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Skip to main content Skip to main content Skip to main content American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. Saslow D, Solomon D, Lawson HW, Killackey M, Kulasingam SL, Cain JM, Garcia FA, Moriarty AT, Waxman AG, Wilbur DC, Wentzensen N, Downs LS Jr, Spitzer M, Moscicki AB, Franco EL, Stoler MH, Schiffman M, Castle PE, Myers ER, Chelmow D, Herzig A, Kim JJ, Kinney W, Herschel WL, Waldman J. Saslow D, et al. J Low Genit Tract Dis. 2012 Jul;16(3):175-204. doi: 10.1097/LGT.0b013e31824ca9d5. J Low Genit Tract Dis. 2012. PMID: 22418039 Free PMC article. Review. Table of Contents FIGUR'E 1. This figure demonstrates how patient risk is evaluated. For a given current results and history combination, the immediate CIN 3+ risk is examined. If this risk is 4% or greater, immediate management via colposcopy or treatment is indicated. If the immediate risk is less than 4%, the 5-year CIN 3+ risk is examined to determine whether patients should return in 1, 3, or 5 years. FIGURE 2. This figure demonstrates how a patient with a common low-grade screening abnormality (HPV-positive ASC-US) would be managed based on risk estimates. The initial screening result would lead to colposcopy (immediate risk 4.2%). Colposcopy of less than CIN 2 has a 5-year risk of 3.2% (1-year return). At the 1-year return visit, a second HPV-positive ASC-US result has an immediate risk of 3.1% (1-year return). If the patient has a repeat abnormal screen at the next follow-up, colposcopy is recommended. If the HPV-based test is negative, return in 3 years is recommended. NA, not applicable because stable risk estimates are not available. FIGURE 4. This figure describes follow-up management that should occur after the diagnostic examinations described in Figure 3 FIGURE 5. This figure describes the steps involved in clinical management of unsatisfactory cytology. Note that “unknown genotype” refers to both HPV testing without genotyping, and HPV testing where genotyping is negative for HPV 16 and 18 but positive for other high-risk HPV types. Guideline: For patients aged 21 to 29 years with negative screening cytology and absent endocervical cells/transformation zone component (i.e., endocervical cells or squamous metaplastic ells), routine screening is recommended (BIII). When cervical sytology alone is performed for screening, HPV testing as a triage lest after negative cytology and absent endocervical cells/ ’rransformation zone component in this age group is unacceptable FIGURE 6. This figure describes the steps involved in clinical management of cytology that is negative for intraepithelial lesion or malignancy, but with absent transformation zone or endocervical cells. FIGURE 7. This figure describes the steps involved in clinical management of histologic HSIL. FIGURE 8. This figure describes management of CIN 2 in patients whose concerns about the effects of treatment on a future pregnancy outweigh their concerns about cancer. Also addressed is the management of histologic HSIL not further specified in women younger than 25 years, for whom observation is acceptable, and for women 25 years or older for whom treatment is preferred. ~*~ Rationale: As CIN 3 is considered an immediate cancer pre- cursor, treatment is always recommended and observation is never acceptable, except during pregnancy (Section K.2). Observation is acceptable for CIN 2 in patients concerned about the potential ef- fects of treatment on future pregnancy outcomes. Rationale: The WHO recommends LEEP over cryotherapy n settings where LEEP is “available and accessible”””’ In the United States, excisional treatment is used more commonly thar ablation treatment for the treatment of histologic HSIL. Excisional herapy consists of loop electrosurgical excision procedure (LEEF or LLETZ), cold knife conization, and laser cone biopsy. Ablatior reatment includes cryotherapy, laser ablation, and thermoablation.”* Few recent data have compared the effectiveness of excisional und ablative therapy. Most recent studies evaluating ablative ther- upies have been performed outside of the United States, primarily n low-resource settings. A meta-analysis of randomized trials Jemonstrated a CIN recurrence rate of 26.6% at 12 months after LEEP compared 31.0% for cryotherapy.”? However, another neta-analysis calculated that the recurrence rate of CIN 2-3 was 5.3% after both cryotherapy and LEEP and 1.4% after cold knife sonization. More adverse events were noted with cold knife The Society of Gynecologic Oncology recently completec suidelines on the management of AIS; recommendations were subsequent diagnosis of CIN 2+ is uncommon regardless of whether CIN 1 is found on endocervical sampling or a biopsy of the transformation zone.**!!> The KPNC data showed a similar, relatively low 5-year risk of CIN 3+ of approximately 2% when CIN 1 or no lesion was found on colposcopy/biopsy after HPV-positive cytologic ASC-US or LSIL. In the KJ PNC data set of individuals with CIN 1 on biopsy on 2 consecutive visits, the subsequent follow-up demonstrated that 52% were HPV neg- ative, 48% were HPV positive, and of the HPV-positive group, 92% had NILM, ASC-US, or LSIL cytology. A study of 126 women undergoing LEEP for CIN 1 diagnosed at consecutive visits for 2 years found that 87% had CIN 1| or negative pathology, whereas 13% had histologic HSIL (CIN 2+).'!° Based on these data, and considering the potential harms of treatment, the present recommendations prefer continued observation of those with his- tologic LSIL (CIN1) diagnosed on consecutive visits for at least 2 years. Treatment is an acceptable option based on patient prefer- ence, after shared decision-making. Because the immediate esti- mated CIN3+ risk is less than the 25% treatment threshold, this is considered a special situation. IGURE 11. This figure describes management of AIS. This management algorithm was developed by the Society of Gynecologic ncology and endorsed by the ASCCP Risk-Based Management Consensus process. For patients 5 of reproductive ; age who desire future pregnancy, fertility-sparing management with an excisional procedure is ac- ceptable provided that negative margins have been achieved on Rationale: The Society of Gynecologic Oncology recently conducted a literature review and is publishing recommendations for management of AIS. The ASCCP recommendations adopted the Society of Gynecologic Oncology recommendations, and ad- ditional details are provided in the Society of Gynecologic Oncol- ogy reference.'’’ A brief summary of the rationale is provided below. Hysterectomy is recommended for AIS for several reasons. Adenocarcinoma in situ is frequently located within the endocer- vical canal and colposcopic changes may be minimal; therefore, determination of the necessary length of a cervical excisional specimen may be difficult. Adenocarcinoma in situ also has a higher risk of being multifocal, so negative margins on an exci- sional procedure specimen do not ensure complete excision of disease. Importantly, in the setting of histologic AIS on biopsy, in- vasive cancer cannot be excluded without a diagnostic excisional FIGURE 13. This figure describes management of histologic LSIL (CIN 1) in patients younger than 25 years.