

President's Message

Peter Bryson MD



In starting my second year as your President, I'm happy to report that our 2005-2006 academic year was very successful. Our membership has grown. The SOGC-SCC Clinical Practice Guidelines for Training Requirements in

Colposcopy and its Related Treatment Modalities was published in the Journal SOGC in April 2006, the principal author being SCC secretary/treasurer Dr Susan McFaul. Our annual clinical meeting took place at the SOGC meeting in Vancouver on June 23, 2006 and was a great success.

Our goals continue to be focused on education. SCC will be participating in the SOGC regional meetings in Toronto on December 2, 2006 and April 2007 and in Banff in March 2007. Check the SOGC web site and mark your calendars. We also are starting to plan for our next annual clinical meeting at the SOGC Annual Meeting in Ottawa next June. Plans are underway to have a SCC 20th anniversary evening of food, wine,

and music on Friday, June 22 2007. We will keep you posted as the plans evolve.

The big news over the summer was the release of the first vaccine for the prevention of HPV infection with types 6, 11, 16, & 18. Your patients will be asking many questions about the vaccination. Members of SCC are currently participating in the SOGC HPV Guidelines Committee and hope to have a publication ready by March 2007. SCC members are also participating in a SOGC Expert Working Group to raise public awareness about Human Papillomavirus infection.

In closing, I must let you know that Helene Soubliere, our national coordinator for the nearly the last four years, has moved on within the SOGC organization. Helene deserves much of the credit for keeping the executive on track and SCC moving forward. On behalf of the entire SCC membership, I wish Helene all the best and again emphatically thank her for all the hard work she did for SCC. We are, however, very fortunate to have Judy Scrivener as our new SCC National Coordinator. More information about Judy is contained inside this Newsletter.

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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.

HPV Vaccine Update

By Jim Bentley, MD

The last few months have brought about a revolutionary change in the approach to cervical cancer prevention. We are moving into the era of primary prevention with the introduction of Gardasil (Merck). Gardasil is the first approved prophylactic vaccine against the human papilloma virus (HPV). In addition to targeting the viral types 16 and 18 predominantly responsible for cervical cancer, it provides coverage against types 6 and 11 the principle causes of condyloma.

Gardasil was approved for use in the USA in

June 2006. It since has been approved for use in the EEC, Australia and recently in Canada. Health Canada approved the vaccine in mid July and it has been available to physicians since early September. The vaccine is approved for females between 9-26 years of age; however in Australia they have also approved use in males from 9-15 years.

Once regulatory approval is in place various committees have to decide on optimal implementation of the vaccine. This decision in Cana-

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SOGC/SCC/GOC Joint Statement on HPV Vaccine — Summer 2006



In partnership with the Society of Canadian Colposcopists (SCC), and the Society of Gynecologic Oncologists of Canada (GOC), the SOGC released a joint-statement welcoming Health Canada's approval of a new vaccine that can prevent the Human Papillomavirus (HPV).

As many as 80% of Canadian women of reproductive age will be exposed to HPV throughout their lifetime. Transmitted through skin-to-skin contact, HPV is a highly contagious virus that can cause cervical, vulvar, vaginal and other anogenital cancers. Other strains of the virus cause anal and genital warts.

In the July 18 statement, the three societies commend Health Canada for quickly making this vaccine available. In anticipation of the availability of an HPV Vaccine, the SOGC has been working in collaboration with other associations, including SCC and GOC, to draft a clinical guideline that will inform Canadian healthcare professionals on the appropriate usage of an HPV vaccine. This comprehensive guideline will also include information on screening, diagnosis, and treatment of HPV and is expected to be published in early 2007.

"While the vast majority of the HPV infections clear up by themselves, there is a chance that a woman could have a cancer causing strain of the infection and not even know it," said Dr. Peter Bryson, President of the SCC. "We can't emphasize enough the importance of regular cervical

cancer screening and the introduction of this vaccine doesn't change that. However, now when doctors are counseling their patients about sexual and reproductive health, they will be able to offer a vaccine to prevent HPV infection. That is really good news," said Dr. Bryson.

"Each year 400 Canadian women die of cervical cancer and thousands more are diagnosed and successfully treated. Until now, our best defence against this kind of cancer was ensuring women had regular Pap tests so we could catch this disease in its earliest stages. Now, with a vaccine available, we can start talking about preventing cancer and other disease, such as anogenital lesions, caused by HPV in addition to continued screening," said Dr. Donald Davis, President of the SOGC.

While the introduction of a vaccine has the potential to substantially reduce the incidence of cervical cancer in Canada, SOGC, SCC and GOC all stress that it is very important for women to continue to receive regular cervical cancer screening.

To ensure people are aware of the HPV public health threat, the SOGC will be launching a public education campaign about HPV, the importance of pelvic exams and Pap smear screening for cervical cancer. More information on this campaign will be available in the next issue of the SOGC News. For more information on HPV, please visit www.sexualityandu.ca or www.sogc.org.

SCC Executive

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- S.C. Peter Bryson, MD, President
- Monique A. Bertrand, MD, Past-President
- James Bentley, MD, President-Elect
- Susan McFaul, MD, Secretary-Treasurer

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- 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

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SCC News

V. Cecil Wright, MD, Editor

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The SCC Education Report

By Drs. Marie Claude Renaud and Peter Bryson

The SCC held its 20th Annual Post-graduate Comprehensive Colposcopy Course at the SOGC Meeting in Vancouver June 23rd, 2006. There were over 90 registrants for the PG Course.

The morning session featured discussions on management of VIN (Dr. Renaud), the potential use of HPV testing in primary screening (Dr. Tom Ehlen) and a debate on the status of Liquid Based Cytology in current practice with the pro side take by Dr. Terry Colgan from Toronto and the con side by Dr. Dirk van Niekerk from Vancouver. Dr. Laurie Elit from Hamilton presented an abstract on "Colposcopists' agreement on cervical biopsy site"

In the afternoon we focused initially on the efforts being done nationally to provide quality assurance to the practice of Colposcopy. The Colposcopy programs in Nova Scotia and British Columbia, and the SCC/SOGC Clinical Practice Guideline on colposcopy training in Canada were highlighted. Dr. Vyta Senikas (Assistant VP SOGC) concluded the session by presenting the teaching modules developed by SOGC on linking HPV knowledge to the practice of immunization.

We were very pleased to have an old friend of SCC, Dr. John Sellors be our guest speaker for the day. Dr. Sellors

is a senior medical advisor for the Reproductive Health Strategic Program at PATH (Program for Appropriate Technology in Health) in Seattle, Washington. He spoke from 2 questions: "Can we learn anything from screening and development R&D in the developing world" and, "HPV vaccination – Is this a prevention panacea?" The Course ended off with excellent presentations by Dr. Cecil Wright on the significance of blood vessel patterns in colposcopy and Dr. Leslie Sadownik on how to diagnose vulvar ulcerations. The touch pad session was given by Drs. Sadownik, Shier and Bryson.

We wish to thank Superior Medical Ltd. for their continued support of the SCC courses over the last 15 years

and also for donating the Colposcopy Biopsy instruments and complete LEEP kit door prize. A draw for the instruments was held at the conclusion of the PG Course and the lucky winner was Dr. Susan McFaul from Ottawa.

SCC also wishes to thank AMT Electrosurgery, GlaxoSmithKline and Merck Frosst Canada for their support of this meeting.

The SCC Program Committee welcomes ideas for our national meeting at the SOGC ACM next June in Ottawa. You may send these to the SCC National Coordinator, Judy Scrivener in Ottawa by email at jscrivener@sogc.com, or by phone at 1-800-561-2416 ext. 320.



SCC at the SOGC 25th Ontario CME

November 30-
December 2, 2006

Your Society is involved in the upcoming SOGC Ontario CME meeting held in Toronto, on Saturday, December 2, 2006.

- From 10:30 to 11:00, Dr. Joan Murphy will present "Cervical Cancer Screening – Where it fails".
- From 11:00 – 11:30, Dr. Michael Shier will present "HPV Vaccination – Frequently Asked Questions with Answers".
- From 11:30 – 12:30, Drs. Shier, Murphy and Bryson will present "Colposcopy Case Studies".

For additional information including registration information, visit the SOGC web site at www.sogc.org. Register early!

CLINICAL CORNER

Vulvar Lichen Sclerosus (VLS)

By Dr Peter Bryson & Dr Michael Shier

This common vulvar dermatosis is an itchy skin rash usually of long duration. It is often misdiagnosed and under treated. Many patients are told they have vulvar “atrophy” or yeast vulvitis and are treated with topical estrogen cream, low potency corticosteroids, or over the counter antifungal creams. It usually occurs in middle aged and older women but can be seen in prepubertal girls. Some cases are asymptomatic and discovered by routine vulvar examination, e.g. at the time of Pap testing. The cardinal symptom for most patients is moderate to severe pruritus. Severe VLS may cause pain and burning due to ulceration secondary to skin thinning and excessive scratching. The cause is still unknown but it is not caused by an infectious agent or hygienic practices and is not “contagious”. It appears to be an autoimmune disorder of unknown etiology.

Examination of the Vulva

This identifies thin and sometimes wrinkled whitening of the vulvar skin with varying degree of scarring, erosion, capillary fragility and bruising. In many cases, a figure of eight distribution involving the perianal skin is seen as well. VLS does not commonly involve the vestibule or vagina. Chronic scarring, depending on the location, causes loss of labia minora, phimosis of the clitoris, loss of introital elasticity, dyspareunia, and painful defecation with bleeding. With Lichen Sclerosus in mind, the diagnosis is usually obvious in the majority of cases and a biopsy is usually not required. The differential diagnosis is contact dermatitis, VIN (vulvar intraepithelial neoplasia), Lichen Planus, severe chronic inflammatory vulvitis or early invasive squamous cancer.

Treatment Tips:

Stop irritants and scratching. Rule out allergic or contact dermatitis.

Employ vulvar soothing methods:

- Burosol Sitz baths as directed on the



Mild vulvar lichen sclerosis demonstrating the wrinkled whitening of involved skin.



Severe lichen sclerosis with ulceration and hyperkeratotic areas.



Moderate lichen sclerosis with swollen edematous labia.

box. For moisturizing, use a thin application of Vaseline or virgin olive oil at bedtime on nights when not using topical treatments.

Education and support

- Provide information handouts and helpful web links

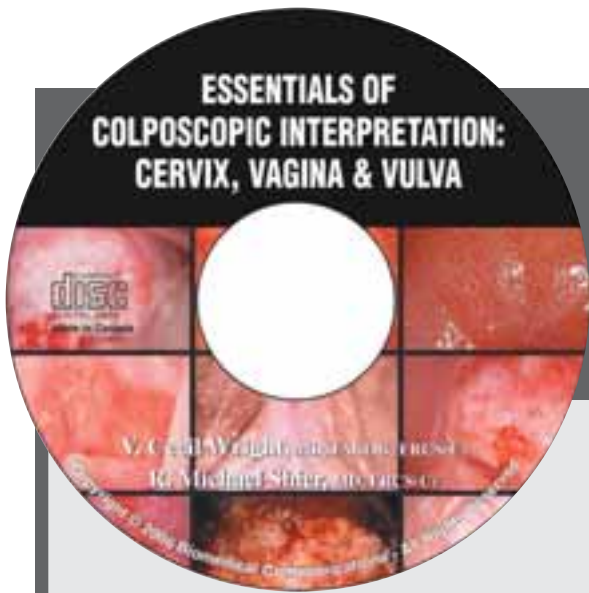
Use a high potency corticosteroid:

- Clobetasol (Dermovate) 0.05% ointment or,
- Halobetasol (Ultravate) 0.05% ointment)
- Apply as a thin layer twice daily for at least 4-6 weeks. With severe cases bid dosing can be extended to 8 to 12 weeks. Then apply once daily for 4-6 weeks. Then apply once weekly thereafter, using 2 applications on that day. Emphasize that treatment should be kept up forever given its chronic nature. Clobetasol is safe for use in prepubertal girls. For thickened or resistant areas, confirm the diagnosis by biopsy.
- Flucinonide 0.05% cream is ideal for hyperkeratotic areas as it has excellent penetration through lichenified, hyperkeratotic, or leukoplakic lesions caused by VLS. It should be used QID at first (sometime under and occlusive dressing for the first week or two) until the lesion clears, but never more than 8 to 12 weeks. Use topical agents for superimposed yeast vulvo vaginitis – Terazol, Nizoral, or oral treatment with Fluconazole

Other Topical Treatments:

- Pimecrolimus or Tacrolimus are immunomodulators applied as an ointment twice daily for 3 – 6 months in cases which do not respond to standard therapy. Informed consent is important given the FDA alert in March 2004 about the rare possibility of skin cancer. These drugs are very expensive and require an

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New Colposcopy CD-ROM Accredited by SOGC

The SCC is pleased to inform its members that the following CD has received accreditation and is available for purchase:

Essentials of Colposcopic Interpretation: Cervix, Vagina and Vulva – including 723 high quality descriptive images (642 true colpophotographs, 14 photos, 17 cytology, 30 histology, 20 schematics) in Powerpoint® presentation. One credit rating per hour to a maximum of four hours

To order, go to www.sogc.org/scc/english/education/index.asp, or call the Secretariat Office at 613-730-4192 ext. 320/1-800-561-2416 ext. 320.

CLINICAL CORNER — Vulvar Lichen Sclerosus (VLS) (continued)

explanation (in Ontario) for why the cost should be covered by the provincial drug plan.

Follow Up Tips:

- Long term follow up required q 6 monthly. Clobetasol is not “too dangerous” if used correctly. Topical Estrogen cream bid may be helpful to treat symptoms caused by vaginal and vestibular atrophy such as introital dysparunia due do dryness. Switch to a mid dose potency corticosteroid cream for maintenance. Colposcope and Biopsy any non-responding areas to rule out other conditions such

as Lichen Simplex Chronicus, Lichen Planus, VIN, Squamous Cell Hyperplasia or invasive cancer knowing that there is a 5% risk of vulvar skin cancer with VLS.

For Steroid Dermatitis:

- Stop the high potency steroid and employ soothing measures, (see above). Apply 1% HC for pruritus and restart mid potency corticosteroid cream or ointment 1-2 times a week after the steroid rash is gone and follow closely.

The Place of surgery:

- Use for scarring in at the introitus (perineotomy and perineoplasty with vaginal advancement) or over the clitoris (unroofing).
- Use in combination with bid topical Clobetasol for 2 weeks to

suppress the VLS.

Flare ups:

- The patient must know that this a chronic condition subject to flare ups from time to time. Flare ups can be triggered by Contact dermatitis, Infection by bacteria or yeast, trauma form scratching or intercourse, VIN, or malignant change. Treat the cause for the flare up and use Clobetasol daily for 7-10 days to suppress the flare up, returning to weekly applications thereafter.

Tell patients Vulvar Lichen Sclerosis is not Multiple Sclerosis (different spelling).

Welcome to the Society of Canadian Colposcopists

The SCC Membership Committee & Executive Council would like to welcome to the Society its new members:

- Olaniyi Agboola, MD, Clarenville, NL, Active-Category I
- Maged Bakhet, MD, Abbotsford, BC, Active-Category I
- Dawood G. Dawood, MD, Ottawa, ON, Active-Category I
- Martine Goyet, MD, Montreal, QC, Active-Category II
- Catherine Hansen, MD, Cold Lake AB, Active-Category I
- Robert Krushel, MD, Yellowknife, NT, Active-Category I
- Washington Munoz, MD, Lethbridge, AB, Active-Category I
- Susan O'Toole, MD, Barrie, ON, Active-Category I
- Dan Reilly, MD, Fergus, ON, Active-Category II
- Suzanne Roberge, MD, Baie-Comeau, QC, Active-Category I
- Donald Tennent, MD, St. John's, NL, Active-Category II
- Frances Wren, MD, Brentwood Bay, BC, Active-Category I
- Gillian Yeates, MD, Collingwood, ON, Active-Category II

HPV Vaccine Update (continued)

da depends on recommendations made by the National Advisory Committee on Immunization. They report to the Canadian Immunization Council, a recommendation will then be made nationally which the Provinces may implement. This has significant cost considerations, as the vaccine is one of the most expensive at about \$420 for the three doses necessary. This cost does not include administration costs.

In the United States the Advisory Committee on Immunization Practices has voted to routinely vaccinate girls when they are 11-12 years old, they also recommended catch-up vaccination of women between 13 and 26. This is interesting as vaccination till the age of 18 is covered for non-injured children under the National Immunization Program.

A second vaccine Cervarix™ (GSK) is currently in the approval process in Canada and worldwide. This, similar to Gardasil™, is a virus like protein vaccine using the virus capsule to provide prophylactic protection against HPV infection. Neither has demonstrated significant therapeutic effect thus far.

Although both vaccines only target two oncogenic types, there is preliminary evidence that they may provide cross protection against other subtypes.

While we await implementation recommendations for a universal program there are situations where the vaccine may be used i.e. catch up in women over 12 who are unlikely to be part of a universal program. Questions remain about other uses; in older women, post treatment in the clinic to prevent re-infection, and vaccination to promote resolution of HPV infection or low-grade abnormalities.

The future promises to be very exciting with the prospect of reducing a significant proportion of colposcopy clinic visits and treatment for cervical cancer.

Calendar

SOGC 25th Ontario CME
Toronto, Ontario
November 30–
December 2, 2006

SCC Postgraduate Course
Toronto, Ontario
December 2, 2006

ASCCP – Advanced Colposcopy and Lower Genital Tract Dermatology
Palm Beach, Florida, USA
December 7–10, 2006

SGO Annual Meeting on Women's Cancer
San Diego, California, USA
March 3–7, 2007

SOGC 20th International CME
Paradisus Varadero
Resort, Cuba
March 5–9, 2007

SOGC 17th West/Central CME
Banff, Alberta
March 29–31, 2007

SOGC 3rd GYN CME
Toronto, Ontario
April 20–21, 2007

SOGC 63rd Annual Clinical Meeting
Ottawa, Ontario
June 21–26, 2007

SOGC 19th FMC du Québec
Le Château Bonne Entente,
Québec (Québec)
September 20–22, 2007

SOGC 26th Ontario CME
Toronto, Ontario
November 29–
December 1, 2007

IFCPC 13th World Congress of Cervical Pathology and Colposcopy
New Zealand
October 19–23, 2008