### Title of Guideline: (must include the word “Guideline” (not protocol, policy, procedure etc.))
Colposcopy service guidelines (includes post-coital bleeding and cervical stenosis)

### Author: Contact Name and Job Title
Alison Kerr, Deputy Sister, Sharon Bhatia, Colposcopy Nurse Specialist, Dr David Nunns, Consultant Gynaecological Oncologist, Women’s Unit, NUH

### Directorate & Speciality
Family Health

### Date of submission
1/1/19

### Explicit definition of patient group to which it applies (e.g. inclusion and exclusion criteria, diagnosis)
Women referred for colposcopy (abnormal cytology, suspicious cervix and post-coital bleeding)

### Version
2

If this version supersedes another clinical guideline please be explicit about which guideline it replaces including version number.
Version 1

### Statement of the evidence base of the guideline – has the guideline been peer reviewed by colleagues?

<table>
<thead>
<tr>
<th>Evidence base</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>NICE Guidance, Royal College Guideline, SIGN (please state which source).</td>
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<tr>
<td>2a</td>
<td>meta-analysis of randomised controlled trials</td>
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<tr>
<td>2b</td>
<td>at least one randomised controlled trial</td>
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<tr>
<td>3a</td>
<td>at least one well-designed controlled study without randomisation</td>
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<td>3b</td>
<td>at least one other type of well-designed quasi-experimental study</td>
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<td>4</td>
<td>well –designed non-experimental descriptive studies (ie comparative / correlation and case studies)</td>
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<td>5</td>
<td>expert committee reports or opinions and / or clinical experiences of respected authorities</td>
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<td>6</td>
<td>recommended best practise based on the clinical experience of the guideline developer</td>
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### Consultation Process
Family Health guidelines group

### Ratified by: David Nunns, Gynae Guideline Lead
Date on which guideline must be reviewed (this should be one to three years)
Date: 1/1/19
August 2021

### Target audience
General gynaecologists (all grades) and colposcopy staff at NUH

### Review Date: (to be applied by the Integrated Governance Team)
01/08/2021

A review date of 5 years will be applied by the Trust. Directorates can choose to apply a shorter review date; however this must be managed through Directorate Governance processes.

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date.
COLPOSCOPY SERVICE - BACKGROUND

- The NUH Colposcopy service follows the guidelines outlined in the NHS Cervical Screening Programme Publication 20 “Colposcopy and Programme Management” (Third Edition March 2016). This is a comprehensive, national document that is based on the most up-to-date evidence and sets the clinical standards of care for the national service. 
- Public Health England (NHS Cancer Screening Programmes) has published Screening Protocol Algorithms for managing patients with abnormal cytology following the introduction of HPV Triage and Test of Cure. These are available in the Colposcopy Clinic.

WORKFORCE

Performance of diagnostic and therapeutic colposcopy

- Colposcopy must be performed by a British Society for Colposcopy and Cervical Cytology (BSCCP) certified Colposcopist or a BSCCP registered trainee under direct or indirect supervision.
- Colposcopy documentation should be adequate; the process is outlined in the department operational policy.

Accreditation of colposcopists

- NUH Colposcopists must have completed their training and satisfy the requirements of the joint body of the BSCCP and the Royal College of Obstetricians and Gynaecologists (RCOG) to become accredited colposcopists. Once accredited, 3-yearly application for reaccreditation and attendance at a colposcopy-related course or conference is required in order to remain on the BSCCP register of colposcopists.
- It is the responsibility of the individual to ensure that they remain accredited and the Lead Colposcopist should maintain records for all colposcopists working in their department.

LOCATION OF COLPOSCOPY SERVICES

- All colposcopy procedures should be carried out in the colposcopy clinic based at the Women’s Endoscopy Unit at the City Hospital.

STANDARD OPERATIONAL POLICY FOR COLPOSCOPY SERVICE

- This is available on request from the Women’s Unit. It details the day to day operation of the service, processes, referral patterns, data collection, standardised letters and mandatory screening returns.

REFERRAL

- Women are referred for colposcopy for the following indications
  - abnormal cytology (usually from primary care cervical screening as per the routine recall)
  - suspicious cervix (usually two-week-wait referral or from gynaecology out-patients)
  - symptoms - commonly post-coital bleeding (usually two week wait referral, GP referral or from gynaecology out-patients)
GUIDANCE FOR COLPOSCOPISTS - CLINICAL GUIDANCE FOR ABNORMAL CYTOLOGY PATIENTS (See document 20)

Excisional biopsy using loop diathermy (Large Loop Excision of the Transformation Zone - LLETZ)
- The treatment of choice in the Unit is LLETZ. We do not offer destructive options.
- LLETZ should ideally be performed at the first visit for patients with high grade smears.
- Treatment at the first visit for borderline nuclear change HR HPV Positive or low grade dyskaryosis HR HPV positive should only be performed if there are convincing high-grade changes at colposcopy.

Management of suspected malignancy in colposcopy clinics
- If frank carcinoma is suspected on clinical grounds a biopsy should be taken by appropriate means. This may be a punch biopsy or a small LLETZ.
- The counselling process should begin in clinic and it may be helpful to inform the patient that a cancer is a possibility.
- The patient should be given a review appointment within 7-10 days and the gynaecology cancer team informed (Consultant or Clinical Nurse Specialists).
- If cancer is confirmed on biopsy, the patient should be given the diagnosis by the initial Colposcopist ideally with a Gynaec-Oncology Nurse Specialist Nurse in attendance.
- The Gynae-oncology MDT should will then take over the patient’s pathway and care.

Management and Treatment of Cervical Ectropion
- Patients with a symptomatic ectropion (e.g. post-coital bleeding or excessive mucous discharge) where CIN has been excluded may benefit from diathermy cautery to the ectropion.
- A biopsy should be taken prior to diathermy being performed if there has been abnormal cytology or colposcopy.

Management of patients with concurrent gynaecological problems
- Some patients will present in the colposcopy clinic with an abnormal smear and a concurrent gynaecological problem. The colposcopy clinic is not the ideal setting in which to undertake general gynaecological assessments. If the problem requires minimal investigation and can be dealt with easily then this should be done while the patient is in the clinic. If more non-related management is envisaged i.e. infertility, vulval problems, pelvic pain, etc. then the appropriate referral back to the GP should be made.
- In other situations, the actual management of the smear may be influenced by concurrent gynaecological problems e.g. a patient with menorrhagia and CIN. This patient might be more effectively managed by hysterectomy. If such a case arises counselling can be dealt with in the colposcopy clinic.

Consent and Counselling
- Patients will have been given written information on their original invitation to the clinic and may have been counselled by their own general practitioner or practice nurse prior to or at the time referral is made. High grade smear referrals are given information on LLETZ at the first visit.
- It is not necessary to obtain written consent for colposcopy. However, any risks and side effects should be explained to the patient in order to allow informed consent. If written consent is not taken, verbal consent for treatment under local analgesia should be obtained and documented on the data sheet.
- See below for preterm delivery risks.
CIN 2 management

- There is a growing body of evidence to support the conservative management of selected patients with CIN 2. The figure below outlines the agreed pathway. It is supported by information sheets to the patient and the GP which are available in the unit.
- All patients should be discussed at the multidisciplinary team meeting to ensure suitability.

Loop diathermy and preterm delivery

- Guidance to colposcopists
  - When counseling patients of reproductive age prior to loop diathermy treatment, it may be necessary to discuss the risk of preterm delivery following the procedure (see Appendix 1 for patient advice).
  - The rates of preterm delivery are outlined below, but it is difficult to predict the depth of loop prior to treatment and the ultimate length will be outlined on the pathology report.
  - It should be possible however to risk assess patients into higher risk groups (e.g. those patients with glandular lesions) who may require deeper loops and therefore need more specific counselling.

- Guidance to obstetricians
  - Back ground pooled rate of preterm delivery is 7%
  - If the patient has 1 LLETZ <10mm depth of excision - no significant increase in pre-term delivery. Hence in ANC, no action required
  - Risk of preterm delivery is increased >10mm
  - If the LLETZ is between 10mm-14mm depth of excision - absolute risk of preterm delivery is 9.6%.
  - If the LLETZ is between 15mm-19mm depth of excision - absolute risk of preterm delivery is 15%.
  - If LLETZ if >20mm depth of excision or if more than one LLETZ - absolute risk of preterm delivery doubles to 18%.
  - It is not clear from an obstetric perspective what is the optimal management of care for women who have had a loop biopsy(is) who are considered at risk.
• Excisions of more than 10mm are responsible for 2.5% of preterm births each year in England.

• Preterm delivery risk with LLETZ and interpretation of loop size from pathology reports
  • The *depth of loop* is a measurement that should be recorded on the pathology report to help the obstetrician assess future risk of preterm delivery amongst pregnant patients.
  • The current risk that we assign our patients who have been treated will be based on parameters as reported in key publications (Castonon 2013) where the original risk was documented.
  • In these papers, the *depth of loop* is the *macroscopic perpendicular distance from the distal or external margin to the proximal or internal margin of the excised specimen*.
  • This applies to the majority of loops in one piece; loops in more than one piece do occur and we will leave *depth of loop* up to the discretion of the pathologist.
  • The loops dimension should be reported as ‘xmm ymm zmm (depth)’ so that this will be clear to the obstetrician in the future when reviewing the report at a future date.
  • Colposcopists need to be mindful of the depth of loops but should be focused on complete excision of HGCIN/HGCGIN tailored to the individual so to avoid a repeat loop (which is also an additional risk factor for preterm delivery).

**Knife conisation/cone biopsy**

• This is performed under general anaesthetic with view to performing either local or extended cervical excision as required. It should be performed either by a BSCCP registered Colposcopist or a trainee under supervision by a BSCCP registered Colposcopist as a day case.

**Treatment complications**

• Primary haemorrhage (within 48 hours of treatment)
  • There is no agreed definition but, in the context of outpatient treatment, it can be defined as bleeding experienced during or within 48 hours of treatment sufficient to warrant the patient to be hospitalised. This complication occurs in around 1% of procedures.
  • If significant bleeding is encountered that cannot be controlled using diathermy or Monsell’s solution the vagina should be packed and the patient admitted.

• Vaginal laceration
  • This is an uncommon complication and may be avoided by use of sheath coated, large speculums and adequate analgesia.
  • If this happens at the procedure advice is required from the senior gynaecologist in the clinic.
  • Management may include 1) silver nitrate application, 2) diathermy to the area or 3) suture. These may require local anaesthetic infiltration.

**Patients on oral anticoagulants**

• Patients on anticoagulants are at increased risk of bleeding and need individual risk assessments based on reasons for anticoagulation and type of drugs.
• Patients taking **Direct Oral Anticoagulants (DOACs)** should follow the NUH Trust guidance on *Guidelines for the management of adult patients taking Direct Oral Anticoagulants (DOACs) who require elective, non-cardiac non-neurosurgical procedures* on the Trusts intranet site within Haematology. A cervical punch biopsy and a loop procedure are classified as **MINOR Bleeding Risk Procedure**.
  • All patient should have a routine FBC performed
  • If there is thrombocytopenia which would increase the risk of bleeding, the patient should be discussed with a haematologist in advance of surgery
  • All patients should have U and E checked within 6 weeks of planned surgical intervention.
All patients should have a formal Cockroft Gault creatinine clearance calculated to guide perioperative anticoagulation management.

Advice should be given to the patient regarding the times of stopping their DOAC drug.

Pre procedure anticoagulation should be stopped as directed in the tables in the document.

Please give the patient a completed standard letter for patients regarding stopping anticoagulation in Appendix 5 of the document with instruction to the patient when to restart the treatment (also if the procedure is cancelled).

- Patients taking Clopidogrel/ anti-platelet agents e.g. Ticagrelor/ Prasugrel please see Trust antiplatelet guidance.
  

- Patients on warfarin who require interruption for surgery,
  - Mechanical valves – discuss with cardiothoracic surgical team (at their request)
  - Other warfarin patients – discuss with Haemotology Senior Registrar if advice needed

- Patients taking aspirin can continue the drug uninterrupted.

Patients within 3 months of venous thromboembolism

- Unless cancer is suspected, treatment should not be performed within 3 months of venous thromboembolism.
- If cancer is suspected local surgical guidelines should be consulted.

Antibacterial prophylaxis for patients having loop diathermy excision

- This is not routinely given to patients unless there are exceptional circumstances.

Follow-up (this is outlined in document 20)

- After treatment for CIN, CGIN, SMILE
  - See Document 20.

- After a diagnosis of carcinoma
  - Follow-up guided by the Gynae-oncology MDT.

- After conservative management of CIN
  - Patients with CIN 1 on histology which correlates with the screening result and colposcopic appearances can be managed conservatively. They can be discharged to the community for screening in 12 months.
  - Non-correlating cases where there is high grade abnormality on screening or biopsy should be discussed at the Colposcopy MDT Meeting with review of the cytology and histology.
  - Patients with non-correlating screening and biopsy and/or colposcopic opinion can be managed conservatively if no high-grade lesion is suspected. A repeat colposcopy and LBC sampling will be arranged 6 or 12 months later. Treatment should be considered for persistent low-grade change managed conservatively as there may be high grade disease present.

- Post hysterectomy smear management
  - Women on routine recall and with no CIN in their hysterectomy specimen, no further vaginal vault cytology is required
  - Women not on routine recall, and with no CIN in their hysterectomy specimen, should have vaginal vault cytology at six months following their hysterectomy and then ceased if the cytology is negative
  - women who undergo hysterectomy and have completely excised CIN should have vault cytology at six and 18 months
  - for women who undergo hysterectomy and have incompletely excised CIN (or uncertain excision), follow up should be as if their cervix remained in situ – CIN 1: vault cytology at
six, 12 and 24 months – CIN 2/3: vault cytology at six and 12 months, followed by nine annual vault cytology samples – follow up for incompletely excised CIN continues to 65 years or until ten years after surgery (whichever is later)

- See Document 20 for further information
- The responsibility for implementing the follow up policy rests with the gynaecologist concerned

- The gynaecologist should advise the GP in writing that the patient has had a hysterectomy and whether vault screening is required. If it is required the GP should be advised that this will be done in the colposcopy clinic.

Cervical stenosis (see document 20 – 2.65)

- Often a colposcopic finding associated with incomplete colposcopy. Relevant with abnormal or inadequate cytology
- Cervical dilatation Consider in the clinic under local anaesthetic 1) a mini-loop diathermy (5mm), or 2) cervical dilatation. Taking the smear at the same time and if appropriate an our-of-programme HPV test (a negative HPV test is reassuring)
- Hysterectomy For higher risk patients eg past history of HG dyskaryosis or CGIN considers hysterectomy in discussion with the patient. For lower risk patients e.g. past history of LG dyskaryosis or low grade hysterectomy is less appropriate.
- Where neither cervical dilatation nor hysterectomy are appropriate, the Colposcopist should consult with the woman and a joint decision may be reached to either
  - withdraw her from the NHSCSP or
  - where the woman declines withdrawal, she should continue to receive invitations to screening and the situation re-evaluated at each subsequent screening episode

MDT DISCUSSION

- See Appendix 2 for guidance for colposcopy MDT referral.

CLINICAL GUIDANCE FOR COLPSCOPY FOR SUSPICIOUS CERVIX

- Patients should be reviewed within two weeks of referral.
- See ‘Management of suspected malignancy’ above.

CEASING FROM CERVICAL SCREENING

- This may need to be considered if screening is difficult or impossible due to:
  - Clinical reasons such as cervical stenosis, insufficient cervical epithelium, patient immobility or very difficult access. In women with severe cervical stenosis it may not be possible to obtain a cytological sample that is representative of the whole transformation zone.
  - Patient anxiety or inability to tolerate screening test
- The case should be discussed at the MDT Meeting and the management options include
  - HPV testing (if HPV negative then the risk of cervical cancer over the next 5 years is very low)
  - Hysterectomy
  - Cervical dilatation
- Ceasing from screening. Cervical dilatation should be considered in all cases where there is a history of high grade CIN, cervical glandular intraepithelial neoplasia (CGIN) or unexplained high-grade cytology. If this is not successful, hysterectomy should be considered. The local call and recall services, the Hospital co-ordinator, and the GP must be informed on the management decision. It is advisable that the decision is fully
discussed with the women and that this is full documented in the notes, as well in a letter to the women summarising the decision and the relevant factors.

**POST COITAL BLEEDING (PCB) - BACKGROUND**
- PCB is a common symptom with very low incidence of cervical cancer (Shapely 2013)
- Most cancers detected can be suspected clinically on visual inspection and digital palpation in clinic without the need for colposcopy and a biopsy can be taken in clinic from an obvious lesion. However, if not confident patients may be referred for colposcopy as this is the gold standard means of cervical assessment (see below).

**CLINICAL GUIDANCE FOR POSTCOITAL BLEEDING**
- Patients should be reviewed within two weeks of referral. See Algorithm.

**ALGORITHM FOR ASSESSMENT AND MANAGEMENT OF POSTCOITAL BLEEDING**

**Guidance for colposcopists**
- A 'one stop' approach should be adopted if there are no other symptoms and cervical cancer has been excluded.
- Patients should be reassured with a normal colposcopy.
- Random biopsies are not recommended.
When patients are referred with PCB and other gynaecological problems, then a plan should be made to the GP for ongoing management e.g. Mirena insertion. A direct referral from colposcopy clinic to the general gynaecology clinic can be made if there is an ongoing problem that is unsuitable for primary care management.

Patients with PCB requiring treatment (for e.g. cervical ectopy) can be managed as advised by the Colposcopist after discussion with the patient.

**CIN detected on non-screening patients (e.g. the PCB group and assumes symptomatic patients do not require treatment)**

<table>
<thead>
<tr>
<th>Colposcopy impression</th>
<th>Biopsy result</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>High or low grade CIN Impression</td>
<td>HG CIN</td>
<td>Loop (or alternative) and then Test of Cure within the screening programme</td>
</tr>
<tr>
<td>High grade CIN Impression</td>
<td>LG CIN</td>
<td>MDT discussion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colposcopy and smear 6 months NB – it is the responsibility of the Colposcopist to instruct the GP to do any follow-up smears. Only when the woman has had her first result recorded on Exeter will the screening programme will start to send invite and reminder letters as per the national call-recall programme</td>
</tr>
<tr>
<td>High grade CIN Impression</td>
<td>Normal/HPV only</td>
<td>MDT discussion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No further colposcopy/ cytology FU if ‘normal/HPV’ on biopsy confirmed (The biopsy will be the gold standard of assessment)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To start screening as per the national call-recall programme</td>
</tr>
<tr>
<td>Low grade CIN Impression</td>
<td>LG CIN</td>
<td>12 months cytology with GP within the screening programme</td>
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<td></td>
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<td>NB – it is the responsibility of the Colposcopist instruct the GP to do this smear. Only when the woman has had her first result recorded on Exeter will the screening programme will start to send invite and reminder letters</td>
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</table>

**Guidance for gynaecologists when managing patients in Gynaecology clinics**

- Patients with PCB may be seen in general gynaecology clinics and the management should follow the algorithm above.
- For patients with PCB using hormonal contraception (esp. under 25) who have a normal cervix, consider change in method or treatment as advised in the FRSH Guidance (See FRSH Problematic Bleeding with Hormonal Contraception: July 2015)
- Not all patients require referral if clinically confident that the cervix looks normal. Please discuss with a senior.
- If the cervix looks normal and there is a mixed picture of PCB and IMB, refer to colposcopy for an assessment of the cervix.
- The colposcopy team will provide a ‘one-stop’ assessment of the cervix and may refer back general Gynaecology clinic for ongoing management (not all colposcopists do general Gynaecology).

**Appendix 1 - Guidance to patients on the risk of preterm delivery (to be included in the**
- There is a small additional risk of preterm delivery following loop diathermy.
- The reasons for this are not clear but may relate to weakening of the cervix following treatment.
- We try to minimize this risk by removing the minimal amount of tissue that is required to adequately treat the precancerous cells.
- If you wish to discuss this further please discuss this with your Colposcopist.
- The treatment should not affect your ability to become pregnant.
- If you get pregnant following this treatment we advise you to inform your GP and midwife that you have had treatment to your cervix.

Appendix 2 - guidance for colposcopy MDT referral

The primary purpose of the meeting is to plan the management of patients with discordant histology, cytology and colposcopic findings

<table>
<thead>
<tr>
<th>Cases suitable for Colposcopy MDT discussion</th>
<th>Cases for management decision outside the MDT (see Document 20)</th>
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</thead>
<tbody>
<tr>
<td>• All cases where high grade cytology has not been confirmed on colposcopy and/or histology (punch biopsy/loop)</td>
<td></td>
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<tr>
<td>• Borderline change in endo-cervical cells, HPV+ with no abnormality on colposcopy and/or histology</td>
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<tr>
<td>• Discussion on further management</td>
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<tr>
<td>• Educational discussion management</td>
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<tr>
<td>• CIN 2 for conservative management</td>
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<tr>
<td>• CGIN and SMILE cases</td>
<td></td>
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<tr>
<td>• Cervical cancer audit cases</td>
<td></td>
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<tr>
<td>• Post hysterectomy smear management (see below and Document 20 – 10.5)</td>
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<tr>
<td>• Cervical cancer cases (should go to the gynaecology cancer MDT)</td>
<td></td>
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<tr>
<td>• CIN detected on non-screening patients (see below)</td>
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<tr>
<td>• Cases for ceasing from screening (see Document 20 – 2.6)</td>
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<tr>
<td>• Cervical stenosis (see below and Document 20 – 2.65)</td>
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References