MANAGEMENT OF PREMALIGNANT LESIONS AND MICRO-INVASIVE CERVICAL CANCER

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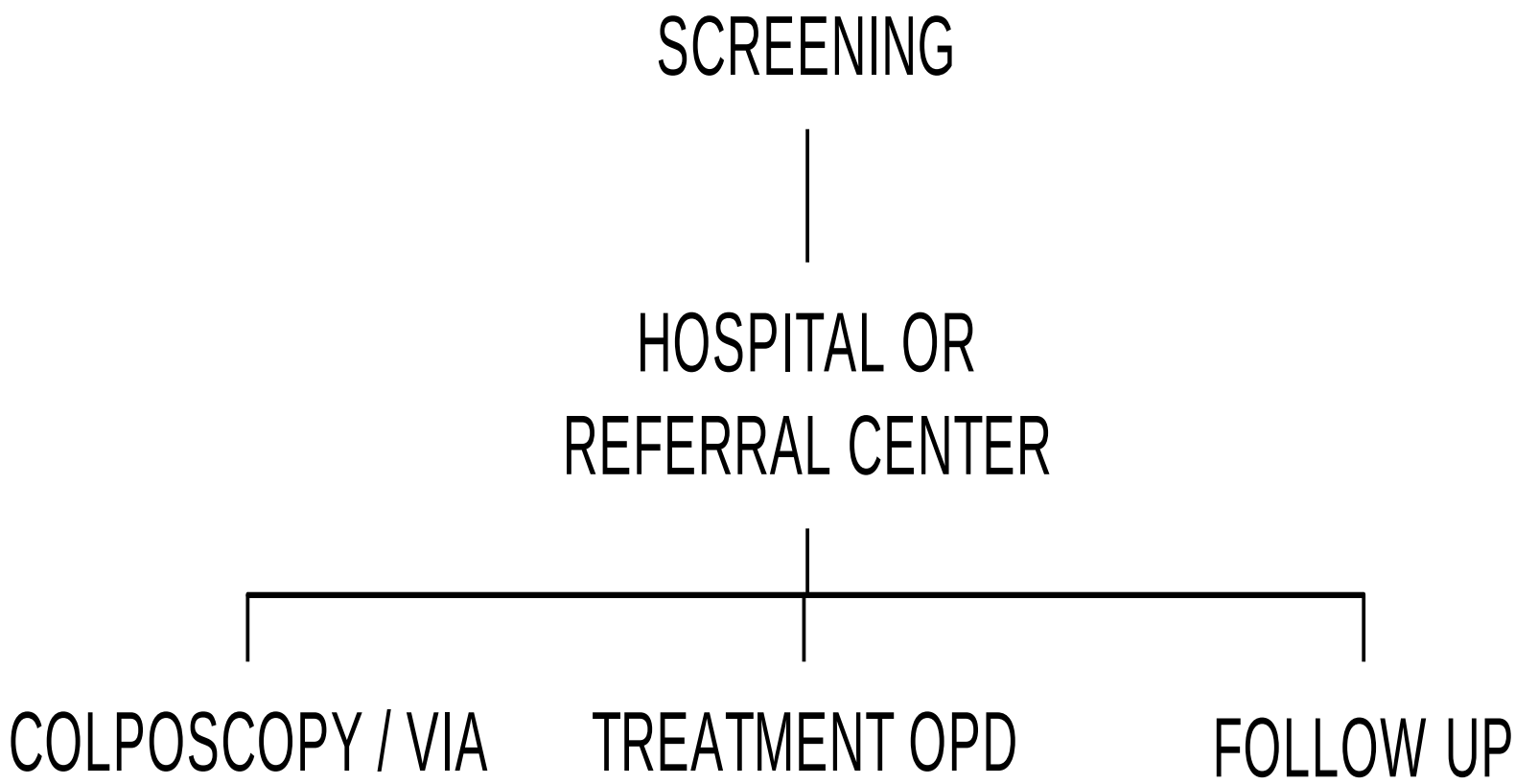
A COMPLETE MANAGEMENT PROTOCOL

- **Treatment should ideally be done as part of a complete management protocol which involves**
  - **screening,**
  - **referral for diagnosis,**
  - **treatment**
  - **and follow-up.**

MANAGEMENT PROTOCOL



MANAGEMENT PROTOCOL

- **All these services should be in place and functioning.**
  - **By treating premalignant lesions, invasive cancer is prevented**

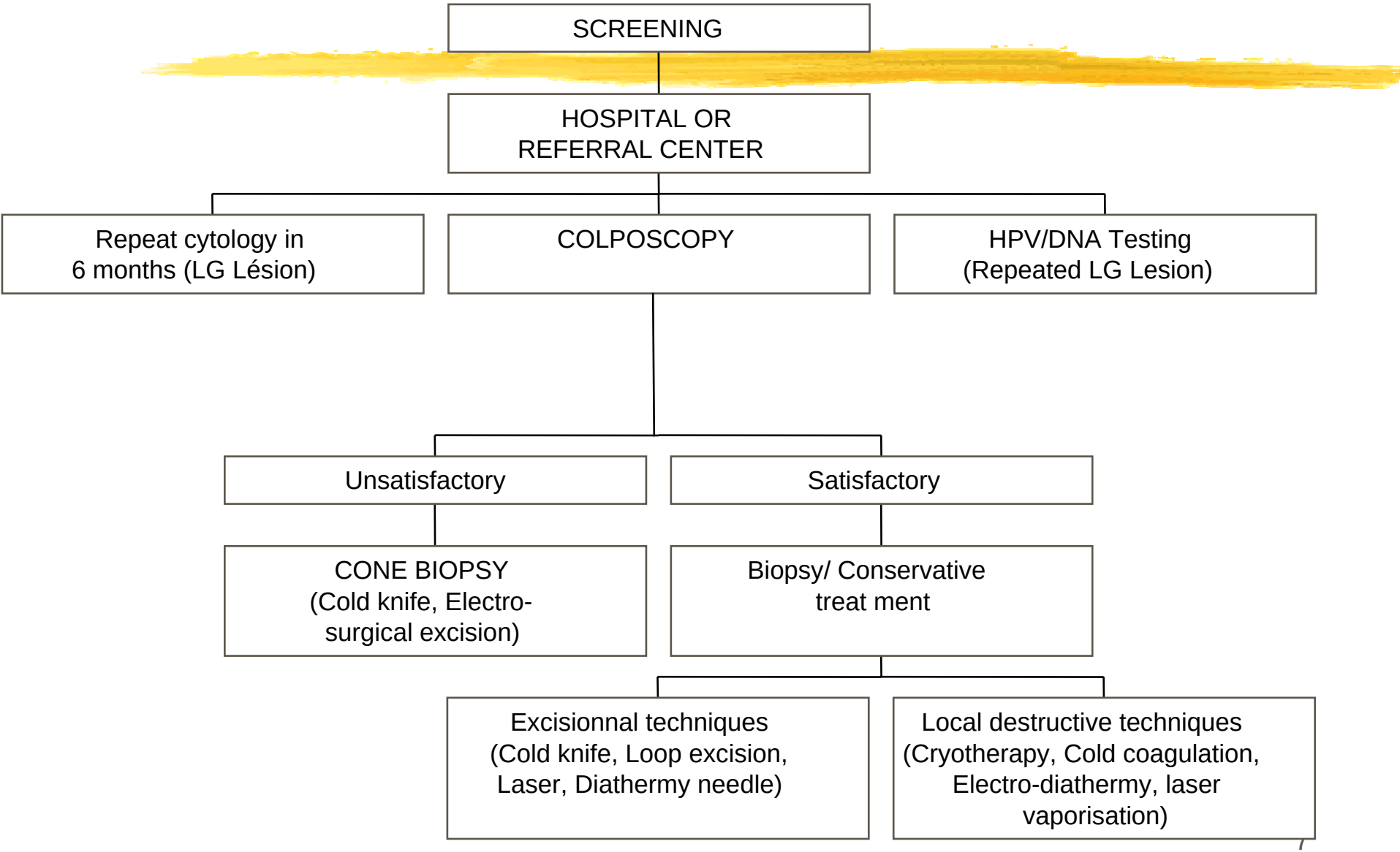
MANAGEMENT OF ABNORMAL SMEARS 1

- ASCUS and AGCUS are reported in some smears in Europe or U.S.A.
  - ASCUS = Atypical squamous cells of uncertain significance
  - AGCUS = Atypical glandular cells of uncertain significance
- These cells of undetermined significance are not to be neglected though because of lack of facilities, the cut off point for disease in developing countries is High grade SIL.

MANAGEMENT OF ABNORMAL SMEARS 2

- The cut off point for disease in developing countries is High grade SIL.
  - 50% of HG-SIL had previous ASCUS
  - _Repeat cytology still gives a false negative rate of >60%
  - Colposcopy gives less than 50% specificity though more than 90% sensitivity.
  - But with HPV testing the cytology results can be improved upon.
  - If the woman is ASCUS positive but HPV negative a repeat smear should be done in 6 months.

SUMMARY OF MANAGEMENT



MANAGEMENT OF LOW-GRADE CYTOLOGICAL SMEARS

- *30-40 % of women with low grade cytology (LG-SIL) have a high grade epithelial lesion co-existing within the cervix.*
- *8-14% of women with ASCUS smear harbour a high grade lesion.*
- *But regression occurs in 50-70% of these lesions that have been histologically proven.*
- *Therefore, repeat cytology before referring LG – SIL cases for colposcopy; and repeat cytology twice for ASCUS before sending for colposcopy. The cytology is carried out 6 monthly.*
- *Where HPV/DNA testing is available, a positive test in a woman ≥35 years even with a LG-SIL or ASCUS, warrants referral for colposcopy. Remember transient HPV occurs in 10-15% of women under 30 years of age, but in only 3-5% of those over 35 years.*

TREATMENT OF PRE-INVASIVE LESIONS
(Colposcopy available)

- *Transformation zone (TZ) may be completely visible or not*
- *A. TZ completely visible*
  - *1. completely exocervical*
    - *Small size: any method adequate*
    - *Large: cryotherapy not a good option*
  - *2. partially endocervical*
    - *Small size: most conventional treatment methods adequate*
    - *Large: excision methods*
    - *Destructive method if with endocervical curettage*
- *B- TZ not completely visible : Conisation*
    - *(Cold knife ; Electro-surgical loop excision ; Laser)*

TREATMENT OF PRE-INVASIVE LESIONS 2
(Colposcopy available)

- *For local destructive techniques to be used as an acceptable option, the following conditions must be observed:*
  - *No evidence of malignant disease either at cytology or colposcopy.*
  - *The colposcopic examination must be declared satisfactory.*
  - *There must be no great disparity between cytology and biopsy reports.*
  - *The woman must be amenable to follow-up.*

TREATMENT WITHOUT PRIOR COLPOSCOPY 1

- *There is risk of over treating approximately 1/3 of the women.*
- *This is a situation, where HPV/DNA testing would increase specificity.*
- *But it is often in this type of situation that the test is not available.*
- *The precision of treatment can be improved by the application of 3-5 % acetic acid.*
- *The same principles as above then apply i.e. the degree of visibility of the transformation zone and the size of the aceto-white area.*

TREATMENT WITHOUT PRIOR COLPOSCOPY 2

- *CIN I (LG – SIL)*
  - *a) With HPV/DNA testing*
    - *HPV/DNA negative, routine follow-up in 6 –12 months*
    - *HPV/DNA Positive; colposcopy*
  - *b) Without HPV/DNA Testing: Colposcopy and Biopsy*
    - *If negative, follow-up in 6 months.*
    - *If positive treat and follow-up*
    - *If repeatedly positive, treat by excision*

TREATMENT WITHOUT PRIOR COLPOSCOPY 3

- *CIN II and CIN III (HG – SIL)*
  - *Confirm diagnosis by colposcopy + biopsy*
  - *If no colposcopy, punch biopsy after application of acetic acid or lugol's Iodine*
  - *High grade SIL must be treated*
  - *Excisional methods may be preferable to local destructive methods*
  - *Failure occurs because of deviation from standard protocol*

MANAGEMENT OF DIFFICULT CASES

- *3 ENTITIES:*
- *Ø Pregnancy*
  - *Smear and even colposcopy often over-estimated*
- *Ø Menopause*
  - *less than 20% of CIN lesions are detected.*
  - *Local or systemic E_2 given for 10-14 days before colposcopy.*
- *Ø HIV:*
  - *Good correlation of cytology, colposcopy and histology.*
  - *ARV drugs and other measures have improved survival.*

TREATMENT FOR ADENOCARCINOMA IN SITU

- ***AIS is a rare pre-malignant condition often diagnosed by chance on a cervical cone performed for co-existing CIN.***
- ***No reliable colposcopic features of AIS***
- ***Local treatment appropriate provided length of cone >25mm and free margins.***

POST-TREATMENT FOLLOW UP PROTOCOLS

- **Patients treated for HG-SIL must be followed intensely for at east 10 years**

MICRO-INVASIVE CARCINOMA

- Diagnosis made only after a cone biopsy examination by a competent pathologist.
- Stage 1
  - Conisation or simple hysterectomy (Pivers I). No lymph node involvement.
- Stage 1 A2:
  - a. Conisation; lymphadenectomy recommended either by Laparotomy or coelioscopy (MAS).
  - b. Radical trachelectomy (D'argent)
  - c. Coelio Schauta
  - d. Wertheim modified with lymphadenectomy (Pivers II)
  - e. Radiation
- There is a 4-10% risk of pelvic lymph node involvement in stage 1 A2

THANKS!