

Convegno Nazionale GISCI

CATANIA

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Tavola Rotonda su

TRATTAMENTI ESCISSIONALI A CONFRONTO

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I clinica Ginecologica/Ostetrica

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Policlinico S Orsola-Malpighi

Bologna

1. Il trattamento escissionale è sempre il gold standard nella terapia della CIN?

2. L'avvento dell'ansa ha reso obsolete le altre tecniche escissionali?

3. L'asportazione della malattia in "unico pezzo" offre maggiori garanzie di radicalità?

4. Lo stato dei margini influisce sul comportamento clinico successivo?

1. Il trattamento escissionale è sempre il gold standard nella terapia della CIN?

Screening Emilia Romagna

TERAPIA CIN 2-3: 1.560 casi

Tecniche escissionali

Ansa

Bisturi

LASER



94%

Tecniche Ablative Varie

(EDTC, Crio, LASER...)

6%

PROBLEMI DI RECENTE SOLLEVATI:

Progressive terapie conservative
cervicali
e complicanze ostetriche

Anno 2002

**Delivery outcomes following loop
electrosurgical excision procedure for
microinvasive (FIGO stage IA1) cervical
cancer.**

Paraskevaidis E, Koliopoulos G, Lolis E, Pappanikou E, Malamou-Mitsi V, Agnantis NJ
Gynecol Oncol, 2002;86:10-3.

There was **no statistically significant difference** between **cases** and **controls** in the

1. **duration of pregnancy** (37.6-38.4 weeks respectively),
2. **birth weight** (3212-3315 g),
3. **cesarean section rate** (17.8-32.1%),
4. **neonatal unit admission rate** (21.4-10.7%),
and
5. **precipitate labor rate** (13-10.5%).

CONCLUSIONS:

Women treated for microinvasive cancer with **LEEP did not have significantly more delivery complications**

compared with controls apart from shorter duration of labor. There was a possible non-statistically significant trend toward shorter duration of pregnancy in cases.

While caution should be advised when selecting and treating women with microinvasive carcinoma by LEEP, **the apparent safety of the management and the satisfactory delivery outcome seem to justify this approach in many cases.**

Anno 2003

META-ANALISYS

Pregnancy outcome after loop electrosurgical excision procedure: a systematic review.

Crane J. Obstet Gynecol 2003;102:1058–62

....Women who had had LEEP were more likely to have preterm birth ...and low birth weight infants

Anno 2005

The Effect of Loop Electrosurgical Excision Procedure on Future Pregnancy Outcome

Sheri-Lee A. Samson, MD, FRCSC*, James R. Bentley, MBChB, FRCSC*, T. John Fahey, MMath, Deanna J. McKay, BSc and Glenn H. Gill, MD, FRCSC

Obstetrics & Gynecology 2005;105:325-332

The rates of spontaneous *preterm delivery* before 37 weeks were significantly different with

- **7.9% in the LEEP group and**
- **2.5% in the comparison group.**

Table 5. Effect of LEEP Characteristics on Preterm Delivery (< 37 wk)

	N*	Preterm	Not Preterm	OR (95% CI)	P
Mean depth (mm)	561	6.50	6.8465
Mean diameter (mm)	564	18.27	20.2448
Interval from LEEP to delivery (d)	565	1,752	1,11330
Number of passes	535				
1		20	260	1.05 (0.76–1.46)	.87
> 1		20	235		
Endocervical pass ←	536				
Yes		8	79	1.26 (0.65–2.41)	.50
No		32	417		
Number of LEEPs ←	565				
1		41	475	0.77 (0.25–2.38)	1.00
> 1		3	46		
Other procedures [†] ←	565				
Yes		12	78	1.98 (1.06–3.69)	.05
No		32	443		

LEEP, loop electrosurgical excision procedure; CI, confidence interval.

Data are presented as mean or n.

* There were missing data for up to 36 patients; thus, n = 535 to 565.

[†] Other procedures include laser, cryotherapy, electrocautery, cone biopsy, or LEEP.

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Table 2. Gestational Age at Delivery for LEEP and Comparison Groups

	LEEP Group (n = 558)*	Comparison Group (n = 558)	Odds Ratio (95% CI)	P
Gestational age at delivery				
< 37 wk	44 (7.9)	14 (2.5)	3.50 (1.90-6.95)	< .001
< 34 wk	7 (1.25)	2 (0.36)	3.50 (0.85-23.5)	.12
Mean length of gestation (wk)	39.03	39.1471

LEEP, loop electrosurgical excision procedure; CI, confidence interval.

Data are presented as n (%) or mean.

* There were 13 pairs for which the gestational age was not provided for one member of the pair.

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LEEP is still an appropriate choice for the first-line treatment of CIN.

High-grade lesions, including CIN 2 and 3, should be treated as recommended by the American Society for Colposcopy and Cervical Pathology.²⁷

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However, longitudinal studies reveal that

47–57% of CIN 1 will resolve spontaneously. ^{28,29}

Thus, it may be appropriate to follow these patients carefully and treat them only if the lesions persist or progress to a higher grade.

Our results also support a conservative 2-step approach in which

- a biopsy confirms the diagnosis
- and then treatment occurs at a subsequent visit, instead of a "see and treat" approach at one visit.

Anno 2005

Pregnancy outcome after loop electrosurgical excision procedure for the management of cervical intraepithelial neoplasia.

Acharva G, Kieldberg I, Hansen SM, Sorheim N, Jacobsen BK, Maltau JM. Arch Gynecol Obstet. 2005 Jul;272(2):109-12.

were not significantly different among the cases and controls.

.....Overall,

- 1. mean gestation at delivery (38.3 vs. 39.1 weeks),**
- 2. mean birth weight (3,412 vs. 3,563 g),**
- 3. prevalence of preterm birth (11.4% vs. 10.8%) and**
- 4. low birth weight (10.1 vs. 5.1%)**

....But when a relatively **large loop (25 mm)** had been used,

- 1. the risk of preterm delivery** (odds ratio 4.0) and
- 2. low birth weight** (odds ratio 14.0)

**was significantly higher
than in controls**

CONCLUSIONS:

LEEP in women with CIN **did not significantly increase** the risk of low birth weight or preterm birth in subsequent pregnancy in comparison to their controls, *except when the size of electrosurgical loop was relatively large*

2. L'avvento dell'ansa ha reso obsolete le altre tecniche escissionali?

Screening
Emilia Romagna

TERAPIA CIN 2-3

Tecniche escissionali

Ansa

64%

Bisturi

26%

LASER

3%

Tecniche Ablative Varie

(EDTC, Crio, LASER...)

6%

2. L'avvento dell'ansa ha reso obsolete le altre tecniche escissionali?

TERAPIA CIN 2-3

Bisturi /LASER

1. In ampie lesioni che si inoltrano nel cc

2. Nelle recidive/persistenze endocervicali

3. Nel Ca. Microinvasivo

2. L'avvento dell'ansa ha reso obsolete le altre tecniche escissionali?

TERAPIA CONSERVATIVA Adenoca In Situ -AIS

	<u>casi %</u>		<u>margini liberi</u>
*ANSA	35,7%	—————>	46,6%
LASER	19,1%	—————>	50,0%
Bisturi	45,2%	—————>	61,1%

*CIN (lesioni squamose) 75%

2. L'avvento dell'ansa ha reso obsolete le altre tecniche escissionali?

TERAPIA CONSERVATIVA AIS: Follow-up

	<u>Persitenza/Recidiva</u>
Margini <i>in sano</i>	19%
Margini <i>non in sano</i>	65%

3.L'asportazione della malattia in "unico pezzo" offre maggiori garanzie di radicalità?

Il referto patologico dopo terapia
escissionale dovrebbe indicare:

1. Estensione eso-endo cervicale della lesione
2. Stato dei margini
3. Interessamento delle ghiandole
4. N° Quadranti Interessati

3.L'asportazione della malattia in "unico pezzo" offre maggiori garanzie di radicalità?

La frammentazione limita:

1. l'affidabilità diagnostica
2. l'interpretazione dei margini
3. La definizione topografica della lesione

3.L'asportazione della malattia in "unico pezzo" offre maggiori garanzie di radicalità?

	<u>Unico pezzo</u>	<u>Frammenti</u>
Artefatti	20%	77%
Pers/Rec	15%	50%
K inv. Residuo	0	2,9%

Ioffe Obet al., Int J Gynecol Pathol 1999;2:115-121

Tyler LN et al., Arch of Pathol 2006;131:622-624

4. Lo stato dei margini influisce sul comportamento clinico successivo?

Stato dei margini CIN

(Ansa, Bisturi, LASER)

Margini *non in sano* 15% (5-45%)

Eso 5-15%

Endo 10-40%

Laterali 5-10%

4. Lo stato dei margini influisce sul comportamento clinico successivo?

Persitenza/Recidiva CIN

Dopo terapia escissionale

➤ Margini *in sano* 5% (0-15)

➤ Margini *non in sano* 25% (5-45)

Eso 10-15%

Endo 15-25%

Eso-Endo 30-50%

4. Lo stato dei margini influisce sul comportamento clinico successivo?

**Recidiva K Inv.
Dopo terapia escissionale**

**Follow up > 8 anni
0,5-2% K inv.
di cui 60% entro i primi 24 mesi**

4. Lo stato dei margini influisce sul comportamento clinico successivo?

- rischio di persistenza/recidiva esiste in entrambe le situazioni (margini *in sano* e *non in sano*)
- 70-75% clearance spontanea di CIN in margini *non in sano*
- Non sembra necessario immediato reintervento
- Adesione ai protocolli di Follow-up



Grazie