) testing according to current OCSP recommendations when accessible

Ontario Cervical Screening Program updates

Contact your Regional Cervical Screening and Colposcopy Lead (CSCL) for screening or colposcopy related questions

Regional Cancer Program	CSCL name
1. Erie St. Clair	Dr. Rahi Victory
2. South West	Dr. Robert DiCecco
3. Waterloo Wellington	Dr. Emma Wakim
4. Hamilton Niagara	Dr. Dustin Costescu
5/6. Central West / Mississauga Halton	Dr. Paul Gurland
7. Toronto Central	Dr. Michael Shier
8. Central	Dr. Felice Lackman
9. Central East	Dr. Nathan Roth
10. South East	**Dr. Elena Park**
11. Champlain	**Dr. Hélène Gagné**
12. North Simcoe Muskoka	Dr. Laura White
13. North East	Dr. Jennifer Jocko

For CSCL contact information, please email us at ColposcopyCoP@ontariohealth.ca

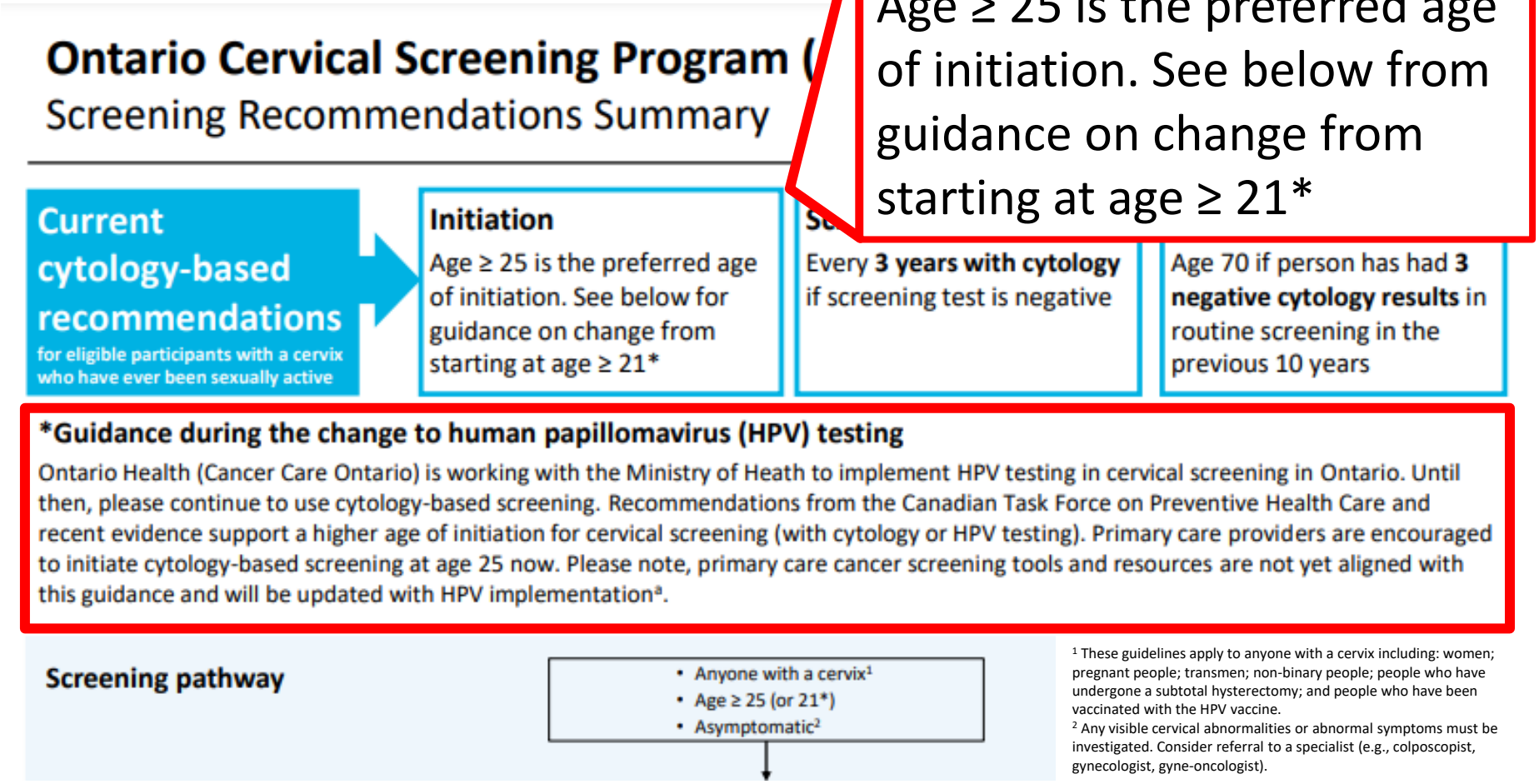
Age of initiation

- Primary care providers are encouraged to initiate cervical screening at **age 25**
  - Based on evidence that there is minimal benefit in cervical screening for people under the age of 25
  - This guidance is aligned with other organized cervical screening programs in Canada such as British Columbia, Alberta, and Nova Scotia

Updates to provider resources

- Relevant webpages have been updated to reflect new guidance
- OCSP provider tool has also been

Initiation
Age ≥ 25 is the preferred age of initiation. See below from guidance on change from starting at age ≥ 21*



Ontario Cervical Screening Program (
Screening Recommendations Summary

Current cytology-based recommendations
for eligible participants with a cervix who have ever been sexually active

Initiation
Age ≥ 25 is the preferred age of initiation. See below for guidance on change from starting at age ≥ 21*

S
Every **3 years with cytology** if screening test is negative

Age 70 if person has had **3 negative cytology results** in routine screening in the previous 10 years

***Guidance during the change to human papillomavirus (HPV) testing**

Ontario Health (Cancer Care Ontario) is working with the Ministry of Heath to implement HPV testing in cervical screening in Ontario. Until then, please continue to use cytology-based screening. Recommendations from the Canadian Task Force on Preventive Health Care and recent evidence support a higher age of initiation for cervical screening (with cytology or HPV testing). Primary care providers are encouraged to initiate cytology-based screening at age 25 now. Please note, primary care cancer screening tools and resources are not yet aligned with this guidance and will be updated with HPV implementation[a].

Screening pathway

- Anyone with a cervix[1]
- Age ≥ 25 (or 21*)
- Asymptomatic[2]

[1] These guidelines apply to anyone with a cervix including: women; pregnant people; transmen; non-binary people; people who have undergone a subtotal hysterectomy; and people who have been vaccinated with the HPV vaccine.
[2] Any visible cervical abnormalities or abnormal symptoms must be investigated. Consider referral to a specialist (e.g., colposcopist, gynecologist, gyne-oncologist).

Update on HPV testing implementation

Ongoing work

- Finalizing Request for Proposals for a provincial HPV test system vendor and laboratory services for HPV testing and cytology
- Working with the Ministry of Health to obtain Treasury Board approval for procurements
- Working with the Ministry of Health on updates to the Physician Services Schedule of Benefits
- Updating OCSP information technology systems (e.g., data collection, correspondence, screening activity report, reporting and analytics)
- Preparing resources for provider change management (e.g., FAQs, continuing professional development modules)
- Updating cervical screening recommendations and best practice pathways for screening-related colposcopy

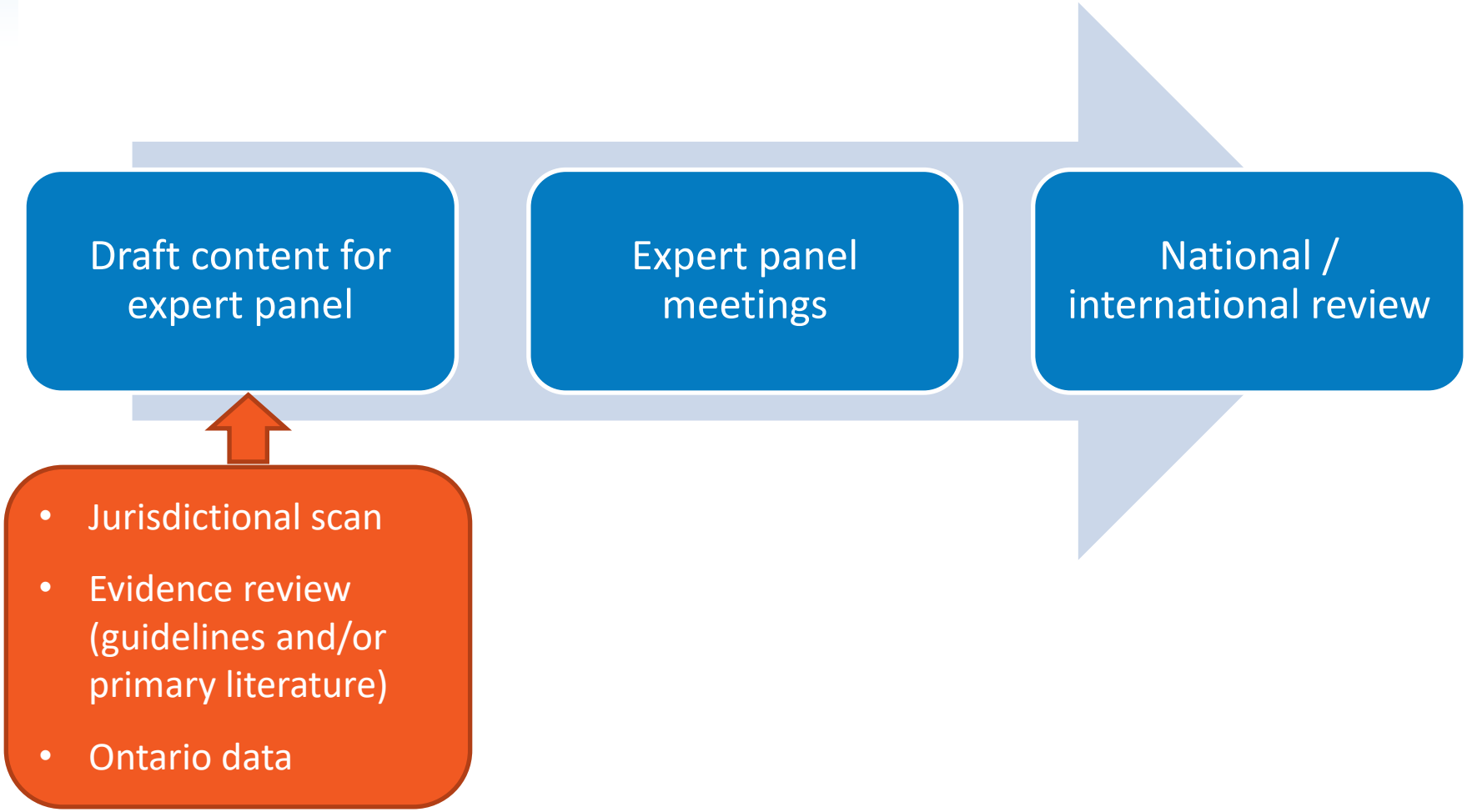
Updating the OCSP screening and colposcopy recommendations

- Key areas under review
  - HPV-based algorithms for screening and colposcopy
  - Screening cessation
  - Management of patients with AGC/AIS
  - Management of people under age 25 in screening and colposcopy
  - Screening for people who are immunocompromised
  - Repeat testing post-unsatisfactory cytology and/or invalid HPV test result
  - Vaginal vault testing for patients with total hysterectomy

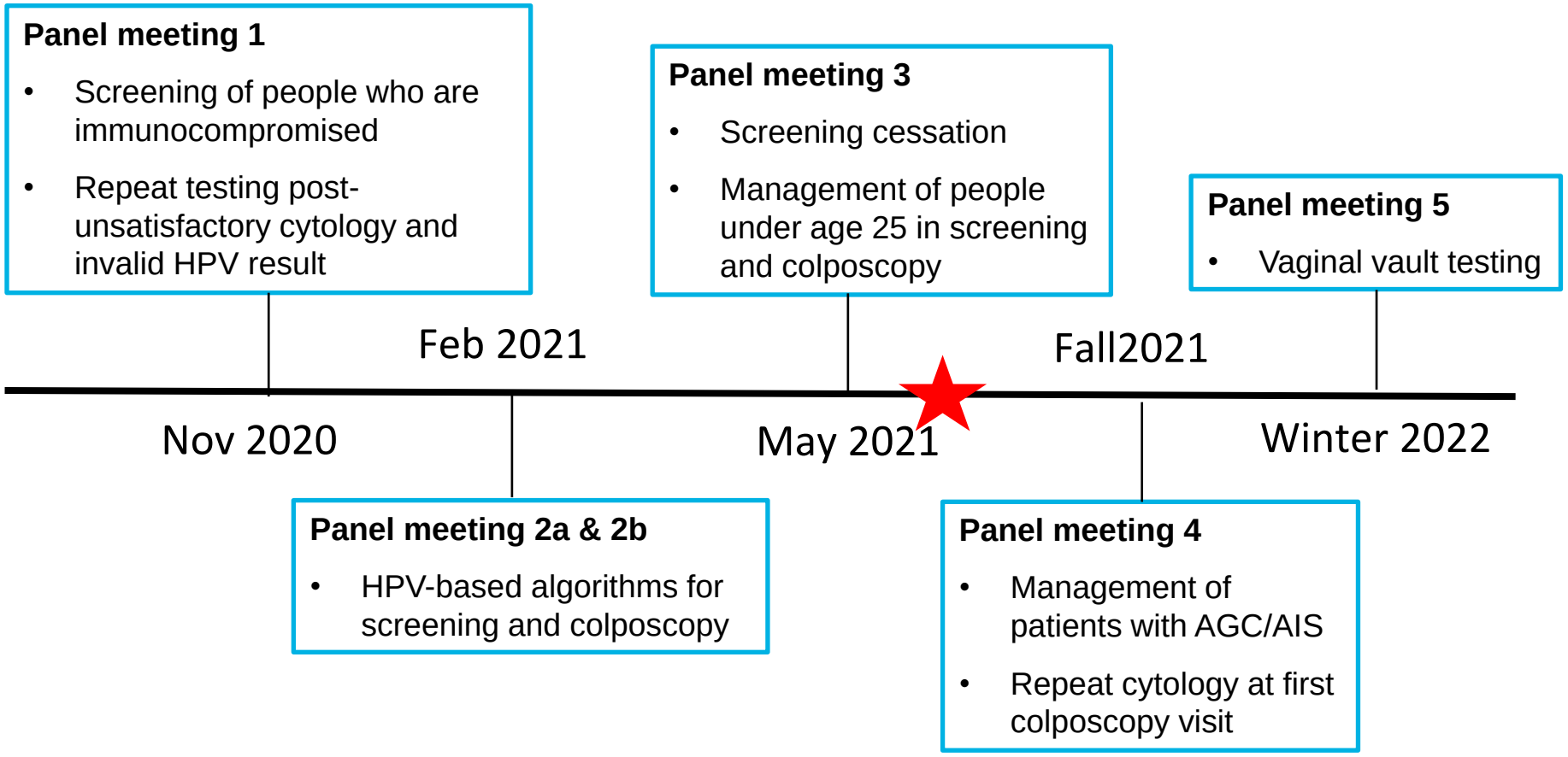
AGC: atypical glandular cells

AIS: adenocarcinoma in-situ

Approach to finalizing the updated recommendations



Timelines for expert panel meetings



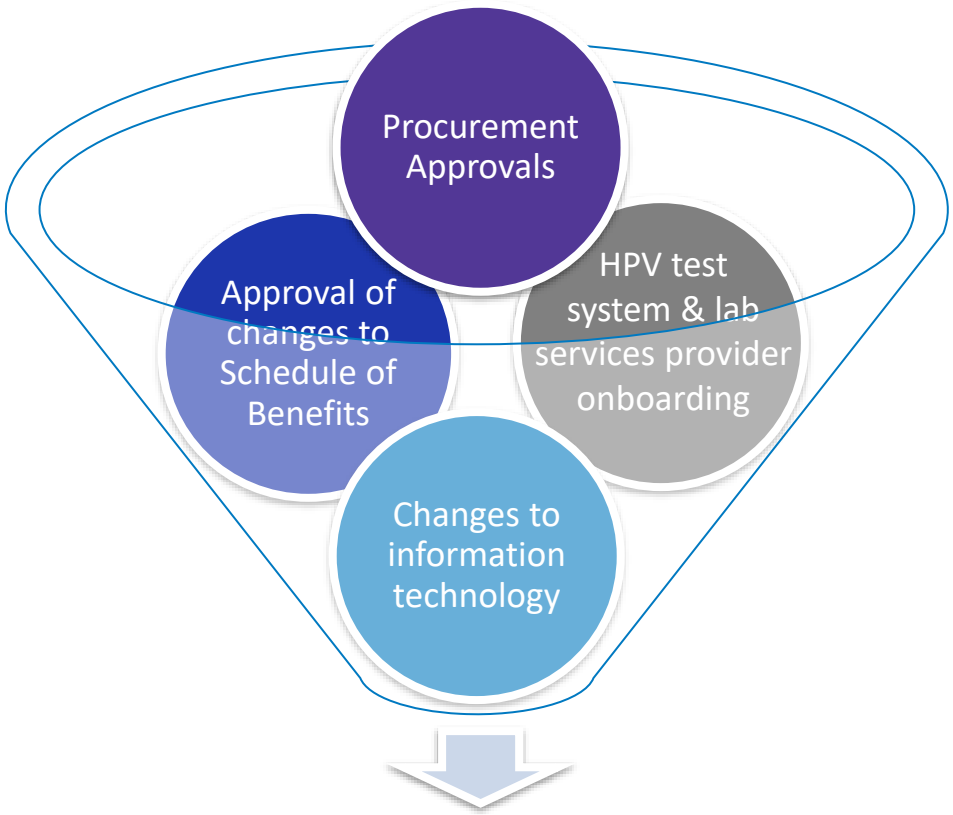
OCSP is moving towards risk-based care

Future cervical screening and colposcopy recommendations will be based on risk of cervical intraepithelial neoplasia 3+ (CIN3+)

- Risk of CIN3+ is based on combination of cytology and HPV test result, and type of HPV infection
- Recommendation for next step is based on **immediate risk** of CIN3+
- Subsequent recommendations (e.g., next screening interval) are based on **5-year risk** of CIN3+

Equal management for equal risk

Launch date


Procurement Approvals
Approval of changes to Schedule of Benefits
HPV test system & lab services provider onboarding
Changes to information technology
Launch Date

Cervical screening and colposcopy during COVID-19: What we are seeing at the provincial level

COVID-19 tip sheets about screening and colposcopy

Created to supplement guidance on resumption of healthcare services issued by the Ministry of Health* and Ontario Health:

- *COVID Tip Sheet for Primary Care Providers #15: Guidance for Resumption of Cancer Screening*
- *COVID-19 Tip Sheet for Facilities Performing Colposcopy #12: Guidance for Increasing Colposcopy*

Tip sheets are available here: www.cancercareontario.ca/en/guidelines-advice/covid-19-resources/cancer-screening-during-covid-19

*For the most up-to-date directives regarding COVID-19, see http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/dir_mem_res.aspx

Guidance for resumption of cervical screening

- People with a first time LSIL or ASCUS should be rescreened with cytology at approximately **12 months**
  - Colposcopy referrals for people with first time ASCUS or LSIL results should be declined
- However, people with a first time LSIL or ASCUS who have had an HPV test and are HPV 16/18 positive should be referred to colposcopy

LSIL: low-grade squamous intraepithelial lesion
ASCUS: atypical squamous cells of undetermined significance

Guidance for colposcopy services during the pandemic

- Colposcopy tip sheet provides framework for prioritization of colposcopy services
- Risk-based approach based on Ontario data and evidence from the literature used to determine priority level of screening abnormalities referred to colposcopy
- Each priority level corresponds to a person's immediate risk of CIN3+ and is based on recent cervical screening history (i.e. cytology and/or HPV test result)

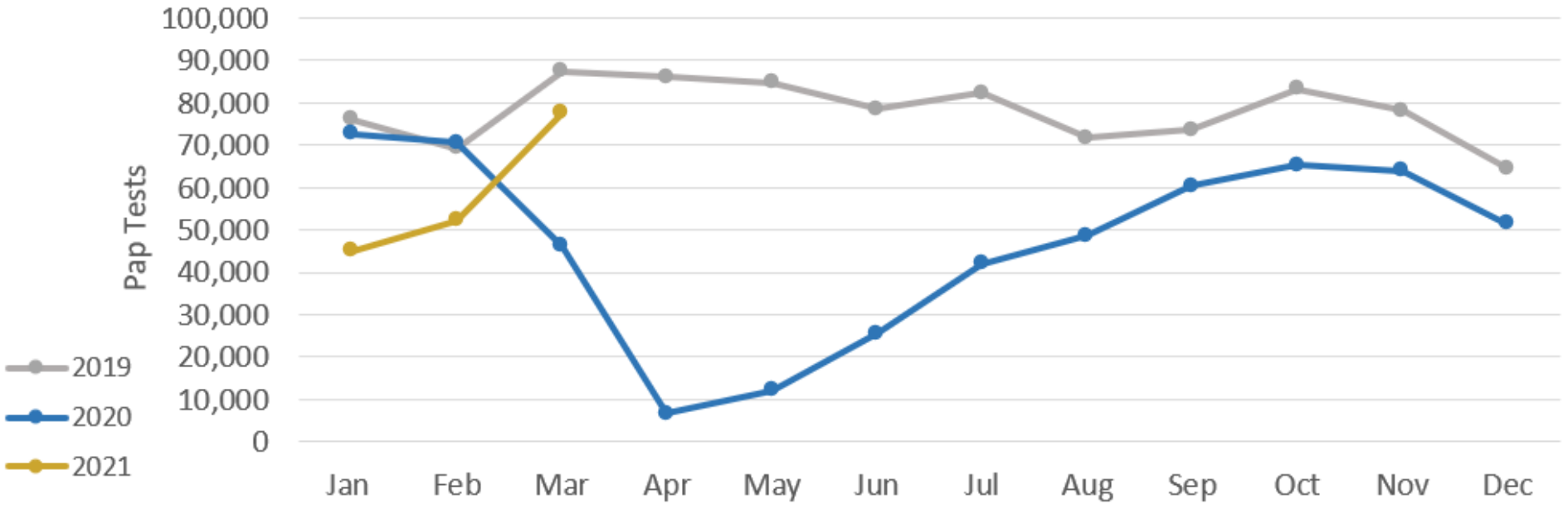
Prioritization framework from COVID-19 Tip Sheet

Priority/Risk-based threshold	Cytology result	HPV status where available
B1 Immediate risk for CIN3+ **> 15%**	AIS	Regardless of HPV status
	HSIL+	
	AGC	
	ASC-H	
B2 Immediate risk of CIN3+ is **7% - 15%**	ASCUS	HPV 16/18 positive
	LSIL	
	LSIL, LSIL	Unknown
	LSIL, ASCUS	
	ASCUS, LSIL	
	ASCUS, ASCUS	
C Immediate risk for CIN3+ **< 7%**	ASCUS	Unknown or HPV positive for non 16/18
	LSIL	

Patients with immediate risk of CIN3+ **<7%** should **not** be referred to colposcopy

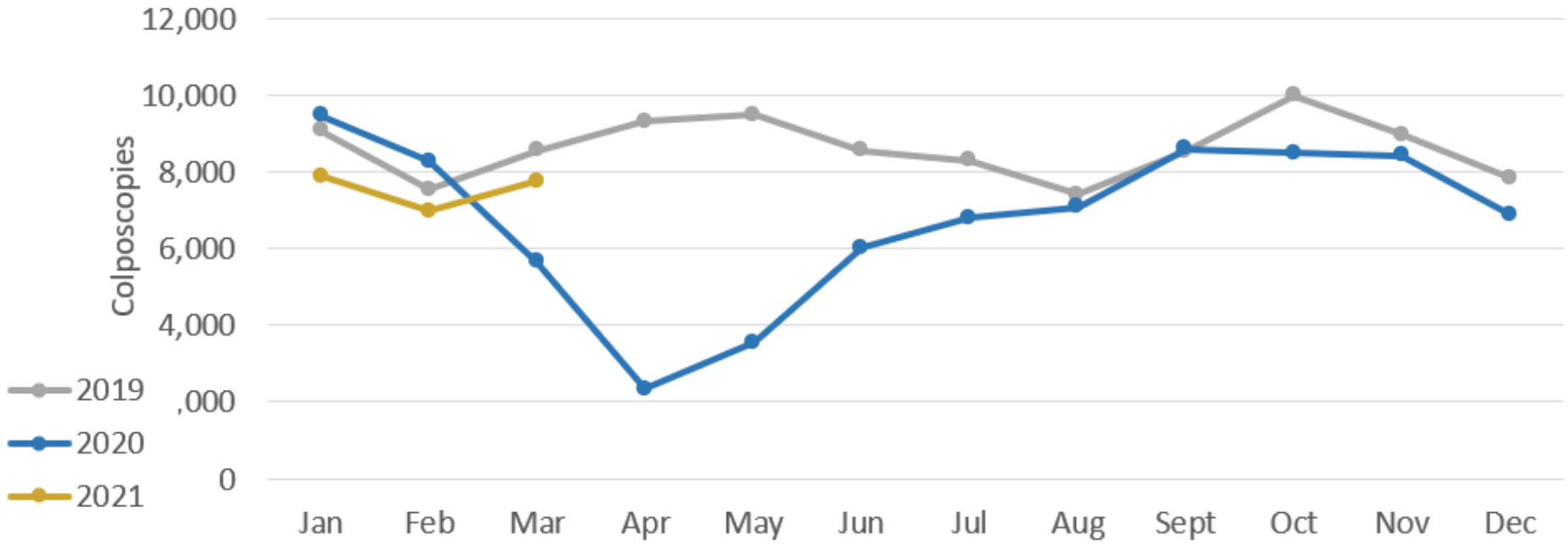
Cheung LC, Egemen D, Chen X, Katki HA, Demarco M, Wiser AL et al. 2019 ASCCP Risk-based management consensus guidelines: methods for risk estimation, recommended management, and validation. J Low Genit Tract Dis .2020 Apr;24(2):90.
Demarco M, Carter-Pokras O, Hyun N, Castle PE, He X, Dallal CM, et al. 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.

Pap test volumes by month



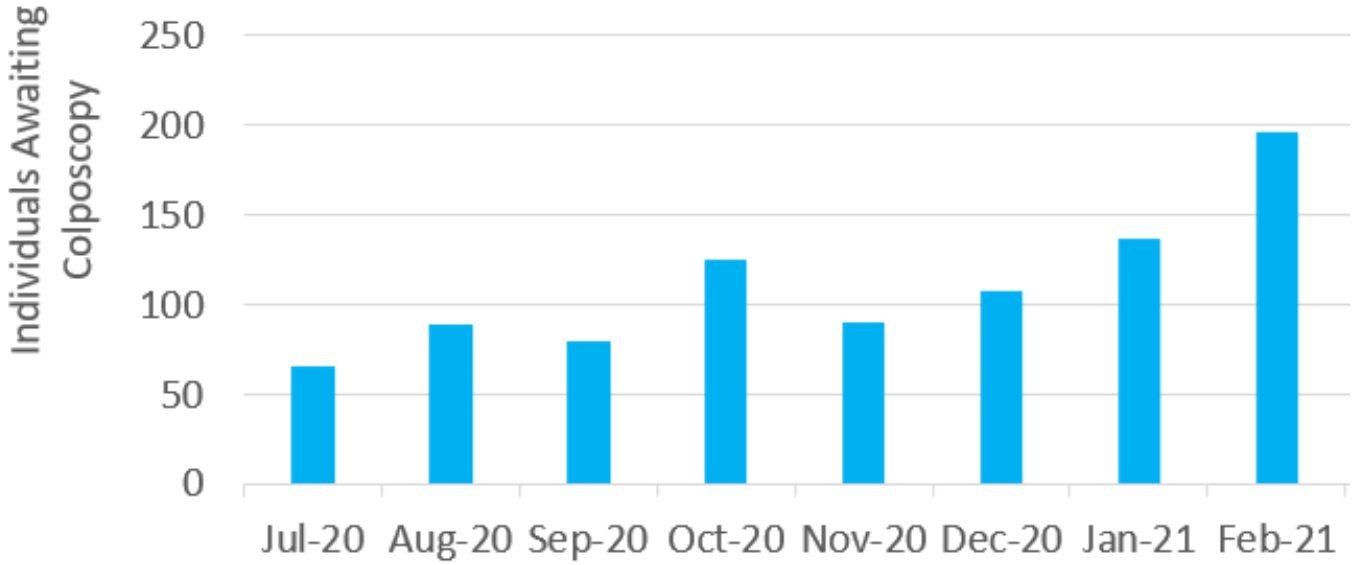
As of March 2021, Pap tests done as part of the OCSP are down by 11% compared to 2019 volumes

Colposcopy volumes by month



As of March 2021, colposcopy volumes are down by 9% compared to 2019 volumes

Participants with high grade Pap test results awaiting colposcopy



- Primary care providers need to ensure that people with high grade results are referred to colposcopy
- Colposcopists need to ensure that people with high grade results are prioritized for colposcopy

Cervical screening and colposcopy quality reporting

Developing a quality management program

Standards and Guidelines:

- Survey and report facilities' adherence to quality standards

Quality Reporting (annual audit & feedback):

- Launched in 2016 - Colonoscopy provincial, regional, facility (n=157) & physician (n=931) levels
- Launched in 2016 - Mammography provincial, regional, facility (n=239) & physician (n=541) levels
- Launching in 2021 - Colposcopy provincial, regional, facility (~90) & physician (n=440)* levels

Clinical Leadership:

- Facility, regional, provincial leadership roles
- Lead QI discussions with physicians

Quality Improvement (QI) Resources:

- Develop QI training tools
- Deliver QI supports

* Physician reports to launch in 2022

Colposcopy quality standards and indicators

- Reports provide an overview of quality measured by select standards and indicators
  - Includes regional and provincial comparators
- Nine quality standards for colposcopy have been developed
  - Communicate priorities for colposcopy quality
  - Assist facilities with focusing their QI efforts
- Facility survey was sent to all facilities providing colposcopy services (hospitals and non-hospitals) in February 2021 (closed: April 30, 2021)
  - Facility survey will assess adherence to and help foster adoption of these standards

Sample Facility Report: Standards

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

Facility: [NAME] Region: [NAME]

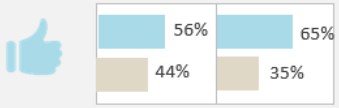
Ontario Health
Cancer Care Ontario

Standards

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

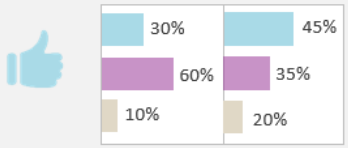
Standard 1. Facilities should require that all colposcopists at their facility demonstrate completion of a colposcopy training program or have demonstrated longstanding expertise.

(1a) Are colposcopists practicing within your facility required to demonstrate either completion of a colposcopy training program or longstanding expertise?

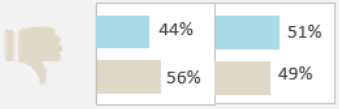


***(1b)** What proportion of colposcopists at your facility have demonstrated completion of a colposcopy training program or longstanding expertise?

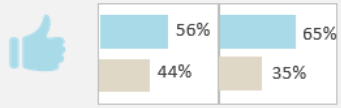
*For % calculations: Number of facilities responding Q1a="Yes" is the denominator.



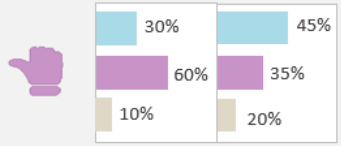
Standard 2. Facilities should require that all colposcopists at their facility maintain colposcopy competency by managing sufficient number of patient, regularly attend and/or provide accredited continuing medical education events and participate regularly in clinical audits or reflective practice.



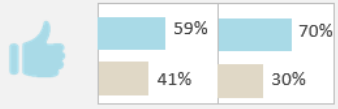
Standard 3. Facilities should have a consistent and well described process in place to manage the intake of referrals for colposcopy. To support equitable access for patients, this process should ensure referrals meet the clinical criteria for entry into the colposcopy system are appropriately triaged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



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



Standard 5. Facilities should provide educational materials (printed, online, or otherwise) and/or patient resources consistent with OCSP's cervical screening and colposcopy recommendations.



Survey response rate:
x out of y (xx%) facilities in your region responded to the survey.
x out of y (xx%) facilities in the province responded to the survey.

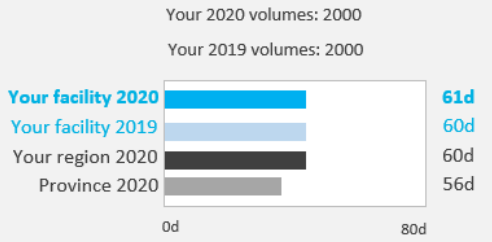
Sample Facility Report: Performance Indicators

Cervical Screening and Colposcopy Quality Facility Report (Release Year 2021)
Facility: [NAME] Region: [NAME]

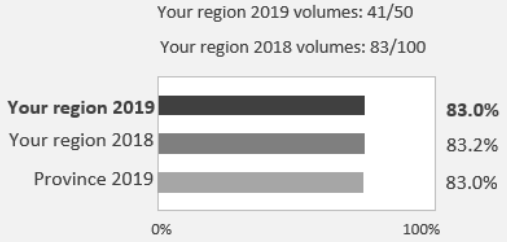
Ontario Health
Cancer Care Ontario

Colposcopy indicators

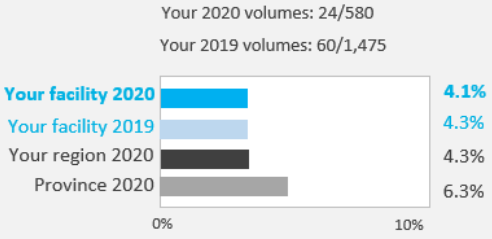
Median wait times in days from high grade cytology test to colposcopy (Total)



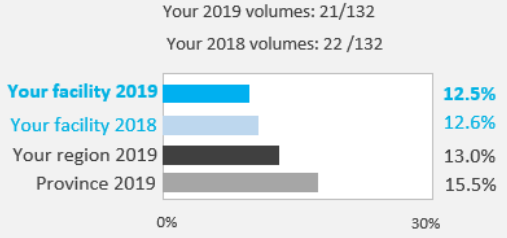
Proportion of people with high grade cytology test who were seen for colposcopy within 6 months



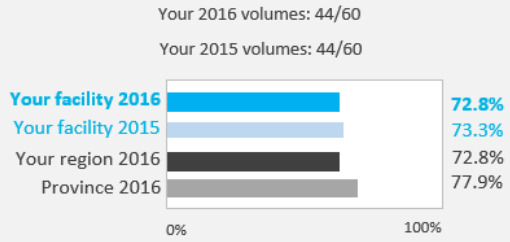
Proportion of people seen for colposcopy following their first ASCUS result



Proportion of people who were not seen for follow-up within 12 months post-treatment



Proportion of people who exited colposcopy after 3 consecutive normal cytology results following treatment



To learn more about the definitions and methodology for the indicators used in this report, visit [Link to be added]

If you have any questions regarding this data or require further information, please contact your Regional Lead (contact information included in your report supplementary information document).

Recipients of quality reports

Audience	Provincial Report*	Regional Report & Facility Summary	Facility Report	*Physician Report*
Provincial Clinical & Scientific Lead	X	X	X	*X*
Cervical Screening/ Colposcopy Leads	X	X (their region)	X (their region)	*X (their region)*
Regional Vice Presidents	X	X (their region)	X	
Regional Directors	X	X (their region)	X (their region)	
Facility leads, administrative and executive contacts	X		X (their facility)	
Colposcopists	TBD			*X (their report)*

Facility onboarding approach

Introductory email with contact request form

- To hospital CEOs (November 2020)
- To non-hospital facility contacts (February 2021)
- Objective: Identify facility contacts

Welcome email

- To facility quality leads, administrative contacts, executive contacts
- Objective: Provide an overview of roles and upcoming activities

Status of facility onboarding (as of May 25, 2021)

Facility type	Total number of facilities that received onboarding communications	Number of returned contact request forms	Percentage of facilities that returned contact request forms
Hospitals	59	59	100%
Non-hospitals	94*	31	33%*
TOTAL	**153**	**90**	**59%**

*A total of 112 non-hospital facilities were identified; 94 have received onboarding communications to date as contact information for the remaining facilities is being confirmed.

Next Steps

- Report Dissemination: September 2021
- Following report dissemination, teleconferences to be scheduled for report recipients to learn more about the reports, report outcomes and Q&As
- If you would like to confirm if your facility (hospital and non-hospital) will be receiving a report, please email: cancerscreening@ontariohealth.ca

Case study 1: Discharge from colposcopy post-treatment

Case study 1

- A 38 year old patient is seen for cervical screening during the COVID-19 pandemic. A cytology test is done
  - Result: **ASC-H**
- The risk of CIN3+ with an ASC-H cytology result is >24%[1]
  - Risk exceeds the threshold to colposcopy outlined in the COVID-19 Tip Sheet → referral to colposcopy is recommended
- Patient is referred to colposcopy

ASC-H: atypical squamous cells; cannot exclude high-grade squamous intraepithelial lesion

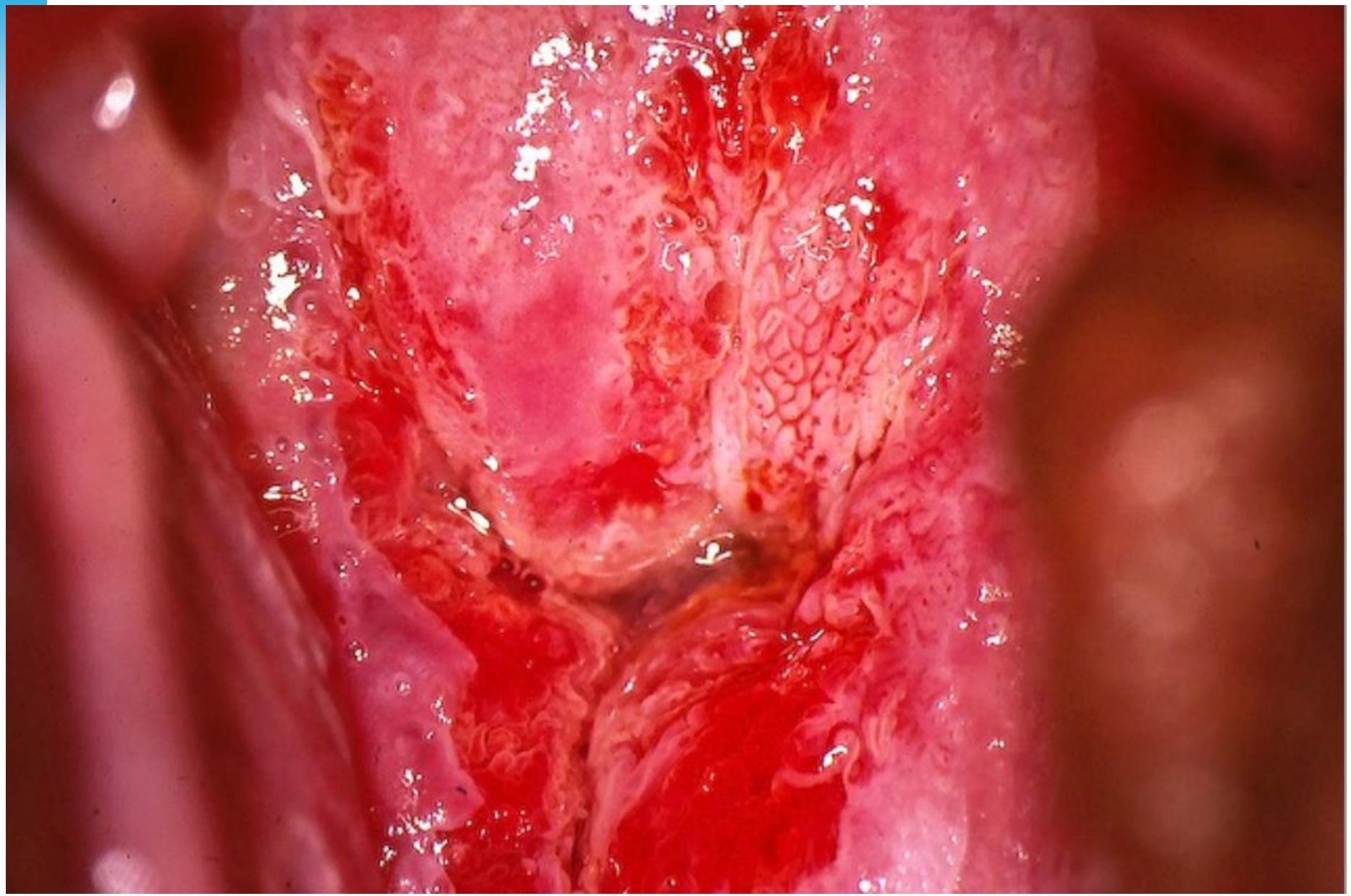
1. Morantz, C. A. (2006). ACOG Releases Guidelines for Management of Abnormal Cervical Cytology and Histology. Am Fam Physicians. 15;73(4):719-729

Risk by HPV subtype and referral cytology

Past history	Current HPV	Current cytology	n^a	$\%^b$	CIN 3+ cases	CIN 3+ immediate risk, %	CIN 3+ 5-y risk, %
Unknown	HC2	ASC-H	3,766		863	26	33
	HPV 16		155	1.3%	77	28	33
	HPV 18		29	0.28%	9	15	18
	HR12		179	2.0%	40	9.5	11

Immediate CIN3+ risk for ASC-H exceeds colposcopy referral threshold

Demarco M, Egemen D, Raine-Bennett TR, et al. A Study of Partial Human Papillomavirus Genotyping in Support of the 2019 ASCCP Risk-Based Management Consensus Guidelines. J Low Genit Tract Dis 2020;24:144–7.



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Colpophotograph provided by Dr. Michael Shier

Case study 1

A biopsy is performed

- Result: **CIN3/HSIL**

Treatment with loop electrosurgical excision procedure (LEEP) is performed

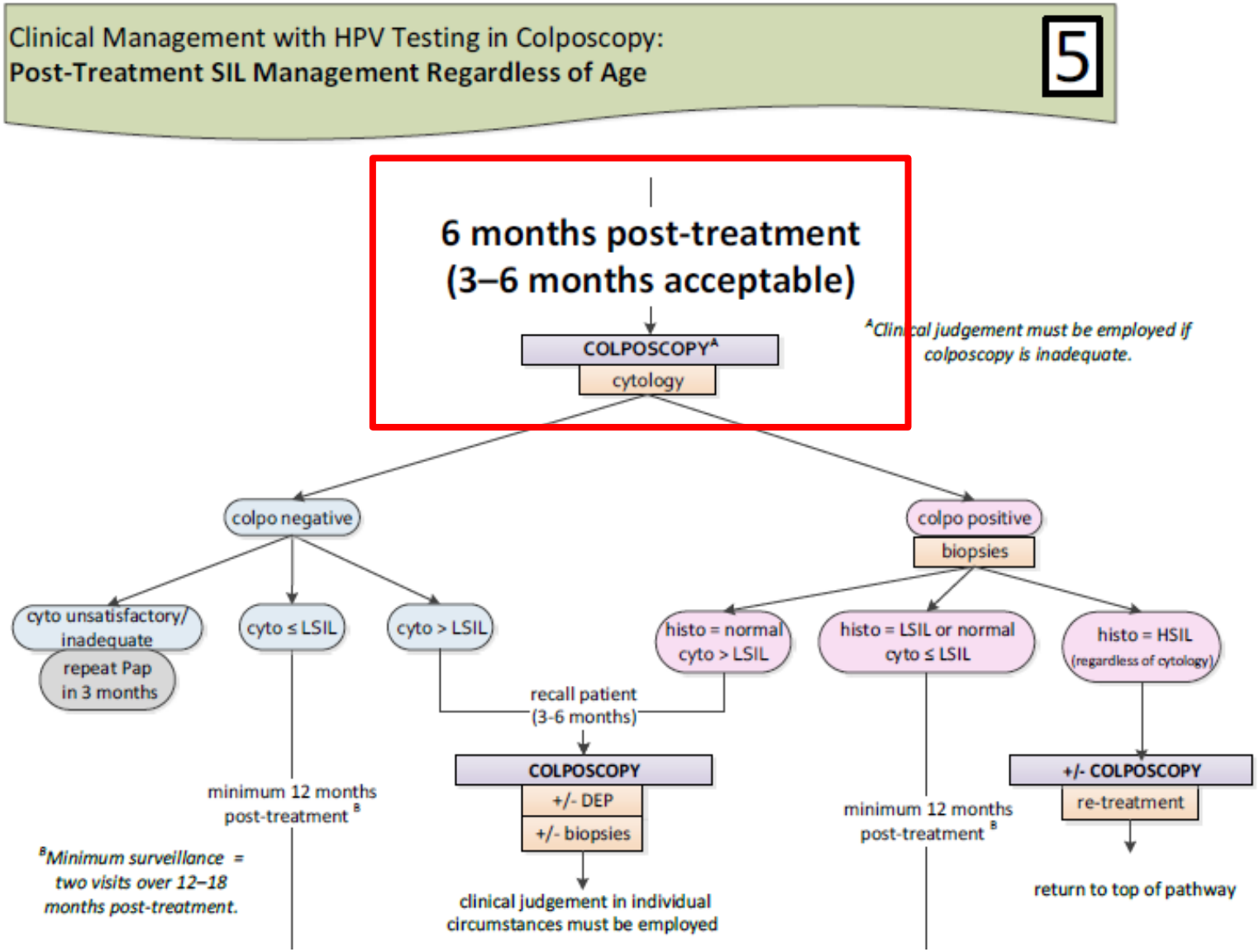
- Result: **CIN3 with negative margins**

What is the next follow-up step?

A. Repeat colposcopy + cytology in 6 months
B. Repeat colposcopy + cytology in 12 months
C. Repeat treatment with LEEP

HSIL: high-grade squamous intraepithelial lesion

Case study 1


Clinical Management with HPV Testing in Colposcopy:
Post-Treatment SIL Management Regardless of Age
5
6 months post-treatment
(3–6 months acceptable)
COLPOSCOPY[A]
cytology
[A]Clinical judgement must be employed if colposcopy is inadequate.
colpo negative
colpo positive
biopsies
cyto unsatisfactory/ inadequate
repeat Pap in 3 months
cyto ≤ LSIL
cyto > LSIL
histo = normal cyto > LSIL
histo = LSIL or normal cyto ≤ LSIL
histo = HSIL (regardless of cytology)
recall patient (3-6 months)
COLPOSCOPY
+/- DEP
+/- biopsies
clinical judgement in individual circumstances must be employed
minimum 12 months post-treatment [B]
minimum 12 months post-treatment [B]
+/- COLPOSCOPY
re-treatment
return to top of pathway
[B]Minimum surveillance = two visits over 12–18 months post-treatment.

Case study 1

Colposcopy is repeated at 6 months post-treatment

- Result: **colposcopy negative, cytology NILM**

Colposcopy is repeated at 12 months post-treatment, and patient requests an HPV test

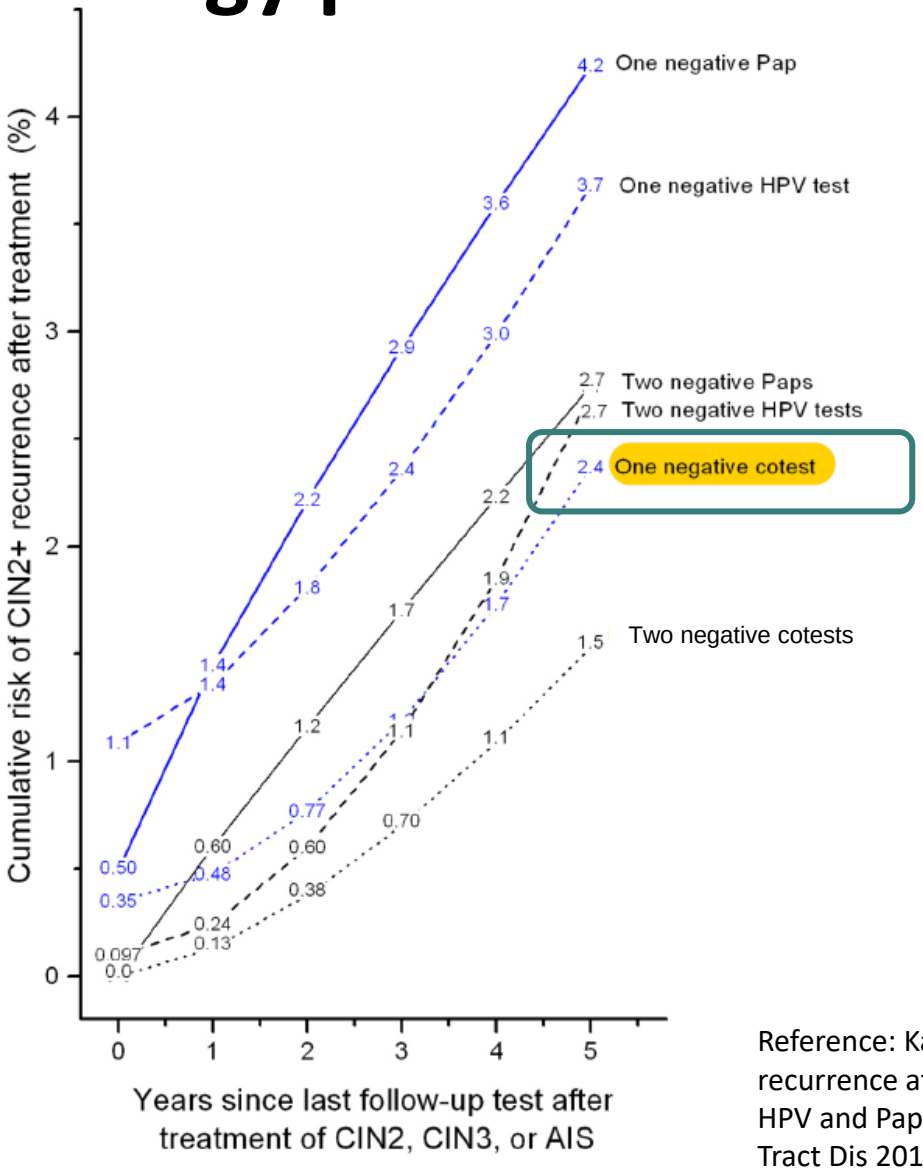
- Result: **colposcopy negative, cytology NILM, HPV-**

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

A. Yes
B. No

NILM: negative for intraepithelial lesion or malignancy

5-year risk of CIN2+ recurrence by follow-up strategy post treatment



Reference: Katki HA, Schiffman M, Castle PE, et al. Five-year risk of recurrence after treatment of CIN 2, CIN 3, or AIS: performance of HPV and Pap cotesting in posttreatment management. J Low Genit Tract Dis 2013;17(5 Suppl 1):S78–84.

Case study 1

What recommendation for next screening test should be communicated to the patient and family doctor?

A. Next cytology screening test in 1 year
B. Next cytology screening test in 3 years
C. Next cytology screening test in 5 years
D. Follow-up in colposcopy in 6 months

FINAL DISCHARGE RECOMMENDATIONS
COLPOSCOPY SERVICES

Colposcopist name:

Contact information:

Date:

Patient identifier:

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

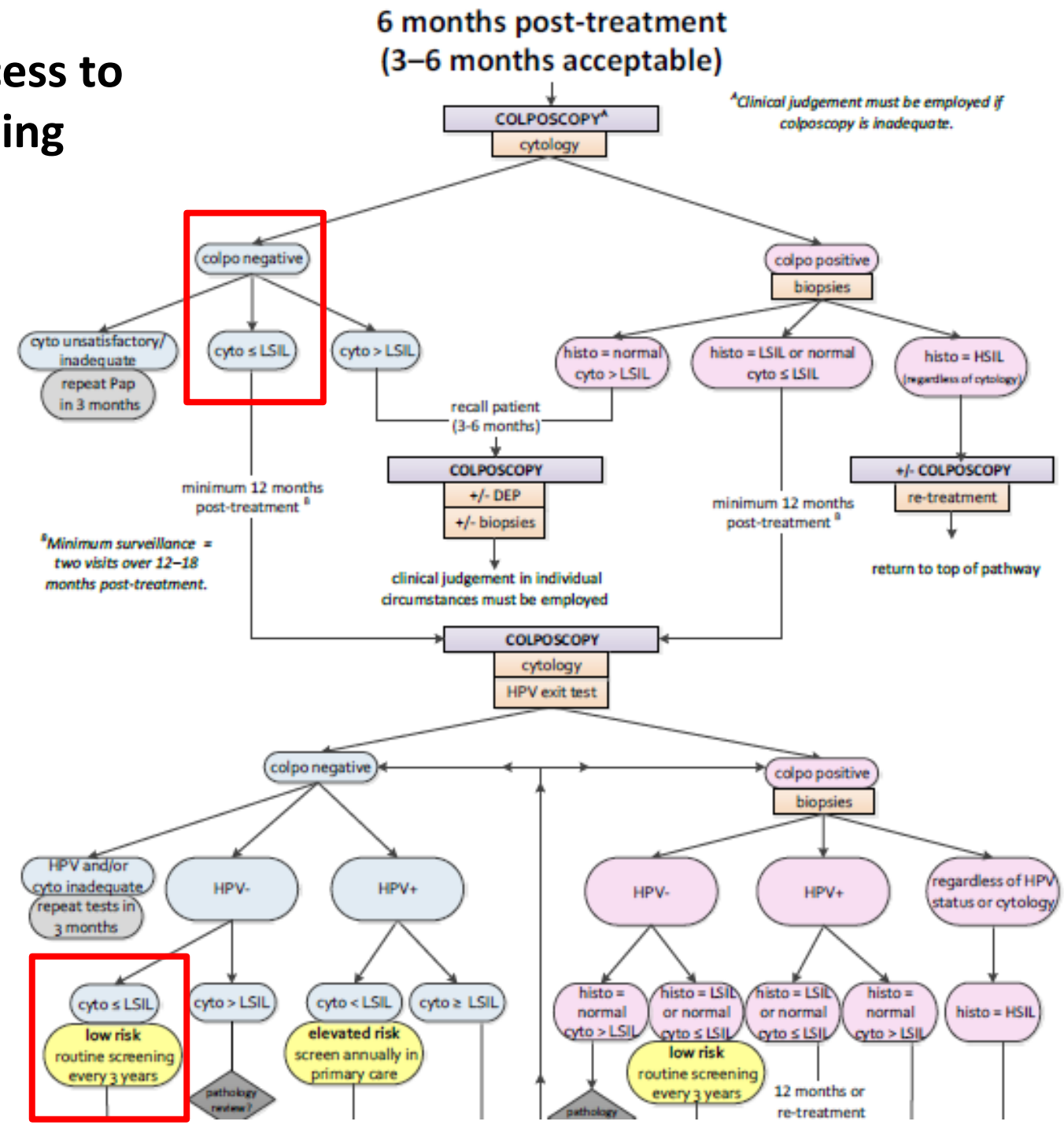
- [x] Every three years (routine cervical screening)
- [ ] Every year (surveillance)

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

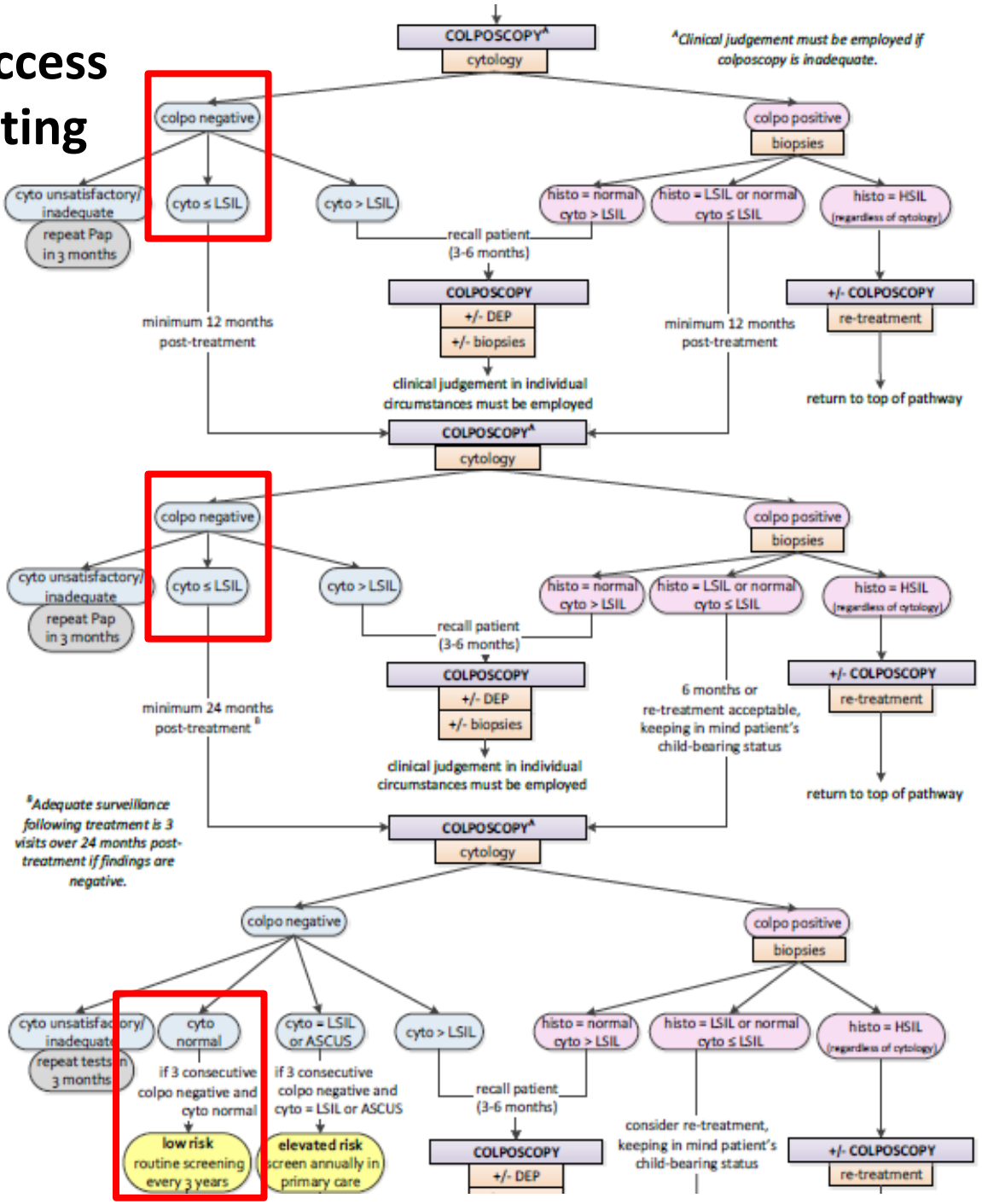
According to the Ontario Cervical Screening Program's recommendations, whether or not a woman has been treated, further colposcopic examinations are not required and she can be discharged to primary care if:

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

With access to HPV testing



Without access to HPV testing



Case study 2: Discharge from colposcopy for untreated patients

Case study 2

- A 28 year old patient is seen for cervical screening during the COVID-19 pandemic. A cytology test is done
  - Result: **LSIL**
- The patient also requests an HPV test (i.e.: patient pay). An HPV test is done
  - Result: **positive for HPV 16/18**
- The risk of CIN3+ with a LSIL cytology and HPV 16/18 positive result is 7-15%
  - Risk exceeds the threshold to colposcopy outlined in the COVID-19 Tip Sheet → referral to colposcopy is recommended
- Patient is referred to colposcopy

LSIL: low-grade squamous intraepithelial lesion

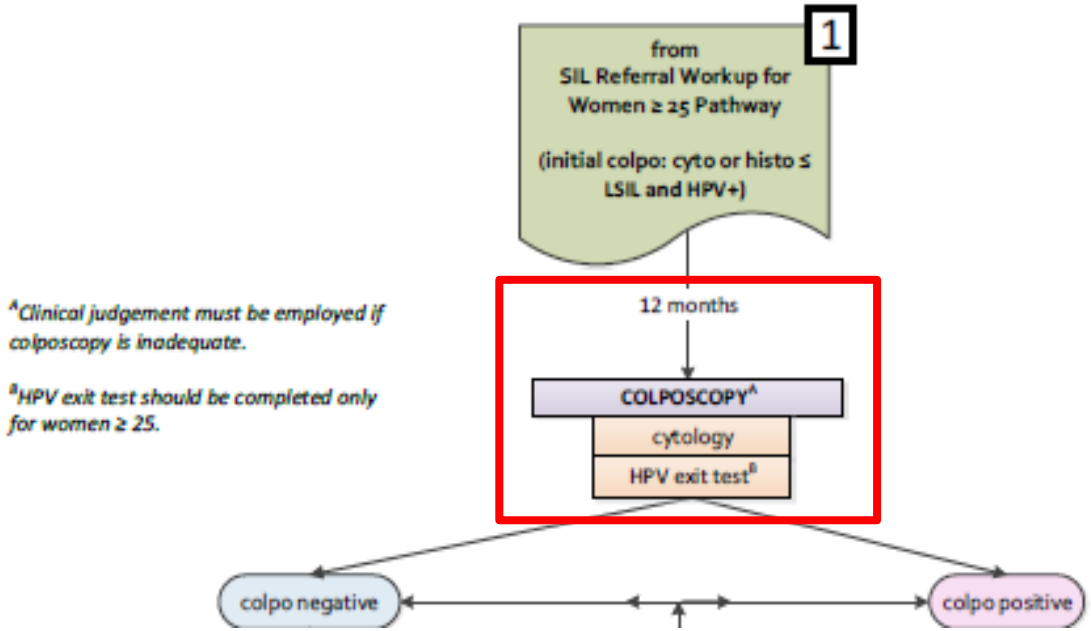
Case study 2

The patient was seen 6 weeks later in colposcopy.
The colposcopist sees a mild aceto white lesion. A biopsy is performed

- Result: **LSIL**

What is the next follow-up step?

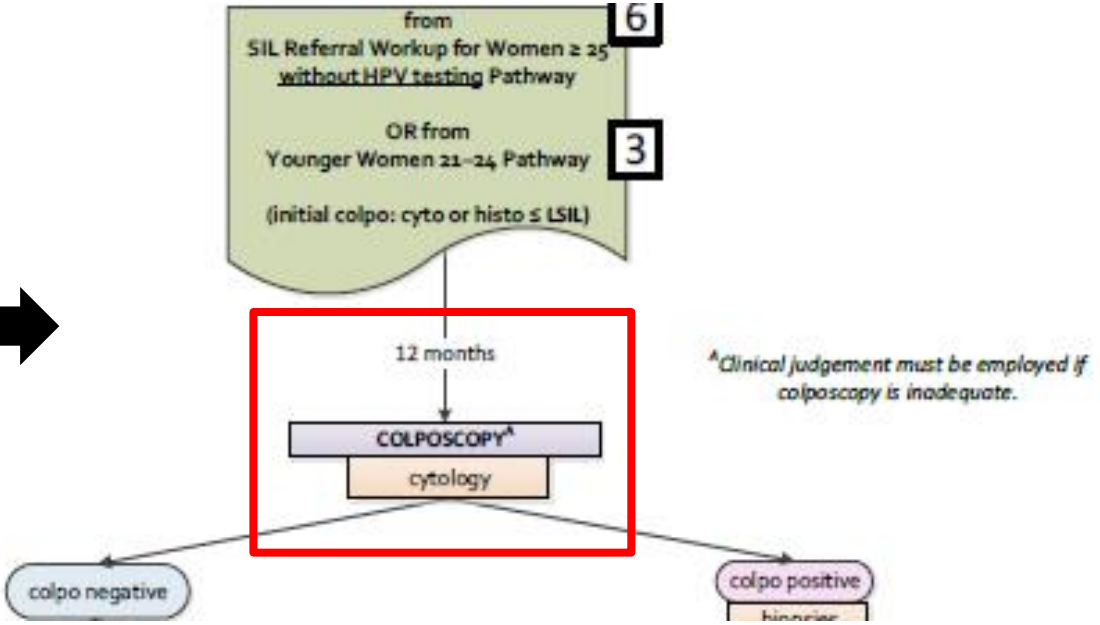
A. Repeat colposcopy in 1 year +/- HPV exit test
B. Perform treatment with LEEP
C. Discharge to primary care for repeat cytology test in 12 months



with access to HPV testing

OR

without access to HPV testing



Case study 2

Colposcopy is repeated in 12 months with HPV exit test

- Result: **colposcopy negative, cytology LSIL, HPV-**

Is the risk of CIN3+ sufficiently low for discharge from colposcopy?

A. Yes
B. No

Case study 2

What recommendation for next screening test should be communicated to the patient and family doctor?

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C. Next cytology screening test in 5 years
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FINAL DISCHARGE RECOMMENDATIONS
COLPOSCOPY SERVICES

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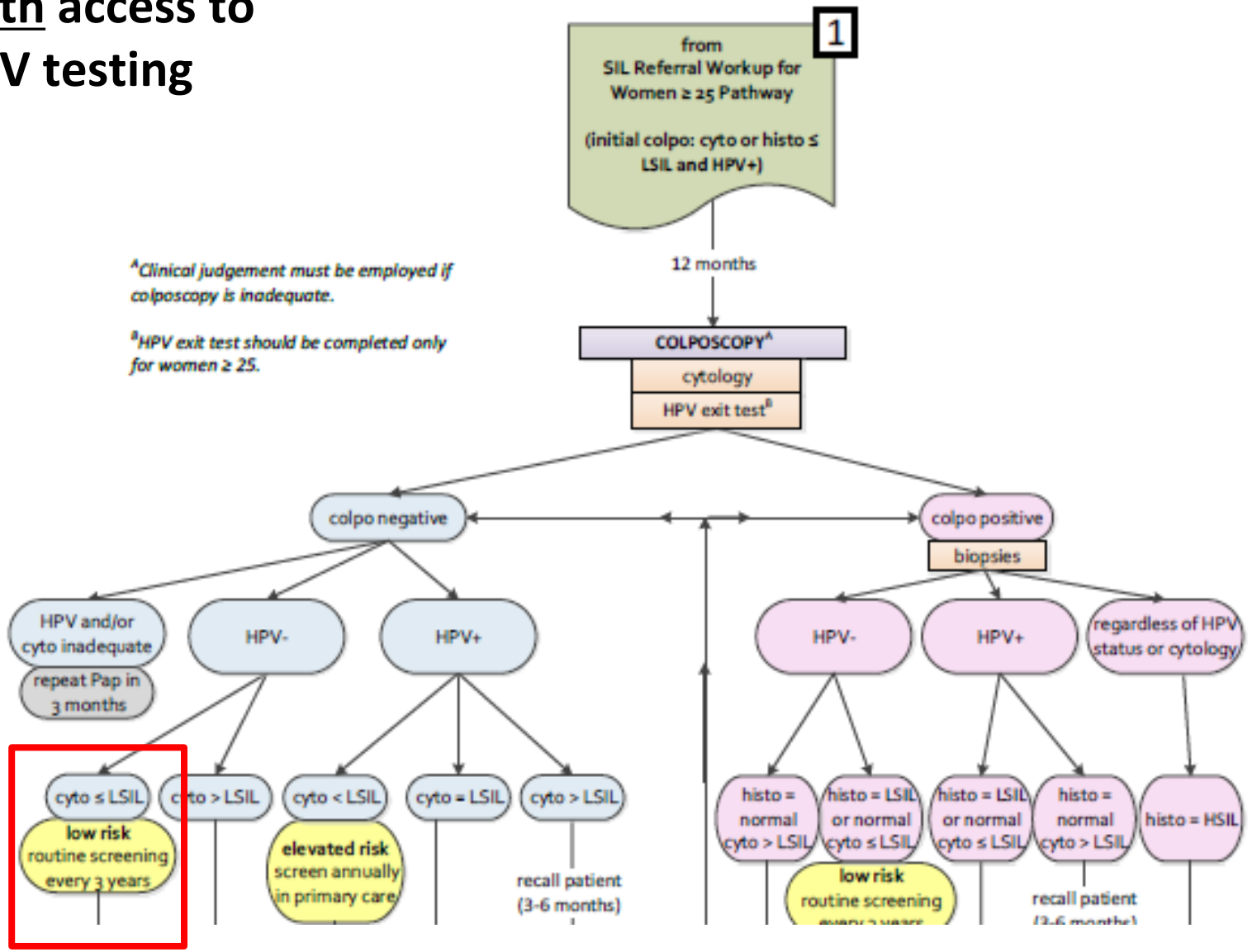
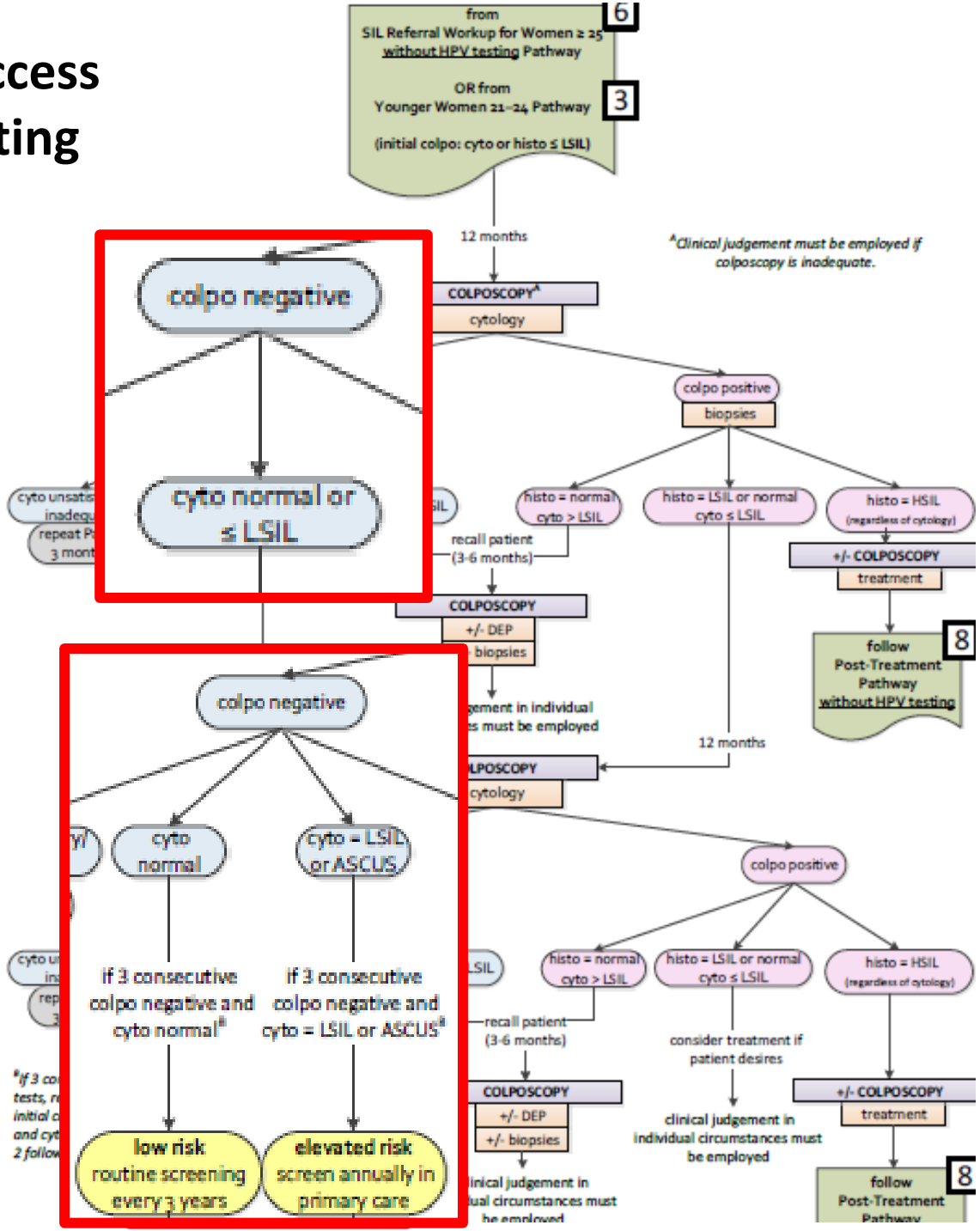
With access to HPV testing



Without access to HPV testing



CIN3+ risk at 1 vs. 3-year post-colposcopy for LG referral cyto and <CIN2 detected

TABLE 2. Risk of CIN 3+ by Reason for Colposcopy Referral and HPV Status for Women in the Precolposcopy and Postcolposcopy Groups

		1 year risk of CIN 3+		3 years risk of CIN 3+	
		Precolposcopy[c]	Postcolposcopy[d]	Precolposcopy[b]	Postcolposcopy[d]
Reason for colposcopy referral[a,b]		Risk[e]	Risk[e]	Risk[e]	Risk[e]
HPV+	HSIL+	44.4 (42.6, 46.2)	7.69 (0.29, 15.0)	45.4 (43.6, 47.3)	9.3 (0.27, 18.3)
	ASC-H	22.2 (20.8, 23.6)	4.7 (1.7, 7.7)	23.9 (22.4, 25.4)	6.5 (2.2, 10.8)
	AGC	23.6 (21.0, 26.4)	5.6 (1.3, 9.9)	26.0 (23.3, 28.9)	8.0 (1.5, 14.5)
	LSIL	3.9 (3.6, 4.2)	1.1 (0.71, 1.5)	4.6 (4.3, 5.0)	1.8 (1.1, 2.6)
	HPV+ ASC-US	4.3 (4.1, 4.5)	1.3 (1.0, 1.6)	5.2 (4.9, 5.4)	2.2 (1.6, 2.8)
	HPV+ NILM[f]	3.4 (3.1,3.8)	1.1 (0.73, 1.6)	4.5 (4.1, 4.9)	2.1 (1.2, 3.0)

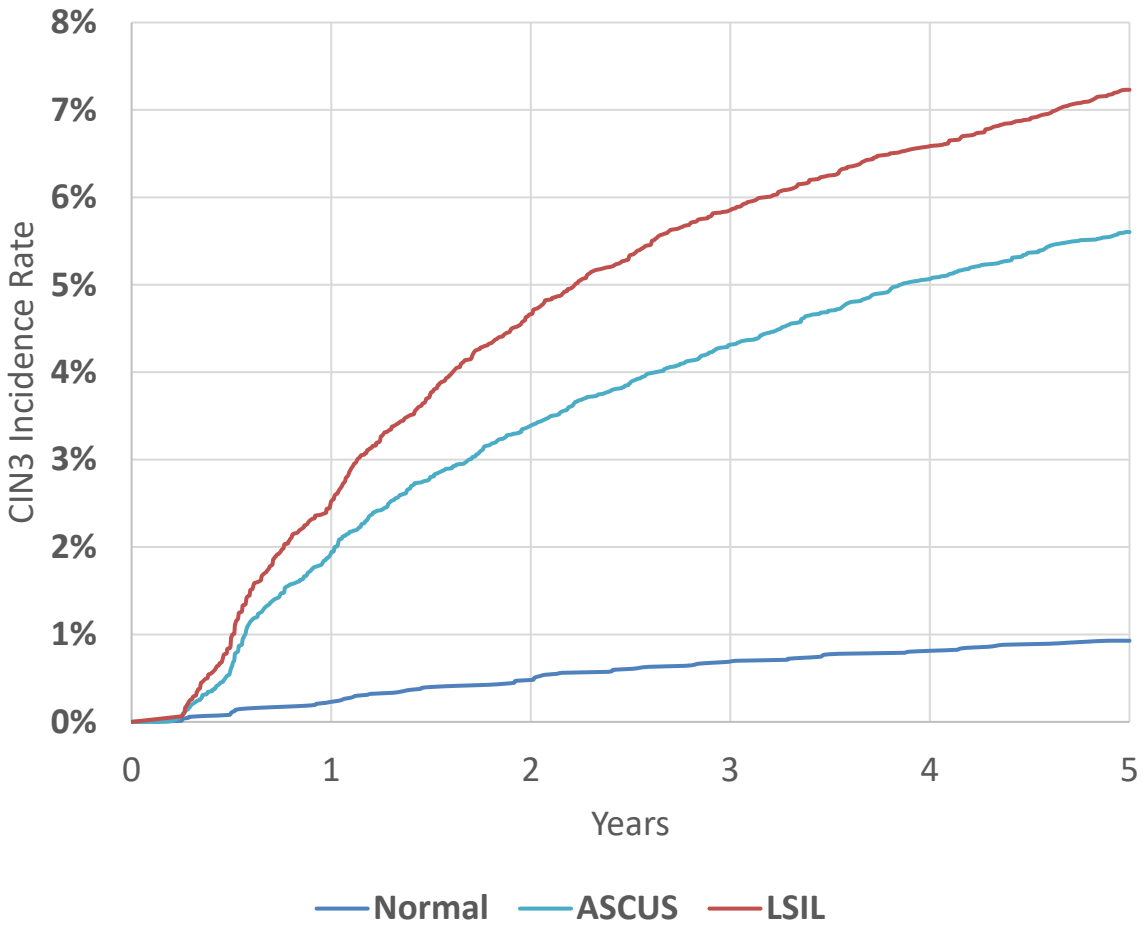
1.1 – 1.3% at 1 year

Risk goes up slightly to **1.8 – 2.2%** at 3 years

Ontario Health
Cancer Care Ontario

Reference: Demarco M, Cheung LC, Kinney WK, et al. Low risk of cervical cancer/precancer among most women under surveillance postcolposcopy. J Low Genit Tract Dis 2018;22:97–103.

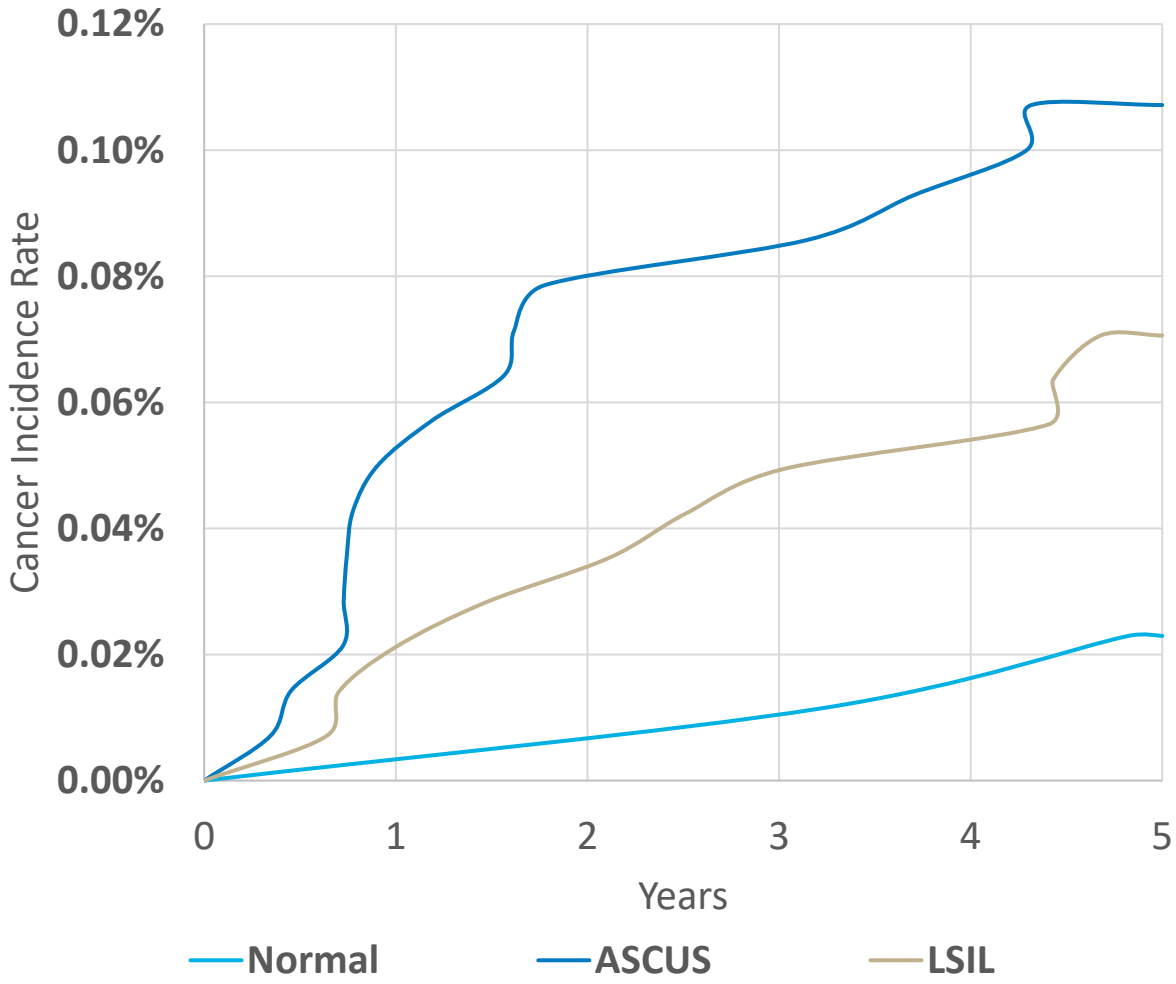
CIN3 incidence rate stratified by index cytology



	3 year rate (%)	5 year rate (%)
Normal	0.69	0.93
ASCUS	4.31	5.60
LSIL	5.85	7.23

Reference: Ontario data

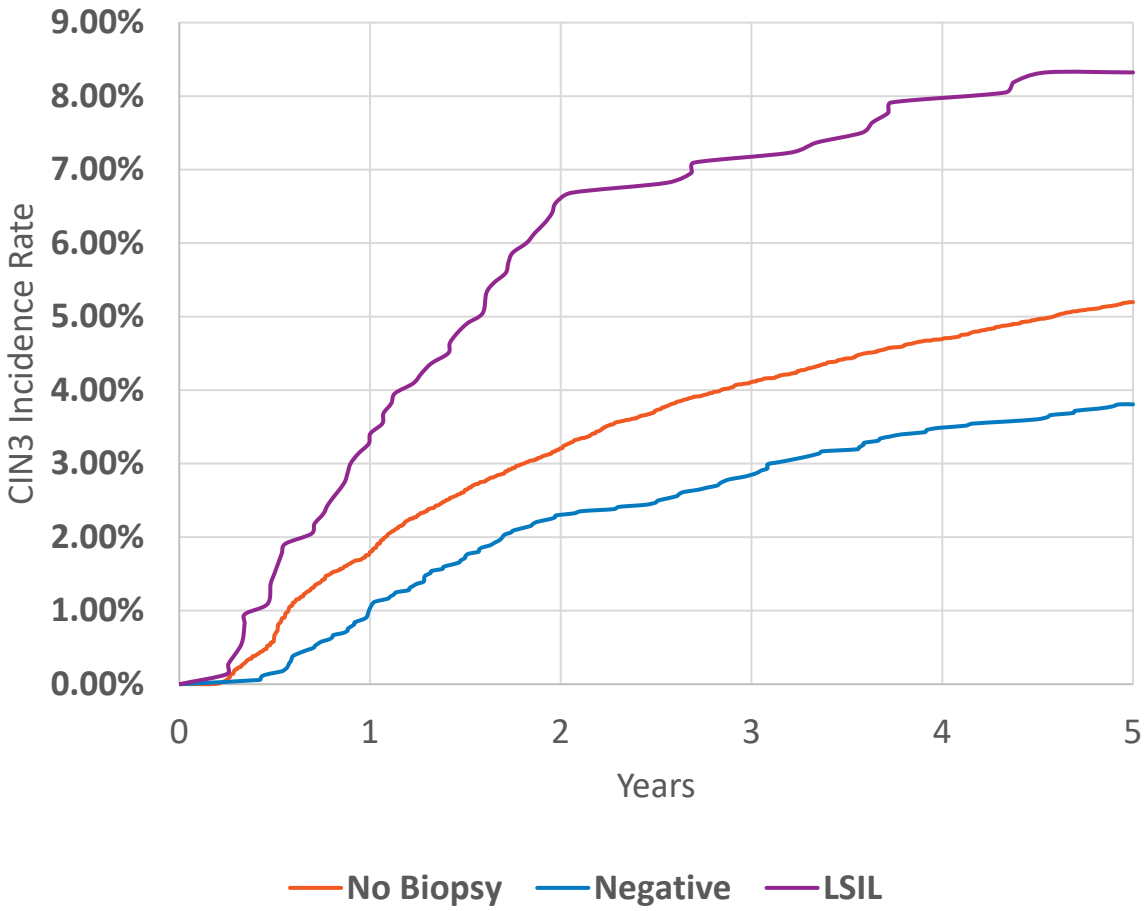
Invasive cancer incidence rate stratified by index cytology



	3 year rate (%)	5 year rate (%)
Normal	0	0.02
ASCUS	0.08	0.11
LSIL	0.04	0.07

Reference: Ontario data

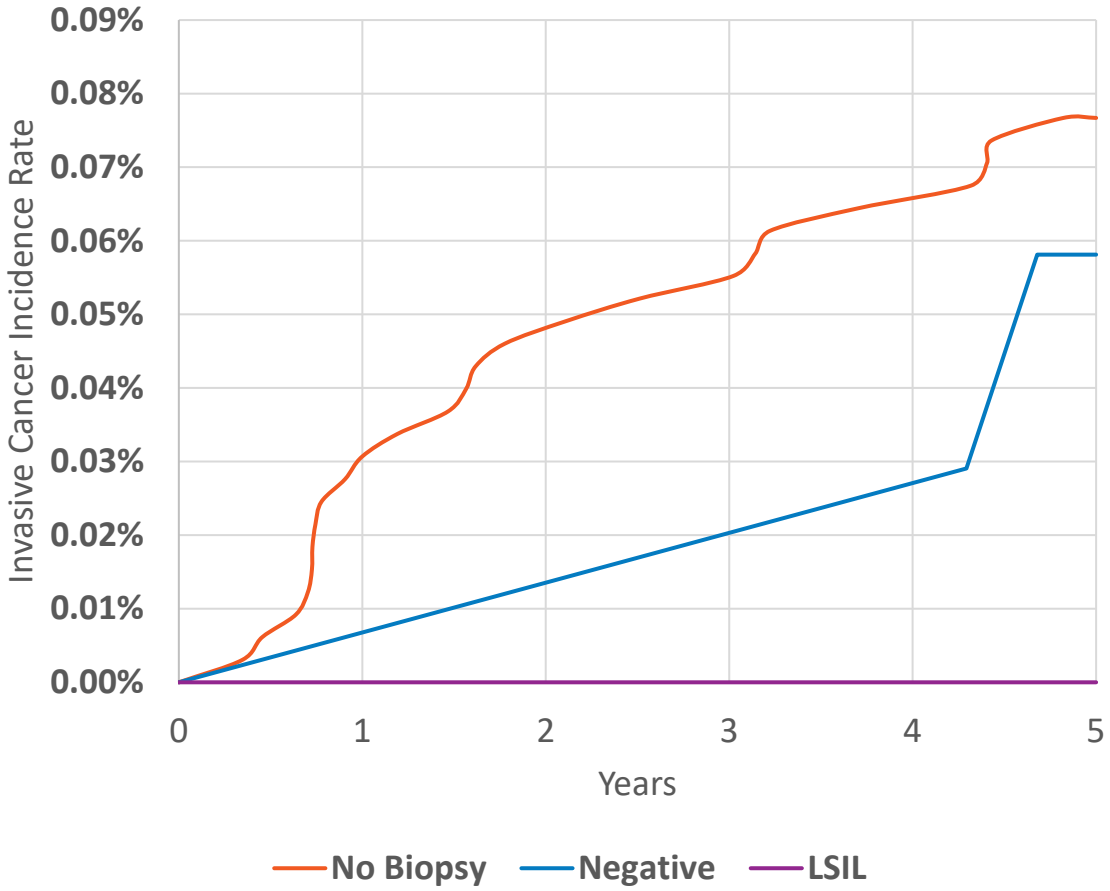
CIN3 incidence rate stratified by index biopsy



Biopsy (N)	3 year rate (%)	5 year rate (%)
No Biopsy (32578)	4.11	5.20
Negative (3441)	2.85	3.81
LSIL (1708)	7.09	8.32

Reference: Ontario data

Invasive cancer incidence rate stratified by index biopsy



Biopsy (N)	3 year rate (%)	5 year rate (%)
No Biopsy (32578)	0.05	0.08
Negative* (3441)	0	0.05
LSIL^ (1708)	0	0

*There were only 2 cases of 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 data

Summary

- Important to consider risk when discharging from colposcopy
- Risk of CIN3 and of invasive disease is low
- HPV clearance supports return to population risk screening
- Must provide specific recommendations to primary care providers for next screening test at discharge from colposcopy

Questions from the field

Questions from the field

Question:

- What are the management recommendations for people post-hysterectomy?

Answer:

- Currently out of scope for the OCSP

Vaginal cancer and VaIN2/3 post hysterectomy is rare

Number of years from hysterectomy to VaIN2/3, in-situ or vaginal cancer following CIN3+ between 2010 and 2015	Number of individuals	Percent
Total	3301	100.0%
0-1 year	26	0.8%
1-2 years	15	0.5%
2+ years	12	0.4%
No VaIN2/3, in-situ or vaginal cancer	[illegible]	98.4%
Total number of VaIN2/3, in-situ or va[illegible]		
Incidence rate of VaIN2/3, in-situ or [illegible] hysterectomy		

Vaginal cancer is rare

473 new cases reported in 2012-2016 in Ontario[1]

1. Ontario Statistics, 2020

VaIN: vaginal intraepithelial neoplasia

Questions from the field

Question:

- When should colposcopy be stopped in diethylstilbestrol (DES) daughters if colposcopy reveals adenosis, negative biannual exam and negative cytology at age 70?

Answer:

- Currently out of scope for the OCSP; individual clinical judgement is required

Concluding remarks

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 2021 (dates TBD)
- Share your feedback and questions with us at ColposcopyCoP@ontariohealth.ca


Thank
You!