Trattamenti distruttivi ed escissionali elettrochirurgici

M. Barbero, T. Cunzolo

Colposcopia

Diagnostica e Operativa del basso tratto genitale

10-11-12 Novembre 2016 Milano

TRATTAMENTO DELLA CIN

TRATTAMENTO DELLA DONNA AFFETTA DA CIN

TERAPIA DELLA CIN

- < 25 anni
- > 50 anni
- in gravidanza
- nella donna immunodepressa

MANAGEMENT OF CIN

While some 60–70% of histologically spected cases will revert to normal over time, some 15% will persist.

Between 0% and 30% will ultimately reveal CIN2-3 and less than 1% will lead to invasive carcinoma.

Pertanto..

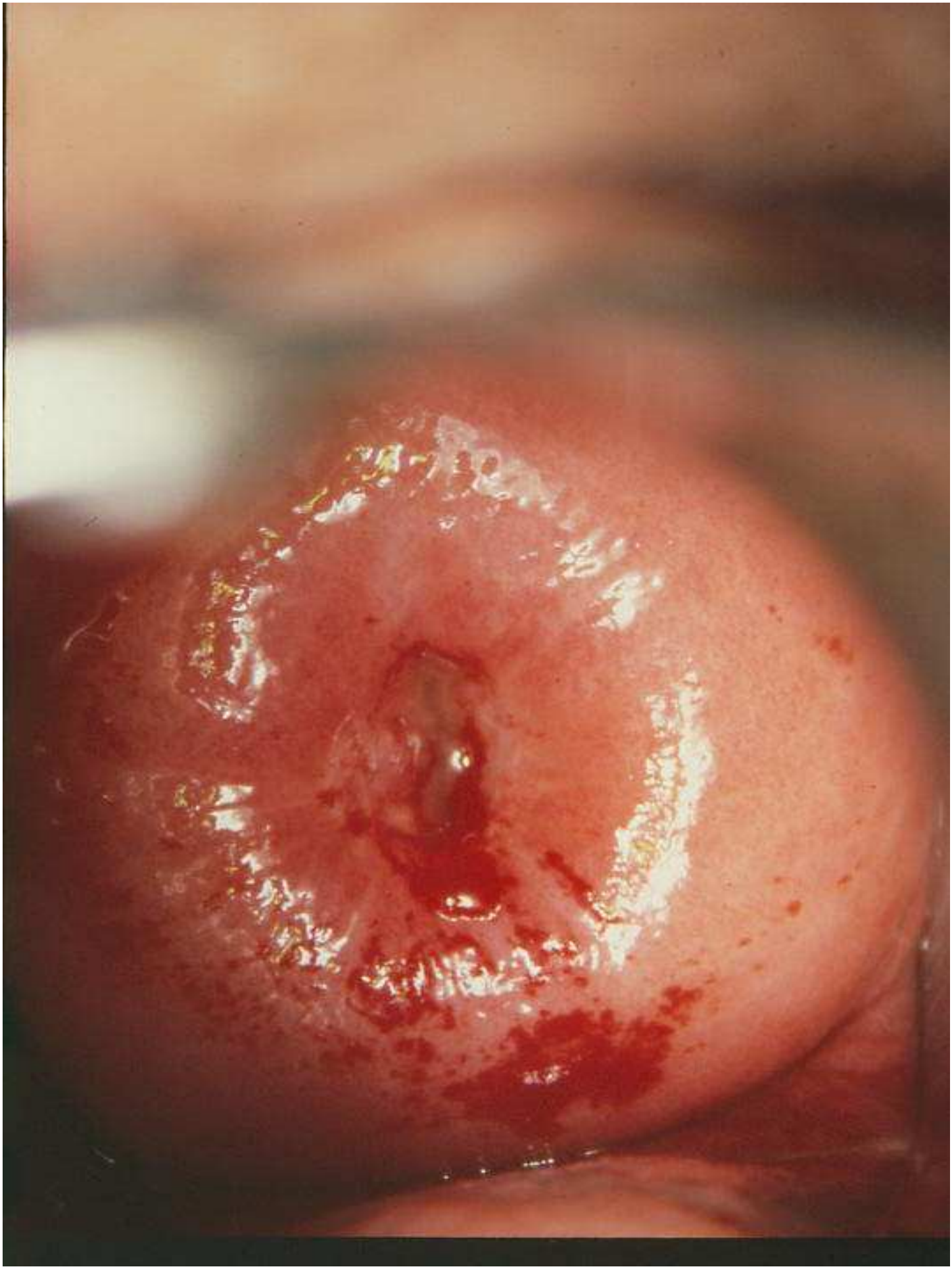
- Cautela nel decidere un trattamento
- Scegliere il trattamento meno invasivo
- Terapia efficace
- Follow up necessario

MANAGEMENT OF CIN
> 50 ANNI

- La zona di trasformazione tende a ritrarsi entro l'endocervice in più del 40% delle donne sopra i 50 anni.
- L'epitelio squamoso diviene atrofico
- Viene persa la glicogenazione
- Frequente stenosi dell'OUE

↓

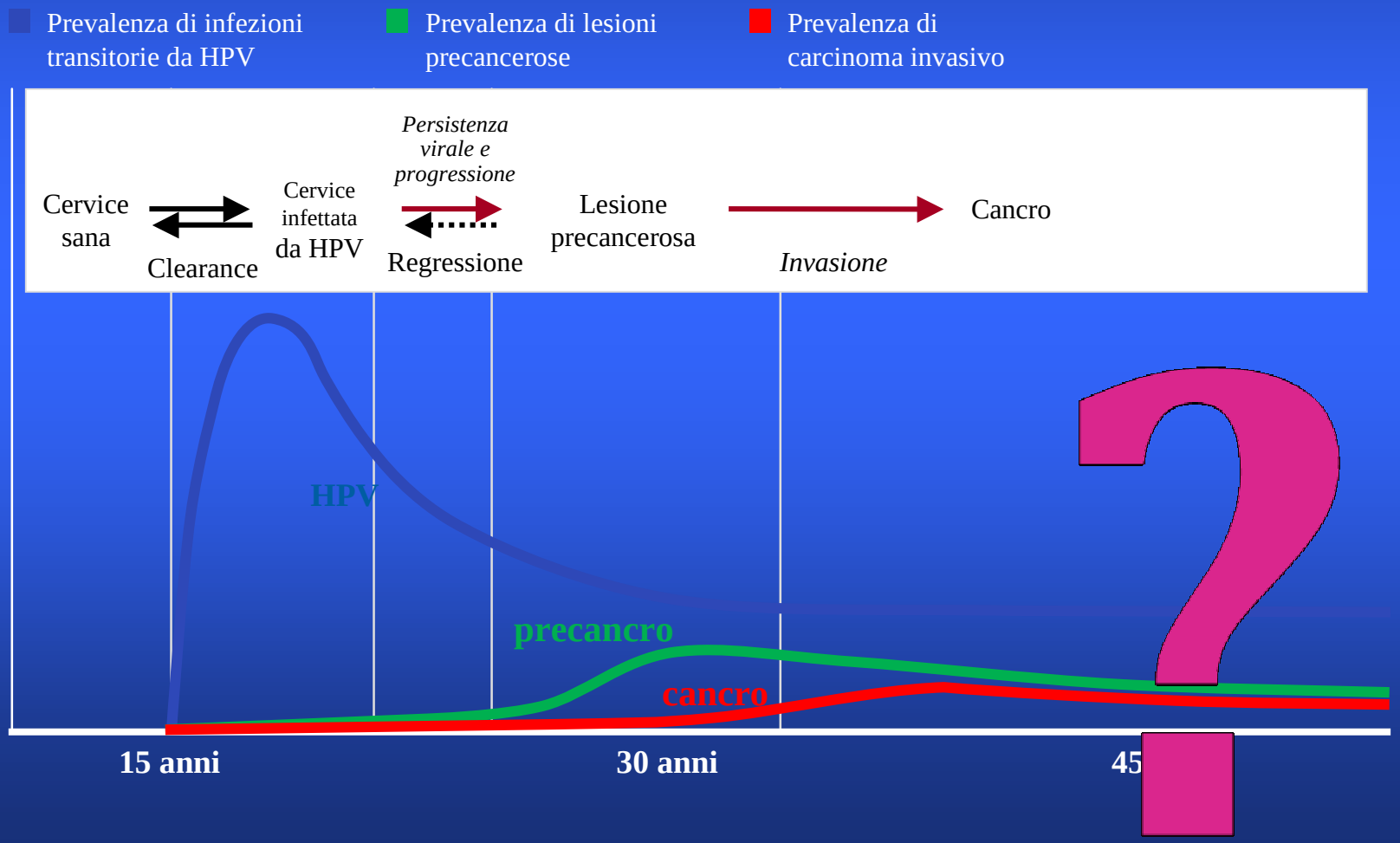
COLPOSCOPIA NON CONCLUSIVA



Pertanto..

- Ripetizione PAP TEST
- Colposcopista esperto
- Terapia estrogenica locale
- Trattamento escissionale
- Ago
- Follow-up intensivo

STORIA NATURALE DEL CERVICOCARCINOMA



Cochrane Database of Systematic Reviews

The Cochrane Library, Copyright 2010,

The Cochrane Collaboration

Surgery for cervical intraepithelial neoplasia

Types of intervention

1) Laser Ablation
2) Laser Conisation
3) LLETZ
4) Knife Conisation
5) Cryotherapy

Conclusions

Implications for practice

The evidence from the 29 RCTs identified suggests that there is no obvious superior surgical technique for treating cervical intraepithelial neoplasia in terms of treatment failures or operative morbidity.

LLETZ appeared to provide the most reliable specimens for histology with the least morbility

Characteristics and Morbidity

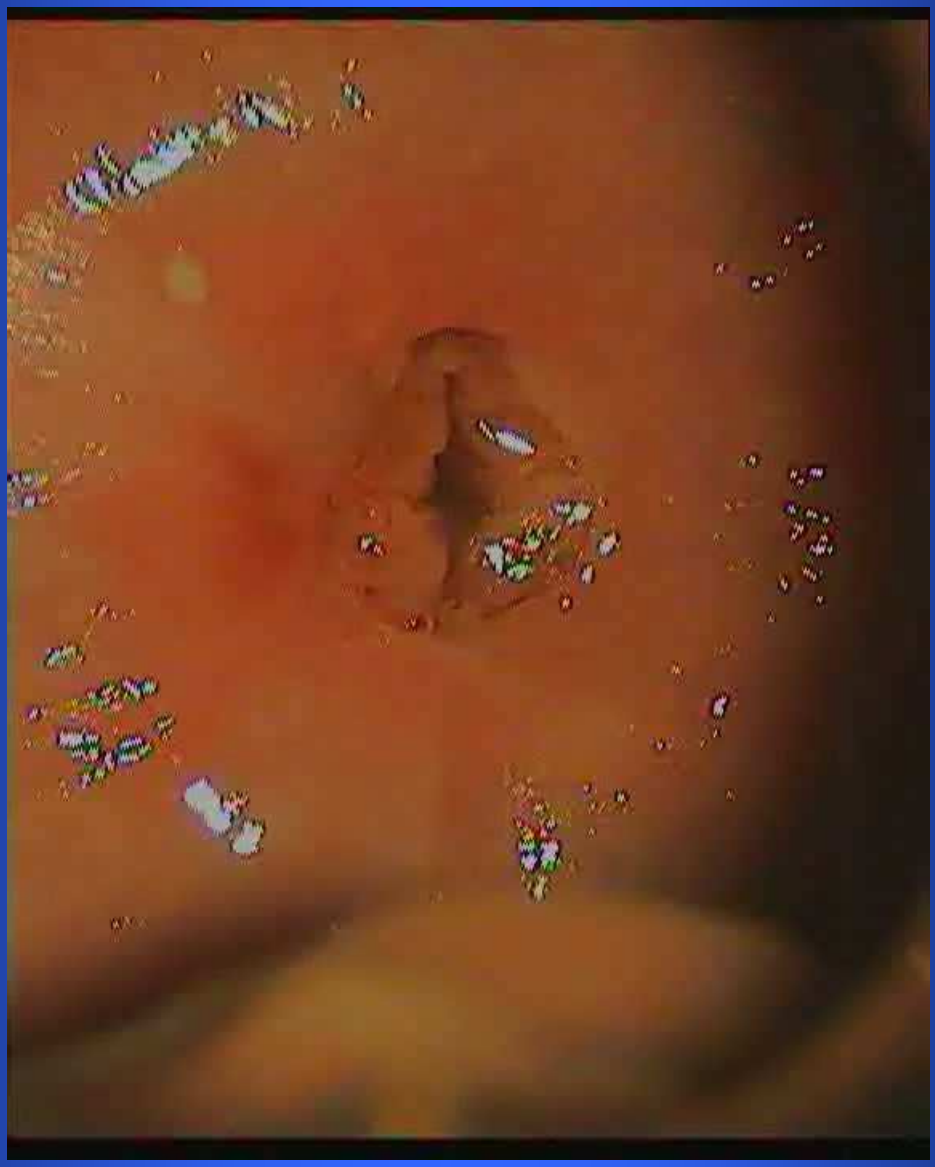
1) Duration of treatment
2) Peri-operative severe pain
3) Peri-operative severe bleeding, primary and secondary haemorrhage
4) Depth and presence of thermal artifact
5) Adequate colposcopy at follow-up
6) Cervical stenosis at follow-up

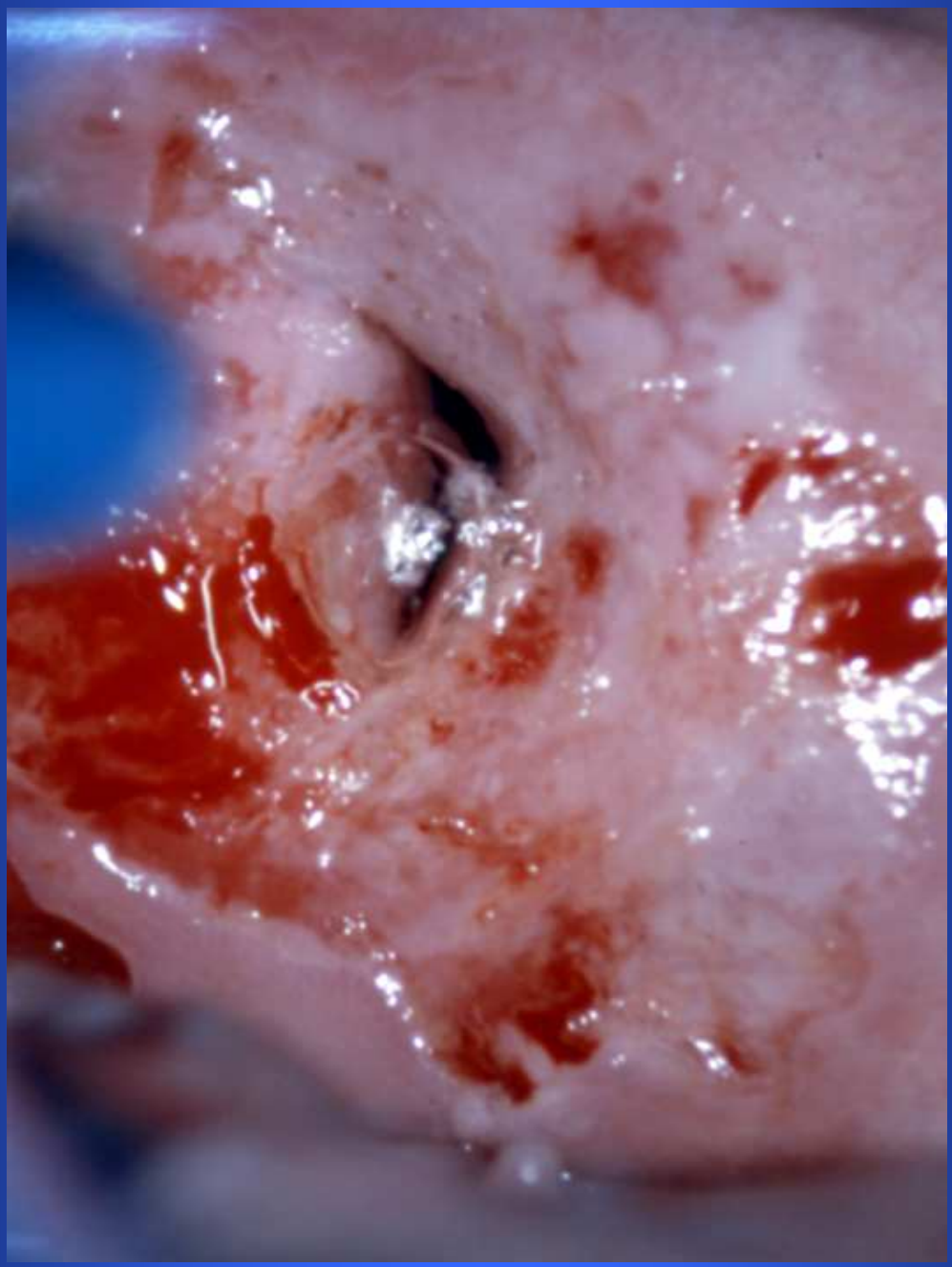
REQUISITI PER IL TRATTAMENTO DISTRUTTIVO

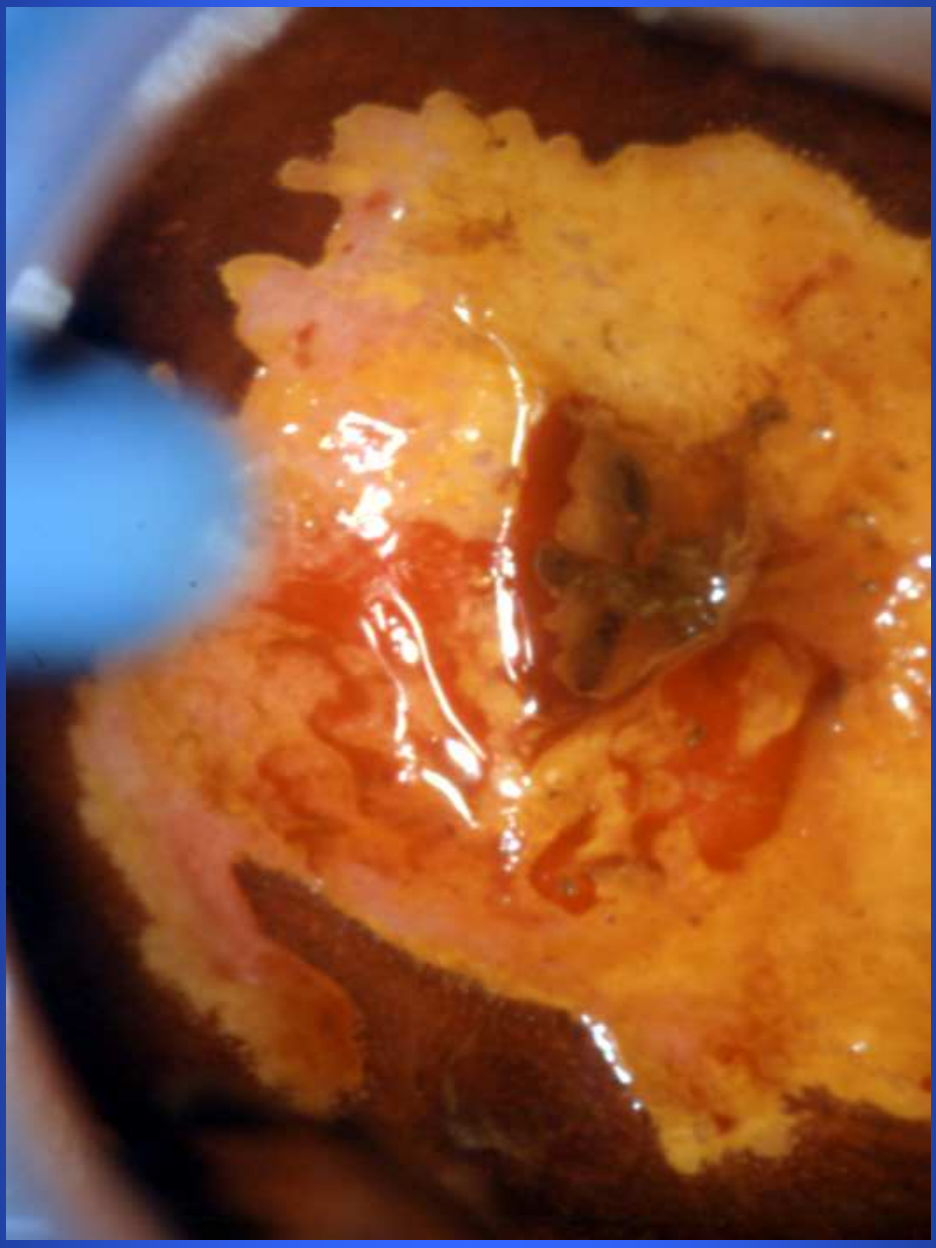
1) Zona di trasformazione interamente visibile (colposcopia soddisfacente)
2) No sospetto di microinvasione o invasione
3) No sospetto di malattia ghiandolare
4) Corrispondenza tra citologia ed istologia

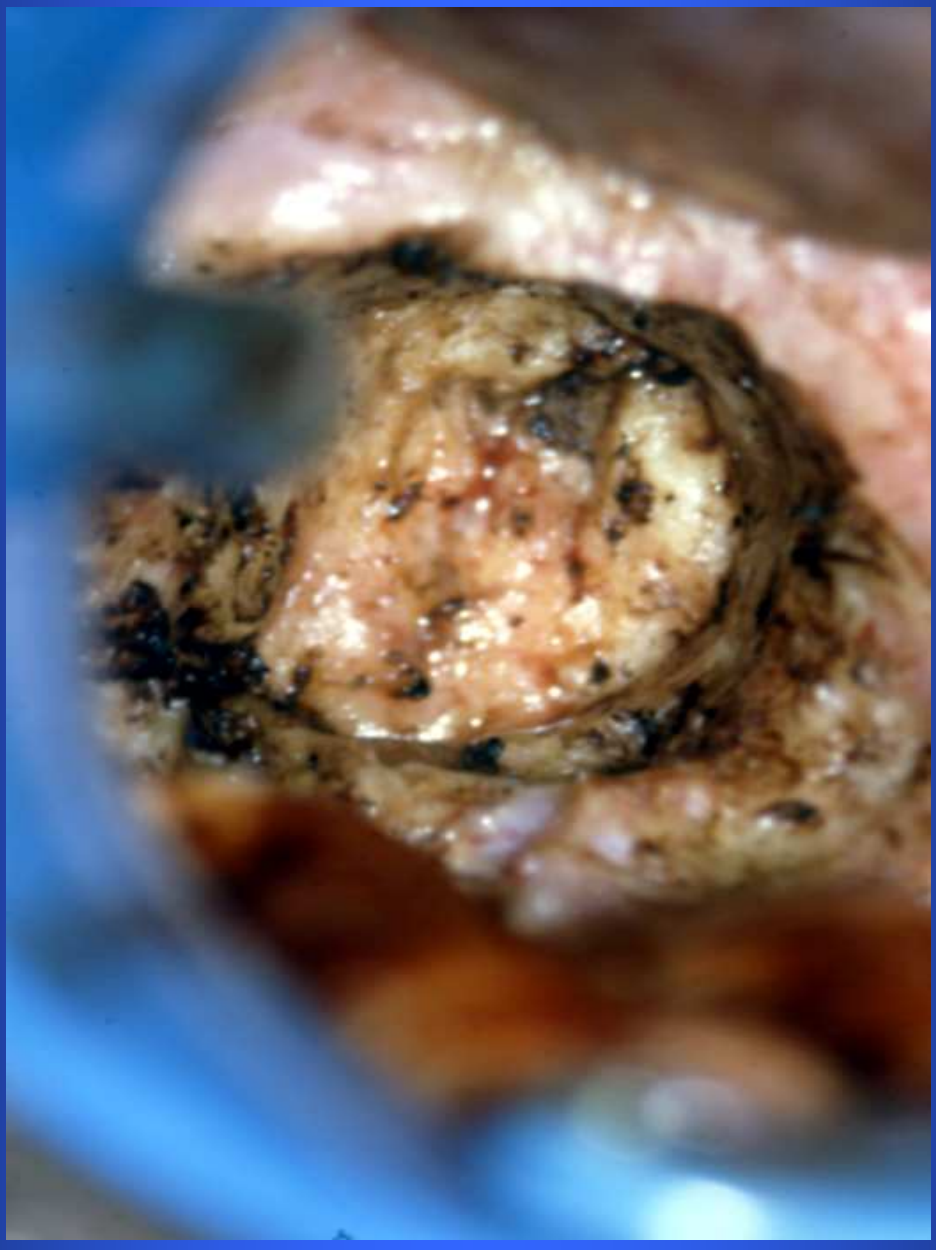
The Cochrane Database of Systematic Reviews, 2004

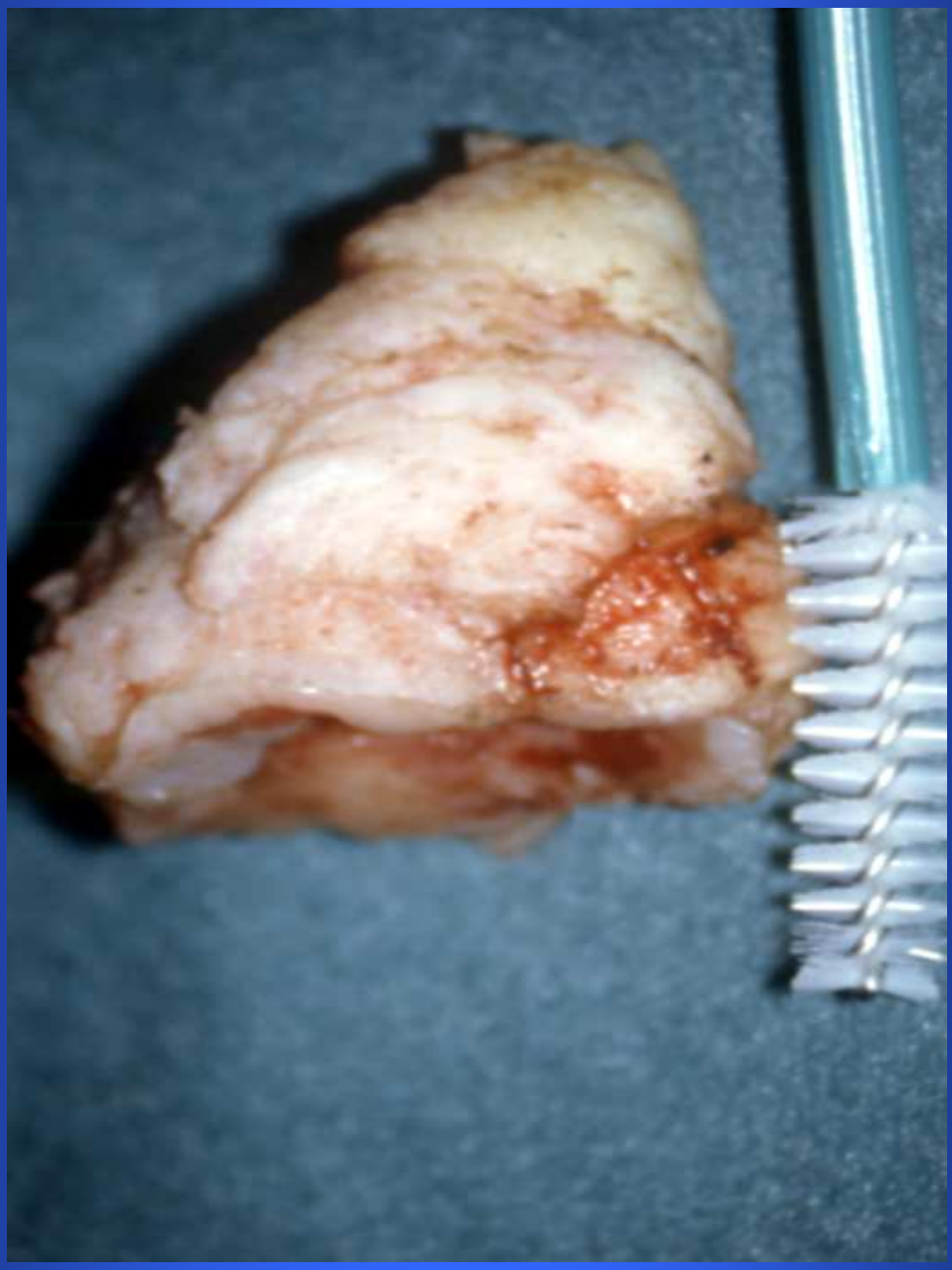
Surgery for cervical intraepithelial neoplasia

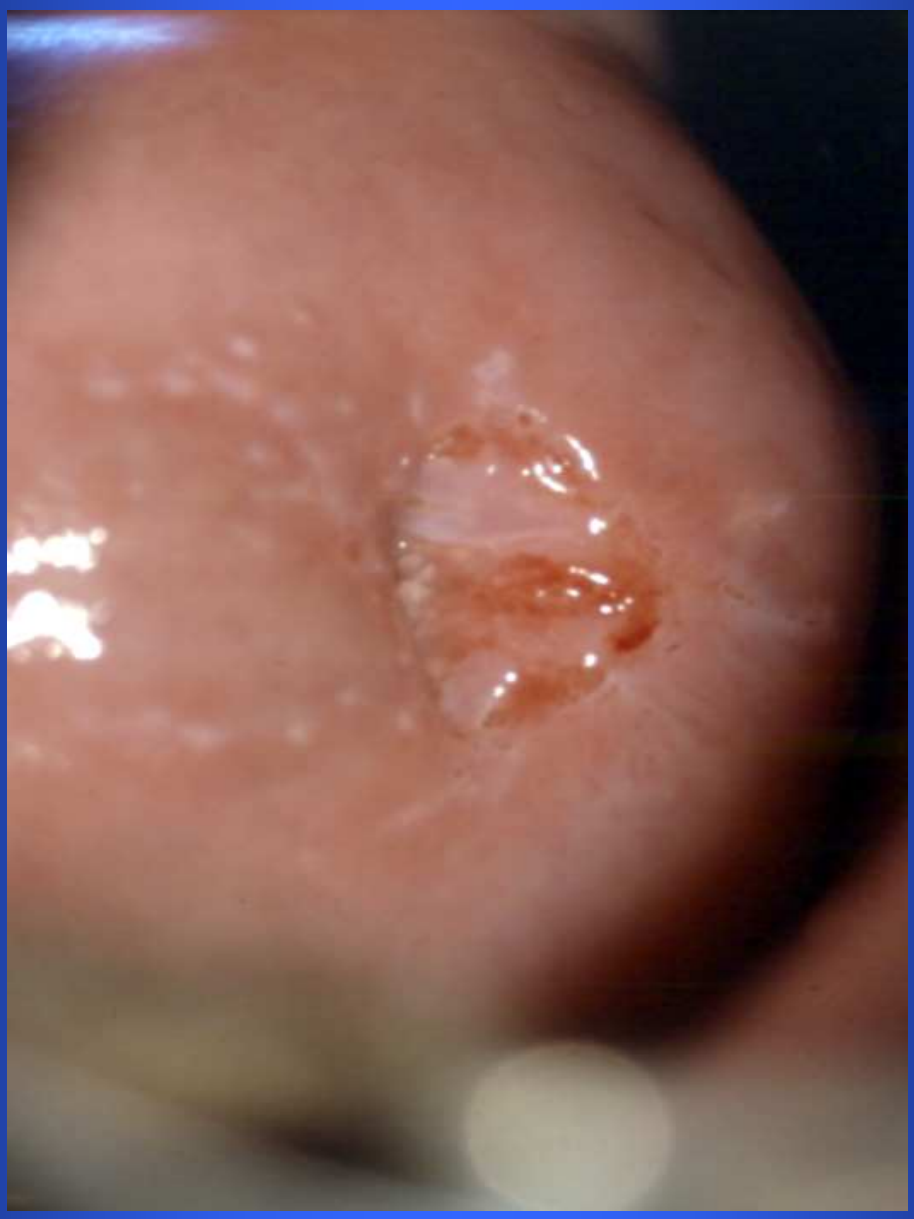


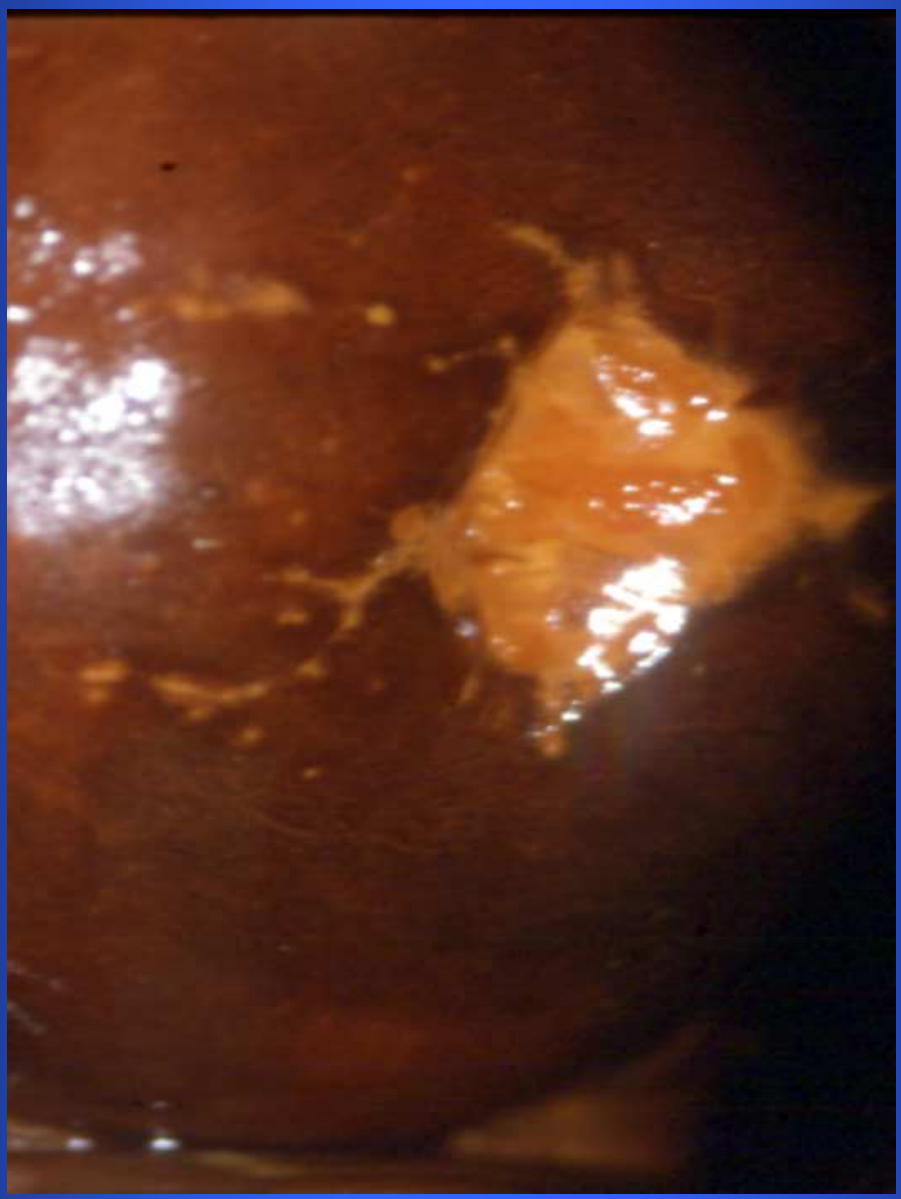


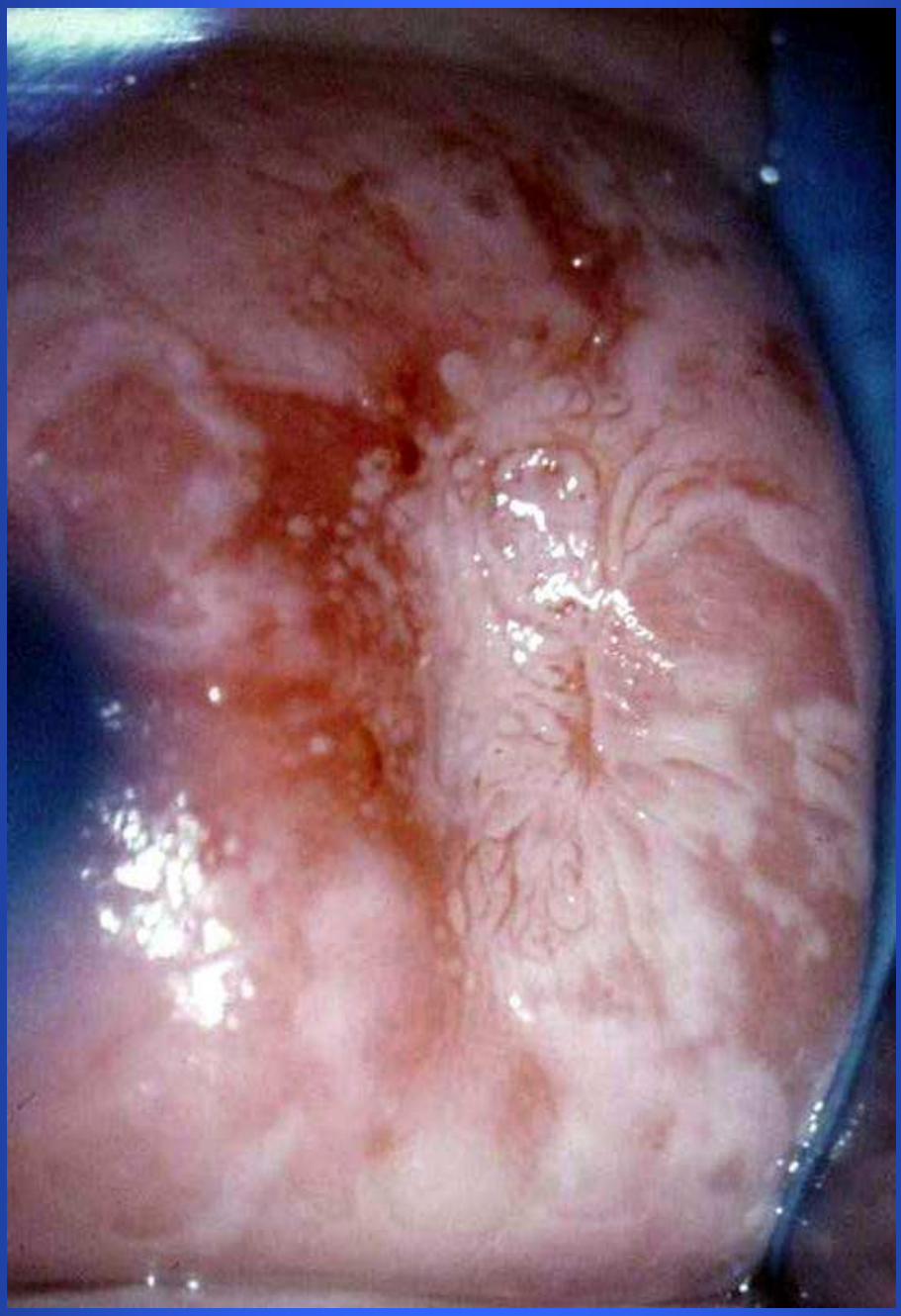


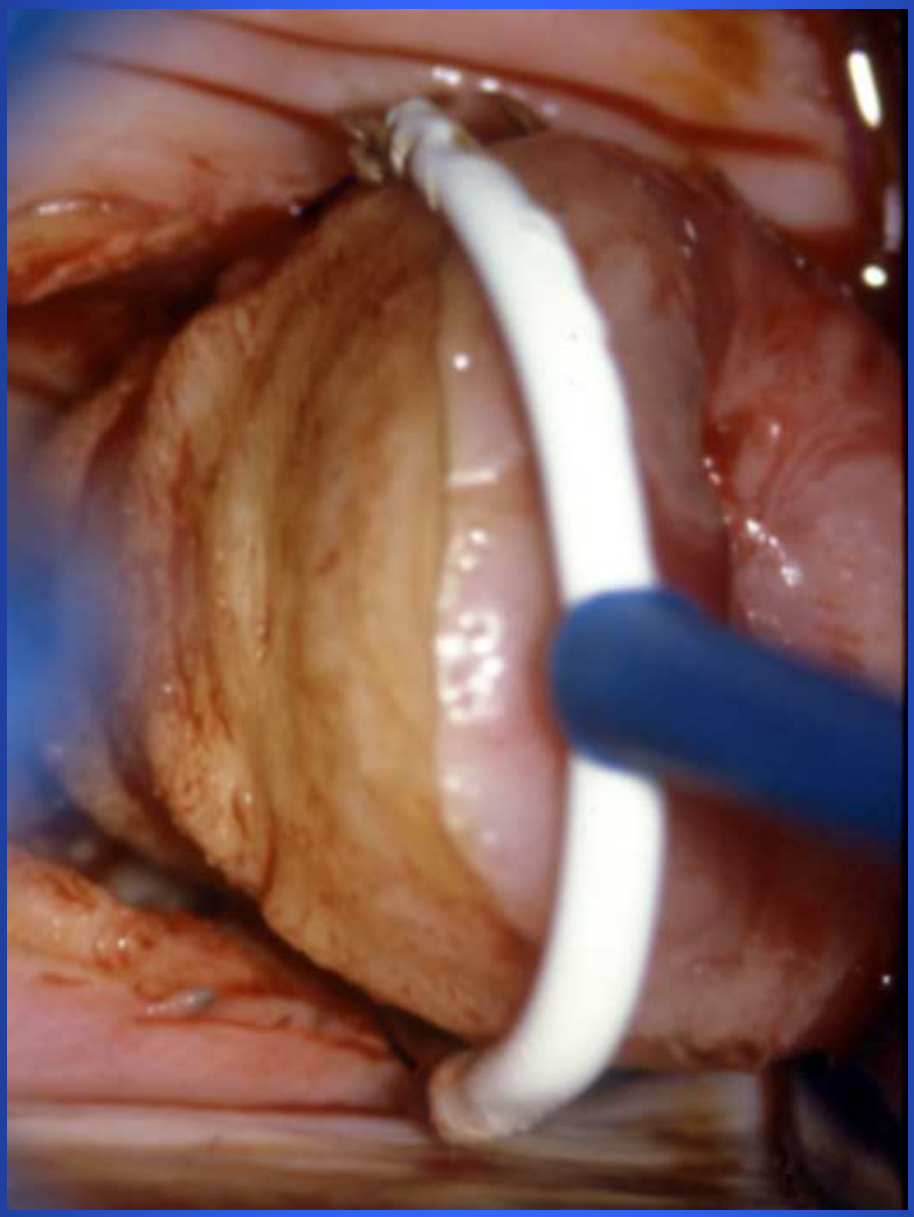


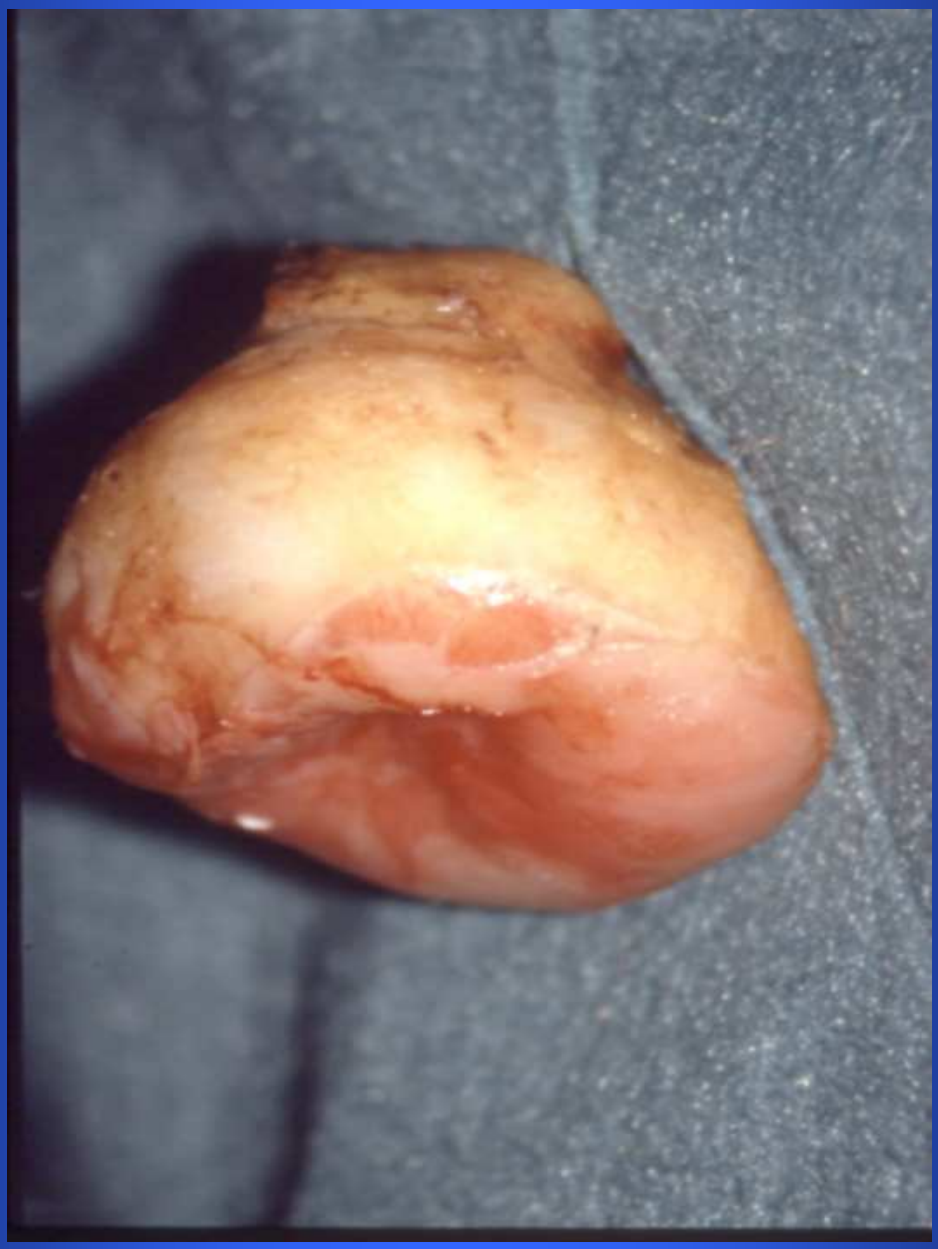


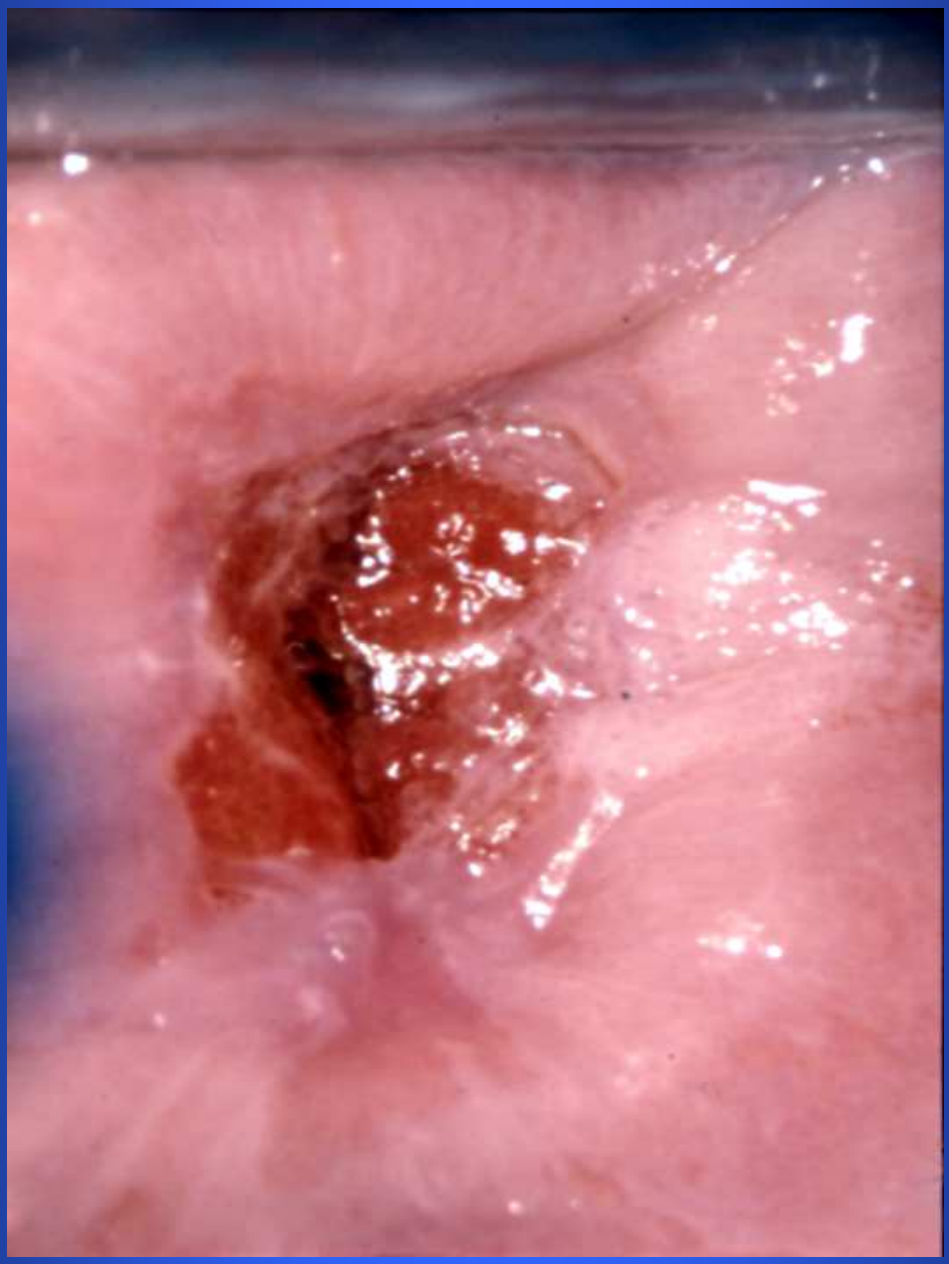


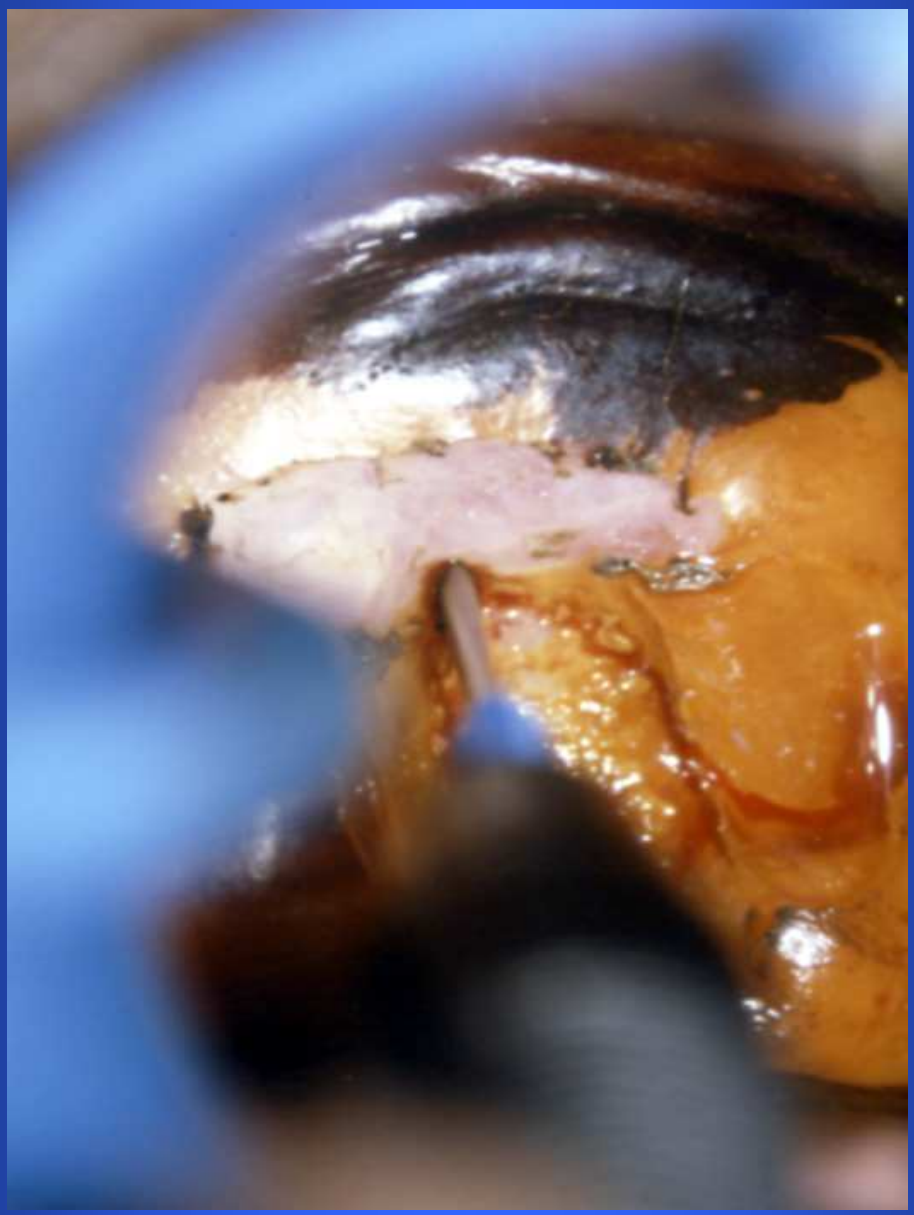


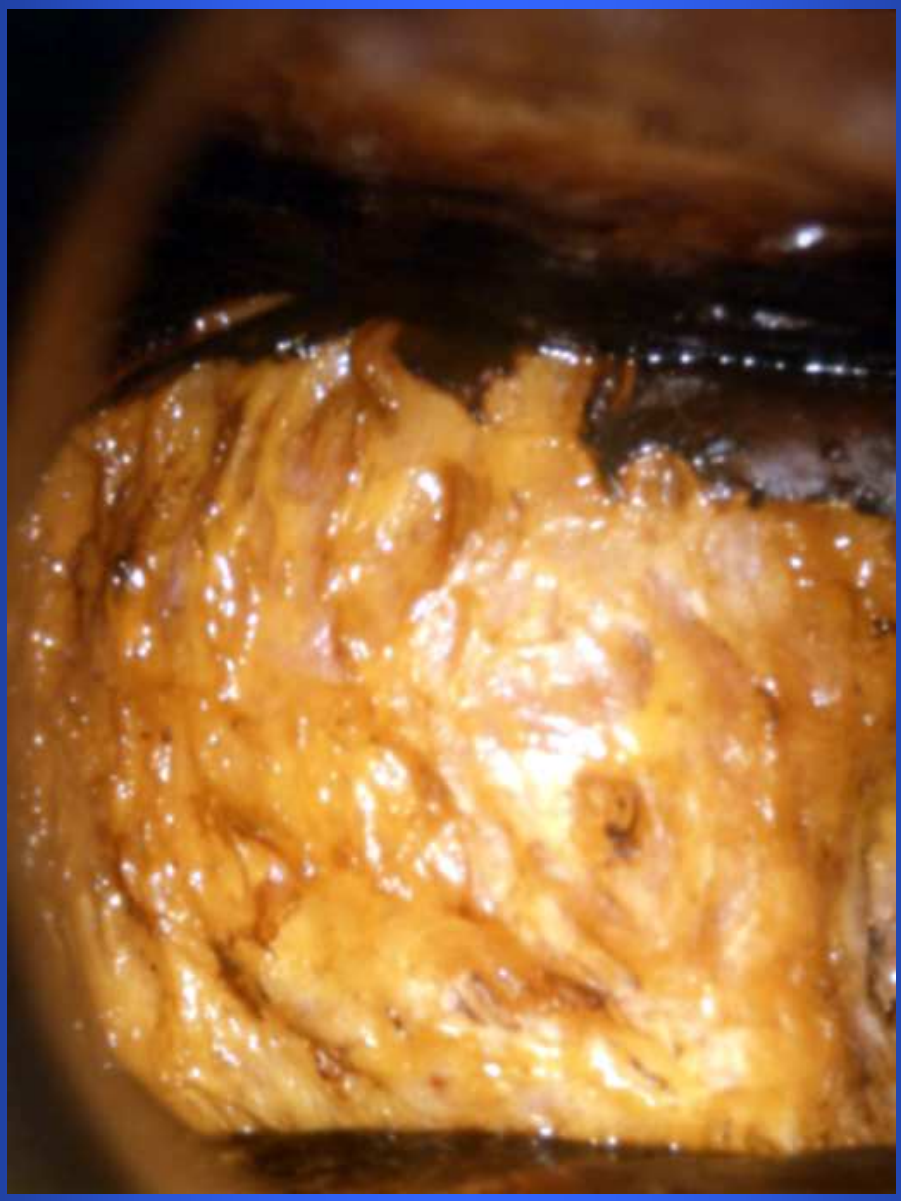


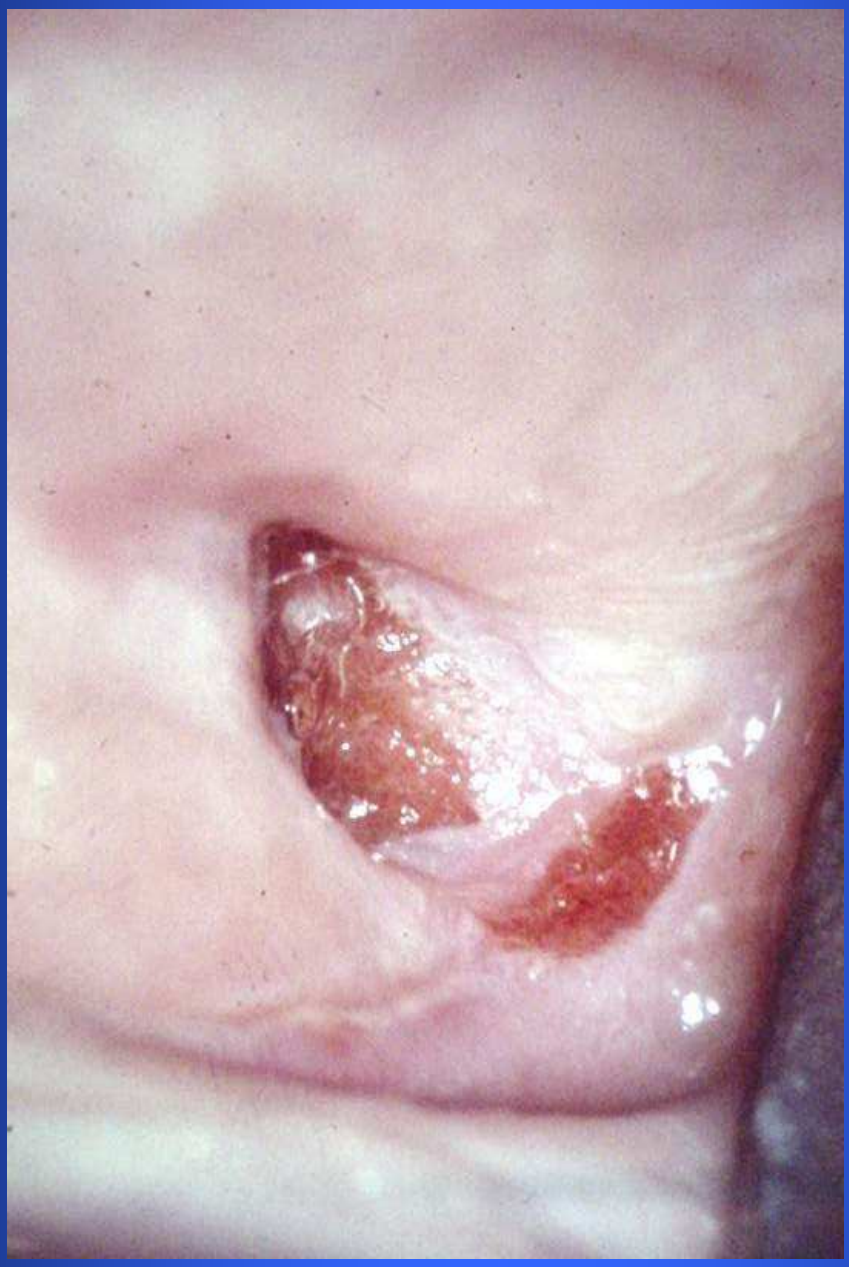


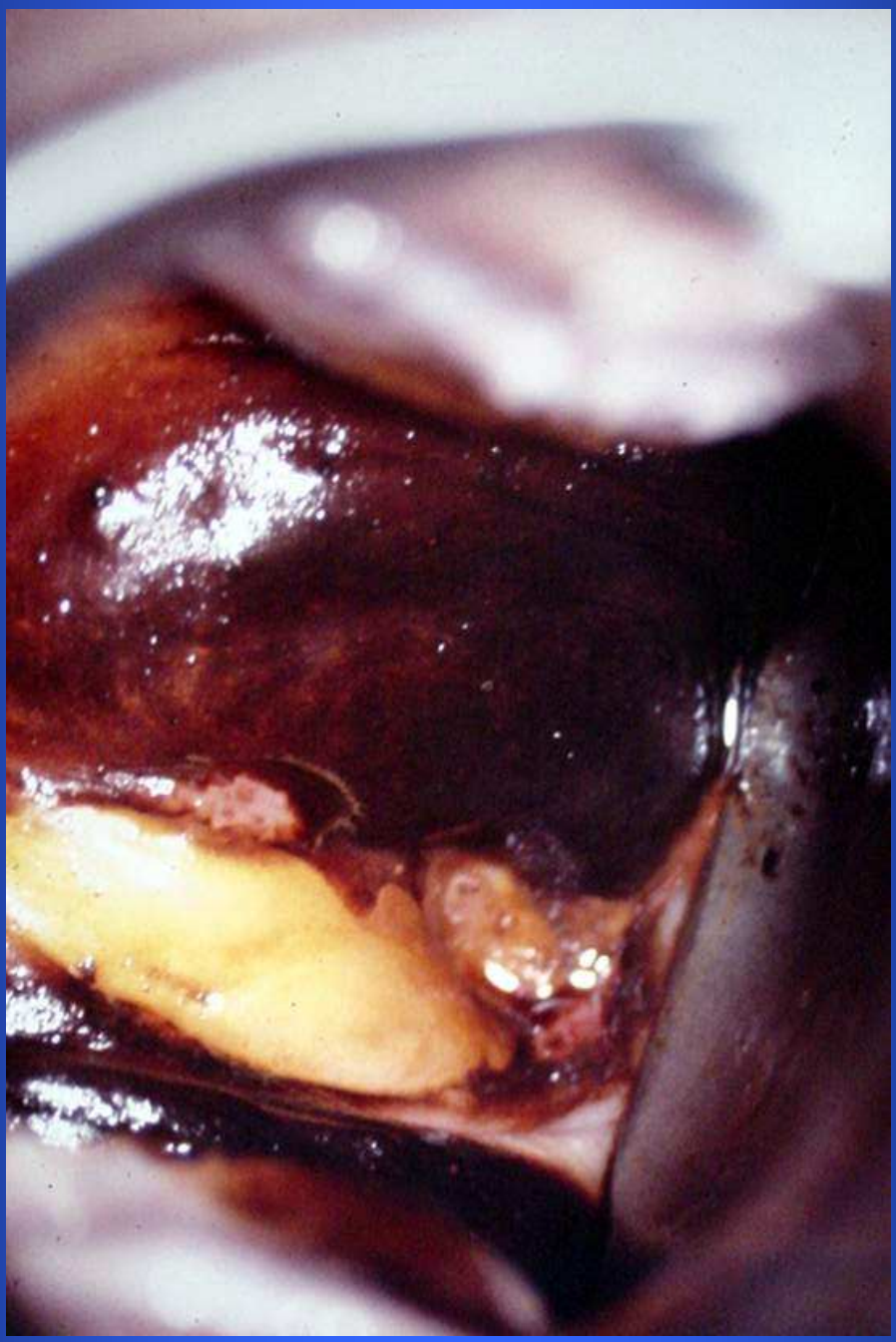












ENDOCERVICOSCOPIA

VALUTAZIONE DELL'ENDOCERVICE

QUANDO ?

- **Giunzione sc che risale nel cc (20% delle donne in età fertile)**
- **Mancata visualizzazione del margine superiore della lesione nel c.c.**
- **Pap – Test anormale in presenza di colposcopia e vaginoscopia negativa**
- **Lesioni ghiandolari al citologico (AGUS)**
- **Stadiazione del K endometrio (adeguato approccio terapeutico)**

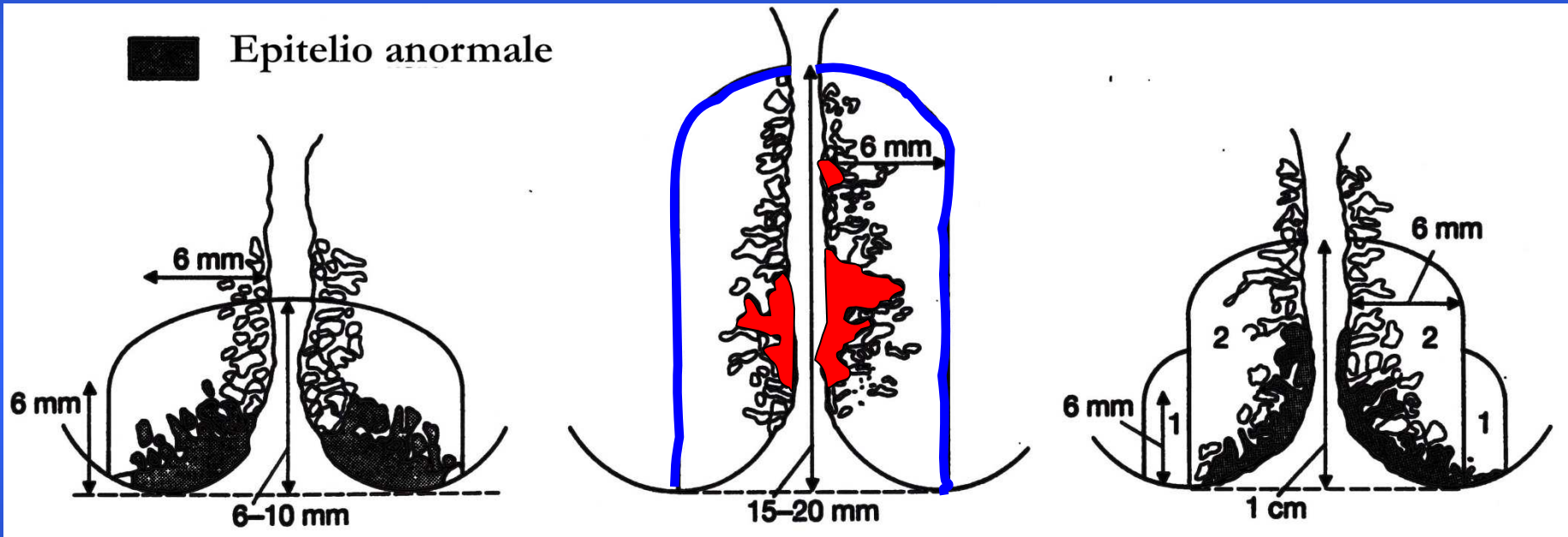
METODICHE PER LA VALUTAZIONE DELL' ENDOCERVICE

- **CITOLOGIA ENDOCERVICALE**
- **COLPOSCOPIA (divaricatore di Kogan / pinze a punta sottile)**
- **CURETTAGE ENDOCERVICALE**
- **MICROCOLPOSCOPIA**
- **ENDOCERVICOSCOPIA**

VALORE DIAGNOSTICO DI COLPOSCOPIA, PAP-TEST ED ENDOCERVICOSCOPIA NELLA DETERMINAZIONE DELLA LESIONE DISPLASTICA NEL CANALE CERVICALE

	Colposcopia		*Citologia*		*Endocervicoscopia*	
	%	*N°*	*%*	*N°*	*%*	*N°*
Sensibilità	*28*	*18/65*	*65*	*39/60*	*69*	*50/72*
Specificità	*100*	*18/18*	*56*	*9/16*	*100*	*17/17*

VARIABILITA’



Modificata da:
Singer A & Monaghan JM “Lower genital tract precancer. Colposcopy, pathology and treatment

ESCISSIONE CON AGO

LINEE GUIDA SICPCV

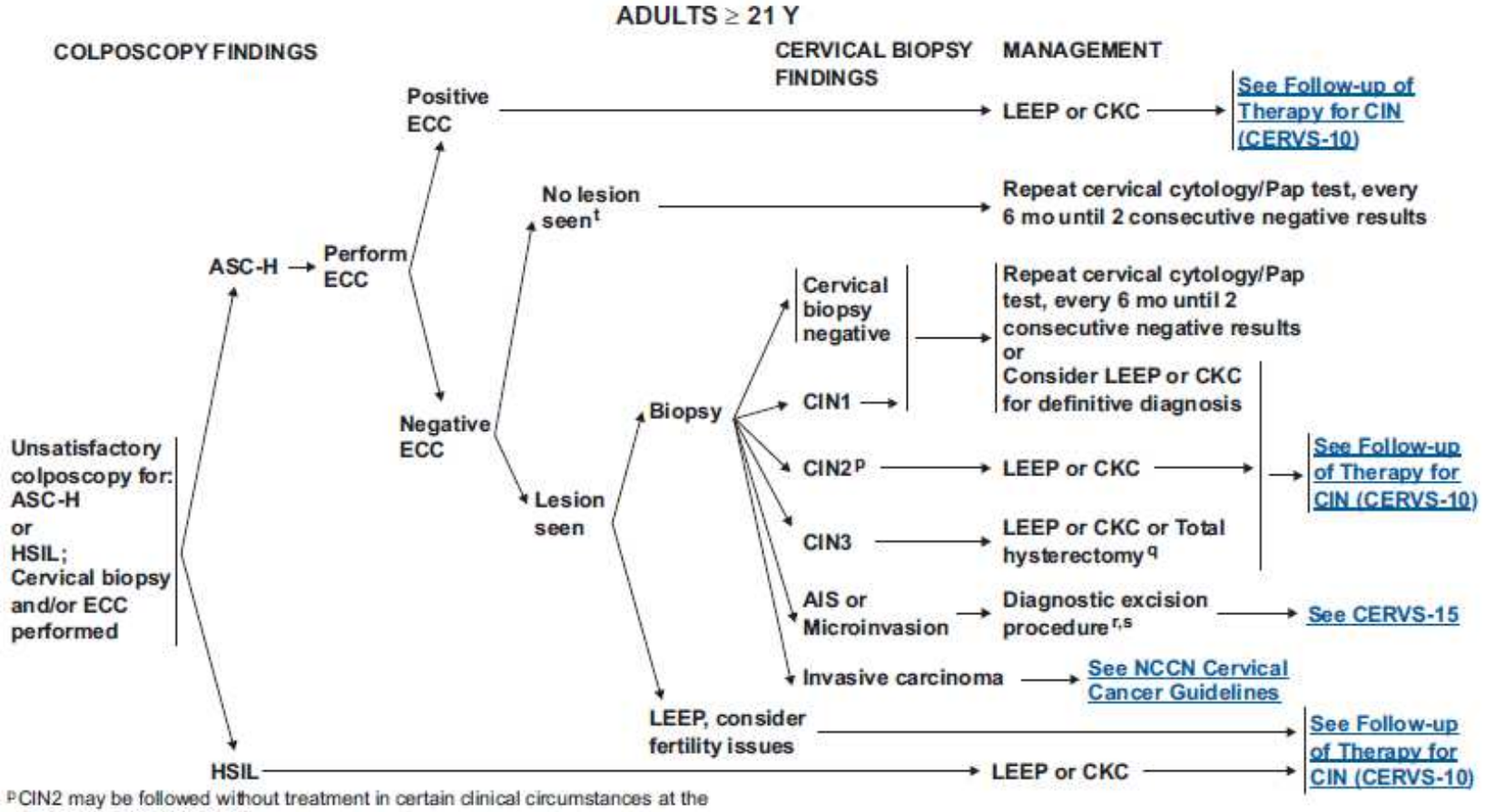
HSIL → COLPOSCOPIA → BIOPSIA MIRATA

TRATTAMENTO

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2012
Cervical Cancer Screening

NCCN Guidelines Index
Cervical Cancer Screening TOC
Discussion



[p] CIN2 may be followed without treatment in certain clinical circumstances at the discretion of the physician.

[q] If appropriate for preexisting pathologic condition or quality of life.

[r] CKC is preferred. However, LEEP is acceptable provided attention is given to adequate margins.

[s] If results favor neoplasia, microinvasion, or adenocarcinoma in situ, follow CKC or LEEP with endometrial sampling if not yet done.

[t] Perform vaginal and vulvar colposcopy.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

152 West Washington St • Hagerstown, MD 21740 • 301-733-3640 • 800-787-7227 • 301-733-5775 (fax)

ASCCP

AMERICAN SOCIETY FOR COLPOSCOPY AND CERVICAL PATHOLOGY

The society for lower genital tract disease since 1964

Search: GO

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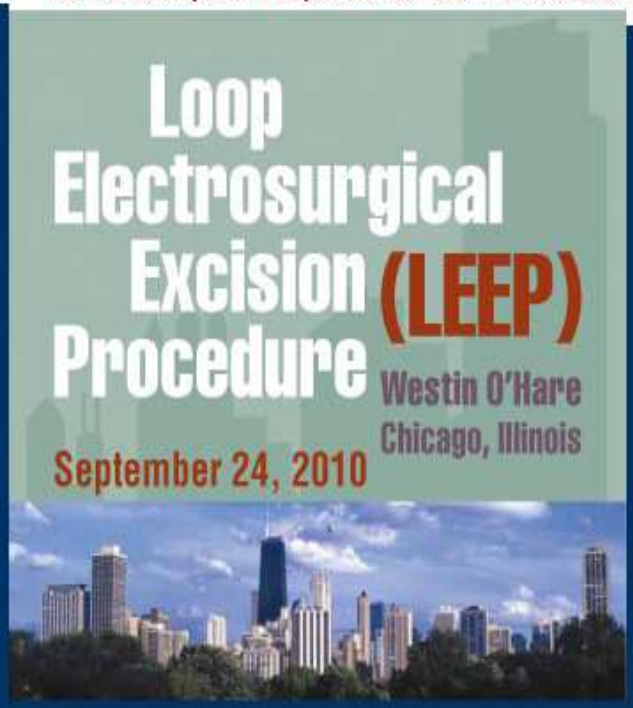
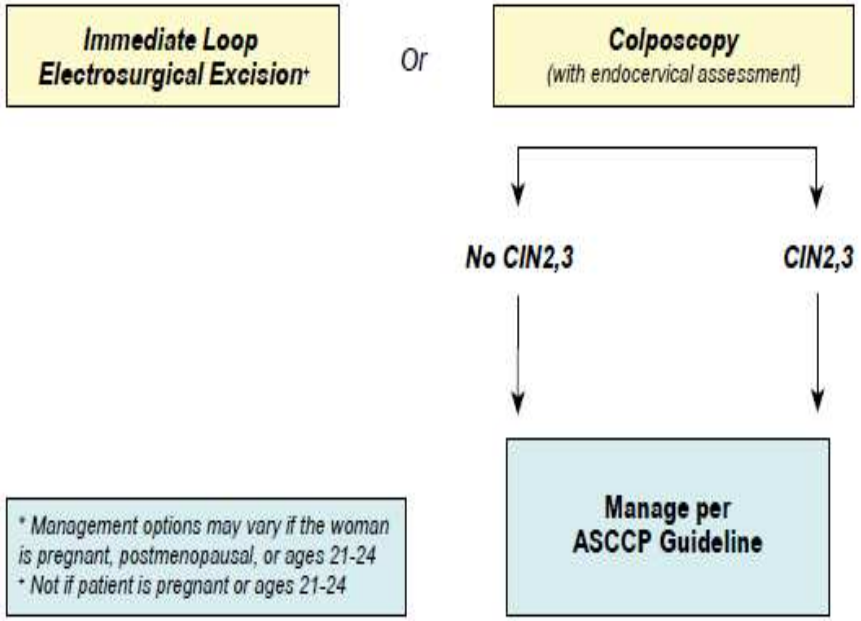


Management of Women with High-grade Squamous Intraepithelial Lesions (HSIL)*



* Management options may vary if the woman is pregnant, postmenopausal, or ages 21-24
\+ Not if patient is pregnant or ages 21-24

H-SIL: QUALE ISTOLOGIA ?

100 casi H-SIL

LLETZ

94% CIN 2 - 3
2% CIN 1
1% NO CIN
3% MICROINV

Dunn TS 2003

SEE AND TREAT

CITOLOGIA ANORMALE

COLPOSCOPIA

TRATTAMENTO

SEE AND TREAT

ASSENZA DI ANOMALIE ISTOLOGICHE	5 %	Luesley,	1990
	5 %	Bicrilg,	1990
	10 %	Howe,	1991
	14 %	Ferenczy,	1996

…. Loop electrosurgical excision procedure using the “see and treat” approach should be limited to cytologically and colposcopically unequivocal intraepithelial lesion….

…. Loop electroexcision represents an attractive means of diagnosing and treating cervical cancer precursors.

Conclusions

Implications for research

We would advocate a large multi-centre trial of sufficient power to evaluate the role of primary “see and treat” versus LLETZ or Laser Ablation after confirmation of disease by representative biopsy

”Evidence supporting see-and-treat management of cervical intraepithelial neoplasia: a systematic review and meta-analysis” RMF Ebisch at all, BJOG Jul 2015

3732 pubblicazioni → **13 studi**

4611 pazienti

OVERTREATMENT → **NO CIN- CIN1**

OVERTREATMENT

HSIL + COLP. G II → 11,6%

HSIL + COLP. G I → 29,3%

LSIL + COLP. G II → 46.4%

LSIL + COLP. G I → 72.9%

TWO STEP 11-35%

CONCLUSIONI

SEE AND TREAT → HSIL+ COLP. G II

In accordo con ASCCP

EFC

NHSCSP

RISULTATI DEL TRATTAMENTO

Grado CIN	N° casi	**Guarigione**	**Persistenza**	**Neoplasia**
I	702	660 (94%)	42 (6%)	1 Adenoca i.m.
II	778	735 (94,5%)	44 (5,5%)	1 Adenoca i.m
III	520	488 (94%)	31 (6%)	30 Microinv. 4 Adenoca i.m. 4 Adenoca
inv.				
TOTALE	**2000**	**1883 (94,3%)**	117 **(5,7%)**	**40**

Correlazione tra esame citologico ed **esame istologico da biopsia mirata:**

372 casi HSIL:

- 2.7% negativi (10 casi)
- 7.5% CIN 1 (28 casi)

POSSIBILE RUOLO DEL SEE AND TREAT

- Citologia H-SIL, Colposcopia G2
- Citologia H-SIL, Lesione endocervicale
- Nel follow-up di pazienti trattate per H-SIL, con colposcopia e citologia positiva
- Nel follow-up di pazienti trattate per ca invasivo, con colposcopia e citologia positiva
- Pazienti non affidabili
- Pazienti in situazioni ambientali e sociali disagiate

NHS CERVICAL SCREENING PROGRAMME
Third Edition 14 March 2016

8.4.3 Depth of excision

TYPE I CERVICAL T.Z

-… remove to a depht/lenght of more than 7 mm (95%)…< 10mm in woman of reproductive age

TYPE II CERVICAL T.Z

- …depth/lenght of 10 mm/15 mm, depending of the position of SCJ in the endocervical canal

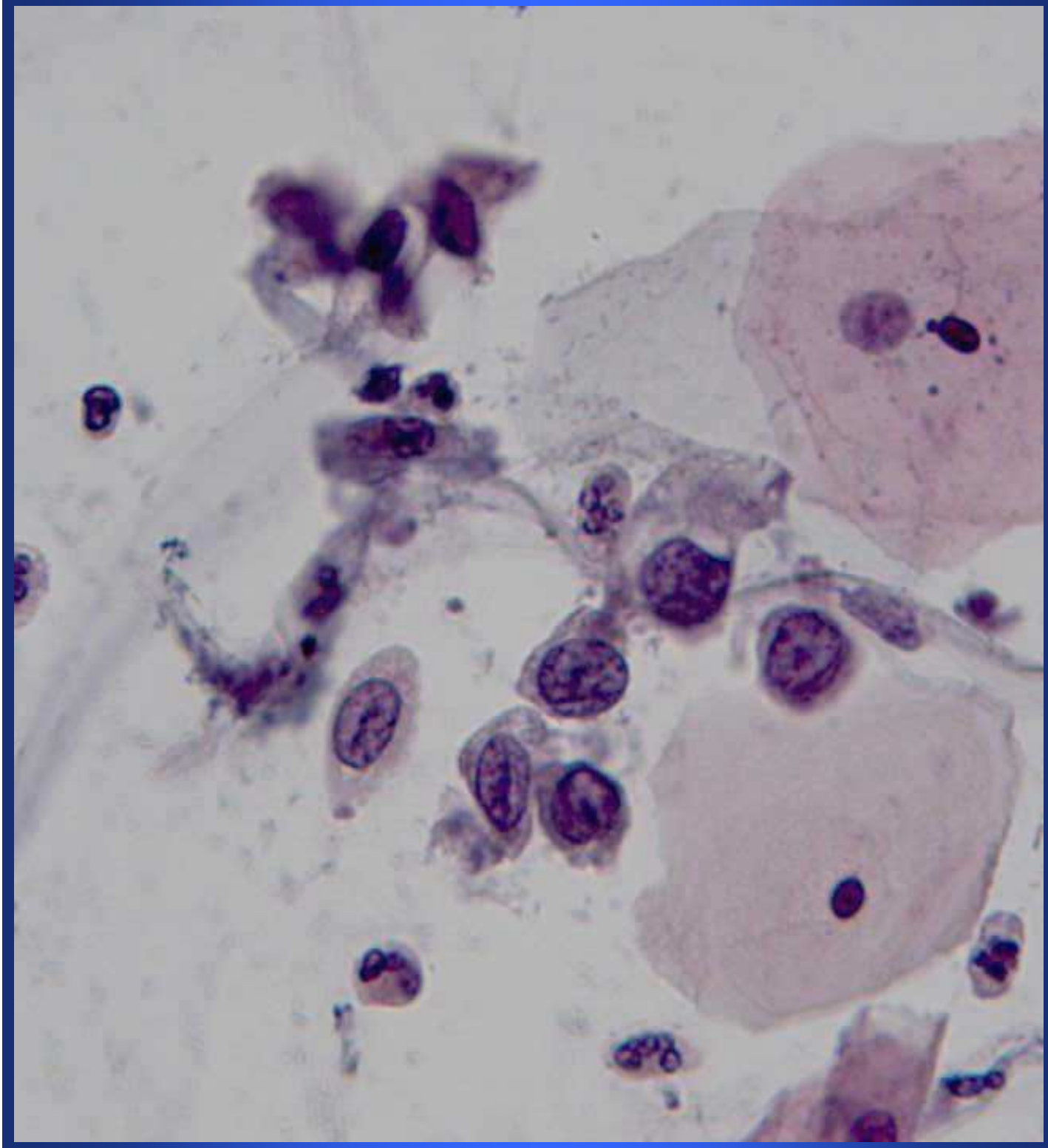
TYPE III CERVICAL T.Z

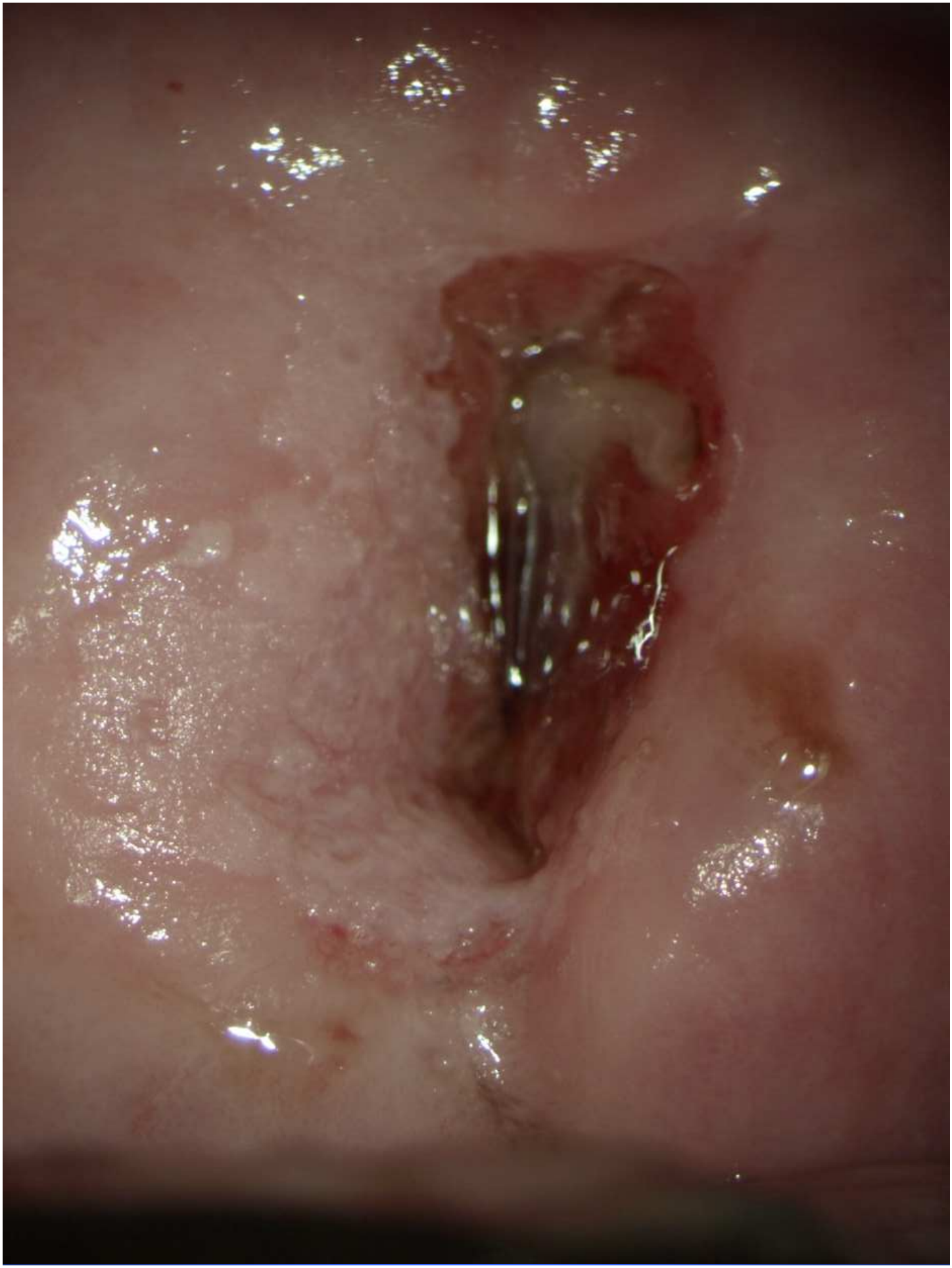
- … of 15 mm to 25 mm

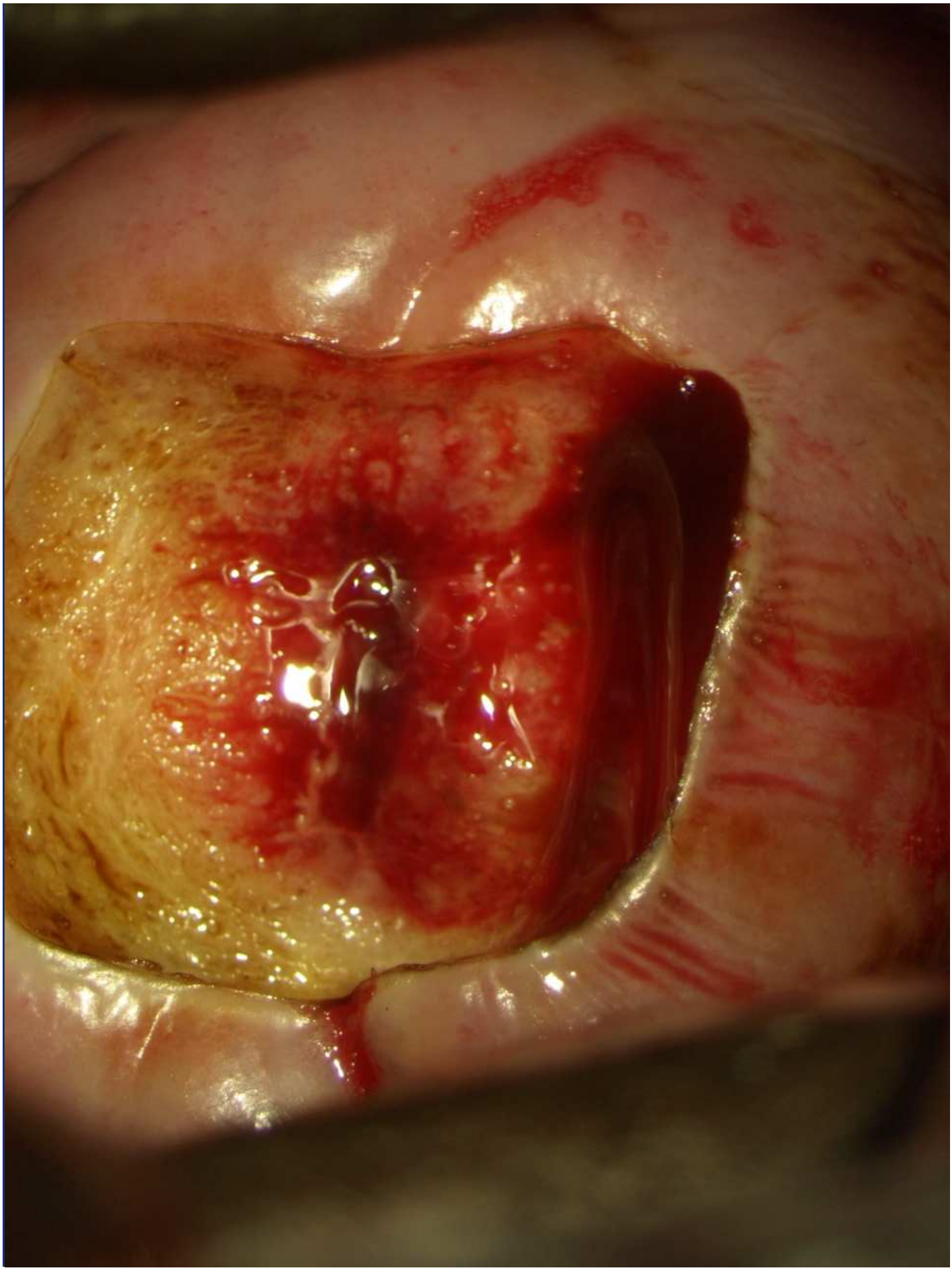
One prospective cohort and 19 retrospective studies

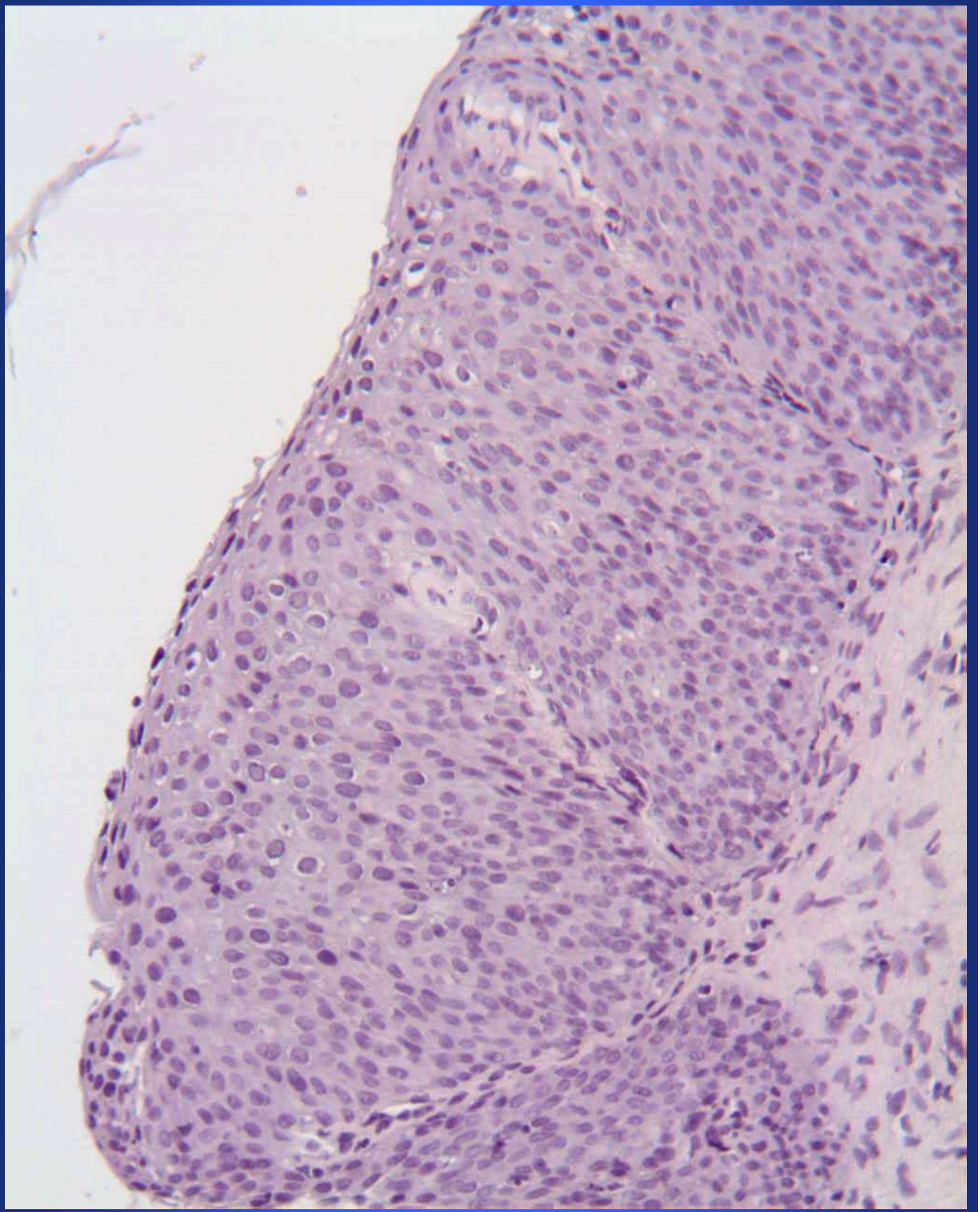
- **Cold knife conisation** was associated with a significantly increased risk of perinatal mortality (relative risk 2.87, 95% confidence interval 1.42 to 5.81) and a significantly higher risk of severe preterm delivery (2.78, 1.72 to 4.51), extreme preterm delivery (5.33, 1.63 to 17.40), and low birth weight of <2000 g (2.86, 1.37 to 5.97).
- **Laser conisation**, was followed by a significantly increased chance of low birth weight of <2000g and <1500 g.
- **Large loop excision** of the transformation zone and ablative treatment with cryotherapy or laser were not associated with a significantly increased risk of serious adverse pregnancy outcomes.
- **Ablation** by radical **diathermy** was associated with a significantly higher frequency of perinatal mortality, severe and extreme preterm delivery, and low birth weight below 2000 g or 1500 g.

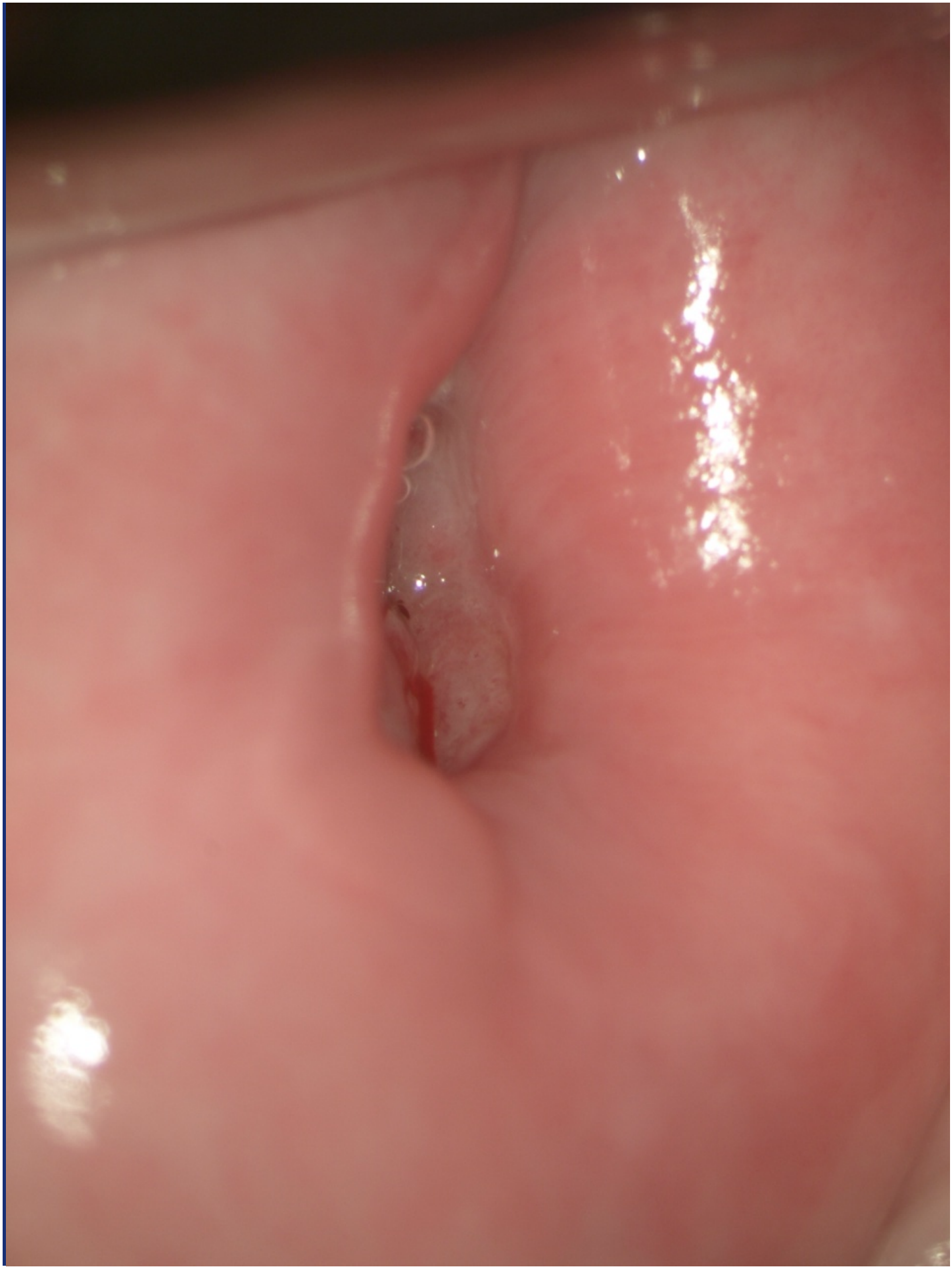
Arbyn M. et al. BMJ 2008;337:a1284











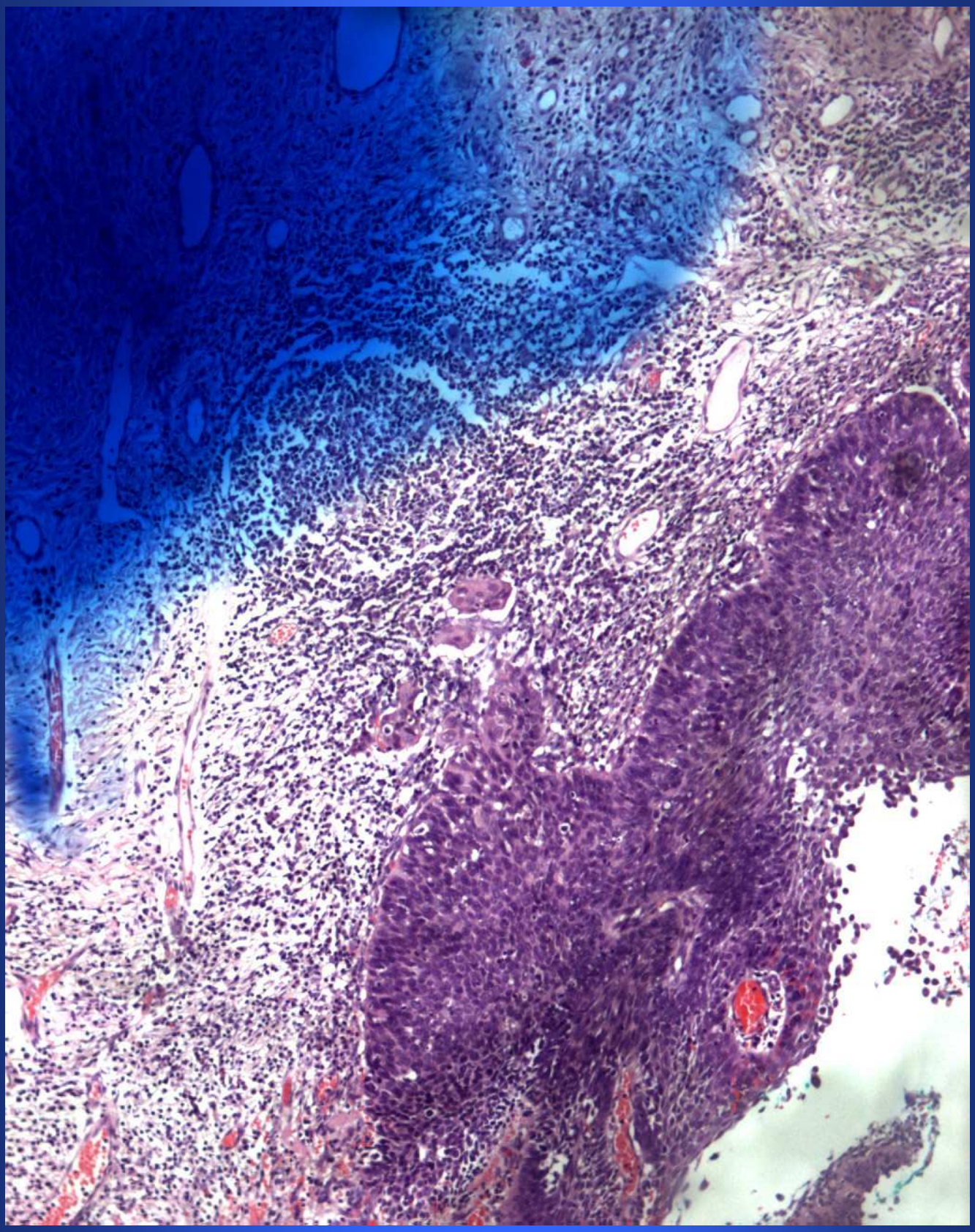
CASO CLINICO

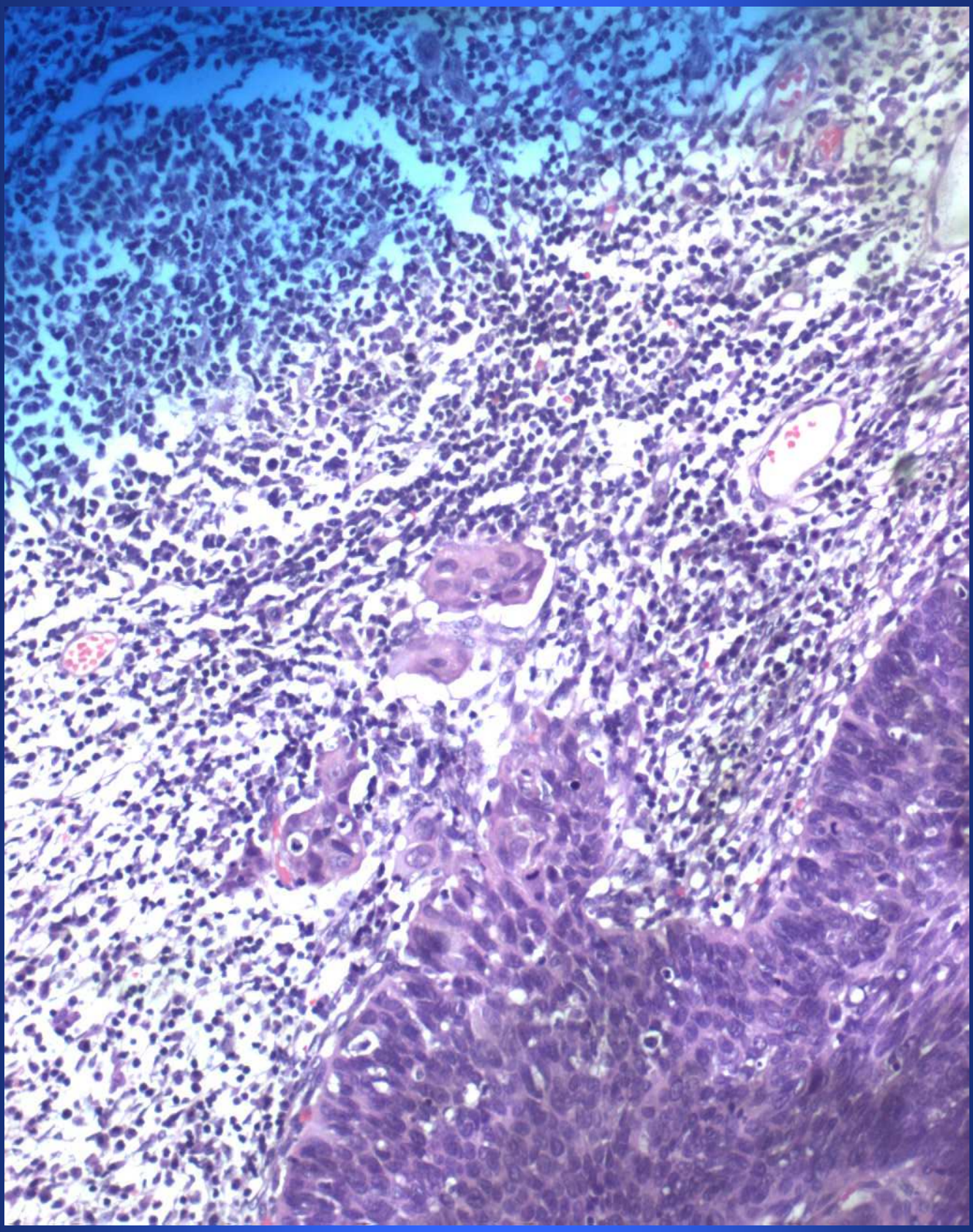
J.N. 21/06/1964

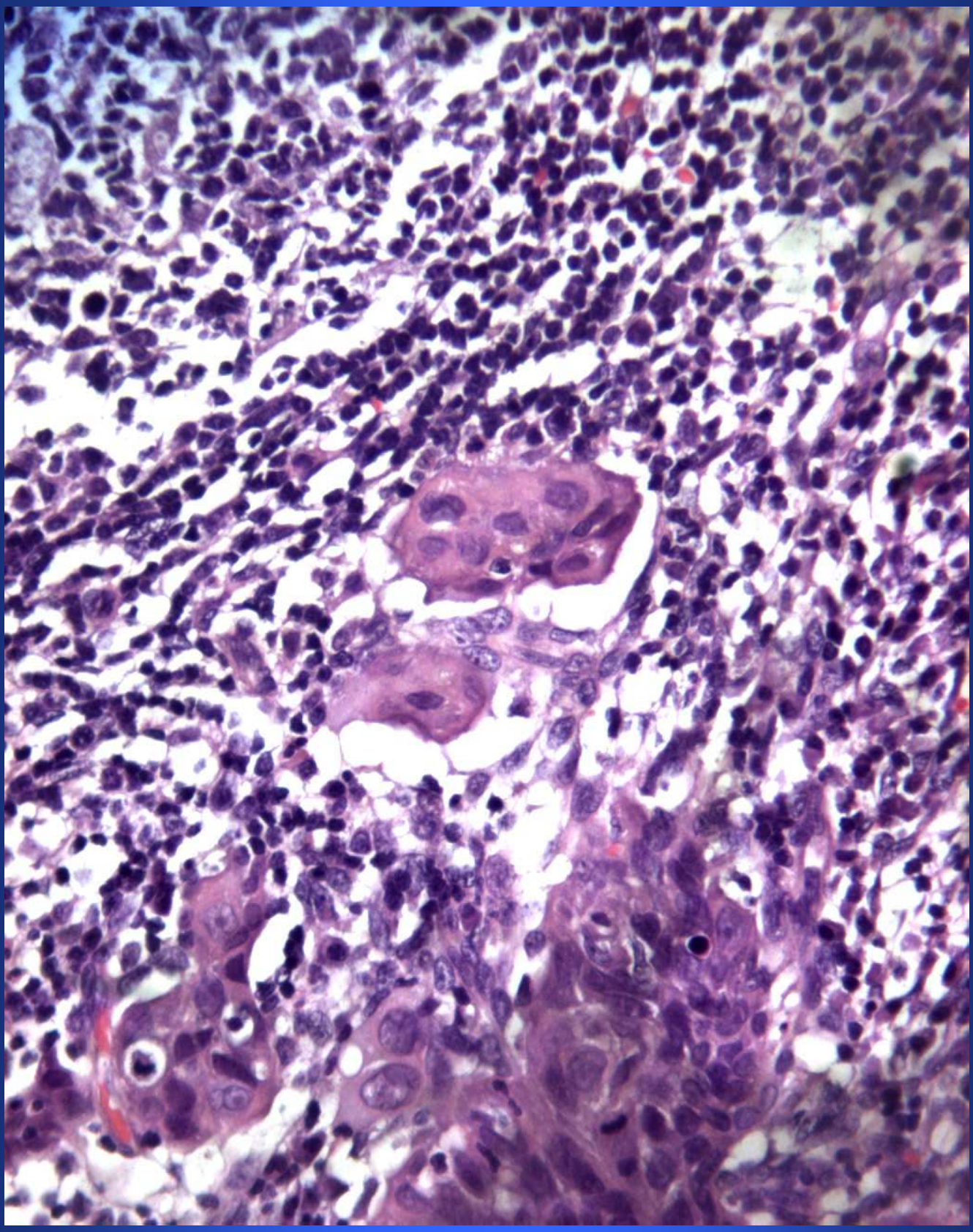
Nel 2000 36 anni Ansa a RF PER CIN III
altezza 1,8 cm

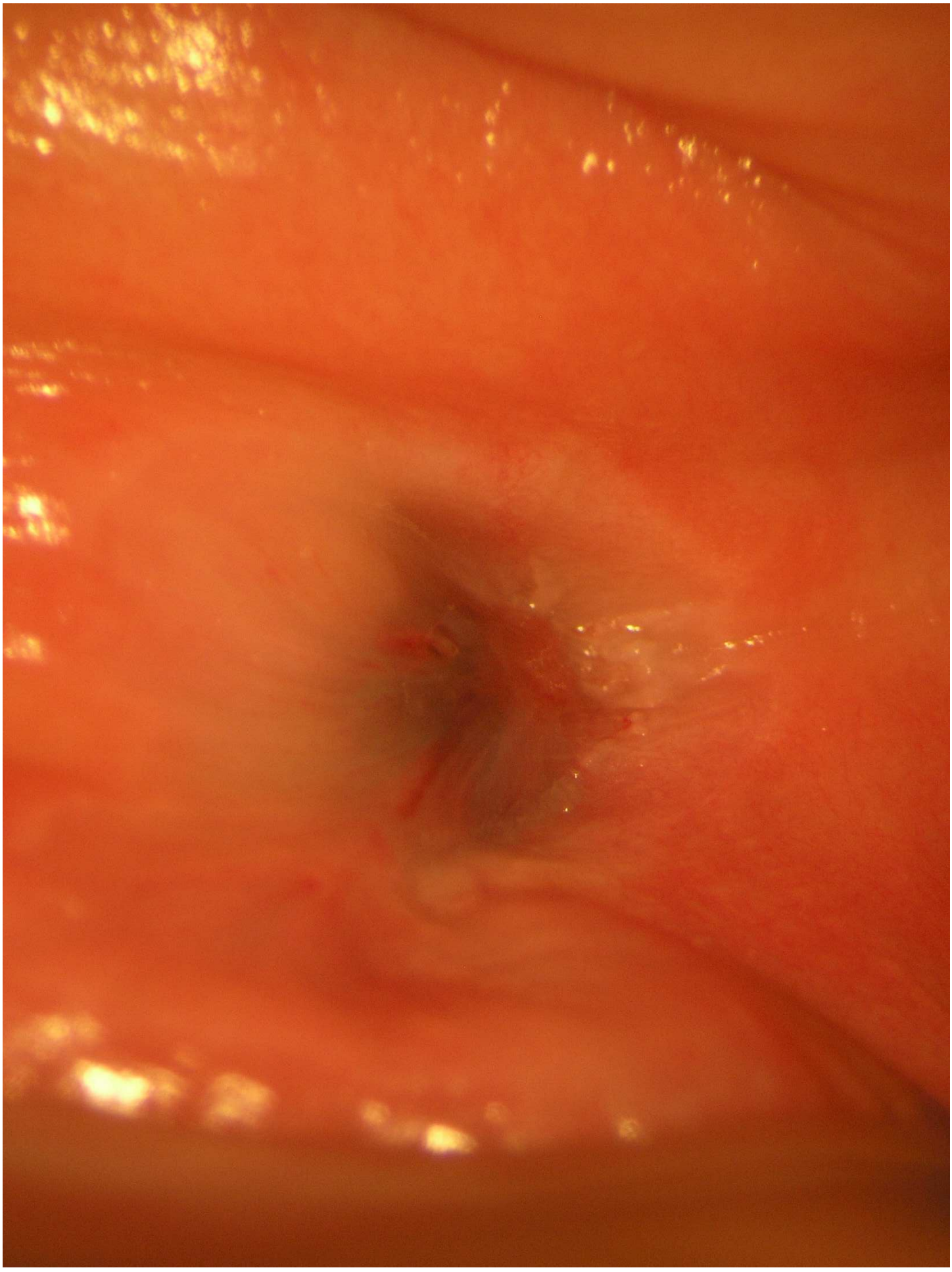
Nel 2012 47 anni Ansa a RF PER CIN III
altezza 2 cm

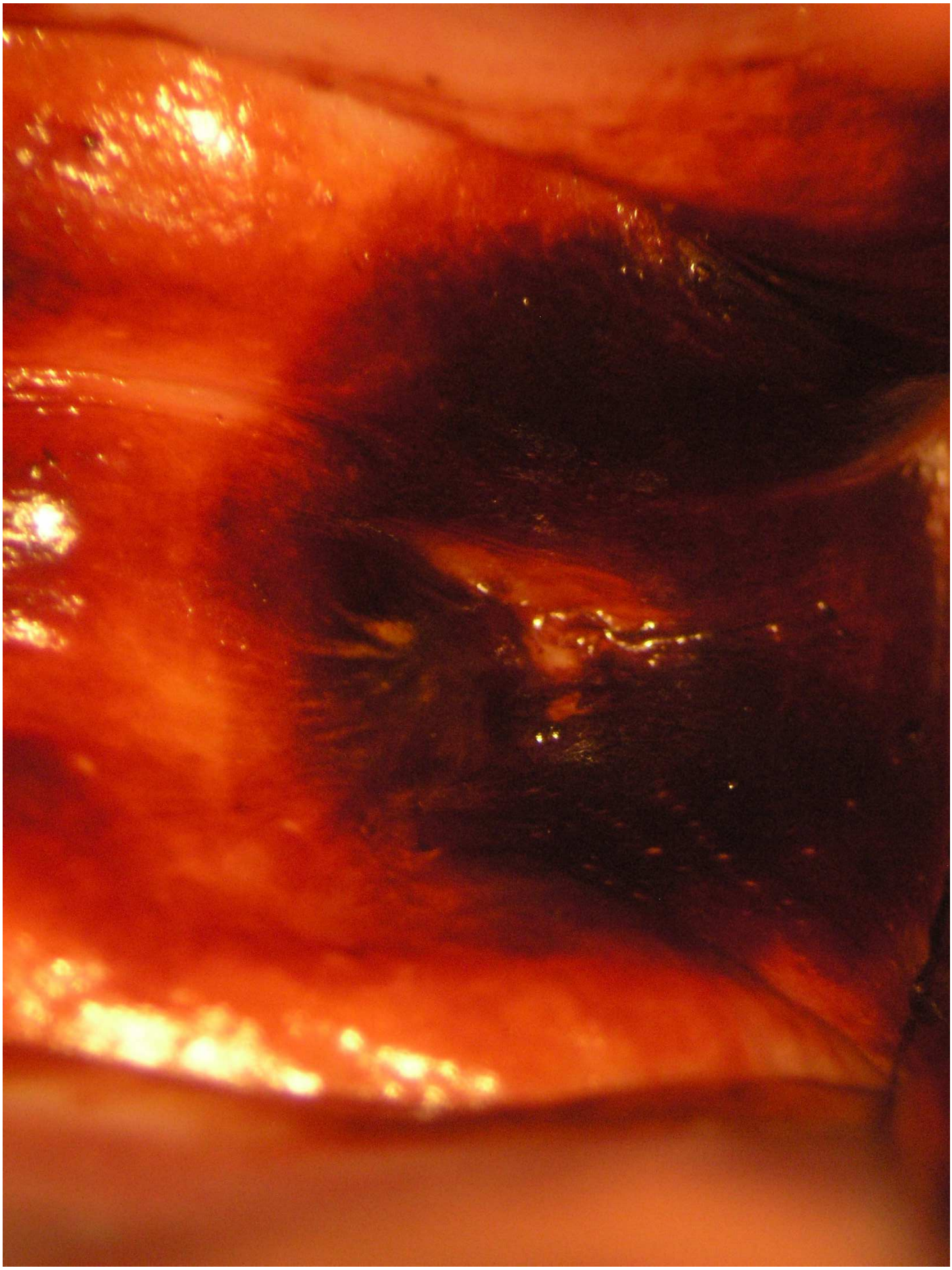
Nel 2013 49 anni Ansa a RF per CA microinvasivo (<1mm)
altezza 2,2 cm











CASO CLINICO

A.D. 29/04/1972

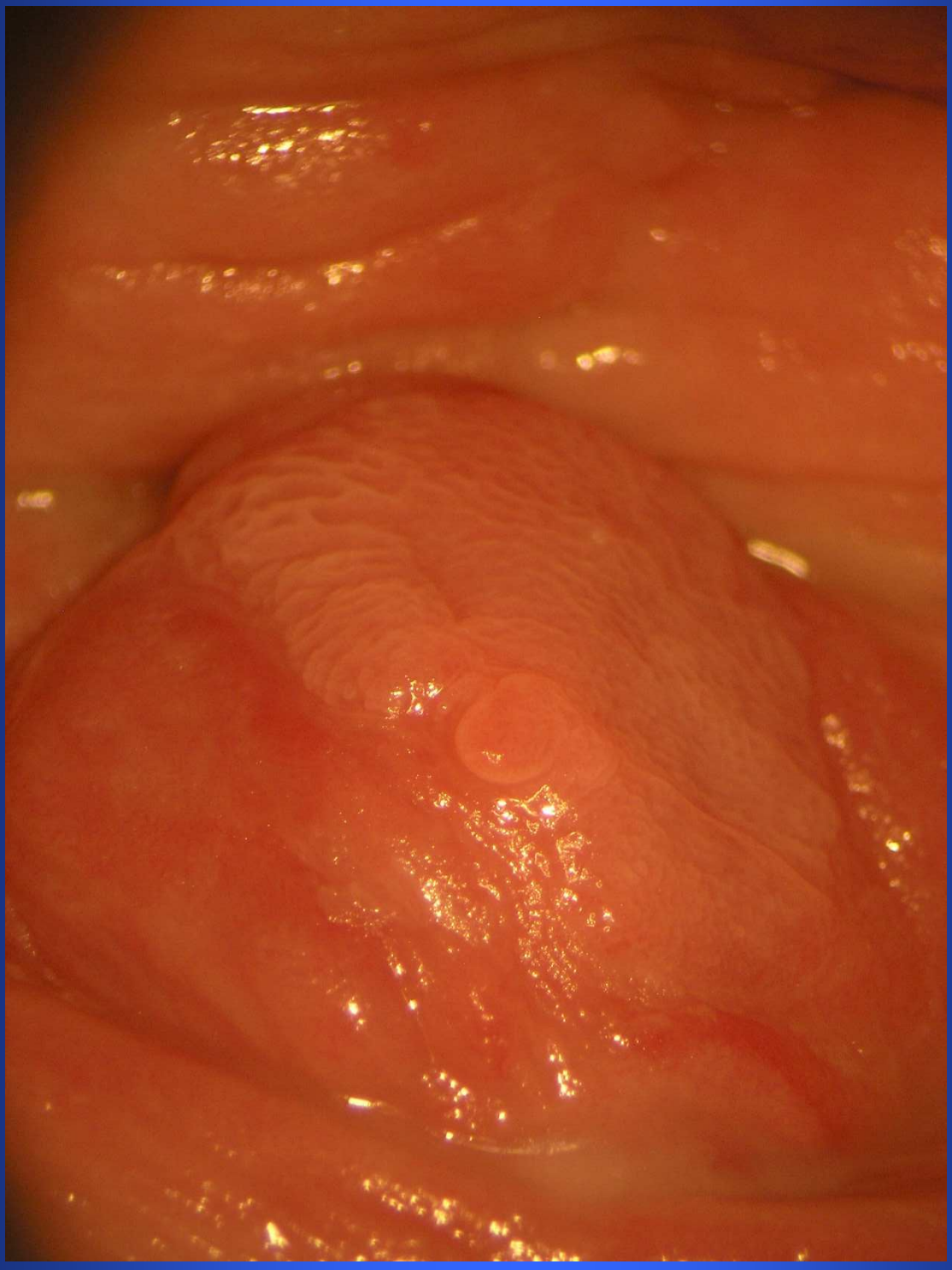
Nel 2013 41 anni - gennaio/luglio 2 Coniz. per CIN 3

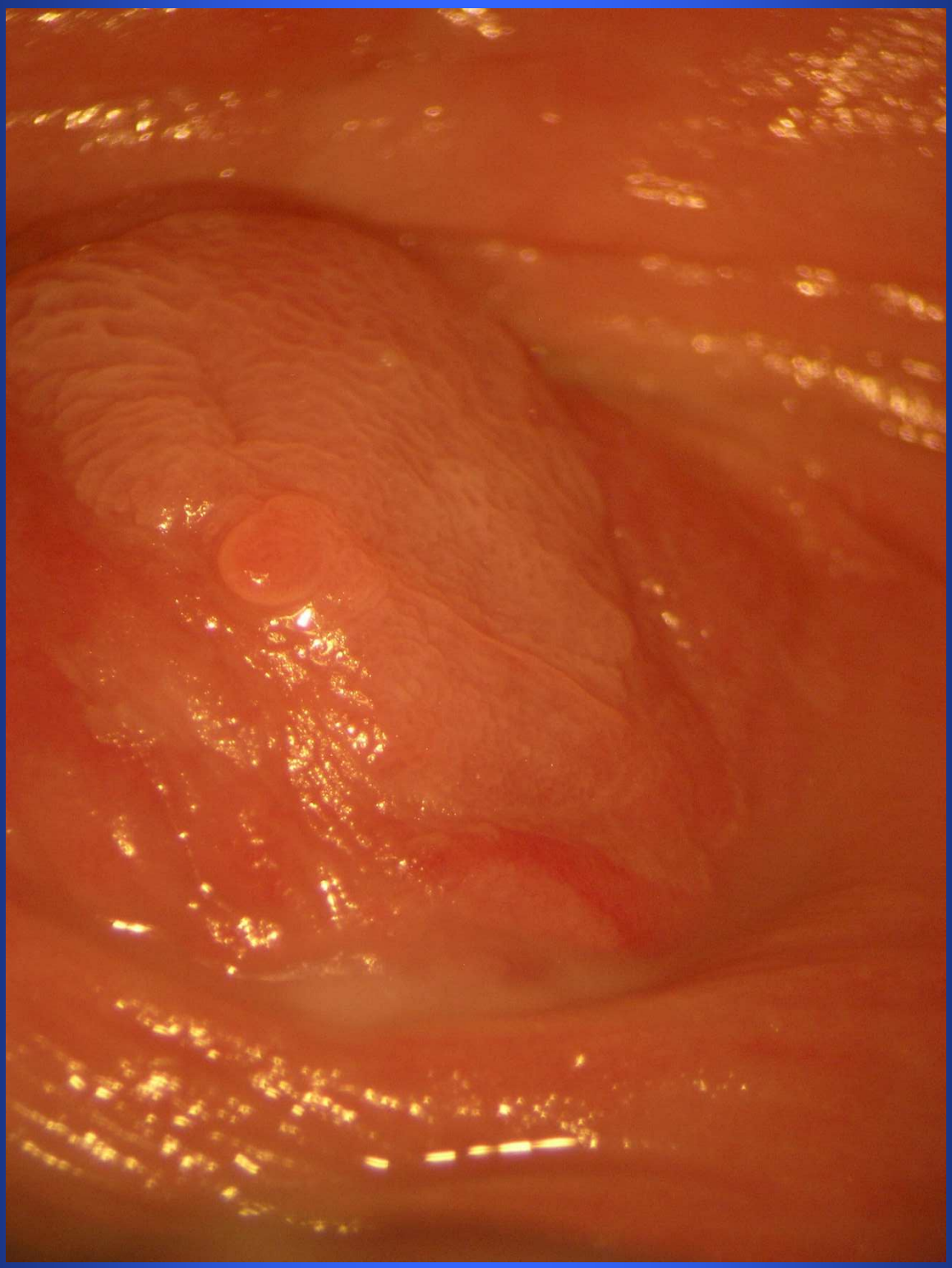
Nel 2013 – ottobre – H-SIL/CIN 3

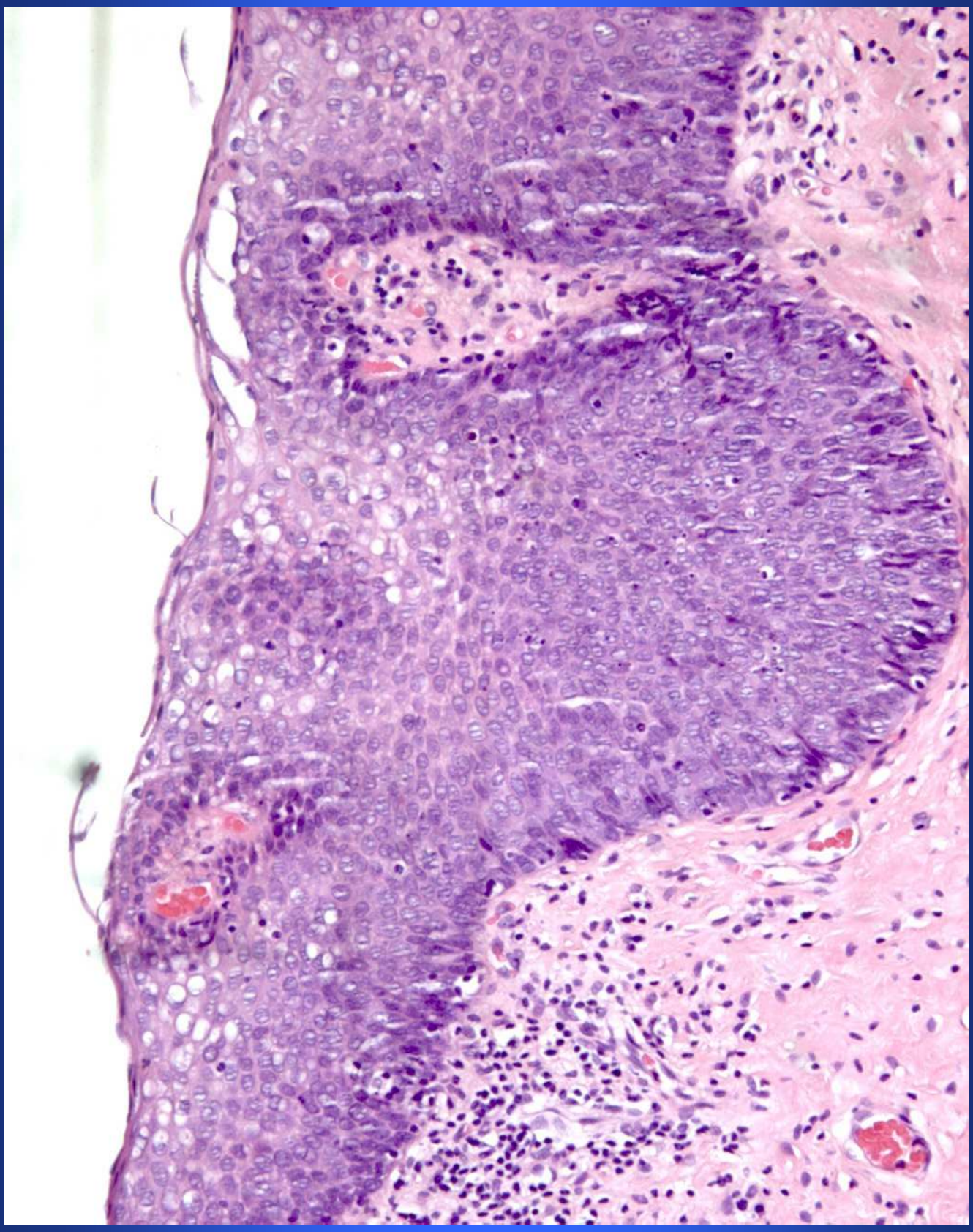
Nel 2013 – dicembre - isterectomia laparoscopica
E.I.: CIN 3 sul margine esocervicale

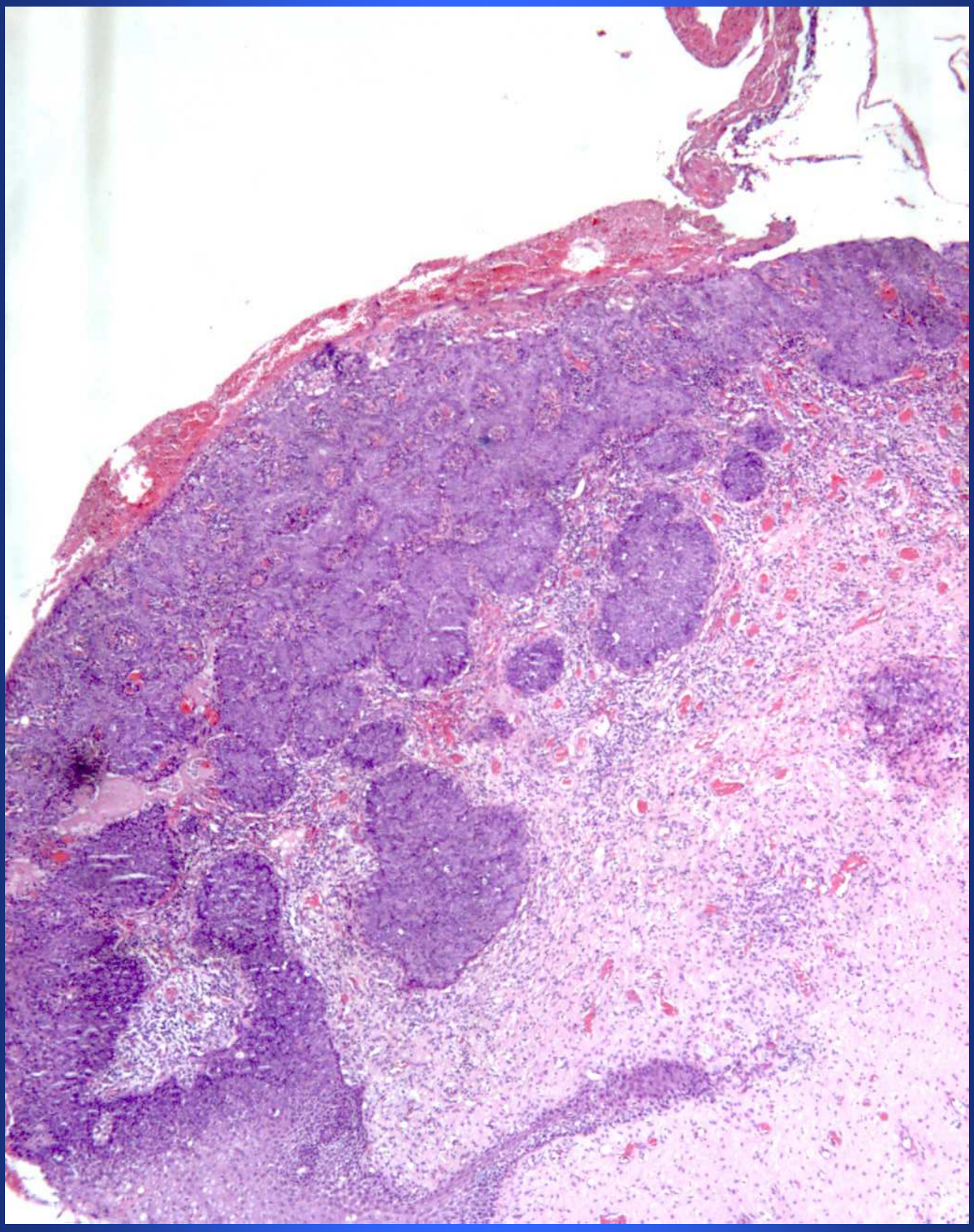
Nel 2014 – marzo- HSIL/VaIN 3

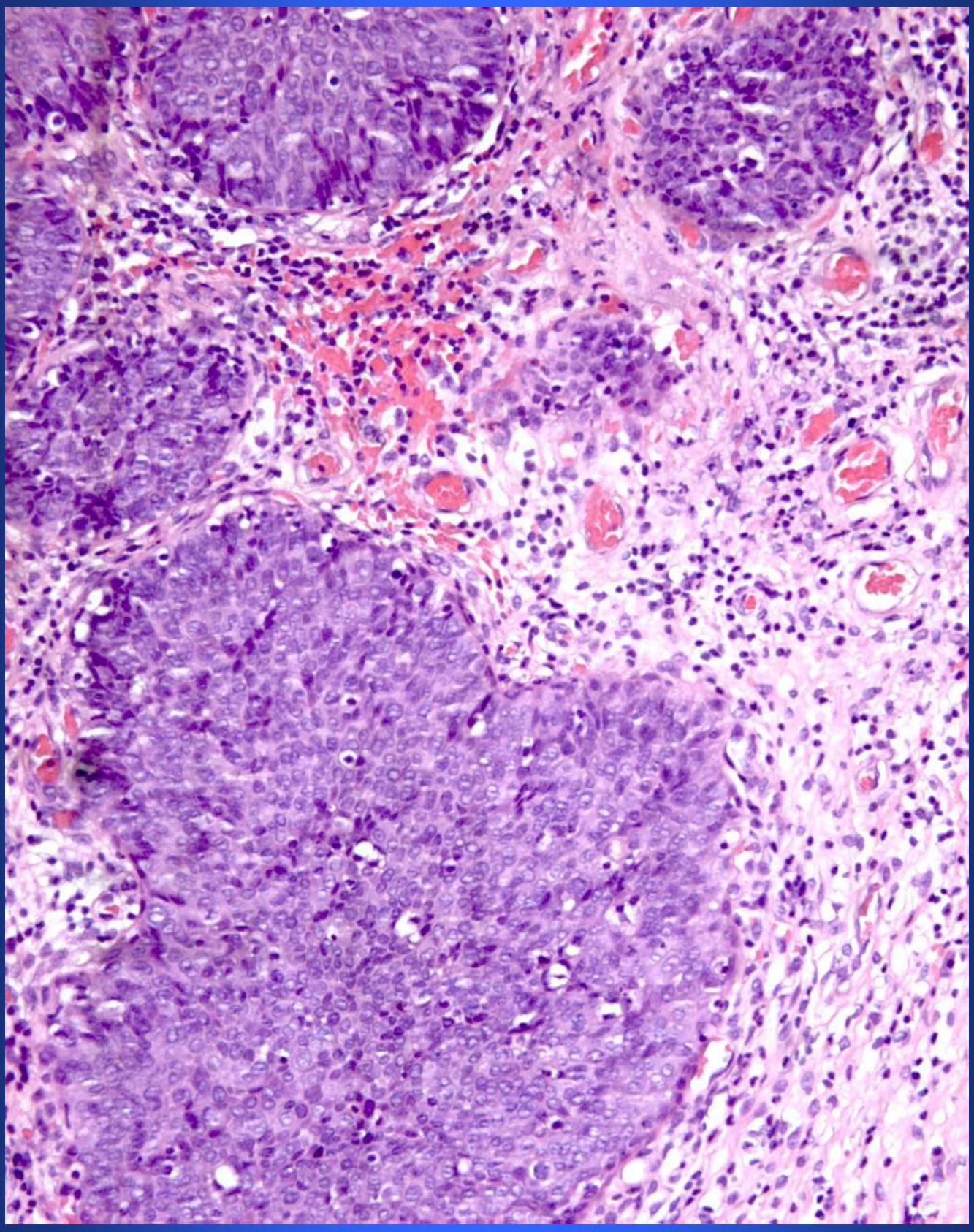
Nel 2014 – settembre – Escissione cupola vaginale con ago a RF

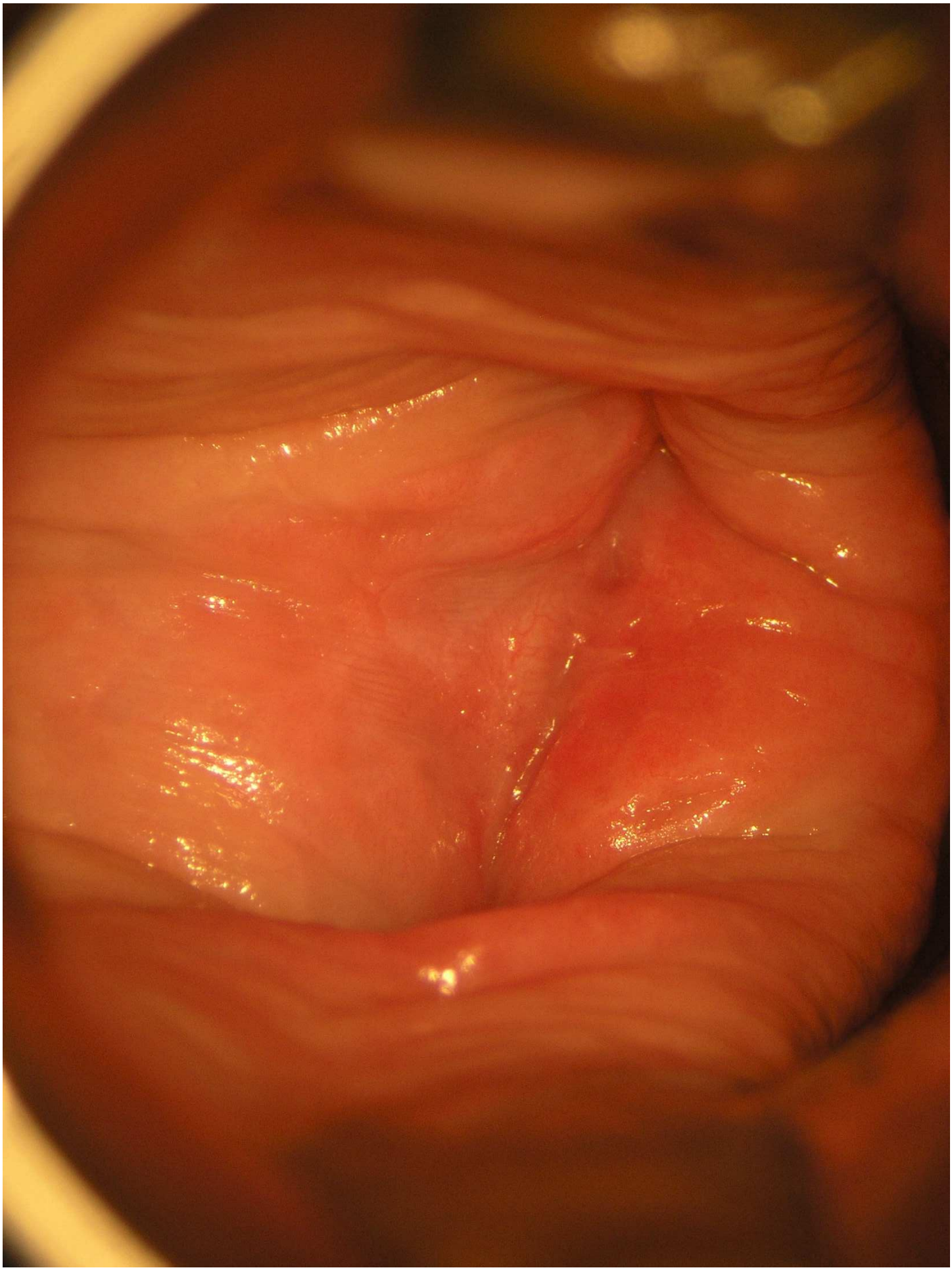


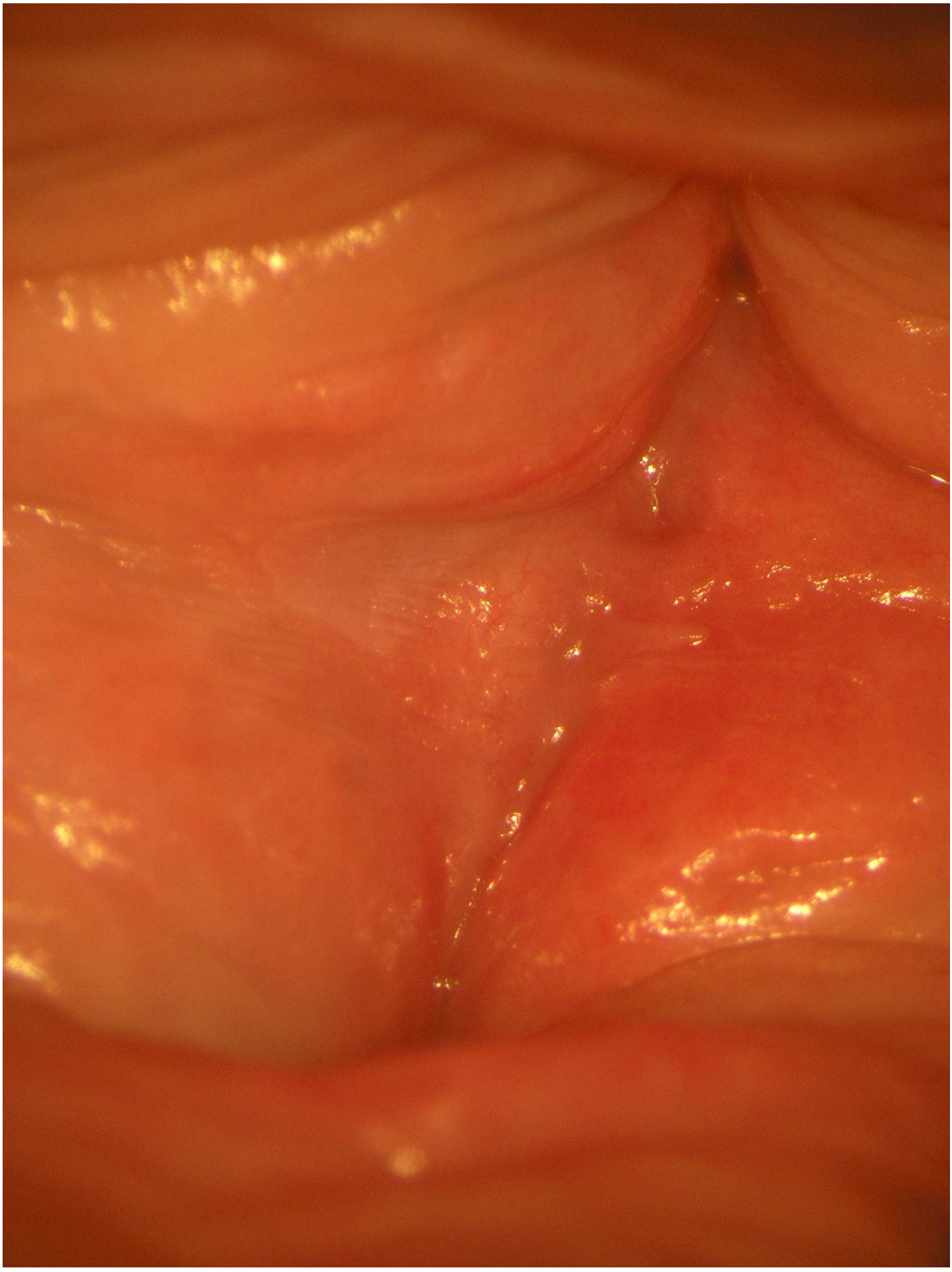


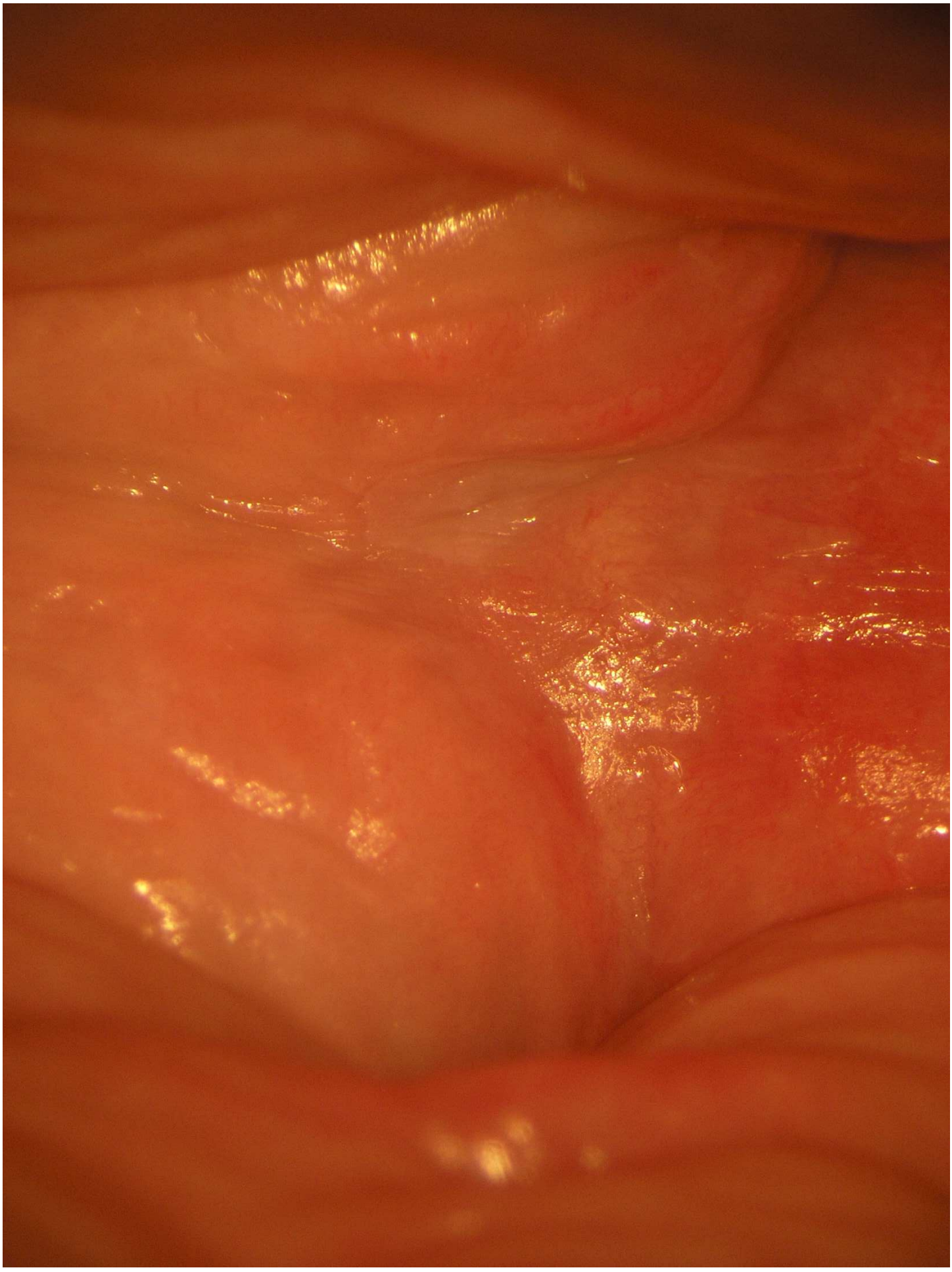


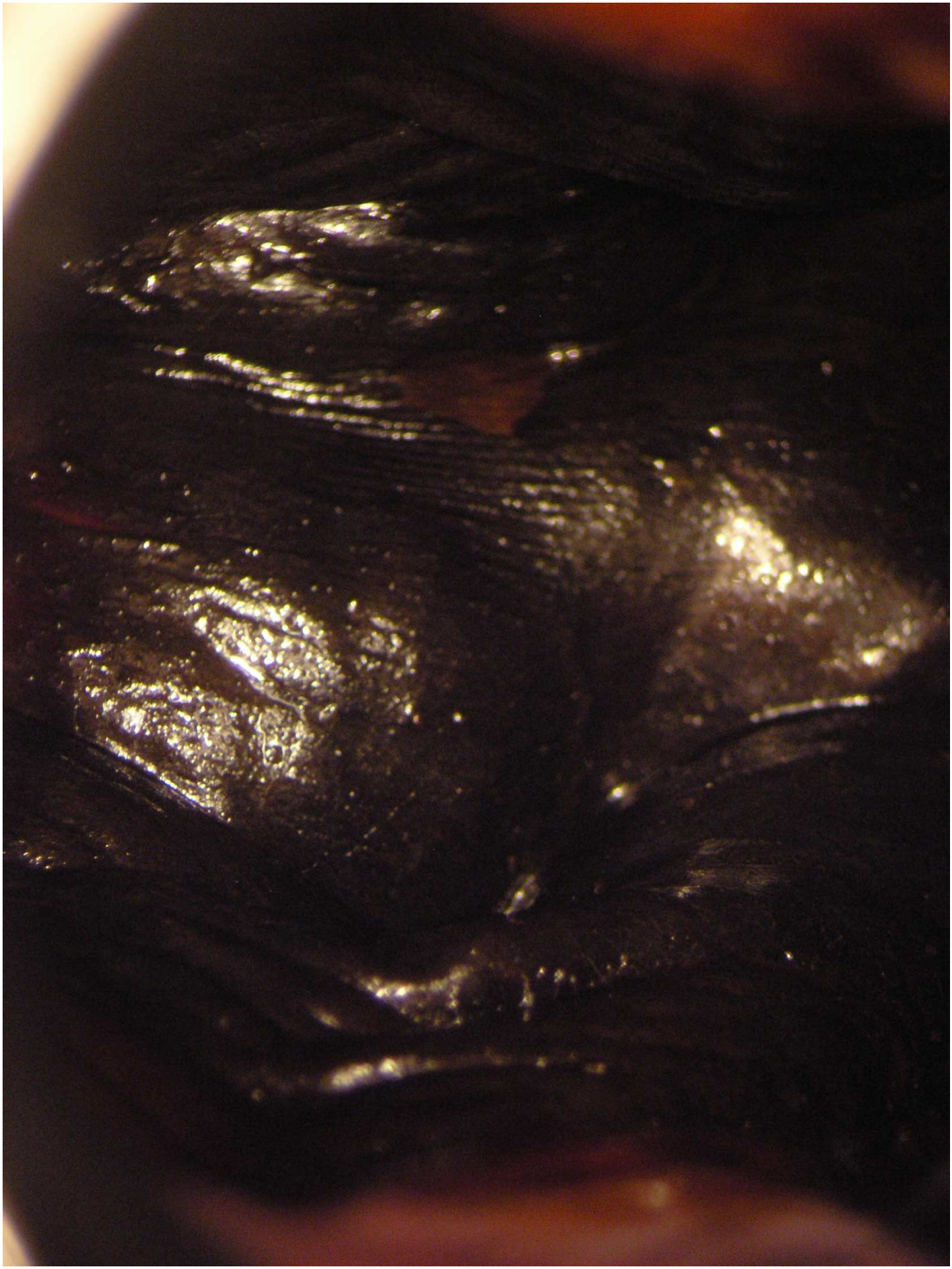












PUNTI FERMI

- Importanza dell’età
- Importanza del follow-up
- Importanza trattamento escissionale
- Biopsia mirata non sempre necessaria
- Ruolo fondamentale della Colposcopia
- Controindicata l’Isterectomia