

## **6<sup>th</sup> EFC Satellite meeting, Saturday 1<sup>st</sup> December 2018**

### **Introduction**

**Pekka Nieminen – President-elect of the European Federation for Colposcopy,  
Department of Obstetrics and Gynaecology, Helsinki University Hospital, Finland**

EFC's aim is to improve the quality of colposcopy throughout Europe. ESGO has asked for the EFC to collaborate with them to develop colposcopy guidelines as required.

The 2nd round of the Delphi is presented. European guidelines were published in 2008.

There are national guidelines but not in each country, yet every country should have them as the clinical problems are slightly different in each country. They should be evidence based and they should be followed. Grilli et al, (2000) noticed that only 5% of guidelines had the type of stakeholder, strategy was in place for evidence collection and the evidence was graded.

Colposcopic practice has changed since 2008 with HPV-based screening and HPV vaccination. Revision of the existing guidelines is needed. The EFC has publications critiquing the use of guidelines and the quality of care in colposcopy. The EFC has a central role in subsequent guideline writing and dissemination. The document should not be a textbook. The guidelines should concentrate on core issues where there is uncertainty, controversy, with variable management in which guidelines are going to be helpful.

The plan is to develop the format, topic, next steps, process and the need for systematic analysis.

The second of Delphi: top 6 after the second round were – what is the ideal assessment of the endocervical canal for patients with AIS (Delphi score 4.35), when is conservative management of HG CIN appropriate (4.09), how best to maximise coverage of the population (4.3). Treatment – what is the most effective way management AIS when local excision required (4.26) and does excision length matter (4.04). Follow-up what is the most effective test of cure (4.3).





### **Colposcopic guidelines: a critique**

**Karl Ulrich Petry – Cancer Center Wolfsburg,  
Germany**

These are costly documents to produce. There is no 1a level evidence for the use of cytology and colposcopy. TOMBOLA provides level 1b evidence for the non-use of loop in the management of low grade disease. There is 1a evidence for HPV vaccination and HPV-based screening. The German screening programme decided that colposcopy should not be used for screening, the threshold for colposcopy for CIN3 should be 10%. Biopsies are reasonable for type 1 and 2 TZ. Colposcopy should be performed in colposcopy clinic. These were consensus statements over some years.

**John Tidy – Consultant Gynaecological Oncologist,  
Royal Hallamshire Hospital Sheffield, UK**

Evidence grading is not used in the UK as the evidence is largely developed by professional consensus. 6th of the national guidelines is review underway. QA assurance is embedded within all 4 programme in the UK. Audits of all cervical cancers has been performed. Revision is required as HPV-based screening is being introduced. A reduction of the number of cytology labs is being managed at present. The screening interval is being reviewed to have 5yrly review from 24.5-64yr. Self testing is being evaluated for non-responders.

What is the ideal threshold for colposcopic referral in UK practice? Currently between 10-23% of women with low-grade cytology in the UK have high-grade CIN depending upon the performance of various labs. These cut-offs have to be re-calculated. In Sheffield, HPV16 prevalence about 10% but less prevalent with other HPV types after HPV persistence with -ve cytology. A new standard is planned with PPV for colposcopic prediction of high-grade disease to 75% and 35% for low-grade disease (cytology negative). There is a need to develop a new computer database for call-recall.

HPV testing has now re-introduced a group of women who are HPV +ve cytology –ve on short term recall that had been removed by the preceding HPV-triage. This group should shrink once the vaccinated cohort enters the screening programme but perhaps only be 30% as HPV 16/18 appears to account for 30% of the HPV population.

**Xavier Carcopino – Chair Education Committee of EFC,  
Head of department of colposcopy and cervico-vaginal pathologies North University Hospital of  
Marseille, France**

Guidelines provide optimal patient management, to keep colposcopists up to date, provides ideal outcomes in terms of public health, patient information/ reassurance and medicolegal support. Guidelines assess evidence quality supporting case management. With the same evidence why are there discordant statements. There are many evidence defects. Should we have expert opinion is the absence of evidence in relying on subjectivity, possible error and could have a medicolegal impact?

A question from the audience was that the EFC will not provide any level 1 evidence. Some of the Delphi issues may be answered by research in the near future. An evidence level should be quoted in guidelines. Prof Gultekin from ESGO added that guidelines have more authority than individual publications. A Turkish representative advised that HPV 33 has almost the same underlying incidence of CIN3 as HPV 16.



**What areas warrant evaluation?**

**Marc Arbyn – Coordinator of the Unit of Cancer Epidemiology,  
Belgian Cancer Centre at the Scientific Institute of Public Health, Brussels, Belgium**

The Delphi outcomes are re-considered for the following topics:

What is the most effective way of assessing the endocervical canal with AGC? Could pool studies (Delphi 4.35). Update of meta-analysis.

What is the best way to maximise screening? (4.30) – self sampling. Needs continuous update.

When is conservative management of HSIL acceptable? (4.09)

Most effective way to manage cGIN for treatment of local disease? (4.26)

Does length of excision influence outcome? – database pooling.

What is the most effective test of cure after cervical pre-cancer? (4.30).

Best way to manage management of persistent post-treatment HPV with normal colposcopy and cytology? (4.13)

How should treatment for CIN be performed in women who develop stenosis?

There is a problem with the US literature that SIL is used both for cytology and histology.

A delegate suggested that P16 status could be included. P16 +ve disease should be considered for treatment according to one of the delegates.

Any suitable subjects for meta-analysis will need to look at subgroups.

Other subjects could be:

- RNA testing or not?
- The qualitative relationship between cone dimension and obstetrical outcomes who become pregnant after treatment.
- Communicate with the EU commissioner for health, president of the EU commission, European Council to claim for new CC prevention guidelines as screening is not a priority at present. New comprehensive guidelines could be considered in a few years to advise how to eradicate cervical cancer. Histologist should also be invited.
- Self sampling with point of care testing.



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## Discussion

**Moderated by Pekka Nieminen – President-elect of the European Federation for Colposcopy, Helsinki University Hospital, Finland**

A delegate suggested a word of caution is needed before a project is taken on that cannot be delivered. Dr Arbyn responded by saying the money raised can be used for calls for relevant research with a view to produce a new guideline around 2025. Consensus was agreed.

Delegates were asked whether local and European guidelines were necessary. Delegates felt that both were ideal. Prof Petry felt that both sets of guidelines are not mutually exclusive. The Delphi projects could be used for subsequent guidelines.

The meeting agreed to look at what is the most effective way of assessing the endocervical canal with AGC. ECC may be effected with the form of curette used. There is a very small proportion of AGC that are HPV –ve of gastric-type histology (less than 1% of all cancers).

What is the most effective way to manage cGIN for treatment of local disease? Is LLETZ or cold knife cone biopsy needed?

## QI update and next steps

**Karl Ulrich Petry – Cancer Center Wolfsburg, Germany**

6 quality indicators (QIs) agreed published by Moss et al, 2013. Member societies were asked to review these QIs to see if they were useful. These were subsequently refined and re-published in 2017 (Petry et al). Does a standard requesting clear margins at excision cause more obstetric morbidity than benefit? HPV testing is a better predictor of success of treatment than margin status. The 100% targets should be reduced to >95% minimum aim and the margin status should be 75% minimum aim. Excision treatments should have histology of >85% but excluding type 3 TZ and over 45 years. These changes are to be considered for Rome 2019.



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Should a new QI be introduced that colposcopy should have biopsies in type 1 or 2 TZ with minor or major changes with atypical screening results? Delegates discussed this point and may need slight modification.

Another was % of patients with +ve margins and -ve HPV testing at 6-18 months or were called for colposcopy. A delegate asked care is needed with the target (offered at 90%). There was no parameter for ablative treatment. Simplification was suggested by delegates. A counselling QI was circulated and needs to made more practical.

## **Nominations for the executive and EFC 2025**

**Simon Leeson – Secretary of the European Federation for Colposcopy,  
Department of Obstetrics and Gynaecology Betsi Cadwaladr University Health Board, UK**

Nominations for the EFC executive and for the congress following Helsinki 2022 was discussed. The mechanism of voting was also discussed.

