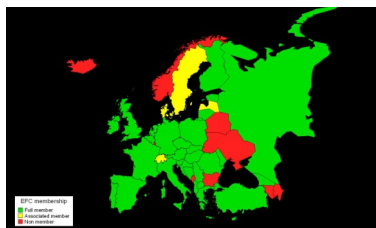




EUROPEAN
FEDERATION
FOR COLPOSCOPY **org**
AND PATHOLOGY OF THE LOWER GENITAL TRACT

Dear Colleagues



I hope that you enjoy reading the latest newsletter from the European Federation for Colposcopy which should bring you up-to-date with what has been happening within the Federation since we all met in Berlin in May 2010 for the 5th European Congress. It will not be long before it is time to meet again for the 6th European Congress which will be held in one of Europe's leading Congress Centres in Prague on 5th -7th September 2013 www.kcp.cz/an. It will be an interesting programme and will include some of the bestknown speakers from all over Europe who will be bringing you up-to-date with the latest advances in colposcopy and HPV testing. It promises to be a memorable meeting at which our Member Countries will be able to hear just how much we have achieved as a Federation since our humble beginnings in 1999.

Liz Dollery



6th European Congress of the European Federation for Colposcopy
and Cervical Pathology
Prague Congress Centre, Czech Republic
5-7 September 2013

EFC NEWSLETTER WINTER 2012

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We're on the web:
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President's Letter



Dear Colleagues

Following our last congress in Berlin it became apparent that all member societies expect that EFC, as their roof organization, should develop common European standards of how to train and practice high quality colposcopy .

The implementation of HPV vaccination and the shift to primary HPV screening for cervical cancer prevention in some member societies are a challenge to colposcopy. I am convinced that this challenge offers a chance to redefine the role of colposcopy as the key method for a professional management of atypical screening results for the next decades. To address the need for European standards in colposcopy, EFC invited delegates from all member societies for the first EFC satellite meeting in Berlin in May 2011. Personally I was impressed very much by your support. It was a great motivation for continuous efforts to see that most member societies were represented by delegates and helped us to collect for the first time information on how colposcopy is used, trained and esteemed in different regions of our continent and neighbouring areas.

You can find the details of the satellite meeting in the report at the end of this newsletter. To summarize the key decisions, EFC will update the "core competencies in colposcopy" and define the best suited "quality indicators in colposcopy" in two separate Delphi processes. All delegates agreed that the number of minimum cases to train should be at least 50 new cases of which at least 30 have abnormal cytology. Trainers must be competent to train and see at least this number per annum. The duration of training should be less than 24 months including theoretical training. In a first step, this European consensus on minimum cases, core competencies and quality indicators will help to harmonize the way how we train and practice colposcopy. The process towards a European colposcopy diploma could be further accelerated by electronic tools to assess the training progress as well as the quality of daily practice. Already existing examples are the electronic log book for colposcopy training used in the UK, internet based courses and examination in Finland and a benchmarking of colposcopy clinics in Germany.

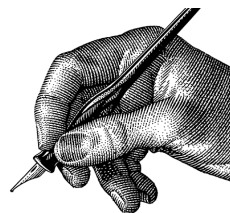
The success of this process depends on you. Without a broad support from member societies we will fail to reach the goal of a high quality network of colposcopy clinics throughout Europe. EFC will invite delegates for another satellite meeting in autumn 2012 to reach a strong consensus during our next congress 2013 in Prague. I would kindly ask to support EFC on this way as much as you can.

At the end of a busy year my special thanks go to Charles Redman for taking the responsibility for the Delphi processes, Simon Leeson and all other lecturers who helped to hold EFC

training courses and Liz Dollery Dollery for getting all links together

I wish you a happy and successful new year

Professor Ulli Petry



Revising the EFC Core Curriculum

In 2000, 51 core competences were identified in a Delphi exercise that involved 28 experts from the then 21 member societies of the EFC. This was a significant step that has enabled increasing consensus towards common standards in European colposcopy training and the competency-based EFC core curriculum has been utilised throughout Europe.

In the EFC symposium on quality standards in colposcopy that was held in Berlin in April 2011, it was agreed that the core-curriculum should be revisited. The drivers for this were:

1. The original core curriculum was over 10 years old and it seemed sensible to review its content in the light of changes and developments that might have occurred
2. The EFC has significantly expanded and such a review would enable the Federation as a whole to have the chance to review the curriculum
3. The curriculum needs review from an educational perspective
 - a. not all the items are actually competences i.e. the current curriculum is, in fact, a hybrid and could be improved
 - b. some unnecessary items e.g. recognition of condylomata acuminata as well as condylomata plana: ? Relevance

It was agreed that this review should be in the form of a further Delphi which will undertaken in the near future.

Dr Charles Redman
Treasurer EFC

Developing EFC Colposcopic Quality

The aim of the EFC is to promote and improve standards of colposcopy in Europe. The initial focus has concentrated education and training but attention is now shifting to the provision of colposcopy itself.

In terms of quality assurance, the agreement on and publication of the European cervical screening guidelines in 2009, which included colposcopy, was an important initial step. These have achieved a consensus on how colposcopy should be incorporated in cervical screening programmes with guidelines on diagnosis and treatment.

With common guidelines agreed, the next important Quality Assurance (QA) step is the compilation of quality standards. There have, in fact, been EFC standards on colposcopic treatment since 2004. Representatives of the EFC member societies developed these using a Delphi process.

It was felt that the scope of the quality standards needed to be extended to encompass the whole process of colposcopy, including diagnosis. To this end, this issue was reviewed and debated at the EFC QA symposium held in Berlin in April 2011 to which representatives from 25 out of the 31 EFC member societies attended.

At the outset, five quality standards were presented by U PETRY (Germany) as a template for further development, viz:

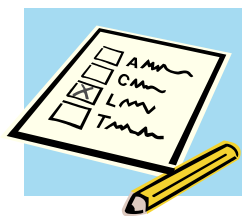
Area	Description	Target (%)
Examination	Documentation of SCJ staging	100
Diagnosis	% of treated patients with CIN2+ on biopsy	> 75
Treatment	Use of knife conisation/hysterectomies in the treatment of CIN	< 3
Treatment	Colposcopy performed prior to treating CIN	100
Outcome	Negative cytology and HPV after treatment	> 85

A number of additional indices were suggested. It was agreed that a Delphi be undertaken to identify a number of Quality Indicators and standards so that there could be an EFC consensus, using evidence based indices wherever possible.

A steering group has been formed which includes M ARBYN (Belgium), C REDMAN (UK) and U PETRY. The Delphi principle investigator is E MOSS (UK). To date, a total of 60 respondents have been recruited and the first round of the Delphi successfully completed. This has collated all standards that have been suggested by the respondents who are then asked to identify the most relevant and important ones to be used. The steering group will present the proposed EFC QA standards at the EFC Scientific Meeting in Prague in 2013.

CWE Redman and E Moss

EFC Education Committee



The Education Committee has had an interesting year. We established a membership in accordance with the terms of reference accountable to the EFC Executive. Tamar Alibegashvili, Carmine Carriero, Damian

Dexeus, Jean-Luc Mergui and Pekka Nieminen agreed to become members. We have had courses in Sweden, Albania, Georgia and Latvia. Two of these were with 'Eurovision', an affiliation with the Royal College of Obstetrics & Gynaecology (RCOG) and the International Federation for Cervical Pathology and Colposcopy (IFCPC). These courses seem to turn out to be something of an adventure combined with the unfailing generosity and enthusiasm of our various hosts. We currently have 2 courses planned for 2012 in Estonia and Antalya which

leaves room for others. I would like to thank our co-presenters who have all given their time and expertise so kindly. There was a meeting of all national society leads in Berlin in April and we made headway in looking for the provision of Colposcopy training in Europe and this has been reported elsewhere.

The Education Committee is also looking to provide some original thinking about the future role for colposcopy in the vaccinated population and when HPV testing may be provided for triage, test of cure and primary screening. Furthermore the performance of colposcopy will be considered in the light of other adjunct tests including biomarkers.

I would anticipate greater use of educational materials on the EFC website and closer liaison with the IFCPC IT and Education Committees.

Simon Leeson

Chair of the EFC Education Committee

Report on the 1st EFC Satellite Meeting on Quality Standards in Colposcopy Berlin 8–9th April 2011

Professor U Petry, President of the EFC

Initiated by the strong interest in standards and quality assessment in training and practice of colposcopy during the 5th EFC congress 2010, EFC invited all 31 member societies and 4 affiliated members to participate in the first satellite meeting on quality standards in colposcopy. The event took place in the nh-Hotel Leipziger Str. in Berlin. It was a closed meeting with 1 to 2 delegates from each national society, the EFC board and a few invited speakers and guests. 25 national colposcopy societies were represented at the meeting by authorised delegates. After a welcome address by J. JORDAN, the first session opened the meeting with lectures on implications of a possible change of cervical cancer prevention to primary HPV screening and of HPV vaccination for colposcopy.

Implications of primary HPV screening for Colposcopy

U. PETRY gave an overview on randomised controlled trials with overall more than 400,000 participants. These trials compared HPV testing with Pap smear screening for cervical cancer and showed with a high level of evidence that HPV testing is better in detecting CIN3+ and is superior in preventing cervical cancer in women who are 30 years or older. An update on a pilot project using primary HPV screening in Wolfsburg/Germany that started in 2006 confirms that HPV screening is more efficient in identifying CIN3+ than cytology and is accepted by participants. However, the success relies on a good quality assessment based on a central screening register and on competent colposcopy management. PETRY showed that out of 158 CIN3+ cases, 149 were diagnosed at the first colposcopy referral, while 5 CIN3 lesions were probably true new cases that developed during observational management of minor lesions. Only 4 CIN3 lesions, including 2 adeno carcinoma in situ, were probably missed at first referral and finally diagnosed during follow-up. All 19 invasive cervical cancers were diagnosed at the first referral for colposcopy. In conclusion HPV screening needs an even more skilled colposcopy management than conventional screening.

Implications of HPV vaccination for Colposcopy

J. PAAVONEN presented the results of the two largest randomised controlled trials on HPV vaccination, the FUTURE (Gardasil) and PATRICIA (Cervarix) surveys. Both vaccines showed an excellent safety profile, and there was no significant difference in adverse events observed between vaccine and placebo arms except for moderate fever and local side effects. HPV vaccines protected HPV naive individuals from HPV 16/18 associated CIN2/3 with almost 100% efficacy and from CIN 2/3 irrespective of the associated HPV type with 43-87% efficacy. Although this significant reduction in risk for cervical neoplasia will change current screening pathways, screening itself, as well as colposcopy management, will be needed even in vaccinated women. PAAVONEN pointed out that colposcopy in vaccinated women will offer new challenges because colposcopic signs of high grade lesions, such as dense acetowhite epithelium, may be a specific property of cervical lesions associated with HPV 16. In a future world with a reduction in HPV 16 infections and associated lesions colposcopy may need to search and define other signs of high-grade lesions induced by other HPV types. In conclusion skilled colposcopy will still be needed in HPV vaccinated women.

Benefits and harms of colposcopy

M. ARBYN showed new data that the global incidence and mortality of cervical cancer will rise by more than 50% until 2020 unless prevention with vaccination and screening is intensified significantly. ARBYN pointed out that the benefits of screening are undisputed and that colposcopy plays a central role in the management of abnormal screening results. The sensitivity of colposcopy targeted biopsies was substantially lower in studies using random biopsy verification than previously thought, but European trials showed a good longitudinal negative predictive value of unsuspicious colposcopy. However, ARBYN pointed out that quality controlled colposcopy centres exist only in the UK and the use of colposcopy is not documented sufficiently for most European countries and quality indicators for colposcopy were not yet defined. Screening colposcopy is still practised in some regions although the use of colposcopy as a primary screening test may result in over diagnosis and treatment.

Meta analyses of excisional treatment of the cervix showed a significant increase in adverse obstetric outcomes such as premature labour and perinatal mortality in subsequent pregnancies. In conclusion well defined quality assessment in colposcopy is needed to assure an optimal selection of those women who are really at risk of developing cervical cancer and benefit from surgical treatment and to protect women with no risk from over diagnosis and unnecessary treatment with associated harm.

What is an expert Colposcopist?

P.WALKER showed elegantly the general development of skills according to Michael Erault (novice, advanced beginner,

[technique](#) or [skill](#) whose faculty for judging or deciding rightly, justly, or wisely is accorded authority and status by their [peers](#) or the [public](#) in a specific well-distinguished domain". An expert colposcopist should recognize the finer points of the transformation zone, have a high positive predictive value for detection of high-grade lesions, recognize and know how to treat glandular lesions, microinvasion and VaIN even in peculiar situations like pregnancy and immunocompromized individuals. She or he should be familiar with several local destructive and excisional treatments and be experienced with second or third time treatment.

2nd Part: Interactive Sessions

Quality assurance – where are we now?

Moderation: *Charles Redman*

The session was introduced by Charles REDMAN (UK), in which the principles of Quality Assurance were described. It was agreed that a set of quality indicators for colposcopic performance needed to be identified which were in keeping with the published European Guidelines for Quality Assurance in cervical screening and to be evidence-based wherever possible.

A number of Quality Indicators (QI) identified by Ulrich PETRY were presented and discussed. A number of additional indices were suggested. It was agreed that a Delphi Survey be undertaken to identify a number of Quality Indicators and Standards so that there could be an EFC consensus. Dr ARBYN (Belgium) suggested that when the QIs have been identified, an evidence based-approach to setting the relevant standards would be helpful.

It was agreed that Charles REDMAN would organize the required Delphi Survey and present the results at the next EFC Scientific meeting in Prague.

European training – where are we now?

Moderation: *Simon Leeson*

- EFC educational program
- European overview of national programs
- Presentations of national societies
- Discussion

European training and quality assurance – where do we wish to be?

Moderation: *U. Petry*

Ulrich PETRY showed the results of an EFC survey on the current status of colposcopy in Europe. A questionnaire had been sent out to all member societies and 16 societies replied prior to the satellite meeting. By the end of the workshop, questionnaires from 25 national societies were completed and evaluated. During the session maps of Europe with information on various aspects about colposcopy were discussed and if necessary modified. The final consented atlas on the status of colposcopy in Europe may be submitted for publication. In the mean time it is not completely available on EFC's homepage, but some maps and analyses can be found there. Overall, screening policies differ significantly between European countries in structure, intervals, age limits and the role of colposcopy. Colposcopy itself is still used as a primary screening tool in some countries in East and Central Europe. In some countries the availability of colposcopy is limited to a few urban areas, while good colposcopy services may be found countrywide in others. There was a very good agreement that the highest priority of colposcopy is the management of abnormal screening results, followed by the management of diseases of the lower female genital tract. However thresholds for transfer to colposcopy differed between countries. Women with repeated ASC-US or LSIL are transferred for colposcopy in all participating countries. HPV testing in the triage of ASC-US and to a lesser extent of LSIL is already implemented in many parts of Europe. 70% of the national societies replied that HPV-HR positive ASC-US is transferred for colposcopy.

New tools for quality assurance in practice and training were presented, like the electronic logbook used by BSCCP for the monitoring of training in colposcopy, and the web-based benchmarking system of the German colposcopy network that offers external comparison of participating colposcopy clinics in quality indicators and case or treatment numbers, as well as the monitoring of clinical studies.

Data

A training programme is essential for practice in eight of the 20 states which responded to the pre-meeting survey of training (Croatia, Ireland, Lithuania, Macedonia, Russia, Slovakia, Turkey and the UK). A training programme is available in 15 out of 23 respondents and a training programme course is available in 21 out of 23. A committee for training has been identified in 12 states and there are currently adequate training places in 15 states.

As far as a training course is concerned a minimum caseload stated for trainees is specified for 15 states with a case mix specified for 13 but not in 6. A minimum number of new cases is specified in 15 programmes ranging from 10-300 (median 50). Thirteen courses had assessments of which an objective structured clinical examination (OSCE) or a portfolio/ log book were most popular (10 each) with problem based learning and multiple choice questions being less popular.

Saturday 9th of April

3rd Part: Interactive Sessions

EFC-Training: Competency to do what? Moderation: *Charles Redman*

In 2000, 51 core competences were identified in a Delphi exercise that involved 28 experts from 21 countries. This was a significant step which has enabled increasing consensus towards common standards in European colposcopy training, and the competency-based EFC core curriculum has been utilised throughout Europe.

In the EFC symposium on quality standards in colposcopy that was held in Berlin in April 2011, it was agreed that the core-curriculum should be revisited. The drivers for this were:

1. The original core curriculum was over 10 years old and it seemed sensible to review its content in the light of changes and developments that might have occurred.
2. The EFC has expanded significantly and such a review would enable the Federation as a whole to have the opportunity to review the curriculum.
3. The curriculum needs review from an educational perspective:
 - not all the items are actually competences i.e. the current curriculum is, in fact, a hybrid and could be improved
 - some unnecessary items e.g. recognition of condylomata acuminata as well as condylomata plana

The wording of existing competencies has to be updated and clarified (e.g. recognise appearance of HPV infection/ and low grade precancerous disease. Low grade is not precancerous). This is to be done by re-circulating a list to see which competencies could be removed/ added and modified. A teaching expert should be brought in to help this process. It was agreed that this review should be in the form of a further Delphi Survey.

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EFC Training standards

Course length for minimum cases to train should be at least 50 new cases of which at least 30 have abnormal cytology. Trainers must be competent to train and see at least this number per annum. The duration of training should be less than 24 months including theoretical training.

EFC-Training: How is competency assessed? Moderation: *Xavier Cortes*

- Presentations by national societies
- Overview on current colposcopy examinations in Europe
- Internet based colposcopy examinations
- Discussion / consensus statements

4th Part : Interactive Sessions

EFC-Diploma: How can training be organised Moderation: *Simon Leeson*

There is no realistic possibility for there to be a single EFC diploma in the near future, but EFC programmes can be developed which the EFC can support and recognise as a charter linked with host national societies (as EFC approved courses). The EFC is not offering instruction and legal support but good governance and advice should be offered: i.e best

courses). The EFC is not offering instruction and legal support but good governance and advice should be offered: i.e best standards to be selected, those standards to be introduced and then audit of that work to be measured against those agreed standards. A Committee for approval of courses would overcome needing courses for reciprocal recognition in other countries and joint badging of courses would assist this process. A 'colposcopy passport' could be considered as a quality badge for training programmes by accepting these governance requirements. If the EU is to provide ratification, the EFC has a seat on the EBCOG Subcommittee for Training and Accreditation (SCTA). EBCOG is answerable to the European Parliament. The EFC should provide training courses to harmonise colposcopy training practice across Europe. Assessment would be by a national body, in turn recognised by the EFC, and would provide accreditation with the support of EBCOG. Therefore course content and structure of the course should be as advised by the EFC and approved by the EFC Training Committee. EFC approval of training, however, could lead to potential problems with EU law. The details of the difference between approving course design and approval of individual trainees needs to be kept distinct.

Data

Results of a pre-meeting questionnaire about colposcopy training were presented at the meeting. There were responses from 23 member states.

Criteria for trainers are required for 14 state training programmes but not for the others. Where stipulated a minimum annual caseload for trainers was between 50 – 400 (median 100-200) cases. Seventeen states preferred a reciprocal recognition of colposcopy training but two did not. Representative comments from respondents included that accredited trainees should be allowed to practice in different European countries, on condition that training programmes/ accreditation processes can become more homogeneous. Also accreditation in one country (providing qualification) should facilitate practice in another country, (or provide some credit towards working in colposcopy in that country). There would need to be period of 'induction' (such as a course) which would orientate colposcopists in the particular requirements of any national programme. There should also be support from colposcopists working in a country as trainers would be needed as mentors, maybe with submission of recent audit of activity (to confirm that trainer practice remains up to date). However common comments about barriers for training included variable levels of training, such as language, national nomenclature and types of professionals expected to provide colposcopy (MD or nurse).

Fifteen respondents said that the EFC would help training but two felt that this would not be the case. Help could be provided in the EU by the EFC, by standardising training programmes ie. prepare curricula, run courses and to continue to standardise requirements for trainees. Further benefits could include sharing and homogenization of national training programmes. A concern about such support would be that the EFC may not be as helpful to states just beginning their formal colposcopy training.

Quality Assurance: Role of National Societies Moderation: *Peter Bösze*

- Presentations by national societies
- How should we control practising colposcopists
- How to control case numbers
- Discussion / consensus statements

Please note:

The President would like to hold the 2nd EFC Satellite Follow-up Meeting on Quality Standards in Colposcopy in

[Berlin on 21st & 22nd September 2012](#)

The EFC Secretariat will be approaching the Officers of the Member Countries within the next few