BC CANCER CERVIX SCREENING
Provincial Health Services Authority

Colposcopy Management Algorithms for Patients Positive for High Risk HPV

Updated: January 2024

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Standard Colposcopic Definitions

Colposcopic Impression: The colposcopist's opinion as to the nature of any lesion seen, based on the classic colposcopic features of surface contour, colour tone, borders, intercapillary distance, vascular patterns, etc. Colposcopic impression is the specific diagnosis that the colposcopist would expect to be returned on any accompanying biopsy material based on their visual interpretation.

Colposcopic Biopsy/Pathology: The histopathological diagnosis of any directed biopsy that was obtained at the time of the colposcopic examination. If more than one biopsy is obtained, the most advanced lesion is recorded.

Colposcopic Evaluation: The clinical working diagnosis based on combining the information from both the colposcopic impression and the biopsy/pathology diagnosis. This diagnosis can never be less than the colposcopic biopsy, but may be greater than the colposcopic biopsy if the colposcopist believes the biopsy is not reflecting the most advanced pathology suspected based on their assessment. The presenting cytology is NOT part of the colposcopic evaluation.

PRACTICE POINTS:

- **Type 1 or 2 TZ** with lesion identified – endocervical sampling "acceptable".
- **Type 1 or 2 TZ** colposcopy with **no lesion** identified – endocervical sampling "preferred".
- **Type 3 TZ** colposcopy – endocervical sampling "required" to rule out high grade disease

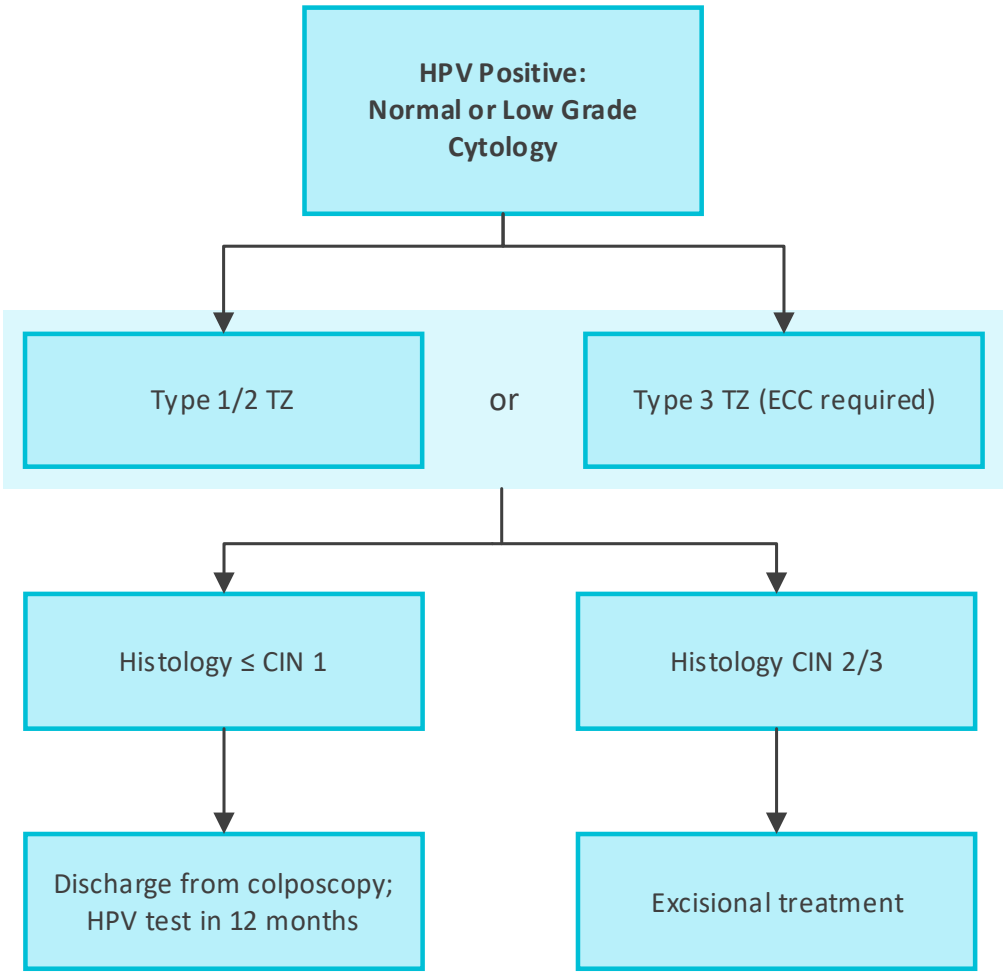
Table 1: Immediate-risk CIN 2+ based on primary HPV-based screening and reflex cytology results

	HPV			
Cytology	Pos HR-HPV (Any)	Pos HPV 16	Pos HPV 18	Pos HPV Other
Normal	3.4%	5.3%	3%	2%
ASCUS	4.4%	9% – 12.9%	5%	2.7% – 4.4%
LSIL	4.3%	11%	3%	4.3%
ASC-H	26%	28%	15%	26%
HSIL	49%	60%	30%	49%

Reference: Willows K, Selk A, Auclair MH, Jim B, Jumah N, Nation J, Proctor L, Iazzi M, Bentley J. 2023 Canadian Colposcopy Guideline: A Risk-Based Approach to Management and Surveillance of Cervical Dysplasia. Curr Oncol. 2023 Jun 13;30(6):5738-5768. doi: 10.3390/curroncol30060431. PMID: 37366914; PMCID: PMC10297713.

Guidelines for the Assessment of Individuals with Positive High Risk HPV

Ia: HPV Positive: Cytology Normal ASCUS, LSIL



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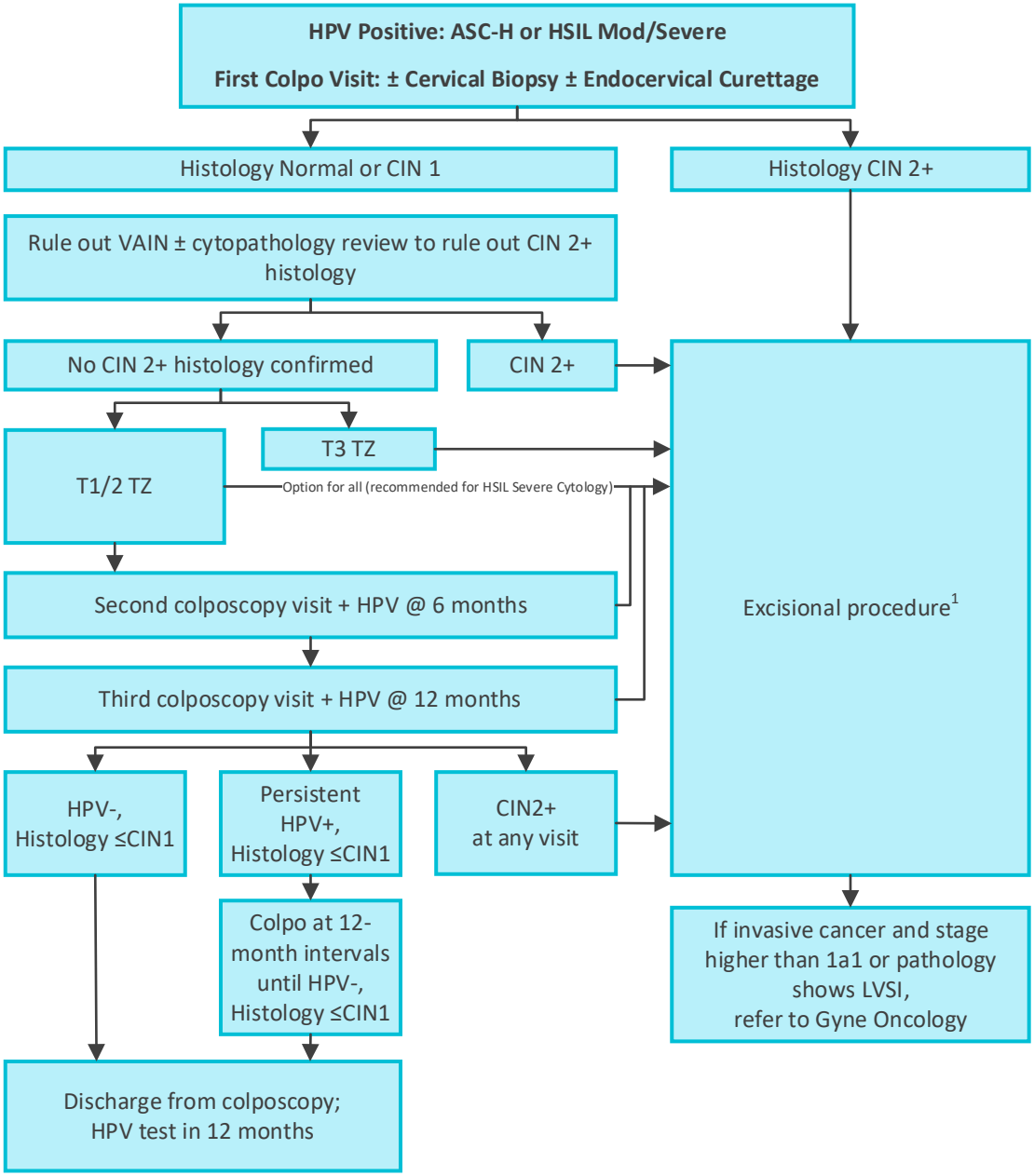
Ib: HPV Positive: Cytology ASC-H or HSIL-Mod/Severe



[1] Laser ablation may also be used to treat histologic CIN 2+ when specific criteria are met. See Guideline IIa.

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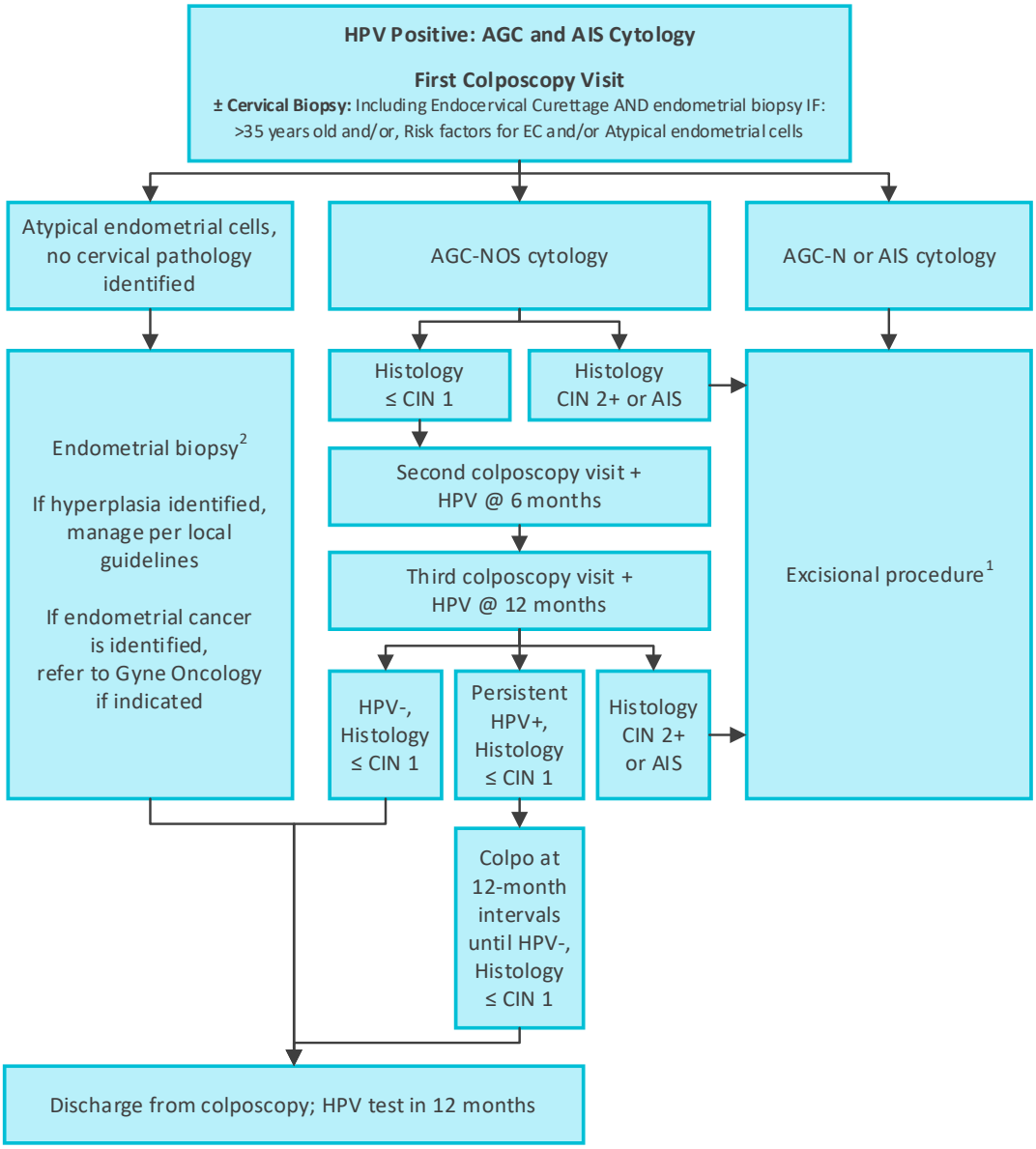
Ic: HPV Positive: Cytology Atypical Glandular Cells: AGC and AIS



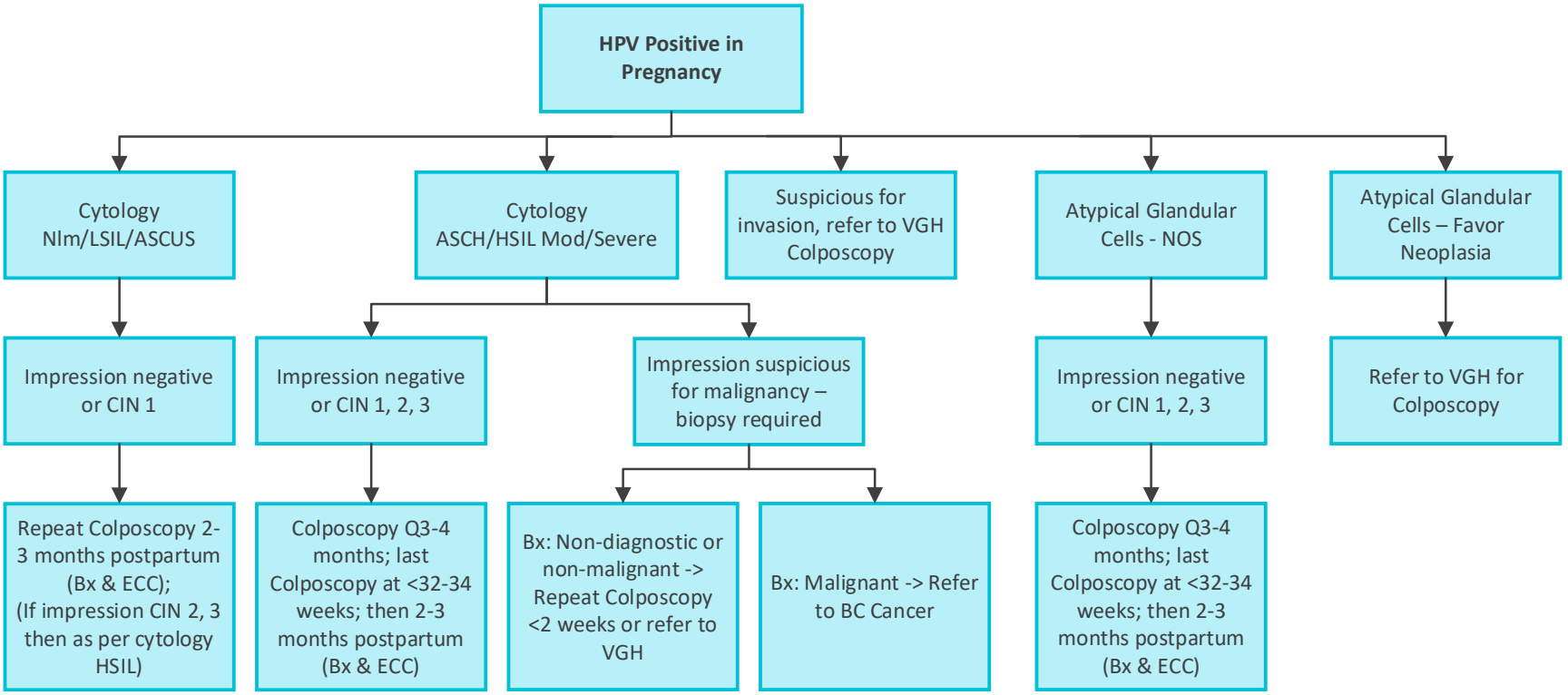
[1] If invasive cancer, refer to Gyne Onc.
[2] If the colposcopist is unsuccessful at obtaining an endometrial biopsy, or the biopsy is insufficient, the colposcopist should arrange for an appropriate evaluation of the endometrial lining.

Table 1: Immediate-risk CIN 2+ based on primary HPV-based screening and reflex cytology results

Cytology	Immediate Risk AIS	Immediate Risk Malignancy
AGC-NOS	2.9%	5.2%
AGC-FN	13%	21%

*HPV Status not defined
Reference: Schnatz, P.F.; Guile, M.; O'sullivan, D.M.; Sorosky, J.I. Clinical Significance of Atypical Glandular Cells on Cervical Cytology. *Obstet. Gynecol.* 2006, *107*, 701–708.

Id: Pregnant Individuals

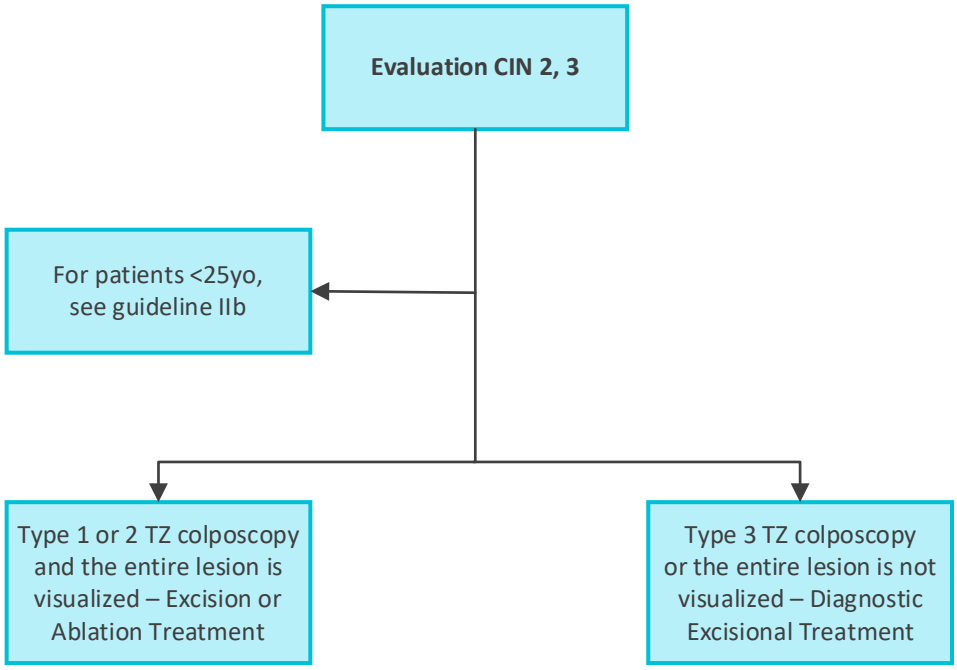


PRACTICE POINTS:

- Endocervical sampling is contraindicated during pregnancy.
- Cervical biopsy is safe in pregnancy and is required for diagnosis if suspicious for microinvasion/invasion.
- No treatment in pregnancy unless invasion is suspected.

Guidelines for the Management of Abnormal Colposcopic Evaluations

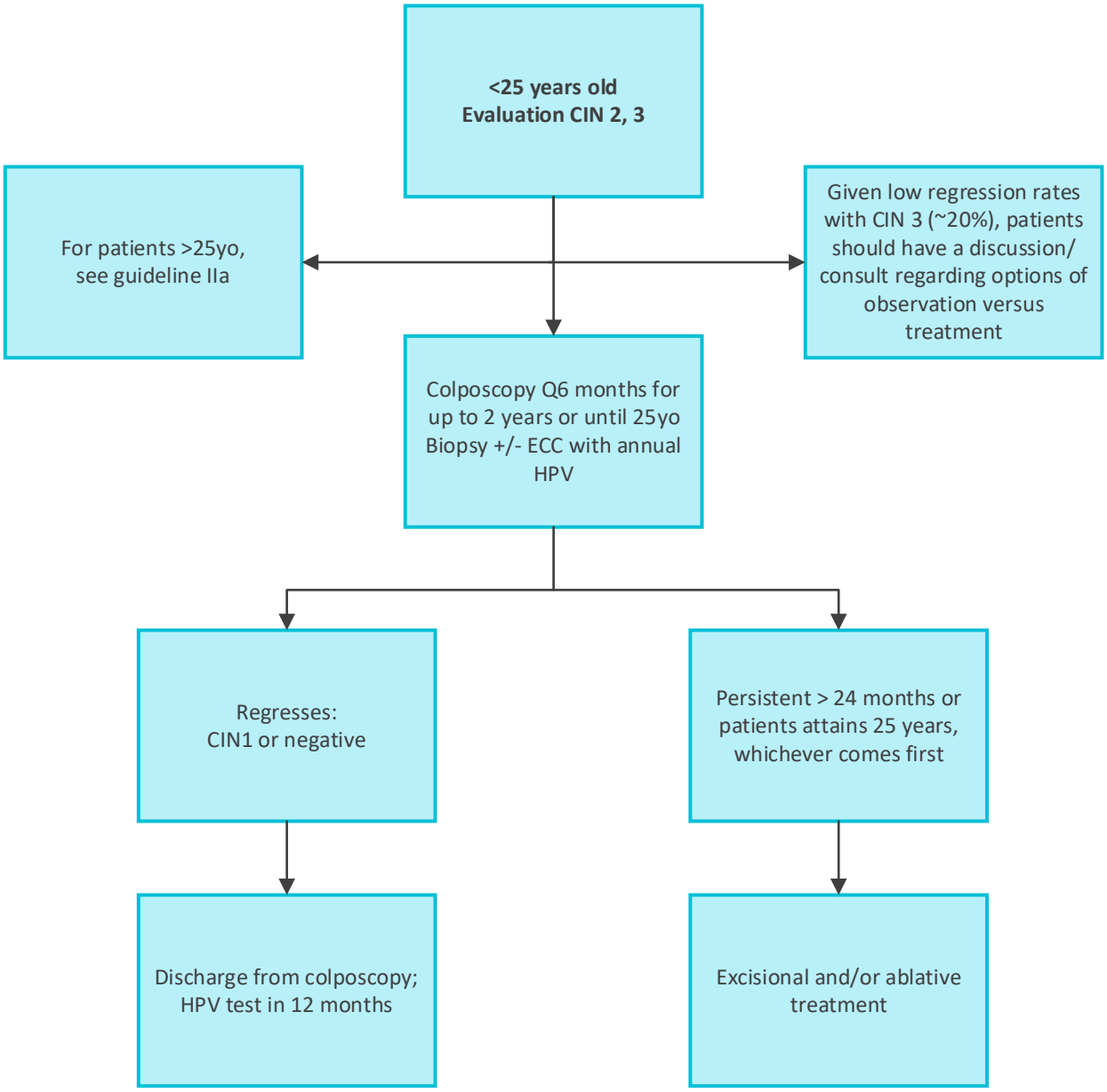
IIa: Management of CIN 2, 3



PRACTICE POINTS:

- Cryotherapy is NOT an acceptable treatment for CIN 2, 3.
- Acceptable treatment approaches for CIN 2, 3 are limited to ablative treatment with laser and or excisional treatment with cold knife cone and or LEEP. LEEP is preferred.
- Recommended depth of specimen 8-10mm.

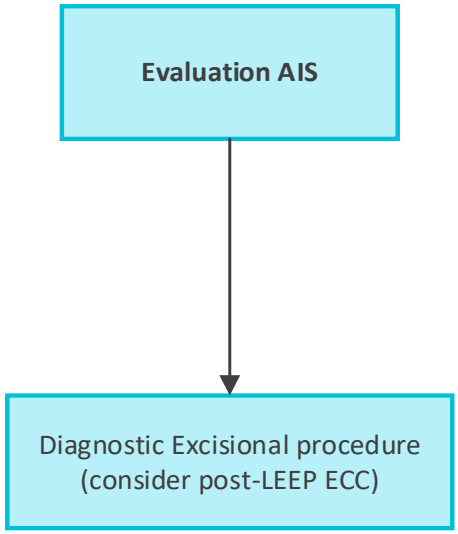
IIb: <25 Years Old Evaluation CIN 2, 3



PRACTICE POINTS:

- Given a compliant patient and a reliable follow up system, it is reasonable to follow young patients for up to 24 months or up to the age of 25 years (whichever comes first). After an informed discussion, and in appropriately selected patients, those with CIN 2 may choose to be followed conservatively up to age 30.
- Treatment recommendations are solely the responsibility of the treating physician. Follow up colposcopy exams should include biopsy +/- ECC.
- If compliance is a concern, then treatment is recommended

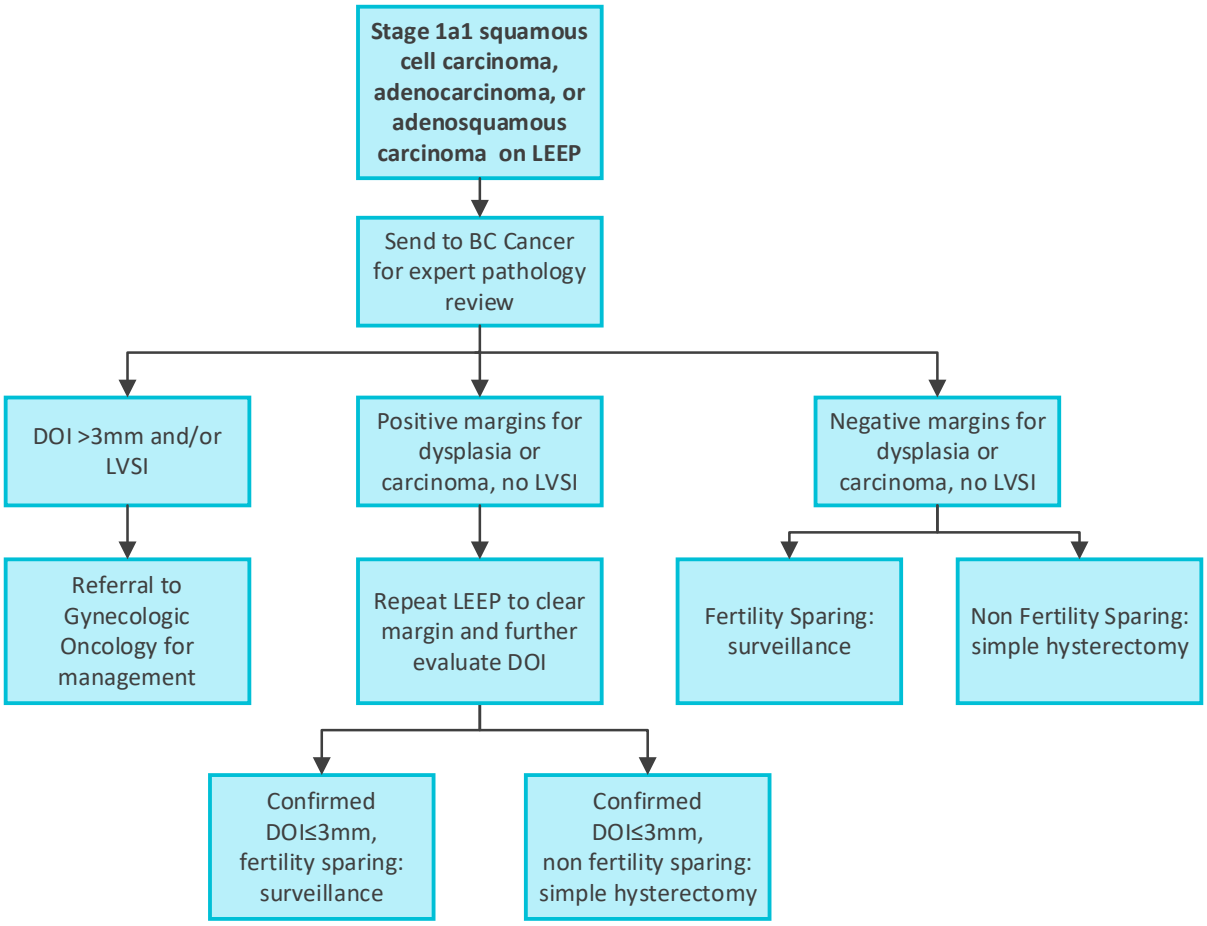
IIc: Management of Adenocarcinoma in Situ



PRACTICE POINTS:

- Diagnostic excisional procedure is NECESSARY to confirm AIS and rule out invasive adenocarcinoma BEFORE proceeding to a hysterectomy. See Guideline IIIb.
- Ablative methods are NOT acceptable treatment for AIS
- Depth of LEEP should be > 10mm. Consider Post-LEEP ECC.

IId: Management of Microinvasive Cervical Cancer



Microinvasive Cervical Cancer (1a1) Invasive cervix carcinoma: measured depth of invasion ≤3 mm in depth. Management of patients with stage 1a1 disease should be individualized depending on the age, the desire for fertility preservation, and the presence or absence of LVSI.

Colposcopists are encouraged to call Gynecologic Oncology, or refer for a consult, if there are any concerns or questions regarding the management plan.

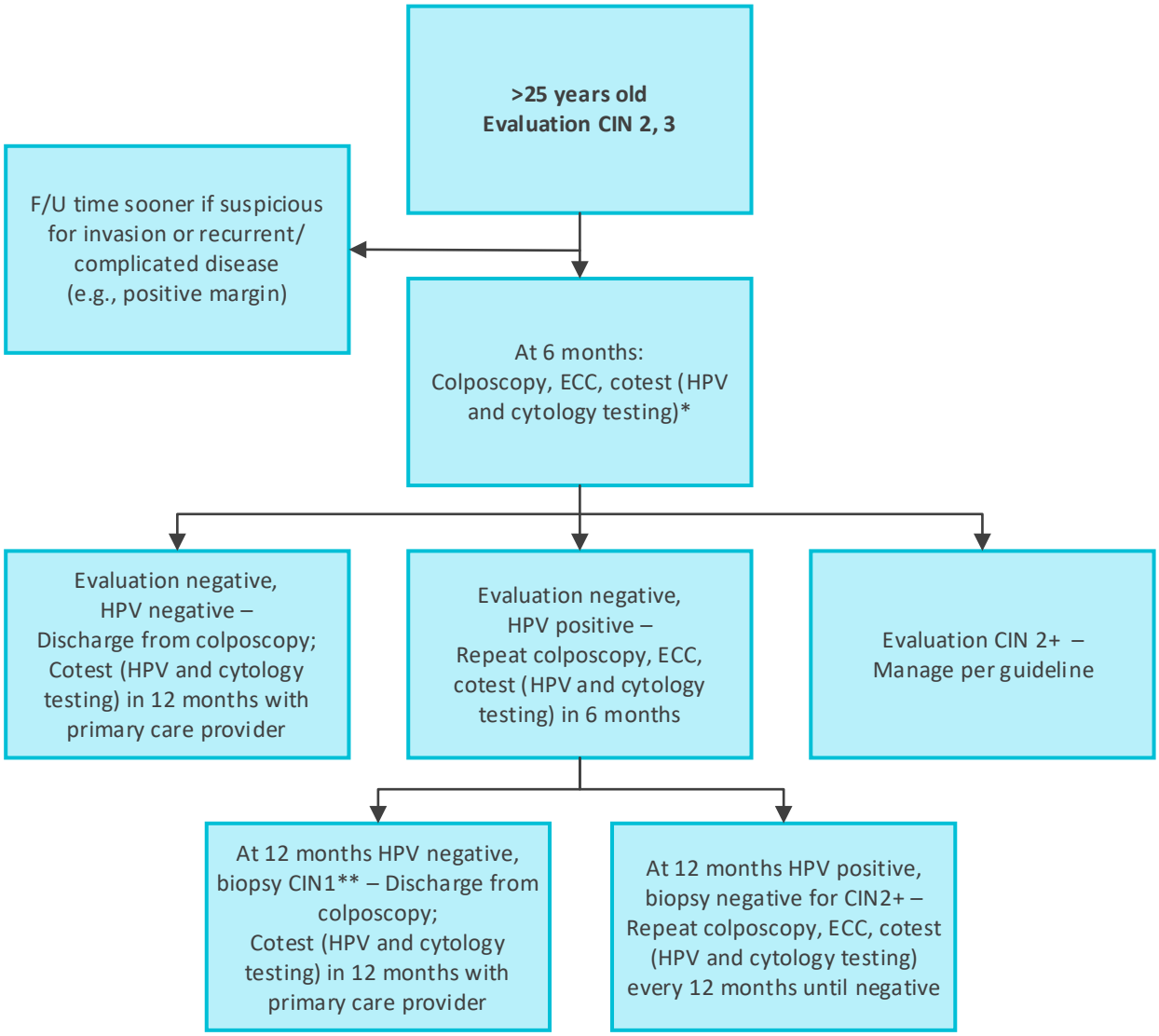
Surveillance Recommendations:

- After Simple Hysterectomy: Follow up colposcopy of the vagina every 6 months for 5 years. History and physical at each visit and a cotest (HPV and cytology testing) on a sample from the vaginal vault at 12 months post hysterectomy. If HPV is negative and cytology is NILM, ASCUS or LSIL, vaginal vault cotesting can be discontinued but vaginal vault colposcopic examination should continue every 6 months for 5 years.
- Fertility Sparing: Follow up colposcopy every 6 months for 5 years. History, Physical, ECC at each visit. Cotest (HPV and cytology testing) at 12 months. If HPV is negative and cytology is NILM, ASCUS or LSIL they can transition back to routine HPV-based screening at 3 year intervals (average risk) or 1 year interval (immunocompromised).

Please note: Once a patient has a cervical cancer diagnosis, they will no longer be recalled as part of BC's Cervix Screening Program. Please ensure that your patient receives the appropriate follow up. Ensure your recommendations for discontinuing HPV tests or your interval recommendation for ongoing testing is clear for the primary care provider prior to discharge from colposcopy.

Guidelines for Follow-Up of Previously Treated Cervical Disease

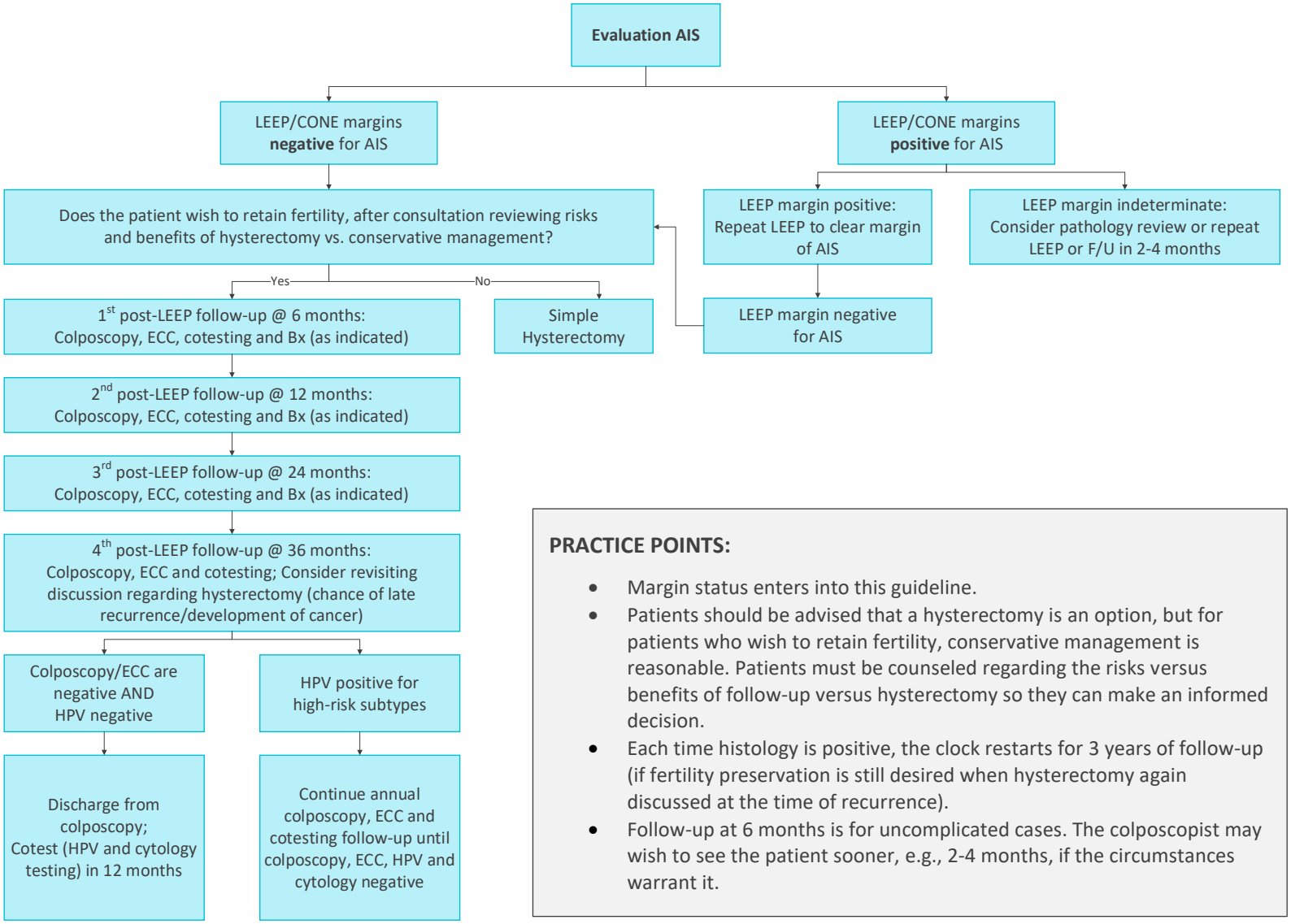
IIIa: Post-Treatment CIN 2, 3



*Starting in June 2018, HPV testing will be done with Roche Cobas4800 HPV test. This test provides specific results regarding typing for HPV 16, HPV 18 and HPV other (non-16/18).

**With a negative HPV test, the risk of CIN2+ is <2%, which is average risk, so the patient may go back to screening with their next cotest (HPV and cytology testing) in 12 months. Therefore, women with biopsy results that are negative or CIN 1 may be discharged if HPV negative.

IIIb: Post-Treatment Adenocarcinoma in Situ



PRACTICE POINTS:

- Margin status enters into this guideline.
- Patients should be advised that a hysterectomy is an option, but for patients who wish to retain fertility, conservative management is reasonable. Patients must be counseled regarding the risks versus benefits of follow-up versus hysterectomy so they can make an informed decision.
- Each time histology is positive, the clock restarts for 3 years of follow-up (if fertility preservation is still desired when hysterectomy again discussed at the time of recurrence).
- Follow-up at 6 months is for uncomplicated cases. The colposcopist may wish to see the patient sooner, e.g., 2-4 months, if the circumstances warrant it.

Guidelines for Post-Discharge from Colposcopy