



Standards in Colposcopy and Treatment

The Report of a RANZCOG and ASCCP
Working Party



STANDARDS IN COLPOSCOPY AND TREATMENT

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1. INTRODUCTION

In 1997 the Australian Society for Colposcopy and Cervical Pathology (ASCCP) and the then Royal Australian College of Obstetricians and Gynaecologists (RACOG) * resolved to establish a joint working party to address the issue of standards in colposcopy and related treatments. The need to address quality issues in all steps in the screening pathway was raised in the *Options for Change* report¹ and emphasised in the report *Making the Pap Smear Better* released in 1994.² Other bodies, such as the National Pathology Accreditation Advisory Council (NPAAC), have addressed standards in cytopathology.^{3,4}

Currently 97 per cent of diagnostic colposcopies and virtually all treatments are carried out by specialist gynaecologists or trainees under their supervision.⁵ The matter of colposcopy by other than specialist gynaecologists was not specifically addressed by the RANZCOG and ASCCP Working Party, which considered that this should be discussed at a later time by a broader group. The Working Party specifically addressed the issue of standards for specialist gynaecologists. The Working Party also decided that issues such as equity of access and geographic delivery of colposcopy services throughout Australia would be better addressed by other bodies, including the RANZCOG, the ASCCP and the various State and Federal Health Departments.

Continuous quality improvement is essential to a high quality, organised public health program such as the National Cervical Screening Program. The Working Party decided that measurable and realistic performance standards should be identified and defined wherever possible, and that the same standards should apply in both the public and the private sectors and across the various hospitals offering colposcopy and related treatment.

The RANZCOG recently completed a National Quality Assurance in Colposcopy Project (NATQAC). In this project performance standards were identified and arbitrarily defined as the level of performance which was achieved by 80 per cent of the 209 participants in this large study, which involved 12,105 patients who underwent colposcopy. Of these, 5710 underwent treatment.⁶ The Working Party believes that these performance standards should be a benchmark and a basis for further improvement, and recommends that the RANZCOG should continue to offer relevant quality assurance and practice improvement projects in this area of gynaecology.

The Working Party has also made some recommendations relating to clinical management. These are intended to complement the National Health and Medical Research Council (NHMRC) report *Guidelines for the Management of Screen Detected*

* The Royal Australian college of Obstetricians and Gynaecologists (RACOG) amalgamated with the Royal New Zealand College of Obstetricians and Gynaecologists (RNZCOG) in 1998 to become the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

*Abnormalities*⁷ and expand upon some areas which were not addressed fully in that document.

The contentious issue of accreditation and/or certification was addressed and, as expected, there was a diversity of opinion. The Working Party recommended that this matter should be addressed jointly by both the RANZCOG and the ASCCP, and that the concept of a Colposcopy Recognition Award be considered.

The members of the Working Party hope that this report will continue to improve the quality of care for women who are found to have an abnormal Pap smear and who require colposcopy and possible further treatment.

In conclusion I would personally like to thank the members of the Working Party, who all gave freely of their valuable out-of-hours time to make this project viable and see it through to completion. In particular I would like to thank Jan Campbell, the Project Officer, for her help and persistence.

Robert Rome
Chairman

CHAPTER 2. EXECUTIVE SUMMARY & RECOMMENDATIONS

The Working Party addressed a range of issues relating to colposcopy and treatment. It has made a series of recommendations that will need to be considered by the RANZCOG, the ASCCP and those practitioners and institutions who are responsible for the management of women with abnormal Pap smears. The recommendations are summarised in this chapter, but readers are referred to the body of the report for details.

Colposcopy Services

The Working Party considers that the same basic standards should apply to all colposcopy services, whether public or private, urban, rural or remote, and makes a series of recommendations covering personnel, facilities, documentation and the management of patient default. The details are presented in Chapter 3.

Diagnosis and Treatment

The Working Party makes a series of recommendations regarding diagnostic colposcopy and treatment which are intended to complement the NHMRC report *Guidelines for the Management of Screen Detected Abnormalities*. The details are presented in Chapter 4.

It specifically recommends that:

- The NHMRC document should be reviewed.
- No woman with an abnormal Pap smear should be treated without prior colposcopic assessment.
- In cases of high-grade cytological abnormalities in pregnancy, consideration should be given to obtaining a second opinion from an experienced colposcopist if or when there is any suspicion of invasive cancer.

The Working Party's report also summarises the principles regarding management of high and low-grade abnormalities and recommends that these should be adhered to. It also covers informed consent, information regarding treatment, the place of a preliminary pelvic examination, anaesthesia and documentation. The indications for the various ablative and excisional treatment modalities are also reviewed.

It specifically recommends that:

- Excisional treatment should be the subject of individual and national audit.

The role of the 'See and Treat' approach to management is also reviewed, the importance of follow-up is emphasised and suggestions are made on the prevention and management of complications.

Performance Standards and Quality Assurance

The NATQAC project defined minimum performance standards. These need to be reviewed in light of the change in terminology to high and low-grade.

The Working Party specifically recommends that:

- The same minimum performance standards should apply to all colposcopists working in both the public and private sectors throughout Australia.
- Colposcopists should regularly participate in practice improvement activities.

A range of possible practice improvement activities is suggested. These include comparison of performance against the already defined performance standards, clinicopathology reviews (including an audit of excisional treatment) and service audits (including patient satisfaction surveys).

Training, Education and Certification

The Working Party recommends that:

- The RANZCOG should review its colposcopy module with regard to its content and effectiveness.
- Further supervised experience should be available during elective training (levels 5 and 6) for those intending to enter independent specialist practice in this area of gynaecology.
- The RANZCOG and the ASCCP should develop advanced training opportunities for gynaecologists.
- Colposcopists should regularly participate in relevant continuing education programs.

The Working Party recommends that:

- Colposcopists should manage sufficient numbers of patients with abnormal Pap smear problems to develop, maintain and improve their skills in this area of practice.
- A requirement to see a minimum number of cases per annum was not supported.

The Working Party identified certain uncommon problems that may provide management challenges and recommends that:

- Clinicians who are in doubt about difficult management situations should seek a second opinion from an experienced colposcopist.

The Working Party recommends that:

- The introduction of a Colposcopy Recognition Award should be jointly considered by the ASCCP and the RANZCOG.

Such an award could be granted on the basis of participation in practice improvement activities and relevant continuing medical education programs.

CHAPTER 3. COLPOSCOPY SERVICES

Colposcopy services should offer integrated and continuous care for women with abnormal cytology, including diagnosis, treatment where indicated, management of complications and follow-up.

The Working Party considered that the same basic standard should apply to all colposcopy services, whether in the public or private sectors and across all settings – urban, rural or remote. It made the following recommendations regarding colposcopy services:

3.1 PERSONNEL

3.1.1 Public Hospital *Colposcopist*

- a) Any public hospital offering a colposcopy and treatment service must have an experienced colposcopist overseeing the management of patients. This medical practitioner colposcopist must be capable of:
 - interpretation of cytology results
 - colposcopic evaluation of the cervix, vagina and vulva
 - the appropriate use of a colposcopically directed biopsy
 - interpretation of histopathology results
 - selection of appropriate treatment modality for each patient
 - appropriate follow-up, short and long term.
- b) Wherever possible a second experienced colposcopist, for peer support, should also be within the service to cover leave or other absences and to maintain the service standard.
- c) Less experienced staff (consultants in training, registrars or residents) must be overseen by the senior colposcopist to ensure appropriate management of each patient.
- d) *Trainees & students* Trainees who are not part of the treating team should be introduced to the patient and permission obtained for their presence during the procedure. Local tertiary institution guidelines should be followed for students attending colposcopy procedures.

- Nursing staff***
- e) Where possible, colposcopists within a service should have a nurse attending to the patient. The nurse must be able to communicate effectively with patients to answer their questions and allay anxiety.
- f) The nurse should be familiar with the following procedures:
- positioning of the patient to minimise patient discomfort and embarrassment
 - the colposcopy procedure
 - smear taking and labelling and handling of slides
 - labelling and handling of specimens
 - care of biopsy instruments
 - infection control and sterilisation procedures.^{8,9}
- g) Ideally there should be a senior registered nurse designated to coordinate services and to assist in the review of results and general facilitation of the service.
- Reception staff***
- h) Reception staff assisting patients within the clinic should have an understanding of the procedures and be able to assist patients in a sympathetic manner. Patients arriving for colposcopy may be extremely anxious and confusing directions must be avoided. Any waiting time should be indicated on arrival. Registration details should include the patient's name, contact details and referring doctor's name and address.
- Pathology***
- i) The service must have support from an experienced pathologist.
- Oncology liaison***
- j) The service should have an established liaison with a gynaecological oncology unit or gynaecological oncologist(s).
- Interpreters***
- k) Interpreter services should be utilised where possible. Information regarding these services can be obtained through the relevant State Health Department. Relatives and friends can be utilised but this may at times be inappropriate and have limitations.

***Culture &
Religion***

- l) Sensitive inquiry regarding cultural and religious requirements of women is advisable prior to consultation. Practitioners and staff should be aware of, and responsive to, such requirements.

**3.1.2 Private Rooms
*Colposcopists***

- a) Medical practitioners offering colposcopy services in private practice should have had adequate training and have the capabilities listed above in 3.1.1 (a).

Nursing staff

- b) If a nurse is available within the practice the standards listed for (e) and (f) above should apply. If a nurse is not available, the colposcopist must fill this role.

Other

- c) The same standards should apply in both public and private settings in relation to reception staff, pathology support, oncology liaison, interpreters and cultural and religious requirements.

3.2 INFORMATION

Referring practitioners are encouraged where possible to provide information about colposcopy before the patient's appointment. Information on abnormal smears, colposcopy and treatments is available in a number of formats and languages from State cancer councils and cervical screening programs (phone 13 11 20). This may reduce patient anxiety although one study suggested that this was ineffective when used in isolation.¹⁰ Written information about dysplasia, colposcopy and possible treatment options should also be available for women on arrival. Written information should be seen as an adjunct to, and not a substitute for, verbal information given by the practitioner during a consultation and/or procedure.

3.3 FACILITIES

- a) The reception area should be clearly identified.
- b) Waiting, interview and examination areas should be maintained at a comfortable temperature.
- c) Other facilities (e.g. magazines, books, videos and television) are useful.

- d) A private changing area with adjacent toilet facilities must be available.
 - e) An appropriate examination couch, colposcope and instruments should be available.
 - f) If undergraduate teaching is performed, closed circuit video to a separate viewing area can maintain patient privacy during the procedure. Video may also help patients to understand their condition better.
- Treatment**
- g) Ambulatory treatment facilities must fulfil criteria (b)-(d).
 - h) Treatment equipment must be in good working order.
 - i) Infection control standards must be maintained.^{8,9}
 - j) Appropriate resuscitation equipment must be available.
 - k) A recuperation area should be available to patients following treatment and their recovery period should be supervised.

3.4 OTHER FACTORS

3.4.1 Documentation

- a) Standard history and examination forms for colposcopy help to ensure all appropriate history is taken and details recorded. This is most important for clinics involved in training of junior staff. Such a colposcopy record should include:
 - lesion grade(s)
 - lesion topography
 - endocervical extension of TZ/lesion
 - any stigmata of invasive carcinoma
 - location of any biopsy taken
 - subsequent plan of management

Diagrammatic recording of results allows for comparison at subsequent visits.

- b) After colposcopic assessment, patients must receive a clear plan of management which should indicate how results will be communicated and the date, time and place of their next review or treatment.
- c) Treatments should be properly documented (4.5.5)
- d) Referring practitioners must receive correspondence regarding management, results of tests and arrangements for follow-up.
- e) Results should not be filed until reviewed by the responsible clinician, and every attempt should be made to make the system fail-safe.

3.4.2 Patient default

In both public clinics and private rooms a documented system needs to be in place to notify or recall patients who default at first consultation, treatment or follow-up. Optimal practice requires that the referring doctor's details should be recorded for each new patient. Women should be advised that they should notify the clinic or rooms of any change of their address and other contact details.

- a) Default at first consultation:
 - patients should be offered another appointment.
 - the referring doctor should be notified in writing that the patient did not attend.
- b) Default for treatment:
 - patients should be contacted and another treatment time arranged.
 - two or three attempts to arrange treatment would appear to be reasonable current practice.
 - for patients with high-grade lesions who refuse or default treatment it should be clearly documented that they have been informed in writing of the possibility of their developing cancer.
- c) Default at follow-up:
 - recall letters should be sent to patients missing appointments.

- two or three attempts would appear to be reasonable current practice.
- contact should be made with the referring doctor to encourage patient return or to make alternative arrangements.

The role of any State Cytology Register in the identification of defaulters should be seen as an adjunct to the above system and not as a replacement.

lesions where there is concern about cancer. Colposcopic assessment later in the pregnancy may be indicated in high-grade lesions and cytological and colposcopic follow-up is usually required at the postnatal visit.

The Working Party recommends that, in cases of high-grade cytological abnormalities in pregnancy, when there is any suspicion of invasive cancer consideration should be given to obtaining a second opinion from an experienced colposcopist (see also 6.3.2).

4.5 Treatment

Treatment of women with abnormal smear problems should be appropriate, safe, timely, effective and minimally complicated. Women should be well informed about the treatment options, likely outcomes and possible complications.

The Working Party considered it important to recommend that the following principles relating to treatment be adhered to:

4.5.1. Indications for treatment

All high-grade abnormalities require treatment:

- Histologically confirmed high-grade squamous abnormalities.
- High-grade glandular abnormalities whether detected on cytology or biopsy.

Low-grade squamous abnormalities continue to provide a management dilemma. It may be appropriate to treat low-grade lesions that are extensive or persistent, or if there is undue patient anxiety. The detection of a high-risk HPV genotype in women with a low-grade abnormality may also be an indication for treatment. Where the patient has a good understanding and agrees to follow-up, low-grade abnormalities can be safely managed by appropriately timed cytological follow-up with or without colposcopy.

Low-grade glandular abnormalities should be regarded with a degree of caution. There should be early recourse to excision especially if the abnormality is persistent.

- 4.5.2. Informed consent & information regarding treatment** Prior to treatment information should be provided about the treatment and alternatives. The patient should also be provided with information regarding complications and what to do if any complications arise after treatment. An information template is provided in Appendix II.
- 4.5.3. Pelvic examination** Prior to treatment a pelvic examination should be performed in order to exclude a large endocervical carcinoma or other pelvic pathology which may complicate or modify treatment, such as pelvic inflammatory disease. Early pregnancy should also be excluded prior to treatment.
- 4.5.4. Anaesthesia** In most instances local anaesthesia is preferred except for cold-knife cone biopsy which requires general (or regional) anaesthesia. General anaesthesia should be an available option and the decision about anaesthesia should occur after discussion with the patient.
- 4.5.5. Documentation** All treatment should be properly documented and the record should include:
- consent - preferably written
 - colposcopic review
 - treatment modality used
 - surgeon
 - anaesthetist
 - anaesthesia
 - adverse reactions, difficulties and/or complications
 - post-operative instructions
 - follow-up instructions
- 4.5.6. Treatment methods** A variety of treatment modalities are available for the treatment of women with precancerous cervical abnormalities. Clinical circumstances such as patient age, and other issues such as operator experience, preference, skill and equipment availability, will often determine the method used.
- 4.5.6.1. Ablation** The following requirements should be met for ablative treatments such as electrocoagulation diathermy or laser ablation:
- the abnormal transformation zone/lesion should be completely visualised.
 - there should be no cytologic, colposcopic or biopsy suggestion of invasive cancer.

- the abnormality should be purely squamous.
- a preliminary colposcopically directed target biopsy is mandatory.

4.5.6.2. *Excision*

An excision procedure is indicated in the following situations:

- the abnormal transformation zone (TZ) cannot be completely visualised, especially with high-grade lesions.
- there is cytological, colposcopic or biopsy suspicion of invasive cancer.
- there is a high-grade glandular cytological abnormality.

Particular care should be taken when dealing with these problems (see 5.3). Cold-knife cone biopsy is the established method of excision but laser cone biopsy and loop electro-excisional procedures (LEEP) are utilised by some.

Until the ongoing concerns regarding the equivalence of these procedures for these indications in terms of clinical outcome and specimen quality are resolved by high-level evidence, the Working Party recommends that excisional treatment should be the subject of individual and national audit (see 5.3).

All excised tissue should be sent for histopathological examination. The pathologist should indicate the extent of their sampling and the quality of the surgical margins.

4.6 ‘See and Treat’

Colposcopy and immediate treatment – referred to as ‘See and Treat’ - should be considered only if the circumstances are appropriate and there is a high-grade lesion which can be fully visualised. Excision should be used in preference to ablation.

‘See and Treat’ is appropriate when there are one or more imperatives such as:

- concern about the woman’s ability to return for treatment within a set time period due to geographic reasons or relocation.
- concern about default
- financial and/or resource allocation considerations.

Women should be informed that no significant pathology will be found in the excised specimen in about 25 per cent of cases overall¹² but in a lower percentage when the cytological and colposcopic prediction is that of a high-grade lesion.

4.7 Follow-up

Follow-up after diagnosis and/or treatment is important to assessment of treatment success targets. Women should be given written information about the importance of follow-up around the time of treatment (see Appendix II). They should also be aware of the arrangements for such follow-up. This should be clearly recorded in the colposcopy record and, wherever possible, conveyed to the appropriate practitioner.

Follow-up should be in accord with the current NHMRC guidelines⁷ and ideally should initially be with the treating doctor or clinic where treatment took place. Some women referred from a non-gynaecological colposcopist may prefer to have follow-up carried out by this doctor or clinic. For women from remote areas it may be appropriate to have follow-up performed locally.

4.8 Complications

Patients need to be informed before treatment that post-operative complications sometimes occur. They should know who to contact and how to contact them if they experience problems (see Appendix II).

4.8.1. Haemorrhage

Delayed or secondary haemorrhage after treatment may be minimised but not totally obviated by the avoidance of coitus in the first three weeks after treatment and the possible use of an intravaginal cream such as sultrin or clindamycin. There is no high-level evidence that the use of antibiotics or Monsel's solution at the time of treatment reduces the risk of infection.^{13,14}

Bleeding usually eases with rest but if it continues despite rest it may be necessary to examine the patient and apply a styptic such as Monsel's solution, ferric chloride or silver nitrate. A course of oral antibiotics is also advisable. Occasionally it is necessary to admit the patient for observation, bed rest, packing or, rarely, suturing under anaesthesia.

4.8.2. Infection

Patients with a history of pelvic infection should be given prophylactic antibiotics. Pelvic infection after treatment is uncommon and should be treated on an individual basis after the relevant swabs have been taken.

4.8.3 Cervical stenosis

This complication, which usually occurs after excision biopsy, is not unusual in post menopausal women and may be reduced by the post-operative use of a vaginal oestrogen cream. Stenosis raises concerns about the subsequent ability to sample the endocervical canal cytologically and the masking of symptoms of endometrial pathology at some later time.

Options for management of cervical stenosis depend on the menopausal status of the patient, desire for preservation of fertility, the histopathology and the presence or absence of symptoms relating to the stenosis.

- a) Endocervical margins involved:
 - hysterectomy is indicated in women not wishing preservation of fertility.
 - a further excision biopsy should be performed to exclude/remove residual disease when preservation of fertility is an issue.

- b) Endocervical margins not involved:
 - in premenopausal women cervical dilatation is generally required.
 - in postmenopausal women the management of cervical stenosis should be individualised. The options include observation with or without ultrasound, cervical dilatation or hysterectomy.

In cases of doubt further advice should be obtained from an experienced colposcopist.

CHAPTER 5. PERFORMANCE STANDARDS IN COLPOSCOPY

Colposcopy and treatment are carried out in a diversity of settings throughout Australia. The Working Party agreed that an attempt should be made to set minimum performance standards and to devise strategies to improve and build upon this base.

5.1 Clinical indicators Clinical indicators are one means by which the management and outcomes of patient care can be measured, assessed and demonstrated. They lend both objectivity and interest to quality assurance activities by allowing for comparison of performance against thresholds and aggregate data. Clinical indicators relevant to colposcopy and treatment were developed for the NATQAC project (see below).

5.2 Performance standards Performance standards were determined for the Australian environment in the NATQAC project.⁶ Data was collected from both metropolitan and rural practitioners across a range of private and public settings. These minimum standards were achieved by 80 per cent of the 209 participants in the project.

The performance standards which were determined by the NATQAC project included:

- Colposcopy-biopsy concordance within one histologic (CIN) degree >80%
- Complications after treatment < 5%
- Readmission for complications after treatment < 2%
- Residual disease after treatment < 5%
- Retreatment rate < 3%

The Working Party considers that there is a need to re-examine the colposcopy-biopsy indicator in view of the change in terminology to high-grade/low-grade.

The Working Party considers that the same minimum performance standards should apply to all practitioners in both the public and private sectors in metropolitan and rural Australia.

5.3 Practice improvement activities

The Working Party recommends that colposcopists should regularly participate in practice improvement activities such as:

- Clinical indicators: data on a minimum of 100 consecutive diagnostic colposcopies and 50 consecutive treatments provided, say every five years, and compared with the performance standards outlined above.
- Tissue audit: reviews of excisional biopsies, microinvasive cancers, glandular neoplasms and other pathology of interest. Audit of excisional treatment with particular emphasis on specimen quality and clinical outcome (see 4.5.6.2)
- Patient satisfaction surveys: a survey form suitable for collecting data in consulting rooms or clinics was developed by the NATQAC project.¹⁵ Data from 100 consecutive patients could be collected as part of an individual, group or institutional practice improvement activity.
- Service audit: assessment of waiting times for women with high and low-grade abnormalities, distances travelled, quality of documentation, proportion of women treated under general anaesthesia and the proportion of CIN in treated patients.

In practice improvement projects baseline data should be collected in order to determine what is currently being achieved. Arbitrary setting of standards may result in unachievable targets.^{16,17}

Practice improvement activities such as those outlined above could form one of the bases for receipt of a Colposcopy Recognition Award (see 6.4).

CHAPTER 6. TRAINING, EDUCATION AND CERTIFICATION

Colposcopy is required for the optimal management of women with abnormal smears and other disorders of the lower genital tract. It should not simply be regarded as a stand-alone procedure because it is an integral part of treatment and subsequent follow-up.

6.1 Basic training

The RANZCOG has developed a training module in colposcopy and related treatments.¹⁸ The Working Party agrees that this area of gynaecology should be taught and assessed to a basic level by the end of the Integrated Training Program (level 4).

The Working Party recommends that the RANZCOG should review the colposcopy module with regard to its contents and effectiveness.

The basic training outlined in the module should be regarded as only the beginning of an ongoing learning process. The Working Party recommends that further supervised experience should be available during elective training (levels 5 and 6) for those who intend to enter independent specialist practice in this area of gynaecology.

6.2 Advanced training

Further or advanced training should also be available to RANZCOG Fellows who wish to develop and enhance their skills in this area of gynaecology.

6.2.1. Clinical fellowships

Practical aspects of colposcopy and treatment can be taught through clinical fellowships. The major colposcopy units should be encouraged to offer these. It may be reasonable for a fee to be charged if it is considered appropriate.

The Working Party recommends that the RANZCOG and the ASCCP develop advanced training opportunities.

6.2.2. Continuing education

Courses and Meetings such as those conducted by the ASCCP, RANZCOG and other bodies are available for training and continuing education (CE). Cognate points are available for Fellows through this program.

The Working Party recommends that colposcopists should regularly participate in relevant continuing education programs. Such participation could form one of the bases for receipt of a Colposcopy Recognition Award (see 6.4)

6.3 Maintaining professional standards

In the maintenance of standards the following matters also need to be addressed:

6.3.1. Colposcopy numbers

In the National Health System Cervical Screening Program report *Standards and Quality in Colposcopy*,¹⁹ it was recommended that in order to maintain skills, individual colposcopists need to manage a minimum of 100 new cases per annum. A recommendation about numbers is arbitrary, cannot be made mandatory and was not supported by the Working Party.

Nevertheless the Working Party recommends that colposcopists should manage sufficient numbers of patients with abnormal Pap smear problems to develop, maintain and improve their skills in this area of their practice.

In larger centres it may be easy to accrue such numbers but this may not be the case in smaller centres. In these situations there is a good case to be made for one individual being made responsible for the management of difficult cases so that expertise can be developed.

6.3.2. Management challenges

It should also be recognized that certain uncommon problems can provide significant management challenges, including:

- high-grade glandular abnormalities
- suspicion of invasive carcinoma
- high-grade lesions in pregnancy (see 4.4)
- vaginal intraepithelial neoplasia (VAIN)
- lower genital tract neoplasia in the immunocompromised
- diethylstilboestrol (DES) exposure.

The Working Party recommends that clinicians who are in any doubt in potentially difficult management situations should seek a second opinion from an experienced colposcopist. In many of these situations a phone call may

suffice.

6.4 Certification or a recognition award

The Working Party considered the role of certification or some form of recognition in the development of standards. This matter has been approached in different ways in the UK and the USA. Two concepts were considered by the Working Party.

6.4.1 Certification

This is a formal process which involves supervised training, ongoing assessment and logbooks and an exit assessment. Certification such as this was not recommended by the Working Party as it would be expensive and unlikely to be undertaken by Fellows.

6.4.2 Recognition award

A recognition award is a different concept which indicates that a practitioner has participated in certain professional development and quality of care activities such as continuing education and practice improvement programs.

This latter approach was favoured by the Working Party which recommends that the introduction of a Colposcopy Recognition Award should be jointly considered by the ASCCP and the RANZCOG.

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APPENDIX I. MEMBERS OF THE WORKING PARTY

Mr Robert Rome (Chairman)

Chairman RANZCOG Colposcopy Committee, Melbourne

Dr Chris Hunter (Co-Chairman)

President ASCCP, Sydney

Dr Chris Dalrymple

Sydney

Dr Graham Hamdorf

Adelaide

Dr Hamish McGlashan

Derby

Dr Jim Nicklin

Brisbane

Dr Miriam O'Connor

Melbourne

Dr Michael Quilter

Wollongong

Dr Trish Vezgoff (Consumer viewpoint)

Wollongong

Ms Jan Campbell (Project Officer)

Melbourne

APPENDIX II.

TEMPLATE FOR A POST-OPERATIVE INFORMATION LEAFLET FOR PATIENTS FOLLOWING LASER, DIATHERMY, LOOP THERAPY OR CONE BIOPSY OF THE CERVIX

It is suggested that you keep this leaflet until after you have had your post-operative check. If you or your local practitioner have any queries regarding any of these matters please do not hesitate to contact me (*) at the above number(s).

1. There is usually no pain following treatment but you may experience period-like cramping abdominal pain. This is usually relieved simply by aspirin or paracetamol tablets. Please contact me* if you have any severe or increasing pain which is not relieved by the above measures.
2. It is normal to have a slight blood-stained discharge for two to three weeks following treatment; this is part of the healing process. Heavier bleeding is unusual but usually eases with rest and 'putting your feet up'. If you have bleeding which is heavier than your normal period please contact me (*).
3. Sometimes the menstrual pattern is disturbed. Your next period may be early, late or be missed completely. It may be light or heavy. If you are taking the oral contraceptive pill you should continue to take it as usual.
4. You should **not** have sexual intercourse, use tampons, have baths or go swimming for the first three weeks following treatment while the cervix is healing.
5. You may be prescribed antibiotic vaginal cream or tablets. Please follow the instructions regarding this.
6. Your continued follow-up is **vital**. There is a small risk that you will have further abnormal Pap smears and an ongoing or recurrent problem on your cervix. This can only be detected at your follow-up appointments. If you are unable to keep an arranged appointment please ensure that you make another one as soon as possible for your own well-being.

Yours sincerely,

Gynaecologist (*)

* or Clinic, Hospital, RMO, Registrar etc