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e-Newsletter

ISCCP

Member International Federation of Cervical Pathology and Colposopy

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

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From the President's Pen

Dear ISCCP members

With the onset of COVID 19 pandemic, cervical cancer screening was suspended across all countries as it was not clear if transmission occurs during cervical screening and treatment. With better understanding of the virus transmission now and resumption of clinical work with PPE in place, guidelines for cervical cancer screening were urgently needed to prevent cervical cancer which still kills more women than COVID in India. We developed these guidelines which were endorsed by AOGIN and the Oncology Committee of FOGSI as well.

Hope these guidelines help you in screening and management of your patients during difficult times.

Dr Saritha Shamsunder
President ISCCP

From the Editor's Pen

Dear All

Greetings from ISCCP and a Healthy life to all,

Besides the screening guidelines, this issue also contains 'Journal Scan' and 'News from around the world' sections.

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

Wishing all of you healthy and Happy New Year 2021 from the editorial team.

Stay Home and Stay Healthy

Chief Editor
Prof Aruna Nigam
Department of Obstetrics and Gynaecology
Hamdard Institute of Medical Sciences and Research, Jamia Hamdard
New Delhi
prakasharuna@hotmail.com

Forthcoming Conference

IFCPC 2021 World Congress
1st-5th July, 2021

Abstract Submission Open till
28th February, 2021

ISCCP, FOGSI Gynae Oncology, AOGIN India, Consensus Guidelines for Cervical Cancer Screening, HPV Vaccination and Management in the COVID-19 Pandemic and Beyond

Drafted by: **Dr Shalini Rajaram, Dr Roopa Hariprasad**

Comments by: **Dr Partha Basu, Dr Neerja Bhatla, Dr Saritha Shamsunder, Dr Vijay Zutshi, Dr Vijay Ahuja Dr Bhagyalakshmi Nayak, Dr Ruchi Pathak, Dr Sabhyata Gupta, Dr Rengaswamy Sankaranarayanan**

On behalf of the ISCCP Governing Body & AOGIN Executive Committee
Dr Abraham Peedicayil, Dr Achla Batra, Dr Amita Suneja, Dr Anita Sabharwal, Dr Aruna Nigam Dr Bindiya Gupta, Dr Deepti Goswami, Dr Devika Rathi, Dr Gauri Gandhi, Dr Jaideep Malhotra Dr Krishnendu Gupta, Dr Leela Digumarti, Dr Mamta Dagar, Dr Meena Nayak, Dr Nikhil Parwate Nirmala Agarwal, Dr Nisha Singh, Dr Pakhee Aggarwal, Dr Pratima Mittal, Dr Priya Ganesh Kumar Dr Puneet Chandna, Dr Raksha Arora, Dr Ranjana Desai, Dr Rashmi Bagga, Dr Rema P, Dr Roopa Hariprasad Dr Sarita Bhalerao, Dr Sharmila Patil, Dr Sujata Das, Dr Sumita Mehta, Dr Sunita Malik, Dr Swaraj Batra Dr Sweta Balani, Dr Uma Singh, Dr Usha Bohra, Dr Vasundhara Parliker, Dr Veena Acharya Dr Latha Balasubramani, Dr Sandeep R Mathur, Dr Rupinder Sekhon, Dr Dipanwita Banerjee, Dr Seema Singhal Dr Anita Thomas, Dr Anupama Rajanbabu, Dr Kanika Batra Modi, Dr Pranay Tanwar

Introduction

India has one-fifth of the cervical cancer cases in the world. GLOBOCAN 2018 estimated over 96,922 new cases of cervical cancer and 60,078 cervical cancer deaths per annum around 2018 in India[1]. Prior to the COVID-19 pandemic, cervical cancer screening and prevention efforts were stepped up in India by the introduction of the National Programme for Screening of Breast, Oral and Cervical Cancers by the Ministry of Health & Family Welfare, Government of India (2016) as well as professional societies which include Indian Society for Colposcopy and Cervical Pathology (ISCCP), Federation of Obstetric and Gynaecological Societies of India, Asia Oceania research organisation on Genital Infections and Neoplasia, India (AOGIN-India), Association of Gynecologic Oncologists of India (AGOI)[2,3]. In response to the COVID-19 pandemic caused by the SARS-Cov-2 virus, health regulatory bodies adopted various preventive strategies and Centre for Disease Control, CDC, USA recommended that healthcare systems prioritize urgent visits and delay elective care to mitigate the spread of COVID-19 in healthcare settings4.Such measures resulted in suspension of all elective medical services and limited practice to emergency cases only for a considerable period; this also meant that cervical cancer screening came to a virtual standstill in India, just as it did in almost all countries affected by the pandemic. We need to rethink resumption of screening and management strategies for cervical cancer control. This will be dictated by local COVID-19 control striking a balance in patient care and physician safety. The pandemic has given us the opportunity of exploring telemedicine and telehealth services using social media, mobile phone-based applications (WhatsApp Telegram etc), phone calls, text messages in re-organising health care delivery, education and counselling[5,6] 'Follow up consultations to patients can be provided using Telemedicine and Telehealth. Newer consensus guidelines by for cervical cancer screening have adopted risk-based approach and these need to be incorporated in due time[7]. These guidelines are primarily based on primary human papilloma virus testing (HPV) testing, although co-testing and cytology are also considered[7,8]. Briefly, when women have an estimated 5-year cervical intraepithelial neoplasia 3 or worse (CIN3+) risk of less than 0.15% based on past history and current test results, return to routine screening at 5-year intervals using HPV-based testing is recommended. Women with a risk estimate of CIN3+ of 4% or more need expedited treatment or colposcopy. Risk estimate tables are freely available on the National Institutes of Health website[9]. It must be understood that screening with a highly sensitive test like HPV can reduce screening intervals to five years in women with a negative test report and is the screening method of choice to be adopted if resources permit.

For cervical cancer management several organisations and societies have given their recommendations and these have been considered in this document[10,11]. Recent reviews define patients as high, medium and low priority and strategize treatments accordingly[12,13].

Principles of Screening and Vaccination During and After The COVID Pandemic

HPV Vaccination

1. Measures should be taken to complete vaccination schedule of girls and young adults who have begun

HPV vaccination and the next dose may be given in the next 12-15 months[14]. Recent data shows that single dose HPV vaccination is effective and second dose may be delayed by 3-5 years[15].

2. HPV vaccination maybe continued as before in areas with no or sporadic cases. If there are clusters of cases and community transmission is on-going, guidelines maybe drawn from National and regional authorities to guide mobility of girls and women and healthcare workers to minimise SARS-CoV-2 transmission. In Sikkim the school-based HPV vaccination has shifted to health facility based due to closure of schools during the pandemic and how this will affect coverage remains to be seen.

Screening

1. Telemedicine and Tele-health facilities should be utilised for virtual consultations to reach out to women needing vaccination and screening[5,6].
2. Women who are due for any kind of screening test should be advised to reschedule the visit once the pandemic settles and should be reassured that a delay of a few months will not have a significant impact[10,12]
3. Whenever OPDs resume and opportunistic screening is possible it may be carried out using any method (Cytology/VIA/HPV test) ensuring that the facility is not over-crowded and social distancing is maintained. Where possible, women should be encouraged to fix prior appointments for this purpose.
4. Institutions and hospitals should be encouraged to switch over to HPV testing using self-collected cervical sample as the method of screening. This should be promoted during the COVID pandemic as it curtails travel and therefore risk of transmission of SARS-CoV2 virus[14]. HPV sample kits are to be provided to the woman. The self- collected samples may be sent to the laboratory for testing. Test reports can be sent as a text message on mobile phones.
5. Women with symptoms such as irregular bleeding PV, post-coital bleeding, foul smelling discharge from vagina, with or without loss of weight or new onset back pain should report to a health care facility, cared for as a priority and receive appropriate testing and treatment.
6. Outreach extension screening clinics (aka "camps") should be avoided till the pandemic settles. Instead HPV self-collection of samples by the women can be done (enabled by step by step pictorial display of sample collection technique by healthcare workers), taking due precautions, and samples can be brought to the facility for the testing. HPV sampling kits may be distributed and collected by health care workers. Suitable logistics need to be worked out for this purpose.

Management of Screen Positive Women

Colposcopic evaluation is determined by the screening test results. Women with low grade cytology can be triaged with colposcopy. Women with high grade smears should be scheduled as soon as possible for colposcopy and those suspicious for malignancy should definitely be seen within two weeks (Table 1). Management of an HPV positive report is given in Table 1.

Table 1: Management of abnormal reports (modified)[13,16]

	Pap report or HPV testing as primary screening test	Management
1	Low-grade cervical cancer screening tests (Repeated Inflammatory, ASCUS, LSIL)	Colposcopy
	• HPV Negative	Repeat Pap in after 12 months
	• HPV Positive	Colposcopy in 3 months
2	High-grade cervical cancer screening tests:HSIL, ASC-H (atypical squamous cells – high grade) AGC -NOS (Atypical glandular cells, not otherwise specified)	Colposcopy/biopsy to be performed as soon as feasible.
3	Suspicious of malignancy -AGC-FN (Atypical cells glandular cells favouring neoplasia), adenocarcinoma in- situ (AIS), squamous cell carcinoma, adenocarcinoma	Immediate evaluation by colposcopy/biopsy (within 2 weeks) and treatment planning in the next two weeks
4	HPV Test positive	VIA/Cytology – if either positive referred for colposcopy **or** HPV 16, 18 Genotyping HPV 16, 18 negative, repeat HPV testing after one year HPV 16, 18 positive women should have colposcopy in 3 months

VIA Positive Cases

With the current pandemic and suspension of routine OPD services and outreach camps the opportunity of performing VIA becomes limited but opportunistic screening in all health facilities may continue with necessary precautions. If screening has occurred in the past and the patient has a VIA positive report it may be managed by ablative therapy if the criteria for ablation are fulfilled as per Government of India guidelines2 (Appendix 1). Colposcopy and biopsy should not be delayed in women with a suspicion of invasive cancer (within 2 weeks). Once the pandemic is over, screening with VIA should resume in all primary health centres as per the Government of India Guidelines 2

Management of Preinvasive Disease

With elective surgery being suspended, management of preinvasive disease is dictated by risk of progression. Some women may need to be scheduled for an excision /ablative procedure (high grade disease). Ablative procedures in those fulfilling criteria for ablation may be done with thermal ablation/cryotherapy as per availability. Women with an invasive cancer will need staging and treatment planning. (Table 2)

Women with CIN1 can be called in12 months for an HPV test/Cytology. Women with CIN 3 should be treated as soon as possible (Table 2)

Table 2: Management based on histopathology report

Histopathology Report	Management
Cervical Intraepithelial neoplasia (CIN1)[8] (if the preceding smear is ASC-H or HSIL-a histopathology review is needed)	a) Follow up in 12 months
Cervical Intraepithelial Neoplasia (CIN 2 and CIN 3)	Treatment should be provided as early as possible
Invasive Cancer Early stage cervical cancer[10]	If surgical services are available, proceeding with standard-of-care is recommended. If access to surgery is limited, she may be referred to centres offering surgical services/radiotherapy.
Locally-advanced disease[10]	Chemoradiation with hypofractionation (increasing dose per day and reducing the number of fractions) to reduce the number of hospital visits

Management of Invasive Cancer

There have been a number of guidelines and statements released since the pandemic on treatment of cervical cancer and follow similar principles. It has to be understood that invasive cancer patients will need treatment and should be strategized as soon as histopathological diagnosis is available. A treatment plan including staging and investigative work-up must be in place within 2 weeks. Surgical treatment with curative intent depends on the stage and availability of cancer centres doing oncosurgery during the pandemic. Surgery for Stage IA1 (microinvasive cancer) may be delayed for 8 weeks considering slow rate of growth[15]. This can be decided on the COVID situation in a particular area. For patients with Stage IA2, IB1-2, II A, radical surgery can be planned within 6-8 weeks[10,17]. These patients can also receive definitive chemoradiation if surgery is not possible considering the current COVID situation in a particular area. Patients with locally advanced and advanced cancers need chemoradiation with hypofractionation techniques (increasing dose of radiation and decreasing number of fractions). Whatever be the plan, patient anxiety must be addressed, counselling done and every effort made for referrals and treatment within a stipulated time.

General measures to be followed during screening and other diagnostic services

1. All women coming to the clinic should first be screened for symptoms or signs of COVID-19, including fever, respiratory and/or gastro-intestinal symptoms, and also checked for place of residence, whether a known hotspot area or containment zone. All COVID-suspect cases should be directed to the emergency room/ respective clinics for evaluation and management. Screening and diagnostic procedures may be deferred in these individuals.
2. All health care providers should wear appropriate PPE and patients should be given a mask to wear during consultation and examination.
3. Hands should be cleaned with soap and water or hand sanitizer that contains at least 60% alcohol before and after examining the patient. Recommended social distancing to be maintained in waiting areas (6 feet/2 metres)
4. Disinfection of the clinic and OT area is to be done at regular intervals as recommended[4]
5. All diagnostic procedures including colposcopy, biopsy, ablative procedures, and LLETZ, should be performed in outpatient settings. A negative COVID test report preferably RT-PCR is desirable 72 hours before the procedure. She should also self- isolate at home for at least two weeks prior to procedure. A serviced smoke extractor preferably with HEPA filters must be used for LLETZ procedures considering the theoretical risk of transmission by aerosolised particles
6. The minimum number of staff should be present during procedures.
7. Only one attendant/family member can accompany the patient
8. Details of OT set up with air conditioning requirements are available in the Indian Society of Anaesthesiology position statement18. The main principle would be to not allow virus laden particles out of the OT in which a COVID positive patient is being operated and at the same time keep viral load low in the OT by disinfection of surfaces as per protocol. OT should have its own ventilation system with an integrated high-efficiency particulate air filter (HEPA). Room AC's with exhaust fans and a fan blowing in air and a window kept slightly open also will work.[18]

9. Traffic and flow of contaminated air should be minimised by locking all doors of the OT during surgery, with only one possible route for entry/exit via the scrub room.
10. All electronic gadgets like pagers, laptop or mobile and hospital case sheets should be left outside the OT. Disposable pens are to be used if available.

Conclusions

The COVID-19 pandemic has pushed back cervical cancer screening programs, which had gained momentum in the previous years, to a virtual standstill. We need to re-think vaccination and screening strategies as outlined above with an expedited need to treat high grade lesions and suspect invasive cancers. This has also been an opportunity to introduce telemedicine and telehealth into screening practice and will allow women remain in contact with the health care system. Self-sampling for HPV testing must be explored and a liaison with the pathologist and community health workers developed. Visual Inspection testing with proper patient and physician safety can be carried out in places where the COVID cases are on the decline. Finally, OT protocols for adequate ventilation and mitigating viral load must be considered.

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Appendix 1

Eligibility for Cryotherapy/Thermal ablation	Cryotherapy / Thermal ablationnot recommended in
The lesion should not be spread over more than 3 quadrants of the cervix	Postcoital bleeding
The TZ type should be type I. The entire lesion is located in the ectocervix with no extension to vagina/and or endocervix	Postmenopausal bleeding
The lesion is visible in its entire extent	Overt cervical growth
The lesion can be adequately covered by the largest available cryotherapy probe	Irregular surface
There should be no suspicion of invasive cancer	Bleeds on touch

Follow-up by VIA is recommended 1 year following cryotherapy/ Thermal ablation

Journal Scan

Deepti Goswami
MD, FRCOG, Director Professor, Obstetrics & Gynaecology, Maulana Azad Medical College, New Delhi

Trimble CL, Levinson K, Maldonado L, Donovan MJ, Clark KT, Fu J, Shay ME, Sauter ME, Sanders SA, Frantz PS, Plesa M.

A First-in-human Proof-of-concept Trial of Intravaginal Artesunate to Treat Cervical Intraepithelial Neoplasia 2/3 (CIN2/3).

Gynecol Oncol. 2020 Apr; 157(1):188-194.

Artesunate, a compound that is WHO-approved for treatment of acute malaria, also has cytotoxic effect on squamous cells transformed by HPV. Authors from the USA conducted a first-in-human Phase I dose-escalation study to assess the safety and efficacy of self-administered artesunate vaginal inserts in biopsy-confirmed CIN2/3.

Adult, immunocompetent women who had a biopsy-confirmed tissue diagnosis of CIN2/3, a visible residual lesion, and detectable HPV were eligible for study participation. Eligible subjects of childbearing age had to commit to using effective adequate contraception through week 15 of the study.

The formulation of the artesunate suppositories was confidential and not disclosed in the published paper. After a screening period of not >6 weeks, subjects were assigned sequentially to one of 4 treatment groups. Subjects in the first group received one treatment cycle of 50 mg inserts. Subjects enrolled in the next 3 groups received 1, 2, or 3 treatment cycles of 200 mg insert(s), at study weeks 0, 2, and 4. Each treatment cycle was comprised of 5 consecutive nightly doses of single vaginal inserts. The artesunate vaginal inserts were self-administered at bedtime using a vaginal applicator, followed by a tampon, which was removed in the morning. Subjects kept diary cards to record local vaginal reactions.

Speculum exams to assess the cervicovaginal mucosa were performed at each study visit. An interim colposcopy was done between 6 and 9 weeks after the first dosing visit. Colposcopic exams, including visual assessment, tissue biopsy, cytology, and HPV genotyping were performed at study weeks 15, 28 and 41, the final study visit.

Safety analyses were based on patients who received at least one dose, and were assessed by the severity, frequency, and duration of reported adverse events. Tolerability was assessed as the percentage of subjects able to complete their designated dosing regimen. Modified intention-to-treat analyses for efficacy and viral clearance were based on patients who received at least one dose for whom endpoint data were available. Efficacy was defined as histologic regression to CIN1 or less. Viral clearance was defined as absence of HPV genotoype (s) detected at baseline.

Result

A total of 28 patients received 1, 2, or 3 five-day treatment cycles at study weeks 0, 2, and 4, respectively, prior to a planned, standard-of-care resection at study week 15. Reported adverse events were mild, and self-limited. In the modified intention-to-treat analysis, histologic regression was observed in 19/28 (67.9%) subjects. Clearance of HPV genotypes detected at baseline occurred in 9 of the 19 (47.4%) subjects whose lesions underwent histologic regression.

The authors concluded that self-administered vaginal artesunate inserts were safe and well-tolerated, at clinically effective doses to treat CIN2/3.

Usyk M, Zolnik CP, Castle PE, Porras C, Herrero R, Gradissimo A, Gonzalez P, Safaeian M, Schiffman M, Burk RD; Costa Rica HPV Vaccine Trial (CVT) Group.

Cervicovaginal Microbiome and Natural History of HPV in a Longitudinal Study.

PLoS Pathog. 2020 Mar 26;16(3):e1008376. doi: 10.1371

This study from the USA investigated the role of the cervicovaginal microbiome (CVM) in the natural history of HR-HPV. The researchers wanted to explore why only a small percentage of high-risk (HR) HPV infections progress to cervical precancer and cancer.

This study was nested within the placebo arm of the Costa Rica HPV Vaccine Trial that included women aged 18-25 years of age. Cervical samples from two visits of women with an incident HR-HPV infection (n = 273 women) were used to evaluate the prospective role of the CVM on the natural history of HR-HPV. The CVM was characterized by amplification and sequencing the bacterial 16S V4 rRNA gene region and the fungal ITS1 region using an Illumina MiSeq platform. OTU clustering was performed using QIIME2.

Result

At Visit 1 (V1) abundance of *Lactobacillus iners* was associated with clearance of incident HR-HPV infections (Linear Discriminant Analysis (LDA)>4.0), whereas V1 *Gardnerella* was the dominant biomarker

for HR-HPV progression (LDA>4.0). At visit 2 (V2), increased microbial Shannon diversity was significantly associated with progression to CIN2+ (p = 0.027). Multivariate mediation analysis revealed that the positive association of V1 Gardnerella with CIN2+ progression was due to the increased cervicovaginal diversity at V2 (p = 0.040). A full multivariate model of key components of the CVM showed significant protective effects via V1 genus *Lactobacillus*, OR = 0.41 (0.22-0.79), V1 fungal diversity, OR = 0.90 (0.82-1.00) and V1 functional Cell Motility pathway, OR = 0.75 (0.62-0.92), whereas V2 bacterial diversity, OR = 1.19 (1.03-1.38) was shown to be predictive of progression to CIN2+.

This study demonstrated that features of the cervicovaginal microbiome are associated with HR-HPV progression in a prospective longitudinal cohort. The analyses indicated that the association of *Gardnerella* and progression to CIN2+ may actually be mediated by subsequent elevation of microbial diversity. Identified features of the microbiome associated with HR-HPV progression may be targets for therapeutic manipulation to prevent CIN2+.

Polman NJ, Ebisch RMF, Heideman DAM, Melchers WJG, Bekkers RLM, Molijn AC, Meijer CJLM, Quint WGV, Snijders PJF, Massuger LFAG, van Kemenade FJ, Berkhof J.

Performance of human papillomavirus testing on self-collected versus clinician-collected samples for the detection of cervical intraepithelial neoplasia of grade 2 or worse: a randomised, paired screen-positive, non-inferiority trial

Lancet Oncol. 2019 Feb;20(2):229-238.

In this randomised, non-inferiority trial reported from Netherlands, women aged 29-61 years were invited to participate in the study as part of their regular screening invitation. Women who provided informed consent were randomly allocated (1:1, with a block size of ten stratified by age) to one of two groups: a self-sampling group, in which women were requested to collect their own cervicovaginal sample using an Evalyn Brush; or a clinician-based sampling group, in which samples were collected by a general practitioner with a Cervex-Brush.

All samples were tested for HPV using the clinically validated GP5+/6+ PCR enzyme immunoassay. HPV-positive women in both groups were retested with the other collection method and triaged by cytology and repeat cytology in accordance with Dutch screening guidelines. Primary endpoints were detection of cervical intraepithelial neoplasia (CIN) of grade 2 or worse (CIN2+) and grade 3 or worse (CIN3+).

Result

187473 women were invited to participate. 8212 were randomly allocated to the self-sampling group and 8198 to the clinician-based sampling group. After exclusion of women who met the exclusion criteria or who did not return their sample, 7643 women were included in the self-sampling group and 6282 in the clinician-based sampling group.

569 (7·4%) self-collected samples and 451 (7·2%) clinician-collected samples tested positive for HPV (relative risk 1·04 [95% CI 0·92-1·17]). Median follow-up duration for HPV-positive women was 20 months (IQR 17-22). The CIN2+ sensitivity and specificity of HPV testing did not differ between self-sampling and clinician-based sampling (relative sensitivity 0·96 [0·90-1·03]; relative specificity 1·00 [0·99-1·01]). For the CIN3+ endpoint, relative sensitivity was 0·99 (0·91-1·08) and relative specificity was 1·00 (0·99-1·01).

This study showed that HPV testing done with a clinically validated PCR-based assay had similar accuracy on self-collected and clinician-collected samples in terms of the detection of CIN2+ or CIN3+ lesions. These findings suggest that HPV self-sampling could be used as a primary screening method in routine screening.

Cervical Cancer News from Around The World

Roopa Hariprasad
Scientist E & Head, Division of Clinical Oncology, ICMR-National Institute of Cancer Prevention and Research
(Under Ministry of Health and Family Welfare, Govt. of India)
Co-Editor, Indian Society of Colposcopy & Cervical Pathology
Course Director & Convenor, NICPR-ECHO Online Cancer Screening Program

A Cervical Cancer-free Future: First-ever global commitment to eliminate a cancer

World Health Organization: 17 November 2020 News release

WHO's Global Strategy to Accelerate the Elimination of Cervical Cancer, launched today, outlines three key steps: vaccination, screening and treatment. Successful implementation of all three could reduce more than 40% of new cases of the disease and 5 million related deaths by 2050.

This development represents a historic milestone because it marks the first time that 194 countries commit to eliminating cancer - following adoption of a resolution at this year's World Health Assembly.

Meeting the following targets by 2030 will place all countries on the path toward elimination:

- 90% of girls fully vaccinated with the HPV vaccine by 15 years of age
- 70% of women screened using a high-performance test by age 35 and again by 45
- 90% of women identified with cervical disease receive treatment (90% of women with pre-cancer treated and 90% of women with invasive cancer managed).

To read more: https://www.who.int/news/item/17-11-2020-a-cervical-cancer-free-future-first-ever-global-commitment-to-eliminate-a-cancer

WHO Launches Strategy to Eliminate Cervical Cancer; Can India Achieve The Target?

Mint: November 17, 2020

The World Health Organization (WHO) on 17th November launched a global strategy to accelerate the elimination of cervical cancer, aiming to reduce more than 40% of new cases and 5 million related deaths by 2050 with vaccination, screening and treatment.

The burden of cervical cancer in India is huge and the road to achieve elimination of cervical cancer doesn't seem smooth. India recorded the highest estimated number of cervical cancer deaths in 2018, according to a research paper published in the Lancet Global Health.

Public health experts claim that in India, there is a lack of awareness about cervical cancer screening and hitches associated due to the invasive nature of screening. Less than 30% of women in India aged 30-49 years have been screened for cervical cancer, according to a study by the Indian Council of Medical Research (ICMR) in 2019, despite the disease accounting for the second highest number of new cancer cases and cancer-related deaths in the country.

https://www.livemint.com/science/health/who-launches-strategy-to-eliminate-cervical-cancer-can-india-achieve-the-target-11605605446712.html

Local Anti-cervical Cancer HPV Vaccine Soon

Tribune News Service
New Delhi, November 16

India may soon have a local prevention strategy for cervical cancer, the second most common cancer in Indian women after breast cancer.

The AIIMS, which is taking a lead in the national strategy for elimination of cervical cancer, today said an indigenous HPV vaccine had been developed and was in phase III trials now.

"The indigenous HPV vaccine is expected to be available in the near future. Introduction of HPV vaccine in India is to be taken up and some states have already initiated this vaccination," said the AIIMS as it initiated a national workshop on cervical cancer screening and treatment strategies ahead of the launch of Global Strategy for the Elimination of Cervical Cancer by the WHO tomorrow, after the closing of the 73rd World Health Assembly.

Read more: https://www.tribuneindia.com/news/nation/local-anti-cervical-cancer-hpv-vaccine-soon-171505

India Lagging in Cervical Cancer Prevention, Needs More Screening, Vaccination, Experts Say

The Print: 18 November, 2020 2:18 pm IST

Increased screening, better treatment and including the Human Papillomavirus Vaccines (HPV) in the National Immunisation Programme are some of the ways in which India can eliminate cervical cancer, according to experts.

At a webinar organised by Harvard University's T.H. Chan School of Public Health and health data portal Project Sanchar Tuesday, a panel of health experts discussed the most effective preventive measures and treatment for cervical cancer in India.

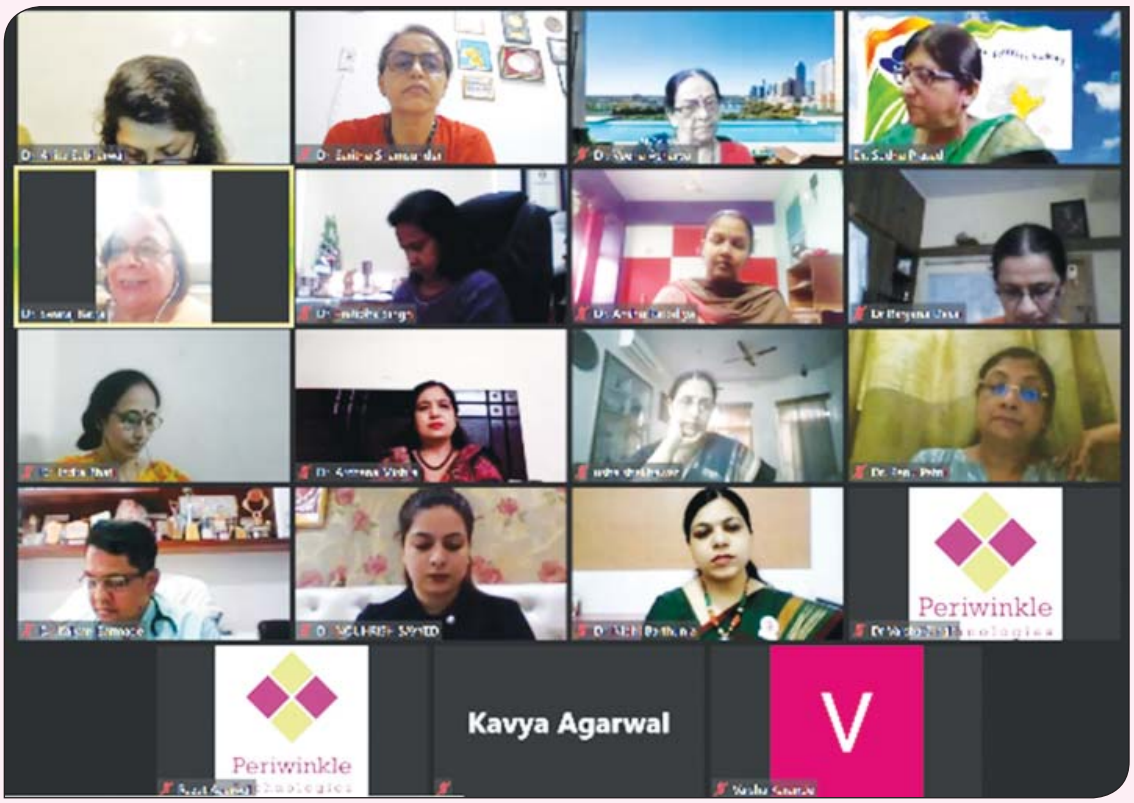
"In India, we have almost 100,000 new cancer cases and about 68,000 cervical cancer deaths in 2018, which constitutes almost a sixth of the global total of the disease in the world," said Dr Rengaswamy Sankarnarayanan, senior visiting scientist at WHO (World Health Organization)-IARC (International Agency for Research on Cancer).

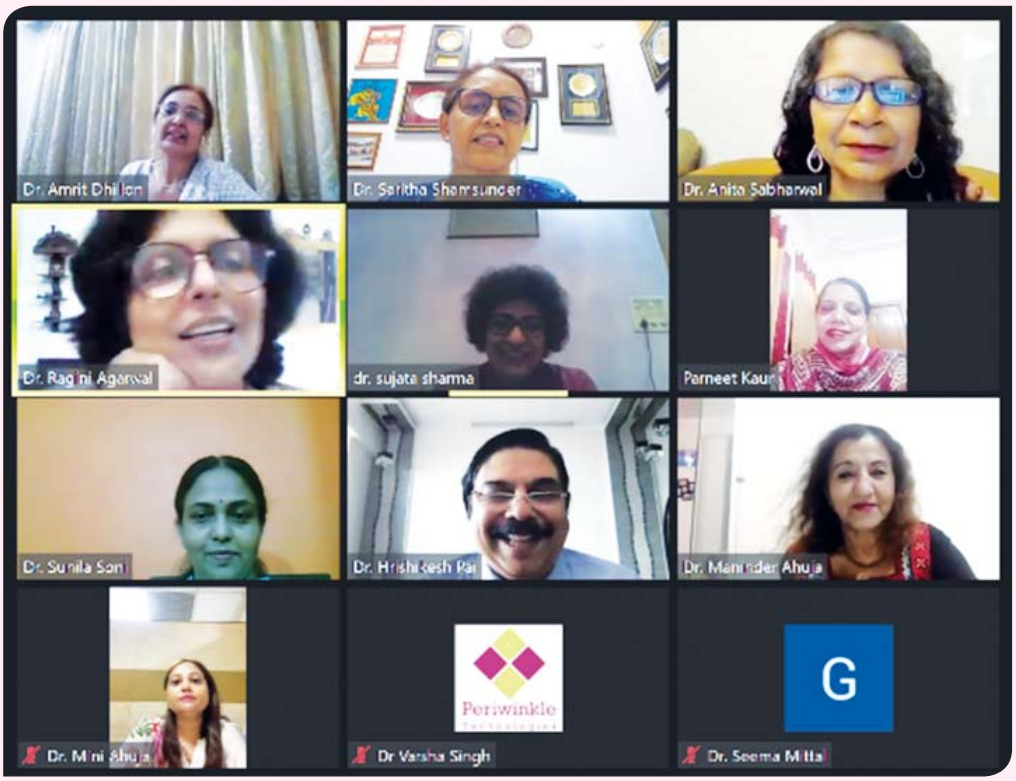
Read more: https://theprint.in/health/india-lagging-in-cervical-cancer-prevention-needs-more-screening-vaccination-experts-say/546700/

ISCCP Activities

Professor Nisha Singh
Department of Obstetrics and Gynaecology, King George's Medical University, Lucknow

Online Public Awareness Sessions for Rajasthan, Punjab & Haryana 16th-17th July 2020

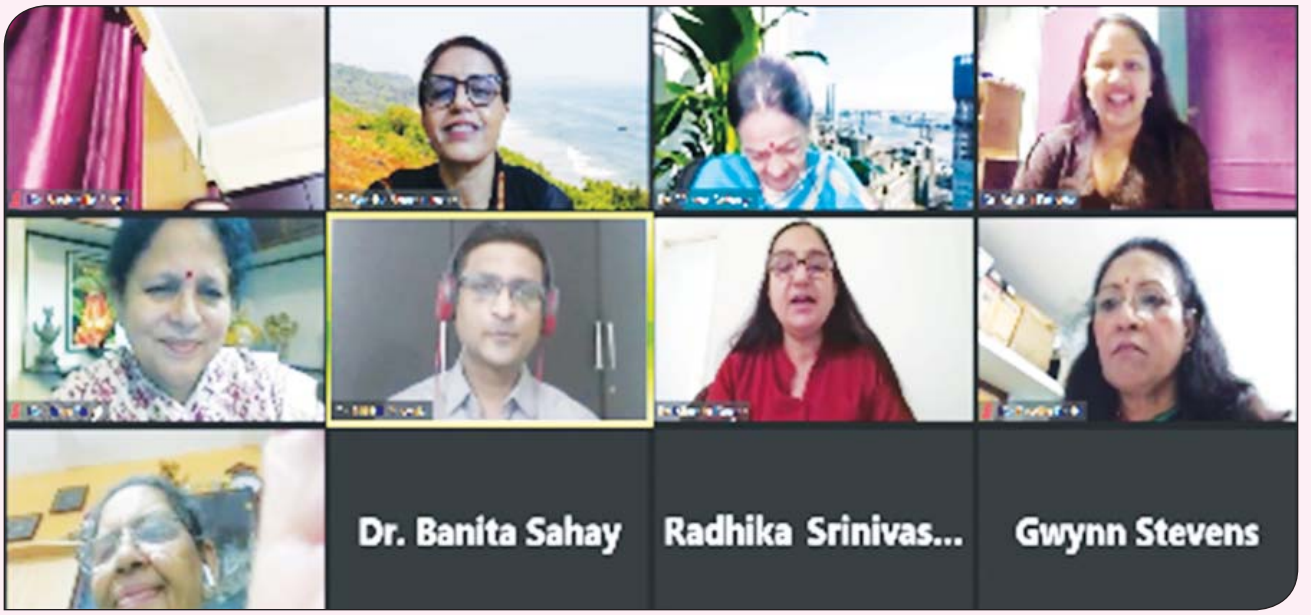




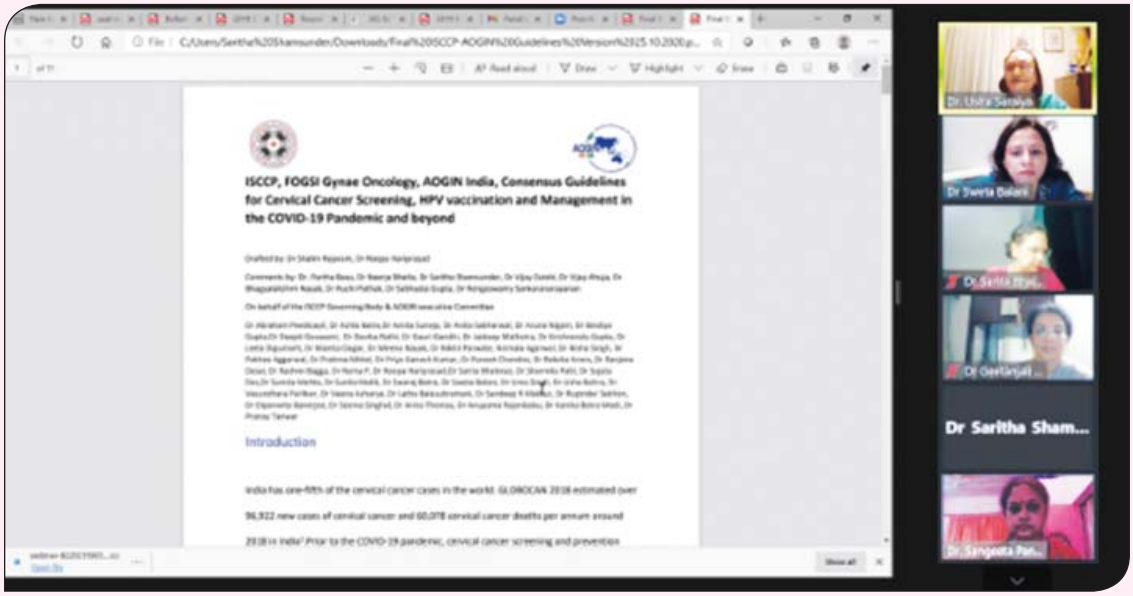
Online Public Awareness Sessions for UP & MP 21st-23rd July, 2020

Concepts and Case Discussion from 27th September - 8th November with FOGSI Oncology Committee

Webinar Series with lectures followed by clinical case scenarios was done in 4 sessions. Event was supported by Cepheid India & CLirnet



Release of ISCCP, FOGSI Gynae Oncology Committee, AOGIN Guidelines on Cervical Cancer screening and Management in COVID & Beyond by Dr Usha Sariya on 25th October



Virtual Public Forum- 'We can Eliminate Cervical Cancer' organized by ISCCP and Sant Parmanand Hospital on 15th Nov 2002: It was attended by 490 people. The event was moderated by Dr Geetika Jain and the experts were Dr Neerja Bhatla, Dr Nirmala Agarwal, Dr Saritha Shamsunder & Dr Sweta Balani