



E-Newsletter

ISCCP

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

Secretariat: Department of Obstetrics & Gynaecology,
MAMC & Lok Nayak Hospital, New Delhi 110 002

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Editor's Message

Dear Friends

Greetings & best wishes for the new year!

Friends, you are the empowered, let us also empower all our women by preventing them against the menace of cervical cancer by screening & vaccination.

We urge you carry out some activity this year to spread the message, let the fire in you ignite many more to wipe out the menace!

"Change your thoughts and you can change your world"

- Norman Vincent Peale

In this issue Pakhee brings you an article on the latest Colposcopic terminology. Veena & team invite you for the annual meeting at Mumbai, hurry up & fill in the registration form. Hope to see you all soon in Mumbai.

Saritha Shamsunder
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Forthcoming Events

8th Annual Conference of ISCCP
at
Mumbai

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Dr Nikhil Parwate
nparwate@hotmail.com

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Updates in Colposcopic Terminology

Dr Padmini¹, Dr Pakhee Aggarwal²

¹Senior Resident, ²Assistant Professor, Department of Obstetrics & Gynecology, Lady Hardinge Medical College and Associated Hospitals, New Delhi

Cervical cancer is the leading cause of cancer death in women in both rural and urban areas of India. It has a death rate of 16 per 100 000 suggesting that a 30-year old Indian woman has about 0.7% risk of dying from cervical cancer before 70 years of age in the absence of other diseases¹. Although there has been a regular campaign against cervical cancer for 30 years in India, this has had little impact on the morbidity and mortality from the disease, with India ranking fourth worldwide. This article covers the recent updates in colposcopic terminology given by International Federation for Cervical Pathology and Colposcopy (IFCPC) in 2011.

2011 Colposcopic Terminology of the Cervix

The 2011 terminology (Table 1) was proposed by IFCPC to describe features of disease to aid those who are trained and those in training to identify significant disease, plan treatments in a rational way to avoid over treatment of CIN and to describe colposcopic features to facilitate research collaboration.

Table 1: 2011 Updated Colposcopic Terminology of the Cervix³

General assessment		<ul style="list-style-type: none"> • Adequate /inadequate for the reason • Squamocolumnar junction visibility • Transformation zone types 1,2,3 	
Normal colposcopic findings		Original squamous epithelium <ul style="list-style-type: none"> • Mature • Atrophic Columnar epithelium <ul style="list-style-type: none"> • Nabothian cysts • Crypt (gland) opening Deciduous in pregnancy	
Abnormal colposcopic findings	General principles	Location of the lesion	
		Size of the lesion	
	Grade 1(minor)	Thin acetowhite epithelium Irregular, geographic border	Fine mosaic Fine punctation
	Grade 2(major)	Dense acetowhite epithelium Rapid appearance of acetowhiting Cuffed crypt (gland) opening	Coarse mosaic Coarse punctation Sharp border Inner border sign Ridge sign
	Non specific	Leukoplakia (keratosis, hyperkeratosis), Erosion, Lugol's staining (schiller's test): stained /nonstained	
Suspicious for invasion		Atypical vessels	
		Additional signs: fragile vessels, irregular surface, exophytic lesion, necrosis, ulceration (necrotic), tumor/ gross neoplasm	
Miscellaneous findings		Congenital transformation zone, condyloma, polyp(ectocervical/ endocervical), inflammation	Stenosis, congenital anomaly, post treatment consequence, endometriosis

Thus, according to the new terminology the colposcopic examination should be assessed for three variables:

1. Adequate or inadequate, with the reason given;
2. Squamo-columnar junction (SCJ) visibility;
3. Transformation zone type

The popular terms “satisfactory colposcopy” and “unsatisfactory colposcopy” have been replaced by “Adequate or inadequate for the reason”. The examination may be inadequate because the cervix is obscured by inflammation, bleeding, or scarring. Squamo-columnar junction visibility may be complete when 360° of the squamo-columnar junction is seen and partially visible when most of the squamo-columnar junction is visible but a section of it is inside the endocervical canal or when a lesion covers the squamo-columnar junction with its inner border in the endocervical canal. The squamo-columnar junction may not be visible when all or most of the squamo-columnar junction cannot be seen because it is in the endocervical canal. It can be described as “completely visible”, “partially visible”, or “not visible”. The reason that the visibility and site of the squamo-columnar junction are so important is that it dictates the ability to do a complete examination and, when treatment is indicated, the extent and type of excision. The terms “adequacy” and “squamocolumnar junction visibility” are not mutually exclusive. For example, the squamo-columnar junction may be “partially visible” because a portion of its inner margin is located high in the endocervical canal, whereas the test is still “adequate” because the cervix itself is not obscured by blood or inflammation. The third parameter involves assigning a transformation zone type. Transformation zone has been classified into three types (a) Type 1 transformation zone is completely ectocervical and fully visible, and may be small or large (b) Type 2 transformation zone has an endocervical component, is fully visible, and may have an ectocervical component that may be small or large (c) Type 3 transformation zone has an endocervical component that is not fully visible and may have an ectocervical component that may be small or large (Fig. 1).

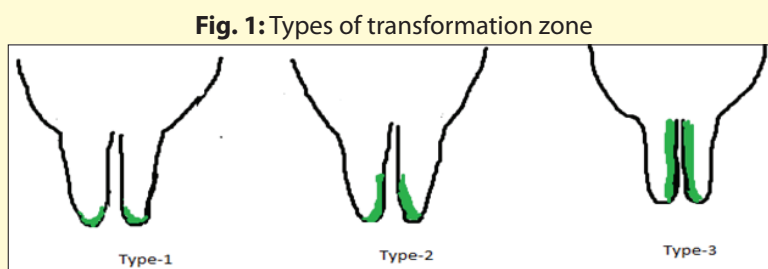


Fig. 1: The three types of transformation zone corresponding to the three excision treatment types

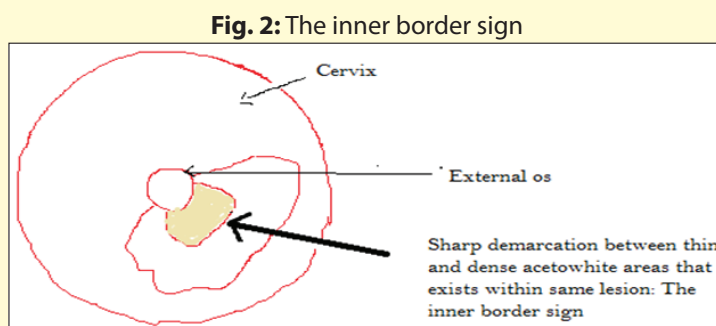
Salient features are the localization of the lesion and determinants of size of cervical lesion. Two new signs were included in the terminology- the “inner border sign” and “ridge sign”. In addition the terminology includes standardization of cervical excision treatment types and cervical excision specimen dimensions.

Location of the lesion is relative to the original squamo-columnar junction. “Inside” location means medial to the original squamo-columnar junction (towards the cervical os) and vice versa. Sharp border has also been associated with a more severe lesion. Other edge definitions are feathered or geographical margin, usually associated with a low-grade lesion, and rolled peeling edges that may be associated with a high-grade lesion. A lesion within the transformation zone, as opposed to one outside, has been shown to be an independent predictor of a high-grade lesion or carcinoma⁴.

The term leukoplakia or keratosis is considered a major lesion in the terminologies because leukoplakia or keratosis is shown to have a 25% independent predictive value of containing high-grade or invasive neoplasia⁵

The size of the cervical lesion has been found to have a predictive value for a high histologic grade⁶. Several determinants of size as well as of location of cervical lesions are included in this latest terminology: the number of cervical quadrants the lesions covers, size of the lesion as a percentage of the cervix, and location of the lesion by clock position(s).

The inner border sign (Fig. 2) is a sharp demarcation between thin and dense acetowhite areas within the same lesion⁷. The ridge sign is an opaque protuberance at the area of a white epithelium within the transformation zone⁸.



Miscellaneous findings: A cervical polyp is a common finding and is in the “miscellaneous findings”, including its origin as being ectocervical or endocervical.

Post-treatment effect may or may not be an adverse feature; for example, stenosis, deformation or distortion, scarring, thickening or increased fragility of the mucosa, cervical endometriosis.

Excision treatment types³ has been added to avoid using terms: “conization,” “cone biopsy,” “big loop excision”, and “small loop excision.” The excision of each of the transformation zone types is associated with a different technique as well as altered risk of incomplete excision and subsequent morbidity. The excision types corresponding to the transformation zone-type classification describes three types, which are classified according to the site, size, and visibility of transformation zone. The excision itself may be carried out by any of the accepted methods: large loop excision of the transformation zone (LLETZ), which is identical to loop electrosurgical excision procedure, by needle excision of the transformation zone, by straight wire excision of the transformation zone, or by cold knife conization.

Type 1 excision: It resects a completely ectocervical or type 1 transformation zone.

Type 2 excision: It resects a type 2 transformation zone. It will resect a small amount of endocervical epithelium that is visible with a colposcope.

Type 3 excision: It resects a type 3 transformation zone. It will resect a longer and larger amount of tissue than type 1 or type 2 excisions and will include a significant amount of endocervical epithelium. It may also be used to treat glandular disease or microinvasive disease or women who have had previous treatment.

Excision specimen dimension³

There is a lack of consensus in the published literature concerning the terms “length,” “depth,” and “height” of the specimen, the newer terminology advises abandoning the term “depth” and “height” and instead proposes the terms “length” and “thickness”³. Length is the distance from the distal or external margin to the proximal or internal margin of the excised specimen. Thickness is the distance from the stromal margin to the surface of the excised specimen. Circumference is the distance surrounding the perimeter of the excised specimen.

The Modified Reid Colposcopic Index has been the most popular scoring system to standardize colposcopic assessment. The variables included in it are colour of the lesion, lesion margin, vessels and iodine staining. In the new terminology test of Lugol’s staining (Schiller’s test) has been moved from the “minor grade” category to the “non-specific” category of the “abnormal colposcopic findings” section is because several studies such as those associated with the ASCUS-LSIL Triage Study showed poor reliability of Lugol’s staining^{9,10}.

Summary

Colposcopy is an important component of cervical cancer screening. An evidence based approach to colposcopy requires familiarity with 2011 colposcopic terminology update. The IFCCP recommends that the 2011 terminology replace all others and be implemented for diagnosis, treatment, and research. The popular terms satisfactory colposcopy and unsatisfactory colposcopy have been replaced. The colposcopic examination should be assessed for three variables: 1) adequate or inadequate, with the reason given; 2) squamo-columnar junction visibility; 3) transformation zone type. Although this terminology is different from the widely accepted Modified Reid Colposcopic Index, it is hoped that after wide dissemination this terminology may come into practice and help to standardize care of women being screened and treated for precancerous lesion.

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ISCCP-2013

15 ICOG credit points & MMC credit points applied

KEY ISSUES IN PREVENTION & EARLY DETECTION OF CERVICAL CANCER

VIII NATIONAL CONFERENCE OF THE INDIAN SOCIETY OF COLPOSCOPY & CERVICAL PATHOLOGY IN ASSOCIATION WITH DEPARTMENT OF PREVENTIVE ONCOLOGY TATA MEMORIAL CENTRE



23rd & 24th March, 2013 - Rustom Choksi Auditorium, Tata Memorial Centre, Mumbai

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