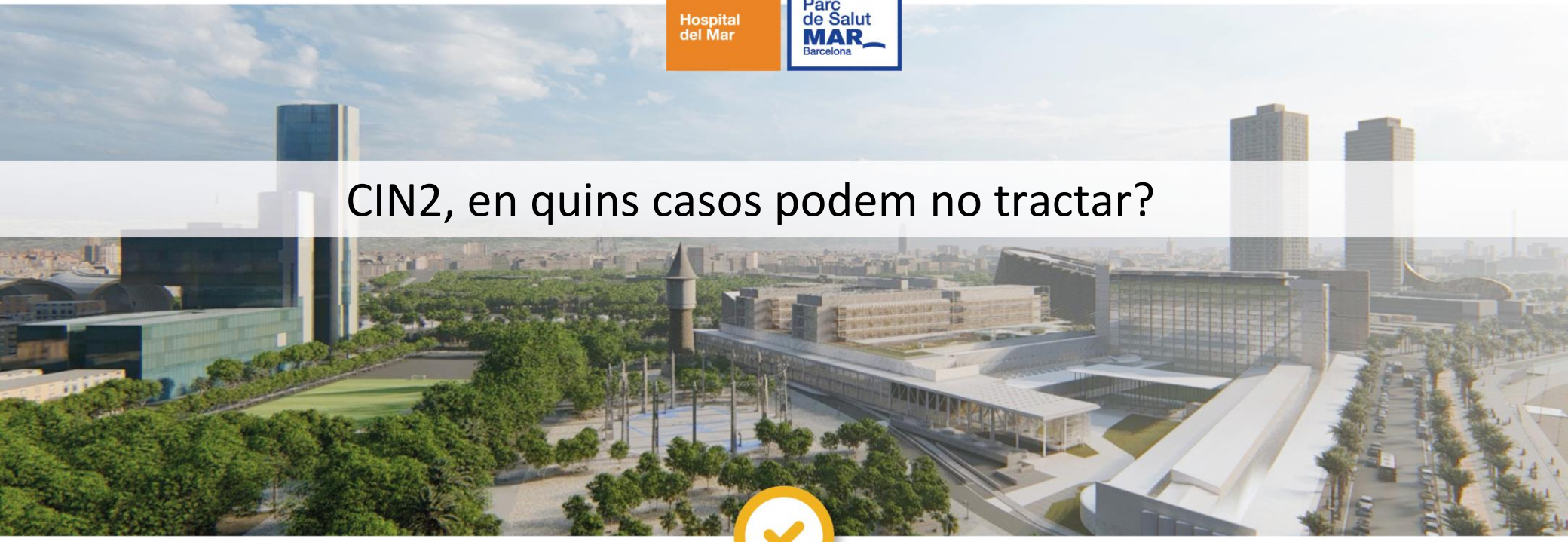
II Jornada Multidisciplinar del Virus del Papil·loma Humà

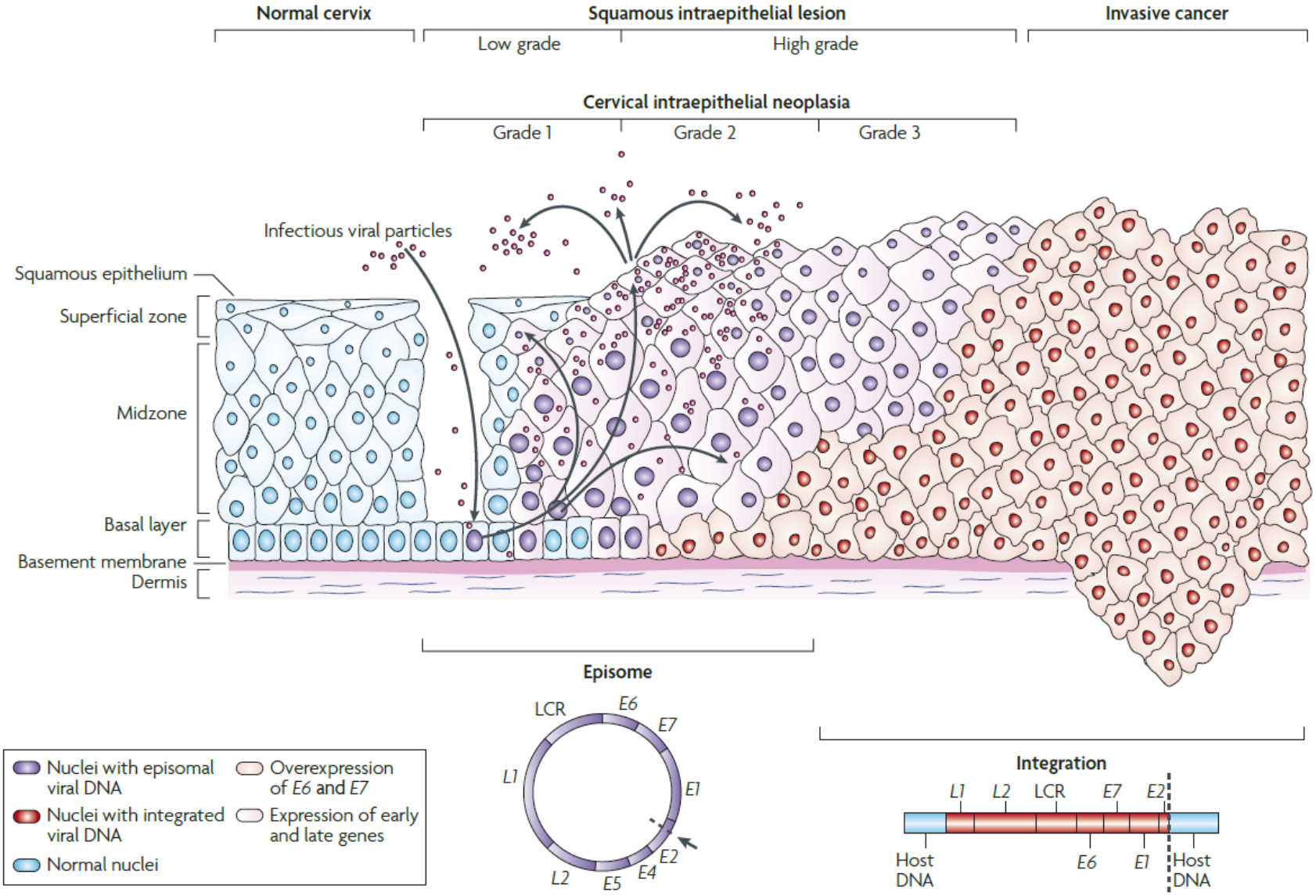
Hospital del Mar

Parc de Salut MAR Barcelona



CIN2, en quins casos podem no tractar?

Josep M Solé
Servei de Ginecologia i Obstetrícia
Hospital del Mar (Barcelona)



Woodman, Ciaran B. J., Stuart I. Collins, y Lawrence S. Young. «The natural history of cervical HPV infection: unresolved issues». *Nature Reviews Cancer* 7, n.º 1 (01 de 2007): 11-22

Di Saia Creasman

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Treatment Options

Women with CIN I can be followed without definitive treatment. This is particularly true if the preceding Pap smear result shows ASCUS, ASC-H, or LSIL. These

with repeat colposcopy and treatment if abnormality persists or further observation is acceptable. In women with CIN II or III therapy is indicated. For those with CIN I observation is an appropriate option. Many treat-

2012

EIGHTH EDITION

1 Cone biopsy for endocervical disease. Limits of the ot seen colposcopically.

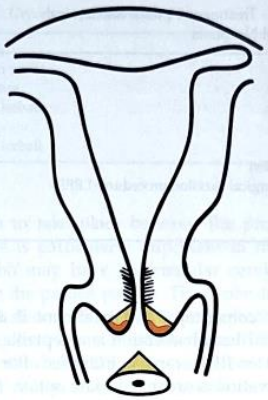


FIGURE 1-12 Cone biopsy for cervical intraepithelial neoplasia of the exocervix. Limits of the lesion were identified colposcopically

oted in the schema that we have presented for of the abnormal Pap smear, we prefer that an s performed on all nonpregnant patients. It is ated that there are data to suggest an ECC is not f an adequate colposcopy is present. There also hat suggest endocervical brush cytology is to an ECC. Diagnostic conization must be en ECC shows malignant cells or when col- examination is unsatisfactory (the entire lesion n). Because curettage is performed from the al os to the external os, the lesion that extends only y into the canal is often picked up by the curet, sulting in a number of false-positive ECC results.

lposcopic evaluation of the cervix in the patient with an abnormal cervical smear has dramatically altered management of the patient afflicted during preg- The schema previously outlined is closely fol- pregnancy, when the transformation zone is king visualization of the entire lesion almost y. Cone biopsy is rarely indicated during preg- nch biopsy suggests microinvasion, further needed. In many cases, a "wedge" resec- spicious area confirms the diagnosis of and conization is unnecessary. If not, to allow proper management may be gnant patients with a firm diagnosis of oinvasive disease of the cervix should aginally, and further therapy can ir needs after delivery. The cervix is g pregnancy; thus avoiding a cone terest of both the mother and the fetus. *Small* biopsies of the *most* colposcopically abnormal areas are recommended in an effort to minimize bleeding in the diagnostic evaluation. When a patient is in the second or third trimester and the result of the colposcopic examination is negative for any suspicion of invasion, many colposcopists will defer all biopsies to the postpartum period. Lurain and Gallup reported on 131 pregnant patients with abnormal Pap smear results managed in this manner with excellent results, and no invasive cancers were missed.

Roberts and colleagues noted that only two patients had CIN III on cervical biopsies during pregnancy and had microinvasion (stage IA1) on cold knife conization postpartum. Whether this is progression or sampling error is unknown. Post and associates noted CIN II and III in 279 antepartum biopsies. Regression of 68% and 78%, respectively, among patients with CIN II and III was noted postpartum. No progression to cancer was noted. Regression rates did not depend on vaginal deliveries compared with cesarean deliveries. Complete reevaluation postpartum appears to be indicated so that overtreatment does not occur.

Treatment Options

Women with CIN I can be followed without definitive treatment. This is particularly true if the preceding Pap smear result shows ASCUS, ASC-H, or LSIL. These women can be followed with either HPV-DNA testing every 12 months or repeat cytology at 6- to 12-month intervals. If abnormal results remain, further follow-up

Conservative Management of Adolescents With Abnormal Cytology and Histology

Anna-Barbara Moscicki, MD, *San Francisco, California*

© Journal of the National Comprehensive Cancer Network | Volume 6 Number 1 | January 2008

GENERAL GYNEC

Adolescent cer
treatment, and

Kathleen Moore, MD; Amand

OBJECTIVE: The purpose of this st
ings and outcomes among adolesc

STUDY DESIGN: Patient charts (2
lence of cervical intraepithelial ne
progression and regression were r

RESULTS: Five hundred one patie
patients (65%) had CIN 1 or less
≥2. Twenty-nine percent of the pa
vative treatment vs excision. Over
the patients regressed; the conditio

Cite this article as: Moore K, Cofer A,
Am J Obstet Gynecol 2007;197:141.e1-

177 dones adoles
29 actitud expecta
65% regress
20% estable
5% progressió a CIN3

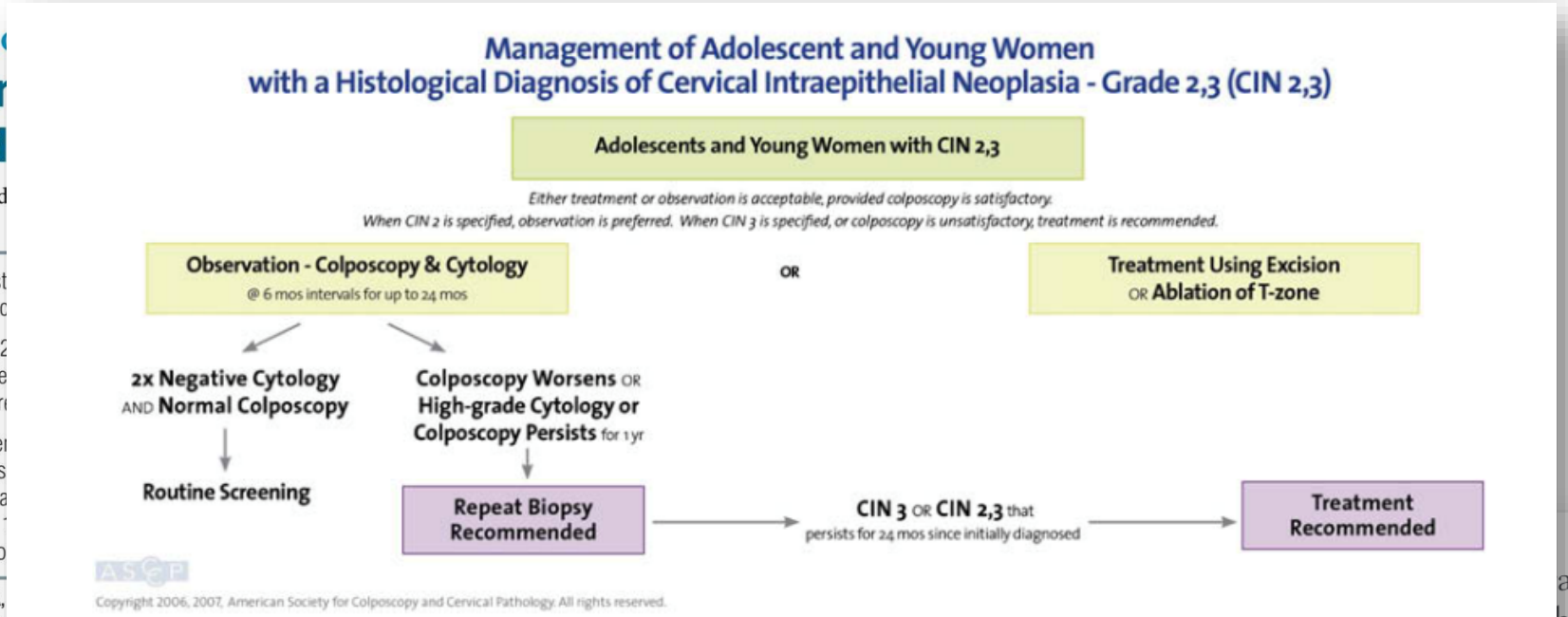


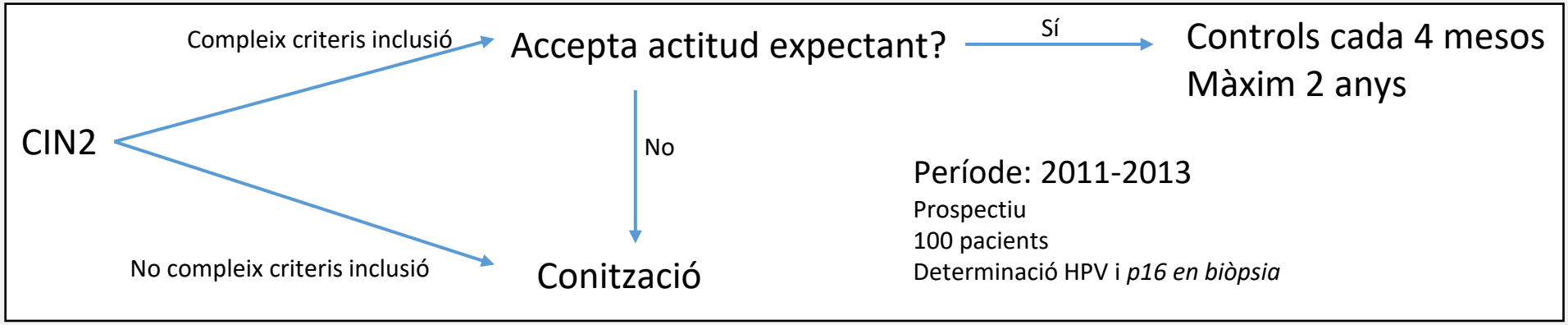
Fig. 4. Management of adolescent and young women who have a histologic diagnosis of CIN 2,3. (*Reprinted from* The Journal of Lower Genital Tract Disease Vol. 11 Issue 4, with the permission of ASCCP © American Society for Colposcopy and Cervical Pathology 2007. No copies of the algorithms may be made without the prior consent of ASCCP.)

pelvic inflammatory disease, which underscores the importance of screening for sexually transmitted infections before treatment.[33]

Estudi CIN2 expectant – Hospital del Mar

Estudiar la viabilitat de l'actitud expectant de les lesions CIN2 de forma prospectiva.

Criteris d'inclusió	Criteris d'exclusió
Edat ≥ 18 anys	Tractament cervical previ
Biòpsia exocervical de CIN2	Biòpsia endocervical de CIN2 Citologia prèvia amb atípia glandular
Colposcòpia satisfactòria	Immunosupressió
Signar consentiment informat de l'estudi	Preferència de realitzar la conització
Seguiment durant 2 anys	No possibilitat de seguiment durant 2 anys



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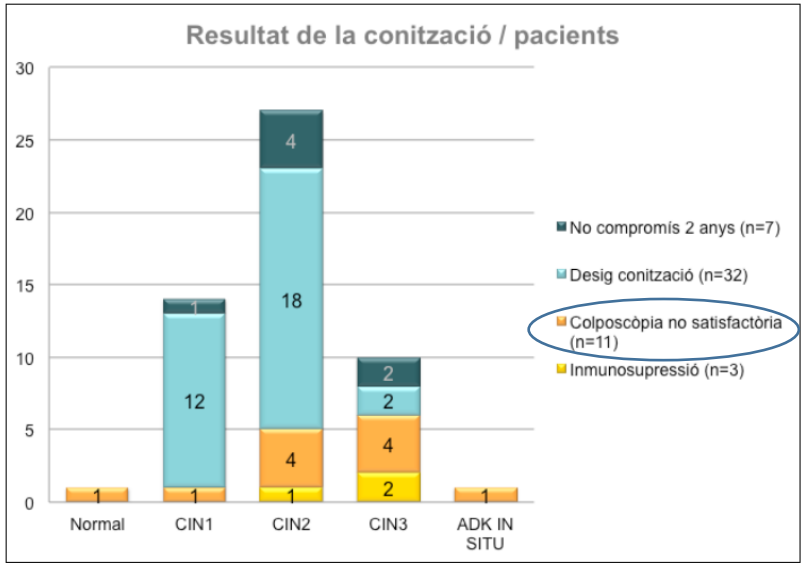
Seguiment durant 2 anys	No possibilitat de seguiment durant 2 anys

Gràfic 2: Diagnòstic de la conització segons el motiu d'exclusió



Usefulness of p16^{INK4a} staining for managing histological high-grade squamous intraepithelial cervical lesions

Ester Miralpeix[1], Jordi Genovés[1], Josep Maria Solé-Sedeño[1], Gemma Mancebo[1], Belen Lloveras[2], Beatriz Bellosillo[2], Francesc Alameda[2,3] and Ramon Carreras[1,3]

[1]Department of Obstetrics and Gynecology, Hospital del Mar, Universitat Autònoma de Barcelona, Barcelona, Spain and [2]Department of Pathology, Hospital del Mar, Universitat Autònoma de Barcelona, Barcelona, Spain

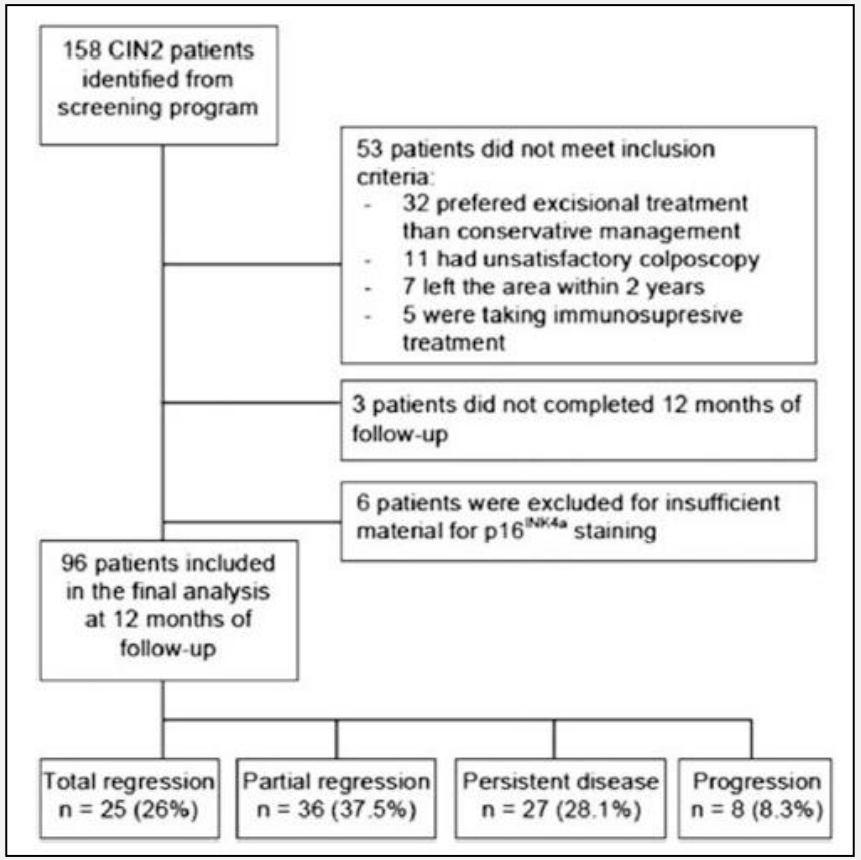


Table 2 Results of p16^{INK4a} staining in the initial HSIL/CIN2 biopsy and final outcome after follow-up

Evolution at follow-up	n	*p16^{INK4a} negative* n *(%)*	*p16^{INK4a} positive* n *(%)*	P-*values*
Total regression	25	8 (53)	17 (21)	0.008
Partial regression	36	7 (47)	29 (36)	
Persistence	27	0 (0)	27 (33)	
Progression	8	0 (0)	8 (10)	
Overall	96	15 (16)	81 (84)	

p16^{INK4a} positive was defined as continuous and strong staining of the basal and suprabasal cells in an area, independent of whether superficial cells of the squamous epithelium was stained or not. p16^{INK4a} *negative* was defined as either discontinuous, focal and weak staining of isolated basal cells or any type of staining in superficial and/or suprabasal layers.

Miralpeix, Ester, Jordi Genovés, Josep Maria Solé-Sedeño, Gemma Mancebo, Belen Lloveras, Beatriz Bellosillo, Francesc Alameda, y Ramon Carreras. «Usefulness of p16INK4a Staining for Managing Histological High-Grade Squamous Intraepithelial Cervical Lesions». *Modern Pathology* 30, n.º 2 (febrero de 2017): 304-10.

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Gràfic 3: Distribució per edat de les pacients incloses

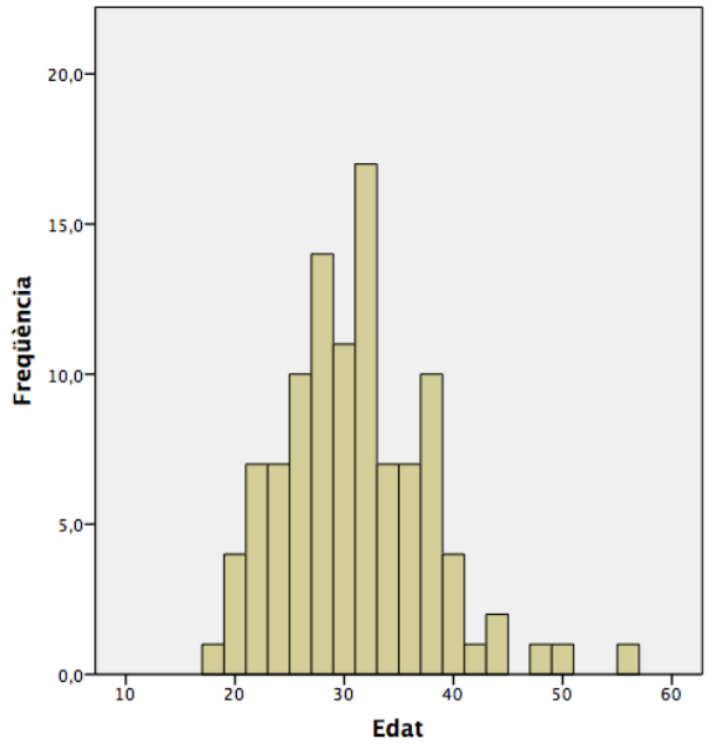


Table 4 Regression rate of HSIL/CIN2 patients at 12 months of follow-up according to different variables

Variables	*Subjects in analysis* n	*Regression < CIN2* n *(%)*	*Non-regression CIN2+* n *(%)*	P-*values*
Overall	96	61 (64)	35 (37)	
p16^{INK4a}				
Negative	15	15 (100)	0 (0)	0.001
Positive	81	46 (57)	35 (43)	
Age				
≤25	25	17 (68)	8 (32)	0.590
>25	71	44 (62)	27 (38)	
Smokers				
No	43	27 (63)	16 (37)	0.890
Yes	53	34 (64)	19 (36)	
Contraception method				
Condom	43	30 (70)	13 (30)	0.310
Hormonal	37	20 (54)	17 (46)	
None or IUD	16	11 (69)	5 (31)	
Age at first intercourse				
≤18	76	46 (61)	30 (39)	0.231
>18	20	15 (75)	5 (25)	
Lifetime sexual partners				
≤10	74	48 (65)	26 (35)	0.621
>10	22	13 (59)	9 (41)	
Parity				
Nulliparous	71	48 (68)	23 (32)	0.163
Parous	25	13 (52)	12 (48)	

Abbreviation: IUD, intrauterine devices.

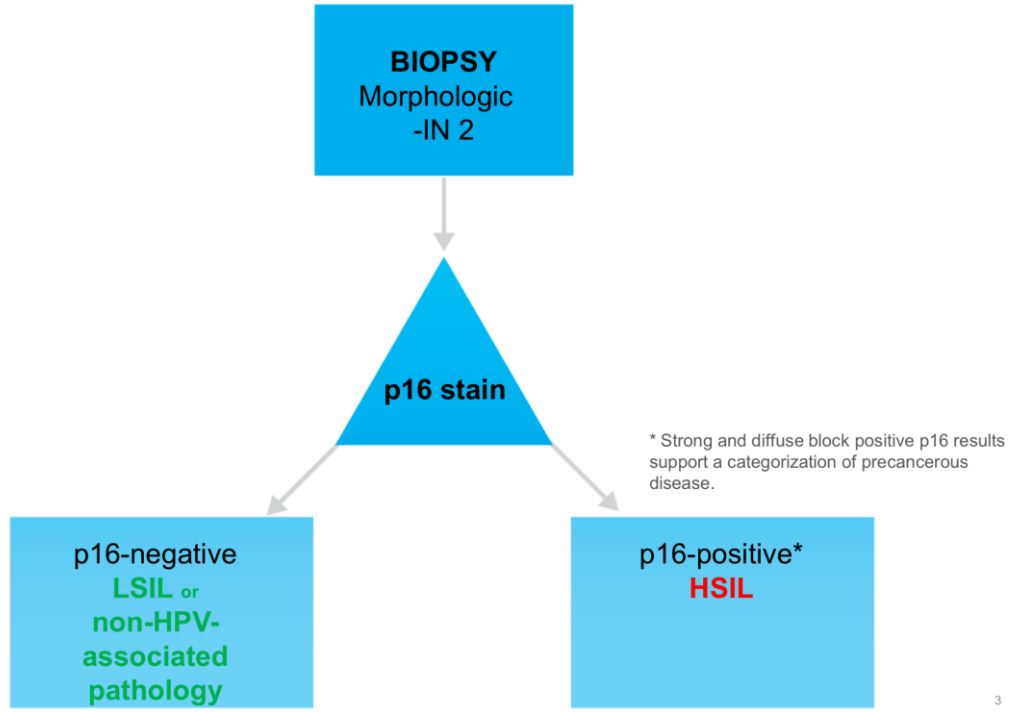
COLLEGE of AMERICAN PATHOLOGISTS

ASCCP

CAP-ASCCP Lower Anogenital Squamous Terminology (LAST) Standardization Project

Biomarkers in HPV-Associated Lower Anogenital Squamous Lesions

Recommendation 2



CAP

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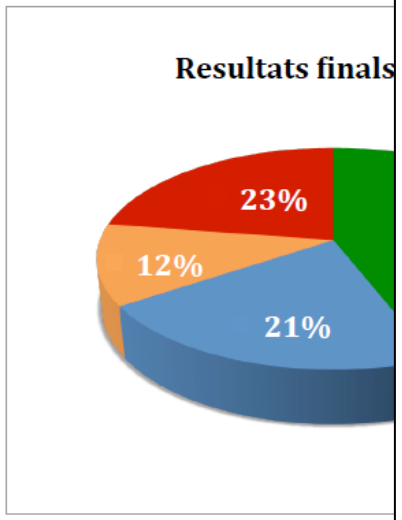
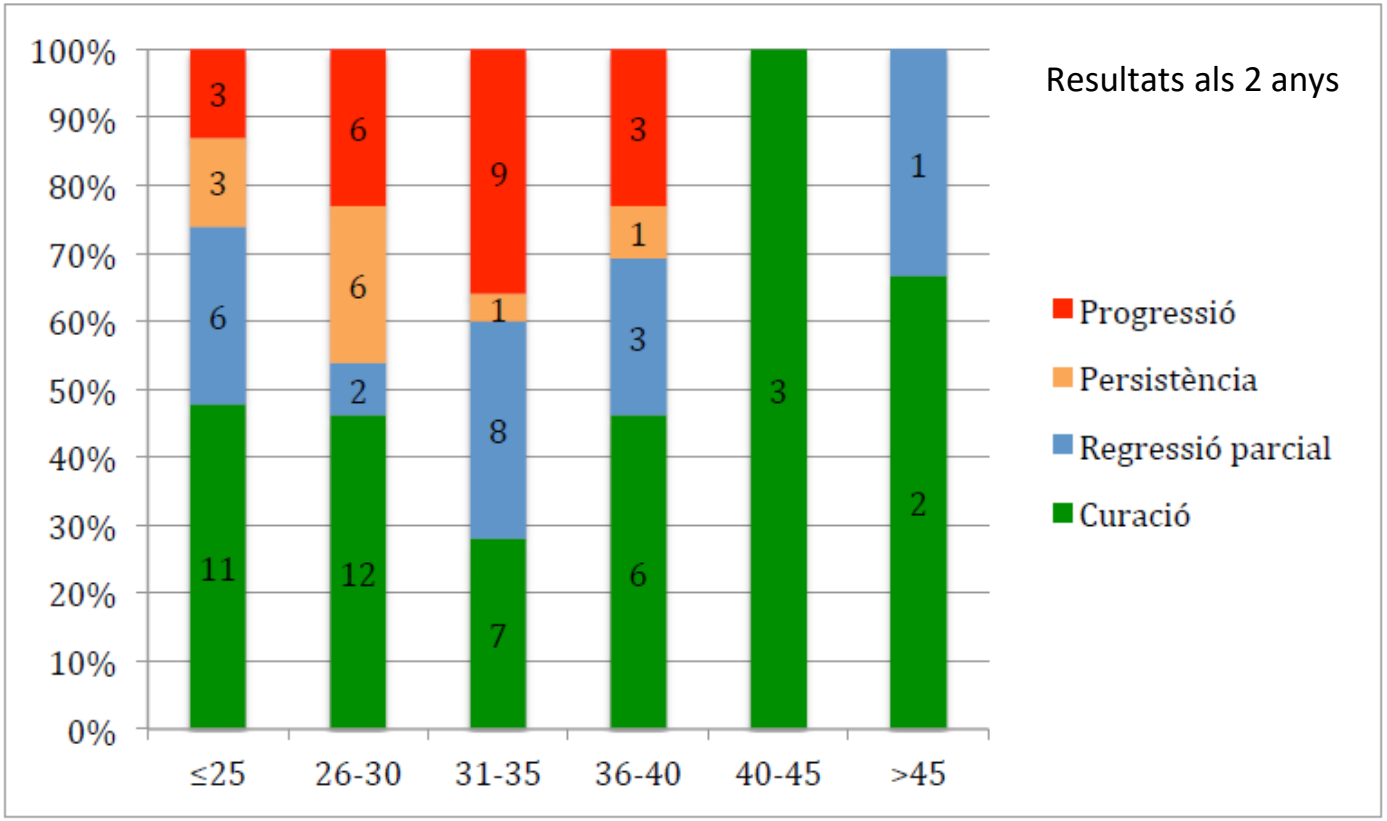
Gràfic 11: Evolució de les lesions de CIN2



Gràfic 12: Representació de l'evolució del CIN2 en funció de l'edat en grups de 5 anys



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Conclusions:

Actitud expectant de CIN2 és segur

ZT tipus 3 com a criteri d'exclusió és necessari

lesions p16 negatives no haurien de ser conitzades

l'edat no s'hauria de tenir en compte

Table 4 Regression rate of HSIL/CIN2 patients at 12 months of follow-up according to different variables

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Predictor factors for conservative management of cervical intraepithelial neoplasia grade 2: Cytology and HPV genotyping

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Criteris d'inclusió	Criteris d'exclusió
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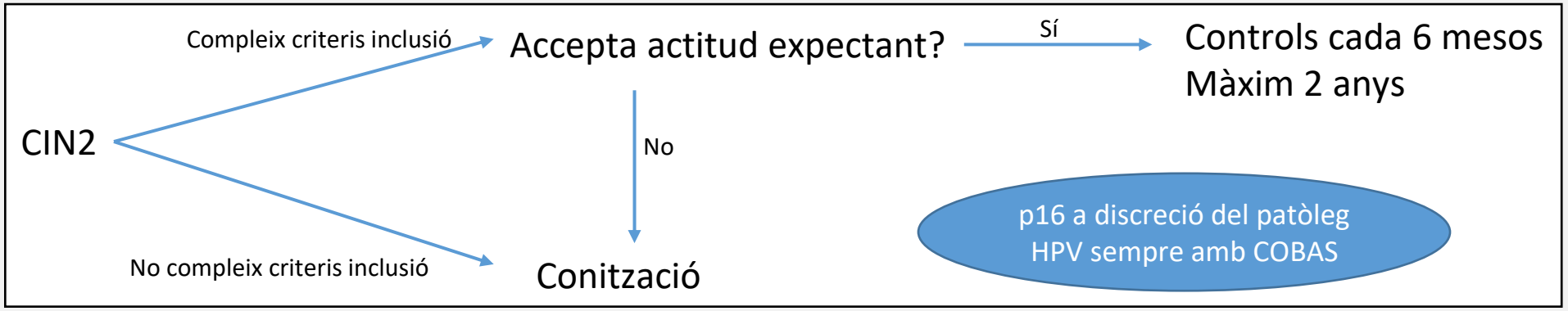
Colposcòpia satisfactòria	Immunosupressió
~~Signar consentiment informat de l'estudi~~	Preferència de realitzar la conització
Seguiment durant 2 anys	No possibilitat de seguiment durant 2 anys

1era fase: 2011-2013
Prospectiu
100 pacients
Determinació HPV i *p16 en biòpsia*

2ona fase: 2013-2017
Incorporat com a protocol
200 pacients
Determinació HPV, p16 a criteri del patòleg



Salvadó, Ariadna, Ester Miralpeix, Josep M. Solé-Sedeno, Nadwa Kanjou, Belen Lloveras, Xavier Duran, y Gemma Mancebo. «Predictor Factors for Conservative Management of Cervical Intraepithelial Neoplasia Grade 2: Cytology and HPV Genotyping». *Gynecologic Oncology* 162, n.º 3 (septiembre de 2021): 569-74.

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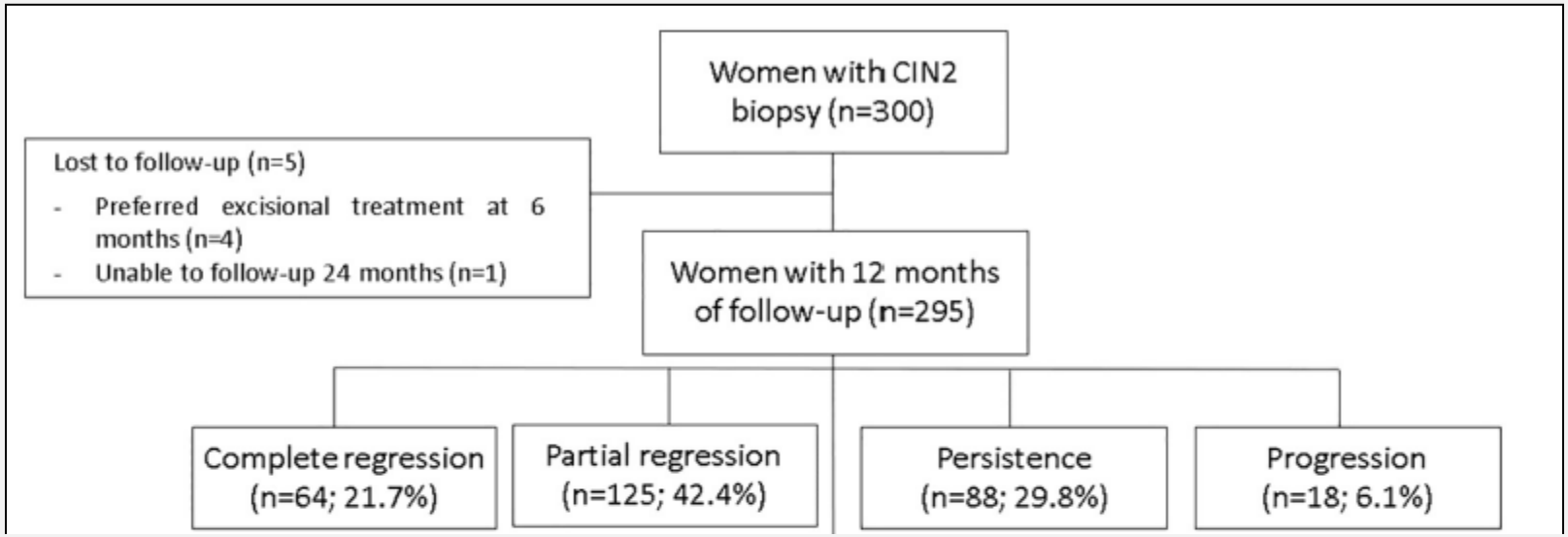

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Table 1
Baseline characteristics of patients according to final diagnosis after 24 months of follow-up.

Patients characteristics	Total (n = 291)	Final diagnosis <CIN2 (n = 214)	Final diagnosis CIN2+ (n = 77)	p value
Median (range)				
Age first intercourse, years	17.00 (12–29)	16.85 (12–29)	17.31 (12–28)	0.153
No. sexual partners	9.50 (1–50)	9.86 (1–50)	8.58 (1–30)	0.228
No. sexual partners (two last years)	2.11 (0–20)	2.15 (0–20)	2.03 (1–10)	0.631
Age, years	30.50 (16–64)	30.45 (16–64)	30.48 (18–64)	0.979
n(%)				
≤ 25 years	83 (28.5)	65 (78.3)	18 (21.7)	
26–40 years	183 (62.9)	128 (70.0)	55 (30.0)	
>40 years	25 (8.6)	21 (84.0)	4 (16.0)	
Race/ethnicity				0.870
European	235 (80.8)	173 (73.6)	62 (26.4)	
Hispanic or Latino	42 (14.4)	31 (73.8)	11 (26.2)	
African	9 (3.1)	7 (77.8)	2 (22.2)	
Asiatic	5 (1.7)	3 (60.0)	2 (40.0)	
Smokers				0.910
Yes	149 (51.2)	110 (73.8)	39 (26.2)	
No	142 (48.8)	104 (73.2)	38 (26.8)	
Contraception method				0.653
Condom	113 (38.8)	78 (69.0)	35 (31.0)	0.175
Hormonal	104 (35.8)	84 (80.8)	20 (19.2)	0.450
IUD or none	74 (25.4)	52 (70.3)	22 (29.7)	0.450
Parity				0.533
Parous	68 (23.4)	48 (70.6)	20 (29.4)	
Nulliparous	223 (76.6)	166 (74.4)	57 (25.6)	
Pregnancy				0.896
Yes	18 (6.2)	13 (72.2)	5 (27.8)	
No	273 (93.8)	201 (73.6)	72 (26.5)	
HPV vaccine				0.051
Yes	26 (8.9)	23 (88.5)	3 (11.5)	
No	265 (91.1)	191 (72.1)	74 (27.9)	

CIN2: Cervical intraepithelial neoplasia grade 2; IUD: intrauterine device HPV: human papillomavirus. *$p < 0.05$.

Table 2
Pathological and HPV data of patients according to final diagnosis after 24 months of follow-up.

Pathological and HPV data	Total (n = 291)	Final diagnosis <CIN2 (n = 214)	Final diagnosis CIN2+ (n = 77)	p value
n(%)				
HR-HPV				
HPV-16	108 (37.1)	69 (63.9)	39 (36.1)	0.006*
HPV-18	12 (4.1)	10 (83.3)	2 (16.7)	0.552
HR-HPV no16no18	150 (51.6)	114 (76.0)	36 (24.0)	0.354
Negative	21 (7.2)	21 (100.0)	0 (0.0)	0.002*
Previous cytology				
Negative	2 (0.7)	2 (100.0)	0 (0.0)	<0.001*
ASCUS-HPV negative	0	0	0	
ASCUS-HPV positive	57 (19.6)	47 (82.5)	10 (17.5)	
LSIL	59 (20.3)	51 (86.4)	8 (13.6)	
ASC-H	54 (18.5)	44 (81.5)	10 (18.5)	
HSIL	119 (40.9)	70 (58.8)	49 (41.2)	

Predictor factors for conservative management of cervical intraepithelial neoplasia grade 2: Cytology and HPV genotyping

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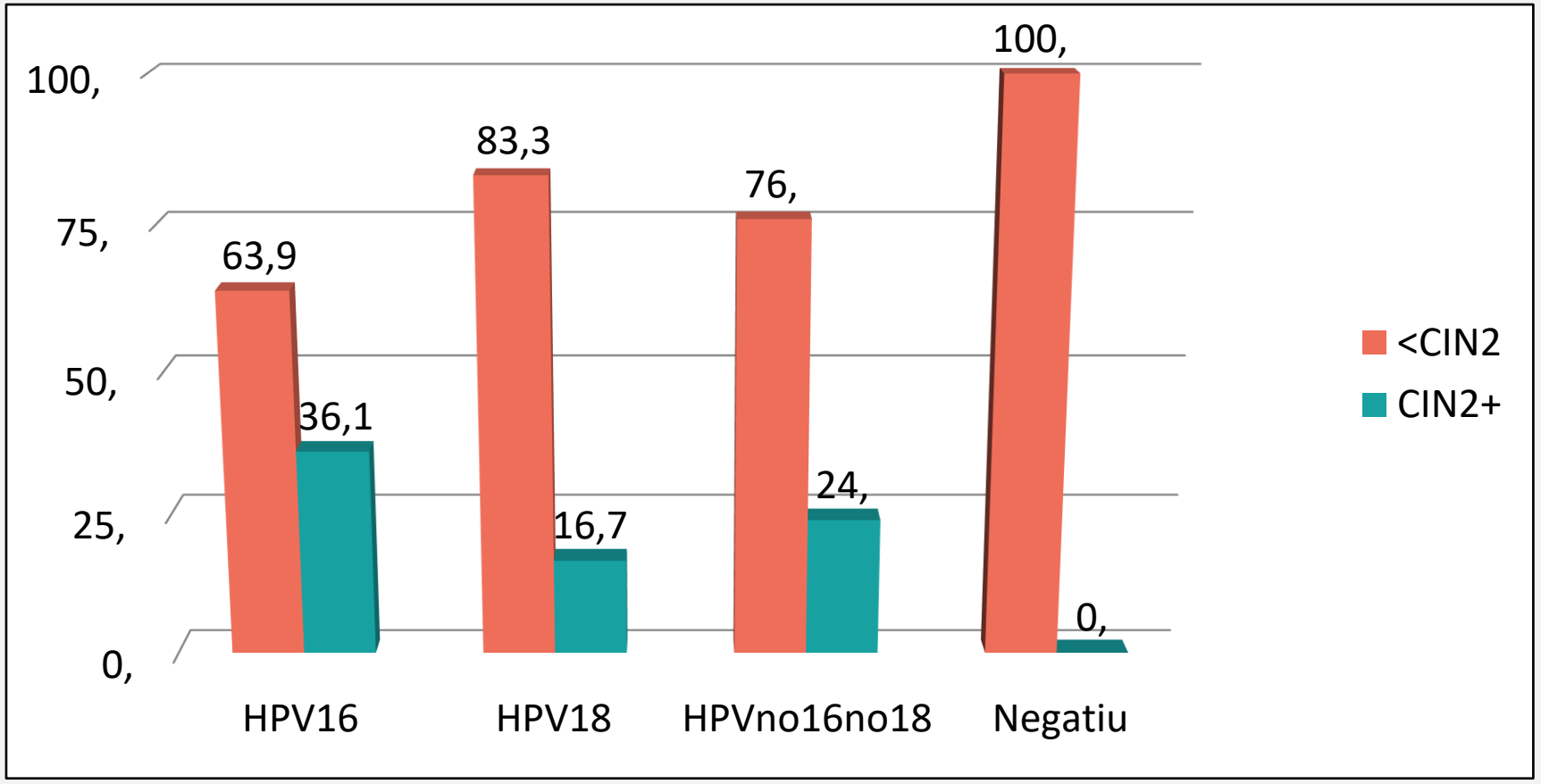
Resultat CIN2 expectant segons HPV, als 2 anys



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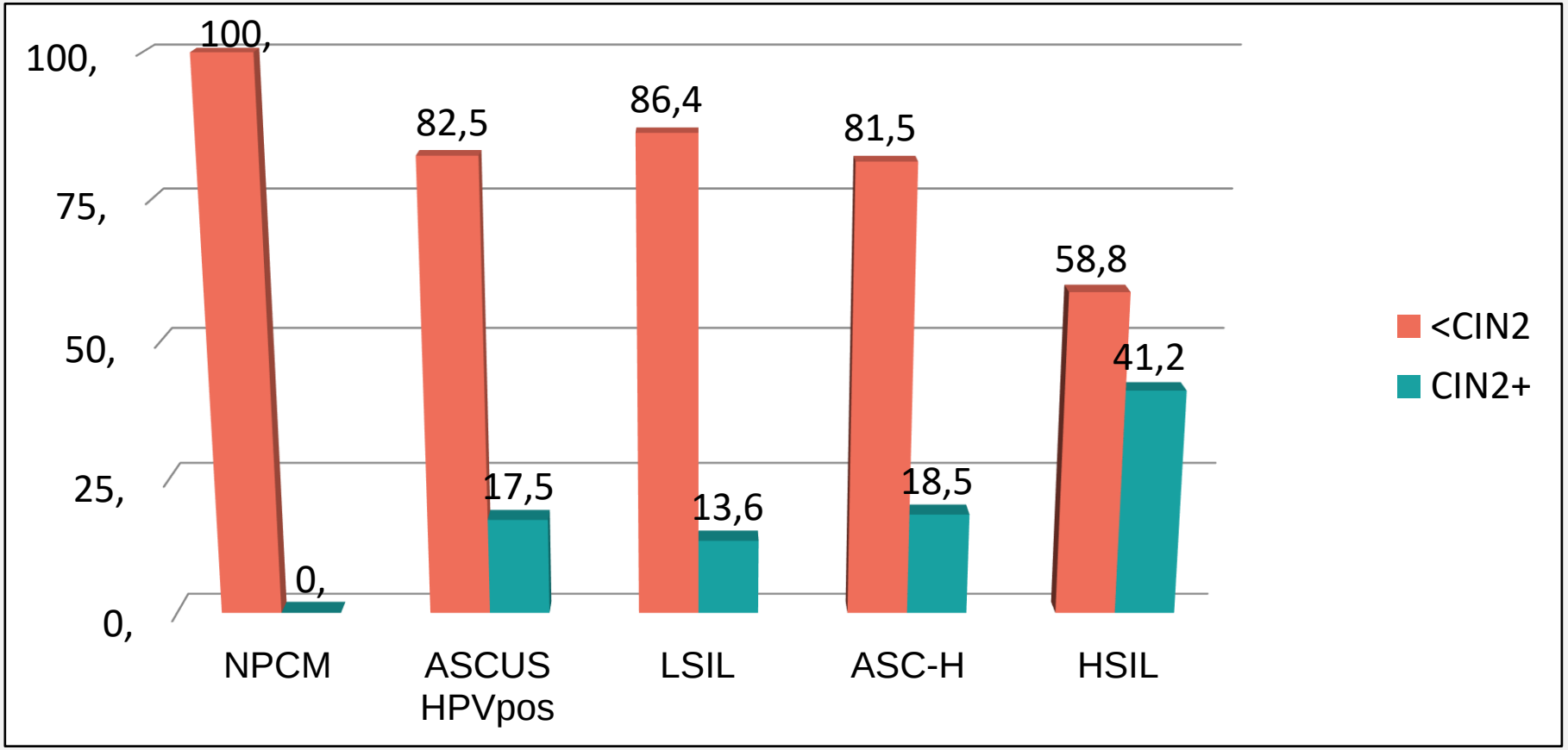
Resultat CIN2 expectant segons citologia prèvia, als 2 anys



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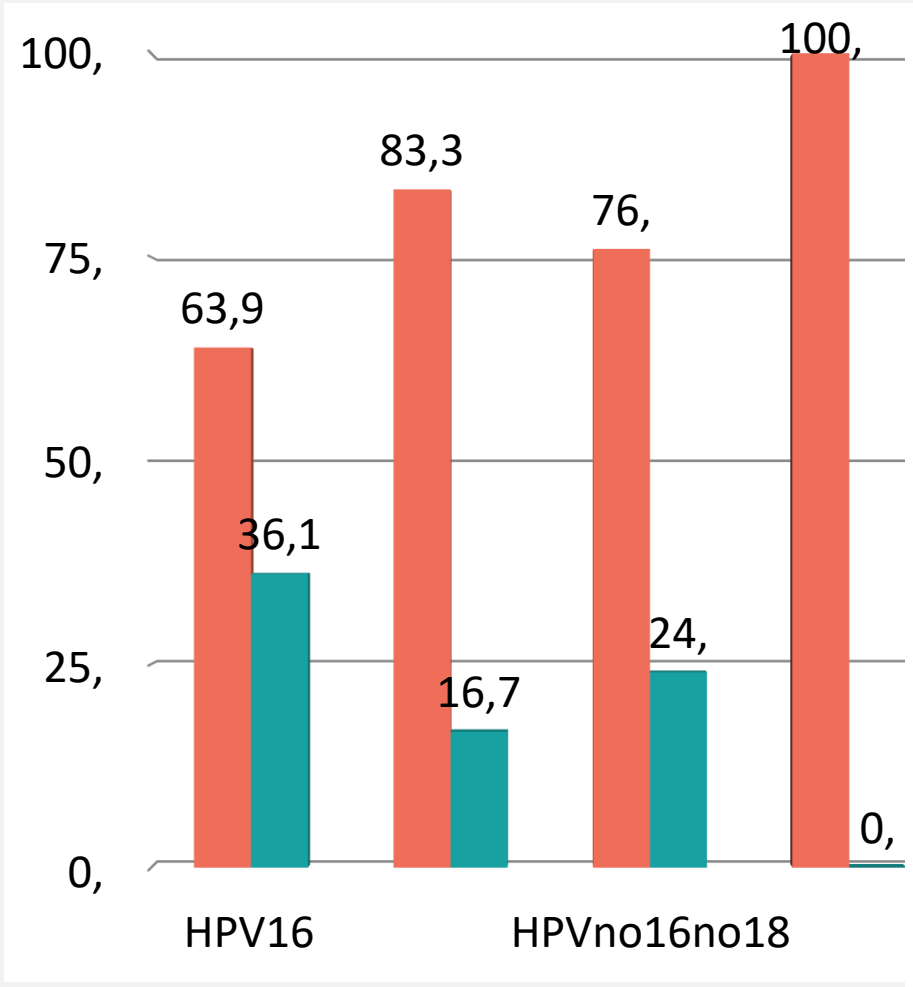

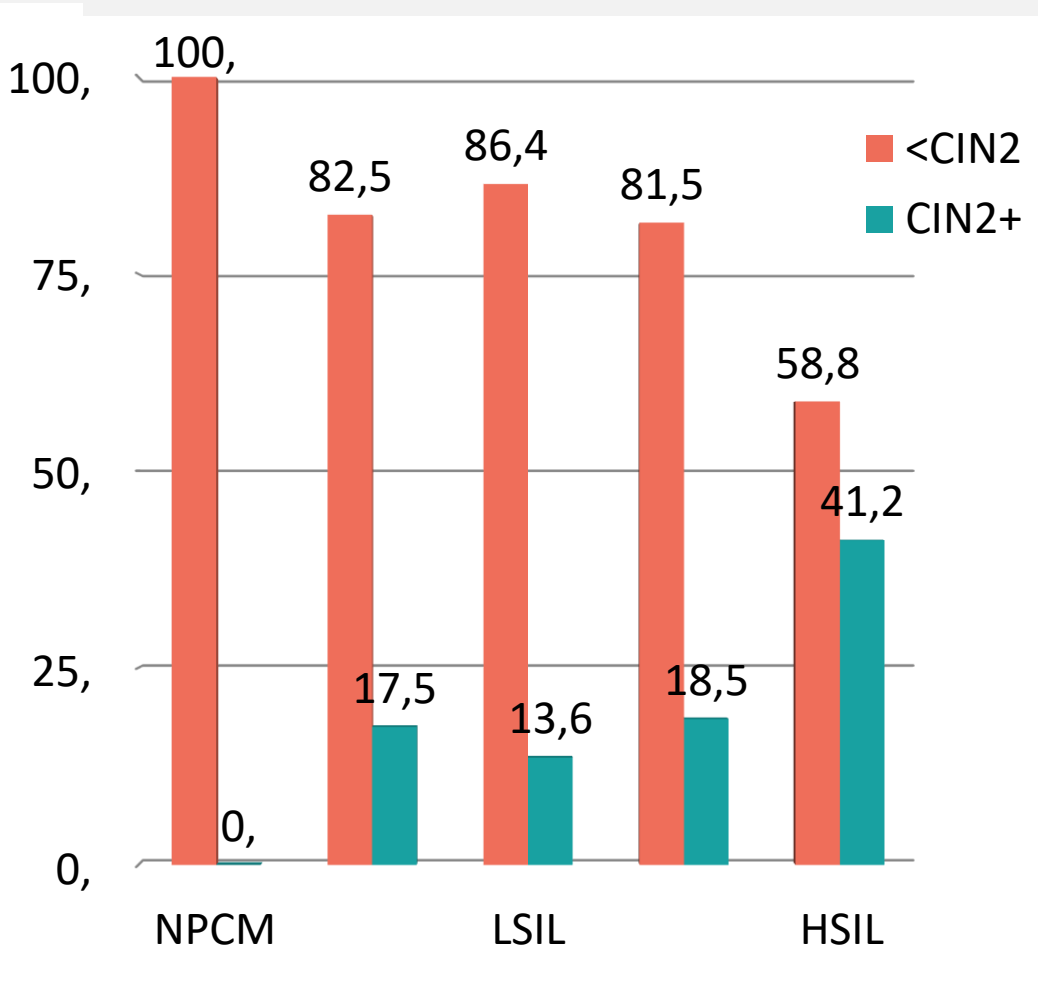

Predictor factors for conservative management of cervical intraepithelial neoplasia grade 2: Cytology and HPV genotyping

Ariadna Salvadó [a], Ester Miralpeix [a], Josep M. Solé-Sedeno [a], Nadwa Kanjou [a], Belen Lloveras [b], Xavier Duran [c], Gemma Mancebo [a,*]

[a] Department of Obstetrics and Gynecology, Hospital del Mar, Universitat Autònoma de Barcelona, Barcelona, Spain
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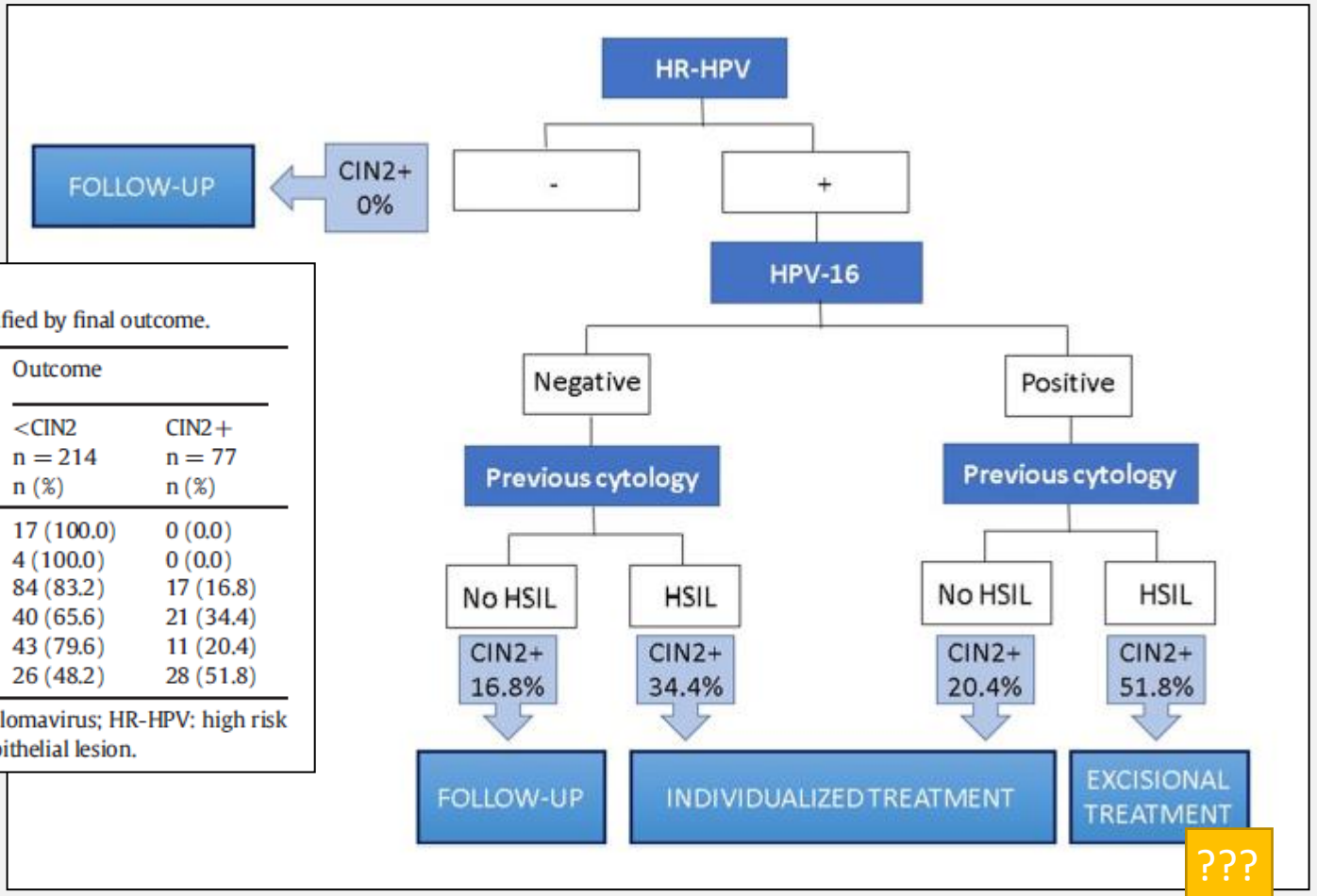
[c] Department of Epidemiology, Hospital del Mar, Universitat Autònoma de Barcelona, Barcelona, Spain

Table 4
Distribution of risk factors for CIN2+ among patients stratified by final outcome.

Risk factors				Outcome	
HR-HPV	HPV-16	Previous cytology	Total, n (%)	<CIN2 n = 214 n (%)	CIN2+ n = 77 n (%)
HR-HPV -	–	No HSIL	17 (5.8)	17 (100.0)	0 (0.0)
HR-HPV-	–	HSIL	4 (1.4)	4 (100.0)	0 (0.0)
HR-HPV +	–	No HSIL	101 (34.7)	84 (83.2)	17 (16.8)
HR-HPV +	–	HSIL	61 (20.9)	40 (65.6)	21 (34.4)
HR-HPV +	+	No HSIL	54 (18.6)	43 (79.6)	11 (20.4)
HR-HPV+	+	HSIL	54 (18.6)	26 (48.2)	28 (51.8)

CIN2: cervical intraepithelial neoplasia; HPV: human papillomavirus; HR-HPV: high risk human papillomavirus; HSIL: high grade squamous intraepithelial lesion.

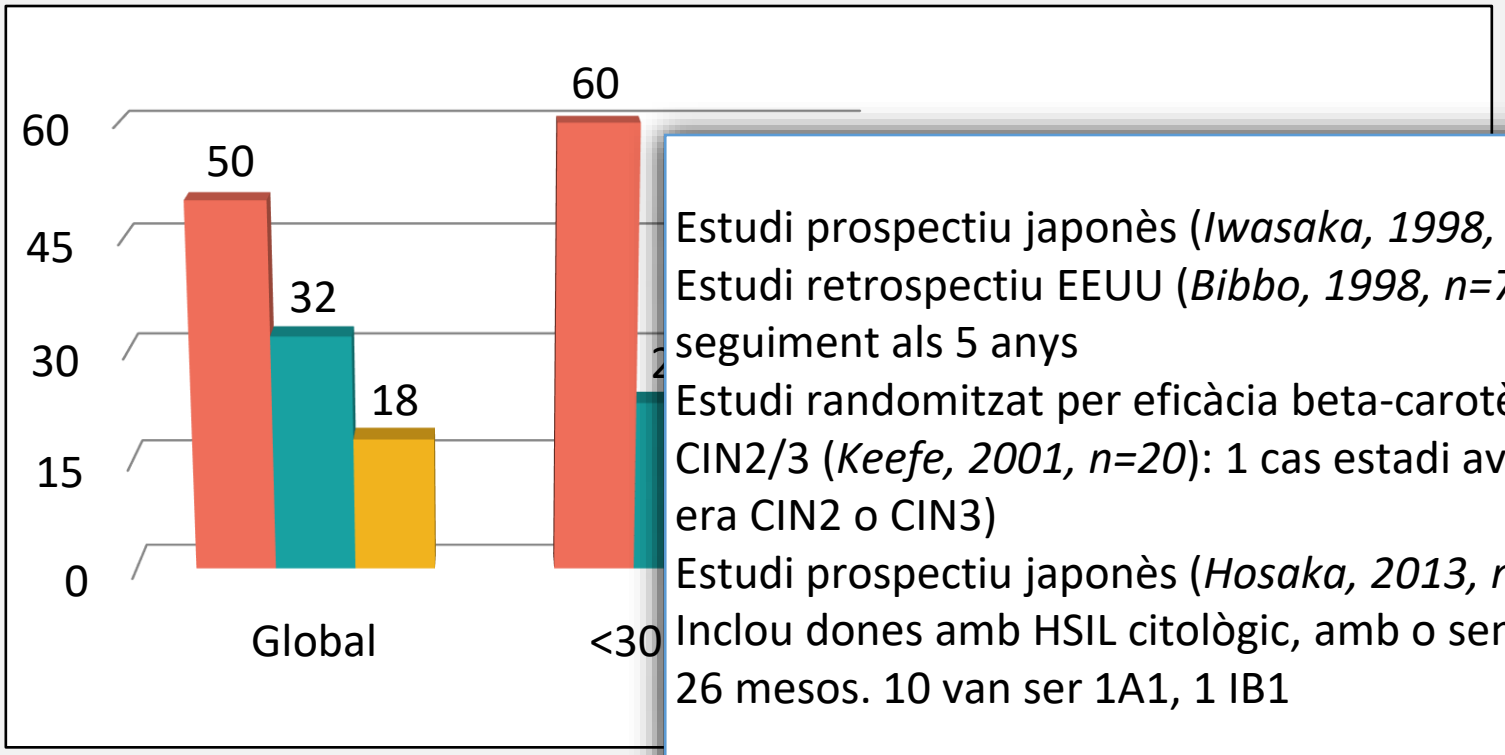


?

Clinical course of untreated cervical intraepithelial neoplasia grade 2 under active surveillance: systematic review and meta-analysis

Karoliina Tainio,[1] Antonios Athanasiou,[2] Kari A O Tikkinen,[3] Riikka Aaltonen,[4] Jovita Cárdenas Hernándes,[5] Sivan Glazer-Livson,[1] Maija Jakobsson,[1] Kirsi Joronen,[4] Mari Kiviharju,[1] Karolina Louvanto,[1,6] Sanna Oksjoki,[4] Riikka Tähtinen,[7] Seppo Virtanen,[1] Pekka Nieminen,[1] Maria Kyrgiou,[8,9] Ilkka Kalliala[1,8]

36 estudis
3160 dones
7 estudis randomitzats
16 cohorts prospectives
13 cohorts retrospectives

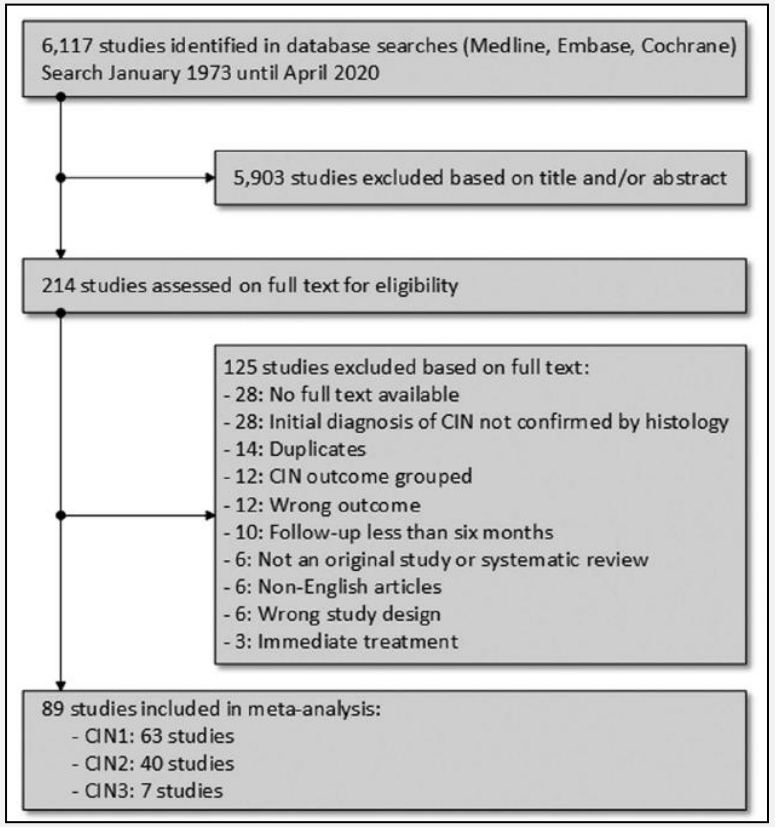


Estudi prospectiu japonès (*Iwasaka, 1998, n=44*) : 2 IA1
Estudi retrospectiu EEUU (*Bibbo, 1998, n=78*): 1 cas amb seguiment als 5 anys
Estudi randomitzat per eficàcia beta-carotè oral en el tt de CIN2/3 (*Keefe, 2001, n=20*): 1 cas estadi avançat (es desconeix si era CIN2 o CIN3)
Estudi prospectiu japonès (*Hosaka, 2013, n=231*) : 11 casos. Inclou dones amb HSIL citològic, amb o sense biòpsia, seguiment 26 mesos. 10 van ser 1A1, 1 IB1

Tainio, Karoliina, Antonios Athanasiou, Kari A O Tikkinen, Riikka Aaltonen, Jovita Cárdenas, Hernándes, Sivan Glazer-Livson, et al. «Clinical Course of Untreated Cervical Intraepithelial Neoplasia Grade 2 under Active Surveillance: Systematic Review and Meta-Analysis». *BMJ*, 27 de febrero de 2018, k499.

The Natural History of Cervical Intraepithelial Neoplasia Grades 1, 2, and 3: A Systematic Review and Meta-analysis

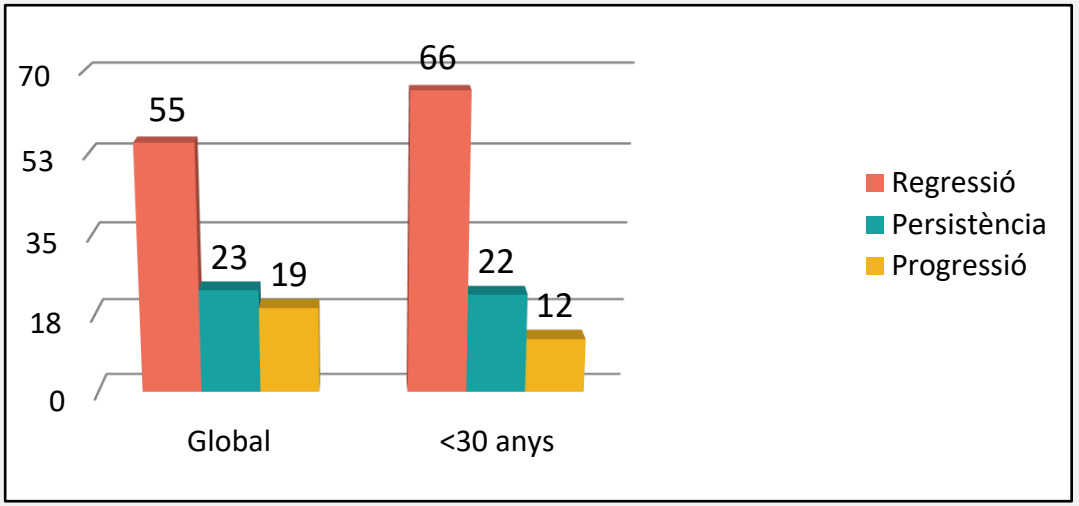
Diede L. Loopik, MD, PhD,[1] Heidi A. Bentley, MD,[2] Maria N. Eijgenraam, MsC,[1] Joanna IntHout, PhD,[3] Ruud L. M. Bekkers, MD, PhD,[4,5] and James R. Bentley, MB, ChB, FRCSC[6]



3830 dones

42 estudis:

- 40% amb menys de 50 dones
- 43% 50-100 dones
- 17% 100 o més dones



Loopik, Diede L., Heidi A. Bentley, Maria N. Eijgenraam, Joanna IntHout, Ruud L. M. Bekkers, y James R. Bentley. «The Natural History of Cervical Intraepithelial Neoplasia Grades 1, 2, and 3: A Systematic Review and Meta-Analysis». *Journal of Lower Genital Tract Disease* 25, n.º 3 (julio de 2021): 221-31.

The Natural History of Cervical Intraepithelial Neoplasia Grades 1, 2, and 3: A Systematic Review and Meta-analysis

Diede L. Loopik, MD, PhD,[1] Heidi A. Bentley, MD,[2] Maria N. Eijgenraam, MsC,[1] Joanna IntHout, PhD,[3] Ruud L. M. Bekkers, MD, PhD,[4,5] and James R. Bentley, MB, ChB, FRCSC[6]

TABLE 1. Summary of the Natural History of CIN 1, CIN 2, and CIN 3

	Regression to normal % (95% CI)	Regression to CIN 1 or less % (95% CI)	Persistence % (95% CI)	Progression to CIN 2 or worse % (95% CI)	Progression to CIN 3 or worse % (95% CI)	Progression to cervical cancer % (95% CI)
CIN 1	60 (55–65)	—	25 (20–30)	11 (8–13)	2 (1–3)	0.03/0.00 (0–0)[a]
CIN 2	47 (42–51)	55 (50–60)	23 (19–28)	—	19 (15–23)	0.3/0.00 (0–0)[a]
CIN 3	18 (6–34)	28 (17–41)	67 (36–91)	—	—	2 (0–25)

[a]Pooled proportions of the individual study results without using/with using random-effects meta-analysis.

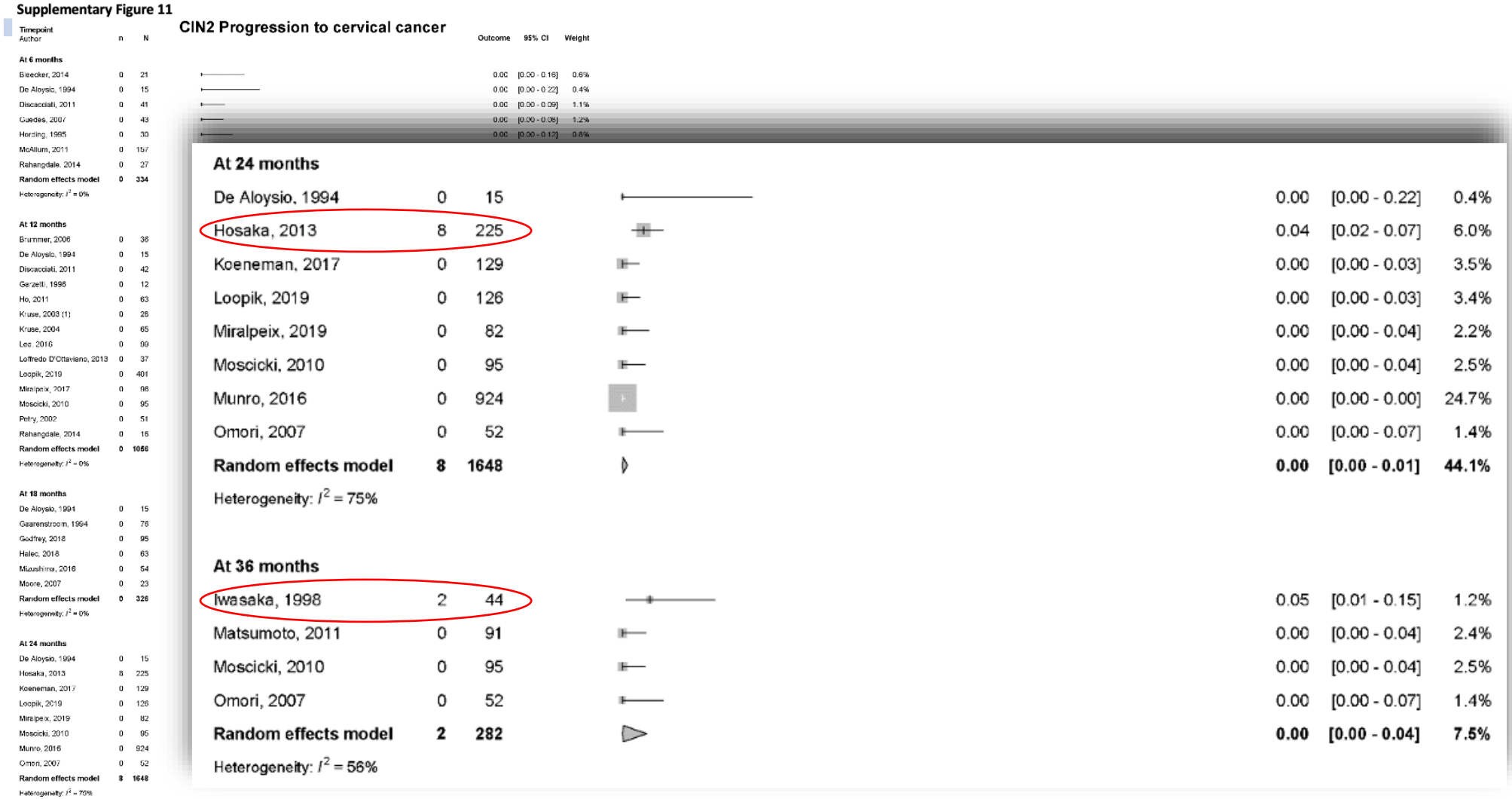
Supplementary table 10. Progression rates of CIN2 in all time points and subgroup analyses

		Progression at 6 months	Progression at 12 months	Progression at 18 months	Progression at 24 months	Progression at 36 months	Progression at ≥54 months	Total [b]	P-value [c]
Main analysis	**N of studies n/N [a]**	9 156/1007	17 180/1275	6 57/326	10 398/1832	4 51/282	2 17/92	36 718/3830	
	Outcome % (95% CI ; I²)	19 (9-32; 83)	15 (9-21; 86)	18 (10-27; 55)	22 (15-31; 93)	18 (11-26; 9)	18 (4-41; 0)	19 (15-23; 88)	
Progression to cervical cancer only	**N of studies n/N [a]**	7 0/334	14 0/1056	6 0/326	8 8/1648	4 2/282	2 0/92	31 10/3037	<0.001 *
	Outcome % (95% CI ; I²)	0 (0-0; 0)	0 (0-0; 0)	0 (0-0; 0)	0 (0-1; 75)	0 (0-4; 56)	0 (0-0; 0)	0 (0-0; 19)	

The Natural History of Cervical Intraepithelial Neoplasia Grades 1, 2, and 3: A Systematic Review and Meta-analysis

Diede L. Loopik, MD, PhD,[1] Heidi A. Bentley, MD,[2] Maria N. Eijgenraam, MsC,[1] Joanna IntHout, PhD,[3] Ruud L. M. Bekkers, MD, PhD,[4,5] and James R. Bentley, MB, ChB, FRCSC[6]

Supplementary Figure 11



Incidence risk of cervical intraepithelial neoplasia 3 or more severe lesions is a function of human papillomavirus genotypes and severity of cytological and histological abnormalities in adult Japanese women

Masayoshi Hosaka[1], Hiromasa Fujita[2], Sharon JB Hanley[1,3], Takayuki Sasaki[2], Yozo Shirakawa[2], Mitsuharu Abiko[2], Masataka Kudo[1], Masanori Kaneuchi[1], Hidemichi Watari[1], Kohkichi Kikuchi[4] and Noriaki Sakuragi[1]

[1] Department of Obstetrics and Gynecology, Hokkaido University School of Medicine, Sapporo, Japan
[2] Cytoscreening Center, Hokkaido Cancer Society, Sapporo, Japan
[3] Department of Public Health, Hokkaido University School of Medicine, Sapporo, Japan
[4] Hokkaido Cancer Society, Sapporo, Japan

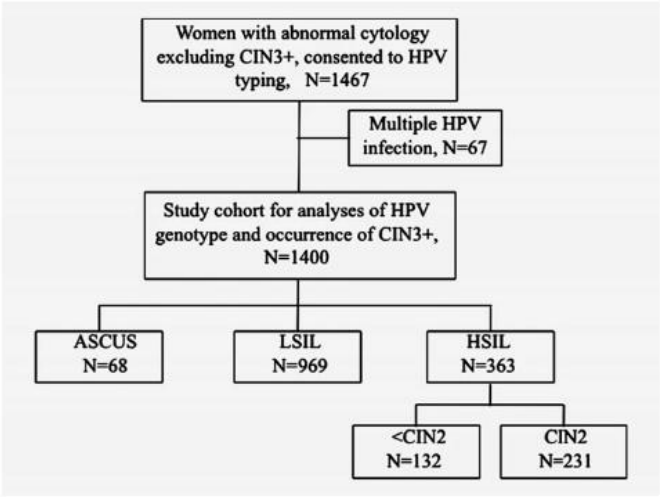


Figure 1. Study design.

Among 363 HSIL cases either with or without histology-proven CIN2, there were 140 CIN3 cases and 11 cases of cervical cancer, which included 10 microinvasive and one small (<2 cm) stage IB1 invasive cancer during the follow-up period.

Even in the absence of histological evidence for CIN2, we frequently observed incidence of CIN3+ in HSIL cases with HPV16/18/33, which showed increased 1- and 5-year CIRs at 27.1% and 47.0%, respectively. There was a significant relationship between incidence of CIN3+ and high-risk HPV subgroups in HSIL/CIN2(−) ($p = 0.049$).

Cervical cancer occurred only in HSIL cases. All cervical cancer occurred in cases of seven high-risk HPV types (11/198) but not in cases of other HPV types or undetectable/negative-HPV (0/165) ($p = 0.0013$). The HPV types associated with cervical cancer were HPV16 (4/50), HPV18 (3/13), HPV52 (2/58) and HPV58 (2/50). Notably, three cases of cervical cancer occurred in HSIL/CIN2(−) when HPV16/18 was positive (one with HPV16 and two with HPV18). HSIL with HPV16/18, even in the absence of histological diagnosis of CIN2, should be observed carefully. The ratio of cervical cancer incidence in cases of HPV16 and 18 (7/63 = 11.1%) was higher than in cases of the other five HPV genotypes (4/135 = 3.7%). There was a statistically significant difference between the two groups ($p = 0.026$).

Discussion

The distribution of oncogenic HPV genotypes in female population-based samples varies among different geographical regions, although HPV16 is the most common type in most continents.[20] It is notable that HPV45 is quite rare in Japan. Onuki *et al.* reported no cases of Type 45 among 342

AEPCC Guías

ASOCIACIÓN ESPAÑOLA DE PATOLOGÍA CERVICAL Y COLPOSCOPIA

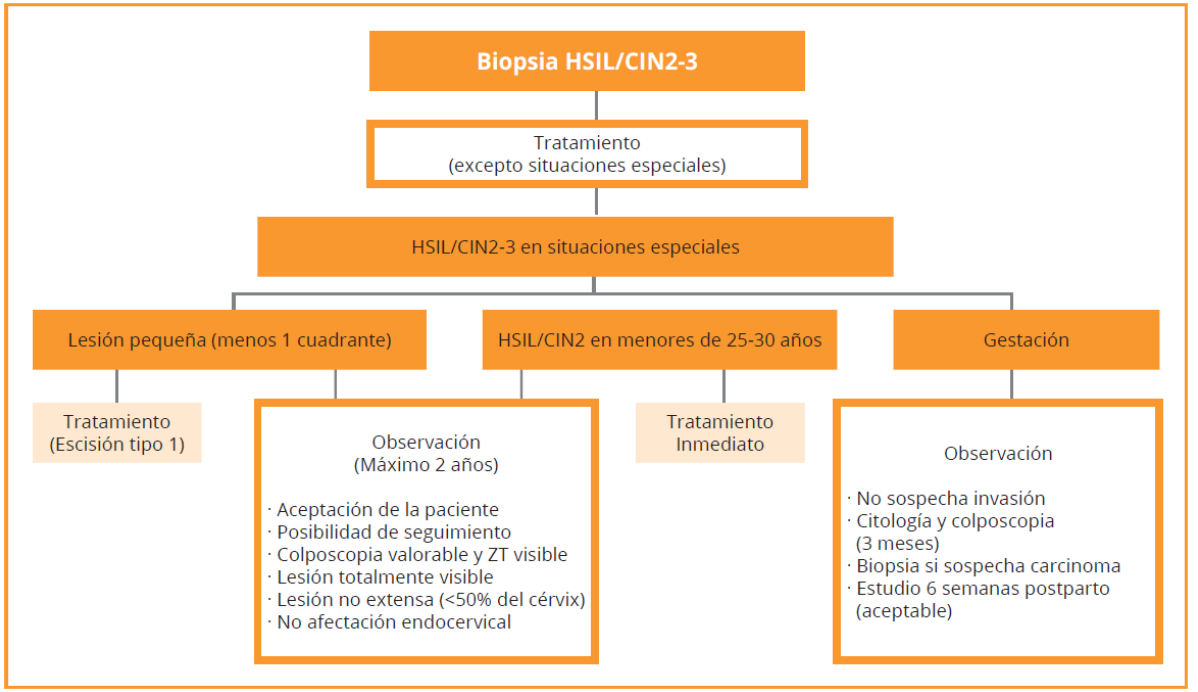
PREVENCIÓN DEL CÁNCER DE CUELLO DE ÚTERO 2014

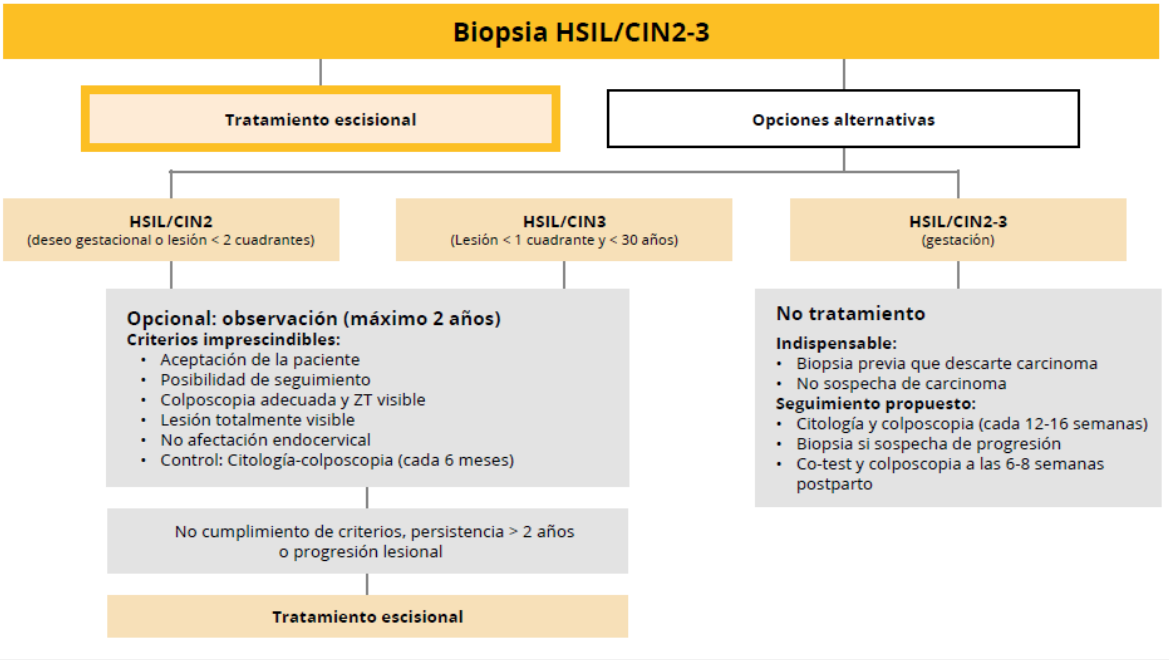
Criteri d'edat desapareix
Es manté criteri de lesió no extensa
Desig gestacional

AEPCC Guías

ASOCIACIÓN ESPAÑOLA DE PATOLOGÍA CERVICAL Y COLPOSCOPIA

PREVENCIÓN SECUNDARIA DEL CANCER DE CUELLO DEL ÚTERO, 2022.





OPEN

2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors

Rebecca B. Perkins, MD, MSc,[1] Richard S. Guido, MD,[2] Philip E. Castle, PhD,[3] David Chelmow, MD,[4] Mark H. Einstein, MD, MS,[5] Francisco Garcia, MD, MPH,[6] Warner K. Huh, MD,[7] Jane J. Kim, PhD, MSc,[8] Anna-Barbara Moscicki, MD,[9] Ritu Nayar, MD,[10] Mona Saraiya, MD, MPH,[11] George F. Sawaya, MD,[12] Nicolas Wentzensen, MD, PhD, MS,[13] and Mark Schiffman, MD, MPH[14] for the 2019 ASCCP Risk-Based Management Consensus Guidelines Committee

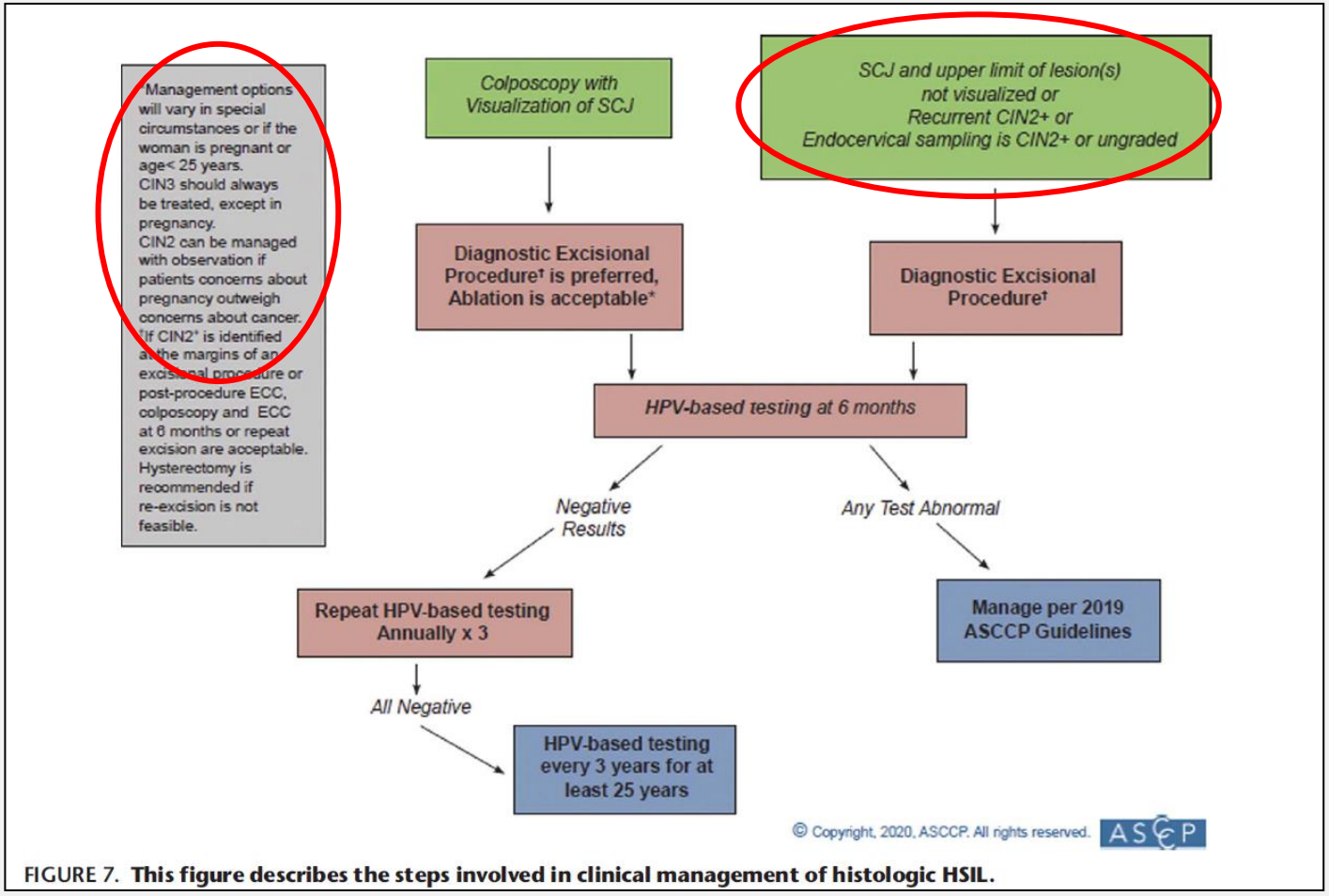


FIGURE 7. **This figure describes the steps involved in clinical management of histologic HSIL.**

OPEN

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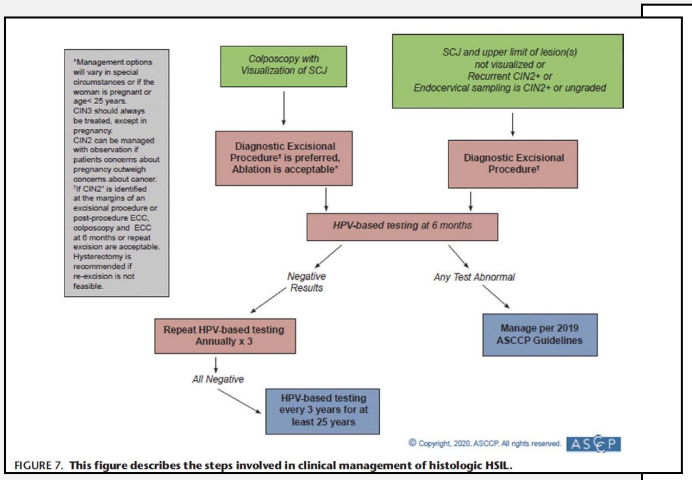

FIGURE 7. **This figure describes the steps involved in clinical management of histologic HSIL.**

Criteri d'edat es té en compte però no determinant
Desig gestacional

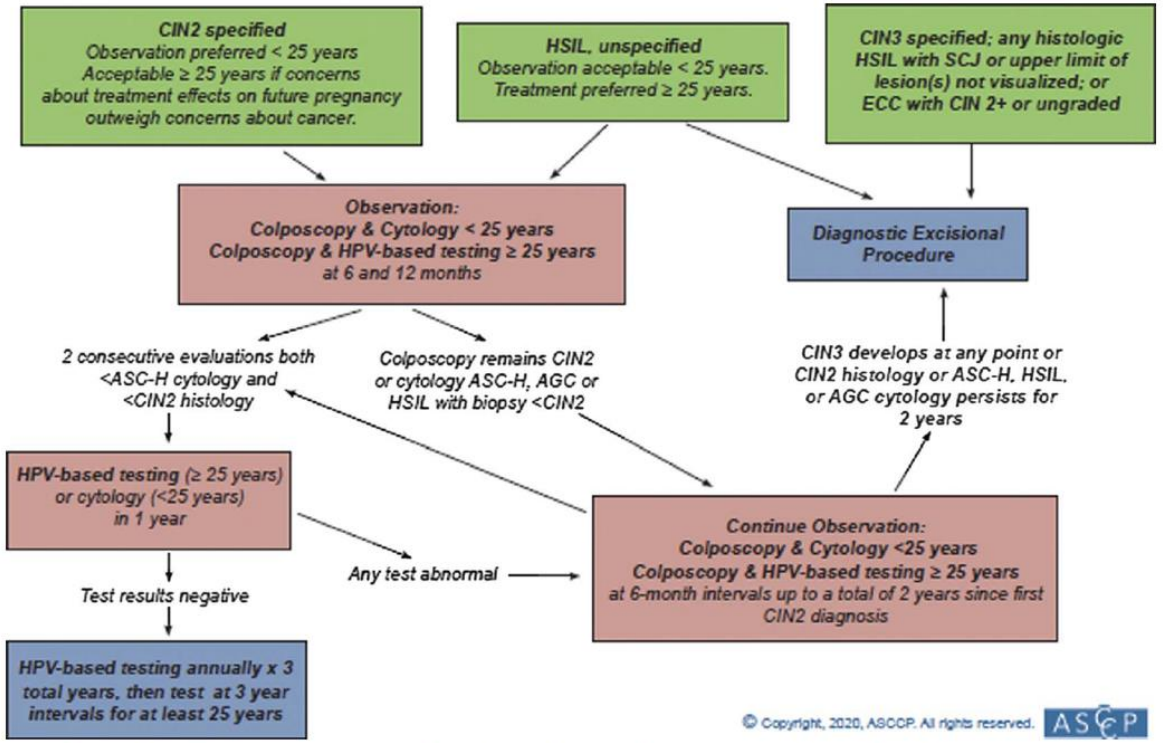

FIGURE 8. **This figure describes management of CIN 2 in patients whose concerns about the effects of treatment on a future pregnancy outweigh their concerns about cancer.** Also addressed is the management of histologic HSIL not further specified in women younger than 25 years, for whom observation is acceptable, and for women 25 years or older for whom treatment is preferred.

European Journal of Obstetrics & Gynecology and Reproductive Biology 155 (2011) 204–208

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.elsevier.com/locate/ejogrb

Estudi de cohorts
50 dones

Outcome of expectant management of cervical intraepithelial neoplasia grade 2 in women followed for 12 months☆

Michelle G. Discacciati [a,b], Carlos André S. de Souza [a,b], Maria Gabriela d'Otavianno [a,b], Liliana A.L. Ângelo-Andrade [a,d], Maria Cristina A. Westin [a,b], Silvia H. Rabelo-Santos [a,c], Luiz C. Zeferino [a,b,*]

[a] Woman's Hospital Prof Dr Jose Aristodemo Pinotti-CAISM, State University of Campinas (UNICAMP), Campinas, São Paulo, Brazil
[b] Departament of Obstetrics and Gynecology, School of Medical Sciences, State University of Campinas (UNICAMP), Campinas, São Paulo, Brazil
[c] School of Pharmacy, Federal University of Goiás, Goiânia, Goías, Brazil
[d] Departament of Pathology, State University of Campinas (UNICAMP), Campinas, São Paulo, Brazil

Dades pròpies (1era sèrie 100 casos)

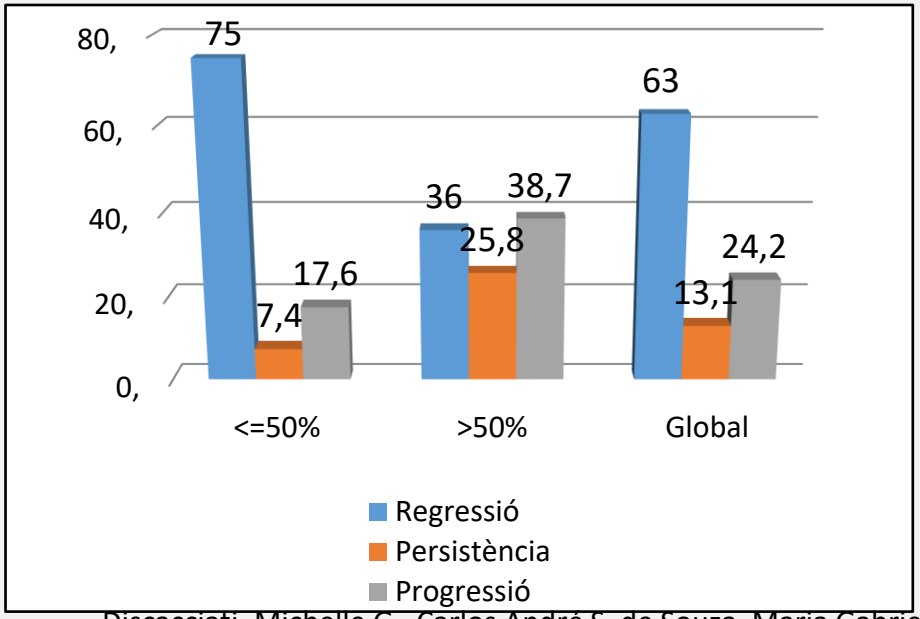

Table 3
Association between CIN 2 outcome and number of quadrants of the lesion extension at first colposcopic evaluation.

	One quadrant	More than one quadrant	OR (95% CI)
Outcome	*n* (%)	*n* (%)	
3 months follow-up			
Regression	13 (52)	02 (14)	6.50 (1.20–35.23)
Persistence or progression	12 (48)	12 (86)	Reference
6 months follow-up			
Regression	20 (71)	06 (46)	2.92 (0.75–11.41)
Persistence or progression	08 (29)	07 (54)	Reference
9 months follow-up			
Regression	21(75)	07 (58)	2.14 (0.21–8.97)
Persistence or progression	07 (25)	05 (42)	Reference
12 months follow-up			
Regression	23 (79)	08 (67)	2.40 (0.46–12.72)
Persistence or progression	06 (21)	05(33)	Reference

OR: odds ratio; CI: confidence interval.
The cases that were discontinued or missed the follow-up were not included in the analysis.

Discacciati, Michelle G., Carlos André S. de Souza, Maria Gabriela d'Otavianno, Liliana A. L. Ângelo-Andrade, Maria Cristina A. Westin, Silvia H. Rabelo-Santos, y Luiz C. Zeferino. «Outcome of expectant management of cervical intraepithelial neoplasia grade 2 in women followed for 12 months». *European Journal of Obstetrics and Gynecology* 155, n.º 2 (01 de 2011): 204-8

Conclusions

01 L'actitud expectant amb el CIN2 és segura

Regressió del 84 al 48%

Progressió del 16 al 52%

02 El resultat dependrà del genotip del VPH, la citològia prèvia i el tamany de la lesió

03 Tot i en el pitjors dels casos, l'actitud expectant podria ser una opció

Moltes gràcies

www.futurhospitaldelmar.cat/ca/futur/