	ASCCP	BSCCP
3 Borderline Nuclear Changes(ASCUS) in a 10yr period, or 3 Inadequate Samples	**11% CIN2+** - Cytology: X2 negative, or 6mo,12mo,24mo - Colposcopy: HPV, Cyto - HPV DNA	**36% prospective study CIN2+** **Refer For Colposcopy** X3 negative – routine recall (If Endocervical cells, immediate referral for colposcopy – 4-16% malignant changes, 17-40% pre-invasive disease)
LGSIL **(Mild Dyskaryosis)**	For Colposcopic assessment, unless adolescent.	Recommended: Immediate referral for Colposcopy If Normal, repeat cytology at 6months, otherwise, repeat colposcopy in 1 yr If persistent after 2 years, Biopsy Acceptable: 1 repeat test 3 negative tests required to discharge to routine recall 14-64% incidence of CIN2+ TOMBOLA Study
HGSIL/ASCUS-H **(Moderate/Severe Dyskaryosis)**	For Colposcopy – Treatment depends on if 'Special Population'	IMMEDIATE colposcopy referral 62-day treatment pathway and 18wk commitment pathway if cancer excluded. Multiple biopsies recommended 'See And Treat' Criteria 77-90% incidence of CIN 2+
AGN	– If atypical endometrial cells, then for endometrial and endocervical sampling. Colposcopy only if no endometrial pathology – Other types of glandular neoplasia, for colposcopy	? Invasion (56% PPV for Ca) ?glandular cells (40-43% Ca, 20-20% pre-invasive) - **Immediate colposcopy**
Benign Endometrial cells in LBC		<40 not significant >40 and after D14 menses, refer!
CIN 1	- If preceded by low grade smear, No treatment necessary. – If high grade smear, either treat or follow-up with 6monthly colposcopy+cytology. – If negative smears x2, routine followup.	After Rx: After 2 years of negative cytology, routine recall
CIN 2/3	20yrs followup.	CIN 3 extending to margins: - Repeat cytology and coloposcopy recommended,

		as long as not ?glandular/? invasion and <50yrs old. Follow-up: 6mo, 12mo, then yearly for 10yrs
AIS/cGIN	Hysterectomy or uterine conserving cervical excision therapy cGIN: 6monthly for 5 years, then annual for 5 years. Must contain endocervical cells. (No role for punch biopsy!) Cone Biopsy recommended: <36yrs old: 1cm above TZ >36yrs old: 2.5cm above TZ	

1) HPV not mainstream screening tool (Good negative predictive value, but less specific) (ARTISTIC and POBASCAM Studies)

2) Test of cure Study: If Cytology & HPV negative at 6/12, then risk of CIN2+ <0.5% over 2 years.

3) Post-Hysterectomy: Discretion of Gynaeoncologist and MDT

4) BSCCP Followups

   - Priority Type 3 (2-wk wait)
   - 31days to treatment for Ca
   - 62 day referral to treatment
   - 18wks commitment

5) Infections:

   - ALO (If Asymptomatic, no treatment; if symptomatic, amoxicillin 250mg tds or erythromycin 500mg tds for 2/52)
   - BV, Candida: Treat only if symptomatic (Treat BV if patient pregnant)
   - Herpes/Trichomonas: Refer to GUM clinic and Treatment required

     (Acyclovir 200mg 5x/day for 5days; Flagyl 400mg tds for 1/52)

6) Immunosuppressed:

   - HIV annual screening
   - Renal Transplant (Cytology within a year of transplant)
   - No evidence to suggest anything other than routine screening in patients taking cytotoxic/chemo drugs/steroids.
   - CKD/Transplant patients also subject to routine recall

7) Ablative therapy suitable only if:

- Entire TZ seen
- No glandular abnormality/no invasion
- No major discrepancy between cytology and histology
- If >50yrs old, must have good reason for carrying out ablation

8) Ectocervical lesions: Depth >7mm recommended (CIN 3 mean depth: 1-2mm with max 5.2mm and +3SD(99.7%) of 3.80mm.

9) Followup – With Endo-cervex brush

10) Post-Hysterectomy:
    - Routine recall, no CIN
    - Not on routine recall, no CIN (6/12 post-op)
    - Completely excised CIN (6 + 18 months)
    - Incompletely excised CIN

      (CIN 1: vault smear at 6,12,18mos; CIN2/3:Vault smear 6 and 12mos, then anuualy x9)

      Followup 10yrs post-op or until 65, whichever is later

      Initial CIN, post hysterectomy (Recurrent intra-epithelial lesion 522 vs 1487 per 100k women years in Hystereectomy, compared to excisional treatments; Invasive lesions similar 57vs67/100k)
    - Trachelectomy – Colpscopy/Cytology followup

11) Specificity of high grade cytology in diagnosing CIN2+ ~90%; Colpscopic anomaly detection ~48%, Colposcopic detection of high grade anomalies ~57%)

12) Special Populations
    - Pregnancy (end 2nd trimester colposcopy if ?invasive; otherwise wait 3/12 post-partum. Treating during pregnancy increases risks of persistent disease)
    - IUCD
    - Hyseterectomy
    - IUCD
    - HRTs
    - In-Utero DES exposure (Initial colposcopy, then either routine or annual screening)

13) Endocervical Curettage to diagnose GIN: not recommended as sensitivity poor!! (Offer Cone Biopsy instead)

- Lucas Luk (2013)