Cervical Screening programme NI
GP update

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Learning Objectives

- Take a high quality cervical smear
- Know how and when to refer to colposcopy (including clinical indications)
- Understand colposcopy management and follow up
- Apply correct post hysterectomy follow up

Why smear quality matters?

- Screening alone prevents 70–80% cervical cancer
- Inadequate samples → repeats & anxiety
- Missing TZ → missed CIN
- Technique directly affects detection

The TZ

Anatomy of Transformation Zone

The transformation zone is where columnar and squamous epithelia meet and where most cervical cancers develop.

HPV Vulnerability

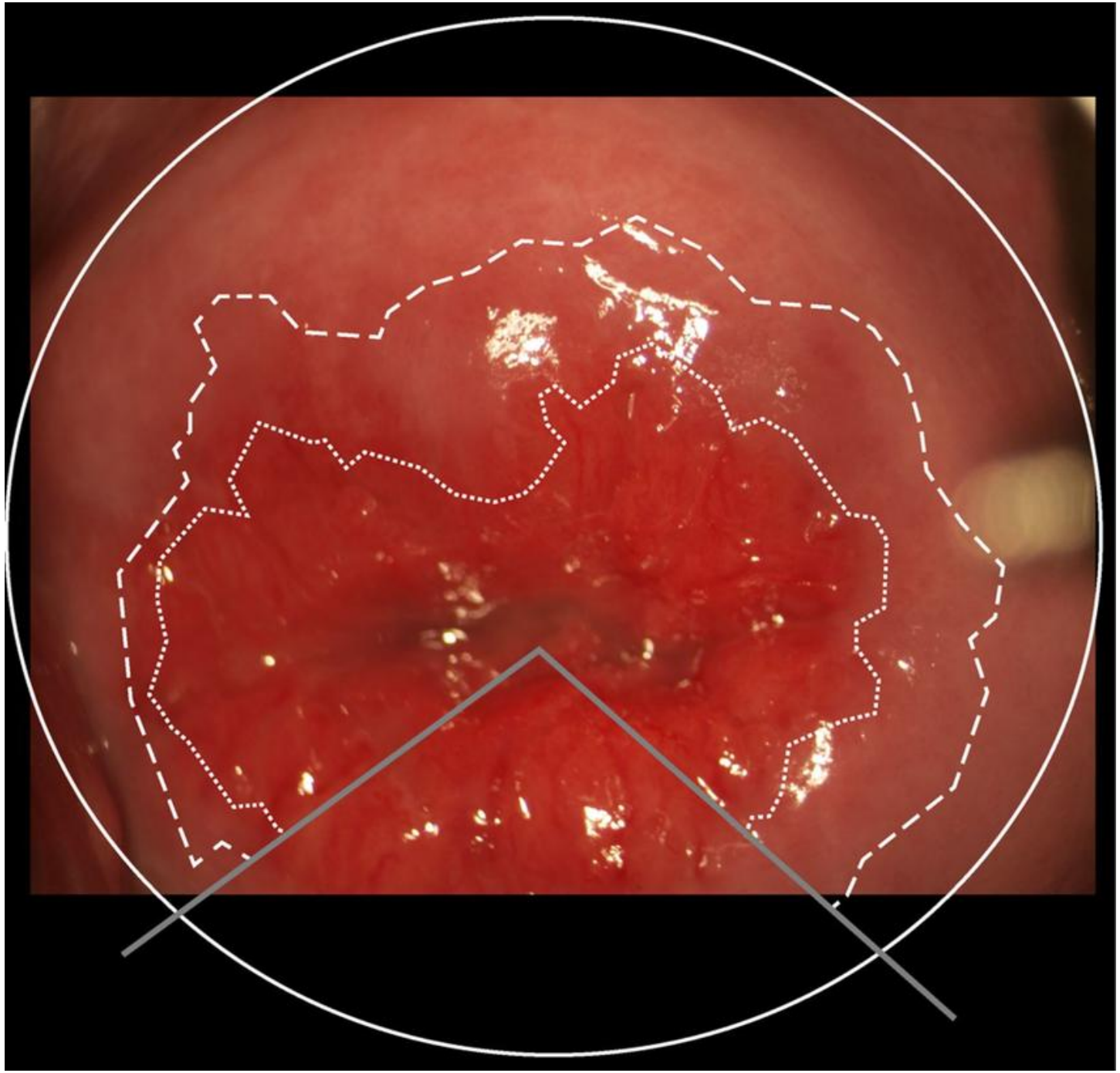
Immature metaplastic cells in the zone are highly susceptible to high-risk HPV infection causing cervical lesions.

Dynamic Positioning of TZ

The transformation zone shifts location during puberty, pregnancy, and menopause.

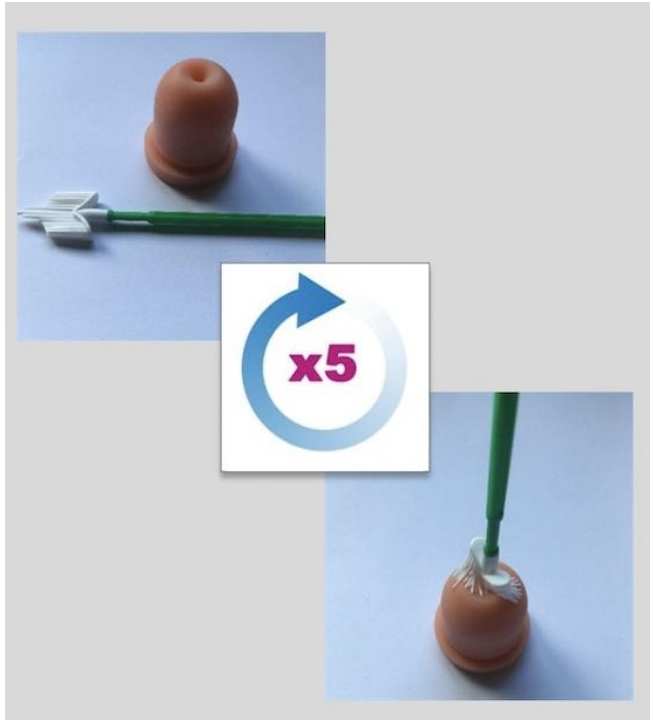
Importance of Targeted Sampling

Effective cervical screening requires identifying and sampling the entire transformation zone despite its movement.



Obtaining an adequate sample

- CIN can develop anywhere in the vaginally exposed columnar epithelium.
- The position of the TZ varies
- If the SCJ is visible the sample must include the whole circumference of the SCJ and 1cm of squamous epithelium
- If the SCJ is in the endocervical canal and not visible the sample must include cells from the canal in addition to the ectocervix

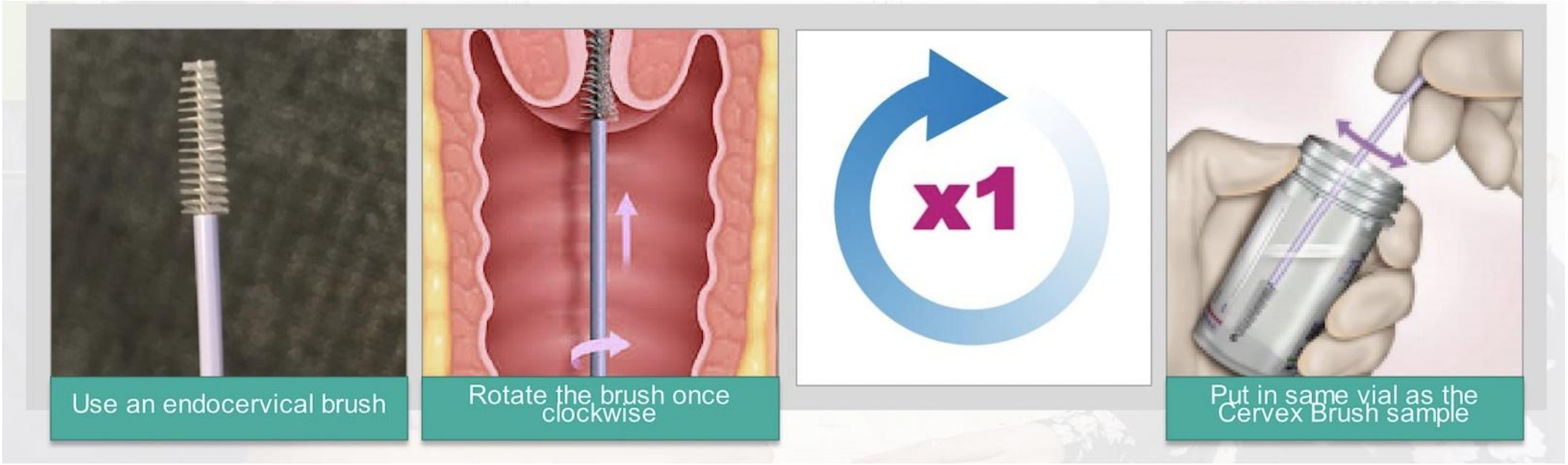


Insert the central bristles of the brush into the endocervical canal so that the shorter, outer bristles are in full contact with the ectocervix.

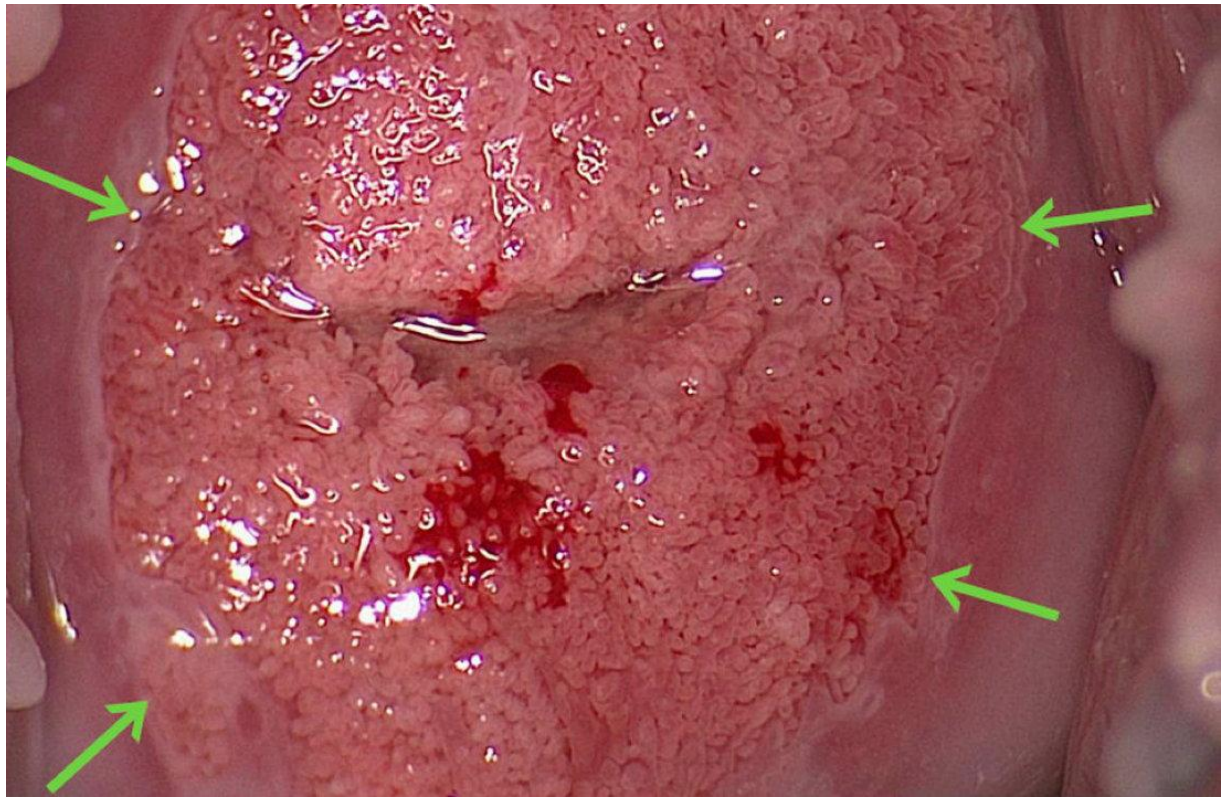
Using pencil pressure, rotate the brush five times clockwise.

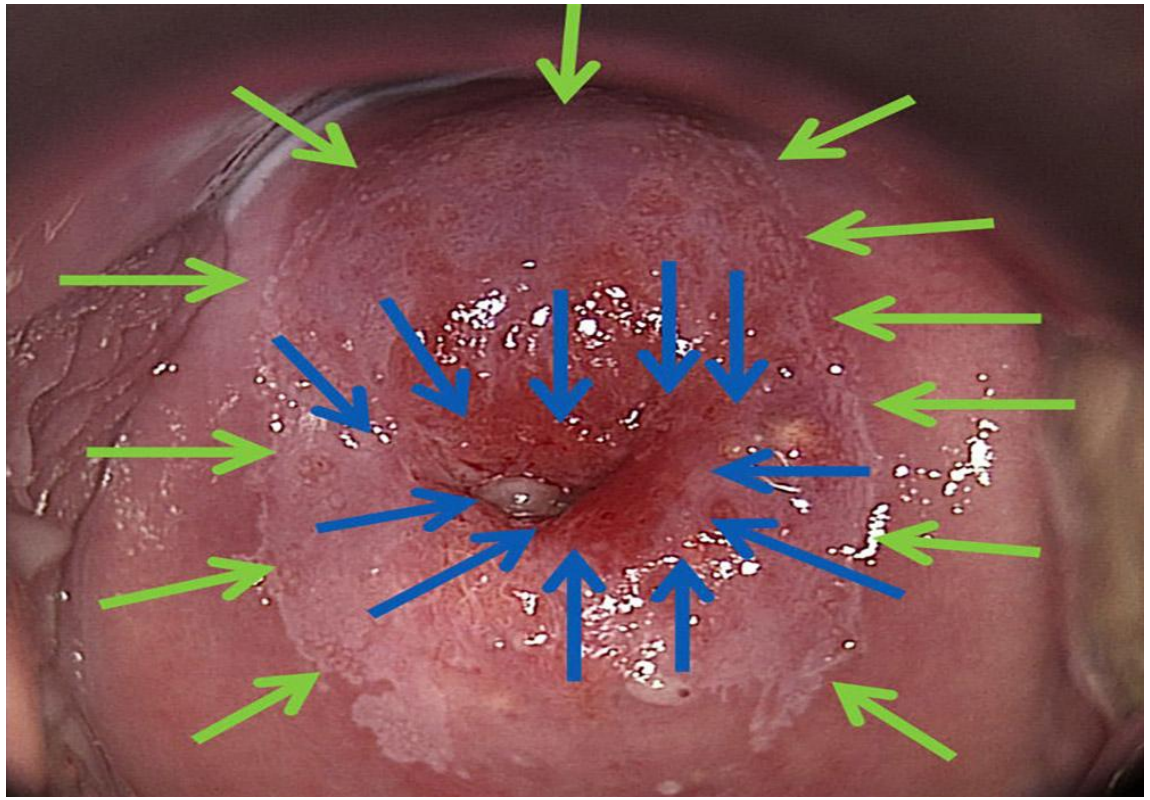
If you see a wide ectropion use a Cervex-Brush® to collect the sample as above.

Use the same brush or an additional Cervex-Brush® to sample the squamocolumnar junction put both samples in the same vial and record it on the cytology request form



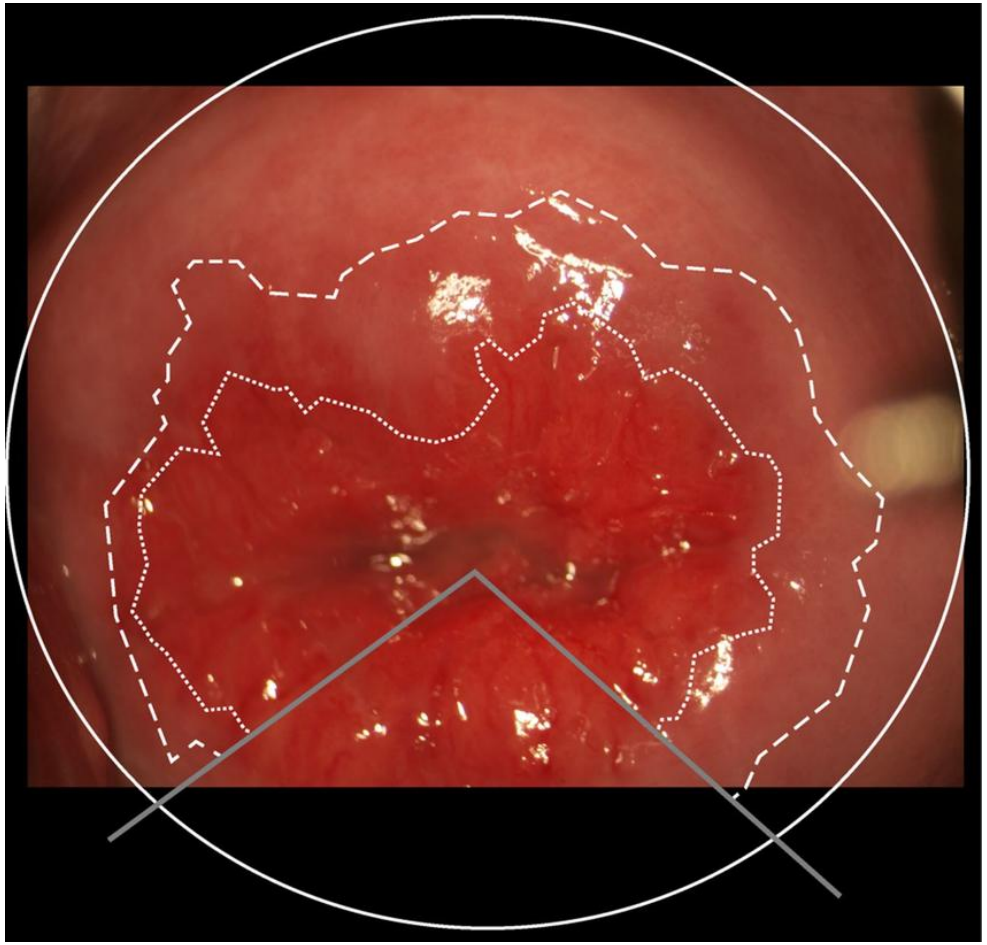
The Squamocolumnar Junction varies in size and shape





Normal cervix





Atrophic Cervix



Factors affecting whether cervical screening is appropriate?

- Symptoms suggestive of cervical cancer require referral, not routine screening.
- Avoid screening during menstruation if possible.
- No sexual intercourse for 24 hours before screening.
- Menopausal patients may require lubrication or short-term vaginal oestrogen.
- Delay screening 12 weeks after cervical procedures.

Colposcopy referrals- Screening programme

- High grade referrals should be seen within 2 weeks
- Low grade referrals should be seen with 6 weeks
- Over 2/3 of referrals are low grade and the majority can be managed conservatively.
- Around 10 % referrals are for clinical findings not related to the screening programme, these are sent from the GP practice via CCG pathways.

“Contact bleeding at time of smear taking is not an indication for referral”

Management and referral guidelines for Colposcopy NHSCCP

Referrals for clinical indications- PCB/ abnormal cervix

Abnormal cervix- sample takers must make a suspected cancer pathway referral for individuals if on examination, the appearance of the cervix is consistent with cervical cancer **NHSCCP**

Appearance of cervix consistent with cervical cancer- consider a suspected cancer pathway referral (2 week wait) **NICE**

Red flag referral- patients with clinical features of cervical cancer. A smear test is not required and a previous negative result should not delay referral.
Consider red flag referral for patients with persistent IMB and negative pelvic examination **NICAN**

Individuals presenting with symptoms of cervical cancer are not suitable candidates for screening (for example post coital bleeding or persistent vaginal discharge.....) If the common causes are excluded.....the individual must be referred for examination by a gynaecologist experienced in the management of cervical disease **NHSCCP**

PCB

Experienced by 6% of women per year

- Evidence for the precise ppv of post coital bleeding for cervical cancer is poor
- 1 in 44000 aged 20-24 and 1 in 2400 aged 45-54 will have cervical cancer
- Majority of cases are not malignant, chlamydia and problems with contraception most likely causes.
- Often associated with IMB and other symptoms

Box 1. Causes of postcoital bleeding

Benign conditions
- Urogenital atrophy
- Benign vascular tumours of the genital tract, e.g. haemangiomas, A-V malformation
- Cervical or endometrial polyps
- Cervical ectropion
- Cervical endometriosis

Infection
- Vulvovaginitis secondary to candidiasis or trichomonas
- Cervicitis secondary to chlamydia or gonorrhoea
- Endometritis in presence of intrauterine coil device (IUCD)

Vulval
- Vulval dermatoses, e.g. lichen sclerosus
- Genital warts
- Genital ulcers, e.g. herpes, chancroid
- Syphilis
- Lymphogranuloma venereum

Malignancy
- Vulval cancer
- Vaginal cancer
- Cervical cancer
- Endometrial cancer

Other
- Trauma and genital piercings
- Bleeding disorders
- Foreign bodies
- Sexual abuse
- Pregnancy-related
- Female genital mutilation (FGM)

Regional Variation in practice

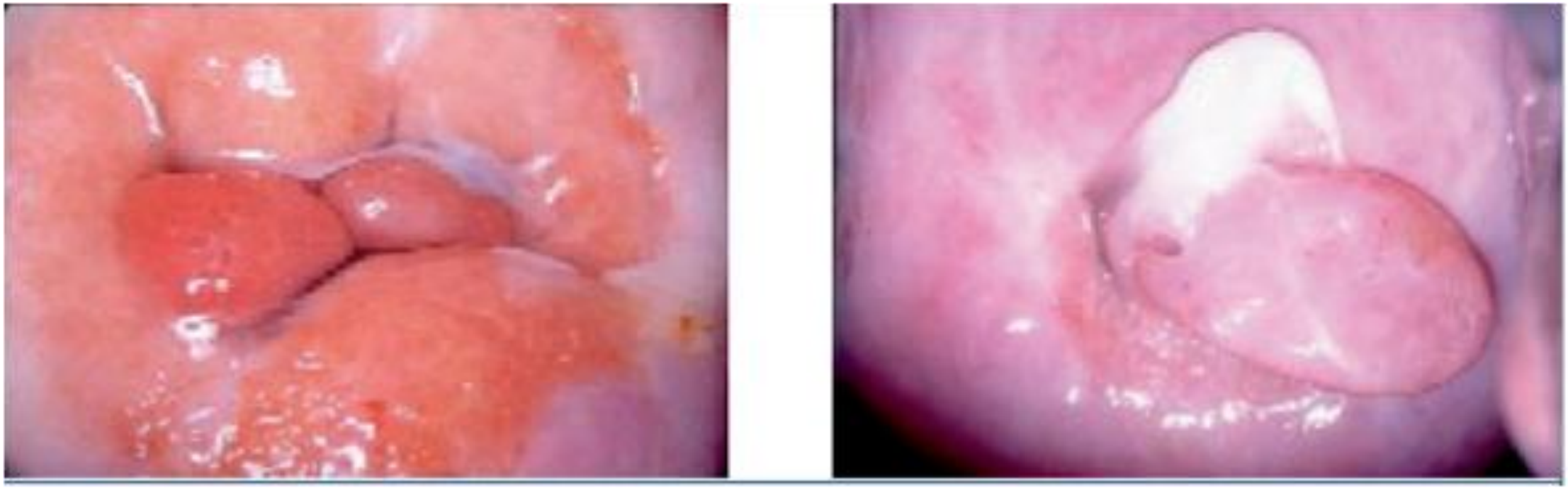
Belfast Trust- dedicated ‘Cervix’ clinic. No access to colposcopy or biopsy.

Northern Trust- Colposcopy for cervical screening only, abnormal cervix and symptomatic patients seen in gynae clinic

Southern- all go to Colposcopy

Western- abnormal screening history Colposcopy, normal screening history gynae.

Cervical polyps

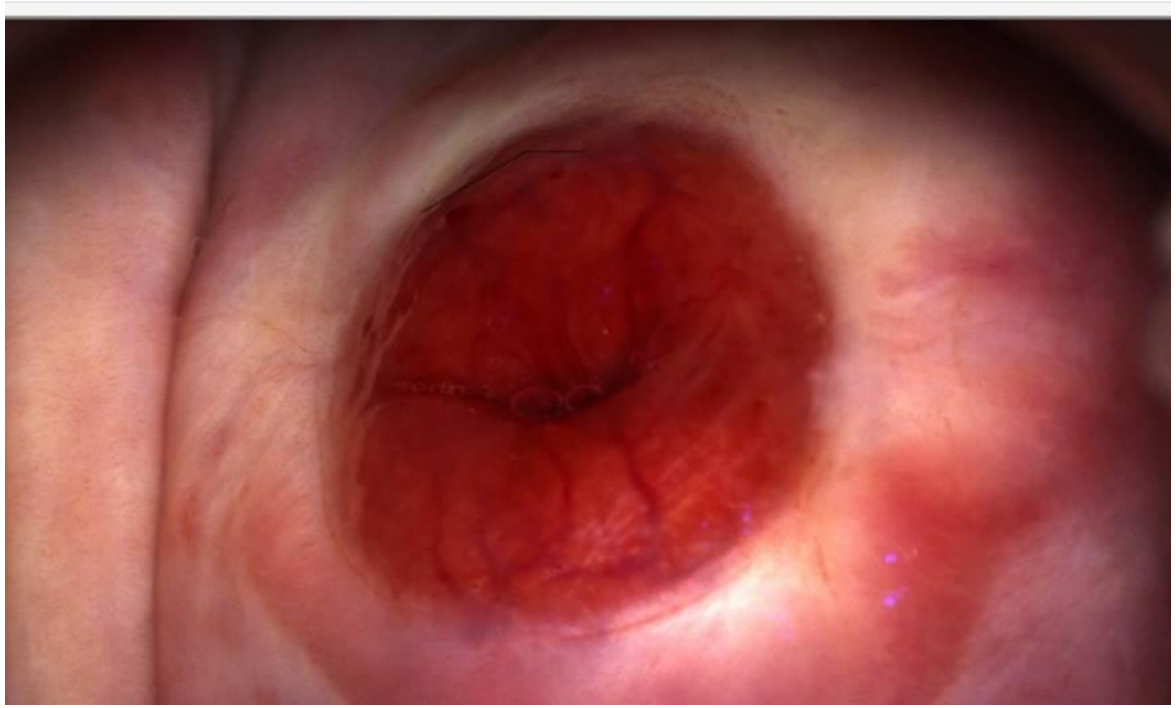


Nabothian follicles

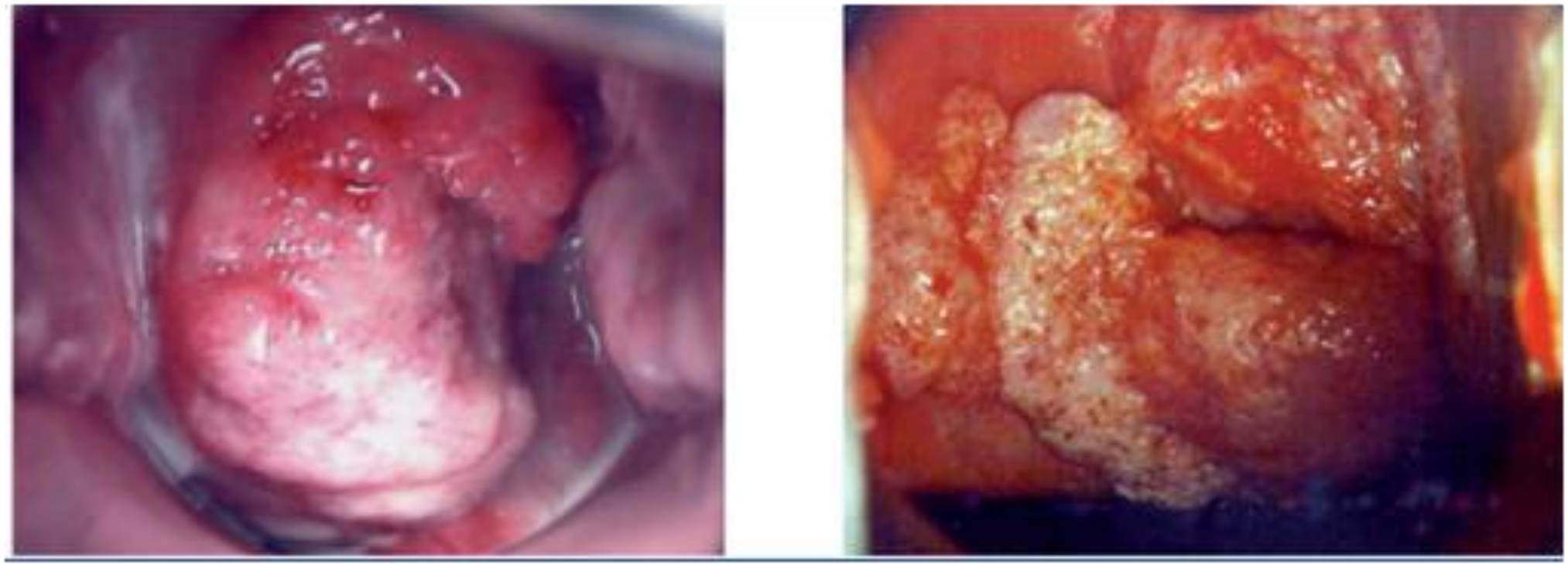


Previous LLETZ





Cervical Cancer

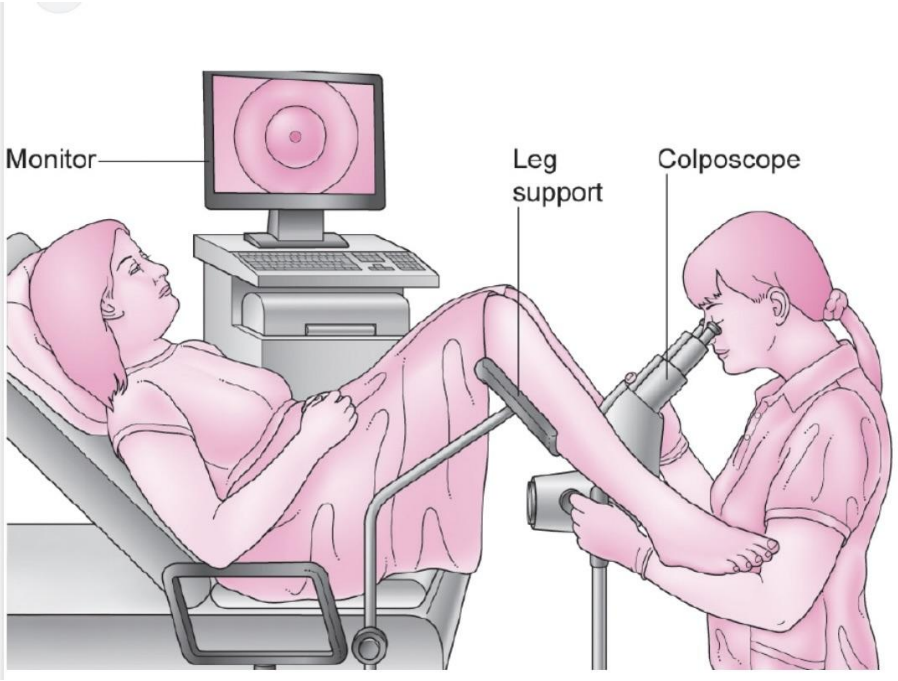


Colposcopy

A Colposcope is an optical system that offers illumination and magnification between 10 and 16 times

Examination should be assessed for:

1) adequate or inadequate, with the reason given
2) squamocolumnar junction visibility
3) transformation zone type
4) position and size of the Lesion.
5) Location of the lesion by clock position



Cervical Abnormalities

Before and after application of acetic acid





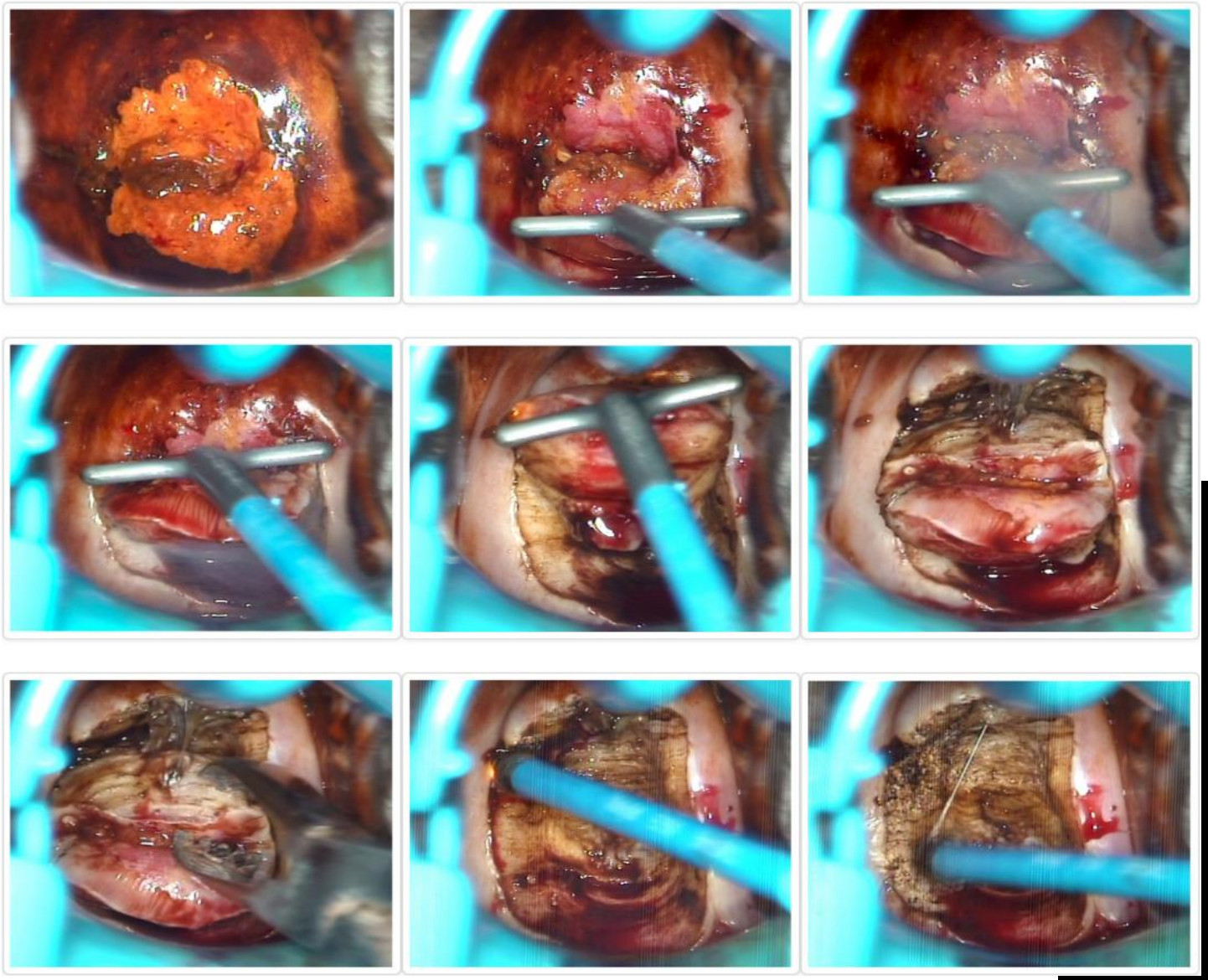




Treatment of CIN

- Cervical premalignant lesions can be treated either by an ablative method (cold coagulation) or by excision (LLETZ) depending on certain criteria.

- The basic principles of treatment of cervical intraepithelial neoplasia is the entire transformation zone should be treated (ablated or excised), irrespective of the size of the lesion.



Conservative management

- Offered for low grade abnormalities seen on colposcopy or biopsy.
- Toc smear facilitated at smear clinic at 12 months (variation from NHSCCP)
- Treatment offered if lesion has not resolved within 2 years.
- Conservative management of CIN 2 not routinely offered in NI.

Follow up following treatment and conservative management

- NI practice varies from NHSCCP guidance.
- Patient attend smear clinics in secondary care at 6 month or 12 month intervals for TOC
- When suitable for discharge a letter is sent to patient and GP and failsafe notified to return patient to routine recall- vital step.

Follow up after hysterectomy- Vault smears secondary care

Category	Management
Routine recall and with no CIN in their hysterectomy specimen	No further vaginal vault sampling is required.
Not on routine recall, and with no CIN in their hysterectomy specimen	Vaginal vault HPV test at six months following their hysterectomy and then ceased if the hrHPV test is negative.
Completely excised CIN on the hysterectomy specimen	Women who undergo hysterectomy and have completely excised CIN should have vaginal vault sample at 6 months following their hysterectomy; if they have a negative HPV result they can be discharged from the screening programme. Women who have completely excised CIN, and are hrHPV positive cytology negative at 6 months, should be referred to colposcopy; if there is no evidence of VaIN at colposcopy the individual can be discharged from the screening programme.
Incompletely excised CIN (or uncertain excision) on the hysterectomy specimen	women who undergo hysterectomy and have incompletely excised CIN (or uncertain excision), primary HPV screening follow up should be CIN 1: vault sample at six, 12 and 24 months. CIN 2/3: vault sample at six and 12 months, followed by nine annual vault samples. Follow up for incompletely excised CIN continues to 65 years or until ten years after surgery (whichever is later)

KEY TAKE-HOME MESSAGES

- Sample the whole TZ
- High grade referrals target changed to 2ww- need for timely patient results letters.
- Symptoms/ suspicious cervix require 2ww referral (will be triaged at secondary care to gynae or colposcopy).
- TOC and vaults smears taken in secondary care in NI