

## General review for Question 3b

### PICO Question 3b

For HPV-positive women with a referral cytology finding of p/dHSIL and who have an unsatisfactory colposcopy, what is the safety and effectiveness of conservative management compared with diagnostic excision of the transformation zone?

Population	Study design	Intervention	Control	Outcomes
HPV positive women who have undergone colposcopy and the colposcopy was unsatisfactory and cytology was: p/d HSIL	Randomized or pseudo-randomized controlled trial	Conservative management: Co-testing at 3-6 months or repeat HPV test at 12 months	Diagnostic excision of the transformation zone	Cervical cancer mortality Cervical cancer diagnosis Precancerous high grade lesion detection

*dHSIL = definite HSIL; HSIL = high-grade squamous intraepithelial lesion; pHSIL = possible HSIL*

### Definitions

**An unsatisfactory colposcopy** is a colposcopy in which the transformation zone is not fully visible (Jordon et al., (2008) European guidelines for quality assurance in cervical cancer screening: recommendation for clinical management of abnormal cervical cytology, part 1. Cytopathology 19: 432-354).

### Background to this general review

A systematic search of the literature found no studies that directly addressed this question (Please see Question 3a and b technical report). As a result it was decided to undertake a general review of the literature on the management of women with HSIL cytology and an unsatisfactory colposcopy to inform the drafting of relevant consensus-based recommendations.

## GENERAL REVIEW OF THE LITERATURE

### Existing guidelines

#### 1. Current (2005) Australian guidelines

*Cone biopsy may be necessary to treat women with high-grade squamous lesions and absolute indications that include: failure to visualise the upper limit of the cervical transformation zone in a woman with a high-grade squamous abnormality on her referral cervical smear (ie unsatisfactory colposcopy. (Consensus)*

*Careful attention should be paid to tailoring treatment to the individual woman, taking into account the size, extent, situation and severity of the lesion. (Consensus)*

## 2. Other existing potentially relevant guidelines

Title	Organisation	Evidence-based?	Recommendation
2012 Updated consensus guidelines for the management of abnormal cervical cancer screening tests and cancer precursors	American Society for Colposcopy and Cervical Pathology.	Consensus based on literature searches and Kaiser Permanente Northern California data	A diagnostic excisional procedure is recommended for women with <b>HSIL</b> when the colposcopic examination is inadequate, except during pregnancy (BII).
2012 Colposcopic management of abnormal cervical cytology and histology	Society of Obstetricians and Gynaecologists of Canada	Unclear as to evidence base	In women with <b>HSIL</b> , when the transformation zone is not seen in its entirety and endocervical curettage and/or biopsy results are negative, a diagnostic excisional procedure should be considered. (III-B) An endocervical curettage should be performed when the transformation zone is not visible in women with an AGC Pap smear and in women over 45 years old with <b>high-grade cytology</b> . (II-2B)
2009 European guidelines for quality assurance in cervical cancer screening: recommendations for clinical management of abnormal cervical cytology, Parts 1 and 2	European Cancer Screening Network and European Cancer Network	Unclear if evidence based	For women with <b>HSIL</b> cytology if colposcopy is unsatisfactory, presence of an endocervical localization of the lesion must be ruled out, therefore diagnostic excision of the TZ or conisation should be performed. <b>High grade abnormal cytology confirmed on review</b> If the SCJ is not visible, and no abnormality can be identified on the cervix or the vagina, then the TZ should be excised in its visible entirety and the lower third of the endocervical canal should also be removed. This should be followed by an endocervical curettage.

### Search Strategy

Medline, Premedline and Embase databases were searched from 2004 onwards for studies reporting outcomes for women with unsatisfactory or inadequate colposcopies. We examined these studies for any relevant data for women with possible or definite HSIL diagnosis on initial cytology

## Results

**Question 3b:** Results for women with normal cytology and HPV positive, or a possible or definite **HSIL** diagnosis on initial cytology

Longitudinal studies following-up women with p/dHSIL initial cytology and an unsatisfactory colposcopy and review cytology p/dHSIL – **No studies found**

Longitudinal studies following-up women with p/dHSIL initial cytology and an unsatisfactory colposcopy – **No studies found**

Cross-sectional studies of women with p/dHSIL initial cytology and an unsatisfactory colposcopy – **2 studies (Table 1)**

**Table 1:** Characteristics and results of studies of women with **p/dHSIL** initial cytology and an unsatisfactory colposcopy

Study	Study design	Population	Results
<b>Women underwent LEEP</b>			
Massad 2005 (USA)	Retrospective cohort Cross-sectional	Women with <b>HSIL cytology</b> who underwent colposcopy between 1996 and 2002 which <b>was unsatisfactory</b> (entire transformation zone including squamocolumnar junction not visible) followed by <b>LEEP</b> N = 78 HPV status not reported No information as to review cytology for a given referral cytology status LEEP (individualised) undertaken for unsatisfactory colposcopy following HSIL cytology	<b>Women with unsatisfactory colposcopy n = 78</b> 55.1% (n = 43) diagnosed with CIN2+ disease on LEEP 1.3% (n = 1) diagnosed with cervical cancer on LEEP <b>Women with unsatisfactory colposcopy and HSIL on review cytology n = 47</b> 74.5% (n = 35) diagnosed with CIN2+ disease on LEEP 2.1% (n = 1) diagnosed with cervical cancer on LEEP
<b>Women underwent cone biopsy</b>			
Da Viegua 2009 (Brazil)	Retrospective cohort Cross-sectional	Women with <b>HSIL cytology</b> who underwent colposcopy between 1989 and 2007 with <b>no visible lesions</b> and which <b>was unsatisfactory</b> (entire transformation zone not visible) followed by <b>cervical conisation</b> N = 65 Mean age = 46 years HPV status not reported Review cytology not reported Conisation undertaken for unsatisfactory colposcopy following HSIL cytology	<b>Women with unsatisfactory colposcopy and no visible lesions on colposcopy n = 65</b> 38.5% (n = 25) diagnosed with CIN2+ disease on conization 4.6% (n = 3) diagnosed with cervical cancer on conization

*CIN = cervical intraepithelial neoplasia; CIN2+ = cervical intraepithelial neoplasia grade 2 or worse; HSIL = high-grade squamous cell lesions; LEEP = loop electrosurgical excision procedure*

## References

1. Massad LS, Tate N, Cejtin E et al. Quantifying the risk of cervical intraepithelial neoplasia in women with unsatisfactory colposcopy results. *J Low Genit Tract Dis.* 2005;9:23-28.
2. Veiga FR, Russomano FB, Camargo MJ et al. Prevalence of high-grade squamous intraepithelial lesions and cervical cancer among patients with unsatisfactory colposcopic examination, without visible lesion. *Sao Paulo Med J.* 2009;127:266-26

DRAFT

