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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 Editor's Pen

Dear ISCCP members,

Greetings from ISCCP and a Happy New Year,

We wish all the ISCCP members a very happy and prosperous year 2019. May our joint efforts towards preventing cervical cancer reach new heights, and we attain our goals in improvising women's health. This issue contains an article on management of cervical cancer during pregnancy along with an interesting case report by Dr Priya.

Due to the growing advancement in the imaging modalities, minimal invasive surgeries and chemoradiation therapies, the FIGO gynaecological society has changed the staging system of cervical carcinoma under the chairmanship of Dr Neerja Bhatla (FIGO cancer report 2018 by Bhatla et al). I am attaching below table containing the changed staging system with highlights on where the changes have been done.

FIGO staging of cancer of the cervix uteri (2018)

Stage I: The carcinoma is strictly confined to the cervix (extension to the uterine corpus should be disregarded)

- IA Invasive carcinoma that can be diagnosed only by microscopy, with maximum depth of invasion <5 mm[a]
  - IA1 Measured stromal invasion <3 mm in depth
  - IA2 Measured stromal invasion **≥3 mm and <5 mm in depth**
- IB Invasive carcinoma with measured deepest invasion ≥5 mm (greater than Stage IA), lesion limited to the cervix uteri[b]
  - IB1 Invasive carcinoma ≥5 mm depth of stromal invasion, and <2 cm in greatest dimension
  - **IB2 Invasive carcinoma ≥2 cm and <4 cm in greatest dimension**
  - **IB3 Invasive carcinoma ≥4 cm in greatest dimension**

Stage II: The carcinoma invades beyond the uterus, but has not extended onto the lower third of the vagina or to the pelvic wall

- IIA Involvement limited to the upper two-thirds of the vagina without parametrial involvement
  - IIA1 Invasive carcinoma <4 cm in greatest dimension
  - IIA2 Invasive carcinoma ≥4 cm in greatest dimension
- IIB With parametrial involvement but not up to the pelvic wall

Stage III: The carcinoma involves the lower third of the vagina and/or extends to the pelvic wall and/or causes hydronephrosis or non-functioning kidney and/**or involves pelvic and/or para-aortic lymph nodes**[c]

- IIIA Carcinoma involves lower 1/3 of vagina, with no extension to pelvic wall
- IIIB Extension to the pelvic wall and/or hydronephrosis or non-functioning kidney (unless known to be due to another cause)
- IIIC **Involvement of pelvic and/or para-aortic lymph nodes,** irrespective of tumor size and extent (with r and p notations)[c]
  - IIIC1 Pelvic lymph node metastasis only
  - IIIC2 Para-aortic lymph node metastasis

Forthcoming Conference

14th Annual Conference of ISCCP

19th-21st April, 2019
at Vishakhapatnam

Organizing Secretary:
Dr Leela Digumarti
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Stage IV: The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. (A bullous edema, as such, does not permit a case to be allotted to Stage IV)

- IVA Spread to adjacent pelvic organs
- IVB Spread to distant organs

When in doubt, the lower staging should be assigned.

[a]Imaging and pathology can be used, where available, to supplement clinical findings with respect to tumor size and extent, in all stages.

[b]The involvement of vascular/lymphatic spaces does not change the staging. The lateral extent of the lesion is no longer considered.

[c]Adding notation of r (imaging) and p (pathology) to indicate the findings that are used to allocate the case to Stage IIIC. Example: If imaging indicates pelvic lymph node metastasis, the stage allocation would be Stage IIIC1^{r}, and if confirmed by pathologic findings, it would be Stage IIIC1^{p}. The type of imaging

modality or pathology technique used should always be documented.

I again request all the ISCCP members to contribute in the Newsletter in the form of review article/original articles/view point/case reports/images.

ISCCP members are continuously involved in the educational and public awareness activities in the field of cervical cancer prevention. Details of the activities held in last 3 months have been included in this issue along with 'Journal Scan' and 'News from around the world' sections.

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Management of Cervical Cancer in Pregnancy

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Introduction

Cervical cancer (CC) is one of the most common gynaecological cancers in pregnancy with an estimated incidence of 0.1-12 per 10,000 pregnancies.[1] Yet, being a rare condition randomized trials are not available, and management remains a challenge to the clinician as standardization of treatment is often difficult. The management of cervical cancer during pregnancy requires complex medical and ethical decisions based on several factors, such as the histological subtype, stage of disease (tumor size), lymph node involvement, duration of pregnancy, obstetrical complications, the parent's wish to continue pregnancy, and future child-bearing desire.[2]

Dilemma arises in choosing the treatment option between traditional approach where standard treatment is offered in post-partum period after pregnancy termination *versus* more recent pregnancy preservation and treatment during pregnancy. However, treatment needs to be individualized after counselling regarding the risk to mother and foetus. If the mother chooses to continue the pregnancy, treatment depends on the stage of disease (tumour size), lymph node involvement, and duration of pregnancy.

Clinical Features

Pregnancy is an excellent opportunity to screen women for CC but ironically diagnosis of CC in pregnancy may be delayed due symptoms mistaken as complications of pregnancy and lack of awareness about screening methods. Symptoms include post coital bleeding (most common), abnormal vaginal discharge, low back pain, urinary and bowel symptoms. The diagnosis of cervical carcinoma in pregnant women is based on clinical findings i.e. inspection of the uterine cervix, PAP smear, colposcopy, directed biopsy and imaging examinations.[3] However, it is extremely important that the physician performing the PAP smear should inform the cytologist that the test is from a pregnant woman, because of the physiological changes in cervical cytology that occur during pregnancy (hyperplasia of the glandular epithelium, presence of decidual cells and Arias-Stella reaction).[4]

Staging

Accurate staging is crucial in helping achieve the best clinical outcomes. Staging for CC in pregnancy is done similar to CC in non-pregnant patients based on International Federation of Gynaecology and Obstetrics (FIGO) staging guidelines. Examination under anaesthesia may be done if exact staging is not possible on pelvic examination.[5]

Role of Magnetic resonance Imaging (MRI)

MRI is a safe tool for diagnostic evaluation of CC in pregnancy. It gives valuable information regarding size of tumour, invasion of stroma, vaginal, parametrial invasion and lymph node infiltration.[6] Gadolinium contrast (category C) should be used cautiously. No adverse effects on foetus have been reported after its exposure in all trimesters.[7]

In the hands of expert, ultrasound done transvaginally or transrectally is comparable to MRI in determining the local disease extension during preoperative staging.[8]

Evaluation for Metastases

Computed tomography (CT) of pelvis and fluorodeoxyglucose positron emission tomography (FDG-PET) should not be done unless likely to give any significant information about maternal disease. Both investigations can be done without compromising the foetal safety. CT thorax may be done with abdominal shielding in cases of suspected metastases to lungs.[9]

Treatment

A multidisciplinary team approach is required involving obstetrician, gynecological oncologist, medical oncologist, radiologist, radiotherapist and neonatologist. Treatment of preinvasive disease (CIN 1 to CIN 3) may be deferred till 6-8 weeks post-partum provided colposcopy is performed by an expert in each trimester. The management of CC during pregnancy depends on the period of gestation at diagnosis, stage of cancer and desire to continue pregnancy. Treatment plan should be tailored keeping in mind oncological safety of patient with no additional harm to the foetus. Definitive treatment should be started in patients where lymph node metastases is present, or the disease is progressing if the patient agrees to terminate the pregnancy. Patient may opt for radical surgery or definitive chemoradiation as recommended for the stage of disease without preservation of pregnancy with or without previous pregnancy termination.

Patients who wish to continue pregnancy are divided into two groups according to the gestational age at diagnosis (figure 1) as per the second international consensus guidelines and European society of gynaecological oncology task force (ESGO): less than 22–25 weeks (Group I) and more than 22–25 weeks (Group II).[2]

Group I (Gestational Age Less Than 22–25 Weeks)

After evaluation of lymph node negativity, the management of the disease depends on its stage. MRI scans can assess lymph node involvement, thereby providing the basis for prolonging pregnancy. Also, laparoscopic lymphadenectomy has emerged as an effective and more precise procedure during pregnancy.[10] Histopathological assessment of lymph nodes is the most accurate method for the assessment of nodal status. Laparoscopic pelvic lymphadenectomy enables the identification of patients with positive nodes and thus high-risk disease that may necessitate termination of pregnancy and application of standard treatment. Delay of treatment until after delivery is a possibility with negative lymph nodes. ESGO recommends para-aortic lymph node dissection (PALND) only for tumours>4 cm in size. For tumours<4 cm in size, only pelvic lymphadenectomy (PLND) is recommended.[2] It is important to emphasize that pelvic lymphadenectomy is a diagnostic and not a therapeutic tool, and upfront neoadjuvant chemotherapy during pregnancy without surgical lymph node staging may be another option in selected cases when primary surgery is not a good option.

Stage-IA1 disease is managed using conisation, recommended at 12–20 weeks of gestation. In patients with squamous histological subtype and negative surgical margins, the treatment is considered to be complete.[2] This procedure should be done in operation theatre with care taken not to injure the foetal membranes. Prophylactic cerclage can be combined to prevent preterm labour as well as decrease blood loss during conisation.

Stage-IA2 and stage-IB1 tumours<2 cm: Simple trachelectomy (excision of cervix 1 cm above tumor margin) or large conisation is recommended for patients with stage-IA2 and stage-IB1 tumours <2 cm in size for whom the parametrial involvement risk is <1%.[11] When progressive disease is observed, either by clinical examination or MRI, termination of pregnancy or neoadjuvant chemotherapy (NAC) is advocated.

Stage-IB1 tumours >2 cm: In pregnant patients with a tumour size > 2 cm and with stage IB1 or higher disease, NAC is the treatment of choice. Chemotherapy may reduce tumor size, converting bulky to operable disease, and control distant and lymph nodal micrometastases. The aim of NAC in pregnant women is to obtain disease stabilization or regression until fetal maturity is achieved.[12] Cisplatin and paclitaxel based regimen are most commonly used in NAC.[13,14] The most effective regimen in non-pregnant CC patients is the combined treatment of paclitaxel, ifosfamide and cisplatin; however, Ifosfamide has foetal nephrotoxic effects.[13] Cisplatin is appropriate for first-trimester pregnancies and can be used at a dose of 25– 50 mg/m2 per week or 50–100 mg/m2 per three weeks for up to six cycles. The currently recommended NAC regimen is cisplatin with or without paclitaxel every three weeks.

The estimated teratogenic risk with the use of single and multiple chemotherapy agents during the first trimester is 7.5–17% and 25%, respectively.[15] NAC when used during the second and third trimesters may cause adverse effects like intrauterine growth retardation, in utero death, low birth weight and prematurity.[16] NAC should be terminated

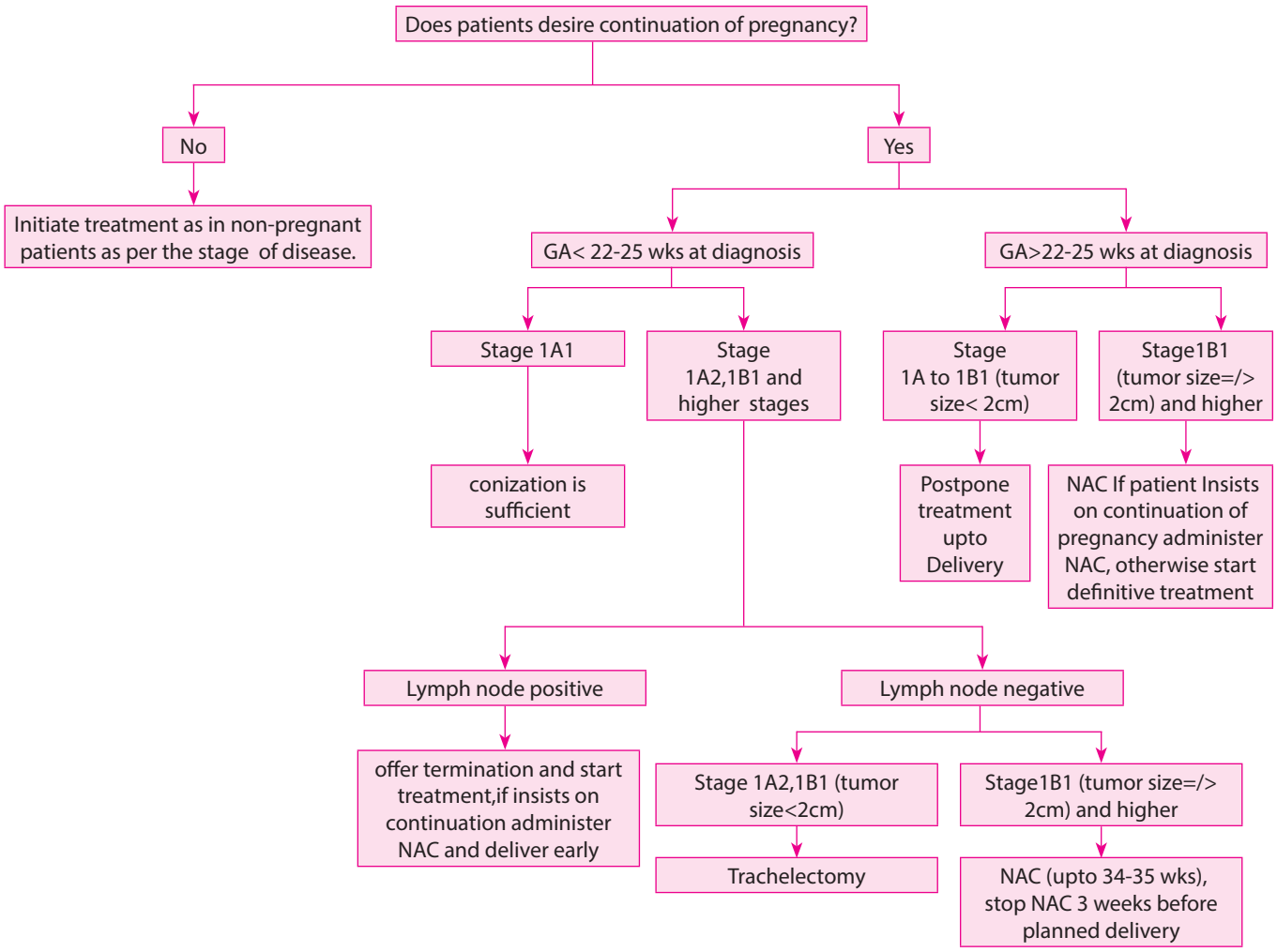

Fig 1: Management of cervical cancer in pregnancy

three weeks before the planned delivery to decrease the possible maternal and foetal complications caused by haematopoietic suppression.[2,13]

Classical indications for NAC in patients with CC in pregnancy are locally advanced tumors and residual cancer after conization without the possibility for further resection to avoid cervical insufficiency (potentially combined with other risk factors such as lymph-vascular space involvement or grading 3).[17]

Stages IB1, tumour size >2 cm and higher stages: When conservative surgical treatment during pregnancy is not possible, neoadjuvant chemotherapy is an option to achieve disease control until foetal maturation, followed by radical hysterectomy postpartum.[13]

NAC in pregnancy is still a topic which needs further studies to determine its role as standard therapy. Optimal chemotherapy regimen, interval, dose, number of cycles are still unknown in pregnancy. It is thus the duty of the multidisciplinary team to make patient aware of experimental character of the treatment.

Lymph-node-positive pregnant patients who choose pregnancy continuation should be informed of the poor prognosis with treatment. If the patient insists on continuing the pregnancy, NAC is the treatment of choice with a planned early delivery.[13]

Group II (Gestational Age 22–25 Weeks or Later)

Evaluation of lymph node involvement with lymphadenectomy after 20 weeks' gestation becomes less feasible due to surgery- related complications. Therefore, when CC is diagnosed at this stage of pregnancy, the disease management is determined mainly by the stage of the disease.[2,13]

In stage-IA and stage-IB1 patients with tumour sizes <2 cm, postponing definitive treatment after delivery is possible. This delay interval ranged from 3 to 40 weeks, and 96% of patients were alive without recurrence.[13] If patients with disease stages higher than IB1 opt to continue their pregnancies, NAC is the treatment of choice and is used primarily for preventing disease progression rather than curing the disease. Patients should be given detailed information regarding the experimental CC treatment features during pregnancy.

Follow-up

Patients with stage-IA1 disease who choose continuation of pregnancy should be followed up with repeated colposcopy and clinical examination during each trimester up until the time of delivery. Patients who prefer delaying treatment after delivery should be followed clinically and by performing pelvic examinations every 3–4 weeks.[13] Imaging modalities such as USG and MRI can be used when disease progression is suspected.[13]

Mode and Time of Delivery

Spontaneous vaginal delivery adversely affect the prognosis of CC in pregnancy. Thus, caesarean section after 32nd week of gestation (if possible) is recommended. Definitive treatment (as recommended for non-pregnant patient with CC) adjusted according to treatment already administered during pregnancy is to be performed at the time of caesarean section or following it. Pregnant women with stage-IA1 or -IA2 CC can deliver vaginally.[19] For stages IB1 and higher, caesarean section is the preferred mode of delivery, and vaginal delivery should be avoided.[2,9,19] Vaginal delivery in advanced cervical cancer stages might increase the risk of lymphatic spread, infections, cervical lacerations and episiotomy-related metastasis. Vaginal delivery was determined as the most important prognostic factor for CC recurrence. In patients with long bone metastasis, the pushing that occurs during vaginal delivery may result in bone fractures; in patients with central nervous system metastasis, normal vaginal delivery may cause increased intra-cranial pressure, and therefore, vaginal delivery should be avoided in these patients.[2]

Conclusion

Pregnancy-associated cancer constitutes an uncommon and difficult to manage clinical situation. Coexistence of cancer with pregnancy adds complexity to treatment recommendations, as both the mother and the foetus may be affected but the outcome is not affected. The optimal therapeutic management of pregnant women with cancer diagnosis should take into account, apart from medical factors, a host of other parameters (ethical, psychological, religious, legal etc). Treatment of cervical cancer in pregnancy requires a multidisciplinary approach taking into consideration the patient's choice but at the same time explaining the risks associated with delaying a definitive treatment.

Summary

- Patient of CC in pregnancy should be treated by a multidisciplinary team approach at an oncology centre with highest level of perinatal care.
- Primary aim is patient's oncological safety without additional morbidity to fetus.
- CC is confirmed by histological examination and staging is done clinically using preferably MRI or expert ultrasound.
- Lymph node sampling (preferred by minimally invasive approach) of suspicious nodes must be done in cases with POG less than 22-25weeks as it has prognostic significance.
- Patient are offered treatment options depending on tumor stage and period of gestation at diagnosis[20]
  - o Removal of tumor by conisation, trachelectomy and lymph node staging with intent to continue pregnancy.
  - o Radical surgery or definitive chemoradiation as per stage without preservation of pregnancy
  - o Delay treatment until fetal maturity (if possible 32weeks) and starting cancer specific treatment immediately after delivery by caesarean section.
  - o Chemotherapy until fetal maturity and delivery by caesarean section followed by immediate institution of cancer specific treatment post-delivery. Platinum based chemotherapy can be given as early as 14weeks of gestation
  - o Caesarean delivery after 32nd week is recommended mode of delivery as spontaneous delivery has negative prognostic impact in patients with CC in pregnancy.

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Spontaneous Regression of HSIL during Pregnancy: Case report

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Introduction

Opportunistic cervical cancer screening should be carried out on patients attending OPD. Pregnancy is a convenient time for opportunistic cervical cancer screening, given the increased contact with the health care providers. Collection of cervical cytology is safe in pregnancy. During pregnancy, the analysis of a cervical smear can present diagnostic difficulties for example the presence of inflammatory and decidual cells may be confused with atypical changes of undetermined significance.

Case Report

28 years old, Para 1 with irregular menstruation of 35-55 days cycle had visited our hospital at Thane, for secondary infertility treatment. She had one living child 9 years old. On speculum examination, her cervix was found to be unhealthy. As a routine PAP smear was taken which reported as ASCUS.

Colposcopy Findings

Acetowhite lesion with dull opaque surface and raised margin (Figure 1B), coarse mosaics(Figure 1C), lugol's uptake negative abutting from squamocolumnar junction at 5 o'clock position(Figure 1D). Swede score- 7

Biopsy

CIN 2/3.

Fig 1A: Green filter

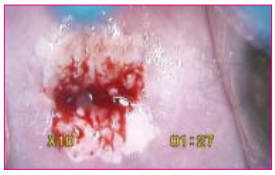

Fig 1B: After Acetic Acid

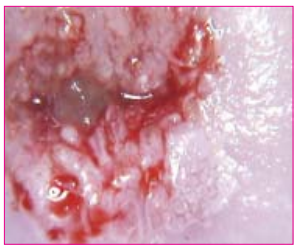

Fig 1C: Showing mosaic pattern

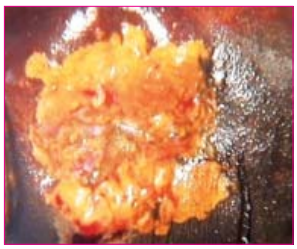

Fig 1D: Showing Lugol's iodine negative area

She was advised LEEP and infertility treatment was deferred. But she conceived spontaneously in the same cycle and LEEP was deferred.

Her repeat Colposcopy (Figure 2A & B) and Pap smear was performed at 4 months postpartum revealed no abnormality indicating spontaneous regression of the lesion

Fig 2 A: after Acetic Acid

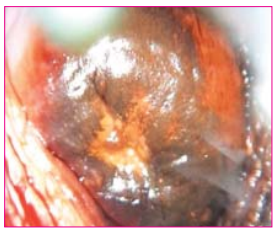

Fig 2B: After Lugol's Iodine

Discussion

If abnormal cervical cytology is found or cervix appears unhealthy on speculum examinationduring pregnancy, colposcopic examination along with guided biopsy should be performed whenever indicated. Doctor performing the colposcopy examination in pregnant woman should be aware of the fact that physiological effects of pregnancy can obscure the examination including the increased cervical

mucus production, prominence of endocervical glands and increased vascularity. Colposcopy directed cervical biopsy is safe in pregnancy(1). The risk of progression of CIN 2/3 to invasive cancer during pregnancy appears to be minimal, however the rate of spontaneous regression post partum is relatively high. Spontaneous regression is reported in 12-97% cases while persistence in the severity of CIN is reported 25-47% cases.(2-4).

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Journal Scan

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Tao L, Amanguli A, Li F, Wang YH, Yang L, Mohemaiti M, Zhao J, Zou XG, Saimaiti A, Abudu M, Maimaiti M, Chen SY, Abudukelimu R, Maimaiti A, Li SG, Zhang W, Aizimu A, Yang AQ, Wang J, Pang LJ, Cao YG, Gu WY, Zhang WJ.

Cervical Screening by Pap Test and Visual Inspection Enabling Same-Day Biopsy in Low-Resource, High-Risk Communities

Obstet Gynecol. 2018 Dec; 132(6): 1421-1429

This prospective cohort trial involved screening of 4,049 women (aged 30-59 years) two low-income Muslim Uyghur communities in China.

The conventional Pap test was modified using a cotton swab to collect cervical cells without scraping the cervix using an Ayre spatula, allowing visual inspection with acetic acid (and visual inspection with Lugol's iodine if visual inspection with acetic acid was negative) to be performed in a single visit. Results from both tests were available within 1-2 hours. Women positive for either or both underwent same-day biopsy that was shipped by a courier service to a central pathology laboratory.

Results

- Single-visit screening incorporating both a modified Pap test and visual inspection achieved a sensitivity of 96.0% (95% CI 91.6-100), which was superior to Pap testing (76%, 95% CI 66.3-85.7; P<.001) or visual inspection with acetic acid-visual inspection with Lugol's iodine (48%, 95% CI 36.7-59.3; P<.001) alone in detecting cervical intraepithelial neoplasia (CIN) 2 or worse lesions.
- Rapid interpretation of both diagnostic procedures facilitated efficient same-day biopsy that achieved a negative predictive value of 98.2% in detecting CIN 2 or worse lesions.
- The increased sensitivity and minimized loss of follow-up allowed this approach to identify an extremely high prevalence of CIN 1 (2,741/100,000, 95% CI 2,238-3,245/100,000), CIN 2 or 3 (1,457/100,000, 95% CI 1,088-1,826/100,000), and cervical cancer (395/100,000, 95% CI 202-589/100,000) among these underscreened, at-risk women.

The authors concluded that single-visit cervical screening with both a modified Pap test and visual inspection has greater sensitivity to detect high-grade CINs, reduces loss of follow-up, and could be an efficient low-cost strategy for low-resource settings..

Ramirez PT, Frumovitz M, Pareja R, Lopez A, Vieira M, Ribeiro R, Buda A, Yan X1Shuzhong Y, Chetty N, Isla D, Tamura M1, Zhu T, Robledo KP, Gebski V, Asher R, Behan V, Nicklin JL, Coleman RL, Obermair A.

Minimally Invasive versus Abdominal Radical Hysterectomy for Cervical Cancer

N Engl J Med. 2018 Nov 15; 379(20): 1895-1904.

In this trial involving patients with stage IA1 (lymphovascular invasion), IA2, or IB1 cervical cancer and a histologic subtype of squamous-cell carcinoma, adenocarcinoma, or adenosquamous carcinoma, patients were randomly assigned to undergo minimally invasive surgery or open surgery. The primary outcome was the rate of disease-free survival at 4.5 years.

A total of 319 patients were assigned to minimally invasive surgery (84.4% laparoscopy and 15.6% robot-assisted surgery) and 312 to open surgery.

Results

- The mean age of the patients was 46.0 years. Most patients (91.9%) had stage IB1 disease. The two groups were similar with respect to histologic subtypes, the rate of lymphovascular invasion, rates of parametrial and lymph node involvement, tumor size, tumor grade, and the rate of use of adjuvant therapy.
- The rate of disease-free survival at 4.5 years was 86.0%

with minimally invasive surgery and 96.5% with open surgery, a difference of -10.6 percentage points (95% confidence interval [CI], -16.4 to -4.7).

- Minimally invasive surgery was associated with a lower rate of disease-free survival than open surgery (3-year rate, 91.2% vs. 97.1%; hazard ratio for disease recurrence or death from cervical cancer, 3.74; 95% CI, 1.63 to 8.58), a difference that remained after adjustment for age, body-mass index, stage of disease, lymphovascular invasion, and lymph-node involvement.
- Minimally invasive surgery was also associated with a lower rate of overall survival (3-year rate, 93.8% vs. 99.0%; hazard ratio for death from any cause, 6.00; 95% CI, 1.77 to 20.30).

In this trial, minimally invasive radical hysterectomy was associated with lower rates of disease-free survival and overall survival than open abdominal radical hysterectomy among women with early-stage cervical cancer.

Melamed A, Margul DJ, Chen L, Keating NL, Del Carmen MG, Yang J, Seagle BL, Alexander A, Barber EL, Rice LW, Wright JD, Kocherginsky M, Shahabi S, Rauh-Hain JA.

Survival after Minimally Invasive Radical Hysterectomy for Early-Stage Cervical Cancer

N Engl J Med. 2018 Nov 15; 379(20): 1905-1914

This was a cohort study involving women who underwent radical hysterectomy for stage IA2 or IB1 cervical cancer during the 2010-2013 period at Commission on Cancer-accredited hospitals in the United States. The study used inverse probability of treatment propensity-score weighting. The authors also conducted an interrupted time-series analysis involving women who underwent radical hysterectomy for cervical cancer during the 2000-2010 period, using the Surveillance, Epidemiology, and End Results program database.

Results:

- In the primary analysis, 1225 of 2461 women (49.8%) underwent minimally invasive surgery. Women treated with minimally invasive surgery were more often white, privately insured, and from ZIP Codes with higher socioeconomic status, had smaller, lower-grade tumors, and were more likely to have received a diagnosis later in the study period than women who underwent open surgery.
- Over a median follow-up of 45 months, the 4-year mortality was 9.1% among women who underwent minimally invasive surgery and 5.3% among those who underwent open surgery (hazard ratio, 1.65; 95% confidence interval [CI], 1.22 to 2.22; P=0.002 by the log-rank test).
- Before the adoption of minimally invasive radical hysterectomy (i.e., in the 2000-2006 period), the 4-year relative survival rate among women who underwent radical hysterectomy for cervical cancer remained stable (annual percentage change, 0.3%; 95% CI, -0.1 to 0.6). The adoption of minimally invasive surgery coincided with a decline in the 4-year relative survival rate of 0.8% (95% CI, 0.3 to 1.4) per year after 2006 (P=0.01 for change of trend).

In this epidemiologic study, minimally invasive radical hysterectomy was associated with shorter overall survival than open surgery among women with stage IA2 or IB1 cervical carcinoma.

Cervical Cancer News from around the World

Dr Roopa Hariprasad
Scientist D, ICMR-NICPR

A Pocket-sized Gadget to Screen Cervical Cancer

The Times: Dec 23, 2018, 02:57 IST

NEW DELHI: All India Institute of Medical Sciences (AIIMS) completed the trials for a pocket colposcope — small-sized device to examine the cervix of women to screen them for diseases like cervical cancer. Unlike the existing machines, which are bigger in size and expensive, the new device developed by scientists from Duke University, UK can fit into a pocket and is expected to cost a few thousands.

"We have used it to screen the patients at our hospitals. The results are positive," Dr Neerja Bhatla, professor of gynaecology at AIIMS said. She did not give out details about the number of patients screened using the device because the research work is yet to be published.

Read more at:
http://timesofindia.indiatimes.comarticleshow/67212243.cms?utm_source=contentofinterest&utm medium=text&utm_campaign=cppst

Cervical Cancer in India: A preventable tragedy that requires urgent attention

NDTV: Health; Updated: December 11, 2018 15:46 IST

It is estimated that in India, about 160 million women aged 30-59 years are at risk of developing cervical cancer, and 77,300 new cases are diagnosed annually with 37,800 deaths, representing a whopping case fatality rate of 49 per cent. Premature death and disability from cancer is a great tragedy that hundreds of thousands of women and their families in India and other developing countries face every year. Of the various cancers that afflict women, that of the cervix, a part of the reproductive system, is one of the most common causes of death in a low socio-demographic index (SDI) country like ours.

For more, read:
https://www.ndtv.com/health/cervical-cancer-in-india-a-preventable-tragedy-that-requires-urgent-attention-1961005

Too Soon to say Cervical Cancer DNA Test will 'Revolutionize Screening'

CRUK: Science blog; December 19, 2018

Cervical cancer screening is in the news, with some headlines saying that a new test can detect the disease 100% of the time and could 'revolutionize screening'. But while the test itself could provide a new option for detecting changes to cells in the cervix, the reality is the test is a long way from being routinely used. And based on the research published so far, it's not yet known if the new test is better than those that are already used.

Scientists from Queen Mary University of London, funded by the Canadian Institutes for Health Research and Cancer Research UK, developed a new test that can pick up changes in chemical 'tags' that sit on top of DNA in cells, called epigenetic changes. The changes can control how the DNA in cells is read and how cells behave.

For more, read:
https://scienceblog.cancerresearchuk.org/2018/12/19/too-soon-to-say-cervical-cancer-dna-test-will-revolutionise-screening/

Over 76, 000 Women Undergo Cervical Cancer Screening in 2018 in Zambia

Lusaka times, Zambia: December 27, 2018

The Ministry of Health has revealed that over 76, 000 women have undergone cervical cancer screening in 2018. Department of Health Promotion, Environment and Social Determinants Assistant Director, Sharon Kapambwe said that 11 percent of the screened women showed signs of cervical cancer cell formation. Dr. Kapambwe said that the affected percentage from the screened women have shown signs of abnormal cells that had not yet developed into cancer. She however revealed that the affected women have been placed on a programme to come in for routine testing.

"Every month an average of 130 women come in with suspected cases of cervical cancer in our local clinics country wide" she said. Dr. Kapambwe has also revealed that of the percentage of women that showed abnormal cells after screening, were being treated in various clinics across the country.

For more, read:
https://www.lusakatimes.com/2018/12/27/over-76-000-women-undergo-cervical-cancer-screening-in-2018/

ISCCP Activities

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

Dr Saritha Shamsunder

1. AICCRCOG Post -Conference comprehensive colposcopy workshop with hands on LEEP Workshop was organised on 5th Nov 2018 in old LT1, Vardhman Mahaveer Medical College and Safdarjung Hospital, New Delhi in association with the ISCCP and NARCHI, Delhi. The curriculum of the course was approved by the IFCPC. The course convenors were Dr Saritha Shamsunder, Dr M. Cruickshank and Dr Theresa Wang from UK. Co- conveners were Dr Mamta Dagar and Dr Sweta Balani. Safdarjung hospital coordinator was Dr Sujata Das. There were 80 delegates and 40 faculties from all over India. Hands on LEEP session had the delegates divided into four groups where all the participants had first hand experience and gained knowledge and confidence to start their Colposcopy units and Hands On LEEP. The feedback from delegates was very positive with a significant increase in post test scores.

2. Post graduate quiz was held on 9th October, 2018 at Safdarjung Hospital under aegis of ISCCP & NARCHI Delhi. 25 PGs participated in a preliminary and final round, all participants enjoyed the interactive quiz!

3. An interactive workshop on "Cervical Cancer Prevention made easy" was organised at MNJ Cancer Hospital, Hyderabad on 8th December, 2018 and was attended by 50 medical officers from Telangana. At the end of the workshop, the medical officers were convinced that prevention was easy.

Dr Shruti Bhatia: Department of Gyne oncology conducted two colposcopy workshops, on 26 November and another on 26 December 2018, at Action Cancer hospital, under the aegis of ISCCP. Each of these workshops were attended by 10-15 gynaecologists from various parts of India. The workshops included lectures on technique of

Colposcopy, basis of colposcopy, IFCPC terminology, HPV, and management of CIN. The lectures were followed by case demonstrations. The workshops were conducted by Dr. Shruti Bhatia and Dr. Renuka Gupta.

Dr Leela Digumarti: screened 400 women from October to December 2018 at Homi Bhabha Cancer Hospital & research centre, Vishakhapatnam. Dr Leela also organized CME on "***Cervical screening and Colposcopy***" on 2nd December, 2018 which was well attended by local Gynaecologists.

Indian Society of Colposcopy & Cervical Pathology (ISCCP)
& Obstetric and Gynaecological Society of Visakhapatnam (OGSV)

In Association With

Homi Bhabha Cancer Hospital & Research Centre, Visakhapatnam
A Grant in Aid Institution of the Department of Atomic Energy, Government of India

ISCCP CONFERENCE 2019

Theme "Benchmarking Cervical Cancer Prevention & Screening"

19, 20, 21 April 2019. Venue: **Novotel Vishakhapatnam Varun Beach**

Supported by:

Digumarti Foundation

Secretariat: Homi Bhabha Cancer Hospital & Research Centre, APIIC Industrial Park, Aganampudi, Visakhapatnam 530 053 Andhra Pradesh.