

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

February 6, 2011 – February 12, 2012

Practice Type		
Clinician	11	42%
Pathologist	13	50%
Other, please specify	2	8%

Years of Experience		
More than 20 years	13	48%
11-20 years	11	41%
10 years or less	3	11%
Currently a resident/student	0	0%

Practice Setting		
Academic	8	31%
Community/Private Practice	14	54%
Government	1	4%
Industry	1	4%
Insurance/Payers	0	0%
*Other, please specify	2	7%
*commercial lab 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

No

no

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

No

There are serious omissions in the Draft Recommendations. Eliminating the three tiered system of classifying CIN will seriously hinder the ability to manage young women with non-CIN 3 lesions (i.e. CIN 2). This is unacceptable to many of us who treat adolescents and young women wishing to optimize fertility in the setting of CIN.

no

no

no

No

no

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

Yes, the statement made that many or most experts believe that CIN 2 is a mixture of CIN 1 and CIN 3 is only true if you poll the right "experts"I was never asked.

no

The approach of the working groups has been primarily histological in nature. I strongly disagree with this approach. Although the evidence suggests that CIN 2 is a poorly reproducible mixture of truly premalignant and benign conditions, practically, according to the ASCCP guidelines, it is managed differently than either CIN 1 or CIN 3, especially in young women. Moving to a two tiered system, while admittedly more reproducible than a 3 tiered system, will result in over-treatment of these young woman. Any system that is developed must either clearly determine whether these lesions are truly premalignant (through biomarkers) or acknowledge that their malignant potential is uncertain allowing clinicians to manage young women with these conditions more conservatively. Similarly, the premalignant potential of VIN 2, VaIN 2 and possibly PIN 2 is probably less than CIN 2 and so if a two tiered nomenclature is chosen for non-CIN lower genital tract histology, in order to avoid over-treatment of women with these conditions (whose premalignant potential is likely limited), consideration should be give to choosing a different cutoff than *IN 2 to separate premalignant from benign

no

no

no

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

more evidence/guidelines on management of dysplasia found on ECS. Often this is "ungraded" due to nature of detached cells from curettage

cin 2

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)	1	17%
Low Grade Squamous Intraepithelial Lesion (LSIL)High Grade Squamous Intraepithelial Lesion (HSIL)	2	33%
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	3	50%

***Other suggestion**

Cervical/Vaginal/Vulvar/Anal/Penile Intraepithelial Neoplasia

please see my earlier comments: Unless the premalignant potential of all lesions can be determined, any system must have a category of "uncertain" premalignant potential *IN-1, *IN -2, *IN-3 is such a system

low grade high risk squamous intraepithelial lesion(LHRSIL), high grade high risk squamous intraepithelial lesion(HGHSIL)

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

Changing the nomenclature will only cause confusion among tens of thousands of practicing clinicians. There is no need for the change in nomenclature particularly since the newly proposed names fail to add to the biologic understanding of the process. Establishing a 2-tiered system for cervix will negatively impact the clinical care of young women.

really not concern if low risk HPV causing abnormality

Good work

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

No

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

I just wonder why grading criteria were not applied to the WG1

No

no

No

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

no

No

no

No

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

how to distinguish between the HPV related and non-HPV related lesions, and does it make a difference clinically?

Next step should be modification of management guidelines for CIN-2 specially in young women. Also role of multiple markers as additional data becomes available

Favoring two tier vs three tier system and its possible effect on Pap biopsy discrepancy follow up.

Post vaccination the genotypes of HPV causing high grade lesions may change and although currently may not be a high percentage of the lesions, a shift if any should be followed.

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)	6	100%
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	0	0%

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

I prefer not to put HPV as part of the diagnosis as it may open the door for medical/legal action. Testing results confirming HPV can be placed as a separate line in the diagnosis or as a comment.

The effort to distinguish real preneoplasia from mimics is important

Agree with WG recommendations

Go ahead and adopt the two tier system for histology.

Other

Practice Type
Industry
Preventive Medicine and Epidemiology

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?

I think that the issues have not been sufficiently thought through on the population level. Solving the pathology nomenclature problems impacts on the cervical cancer prevention effort in a larger sense. This perspective is not sufficiently considered.

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

Yes. Here is my personal view. Cervical cases are much more common than extra-cervical anogenital neoplasia; therefore, the impact of classification decisions at LAST, on a population basis, will affect mainly those with cervical diagnoses. CIN2 is not a biologically distinct category but serves as a buffer zone in terms of clinical concern. CIN3 is a better cancer risk surrogate and making this good category much larger and more amorphous (i.e., less predictive of cervical cancer risk) should only be done for very good cause. That benefit must be shown, and I haven't seen it. Misclassification of CIN2 with CIN1, which is just HPV infection (or nothing), is a major problem. P16 and other biomarkers have not been proven to solve the problem because a sizable minority of CIN1 cases are biomarker positive. If CIN2 and CIN3 are combined at this juncture, CIN1 (acute HPV infections that would resolve spontaneously) will often be misclassified with "High-grade (meaning precancer)" implying a major risk and need for aggressive treatment. The distinction we now make between CIN3 as the best surrogate of risk and CIN2, a bad diagnosis we need to attack and triage over the next few years together, will be lost. We will be stuck with a worse situation, forced to work on triage of "high-grade". Overtreatment will tend to increase because the "high-grade" category will be larger but harder to treat conservatively than CIN2. I personally believe that there is not a compelling need to eliminate the buffer zone at this point.

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

Keeping CIN2 separate because it is a zone of uncertainty (not a biologic reality), we must focus on triaging it the way we have successfully triaged cytologic ASC-US.

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%
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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	100%

***Other suggestion**

Squamous HPV Viral Cytopathic Lesion for what is now CIN1. Could call what is now CIN2 "possible high-grade" and CIN3 : "high-grade" but keep the distinction.

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

I do NOT support the recommendations personally.