

## President's Message

Peter Bryson, MD



I want to take this opportunity to thank my colleagues on the Executive Council of SCC for their continued support as we begin another year of planning, education, and progress. My association with SCC goes back to the initial days of the Society in late 1986 when the leaders in the field, Drs. DePetrillo, Lickrish, Wright, Shier, Ferenczy, Carmichael, Benedet, Roy, Popkin and Roth held the Organizational Meeting of the Society on November 29, 1986. As a member ever since, I have been an active member on several committees, presented topics at annual and regional meetings, was appointed Secretary-Treasurer in 2001 and now am privileged to be your President for the next 2 years.

I encourage you to think about getting involved with SCC by, for example, simply continuing your valued membership, volunteering to participate at one of the regional SOGC meetings on behalf of SCC, encouraging your colleagues who do colposcopy but are not SCC members to join the Society, and letting us know if you are interested in working for the Society at the executive level. We welcome your participation.

Last June, our Annual Clinical Meeting was held in Québec City in conjunction with the SOGC Annual Clinical Meeting and in early June, members of Council were invited to participate in the IFCPC World Congress in Cancun. Both of these events were very successful for us and are reported in this issue.

As you can see, we have changed our Newsletter design and format. We hope you find it not only appealing but also informative.

Our mandate for the next 2 years is as follows:

- 1) Increase membership;
- 2) Reach out and invite membership to play an active role in the mission of the Society;
- 3) Place the Society in the position to be very much a part of the process of cervical screening guidelines, colposcopy training guidelines, and continuing education in colposcopy and lower genital tract disease;
- 4) Work cooperatively with other regional organizations, national societies and organizations e.g. Public Health, GOC, SOGC, APOG, & Health Canada, to name a few, to foster and achieve the goals of SCC;
- 5) Form partnerships with industry to facilitate implementation of newer and improved technologies into our colposcopy practice;
- 6) Keep members aware of advances in the areas of liquid based cytology, HPV testing and HPV vaccination;
- 7) To continue developing relationships with international organizations such as ASCCP, IFCPC, ISSVD and the British and European Colposcopy Societies.

In summary, the Society has a great deal of work to do. I look forward to the challenge and your support.

### In this issue...

Update on the Training Guidelines for Colposcopy ... p.2

Clinical Corner ... p.3

Education Report ... p.4

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The Society of Canadian Colposcopists acknowledges and thanks the Society of Obstetricians and Gynaecologists of Canada for its continuing financial support of the Society for Secretariat services and other support essential to our success.

## Colposcopy CD-ROMs Accredited

The SCC is pleased to inform its members that the following two CDs as advertised in the spring edition of the SCC News have received accreditation from the SOGC as follows:

1. 100 Case Colposcopy Challenge: Cervix, Vagina, Vulva & Adjacent Sites with > 150 images in a PowerPoint Presentation by V. Cecil Wright for 1 credit rating per hour to a maximum of 4 hours.
2. Understanding Cervical Colposcopy by analysis of 240 True Colpophotographs in a Power Point Presentation by V. Cecil Wright for 1 credit rating per hour to a maximum of 3 hours.

Certificates will be mailed to those who have already purchased the CDs.



# Guidelines for Training Requirements in Colposcopy - Update

By Dr. Susan McFaul

The Executive Council of the SCC undertook last year a full review and update of the original SCC Guidelines for Training Requirements in Colposcopy and its Related Modalities. A draft document was presented at the Annual Business Meeting this past June in Québec City. Currently, these guidelines are being reviewed by The Association of Professors of Obstetrics and Gynaecology of Canada (APOG), and the SOGC/GOC/SCC Policy and Practice Guidelines Committee. Once the guidelines are approved by these two groups, they will be submitted for publication and subsequently available on our web site.

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## SCC Participates at the XXI World Congress of the IFCPC

The Triennial World Congress of the International Federation for Cervical Pathology and Colposcopy was held in Cancun, Mexico June 5 to 9, 2005. The SCC was invited to host a clinical half-day with an emphasis on how we do things in Canada. There were at least 700 registrants at our morning session. Our program consisted of the following:

- 1) A summary of cervical screening programs in Canada by Monique Bertrand
- 2) The incorporation of LBC and HPV testing into the new Ontario Screening Guidelines by Peter Bryson
- 3) The Effects of LEEP on subsequent Pregnancy by Jim Bentley (citation)
- 4) Colposcopic identification of ACIS by Cecil Wright
- 5) The use of LEEP in treating SIL of the cervix by Fernando Guijon
- 6) Sentinel lymph node mapping in early invasive cervical carcinoma by Pierre Drouin

Members of the SCC Executive met with the organizers of the next IFCPC meeting to be held in Auckland, New Zealand in October 2008, to discuss SCC's role in planning for and participating in the meeting. We look forward to further collaboration with our international colleagues.

**Executive Council:** S.C. Peter Bryson, MD • Monique A. Bertrand, MD • James Bentley, MD • Susan McFaul, MD • Lizabeth Brydon, MD • Alexandra Schepansky, MD • Marie-Claude Renaud, MD • Fernando Guijon, MD • V. Cecil Wright, MD

**Committees & Chairs:** Susan McFaul, MD, Bylaws • James Bentley, MD, Finance • Fernando Guijon, MD, Membership • V. Cecil Wright, MD, Newsletter • Monique A. Bertrand, MD, Nominating • Marie-Claude Renaud, MD, Programme and Education

**SCC News:** V. Cecil Wright, MD, Editor (Produced and published by The Society of Canadian Colposcopists - ©2005 by the SCC)

## SCC at the SOGC's 24<sup>th</sup> Ontario CME

November 24-26, 2005

Your Society is involved in the upcoming SOGC Ontario CME meeting held in Toronto, on Saturday, November 26, 2005. From 8:30 to 9:00, Dr. Alex Ferenczy will present "HPV-Preparing for the Future".

From 10:30 – 12:30, Drs. Michael Shier and Jason Dodge will present respectively on Colpophotographs of the Cervix and Vagina: Diagnosis and Treatment, and AGC and ACIS. Dr. Bryson will discuss Non-Neoplastic Vulvar Lesions – Diagnosis and Treatment, and Dr. Renaud will present Therapeutic Modalities for VIN.

For additional information including registration information, visit the SOGC web site at [www.sogc.org](http://www.sogc.org). Register early!

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## Welcome

**The SCC Membership Committee & Executive Council welcomes to the Society its new members:**

Lani Almas, MD, Terrace, BC, Active Category I • Marie-Hélène Aubé, Montréal, QC, Active Category I • Cheryl Conrod, MD, Sydney, NS, Active Category I • Greg Hancock, MD, Stratford, ON, Active Category I • Ingrid Harle, MD, London, ON, Active Category II • Jocelyne Martel, MD, Saskatoon, SK, Active Category I • Maggie Morris, MD, Winnipeg, MB, Active Category I • Patti Power, MD, St. John's, NL, Active Category I • Martine Roy, MD, Edmonton, AB, Active Category I • Kathryn Treehuba, MD, Ottawa, ON, Active Category I • Fikry Ywakim, MD, Cornwall, ON, Active Category I

## How to Prevent Cervical Stenosis After Excision

By Drs. Gordon M. Lickrish<sup>1</sup> & Peter Bryson

Narrowing of the external cervical os is occasionally seen after an excisional procedure but symptomatic cervical stenosis remains uncommon. The cervical os can be quite small, and if asymptomatic, nothing should be done unless an adequate endocervical cytology sample cannot be obtained. Symptomatic stenosis presents with increased dysmenorrhea, prolonged menstruation with pre and postmenstrual spotting. Before mentioning how it can be treated, it is best to know that it can be prevented.

Cervical stenosis occurs mainly in hypoestrogenic states such as:

- 1) Reproductive age group women with oligomenorrhea or amenorrhea.
- 2) Women on oral contraceptives with oligomenorrhea or amenorrhea.
- 3) Women who are postpartum and/or breast feeding.
- 4) Women on Depo-Provera.
- 5) Postmenopausal women who are not on HRT

Other causes of cervical stenosis are:

- 1) Deep endocervical excision
- 2) Excessive use of monopolar electro fulguration/desiccation used for hemostasis after the excision is completed.

Prevention of Cervical stenosis:

- 1) In postmenopausal women, prescribe cyclic systemic Estrogen/Progesterone therapy before, during, and after the procedure. Use Estrogen 1.25 mg daily and progesterone 10 mg days 1 to 10 for one month before the procedure and for 3 to 4 months after the procedure. This short course of therapy has minimal complications. However, it should be avoided in women with absolute contraindications to estrogen and progesterone therapy.
- 2) In hypoestrogenic premenopausal women, prescribe topical or tablet vaginal estrogen for one month before the procedure and for 3 months afterwards.

Operative technique is also very important. Generally, the degree of stenosis is related to the length of the endocervical canal removed. Knowing the liner length of the dysplastic lesion allows the operator to remove only enough endocervix to confirm the diagnosis and entirely remove the lesion. When doing the procedure one should use either pure cut or blend mode rather than coagulation mode. In addition, the operator should minimize the use of electrofulguration to treat bleeding. One should use the blade rather than the ball electrode, targeting the bleeding vessels and not the entire excisional bed. Application of Monsel's paste will control most bleeding.

For patients on Depo-Provera, use vaginal estrogen cream or tablets for at least 14 days before the procedure and continue to use for 4 to 8 weeks afterwards.

High-risk patients should be examined every 2 weeks for 6 to 8 weeks following the procedure to ensure the external os and endocervical canal are not narrowing and to review compliance with the prescribed estrogen therapy.

In follow-up, if stenosis is detected and you can't obtain an endocervical sample or if the patient is symptomatic, then consider the following:

- 1) If there is a thin film of squamous epithelium covering the external os, one can vaporize it by very superficial laser therapy under local anesthesia. If repeat LEEP is used to remove the area of stenosis, it should be kept very superficial. These patients should be examined every 2 weeks for 6 to 8 weeks following the procedure to have the external os and endocervical canal dilated and to ensure compliance with the prescribed estrogen therapy.
- 2) When the stenosis extends well into the canal management is more difficult. Repeat excision or laser therapy can result in the same degree of stenosis or worse. If therapy is attempted use topical estrogen as describe above before and after the procedure. In follow up, repeated gentle dilatation under local can help and the use of misoprostol can reduce the degree of stenosis.
- 3) If stenosis persists, have the patient insert a vaginal misoprostol tablet, 200 micrograms, 24 hours prior to her colposcopy clinic visit. Often this will stimulate the cervical os to open enough to obtain an adequate endocervical cytology sample or do an endocervical curettage if needed.



*Complete cervical stenosis after electro-surgical excision demonstrating the stippling effect of the blood vessels radiating outwards from the stenosed external os.*



*The desired result following treatment is dependent on adequate estrogen therapy prior to treatment.*

In summary, while cervical stenosis after an excisional procedure can't be completely prevented, using the fore mentioned methods could lessen the incidence.

1- Lickrish, GM. Colposcopy in the Management of Cervical Intraepithelial Neoplasia: Problems and Suggestions. *J Soc Obstet Gynaecol Can* 200;22(6):429-34

*Pictures shown provided courtesy of Dr. V. C. Wright.*

# The SCC Education Report

By Dr. Peter Bryson and Dr. Jim Bentley

The SCC held its 19<sup>th</sup> Annual Postgraduate Comprehensive Colposcopy Course, in conjunction with the annual SOGC ACM, in Québec City on June 17, 2005. There were 75 registrants attending. Our guest speaker was Dr. Daron Ferris, President of the American Society for Colposcopy and Cervical Pathology (ASCCP).



Dr. Peter Bryson, Dr. Daron Ferris, Hélène Soublière, Dr. Jim Bentley, Dr. Monique Bertrand, Dr. Fernando Guijon, Dr. Lizabeth Brydon, Dr. Jason Dodge, Dr. Susan McFaul and Dr. Michael Shier.

This year, there was special emphasis placed on Guidelines as they pertain to Cervical Cancer screening in Canada (Dr. Monique Bertrand), Colposcopy training (Dr. Susan McFaul), Maintenance of Competence in Colposcopy (Dr. Daron Ferris), and the value of HPV testing (Drs. Peter Bryson and Daron Ferris). Other more clinically oriented

presentations were The Identification and Treatment of LSIL (Dr. Betsy Brydon), HSIL (Dr. Marie-Claude Renaud), Atypical Glandular Cells (Dr. Jason Dodge), VIN (Dr. Michael Shier), LEEP effects on Subsequent Pregnancy (Dr. Jim Bentley) and many knowledge testing touch pad questions, (Drs. Bentley and Shier).

The Society of Canadian Colposcopists would like to acknowledge and thank Digene Corporation, Superior Medical Ltd, and Jac-Cell Medic for providing unrestricted educational grants in support of this meeting. We would especially like to thank Superior Medical for donating the door prize, which consisted of colposcopy clinic instruments. The winner this year is Dr. Karine Nadeau of the Université de Montréal.



Dr. Karine Nadeau (SCC door prize winner), Andrea Adams (Superior Medical Ltd), Christian Collin (Superior Medical Ltd), Sandy Santos (Superior Medical Ltd) and Dr. Peter Bryson.

We welcome your ideas for our national meeting at the SOGC ACM next June in Vancouver. You may send your suggestions to the SCC National Coordinator, Hélène Soublière by email at [hsoubliere@sogc.com](mailto:hsoubliere@sogc.com) or by phone at 1-800-561-2416, ext. 250.

## SCC Membership Dues Increase

By Dr. Peter Bryson

As our Society continues to grow and our activities increase, so do our expenses. Some of these expenses are our new SCC web site, the revamped SCC News, mailings, and the distribution of the Journal of Lower Genital Tract Disease. We have been holding off any dues increase for a number of years but we can no longer do so. At the spring meeting in Québec City, we had to concede that an increase in dues from \$70 to \$125 was necessary to carry out our expanding mandate. Your dues notice is enclosed with this mailing. On behalf of the Executive Council of SCC, I look forward to your continuing support.

## Calendar

SOGC Québec CME  
Montréal, Québec  
November 17-18, 2005

SOGC 24<sup>th</sup> Ontario CME  
Toronto, Ontario  
November 24-26, 2005

SCC Postgraduate Course  
Toronto, Ontario  
November 26, 2005

ASCCP – Advanced  
Colposcopy: The Complete  
Lower Genital Tract  
Phoenix, Arizona  
December 1-4, 2005

ISSVD XVIII World Congress  
Auckland, New Zealand  
February 20-24, 2006

ASCCP 2006 Biennial Meeting  
Las Vegas, Nevada  
March 13-17, 2006

SGO Annual Meeting on  
Women's Cancer  
Palm Springs, California  
March 22-26, 2006

ASCCP – Comprehensive  
Colposcopy  
Chicago, Illinois  
April 21–23, 2006

SOGC 62<sup>nd</sup> Annual  
Clinical Meeting  
Vancouver, BC - June 22-27, 2006

SCC Postgraduate Course  
Vancouver, BC - June 23, 2006



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[www.colposcopycanada.org](http://www.colposcopycanada.org)  
We welcome your  
suggestions for content.