# WG5 - Implications and Implementation of Standardized Terminology - Public Comments

# January 23, 2012 – January 29, 2012

| Practice Type | | |
|---|---|---|
| Clinician | 1 | 33% |
| Pathologist | 2 | 67% |
| Other, please specify | 0 | 0% |

| Years of Experience | | |
|---|---|---|
| More than 20 years | 1 | 33% |
| 11-20 years | 2 | 67% |
| 10 years or less | 0 | 0% |
| Currently a resident/student | 0 | 0% |

| Practice Setting | | |
|---|---|---|
| Academic | 2 | 67% |
| Community/Private Practice | 1 | 33% |
| Government | 0 | 0% |
| Industry | 0 | 0% |
| Insurance/Payers | 0 | 0% |
| *Other, please specify | 0 | 0% |

## Clinician Public Comments

**Question 1: What are the potential implications of standardizing histopathology terminology for lower anogenital lesions? Are there any potential benefits and/or harms not previously discussed in the prior Work Group recommendations which should be considered?**

There is a problem with the use of the terms HSIL and LSIL to refer to histology as well as cytology. It makes many papers difficult to read. The same is true of high grade and low grade disease or lesion. There is no standard definition of these terms. I would suggest if you want to split into an almost nothing and something classification use something like LCIN for CIN1 and HCIN for CIN2/3. I would also recommend trying to influence the Bethesda System gurus to get rid of AGC. It is too close to ASC. Call it Glandular Cell Abnormalityh GCA or PBT for probable bad thing or something that alerts practitioners.

**Question 2: Are there any additional recommendations for strategies to inform clinicians of clinical implications of this new standardized terminology:**

No responses received

**Question 3: What else is needed for successful implementation and dissemination of this terminology? (examples: (a) how best to facilitate adoption among various affected organizations, providers/labs, insurance companies, and industry? (b) what tools should be developed to facilitate dissemination? (c) what metrics are needed to access the uptake and impact of this terminology?)**

No responses received

**Question 4: Other comments:**

No responses received

## Pathologist Public Comments

**Question 1: What are the potential implications of standardizing histopathology terminology for lower anogenital lesions? Are there any potential benefits and/or harms not previously discussed in the prior Work Group recommendations which should be considered?**

A standardized HG and LG terminology (LG - cin 1, HG - cin 2/3) is easier for clinicians to understand and to pursue a treatment algorithm. As stated, the studies are neutral to positive in favor of a 2 tiered nomenclature.

**Question 2: Are there any additional recommendations for strategies to inform clinicians of clinical implications of this new standardized terminology:**

No responses received

**Question 3: What else is needed for successful implementation and dissemination of this terminology? (examples: (a) how best to facilitate adoption among various affected organizations, providers/labs, insurance companies, and industry? (b) what tools should be developed to facilitate dissemination? (c) what metrics are needed to access the uptake and impact of this terminology?)**

No responses received

**Question 4: Other comments:**

p16 is positive in many LG lesions (CIN 1) 60% in the paper by Agoff et al, Mod Pathol 2003;16(7):665–673. It isn't really appropriate to suggest using p16 to confirm CIN 2 versus CIN 1.

## Other

| Practice Type |
| --- |
| No responses received |

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No responses received

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No responses received

**Question 4: Other comments:**

No responses received