

WG2 Terminology for Intraepithelial Lesions, Integrating Morphology, Biology, and Clinical Management - Public Comments

February 13, 2011 – February 17, 2012

Practice Type		
Clinician	11	52%
Pathologist	7	34%
Other, please specify	3	14%

Years of Experience		
More than 20 years	12	57%
11-20 years	6	29%
10 years or less	3	14%
Currently a resident/student	0	0%

Practice Setting		
Academic	13	62%
Community/Private Practice	3	14%
Government	4	19%
Industry	0	0%
Insurance/Payers	0	0%
*Other, please specify	1	5%
*Planned Parenthood		

Clinician Public Comments

Question 1: Were any published articles omitted from consideration (please refer to Work Group scope/key questions and inclusion/exclusion criteria links above)? How would these articles impact the Work Group's conclusions?

no, not that I am aware.

yes. minimize recommendations being influenced by nonhuman studies, body sites other than the anogenital regions, nonHPV related pathology

no

no

NO

Question 2: Do you think there are any significant misrepresentations or biases in the draft recommendations?

no

no

no

no

no

possibly; very pathologist oriented; seems like someone is trying to make black and white a situation where there is no black and white with the tools we have today

Question 3: Do you have any disagreements with the main conclusions and/or evaluations of the literature?

no

no

no

no

no

yes; it seems like the recommendation is if the pathologist believes it is CIN 2 then p16 is used but the report will be highgrade or low grade; i think there should be a choice CIN -2 p16 + or -; similar to ascus HPV +/-

Question 4: What topics/gaps for future research/guidelines should be priorities?

alternative treatments for VIN, especially VIN with underlying vulvar dystrophy

further evaluation in areas outside of the cervix with HPV related cancer risk

Use of HPV typing to triage follow up. Alternative treatment strategies for vain and HPV related vin.

Differences between cervical and other site's lesions

Question 5: Which would be your preference on the following recommended terminologies (please select only one preferred terminology or free-text other suggestion)?

Low Grade HPV-Associated Squamous Intraepithelial Lesion (LHIL)High Grade HPV-Associated Squamous Intraepithelial Lesion (HHIL)	0	0%
Low Grade Squamous Intraepithelial Lesion (LSIL)High Grade Squamous Intraepithelial Lesion (HSIL)	5	71%
Squamous HPV Viral Cytopathic Lesion Squamous HPV Associated Dysplasia (SHAD)	0	%
Condyloma Cervical/Vaginal/Vulvar/Anal/Penile Intraepithelial Lesion	0	%
Low-grade Intraepithelial Abnormality (LGIA)High-Grade Intraepithelial Abnormality (HGIA)	0	%
*Other suggestion	2	29%

***Other suggestion**

Flat condyloma; Squamous intraepithelial lesion (Cervical/vaginal/vulvar/anal/penile)

see earlier statement

Question 6: Other comments (including, if applicable, support for the recommendations):

There is emerging evidence that CIN" can be safely followed in young and not so young women. Are you worried that going to a 2 tier classification will increase unnecessary treatments? Also epidemiological studies show greater validity when restricting to CIN3 as a surrogate for cancer risk. Because CIN2 is more prevalent than CIN3 we may be diluting this effect by lumping both together.

none

The suggested terminology fits pathologist's needs, but not the clinicians needs. Women safety should be the major issue. Clear distiction between HPV infection and possible cancer precursor is mandatory;overtreatment is ill tolerated on the cervix, but it is devastating, moving out from cervix.

Pathologist Public Comments

Question 1: Were any published articles omitted from consideration (please refer to Work Group scope/key questions and inclusion/exclusion criteria links above)? How would these articles impact the Work Group's conclusions?

No

No

None that would have changed conclusions.

Question 2: Do you think there are any significant misrepresentations or biases in the draft recommendations?

Slight bias towards evidence for two-tiered system.

No

Question 3: Do you have any disagreements with the main conclusions and/or evaluations of the literature?

Yes, while I agree that the CIN2 category is least reproducible and that CIN 2 represents a mixture of lesions with different biologic potential, the arguments for abandoning this category to simply improve consistency is not compelling. p16 may be helpful but proportion of CIN2 lesions that would be moved into CIN 3 category is not clear, nor is performance of p16 in routine clinic practice clear. The recent ASCCP consensus conference clarified management strategies based on 3-tier system. Merging CIN2 and 3 would lead to over referral to colposcopy and potential for overtreatment. Literature suggests that not all CIN 3 lesions progress to invasion, so merging CIN 2 and 3 further dilutes important disease categories. Public health monitoring through cancer registries would be negatively impacted by increasing the number of "carcinoma in situ" = high grade lesions to be monitored. Finally merging cytology and histology terminology will lead to confusion. Exfoliated cytology is screening tool not diagnostic tool. Diagnosis is based on histology. It should be clear if the information provided is from cytology or histology.

No

Although there may not be a biologic basis for a three tiered terminology for cervical intraepithelial abnormalities, the evidence is clear that CIN3 (or the worst category of a three tiered system) is a more reproducible, rigorous diagnosis and the best surrogate for cancer risk. Splitting CIN2 and upgrading a proportion to CIN3 will likely dilute the risk associated with CIN3. Why not just use wording such as "CIN2 with p16 positivity" (or whatever marker is used) to convey the information to the clinician, until we have more data regarding the risk of "upgraded CIN2". (One metric of risk might be the proportion of "upgraded CIN2" that is HPV 16 positive, compared to the proportion of CIN3 that is HPV 16.)

Question 4: What topics/gaps for future research/guidelines should be priorities?

Impact of terminology on surveillance and electronic medical records

1. Confirmation that the natural history of CIN2 and CIN3 are identical, justifying implementation of practice guidelines that are based on a 2-tier system. 2. Classification of endocervical glandular intraepithelial lesions.

Question 5: Which would be your preference on the following recommended terminologies (please select only one preferred terminology or free-text other suggestion)?

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Low Grade Squamous Intraepithelial Lesion (LSIL)High Grade Squamous Intraepithelial Lesion (HSIL)	2	67%
Squamous HPV Viral Cytopathic Lesion Squamous HPV Associated Dysplasia (SHAD)	0	0%
Condyloma Cervical/Vaginal/Vulvar/Anal/Penile Intraepithelial Lesion	0	0%
Low-grade Intraepithelial Abnormality (LGIA)High-Grade Intraepithelial Abnormality (HGIA)	0	0%
*Other suggestion	1	33%

***Other suggestion**

Retain 3 grade system – CIN

Question 6: Other comments (including, if applicable, support for the recommendations):

major education would be needed if go to 2 tiers, also will affect training programs in both pathology and gynecology

Other

Practice Type
American College of Obstetricians and Gynecologists, Subcommittee on Gynecologic Oncology Public Health Scientist

Question 1: Were any published articles omitted from consideration (please refer to Work Group scope/key questions and inclusion/exclusion criteria links above)? How would these articles impact the Work Group's conclusions?

No responses received

Question 2: Do you think there are any significant misrepresentations or biases in the draft recommendations?

No responses received

Question 3: Do you have any disagreements with the main conclusions and/or evaluations of the literature?

No responses received

Question 4: What topics/gaps for future research/guidelines should be priorities?

No responses received

Question 5: Which would be your preference on the following recommended terminologies (please select only one preferred terminology or free-text other suggestion)?

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*Other suggestion	1	33%

***Other suggestion**

Three tiered system for histology, CIN1-3

Question 6: Other comments (including, if applicable, support for the recommendations):

American College of Obstetricians and Gynecologists, Subcommittee on Gynecologic Oncology: The terms do not need to be qualified with either HPV status or p16 status. Immunohistochemical staining of specimens can only increase expense and, at this time, is not ready for consensus recommendations. The potential for increasing health care costs is a concern. If a two-tiered classification is used, ASCCP should consider using LG CIN and HGCIN for biopsies and LGSIL and HGSIL for cytology specimens. The inclusion of “H” indicating HPV for option 1 (LHIL and HHIL) is unnecessary and potentially confusing.

It is unclear how HPV and non-HPV related squamous lesions will be defined in the choices for nomenclature.

Combining CIN2 and CIN3 in a single category of HGCIN will result in a lot of overtreatment of women with lesions that have a very low risk of progression to cancer. CIN2 is a poorly reproducible category and includes many low grade, transient lesions that do not need to be treated. CIN3 is a more definitive category. Even CIN3 is not a necessary precancer, only about 30% of large, long term persistent CIN3 will ultimately progress to invasive cancer (McCredie). Many CIN2s regress spontaneously over a 2-year period (Castle in ALTS). Clinicians increasingly implement a more expectant management for women with CIN2, especially for younger women who have not completed their reproductive history. CIN3 is a more defined and comparable endpoint. All current major research studies evaluating cervical cancer screening approaches use CIN3 as an important endpoint, since it is better comparable across different settings. Grouping CIN2 and CIN3 into one category will reverse the trend towards less aggressive treatment of less risky CIN2. It will complicate comparability of screening approaches and biomarkers across different studies. It does not address the potential overcall of low grade lesions into this high

grade category. Currently, overcall of CIN1 as CIN2 may still be addressed by expectant management, while overcall of CIN1 in the HGGIN category would lead to even more treatment of transient disease. A simplified terminology is highly desirable, but should be based on risk estimates, potentially using novel biomarkers. Disease with several risk estimates should be combined into categories that will be managed in the same way.