

Simplified algorithms for the colposcopy management have been generated to address specific clinical scenarios for women referred to colposcopy with squamous or glandular dysplasia on cervical cytology and follow-up for women treated within the colposcopy system. Key best practice changes are highlighted below:

#### **Cytology and histology**

- Cervical cytology may be repeated at the initial colposcopy visit if indicated, as long as it has been **three months** since the last cytology result.
- Management decision must be informed by the histologic diagnosis obtained from the biopsy. If a lesion is not seen, random biopsies may be used at the discretion of the colposcopist.

#### **HPV testing**

- Routine use of HPV testing in women under age 30 is **NOT** recommended; however, it may have utility to inform colposcopy clinical management or for resolving discordant cases for women ages 25 to 29.
- After consecutive positive HPV tests a year apart in colposcopy, further HPV testing is **NOT** routinely indicated. (This recommendation will be updated until further evidence is available.)

#### **Younger women**

- Where possible, conservative management is preferred, especially in women under age 25.
- Management with colposcopy every six months for two years should be considered in younger women ages 21 to 25 with high-grade lesions (histo = HSIL). Treatment may be acceptable if HSIL persists.

#### **Conservative management**

- Where possible, conservative management is preferred, especially in women with low-grade findings who have not completed child bearing.
- Regardless of age, women whose future child bearing status is of concern should be counselled on the risks and benefits of conservative management if chosen/ appropriate.

#### **Treatment**

- Treatment of persistent LSIL is acceptable in women age 25 and older for whom:
  - LSIL persists for two or more years; or
  - Child bearing is not a concern.
- Treatment may be preferred for women with HPV+ LSIL who have completed child bearing.
- Cryotherapy is **NOT** an acceptable treatment for high-grade lesions.

#### **Post-treatment follow-up**

- Post-treatment for LSIL or HSIL: women should be followed up at six months with colposcopy, and then at 12 to 18 months again with colposcopy and an HPV exit test.
- Post-treatment for AIS: women should be followed up in colposcopy every six months for three years and then annually for two years with colposcopy, cytology +/- ECC.
- High risk HPV infection is a necessary condition for AIS. Its role as a predictor of outcome is unclear. Although data is insufficient to make a firm recommendation about HPV testing in the management of women with AIS, consider the use of HPV when appropriate.

#### **Discharge and protocol for primary care**

- Women eligible for discharge from colposcopy whose HPV test is negative are at low risk and can return to primary care for routine triennial screening with the Pap test.
- Women eligible for discharge from colposcopy whose HPV test is positive are at elevated risk and can return to primary care for annual surveillance with The Pap test.
- After a total of five years of post-treatment follow-up with all negative results, women treated for AIS can be discharged to annual screening in primary care or long-term annual colposcopy is acceptable.

- Glossary of Terms
- **Colposcopy** is the examination of the cervix, vagina and, in some instances, the vulva, with a colposcope after the application of a three to five percent acetic acid solution coupled with obtaining colposcopically-directed biopsies of all lesions suspected of representing neoplasia.
- **Colposcopic impression** documents the visual inspection of blood vessel configurations, surface contour, colour tone and lesion demarcation before and after the application of acetic acid and/or Lugol's iodine. A colposcopic impression is considered "satisfactory" or "adequate" if the entire squamocolumnar junction and the margin of any visible lesion can be visualized with the colposcope. A colposcopic impression is considered "normal" if there is no visible abnormality on the cervix.
- **Endocervical curettage (ECC)** uses a spoon-shaped instrument, or curette, to scrape the mucous membrane of the endocervical canal (the passageway between cervix and uterus) to obtain a small tissue sample.
- **Diagnostic excisional procedure (DEP)** is the process of obtaining a specimen from the transformation zone and endocervical canal for histological evaluation and includes laser conization, cold-knife conization, loop electrosurgical excision (LEEP) and loop electrosurgical conization. DEPs can act as both diagnostic and therapeutic tools.
- **Cytopathology** is a branch of pathology that studies and diagnoses diseases on the cellular level; cervical smear tests screen for abnormal cytology.
- **Histopathology** is the microscopic study of diseased tissue.

#### Abbreviations and Acronyms

**AC:** adenocarcinoma

**AGC-N:** atypical glandular cells, favor neoplastic

**AGC-NOS:** atypical glandular cells, not otherwise specified

**AIS:** adenocarcinoma in situ

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

**ASCUS:** atypical squamous cells of undetermined significance

**CIN:** cervical intraepithelial neoplasia

**colpo:** colposcopy

**cyto:** cytology

**DEP:** diagnostic excisional procedure (both a diagnostic and therapeutic tool)

**ECC:** endocervical curettage

**histo:** histology

**HPV:** human papillomavirus

**HSIL:** high-grade squamous intraepithelial lesion

**LEEP/LLETZ:** loop electrosurgical excision procedure/large loop excision of the transformation zone

**LSIL:** low-grade squamous intraepithelial lesion

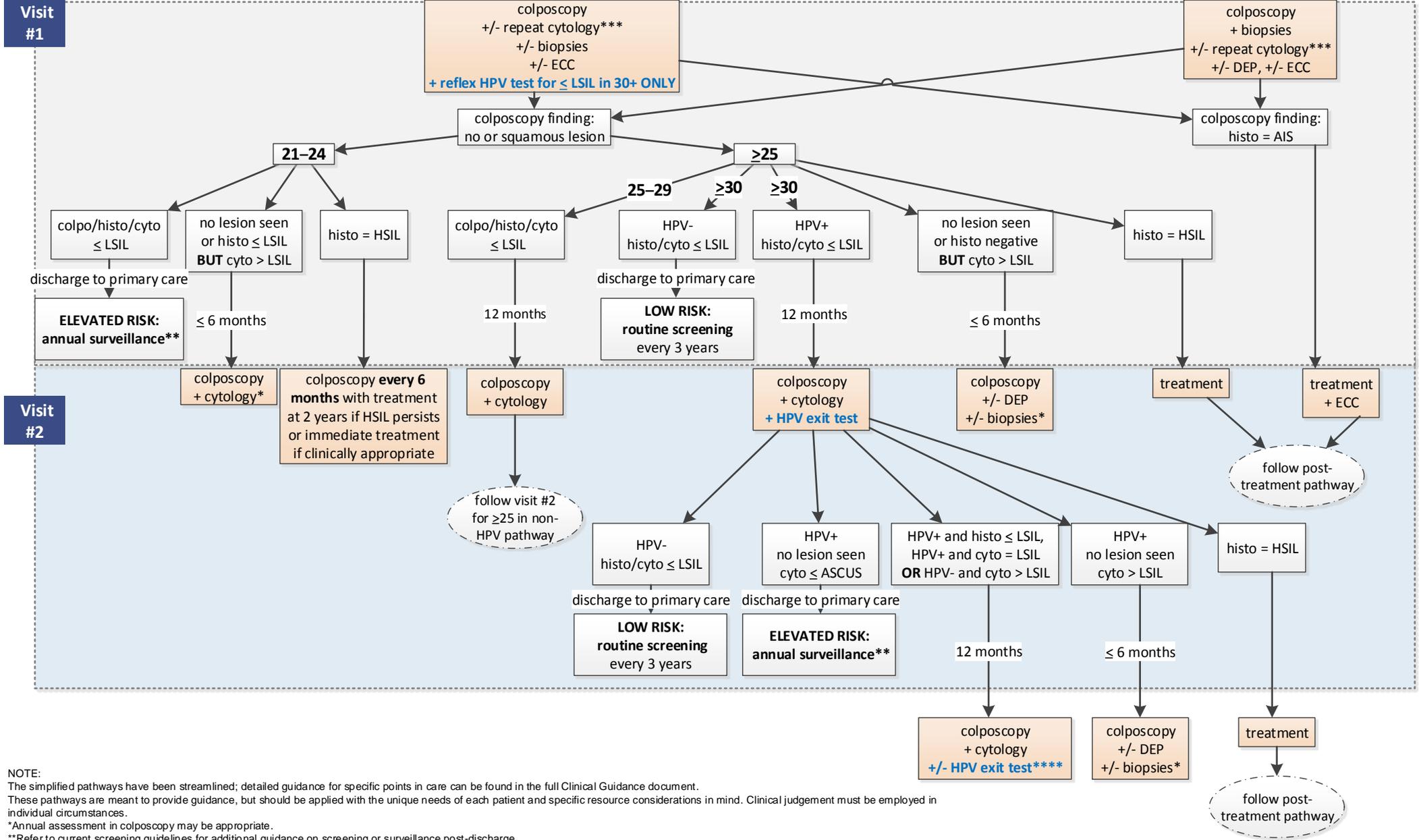
**TZ:** transformation zone (area of the cervix where abnormal cells and dysplasia occur); the location of the transformation zone on the cervix varies from woman to woman

<u>Symbol</u>	<u>Definition</u>
+/-	optional
cyto > LSIL	HSIL and ASC-H
cyto ≤ LSIL	LSIL, ASCUS or normal
cyto < LSIL	ASCUS or normal
histo ≤ LSIL	LSIL or normal

For complete best practice guidance, please refer to *Clinical Guidance: Recommended Best Practices for Delivery of Colposcopy Services in Ontario* at [cancercare.on.ca/common/pages/UserFile.aspx?fileId=361450](http://cancercare.on.ca/common/pages/UserFile.aspx?fileId=361450)

**HPV testing available in colposcopy**  
**Work up, conservative management and treatment**

women referred to colposcopy with screen-detected abnormality as per current referral guidelines

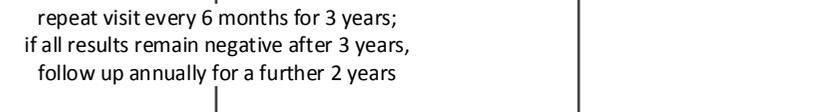
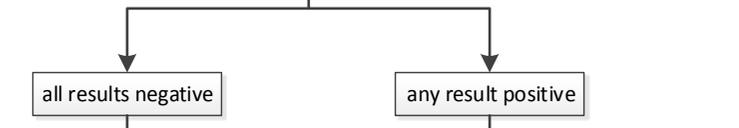
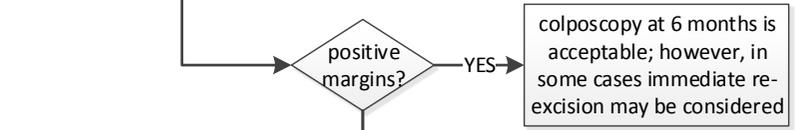
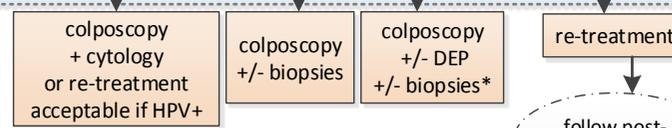
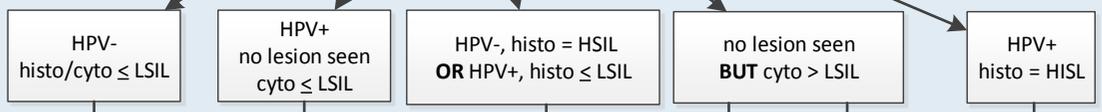
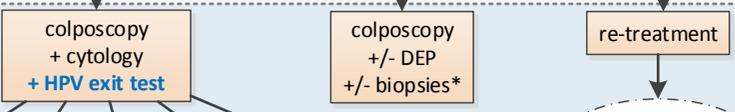
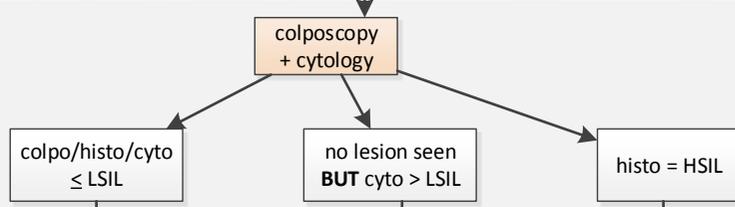
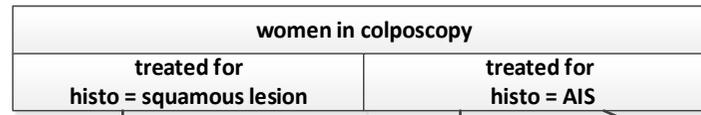


**NOTE:**  
The simplified pathways have been streamlined; detailed guidance for specific points in care can be found in the full Clinical Guidance document. These pathways are meant to provide guidance, but should be applied with the unique needs of each patient and specific resource considerations in mind. Clinical judgement must be employed in individual circumstances.  
\*Annual assessment in colposcopy may be appropriate.  
\*\*Refer to current screening guidelines for additional guidance on screening or surveillance post-discharge.  
\*\*\*Cervical cytology may be repeated at the initial colposcopy if indicated, as long as it has been three months since the last cytology result.  
\*\*\*\*After two consecutive positive HPV tests a year apart in colposcopy, further HPV testing is NOT routinely indicated. HPV test should only be performed if previous HPV result was negative.

**HPV testing available in colposcopy**  
**Post-treatment management**

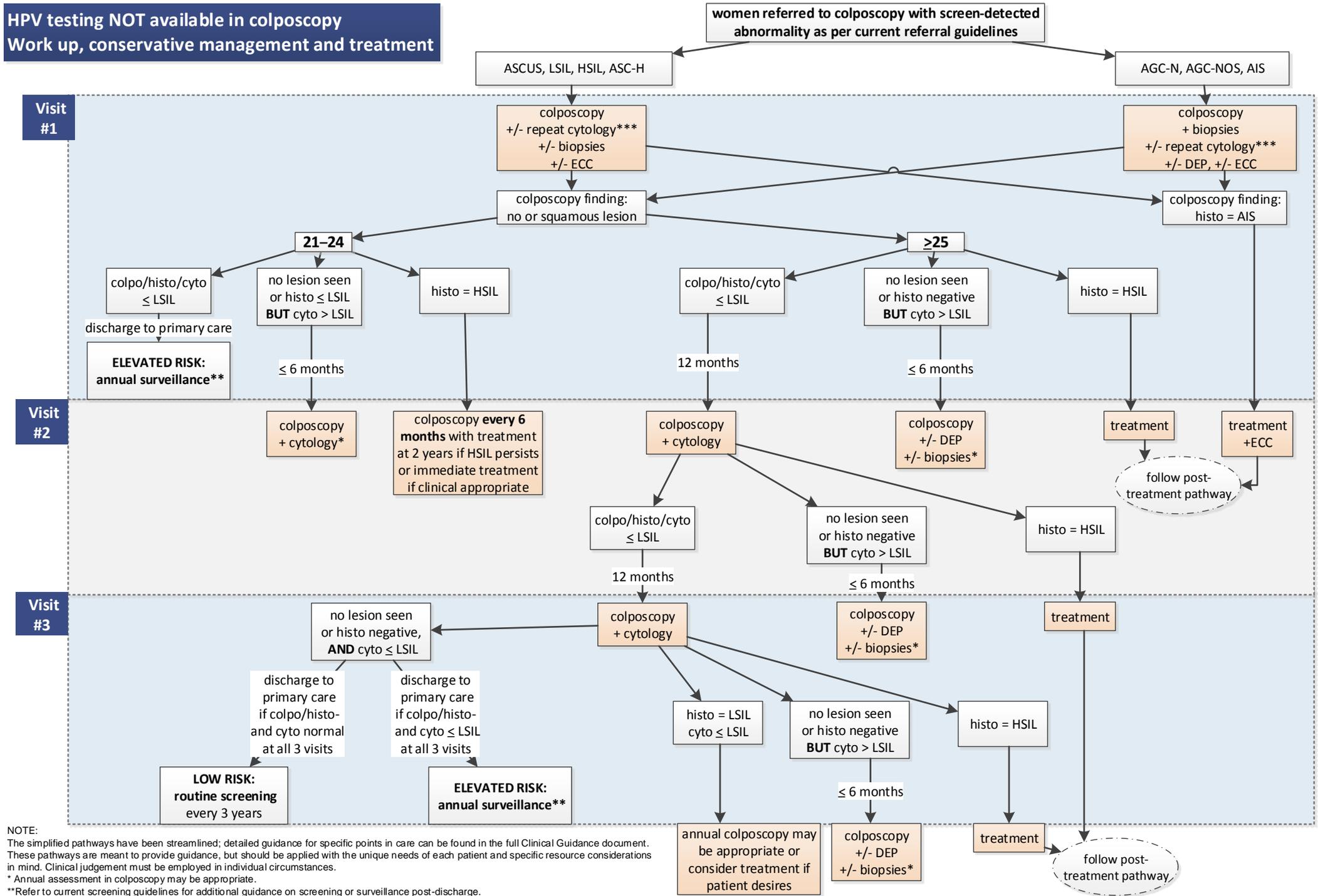
Post-treatment visit #1

Post-treatment visit #2



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**HPV testing NOT available in colposcopy**  
**Work up, conservative management and treatment**



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