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# MANAGEMENT GUIDELINES FOR THE TREATMENT OF CERVICAL PRECANCEROUS LESIONS

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## INTRODUCTION

This is a synopsis of the current European consensus on managing cervical pre-cancer. It is derived from three important sources, namely the evidence based NHS Cervical Screening Programme (1) and European (2) Guidelines and a consensus statement from the European Federation for Colposcopy (3).

## THE ROLE OF COLPOSCOPY

The aim of cervical screening is to reduce deaths from cervical cancer. The vast majority of women screened and even in those women who have abnormal smears will not develop cervical cancer. The potential for harm from needless and poorly executed intervention is significant. Whilst the role of colposcopy is to identify the source of abnormal cells and to decide the most appropriate mode of treatment, its primary aim is damage limitation.

## SELECTION

Avoidance of needless intervention is pivotal. Treatment should be aimed at CIN, preferably high-grade CIN as low-grade changes are often self-limiting. Accurate selection is dependent on the skill of the colposcopist who needs to have been adequately trained in a recognised training programme. Colposcopic selection involves not only competent image recognition but also good clinical judgement. The subjective nature of colposcopy mandates the need for systematic quality assurance using good data collection and audit.

There are obvious attractions and pitfalls to treating patients at their first visit. If undertaken, the colposcopist should be able to demonstrate that CIN is present in  $\geq 90\%$  of the excised specimens.

## TREATMENT METHODS

It is vital that treatment is done properly. Treatment should aim to destroy or remove tissue to a depth of 6 mm. Consequently, diathermocoagulation and cryocautery should not be used as depths of destruction ranges from 2–4 mm. Whilst ablative and excisional treatments seem to be equally effective, excisional treatments are preferred as better histopathological information is provided. This enables better assessment, planning and quality assurance. Examples include glandular and invasive lesions which are under-diagnosed using punch biopsy so ablative treatments will under-diagnose and under-treat these rare but important conditions.

Accurate information allows tailored management. Thus, women with adenocarcinoma in situ/cGIN or microinvasive squamous cancer FIGO Stage 1a1 can be managed by local excision, so long as the lesion is completely removed. Women over the age of 50 years who have CIN3 at the endocervical margin should have a repeat excision to try and obtain clear margins.

Despite these informational gains, there are concerns that excisional treatments may be associated with greater morbidity. Furthermore the ability to assess completeness of excision can be compromised in multiple specimens. As a European quality standard, it is recommended that at least 80% of samples should be removed as a single specimen.

Morbidity in excisional treatments is more associated with the size of the specimen and the number of prior treatments rather than the actual type of excisional modality. However common-sense would support the use of treatments such as loop diathermy excision and laser which can easily be performed under local anaesthesia; 80% of such treatments should undertaken in this way in the UK.

Ablative treatments should only be done when certain clear and well-defined criteria are met: the entire cervical transformation zone must be visible; there must be no cytological evidence of glandular abnormality; and there must be no evidence of invasive disease.

## CONCLUDING COMMENTS

Patients and health-care providers seek high-quality care and this is particularly relevant in cervical screening. In this context, poor colposcopists are at least as dangerous as cervical cancer.

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High quality care should be demonstrated by evidence and not simply be left to trust.

## REFERENCES

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