

## **Notes from EFC 3<sup>rd</sup> Satellite Meeting, Berlin 28<sup>th</sup> Feb/ 1<sup>st</sup> March 2014**

### **Introduction**

Christine Bergeron

Christine Bergeron welcomed 36 delegates from 27 member societies.

### **Summary of previous meetings**

U Petry

During the previous two EFC satellite meetings in Berlin and the EFC General Assembly 2013 in Prague, EFC gave highest priority to the development of quality assessment strategies in colposcopy. The aim is to standardize and harmonize education, training and practice in colposcopy throughout Europe and neighbouring regions. The General Assembly authorized the EFC's educational committee (EEC) and the satellite meeting delegates to develop a frame programme for basic and advanced colposcopy courses with defined time slots for specific core competencies and minimum requirements for exit assessment (may include a dynamic pool of tasks/questions) and a template for training programmes in colposcopy including minimum / maximum time limits and minimum caseloads.

Similarly the General Assembly authorized the EFC Executive Board and the satellite meeting delegates to define a frame for EFC approval of national QA concepts in practice of colposcopy ("expert colposcopist"). So the tasks for the satellite meeting were well defined.

### **Definitions**

CWE Redman

#### *Courses*

These were considered to be limited educational activities that serve to support formal training programmes. They can include lectures, group work and have an electronic format. Such courses can be characterised by content and duration.

#### *Training Programmes*

These are experiential educational activities that necessarily involve, at least in part, patient contact. They should have a stated aim, identified objectives, a curriculum, identified trainers and assessment.

### **Colposcopy Courses – EFC approval**

CWE Redman/U Petry

There was an initial short presentation. The key points, which served as discussed points, were:

- From the EFC perspective, the role of courses is to enable/support colposcopy training programmes

- Basic colposcopy courses are eligible for approval if the EFC core curriculum is covered and the duration of the course is at least 8 hours (or equivalent if electronic and inclusive of breaks – 6 hours exclusive of breaks).
- The EFC would approve those courses run by its member societies that meet these criteria. In countries with a member society, courses run by others are eligible for approval only if these courses are approved by the relevant member society and that they meet the necessary EFC criteria. Courses run by others not based in countries with a member society can seek approval directly from the EFC and are eligible for approval if they meet the necessary criteria.
- The role and criteria for advanced colposcopy courses had yet to be decided.

These proposals were then discussed. Seventeen member societies indicated that they had colposcopy courses and summarised their activities. It was evident that in most countries, colposcopy courses were an integral part of colposcopy training. In some, attendance at a basic colposcopy course was a necessary preliminary to embarking on clinical training. Many countries had what were termed as basic and advanced colposcopy courses. In some cases, advanced courses were part on training whilst in others these were for trained colposcopists and part of continued professional development. The duration of courses involved in colposcopy training ranged from 8 hours to in excess of 40 hours.

*In summary:*

- There was a recognised need for basic colposcopy courses
- It was agreed that basic colposcopy courses should cover the EFC core curriculum
- The duration of the course should be at least 8 hours inclusive of breaks
- A basic colposcopy course could be electronic and that there was a need for such a development.
- The need for and content of more advanced courses would be addressed at a later stage.

### **Colposcopy Training Programmes – EFC Approval**

CWE Redman/U Petry

There was a short introductory presentation. The key points were:

Consensus had already been reached on many of the key areas, *viz:*

- The aim of the training programme was “to enable trainees to obtain the core knowledge, develop the necessary skills, and the personal and professional attributes to enable them to be lifelong learners and compassionate colposcopists” (Training Committee Meeting, Paris 2002).
- The programme curriculum should incorporate the EFC core curriculum devised by the Delphi process in 2002 and revised in a second EFC Delphi in 2012. This was a competency-based curriculum.
- There was agreement that a trainee would see a minimum of 100 cases, of which 50 should be new patients and 30 have abnormal cytology.
- Training should be completed within 24 months
- There should be an exit assessment of some sort.

There followed a number of presentations about assessment options. A number of different methods are used, either in isolation or combination with other types:

- OSCE (Objective Structured Clinical Examination) – testing knowledge and competence in decision making, clinical management and communication. Techniques include oral stations and structured written responses. Only the UK uses this.
- MCQ – testing factual knowledge and image recognition capabilities. This is probably the commonest method.
- Viva Voce - either formal or informally convened in a summative and/or formative setting.

The consensus view supported the initial proposal is that there should be an exit assessment but no particular mode of assessment was specified.

It was recognised that the quality of trainers was a major consideration needing addressing. No member society has fully addressed this issue but it was recognised that an EFC sponsored Training the Trainers course would be desirable.

## **European Colposcopy Diploma**

CWE Redman

An initial presentation summarised the background for a European Diploma. This had become an objective of the EFC at the Berlin Congress in 2010, which has been re-affirmed in the 2011 training survey. Such a qualification would help improve European colposcopy and facilitate the movement of trained colposcopists throughout Europe.

Given the resource limitations, it was proposed that the EFC would offer a quality assured examination for trained colposcopists who had completed a national training programme. This would probably be electronic in format and undertaken in conjunction with a higher education institution. Progression would depend on:

- Support of member societies.
- Support of EBCOG/UEMS
- Cost .

This proposal was discussed. There was support for the proposal but demand would, in part, depend on the number trainees from EFC-approved programmes. However, it was felt that such a qualification could be used as an indicator of competence and knowledge that would be useful to currently practising colposcopists as a mark of quality, especially for those seeking to be trainers. It was agreed that this concept and its feasibility is to be evaluated.

### **European Colposcopy and EBCOG**

K Vetter

This excellent presentation summarised EBCOG's involvement with promotion of European training in obstetrics and gynaecology, plus recent educational developments, which included competence-based curriculae, and electronic educational formats. The complexity of achieving harmonisation of training programmes across Europe was challenging and progress was slow. Prof Vetter felt that the EFC's initiatives were very much in step with EBCOG's strategic direction.

### **Colposcopist Certification**

U Petry

Six representatives summarised their national situation regarding certification. In the main, self-certification was used although in the UK this is supplemented by external QA using mandatory data returns that is used in certain regions. In Germany and UK, arrangements for certification are comprehensive and established, although there are regional differences in UK and certification of colposcopy units in Germany started in just in 2013.

In the ensuing discussion the following points were noted:

- Voluntary self-certification was an important initial step and easy to implement.
- It would be better for standards to be set by clinicians rather than by others. This is an argument for national societies to initiate this process rather than having it imposed.
- National colposcopy societies can play an integral role in this process.

- Certification is an opportunity for colposcopy societies to seize the initiative and gain or increase influence.
- At the outset, number of cases seen may be the simplest and easiest objective parameter. It was considered desirable for defined quality standards, including the current EFC QA standards, to form part of the certification process.

Marcus van den Bergh and Ulrich Petry presented the experience with a voluntary pilot project of ten German colposcopy clinics. Data were collected using ODSdysplasie Version 4.0 (asthenis GmbH; available at <http://www.asthenis.de>), a software specifically developed to document diseases of the lower female genital tract that provides continuous independent electronic quality assessment of participating colposcopy clinics.

All data collected from women referred for colposcopy were anonymized, encrypted and stored in a secure relational database located within the clinics' network. Access to data for all aspects of benchmarking or certification was restricted to registered users. Data from more than 6,000 patients referred for colposcopy were used to compare the performance of participating clinics using the EFC quality indicators. While all met the EFC minimum case numbers, the majority did not reach the recommended targets for clear margins, documentation of SCJ, colposcopy prior to excisional treatment and proportion of CIN2+ among women with excisional therapy. The failure could be in part explained by documentation failures. However there was consensus that such an approach is very attractive to achieve an independent standardized QA in colposcopy that finally may allow the definition of more useful quality indicators. Delegates from 17 EFC member societies were interested to participate in a European pilot project. All will be contacted and enabled to use the software but because of limited resources participation in the first phase of the EFC pilot project will be restricted to a handful of societies. A decision with a proposal on how to proceed will be communicated in June/July 2014.

### **The electronic systems for training and examination**

Ilkka Räisänen

Theoretical (eg natural history of cervical/ vaginal and vulval neoplasia; normal anatomy; recognising abnormality) and practical (20-30 supervised colp examinations) aspects to training are tested with this software.

Resident does at least 50 colposcopies. All trained colposcopists would be competent to perform colposcopy for diagnosis. In Finland residents in O+G have to do Finnish web-based programme.

Duration of training in Finland is usually 4 months.

Web tutorials were also presented – how to take cytology, colposcopy with footnotes/ free but in Finnish.

The web assessment was demonstrated: 60 cases are available with Reid index. Model answers are available. Theoretical questions are also available which are marked and logged as training time. The software could be adaptable to be used for different languages.

## **Evidence-based colposcopy standards**

Marc Arbyn

Map of membership was presented. Maps of HPV triage for ASC-US, LSIL, ToC and screening also produced. No countries in Europe are currently performing HPV-based screening. The Netherlands will be the first to fully convert in 2016 for 30-60yr olds and self-sampling for defaulters. England has 5 trial sites, Italy 3 regions and Sweden has a pilot in Stockholm.

A systematic review of margin status was presented. The risk of failure is:

- Margin +ve PPV
- Margin -ve 1-NPV (cNPV).

27% of loop margins involved compared to laser or cold knife cone (18-22%). This was statistically significant. Perhaps obstetric risk is making colposcopists too cautious.

Margin status to predict recurrence of CIN had a sensitivity of 65% and a specificity of 84%. PPV was 22% and the risk of a -ve result predicting failure (cNPV) was 3.2%.

The relative risk +ve vs -ve margins was 6.6 (3.6-11.8).

Margin status was only important for <35yr and for loops <10mm deep (Ang BJOJ). Strander 2014 (BMJ) noted that CIN treated since 2001 had a higher risk of recurrent CIN, incidence and mortality from cancer in Sweden. This appeared to be more common in older women.

Quality indicators applicable to margin status:

Pertinent	Y
Evidence	Y
Accurate	Y
Feasible	Y
Actionability	+/-
Efficiency	Y

Next to consider which margins involved, relationship to size of lesion on obstetric and oncological outcomes. Need to agree how to measure excision size. Dr Arbyn's work is ongoing and he will report again to the EFC.

## **Final Conclusions**

C. Bergeron and U. Petry

### **EFC approval of basic colposcopy courses:**

The EFC Education Committee will approve basic colposcopy courses from national societies that are part of the overall national training programme. The course should address EFC's core competencies. Submissions to EFC need to include:

- Programme of the course (max. 2 pages)
- Duration 1-2 days

- Evaluation
- EFC will send approval or refusal within 3 months
- Fee of 100 Euros
- Re-approval every 3 years.

**EFC approval of training programmes:**

Only submissions from EFC member societies are accepted. They should have a stated aim, identified objectives, a curriculum, identified trainers and assessment and need to include:

- Duration 6-24 months
- Case load minimum 100 cases including 50 new cases
- Defined qualification of trainers
- Exit assessment
- EFC approval (or refusal) within 3 months
- Fee 100 Euros.

The EFC will produce:

- A basic course template to help societies without course to move forward
- It will on the website in June 2014.
- The Education Committee will develop a template proposal for advanced course before Istanbul 2016.