EUROPEAN FEDERATION FOR COLPOSCOPY

5th Satellite Meeting, Saturday 16 December

Introduction

Charles Redman - President of the European Federation forColposcopy, Consultant Gynaecologist, University Hospital of North Midlands, UK

The introduction of Annual EFC Satellite meetings by the then President Ulli Petry in 2012 has greatly enhanced the momentum of the Federation's progress. It has meant that issues can be regularly reviewed as well as creating a sense of ownership and cohesion.

The role of these meetings was to regularly assemble representatives of the constituent societies and consider key items of the Federation's agenda. The focus has necessarily reflected its core activities, such as Education, Training and Performance Standards. The programme for the 5th EFC Satellite Meetings followed suit. In addition, there was a Training The Trainers course, which was devised by Professor Xavier Carcopino in response to a perceived demand mentioned at earlier meetings.

The programme aimed to address a number of important relevant issues ranging from the question of who should be undertaking colposcopy to how should appropriate training be delivered and best use made of the new opportunities afforded by technological developments. These discussions were enhanced by the involvement of EBCOG and representatives from commercial companies.

The role of the EFC is to promote and improve colposcopy throughout Europe, through dialogue and consensus. The 2017 Satellite Meeting has helped to set the stage to enable this.

Charles Redman

Review of EFC and performance standards

Charles Redman - President of the European Federation forColposcopy, Consultant Gynaecologist, University Hospital of North Midlands, UK

The training core curriculum and standards for basic and advanced courses for colposcopy have been agreed, and colposcopy basic and advanced courses are reviewed and supported. Assessment is ideal at the end of training, and an electronic logbook for training has been developed. Several surveys have assessed the availability of training programmes.

The requirement for all gynaecologists to be trained in colposcopy as recommended by EBCOG in 2014 has been questioned. The EFC has been involved in European guideline development, and certification of colposcopists and quality assurance is being develop and all colposcopists must be adequately trained. A recent survey of the EFC membership with 52 respondents was presented with the following results.

Only a minority of gynaecologists performed colposcopy, and the majority of colposcopists were not formally trained. Most respondents did agree with the EBCOG recommendation that all gynaecologists should perform colposcopy, but most respondents said that more than 100 cases are required to adequately train. This indicated that training of all gynaecologists to perform colposcopy was not feasible.

PRESENTATION

Should colposcopy be a core skill for all gynecologists

Angelique Goverde - Chair of Standing Committee on Training and Assessment at European Board and College of Obstetrics and Gynaecology

EBCOG values the mobility of the obstetric and gynaecology workforce in Europe and therefore recognition of each other's training standards. ENTOG is the subgroup for junior doctors, while FIGO deals with cancer staging and UEMS links with the EU. It is also present a Standing Committee of Training and Assessment dealing with colposcopy training. ENTOG noted significant training disparities across Europe, and some trainees do not feel adequately trained. The EBCOG-PACT in 2012 was to determine the minimum set of skills (competency based) to work as a gynaecologist in any state in Europe. There should be constant formative feedback and assessment. A Delphi process was undertaken to develop a curriculum for core, elective or subspecialty training: training for at least 5 years, 4 for core, 1-2 years of elective training. Simulation training should be included and this includes for colposcopy training, in addition colposcopy, loop excision and conisation should be part of core training. Colposcopy should be a core skill for gynaecologists as this was supported by over 70% of respondents to the Delphi survey. Subsequently cone biopsy was removed after expert review.

Discussion: perhaps the difference is a question of interpretation of degree in that all gynaecologists should have a basic understanding of cervical screening and seeing an abnormal cervix (Ulli Petry). However, management of assessing abnormal screening and treatment should be performed by trained colposcopists. AG stated that a lack of training capacity doesn't mean that the training should not be offered. Just because that person may not perform colposcopy as a consultant should not preclude colposcopy training as a trainee. Improved outcomes are anticipated with more experienced colposcopists and perhaps an introduction to the basic skills with colposcopy only may be allowed into general training (Xavier Carcopino). The EFC recognises that training must fit the needs of the local population (Charles Redman). Joe Jordan noted that there is perhaps little difference from the standpoint of EBCOG or the EFC. The details must be clearly shown in how the training is provided and that there is audit of outcomes and performance. The consensus is to improve the quality colposcopy which in general throughout Europe is poor (Ulli Petry). This will be reviewed with ongoing collaboration with EBCOG.

PRESENTATION

Performance standards

Karl Ulrich Petry - Head of Department of Gynaecology and Obstetrics,
University Medical Center Göttingen, Germany

European guidelines 2nd edition 2015 HPV based screening recommended (not co-testing with cytology) and cytology below 30 years, with screening intervals at least 5 years. Netherlands and Norway have HPV-based screening already. As before, colposcopy is the core skill in the diagnosis and management of CIN2+. However, the failure rate of colposcopy for missed CIN3+ is increased in women with HPV +ve but normal cytology (Petry et al, 2013) and is not appropriate. Colposcopy is effective for those with +ve cytology triage, and a standardised protocol for colposcopy is important (TOMBOLA, 2010). ECC would miss 28% of CIN3+ (Petry et al, 2013) and diagnostic cones/ loops needed for the type 3 TZ. Only 2% of HSIL is detected by random biopsies from a normal cervix (Wentzensen et al, 2015) and so random biopsies are not needed in this context. There is more pressure on the colposcopy service with HPV-based screening.

The EFC have decided and submitted for publication 6 agreed quality indicators (QIs), and the EFC has also published the effectiveness of margin status at excision (Arbyn et al, 2017), which is ineffective and should be replaced. HPV testing is more effective in predicting the risk of relapse. The QIs were updated in Paris 2017 but the margin status QI remained uncharged but a decision was delayed until publication of the Arbyn paper.

PRESENTATION

Standards for colposcopy

Marc Arbyn - Scientific Institute of Public Health, Brussels, Belgium

One the previously agreed QIs was the standard that not more than 20% of margins should be involved. Ghaem-Maghami (2007) found a +ve association with margin involvement and recurrent CIN. The meta-analysis was updated this year and published in Lancet Oncology (Arbyn et al, 2017). Further information on individual patient meta-analysis which should be ready next year, with 25 studies included in the Arbyn meta-analysis. Loop excision had higher margin involvement (26.8%) versus laser or knife cone biopsy. Treatment failure was 6.6% overall. If margin +ve failure 18%, if –ve 4% with relative risk of 4.9. The risk of failure was highest when both ecto and endo margins involved. HPV testing superior to margin status (sensitivity 91.0 v 55.8%) this was significant and specificity was non significantly worse for HPV testing. HPV testing significantly altered pre-test post-test probability indicating that management should be altered for HPV +ve status after treatment but not for margin status. No studies combined obstetrical outcome and margin status in 1 study, and an update of the EU guidelines is recommended.

Discussion: margin status may not be searched for thoroughly as pathologists know that HPV status is checked after treatment (Ameli Trope) in some countries. Whilst HPV testing is not a clear measure of surgical expertise a measure of clearance appears a reasonable surrogate fro success (MA). PPV for HPV +ve is only 0.4%, the UK uses CIN2+ rate at 12 months. So HPV status is a poor measure for outcome of treatment (John Tidy). The negative rate is more useful (Charles Redman).

PRESENTATION

Challenges facing colposcopy in Eastern Europe/ Central Asia

Tamar Alibegashvili - MD, PhD and President of the Georgian Colposcopy Society

In Georgia, cervical cancer is the 2nd commonest cancer in women: poor coverage and lack of laboratory QA are obvious problems. International IFCPC UNFPA EECARO funding has provided training for colposcopy trainees and has been used to help establish a group of trained colposcopists in their native country. This is a structured training programme with an exam on Lyon. 10 Georgian doctors gained certification to date, and E-learning would be useful future considering as long as translation into Russian.

PRESENTATION

The case for an EFC Diploma in Sweden

Sonia Andersson - Professor of Karolinska University Hospital, Stockholm

560 cases/ year of cervical cancer with 200 deaths/ year in Sweden, the lowest mortality in Europe together with Finland. The IFCPC nomenclature is used. Switch to HPV-based screening needing more colposcopists, and colposcopy course provided recognised by the BSCCP.

Discussion: Charles Redman advised that a diploma from the EFC hasn't been developed but individual states can train and certificate colposcopists ideally with an exit assessment. This needs organisation and governance. Jana Zodzika described her service and now runs a Latvian colposcopy course with an exit examination (mcq and clinical cases). Angelique Goverde asked what was the the purpose of a certificate, Dr Andersson answered that the purpose is that it has to be maintained needing re-certification and so maintaining expertise in colposcopy (agreed by Charles Redman, Jana Zodzika and Pella Nieminen). Jean-Luc Mergui said there was no formal accreditation in France, and that universities are not involved in colposcopy training in France.

PRESENTATION

Training and exit assessment – the case for training in colposcopy

Ameli Trope - Head of the Norwegian Cervical Cancer Screening Programme

How can standardised training and certification be applied in Norway? There is no obligatory colposcopy training in Norway, and patients with persistent problems need access to previous records which has been a problem in Norway. There are 370 cervical cancers/ year and 70-80 deaths/ year, incidence of cancer has increased slightly. 1 in 4 women at present have an HPV test as part of a pilot, and cytology ASC-US rate has increased in the HPV pilot. If ASC-US/LSIL then only referred to colposcopy if HPV 16/18 +ve. 40% increase of colposcopy and 50% increase of CIN2+. Strander et al (2014) showed that risk of cancer has increased in each following decade as training has become more conservative, and training stopped after Pier Kolstad died in Norway. Training can be overseas but ideally local training with e-learning would be preferred. EFC need to look at more practical training courses such as treatment sessions, and self-sampling for women should be considered. Training and certification is needed but training must be quality assured.

Discussion: Deirdre Lyons advised that there should be accreditation of trainers.

PRESENTATION

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Thanks for coming! We wish to see you all again next year!

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