Le line guida basate sul rischio: **2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors**

Paolo Giorgi Rossi

AUSL-IRCCS di Reggio Emilia

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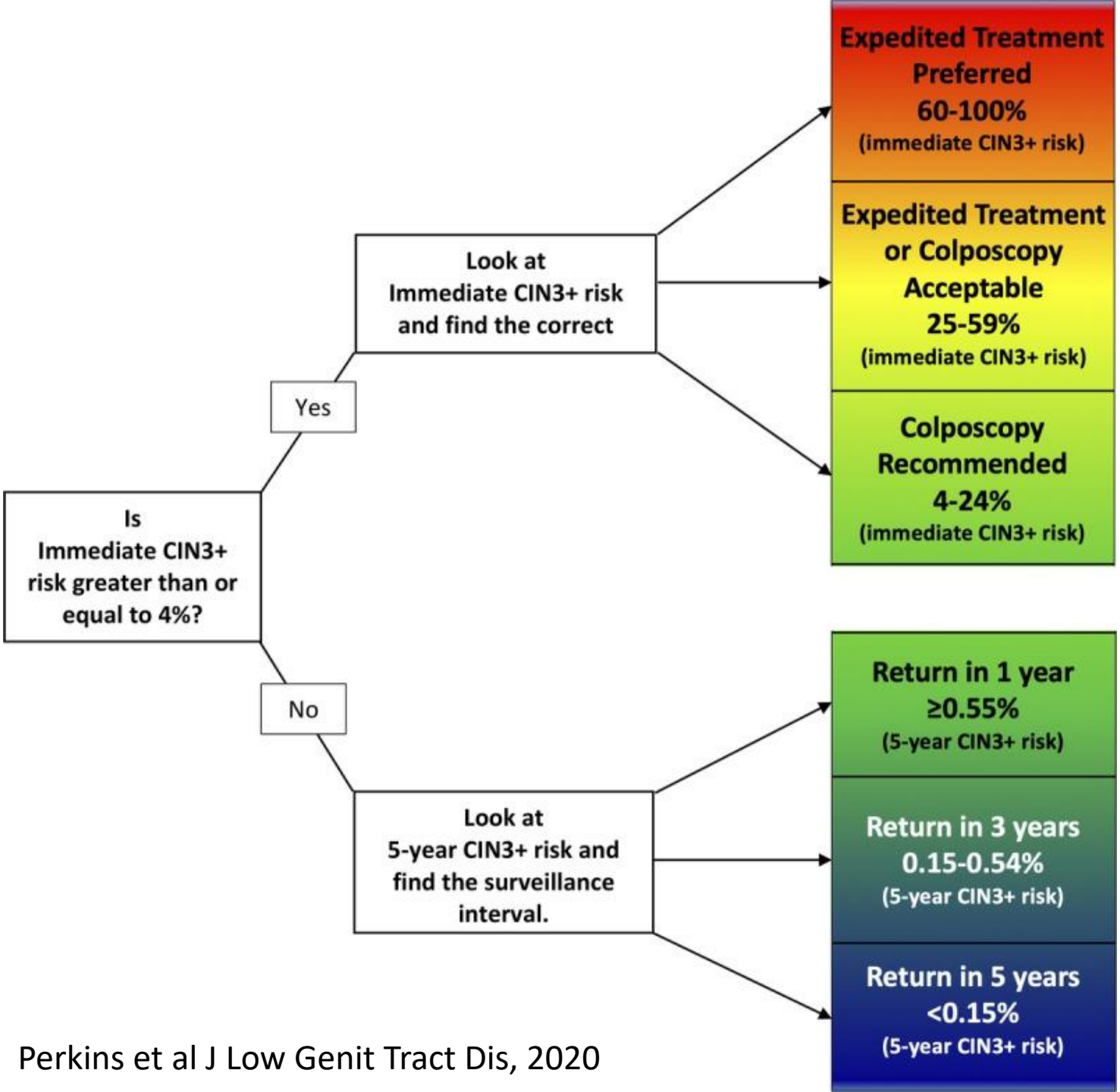
Topics

- I principi
- Le conseguenze
- Un confronto con l'algoritmo italiano
- Qualche problema nel far fittare gli algoritmi con I principi…

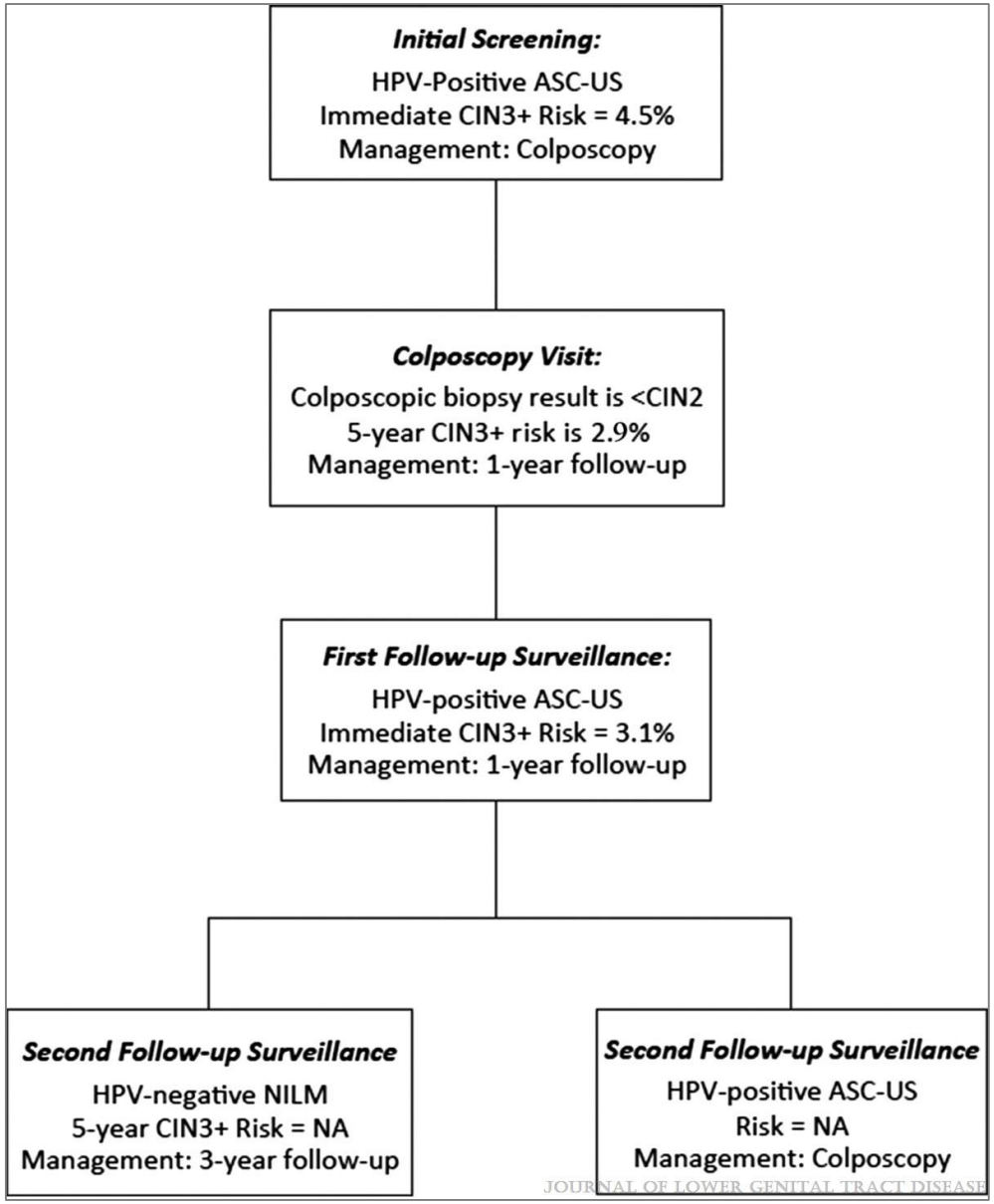
Conflict of interest: as PI of an independent study, funded by the Italian Ministry of Health, I conducted negotiations with Hologic, Roche and Becton Dickinson to obtain reagents at reduced price or for free.

I principi: “Equal Management of Equal Risk,”

- “need for simplicity and stability in clinical guidelines while anticipating continued technologic advances in cervical screening methods.”
- ”the main purpose of cervical screening in the United States is to find precancerous lesions (“precancer”) that can be treated easily to prevent invasive cervical cancer”



Perkins et al J Low Genit Tract Dis, 2020



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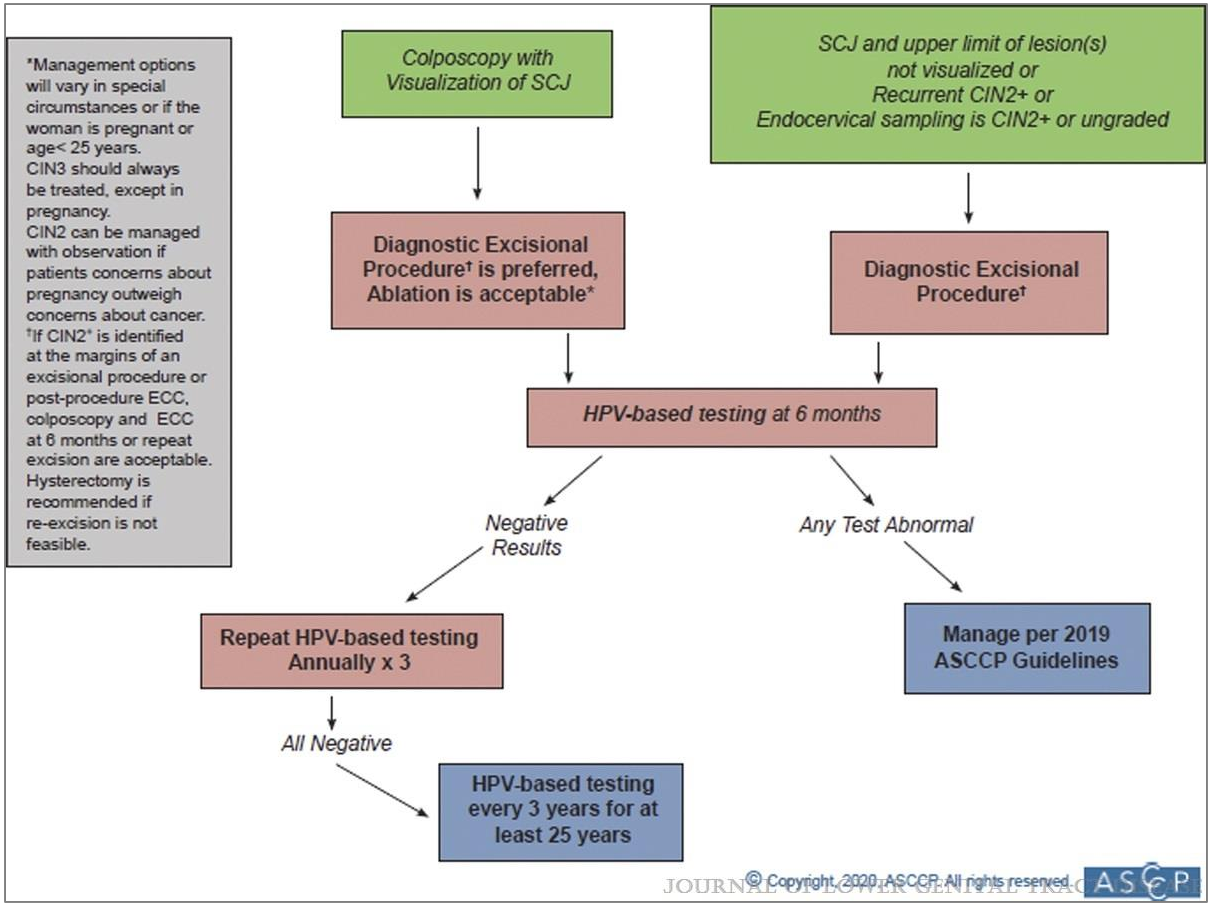
Journal of Lower Genital Tract Disease24(2):102-131, April 2020.
doi: 10.1097/LGT.0000000000000525

This figure demonstrates how a patient with a common low-grade screening abnormality (HPV-positive ASC-US) would be managed based on risk estimates. The initial screening result would lead to colposcopy (immediate risk 4.2%). Colposcopy of less than CIN 2 has a 5-year risk of 3.2% (1-year return). At the 1-year return visit, a second HPV-positive ASC-US result has an immediate risk of 3.1% (1-year return). If the patient has a repeat abnormal screen at the next follow-up, colposcopy is recommended. If the HPV-based test is negative, return in 3 years is recommended. NA, not applicable because stable risk estimates are not available.

clinical management of histologic HSIL.



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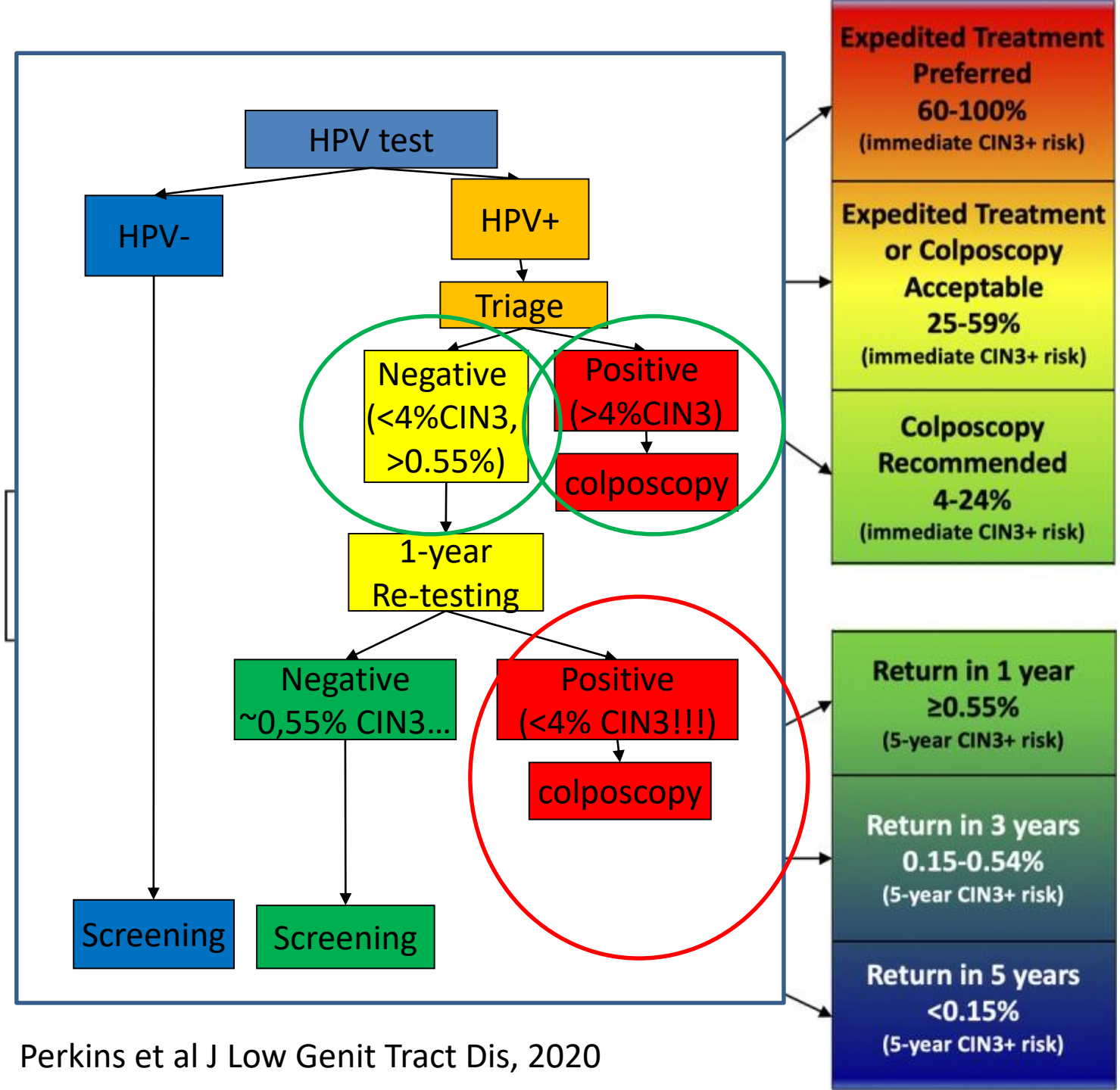
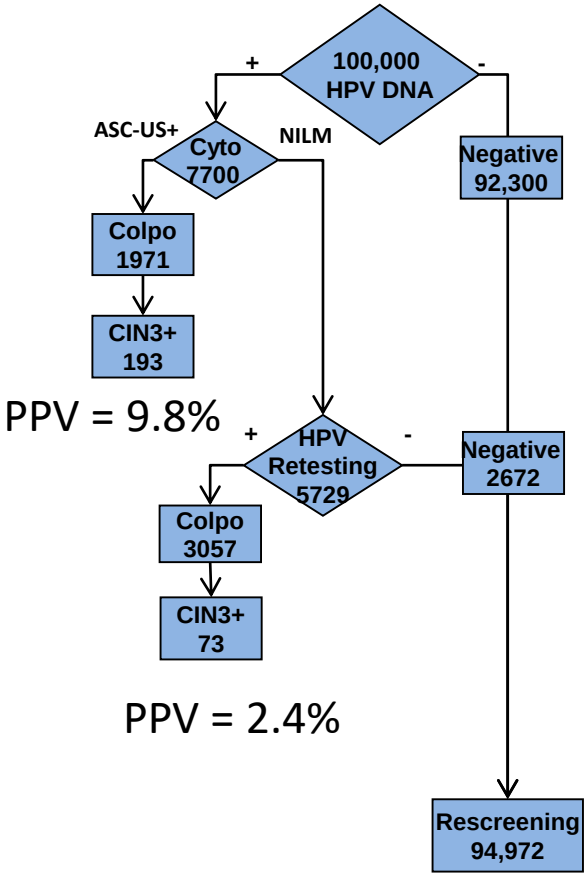
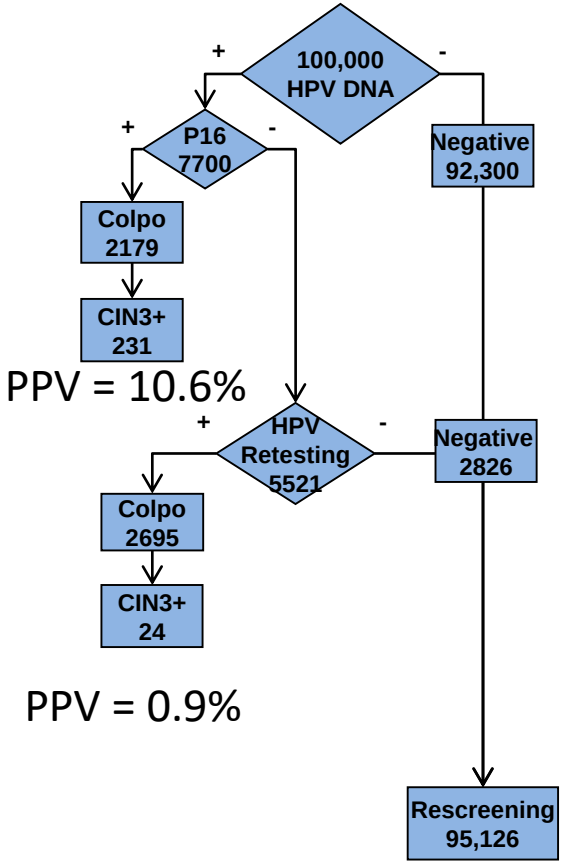
This figure describes the steps involved in clinical management of histologic HSIL.



Perkins et al J Low Genit Tract Dis, 2020

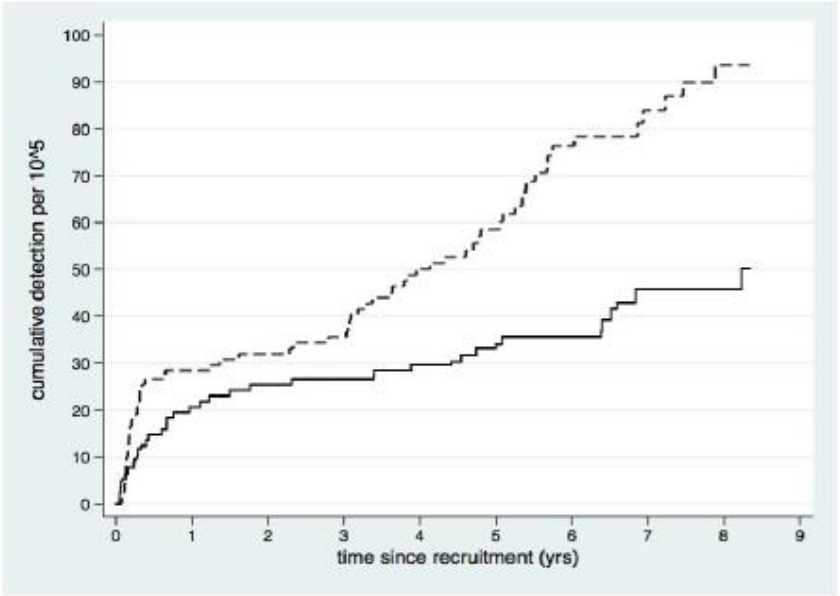
NTCC2 risultati al baseline su 3100 donne HPV positive



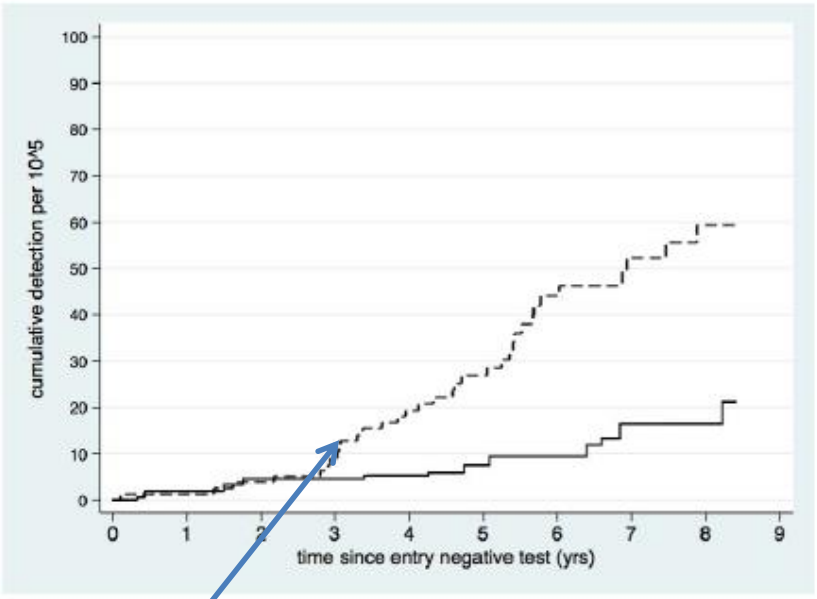


Can cytology negative CIN3 become cancer in 3/5 years?

A) All randomized women

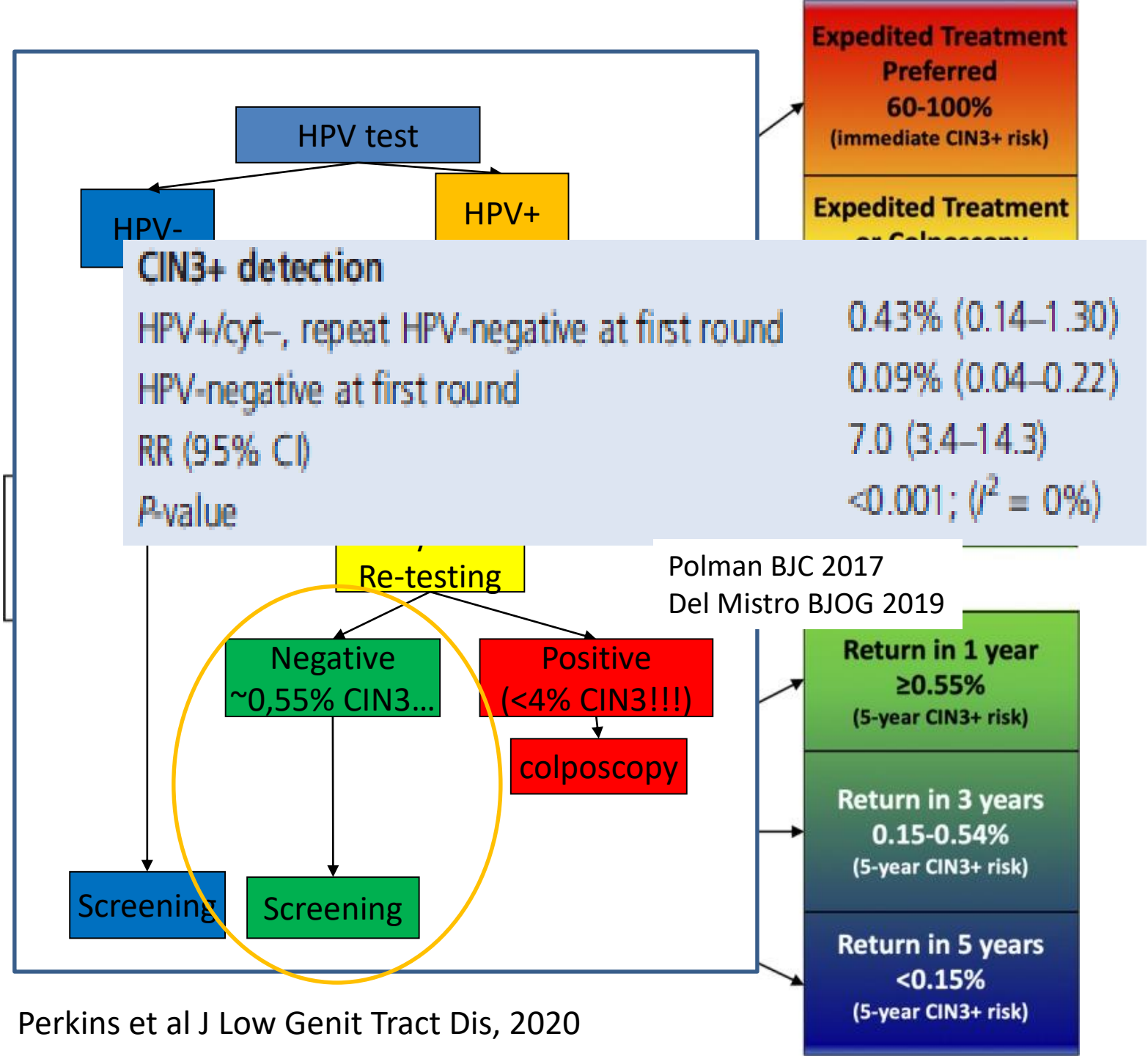


B) Women negative at entry test



Solid lines: HPV group. Dotted lines: cytology group
In panel (B) observations are censored 6 months after CIN2 or CIN3 detection, if any.

- All these cancers were cytology negative 3-5yy before.
- Is the increase in sensitivity due to informed cytology enough?



CIN3+ detection	
HPV+/cyt–, repeat HPV-negative at first round	0.43% (0.14–1.30)
HPV-negative at first round	0.09% (0.04–0.22)
RR (95% CI)	7.0 (3.4–14.3)
P-value	<0.001; (I^2 = 0%)

Polman BJC 2017
Del Mistro BJOG 2019

Perkins et al J Low Genit Tract Dis, 2020

DR CIN2+ al secondo round dopo HPV negativo

	Round1		Round2		Ratio
Este	70/18966	0.37%	4/9368	0.04%	0.12 (0.04-0.32)
Turin	20/7803	0.26%	2/3530	0.06%	0.22 (0.05-1.95)
Umbria	52/6272	0.83%	2/3831	0.05%	0.06 (0.01-0.26)
Valcamonica	149/18728	0.80%	2/3831	0.08%	0.10 (0.05-0.21)
Overall					0.10 (0.06-0.19)

P HET 0.64

Zorzi et al. BJOG 2017
Passamonti et al J Med Screen 2017
Pasquale et al J Med Screen 2020

Conclusioni

- Il principio equal risk equal management garantisce longevità e coerenza alle raccomandazioni in un contest di rapida innovazione tecnologica
- Vi sono alcuni punti in cui si generano incongruenze nel management:
  - Il follow up delle donne HPV+/triage-
  - Il trattamento e a gestione conservativa del CIN2
- È necessario condurre studi che definiscano il rischio associate alle diverse condizioni della donna (stato vaccinale, precedenti HPV test, stato dei biomarker…)

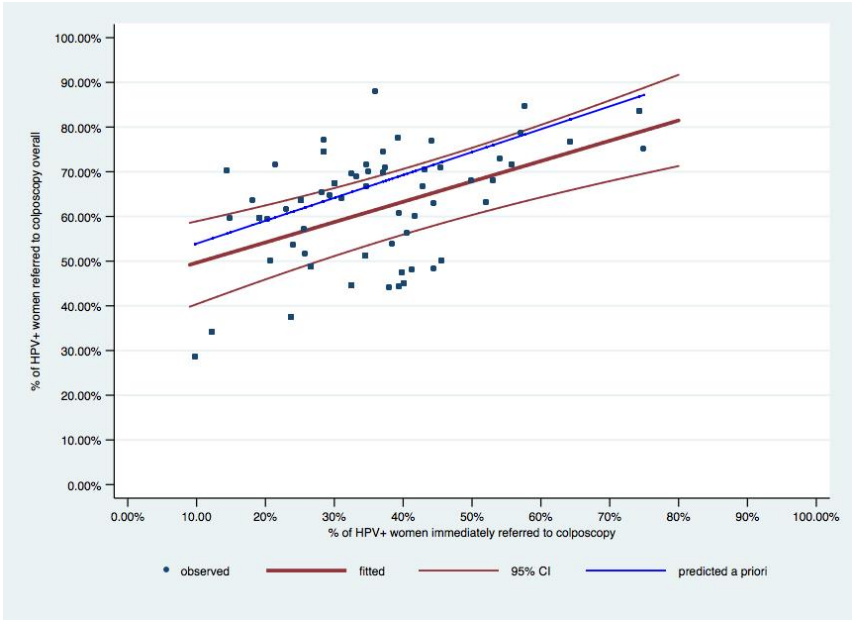
Grazie per l’attenzione

paolo.giorgirossi@ausl.re.it

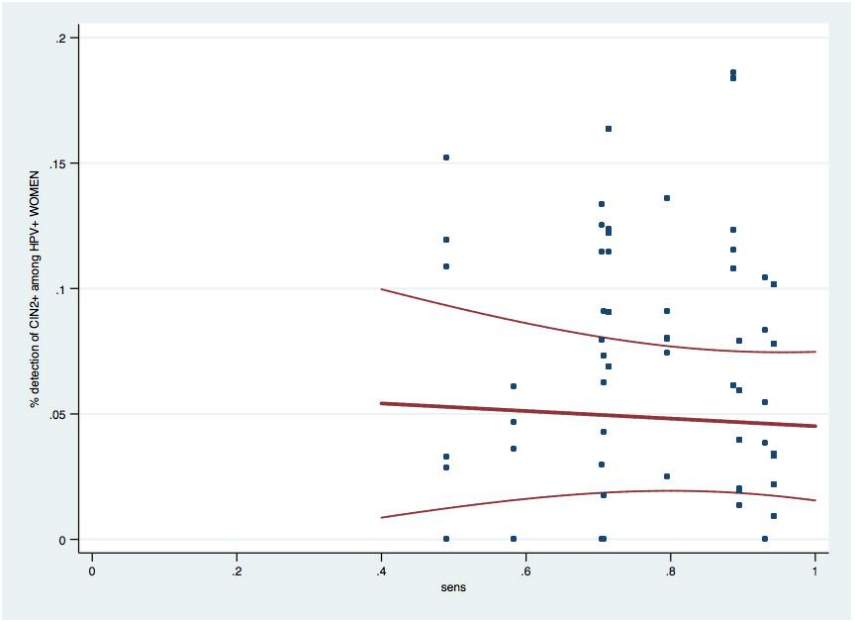
A 10% increase in cytology triage (ex. 30% -> 40%) implies only a 4.5% increase in overall referral HPV+ women.

Overall CIN2+ detection is almost independent from CIN2+ from triage positivity

Overall colposcopy referral (in HPV+) by triage positivity



CIN2+ DR (in HPV+) by triage positivity



Ronco et al Eur J Cancer 2016