

Presidents Message James Bentley, MD



I recently had the pleasure of attending the International Federation of Colposcopy and Cervical Pathology (IFCPC) meeting in the "City of Sails" Auckland, New Zealand. The IFCPC is a multinational organization with representation from over

50 national colposcopy societies. Each member of the SCC is also a member, \$ 5 of your membership dues goes to the IFCPC. Every 3 years there is a scientific meeting, the venue alternat-

ing between North America, Asia and Oceania, South America and Europe.

This year there were over 400 delegates from all over the globe, unfortunately Canada and the USA were not well represented. The scientific program was exemplary; we heard from leaders in HPV immunology and epidemiology including Xavier Bosch from Spain, Margaret Stanley from the UK and Ian Fraser from Australia. Dr Suzanne Garland from Australia gave an update on the performance of the quadrivalent vaccine. There were well-attended scientific sessions and

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The Society of Canadian Colposcopists Education Report

By Drs. Betsy Brydon and Jim Bentley

The SCC held its 22nd Annual Postgraduate Comprehensive Colposcopy Course at the SOGC Meeting in Calgary June 26, 2008. There were over 73 registrants for the PG Course. This was a very good year! Thank you.

The morning started with a thoughtful and very clear presentation by our international guest speaker, Dr. Mark Spitzer on the new ASCCP guidelines, how they have changed from the previous and why. This was followed by Dr. Bentley's review of the Canadian situation. A lively and helpful discussion followed. Dr. Spitzer was very helpful and practical in his approach. Following this, Dr. Jill Nation presented the status quo with respect to low grade lesions. She is proposing a study



From left to right – Dr. Christopher Giede, Dr. Monique Bertrand, guest speak Dr. Mark Spitzer, Dr. Alex Schepansky, Dr. Betsy Brydon and Dr. Jim Bentley.

of the colposcopic management of low grade lesions. Interested units were invited to participate. As a pre-lunch challenge, we visited a few colposcopic slides via touch pad technology

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numerous posters. Other plenary sessions included a look at the contemporary screening and options for anal intraepithelial neoplasia, management of glandular lesions, quality assurance, treatment, nomenclature and interactive sessions from the International Society for the study of Vulvovaginal Disease. One of the more interesting presentations was Dr Ron Jones from Auckland discussing his role as the whistle blower in the “Unfortunate experiment” that occurred in New Zealand. This “study” evolved because a Dr Green did not believe that CIN 3 was premalignant, and that he could differentiate between CIN 3 and micro invasive carcinoma. In subsequent follow-up, 31.3% of the women followed without definitive treatment developed invasive cervical cancer. Of those who had persistent disease at 24 months, the invasive risk was 50.3%. These dramatic figures compared to a 30 year risk of only 0.7% in those treated in a “probable satisfactory fashion”. This long-term study of the natural history helps us understand the nature of true CIN 3; the challenge is the small CIN 3 lesion or CIN 2 which may regress in a young woman.

I had the pleasure of presenting at

the five continents symposium, organized by the incoming president Patrick Walker from London. I gave the Canadian update of where we are with screening and colposcopy. Primary vaccination practices vary in the developed world, with school based vaccination in Canada compared to free vaccination of women up to the age of 25 in Australia and New Zealand. The large worldwide discrepancies became apparent with the presentation by Dr Sankaranarayanan about the status in Asia and Africa. Estimates are that if effective prevention interventions are not implemented there will be over 1 million new cases of cervical cancer a year by 2030. Dr Sankaranarayanan who works with the IARC in Lyon France discussed the challenges in the developing world. The discussion is whether a country can screen once in a lifetime not how many cohorts of school age women can be vaccinated. Institution of vaccination programs will likely reach these areas but not for some time, until the vaccine is much cheaper. It is likely that the poorest of countries will get support from international agencies such as PATH. However, the next tier of a nations may not be so fortunate.

Regarding secondary prevention, much of Sub-Saharan Africa and Asia is unable to provide screening using conventional Pap smear technology. Projects have been implemented that show reduction in CIN of up to 40 % using a single visualization with acetic acid or a combination of acetic acid and lugols (VIA or VILI). These techniques are being done by trained nurses and positive findings are treated at the same visit by the relative low tech technique of cryotherapy. There remains the prospect that rapid HPV screening may become applicable in the near future. This may add increased sensitivity to a VIA and colposcopy approach. There are projects however where screening using pap smears is being introduced. There remains a role for the colposcopist in these areas. It is hoped that the IFCPC can be involved in colposcopic education along with IARC in these implementation projects.

As well as a great opportunity to visit other areas, the conference provided valuable networking with our international colleagues. The next meeting will be in Rio de Janeiro in Brazil 2011 followed by London UK in 2014. We look forward to seeing a larger Canadian contingent at these meetings.

Education Report (continued from page 1)

Over lunch we had our SCC Annual Business Meeting, which generated lively discussion concerning the future plans for the society.

In the afternoon, we had an opportunity to review three abstract presentations in the area of colposcopy, two by Dr. Laurie Elit and one by Dr. Marie Helene Mayrand. Dr. Spitzer then returned to the platform for a delightful, provocative and challenging talk on the management of the adolescent patient. This was followed by the team of Drs. Alex Schepansky and Chris Giede presenting case presentations of glandular

lesions in the touch pad format.

We wish to thank Superior Medical Ltd. for their continued support of the SCC courses over the last 17 years and also for donating a \$5,000 gift certificate towards the purchase of any office equipment as the door prize. A draw for the gift certificate was held at the conclusion of the PG1 Course and the lucky winner was Dr. Barbara Bodmer from Montreal.

The SCC Program Committee welcomes ideas for our national meeting at the SOGC ACM next June in



From left to right: Superior Medical representative, Dr. Mark Spitzer and the door prize winner, Dr. Barbara Bodmer.

Halifax. 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.

Looking forward to seeing you in Halifax!!!

Colposcopy Clinical Corner

Choosing the Right Treatment for CIN

by Jim Bentley

We all accept the need to treat CIN 3 and most CIN 2. Since the 1990's the treatment of choice has become LEEP. The advantages of the procedure including ease of use, relatively low tech, outpatient procedure with a histology specimen are obvious to all colposcopists. Initial reports did not show any significant morbidity however several papers have shown the increased risk of preterm labour

associated with only one LEEP. In the Canadian study by Samson et al (2005) 1 in 19 LEEPS resulted in preterm delivery. The meta-analysis by Kyrgiou (2008) also showed this association and showed that these complications were increased when resection was done to a depth greater than 10 mm. This knowledge needs to be incorporated into clinical practice and it is our responsibility to avoid doing unnecessary harm to women who may contemplate a future pregnancy while avoiding the real risk of cervical cancer developing; particularly in women with CIN 3.

Federation of Cervical Pathology and Colposcopy proposed different transformation zone types in 2003 (fig 1). Designing treatment to suite a particular type may help avoid unnecessary harm.

The system classifies a transformation zone by three factors:

1. the size of the ectocervical component,
2. the position of the upper limit of the transformation zone,
3. the visibility of the upper limit of the transformation zone.

As the zone changes from type 1 to type 3 the age of the patient tends to increase and the rate of persistent disease goes up. Treatment options can be tailored to the transformation zone type, for example it would be inappropriate to use cryotherapy

for a type 3 transformation zone.

Fortunately most patients will have a type 1 or 2 lesion. It is hoped that by careful assessment of the transformation zone appropriate methods can be utilized and over-treatment avoided.

Calendar of Events

27th Ontario CME
Toronto, Ontario (Marriott Downtown, Eaton Centre)
December 4 – 6, 2008

22nd International CME
Cancun, Mexico
March 2-6, 2009

2010 ASCCP Biennial Meeting
Las Vegas, NV
March 24-27, 2010

19th West/Central CME
Banff, Alberta (Fairmont Banff Springs)
March 26-28, 2009

5th GYN CME
Toronto, ON (Marriott Downtown Eaton Center)
April 24-25, 2009

65th SOGC Annual Clinical Meeting
Halifax, Nova Scotia
June 17-21, 2009

21^e FMC du Québec
Charlevoix, Québec (Fairmont le Manoir Richelieu)
September 17-19, 2009

5^e FMC du Québec en OBS
Montréal, Québec
November 19-20, 2009

29th Ontario CME
Toronto, ON (Marriott Downtown Eaton Center)
December 3-5, 2009

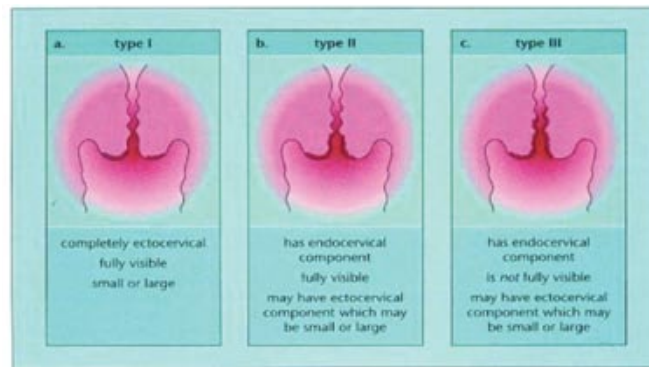


Fig. 1. The three types of transformation zone, as proposed by the new IFCC classification³

The success rate for a LEEP is about 90% and success can often be predicted by margin status. The approach to improve this has often been to use a larger Loop electrode. This in turn will increase the rate of pregnancy complications. The International

Table 1 shows the classification and potential choices for treatment.

TZ type	Size	Site	Visibility	LEEP electrode choice	Alternative
Type 1 _s	Small	Completely ectocervical	Fully visible	2 X 1 cm loop	Laser evaporation
Type 1 _l	Large	Completely ectocervical	Fully visible	2 X 1 cm loop or combination	
Type 2 _o	-	Totally endocervical	Fully visible	2 X 2 cm loop,	Laser excision or cone biopsy
Type 2 _s	Small	Partially endocervical	Fully visible	2 X 1 cm and 1 x 1 cm combination loop or consider straight wire	
Type 2 _l	Large	Partially endocervical	Fully visible		
Type 3 _o	-	Totally endocervical	Not fully visible	2 X 2 cm loop,	
Type 3 _s	Small	Partially endocervical	Not fully visible	straight wire or combination electrode treatment	
Type 3 _l	Large	Partially endocervical	Not fully visible		

Ref : Prendiville et al Colposcopy Management Options 2003 129-133 (Saunders)

Welcome to the Society of Canadian Colposcopists

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

Susan Aubin, Ontario, Active
Douglas Cochen, Ontario, Active
Jason Dodge, Ontario, Active
Christopher Giede, Saskatchewan, Active
Bing Guthrie, Northwest Territories, Active
Brian Harrington, Ontario, Active
Brian Hauck, Alberta, Active
Gulnaz Jiwa, Alberta, Active
Louai Jony, Ontario, Active
Véronique Mareschal, Québec, Active
Duska Vukojevic, Ontario, Active

Colposcopy Course in Mongolia By Laurie Elit, MD



Since 1999, I have been travelling to Ulaanbaatar Mongolia to work with the gynaecologists at the Maternal Children Hospital and First Maternity Hospital and gynaecologic oncologists at the National Oncology Hospital. This began as a teaching role providing lectures to the staff who had limited opportunity to attend international venues. I travel with Medical Education International which is an arm of the Christian Medical Dental Association. MEI invites physicians and allied health care providers to teach in low resource settings. The teams to Mongolia go for two weeks in April or September annually.

On my current journey to Mongolia, I worked with the Mongolian staff (Drs. Tsedmaa, Baigal and Erdenjargal) to provide a 4-day colposcopy course to gynaecologists from Ulaanbaatar and 8 aimags (provinces). UNFPA and

the Government of Luxemburg have provided \$1.5 million to procure equipment for a telemedicine project covering prenatal assessment, cervical screening and management of dysplasia. The colposcopy course took place prior to colposcopy equipment being sent to the aimags.

VIA was introduced to Mongolia as a method for cervical screening in the aimags in 2000. Cervical cytology is used in Ulaanbaatar. Currently anyone in the country with an abnormal screening test needed to travel to Ulaanbaatar for management. With the new colposcopy system that will be set up in 8 aimags, assessment and management can be completed locally.

The Canadian Colposcopy Society generously donated six teaching DVDs authored by Dr. C. Wright. These were distributed to the trainees.

SCC Executive

SCC Executive Officers (2007-2009)

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Alexandra Schepansky, MD, President-Elect
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