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e-Newsletter
ISCCP
Member International Federation of Cervical Pathology and Colposcopy

Newsletter of Indian Society of Colposcopy & Cervical Pathology (Reg.)

www.isccp.in

From the Editor's Pen

Dear ISCCP members,

We hope that the current issue will enlighten you with a few more aspects of cervical carcinoma. I know that we all are going through hard times during this second wave of pandemic. As a healthcare worker, sometimes we feel helpless while fighting this disease due to the dearth of staff, beds, oxygen and drugs. But still we should go on trying our best to save the society. We should be sympathetic to our patients and simultaneously keep on treating the noncovid patients also as much as possible. We should continue the screening whenever possible whilst following covid appropriate behaviour.

This issue contains one research article by Dr Usha Nath and another review article on Neuroendocrine tumours. This issue also contains the details of activities held in the last 3 months along with 'Journal Scan' and 'News from around the world' sections.

On behalf of organizing team, I request all the ISCCP members

to register for a virtual Global event, the first in Asia, centered on theme "Elimination of cervical cancer -call for action" the IFCPC 2021 world congress.

I, once again, request all the ISCCP members to contribute in the Newsletter in the form of review articles/original articles/ viewpoint/case reports/images.

Stay Healthy

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Forthcoming Conference

IFCPC 2021 World Congress

1st-5th July, 2021

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Free Colposcopy Camp and Its Gain: Our experience

Usha Nath
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Cervical cancer is the fourth most common type of cancer affecting women worldwide. In Southeast Asian nations, India has the highest incidence rate of cervical cancer (WHO). And out of highest absolute figure of cervical cancer reported in Asia, an estimated 132,000 new cases, or more than one fourth of the world wide total are reported annually in India ("Prevention of cervical cancer worldwide", ACCP, 1999).

Hence, cervical cancer is a much greater health problem in the developing world than it is in the western world where women now have less than 0.1% chance of developing cervical cancer between ages of 30 to 64, while women in developing world have 3% to 5% chance – a big difference!

The most likely reason for such difference lies in the absence of an effective systematic screening program suited to the indigenous population with low cost settings.

It is now well known that the natural history of cervical carcinoma begins with the start of atypical changes in the epithelial lining of transformation zone (an area of the external os at squamo-columnar junction) of the cervix. There is a long latent phase of recognizable and predictable stages of tissues changes from treatable precursors to fatal invasive carcinoma, which is evident from the following figures:

- 30% have progression from low grade dysplasia to high grade dysplasia on average in 9 years.
- 70% cases of low grade dysplasia would regress spontaneously on follow up within 1-2 years.

- Progression of high grade dysplasia to invasive cancer takes only 3 months to 2 years.

The effective and well planned mass screening has proven to be a definitive way of reducing both the prevalence of invasive carcinoma of cervix and mortality from it in the developed world.

Therefore, as a trial, a free Colposcopy screening camp was organized one each in rural and urban areas respectively to find out its suitability in our social milieu.

Objective

Jharkhand is primarily a rural state as around 75.95% of the population resides in the rural areas. The land is full of forest, rivers and mountain with difficult terrain of accessibilities. And usual Pap's smear or HPV testing method of cervical cancer screening, is therefore not effective in this difficult out of reach larger population

The main aims of free mobile Colposcopy camps were

1. To present Colposcopy uses in a different mode (than it is presently indicated, for evaluation of abnormal smears), which is, to use the mobile Colposcope as a feasible alternative for mass screening in conjunction with VIA.
2. To appreciate the percentage difference in incidence and severity of grades of pre-cancer of cervix in rural and urban women population in critical age groups.

Methodology

Two free Colposcopy camps were organized, one in rural area and another in urban area. Publicity of the camps in rural area was done with help of grass root workers of the mission hospital in just outskirt of Ranchi, who also helped to organize the camp. The workers, over a week, visited several nearby villages and motivated women in high risk groups (20 to 60 yrs), to attend

for examinations. In urban area, the camp was organized at Nath Hospital, Ranchi and, publicity of camp was done by distributing brochure, erecting banners in nearby areas and putting advertisement in the local news papers.

A system of functioning was planned for both free camps. Women were received in smooth fashion and their name, age addresses were recorded and a serial no: was given to each woman. They were then directed to doctor/ nurse who took basic information of gynecological complaints, obstetric and menstrual histories. Menstruating and pregnant women were excluded. Thereafter, one by one they were taken for Colposcopy examination. It was performed by the author and she dictated the findings to an assistant doctor who recorded the detail notes into a register. Any further procedure (biopsy/cryocautery) advised, were undertaken by the mission hospital doctors in rural camp and by the author and her assistant in urban camp, later on. The patients whose Colposcopy had normal findings, were prescribed supplement of iron and calcium as per their general health's assessment.

Result

Although attendances at the camps were higher, but only 70 patients underwent Colposcopy examination. Out of that, 42 patients were at rural and 28 at urban camps.

The results were surprising but in keeping with associated risk factors involved for initiation of dysplasia, i.e. hygienic condition, genital infection, young age sexual commencement, multiparity etc.

In rural camp, out of 42 patients 50% (21 patients) had positive Colposcopy findings of varying grades, 15% (6 patients) were negative, 11 patients had infection, primarily with Trichomonas and in 4 patients the Colposcopy was inconclusive because TZ could not be assessed in its entirety.

The corresponding figures in urban

camp patients were as follow: Out of 28 patients 60% (17patients) had positive Colposcopy findings of varying grades, while only 10.5% (3patients) were negative and rest 28.5% (8 patients) had cervicitis, mainly with Trichomonas.

Discussion

It is obvious that the carcinoma of the cervix is one of the few malignant diseases that is preventable if detected and eradicated in its premalignant forms. In each instances, the cervical screening program was followed by a fall in the incidence of cervical cancer and cancer deaths.

In our deficient economic status, with deficient awareness and lack of well organized cytological lab, we should be thinking of developing some indigenous innovative method of "one-stop" mass screening structure for managing the cervical pre-cancer state, to help downgrade the incidence of cervical cancer and its mortality in India.

From our point of view, single visit approach is a public health approach to cervical cancer that considers a social limitation in lives of all women at disadvantage and, gives them advantage of prevention from developing cervical cancer/or minimizing the disease progression by early detection.

Conclusion

The lack of such interventions in developing nations has led to its high occurrence. Among the Southeast Asian nations alone, India has the highest incidence rate of cervical cancer. (Global Cancer Incidence Statistics 2018).

Therefore, for low resource settings the author advocates the best screening approach with least cost and that could be "Colposcopy combined with mass VIA screening" camps. In this way, if we are successful in targeting to screen the high risk population of women (30 to 50 years' age group), even once or twice in their life time, that could yield

a reduction of 25 to 30% in incidence of cervical cancer, (Shankarnarayan).

If as clinicians we are enough motivated, then we can also believe in,

"That no women should die of this preventable disease" – Lenhart.

Neuroendocrine Tumours of Cervix

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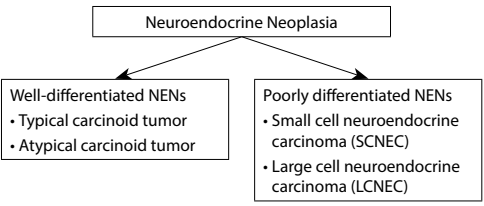
Introduction

Neuroendocrine neoplasia (NEN) of the uterine cervix is a rare and aggressive disease. This disease is derived from neuroendocrine cells which originate from the embryonic neuroectoderm and display an immunohistochemical profile consistent with the cells which have features of both the endocrine (hormonal) as well as the nervous system. NENs are typically located in the gastrointestinal tract, the pancreas, and the lungs.[1]

Rarely, NENs may also occur in other organs such as the female genital tract including the uterine cervix. There are multiple different types of cervical cancer on the basis of microscopic appearance of cells.[2] Neuroendocrine tumours are rare histological variant of cervical cancer accounting for about 1–1.5% of all cervical cancers. It was first described by Albores-Saavedra in 1972.[3]

Pathology

The pathology of NECC is different from squamous cell carcinoma or adenocarcinoma of the cervix regarding a number of characteristics.



Grading of NET is similar to NEN of other locations like lung or the digestive system.

- NET G1 (also known as typical carcinoid)
- NET G2 (also known as atypical carcinoid)
- NET G3 (poorly differentiated neuroendocrine carcinomas).

Of the four subtypes, SCNEC is most common followed by LCNEC second most common of NEC arising from the cervix. Well-differentiated NEC, NEC G1 (typical carcinoid) and NEC G2 (atypical carcinoid), are very rare at this location.

The 2014 World Health Organization (WHO) Classification re-categorizes cervical neuroendocrine tumors as low-grade (it includes carcinoid tumor and atypical carcinoid tumor) or high-grade neuroendocrine carcinomas (it includes small-cell carcinoma or large-cell neuroendocrine carcinoma).[4]

Etiology

Due to uncommon nature of this tumour, the etiology and predisposing risk factors are not well understood. In comparison to squamous cell carcinoma of the cervix, women were slightly younger at the time of diagnosis and there were also a higher proportion of Asian women with NEC of the cervix. While the Human Papilloma Virus (HPV) and smoking are known risk factors for developing most other kinds of cervical cancer, less is known about their role in development NEC of the cervix.[5]

Several studies have demonstrated a relationship between HPV infection and NEC of the cervix. However, unlike HPV-associated squamous and adenocarcinoma (SA) of the cervix which have a preinvasive lesion that can often be detected by routine

screening methods prior to growth of an actual cancer, no such preinvasive phase appears to exist for NEC.[6]

Alejo et al in his study found that HPV was detected in 42 out of 49 samples. HPV16 was the predominant type (54.8%), followed by HPV18 (40.5%) and 4% of tumors were positive for other HPV types. p16 over expression was observed in 38/44 cases (86.4%).[7]

Castle et al published an analysis of 32 studies and found that 85% SCNC were HPV positive, of which 78% were HPV16 and/or HPV18 positive and 93% were positive for p16 by immunohistochemistry. 88% LCNC were HPV positive, of which 86% were positive for HPV16 or HPV18, 30% were singly HPV18 positive, and 29% were singly HPV16 positive.[8]

Symptoms

- Vaginal discharge
- Abnormal vaginal bleeding including postcoital bleeding (bleeding after intercourse)
- Pelvic pain
- In advanced disease, symptoms of weight loss, abdominal bloating, or symptoms specific to metastatic disease (liver, adrenals, bone, bone marrow, and the brain).
- Occasionally, like neuroendocrine tumors of the lung, small cell cancer of the cervix can present with paraneoplastic syndromes affecting the endocrine (hormonal) and/or nervous systems such as hypercalcemia (elevated blood calcium levels), neurologic disorders, Cushing's syndrome, and SIADH.[9]

Immunohistochemistry, Molecular and Immune Profile Testing

Alejo et al (5), found that 65%NECs were positive for at least one immunohistochemical marker (chromogranin, CD56, and/or synaptophysin) with CD56 being the most frequently positive (62%)

followed by chromogranin (39%) and synaptophysin (26%). Similarly, other authors found CD56 to be the most sensitive marker of neuroendocrine differentiation (62%) followed by chromogranin A (39%) and synaptophysin (26%). The most common mutations were in p53 (26%), KRAS (12%), PIK3CA (18%), and c-myc (53%) genes. Loss of heterozygosity was found in 30% of cases.[3]

Diagnosis

Occasionally, disease can be detected by routine screening Pap smear by seeing abnormal cells. Although Pap smear may detect the disease, the efficacy of it as a screening modality is unknown for NEC. Some women with NEC of the cervix have had normal annual Pap smears. The correct diagnosis of NET is made primarily by biopsy and positive immunohistochemical staining for neuroendocrine markers like Neuron specific Enolase (positive in 80% of NEC), chromogranin A (60%), synaptophysin (70%) and CD56.[7]

Once a tissue diagnosis has been made, to know the extent of spread of disease, further investigations are done. Pelvic magnetic resonance imaging (MRI) is considered the best imaging method for tumors greater than 10 mm to evaluate tumor size and local extension of the disease. Given the aggressive nature of the disease and the propensity for early metastases, additional imaging like CT scans of the chest and abdomino-pelvic cavities is recommended. PET imaging may also be considered, although trials are lacking to prove its superiority over routine CT scan in this disease.

Staging

Cervical neuroendocrine carcinomas are staged using the same International Federation of Gynecology and Obstetrics (FIGO) staging system used for other cervical histologies. The 2018 FIGO staging system allows for imaging and pathologic findings to modify tumor stage. The Society

of Gynecologic Oncology (SGO) guideline recommends that given the high rate of distant metastatic disease in neuroendocrine tumors, imaging evaluation should include a computed tomography (CT) or positron emission tomography (PET)/CT scan.[3]

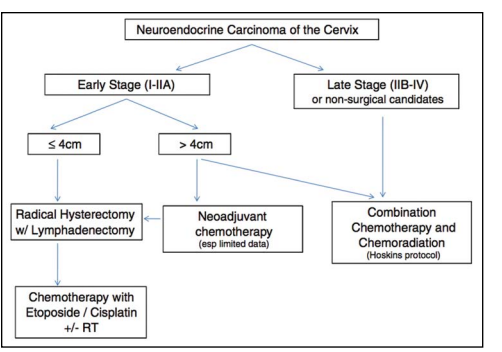
Prognosis

Several studies have reported age, lymph node metastases, race, smoking, pure small-cell histology, and tumor size as independent prognostic factors for neuroendocrine cervical carcinomas. However, stage was the most commonly cited poor prognostic factor in a majority of studies.[3] NEC carries a poor prognosis with a mean overall survival of 40 months and a 5-year overall survival rate of 34%.[10]

Treatment

As NECs are very rare, there are no completed prospective trials to date establishing the standard of care for the treatment of this disease. Multimodality treatment with radical surgery and adjuvant or neoadjuvant chemotherapy with etoposide and cisplatin is the mainstay of treatment for early stage disease. Combined radiochemotherapy and chemotherapy are appropriate for women with locally advanced or recurrent NECC. In 2011, the Society of Gynecologic Oncology issued a clinical document summarizing available literature on NET of the female reproductive tract as shown below[7]

Management Algorithm For Neuroendocrine Carcinoma (NEC) of the Cervix



Chemotherapy

Inspite of high initial response rates (50–79%), recurrent or progressive chemoresistant disease frequently develops. Chemotherapy includes two drugs- cisplatin and etoposide. Another regimen that has been used effectively and was borrowed from treatment of lung cancer is VAC/PE (vincristine, adriamycin and cyclophosphamide, alternating with cisplatin and etoposide). Unlike NEC of the lung, given the uncommon incidence of spread NEC of the cervix to the brain, prophylactic cranial irradiation (PCI) is not recommended at this time.

Surveillance

The recommended surveillance for squamous, adenocarcinoma, and adenosquamous carcinomas consists of a physical examination, including a pelvic exam, every 3 to 6 months for 2 years and then every 6 to 12 months for an additional 3 years. For cervical neuroendocrine tumors, the SGO guidelines recommend physical exam and symptoms review with periodic full-body imaging with either CT or PET/CT scan at regular intervals or according to symptoms. The guideline does not give any recommendation on the frequency of such follow-up.[7]

Clinical Trials

Currently, there are no clinical trials on the treatment due to the rarity of the disease. In the recent past, M. D. Anderson opened a Phase II study of weekly Taxol and bevacizumab for women with recurrent disease. Unfortunately, the trial was closed due to inability to accrue sufficient patients timely.

Future Research

Chemotherapy treatments such as temozolomide and multiple molecular targets for treatment of NECs have been identified and are in clinical trials.[11] Potential therapeutic targets include CD56, a neural cell adhesion molecule that is expressed by neuroendocrine

cancers. A monoclonal antibody for CD56 linked to the cytotoxic compound DM-1 is in phase II trials. Src kinase, a tyrosine kinase, which has differential expression in both small cell and non-small cell lung cancer, is another potential target. The hedgehog pathway and Bcl-2 represent other areas of investigation.

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Journal Scan

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Aarnio R, Östensson E, Olovsson M, Gustavsson I, Gyllensten U.

Cost-effectiveness Analysis of Repeated Self-sampling for HPV Testing in Primary Cervical Screening: A randomized study

BMC Cancer. 2020 Jul 13; 20(1): 645.

The objective of this study from Sweden was to assess whether repeated self-sampling for HPV testing is cost-effective in comparison with Pap smear cytology for detection of cervical intraepithelial neoplasia grade 2 or more (CIN2+) in increasing participation rate in primary cervical screening.

A cost-effectiveness analysis was performed on data from a previously published randomized clinical study including 36,390 women aged 30-49 years.

Participants were randomized to two study groups:

a. either to perform repeated self-sampling of vaginal fluid for HPV testing (n = 17,997, HPV self-sampling arm)
b. or to midwife-collected Pap smears for cytological analysis (n = 18,393, Pap smear arm).

Results

Self-sampling for HPV testing led to 1633 more screened women and 107 more histologically diagnosed CIN2+ at a lower cost vs. midwife-collected Pap smears (€ 229,446 vs. € 782,772).

The authors concluded that repeated self-sampling for HPV testing increased participation and detection of CIN2+ at a lower cost than midwife-collected Pap smears in primary cervical screening. Offering women a home-based self-sampling may be a more cost-effective alternative than clinic-based screening.

Louvanto K, Eriksson T, Gray P, Apter D, Baussano I, Bly A, Harjula K, Heikkilä K, Hokkanen M, Huhtinen L, Ikonen M, Karttunen H, Nummela M, Söderlund-Strand A, Veivo U, Dillner J, Elfstöm M, Nieminen P, Lehtinen M.

Baseline Findings and Safety of Infrequent vs. Frequent Screening of Human Papillomavirus Vaccinated Women

Int J Cancer. 2020 Jul 15;147(2):440-447.

Less frequent cervical cancer screening in human papillomavirus (HPV) vaccinated birth cohorts could produce considerable savings without increasing cervical cancer incidence and loss of life-years. This study from Finland reported the results of safety and accuracy of infrequent screening among HPV16/18 vaccinated females.

The entire 1992-1994 birth-cohorts (30,139 females) were invited to a community-randomized HPV16/18-vaccination trial. A total of 9,482 female trial participants received HPV16/18-vaccination in 2007-2009 at age of 13-15.

At age 22, 4,273 (45%) of these females consented to attend a randomized trial on frequent (ages 22/25/28; Arm 1: 2,073 females) vs. infrequent screening (age 28; Arm 2: 2,200 females) in 2014-2017. Females (1,329), who had got HPV16/18 vaccination at age 18 comprised the safety Arm 3.

Results

- Baseline prevalence and incidence of HPV16/18 and other high-risk HPV types were: 0.5% (53/1,000 follow-up years, 10^4) and 25% (2,530/10^4) in the frequently screened Arm 1; 0.2% (23/10^4) and 24% (2,413/10^4) in the

infrequently screened Arm 2; and 3.1% (304/10^4) and 23% (2,284/10^4) in the safety Arm 3.

- Corresponding prevalence of HSIL/ASC-H and of any abnormal cytological findings were: 0.3 and 4.2% (Arm 1), 0.4 and 5.3% (Arm 2) and 0.3 and 4.7% (Arm 3).
- Equally rare HSIL/CIN3 findings were reported in the infrequently screened safety Arm A3 (0.4%) and in the frequently screened Arm 1 (0.4%).

The results of this study indicate no safety concerns on infrequent screening despite the up to 10 times higher HPV16/18 baseline prevalence and incidence in the former.

Choi YJ, Hur SY, Kim TJ, Hong SR, Lee JK, Cho CH, Park KS, Woo JW, Sung YC, Suh YS, Park JS.

A Phase II, Prospective, Randomized, Multicenter, Open-Label Study of GX-188E, an HPV DNA Vaccine, in Patients with Cervical Intraepithelial Neoplasia 3.

Clin Cancer Res. 2020 Apr 1;26(7):1616-1623.

The objective of this study reported from South Korea was to determine the efficacy of the therapeutic DNA vaccine GX-188E for inducing regression of cervical intraepithelial neoplasia (CIN) 3.

This was a prospective, randomized, multicenter, open-label, phase II clinical trial of GX-188E in CIN3 patients positive for human papillomavirus (HPV) type 16/18. The primary endpoint was to determine the histopathologic regressions to ≤CIN1 at visit seven (V7; 20 weeks after the first GX-188E injection), and an extension study was pursued until visit 8 (V8; 36 weeks after the first GX-188E injection). HPV-sequencing analysis and an ex vivo IFNγ ELISpot assay were performed using the collected cervical biopsy and blood samples from patients.

72 patients were enrolled and

underwent randomization. Of them, 64 patients were included in per-protocol analysis (V7) and 52 in extension analysis (V8).

Results

- 52% (33/64) of patients at V7 and 67% (35/52) of patients at V8 presented histopathologic regression after receiving the GX-188E injection.
- 73% (V7) and 77% (V8) of the patients with histologic regression showed HPV clearance.
- HPV clearance and histopathologic regression were significantly associated at V7 and at V8.
- Compared with the measurements at V1 (baseline), the patients at V8 with HPV clearance showed significantly higher fold changes in their IFNγ ELISpot responses compared with those without HPV clearance.
- The HPV sequence analysis revealed that the HPV type 16 E6/E7 variants D25E, V83L, and N29S were inversely associated with histopathologic regression at V8.

The authors concluded that GX-188E is an effective therapeutic vaccine against a cohort containing only CIN3 patients.

Cervical Cancer News From Around The World

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Division of Clinical Oncology
ICMR-National Institute of Cancer Prevention and Research
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Co-course Director & Convenor, NICPR-ECHO Online Cancer Screening Program

Army Officer, Doctor Develop 4-Second Cervical Cancer Test

TOI: March 9, 2021

PM Narendra Modi and defence minister Rajnath Singh at the kiosk at CCC where Major Ragini Thapa (inset) & oth... Read More

Major Ragini Thapa, a doctor posted at Mhow Military Hospital (MH), and Lt Col Anant Bhatt, a Signals officer, have jointly developed an artificial-intelligence-based system to detect cervical cancer in just 4 seconds. They presented their innovation before PM Narendra Modi and defence minister Rajnath Singh at the Combined Commanders Conference at Kevadia. Maj Ragini said that their system can be used in primary health centres and remote places. It involves a software that requires only a computer and microscope with camera, which are readily available even at peripheral hospitals and the most basic health centres today.

To read more: http://timesofindia.indiatimes.com/articleshow/81407585.cms?utm_sourc e=content of interest & utm_medium=text&utm_campaign=

Maharashtra Receives Its State-of-The-Art US-FDA Approved HPV Test For Primary Cervical Cancer Screening

ET Health World Updated: February 20, 2021

Maharashtra announced the launch of state-of-the-art US-FDA approved molecular diagnostics technology for primary cervical cancer screening. This solution enables timely detection of

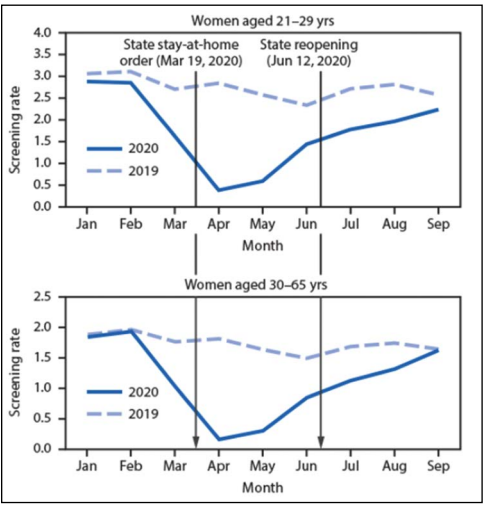
risk of cervical cancer through Human papilloma Virus (HPV) DNA-based screening. It enables screening for the virus, even before the disease begins to manifest symptoms.

The programme is aimed at providing access to primary HPV DNA test with genotyping from a dedicated center for testing at AyuGen Biosciences for 50000 women within next 5 years.

https://health.economictimes.indiatimes.com/news/diagnostics/maharashtra-receives-its-state-of-the-art-us-fda-approved-hpv-test-for-primary-cervical-cancer-screening/81114291

Cervical Cancer Screening Rates Decreased 80% During COVID-19 Lockdown in California

Clinical Advisor: March 8, 2021



"The COVID-19 pandemic has highlighted a critical need for effective cancer screening methods for patients who cannot or prefer not to have in-person appointments," Dr Miller and colleagues noted.

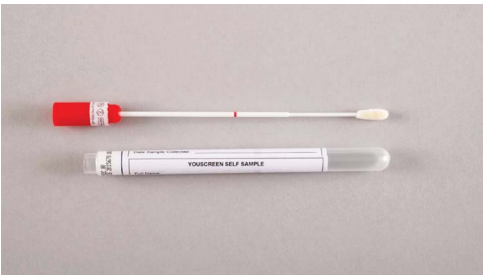
The study authors called for use of evidence-based approaches to education, health promotion, and information dissemination on the importance of screening for cervical cancers and precancers. Triaging women who call for cervical cancer screening appointments based on risk level and screening history may be helpful, they added.

"As the pandemic continues, public health interventions to address decreases in cancer screening rates will be critical to avoid increased incidence of advanced cancers because of delayed detection," Miller et al concluded.

Read more: https://www.clinicaladvisor.com/home/topics/ob-gyn-information-center/cervical-cancer-screening-rates-decreased-covid-19-lockdown-california/

Women to trial 'do-it-at-home' kits for NHS

BBC News: 24th February 2021



About 31,000 women in London are being offered "do-it-at-home" tests to check for early warnings of cervical cancer, as part of an NHS trial. It could be a way to encourage more women to get screened, experts hope. Embarrassment, cultural barriers and worries about Covid, along with many other factors, can stop women going for smear tests at a clinic or GP surgery.

Smear-test delays during the pandemic prompted calls for home-screening kits from cervical cancer charities. Self-sampling is already offered in countries such as Denmark and Australia.

Women aged 25-64, overdue for a check and living in Barnet, Camden, Islington, Newham or Tower Hamlets will be offered a kit from their GP or in the post.

If the results reveal an infection by human papillomavirus (HPV) they will be invited to their GP for a standard smear test to closely examine the cells of their cervix.

Read more: https://www.bbc.com/news/health- 56168 170

ISCCP Activities

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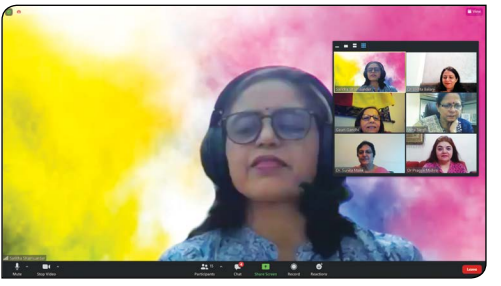
FOGSI – ISCCP Nation wide Cervical Cancer Screening

Poster and Slogan on the Occasion of Women's Day

Department of Obstetrics and Gynaecology, Hamdard Institute of Medical Sciences and Research, New Delhi, conducted Public Forum and Skit on Occasion of Women's Day on 8th March, 2021. 145 patients were screened after the forum.

Nukkadnatak and Flash Mob in mall done by students of Shri shankaracharya institute of medical sciences for cancer awareness under Bhilai FOGSI and ISCCP on international women's day as part of cervical and breast cancer awareness drive.

Virtual General Body Meeting was conducted on 28th March 2021 for passing e-voting.

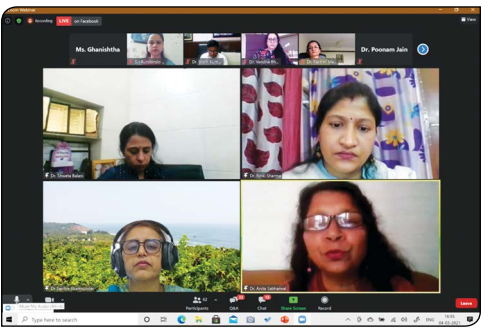


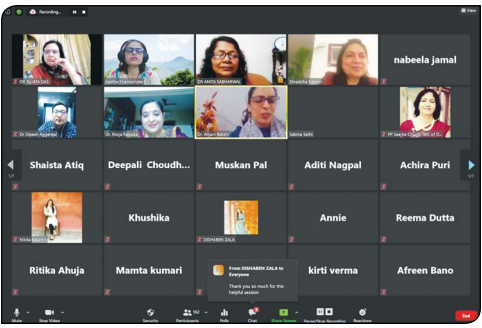
Rewari Obst and Gynae Society organized a webinar on 22nd March,

2021 on " Managing Cervical Lesion on LBC/PAPS

Few more online training sessions and activities conducted by ISCCP affiliated societies are

- Public Forum with Lady Irwin College, Delhi was conducted in february, 2021, 250 students and staff participated in a very interactive session
- Online training for HCW in Madhya Pradesh was conducted with the help of Dr Veena acharya, Dr Roopa Hariprasad, Dr Kavitha, Dr Neelu Khaneja, Dr Ruchi Pathak, Dr Anjana Sabharwal
- UCMS & GTB Hospital has been added as a training centre for colposcopy.




nabeela jamal
Shaista Atiq
Deepali Choudh...
Muskan Pal
Aditi Nagpal
Achira Puri
Khushika
Annie
Reema Dutta
Ritika Ahuja
Mamta kumari
kirti verma
Afreen Bano