VII CONGRESSO CATARINENSE DE OBSTETRÍCIA E GINECOLOGIA

II Congresso Catarinense de Perinatologia

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Edison Natal Fedrizzi

Declaração de conflito de interesse

Não recebi qualquer forma de pagamento ou auxílio financeiro de entidade pública ou privada para pesquisa ou desenvolvimento de método diagnóstico ou terapêutico ou ainda, tenho qualquer relação comercial com a indústria farmacêutica

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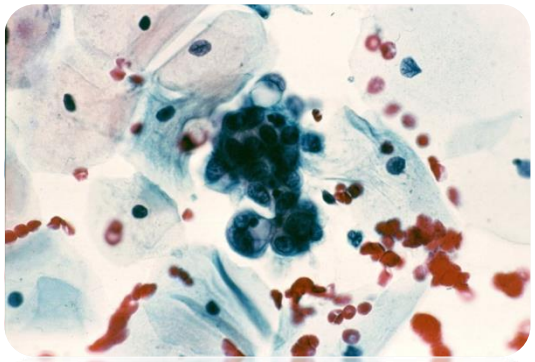
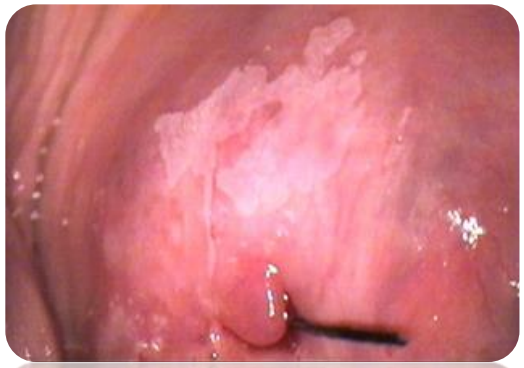
Lesões do Colo Uterino



- Alto Grau -



Edison Natal Fedrizzi

Professor Associado de Ginecologia e Obstetrícia da UFSC

Doutor em Medicina pela EPM/UNIFESP

Membro do Comitê Nacional de Vacinas da FEBRASGO

Chefe do Centro de Pesquisa Clínica Projeto HPV

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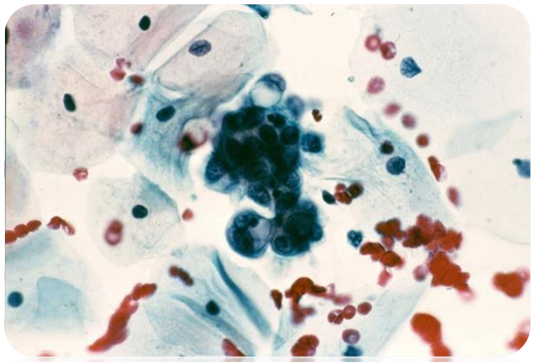

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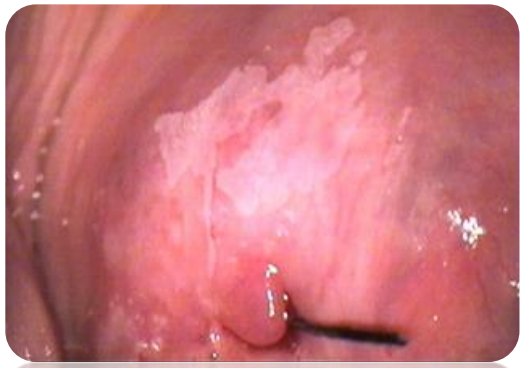


Potencial Conflito de Interesse

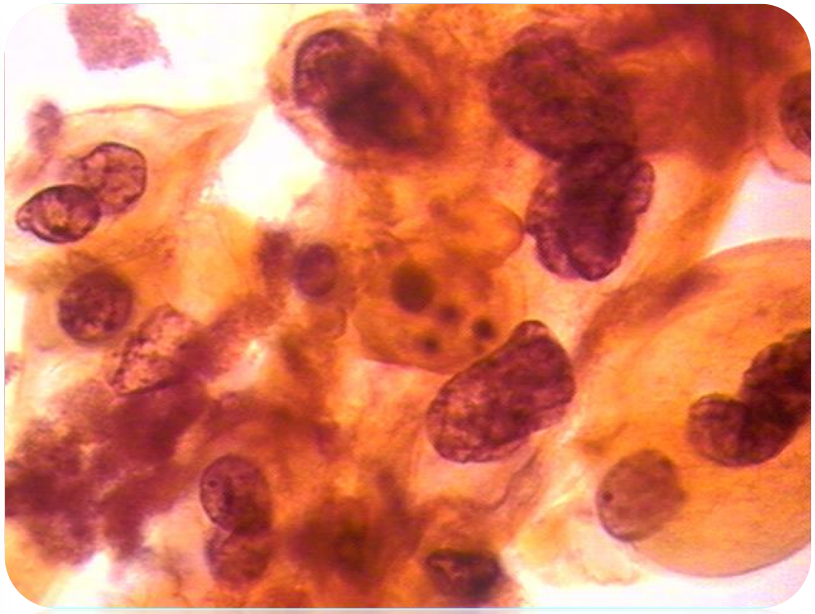
§2º, art 42 RDC nº 96/08, DOU de 17/12/2008

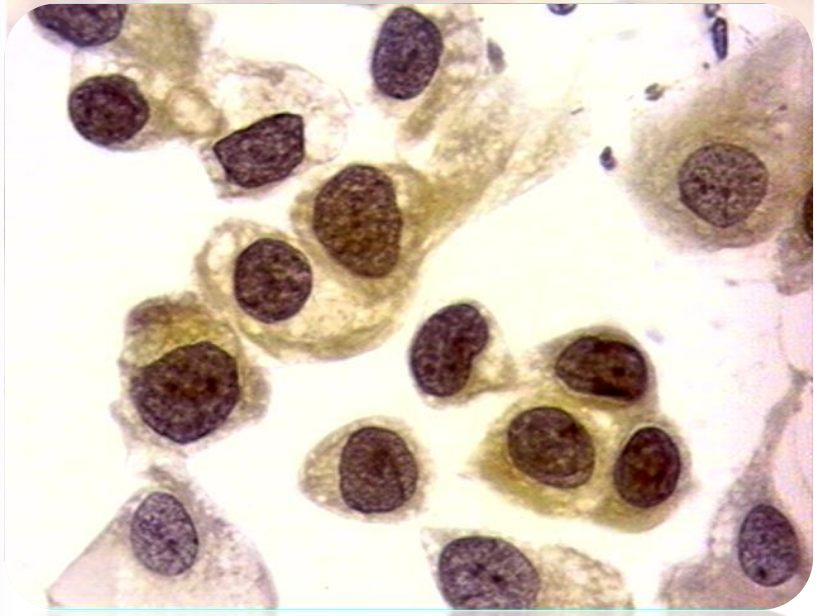
Pesquisador dos Ensaios Clínicos da Vacina Quadrivalente e Nonavalente Anti-HPV

Diretrizes Brasileiras para o Rastreamento do Câncer do Colo do Útero

2011

Ministério da Saúde
Instituto Nacional de Câncer



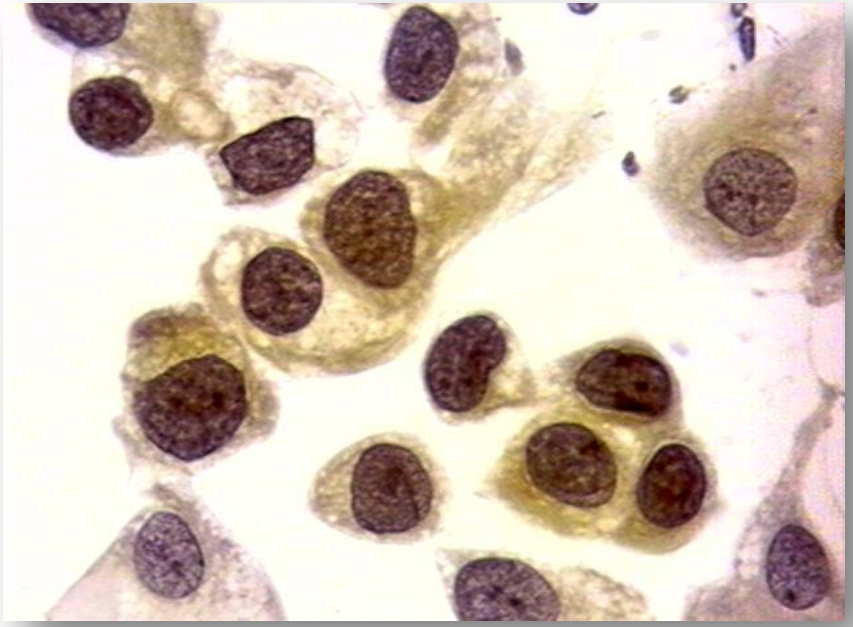


Lesão Intraepitelial Escamosa de Alto Grau - LIEAG

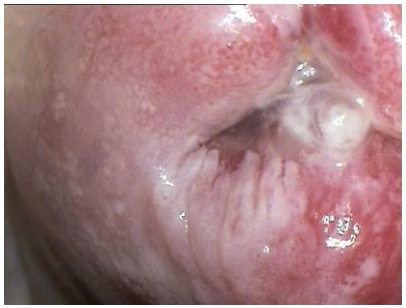
"A prevalência destes diagnósticos citológicos no Brasil foi de 0,26% dentre todos os exames realizados e de 9,1% considerando-se apenas os resultados alterados em 2013"

INCA, 2013

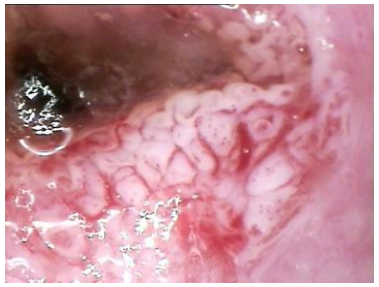
Conduta nas LIEAG



Colposcopia



Manejo das HSIL



“ Cerca de 70-75% das mulheres com diagnóstico de Lesão Intraepitelial de Alto Grau à citologia, apresentam confirmação do diagnóstico à histopatologia e 1-2% terão um carcinoma invasor “

Dunn TS et al. J Low Genit Tract Dis 2003;7:104-6.

Prevenção Carcinoma Cervical

HSIL

- **≤ 20 ANOS** → Colposcopia ⇩ CP 3-6 meses
- **> 20 ANOS** → Colposcopia ⇩ CP endocervical
- **GESTANTE** → Afastar Invasão ⇩ Colpo + CP 3 meses pós-parto
- **IMUNOSSUPRIMIDA** → Colposcopia ⇩ CP 6/6 meses por 2 anos

Diretrizes Brasileiras para o Rastreamento do Câncer do Colo do Útero. Ministério da Saúde, Instituto Nacional de Câncer (INCA), Rio de Janeiro, 2011.

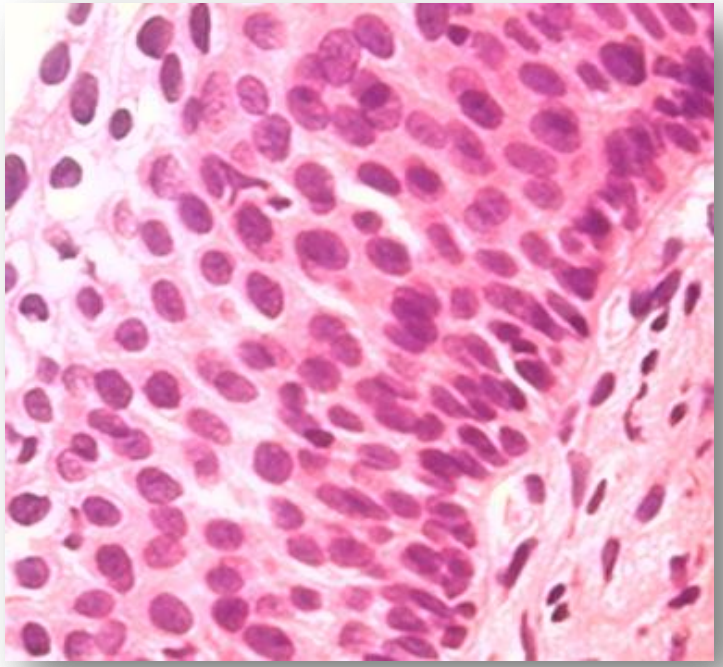
Prevenção Carcinoma Cervical

HSIL

- **≤ 25 ANOS** → Colposcopia ⇩ CP 3-6 meses
- **> 25 ANOS** → Colposcopia ⇩ Ver e Tratar ⇩ Biópsia (invasão)
- **GESTANTE** → Afastar Invasão ⇩ Colpo + CP ⇩ 3 meses pós-parto
- **IMUNOSSUPRIMIDA** → Colposcopia ⇩ CP 6/6 meses por 2 anos

Diretrizes Brasileiras para o Rastreamento do Câncer do Colo do Útero. Ministério da Saúde, Instituto Nacional de Câncer (INCA), Rio de Janeiro, 2011/**2014.**

Conduta nas NIC 2/3



Observar

Excisão da Lesão

História Natural das NIC

“ Em uma revisão da literatura da História Natural das NIC desde 1950 mostra que uma mulher com NIC 2 tem uma chance de 5% de progredir para o câncer invasor de colo de útero, enquanto uma mulher com NIC 3 esta chance é de 12% “

Ostor AG. Natural History of Cervical Intraepithelial Neoplasia: A critical review. Int J Gynecol Pathol 1993;12:186-92.

História Natural das NIC

" 62% das NIC 2 em mulheres com < 25 anos regridem em um período mediano de 8 meses "

Mc Allum B et al. Is the treatment of CIN 2 always necessary in women under 25 years old? Am J Obstet Gynecol 2011;205(5):478-97.

CA CANCER J CLIN 2012;62:147-172

American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology Screening Guidelines for the Prevention and Early Detection of Cervical Cancer

Debbie Saslow, PhD[1]; Diane Solomon, MD[2]; Herschel W. Lawson, MD[3]; Maureen Killackey, MD[4]; Shalini L. Kulasingam, PhD[5]; Joanna Cain, MD[6]; Francisco A. R. Garcia, MD, MPH[7]; Ann T. Moriarty, MD[8]; Alan G. Waxman, MD, MPH[9]; David C. Wilbur, MD[10]; Nicolas Wentzensen, MD, PhD, MS[11]; Levi S. Downs, Jr, MD[12]; Mark Spitzer, MD[13]; Anna-Barbara Moscicki, MD[14]; Eduardo L. Franco, DrPH[15]; Mark H. Stoler, MD[16]; Mark Schiffman, MD[17]; Philip E. Castle, PhD, MPH[18,*]; Evan R. Myers, MD, MPH[19,*]; the ACS-ASCCP-ASCP Cervical Cancer Guideline Committee[20]

An update to the American Cancer Society (ACS) guideline regarding screening for the early detection of cervical precancerous lesions and cancer is presented. The guidelines are based on a systematic evidence review, contributions from 6 working groups, and a recent symposium cosponsored by the ACS, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology, which was attended by 25 organizations. The new screening recommendations address age-appropriate screening strategies, including the use of cytology and high-risk human papillomavirus (HPV) testing, follow-up (eg, the management of screen positives and screening intervals for screen negatives) of women after screening, the age at which to exit screening, future considerations regarding HPV testing alone as a primary screening approach, and screening strategies for women vaccinated against HPV16 and HPV18 infections. **CA Cancer J Clin 2012;62:147-172. ©2012 American Cancer Society.**

Introduction

Cervical cancer screening has successfully decreased cervical cancer incidence and mortality. The American Cancer Society (ACS) guideline for the early detection of cervical cancer was last reviewed and updated in 2002; for the first time, those recommendations incorporated human papillomavirus (HPV) DNA testing.[1] Since that time, numerous studies have been published that support changes to recommended age-appropriate screening as well as the management of abnormal screening results, as summarized in Table 1.[2]

Background

High-quality screening with cytology (Papanicolaou [Pap] testing) has markedly reduced mortality from squamous cell cervical cancer, which comprises 80% to 90% of cervical cancers.[3-5] Since the introduction of cervical cytology in the United States in the middle of the 20th century, cervical cancer, once the most frequent cause of cancer death in women, now ranks

[1]Director, Breast and Gynecologic Cancer, Cancer Control Science Department, American Cancer Society, Atlanta, GA, on behalf of the Steering Committee, Data Group, and Writing Committee; [2]Senior Investigator, Division of Cancer Prevention, National Cancer Institute, National Institutes of Health, Rockville, MD, on behalf of the Steering Committee; [3]Adjunct Associate Professor, Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, GA, on behalf of the Data Group; [4]Deputy Physician in Chief, Medical Director, Memorial Sloan-Kettering Cancer Center Regional Network, Department of Surgery, Gynecology Service, Memorial Sloan-Kettering Cancer Center, New York, NY, on behalf of Working Group 1; [5]Assistant Professor, Division of Epidemiology and Community Health, University of Minnesota, Minneapolis, MN, on behalf of Working Group 1; [6]Professor and Vice Chair, Department of Obstetrics and Gynecology, University of Massachusetts School of Medicine, Worcester, MA, on behalf of Working Group 2; [7]Professor and Director, Center of Excellence in Women's Health, Mel and Enid Zuckerman College of Public Health, University of Arizona at Tucson, Tucson, AZ, on behalf of Working Group 6; [8]Director, Department of Esoteric Testing, AmeriPath Indiana, Indianapolis, IN, on behalf of Working Group 6; [9]Professor, Department of Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque, NM, on behalf of Working Group 3a; [10]Professor of Pathology, Department of Pathology, Massachusetts General Hospital, Harvard Medical School, Boston, MA, on behalf of Working Group 3b; [11]Investigator, Division of Cancer Epidemiology and Genetics, National Cancer Institute, National Institutes of Health, Rockville, MD; [12]Director, Division of Gynecologic Oncology, Department of Obstetrics, Gynecology, and Women's Health, Masonic Cancer Center, University of Minnesota Medical School, Minneapolis, MN, on behalf of Working Group 4; [13]Professor of Clinical Obstetrics and Gynecology, Weill Medical College of Cornell University, New York, NY, on behalf of Working Group 4; [14]Professor, Department of Pediatrics, University of California at San Francisco, San Francisco, CA, on behalf of Working Group 5; [15]Professor, Departments of Oncology and Epidemiology, McGill University, Montreal, Quebec, Canada; [16]Professor of Pathology and Clinical Gynecology, Associate Director of Surgical and Cytopathology, Surgical Pathology, Department of Pathology, University of Virginia Health System, Charlottesville, VA; [17]Senior Investigator, Clinical Genetics Branch, Division of Cancer Epidemiology and Genetics, National Cancer Institute, National Institutes of Health, Bethesda, MD; [18]Executive Director, American Society for Clinical Pathology Institute, Washington, DC, on behalf of the Writing Committee; [19]Professor, Department of Obstetrics and Gynecology, Duke University Medical Center, Durham, NC; [20]On behalf of Working Group 1, 2, 3a, 3b, 4, 5, 6, Data Group, Steering Committee, and Writing Committee.

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*Dr. Castle and Dr. Myers are co-senior authors.

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Journal d'obstétrique et gynécologie du Canada

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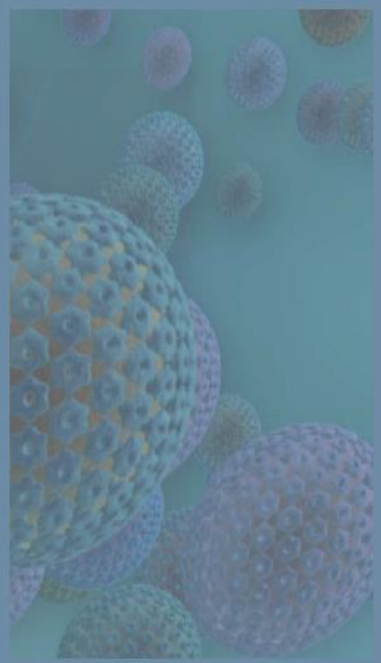

Canadian Consensus Guidelines on Human Papillomavirus

THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA
LA SOCIÉTÉ DES OBSTÉTRICIENS ET GYNÉCOLOGUES DU CANADA

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SOGC JOINT CLINICAL PRACTICE GUIDELINE

J Obstet Gynaecol Can 2012;34(12):1188-1202. No. 284, December 2012

Colposcopic Management of Abnormal Cervical Cytology and Histology

This clinical practice guideline has been prepared by the Executive Council of the Society of Canadian Colposcopists and approved by the Society of Obstetricians and Gynaecologists of Canada/Society of Gynecologic Oncology of Canada/Society of Canadian Colposcopists Policy and Practice Guidelines Committee, the Executive and Council of the Society of Gynecologic Oncology of Canada and the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Disclosure statements have been received from all authors.

Abstract

Objective: To provide a guideline for managing abnormal cytology results after screening for cervical cancer, to clarify the appropriate algorithms for follow-up after treatment, and to promote the best possible care for women while ensuring efficient use of available resources.

Outcomes: Women with abnormal cytology are at risk of developing cervical cancer; appropriate triage and treatment will reduce this risk. This guideline will facilitate implementation of common standards across Canada, moving away from the current trend of individual guidelines in each province and territory.

Evidence: Published literature was retrieved through searches of PubMed or Medline, CINAHL, and The Cochrane Library in October 2008 using appropriate controlled vocabulary (e.g., colposcopy, cervical dysplasia) and key words (e.g., colposcopy management, CIN, AGC, cervical dysplasia, LEEP, LLETZ, HPV testing, cervical dysplasia triage). Results were restricted to systematic reviews, randomized control trials/controlled clinical trials, and observational studies. There were no date or language restrictions. Searches were updated on a regular basis and incorporated in the guideline to July 2012. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology assessment-related agencies, clinical practice guideline collections, and national and international medical specialty societies.

Expert opinion from published peer-reviewed literature and evidence from clinical trials is summarized. Consensus opinion is outlined when evidence is insufficient.

Values: The quality of the evidence is rated using the criteria described by the Canadian Task Force on Preventive Health Care (Table 1).

Validation: This guideline has been reviewed for accuracy from content experts in cytology, pathology, and cervical screening programs. Guideline content was also compared with similar documents from other organizations including the American Society for Colposcopy and Cervical Pathology, the British Society for Colposcopy and Cervical Pathology, and the European Cancer Network.

J Obstet Gynaecol Can 2012;34(12):1188–1202

Key Words: Cervical cytology, cervical cancer, colposcopy, treatment, follow-up, abnormalities, guidelines

Recommendations ≥ 25 years old

29. CIN 2 or 3 should be treated. Excisional procedures are preferred for CIN 3. (II-1A)
30. Women who have positive margins should have follow-up with colposcopy and directed biopsies and/or endocervical curettage. Treatment for recurrent or persistent CIN 2 or 3 should be by excision. (II-1B)

Recommendations < 25 years old

31. The pathologist should be asked to clarify whether the lesion is CIN 2 or CIN 3. (III-B)
32. CIN 2 in women less than 25 years old should be observed with colposcopy at 6-month intervals for up to 24 months before treatment is considered. (II-2B)
33. CIN 3 in women less than 25 years old should be treated. (III-B)

J Lower Gen Tract Dis 2013;17(1):S1-S27.

2012 Updated Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Tests and Cancer Precursors

L. Stewart Massad, MD, Mark H. Einstein, MD, Warner K. Huh, MD, Hormuzd A. Katki, PhD, Walter K. Kinney, MD, Mark Schiffman, MD, Diane Solomon, MD, Nicolas Wentzensen, MD, and Herschel W. Lawson, MD, for the 2012 ASCCP Consensus Guidelines Conference

From Washington University School of Medicine, St. Louis, Missouri; Albert Einstein College of Medicine, New York, New York; University of Alabama School of Medicine, Birmingham, Alabama; Division of Cancer Epidemiology and Genetics and Division of Cancer Prevention, National Cancer Institute, Bethesda, Maryland; The Permanente Medical Group, Sacramento, California; and Emory University School of Medicine, Atlanta, Georgia

■ **ABSTRACT:** A group of 47 experts representing 23 professional societies, national and international health organizations, and federal agencies met in Bethesda, MD, September 14–15, 2012, to revise the 2006 American Society for Colposcopy and Cervical Pathology Consensus Guidelines. The group's goal was to provide revised evidence-based consensus guidelines for managing women with abnormal cervical cancer screening tests, cervical intraepithelial neoplasia (CIN) and adenocarcinoma in situ (AIS) following adoption of cervical cancer screening guidelines incorporating longer screening intervals and co-testing. In addition to literature review, data from almost 1.4 million women in the Kaiser Permanente Northern California Medical Care Plan provided evidence on risk after abnormal tests. Where data were available, guidelines prescribed similar management for women with similar risks for CIN 3, AIS, and cancer. Most prior guidelines were reaffirmed. Examples of updates include: Human papillomavirus–negative atypical squamous cells of undetermined significance results are followed with co-testing at 3 years before return to routine screening and are not sufficient for exiting women from screening at age 65 years; women aged 21–24 years need less invasive management, especially for minor abnormalities; postcolposcopy management strategies incorporate co-testing; endocervical sampling reported as CIN 1 should be managed as CIN 1; unsatisfactory cytology should be repeated in most circumstances, even when HPV results from co-testing are known, while most cases of negative cytology with absent or insufficient endocervical cells or transformation zone component can be managed without intensive follow-up. ■

These guidelines are being published simultaneously in *Obstetrics & Gynecology* and the *Journal of Lower Genital Tract Disease*. The complete algorithms are published in the *Journal of Lower Genital Tract Disease* and are also available on the web site of the American Society for Colposcopy and Cervical Pathology (http://www.asccp.org/).

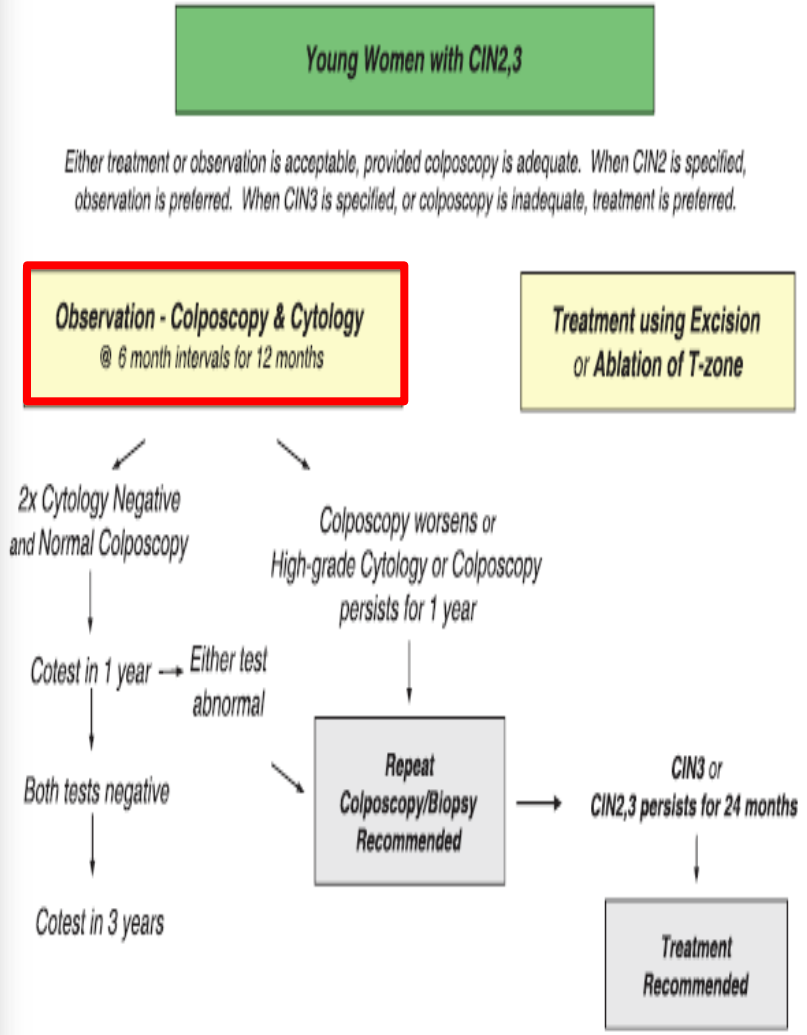
The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the National Institutes of Health or U.S. federal government.Corresponding author: L. Stewart Massad, MD Division of Gynecologic Oncology, Washington University School of Medicine, 4911 Barnes-Jewish Hospital Plaza, St. Louis, MO 63110; e-mail: massadl@wudosis.wustl.edu.

Financial Disclosure

Dr. Massad has served as an expert witness. Dr. Huh has served as a consultant to Roche. Dr. Schiffman has researched reagents for Qiagen and Roche. The other authors did not report any potential conflicts of interest.

By 2001, revised Bethesda system terminology for reporting cervical cytology results and the availability of findings from a recent randomized trial of strategies for managing minor cervical cytologic abnormalities had created the need for a standard approach to managing women with abnormal cervical cytology and cervical cancer precursors (1–3). In response, the American Society for Colposcopy and Cervical Pathology (ASCCP) initiated

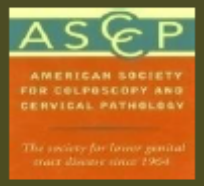
Management of Young Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia Grade 2,3 (CIN2,3) in Special Circumstances



Guidelines Development Process Assumptions 2012

Benefits of screening

- Cancer is the ideal endpoint but unrealistic
- CIN3 is a reliable surrogate marker for sensitivity
- CIN2 is equivocal (a combination of CIN1 and CIN3)
  - hard to diagnose—poor inter-rater reliability
  - often regresses
  - a threshold for treatment



Lesão Intraepitelial Escamosa de Colo Uterino

Biomarcadores de Progressão

- Heterozigosidade
- FHIT
- Telomerase
- DNA ploidia
- PCNA e Ki-67
- p16
- Tipo / Variante HPV
- E6 e E7 RNAm
- Mcm e cdc6

ENF

Int J Gynecol Pathol 2013;32(1):76-115.

International Journal of Gynecological Pathology
32:76–115, Lippincott Williams & Wilkins, Baltimore

Original Article

The Lower Anogenital Squamous Terminology Standardization Project for HPV-associated Lesions: Background and Consensus Recommendations From the College of American Pathologists and the American Society for Colposcopy and Cervical Pathology

Teresa M. Darragh, M.D., Terence J. Colgan, M.D., J. Thomas Cox, M.D., Debra S. Heller, M.D., Michael R. Henry, M.D., Ronald D. Luff, M.D., Timothy McCalmont, M.D., Ritu Nayar, M.D., Joel M. Palefsky, M.D., Mark H. Stoler, M.D., Edward J. Wilkinson, M.D., Richard J. Zaino, M.D., David C. Wilbur, M.D., and For Members of the LAST Project Work Groups

Summary: The terminology for human papillomavirus (HPV)-associated squamous lesions of the lower anogenital tract has a long history marked by disparate diagnostic terms derived from multiple specialties. It often does not reflect current knowledge of HPV biology and pathogenesis. A consensus process was convened to recommend terminology unified across lower anogenital sites. The goal was to create a histopathologic nomenclature system that reflects current knowledge of HPV biology, optimally uses available biomarkers, and facilitates clear communication across different medical specialties. The Lower Anogenital Squamous Terminology (LAST) project was co-sponsored by the College of American Pathologists (CAP) and the American Society for Colposcopy and Cervical Pathology (ASCCP) and included 5 working groups; three work groups performed comprehensive literature reviews and developed draft recommendations. Another work group provided the historical background and the fifth will continue to foster implementation of the LAST recommendations. After an open comment period, the draft recommendations were presented at a consensus conference attended by LAST work group members, advisors and representatives from 35 stakeholder organizations including professional societies

From the University of California (T.M.D., T.M., J.M.P.) – San Francisco, San Francisco, CA; Mount Sinai Hospital (T.J.C.), Toronto, ON, Canada; University of California (J.T.C.) – Santa Barbara Student Health Service (retired), Santa Barbara, CA; UMDNJ-New Jersey Medical School (D.S.H.), Newark, NJ; Mayo Clinic (M.R.H.), Rochester, MN; Quest Diagnostics (R.D.L.), Teterboro, NJ, Thomas Jefferson University, Philadelphia, PA; Northwestern University Feinberg School of Medicine (R.N.), Chicago, IL; University of Virginia Health System (M.H.S.), Charlottesville, VA; University of Florida College of Medicine (E.J.W.), Gainesville, FL; Hershey Medical Center (R.J.Z.), Penn State University, Hershey, PA; and Massachusetts General Hospital (D.C.W), Harvard Medical School, Boston, MA.

This article is reprinted from the Journal of *Lower Genital Tract Disease*, 2012, Volume 16, Number 3, pages 205–242.

Disclosure: ASCCP and the CAP provided the funding for this project; no industry funds were used in the development of the consensus statements and recommendations.

The authors declare no conflict of interest.

Précis: The CAP-ASCCP LAST project provides recommendations for a unified terminology for HPV-associated squamous intraepithelial lesions and superficially invasive squamous carcinomas of the lower anogenital tract.

Address correspondence and reprint requests to Teresa M. Darragh, MD, UCSF/Mt. Zion Medical Center Depts. of Pathology and Obstetrics, Gynecology and Reproductive Science 1600 Divisadero Street, Room B618 San Francisco, CA 94115. E-mail: teresa.darragh@ucsf.edu.

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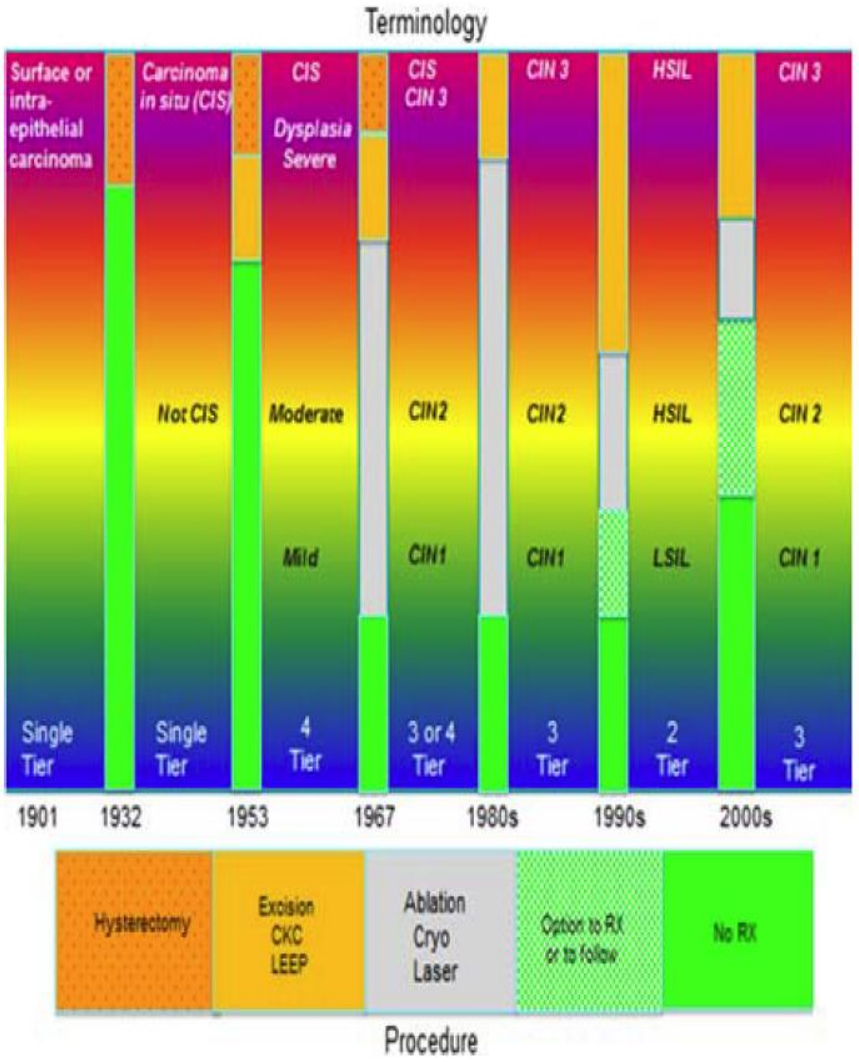


FIG. 2. Changes to the terminology and number of tiers used to describe cervical precancer over time with corresponding management options (procedure). See text for additional details. CKC: cold knife cone; LEEP: loop electrosurgical excision procedure; Cryo: Cryotherapy; RX: Treatment. Modified with permission. Courtesy of J. Thomas Cox.

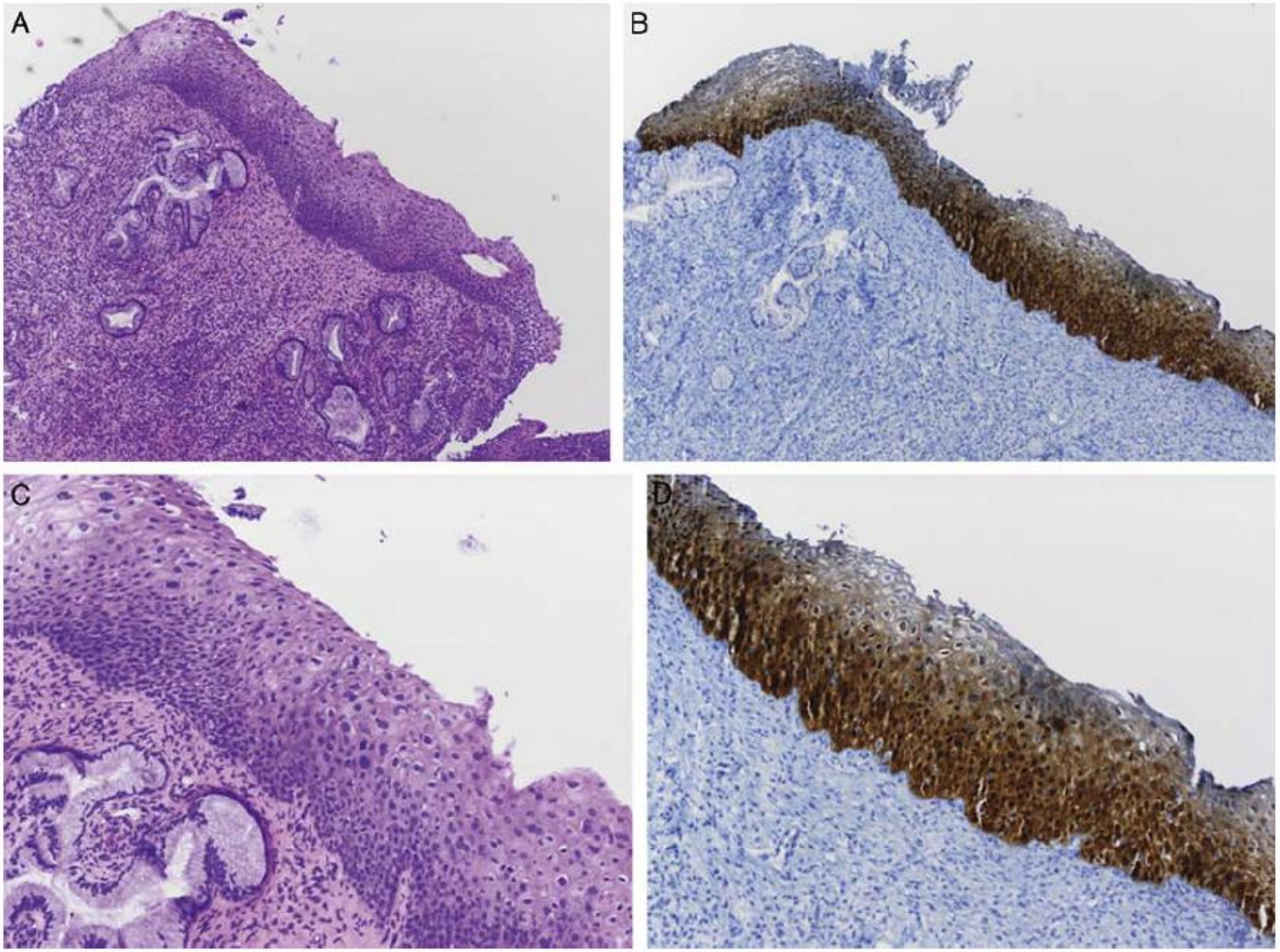
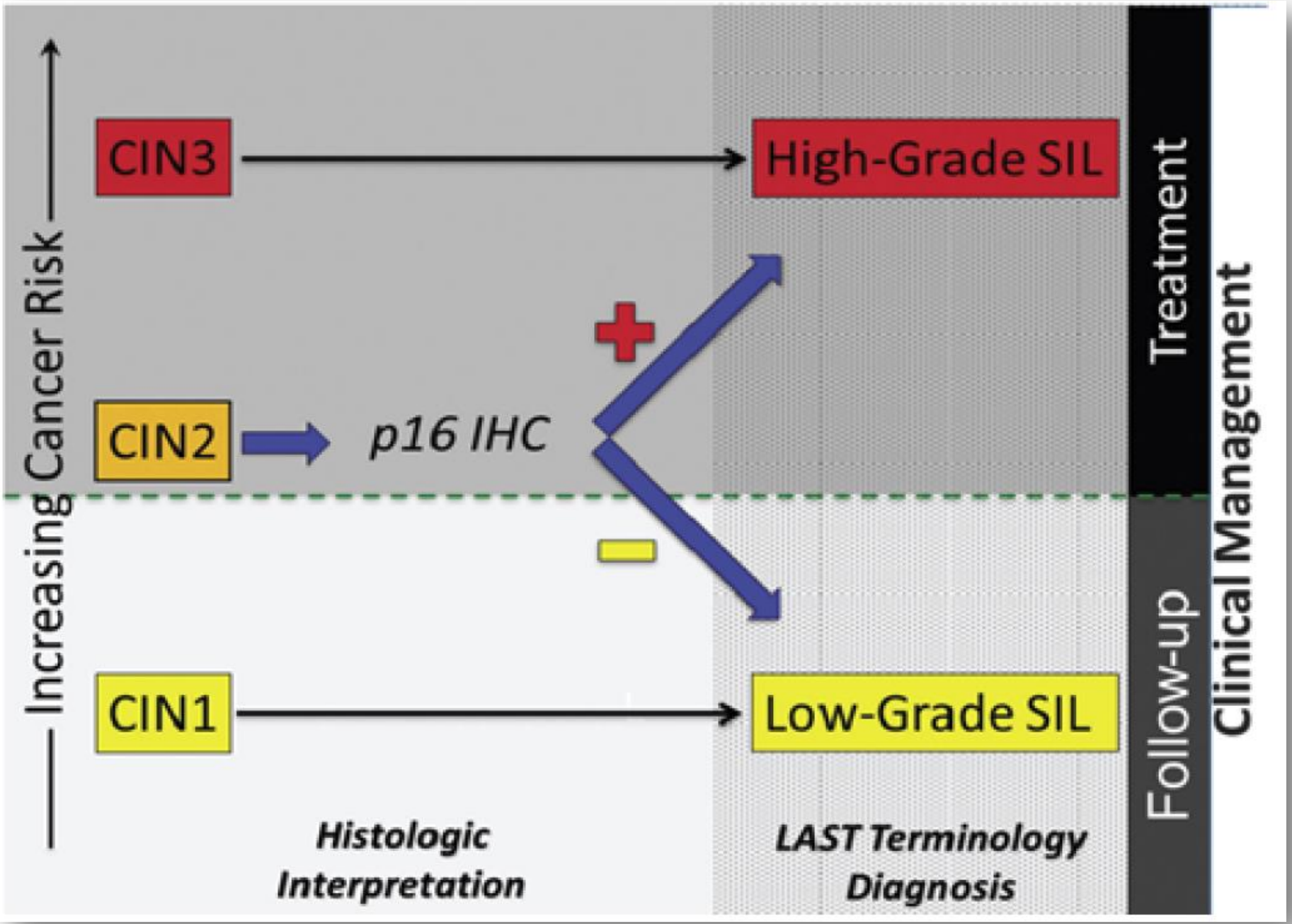


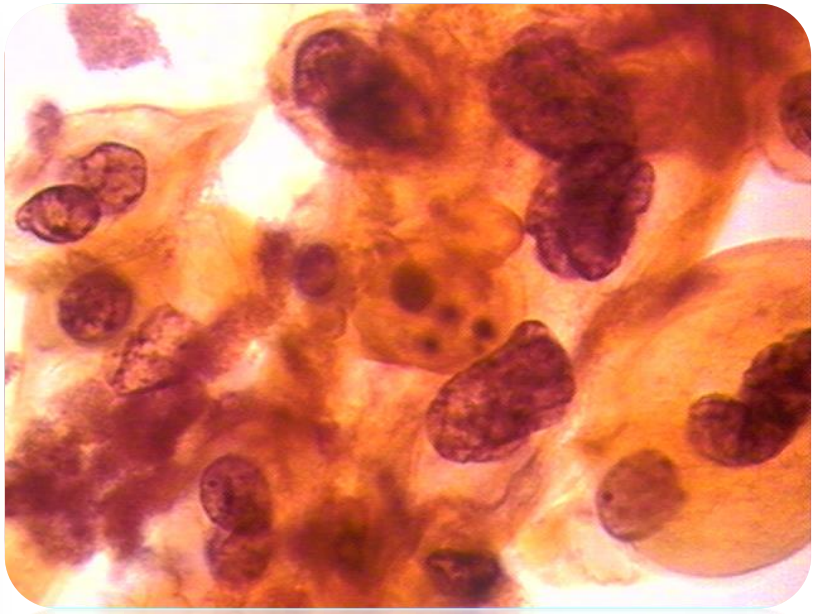
FIG. 14. A cervical biopsy with SIL showing partial maturation; some might question the lesion grade (? CIN2). Panels A & C demonstrate H&E morphology at low and medium power with atypical parabasal like cells extending into the middle third of the epithelium (C). Panels B & D are the corresponding p16 IHC stains with diffuse strong staining meeting the definition of p16 strong diffuse block positive described in the text. Therefore, this case is best interpreted as HSIL.

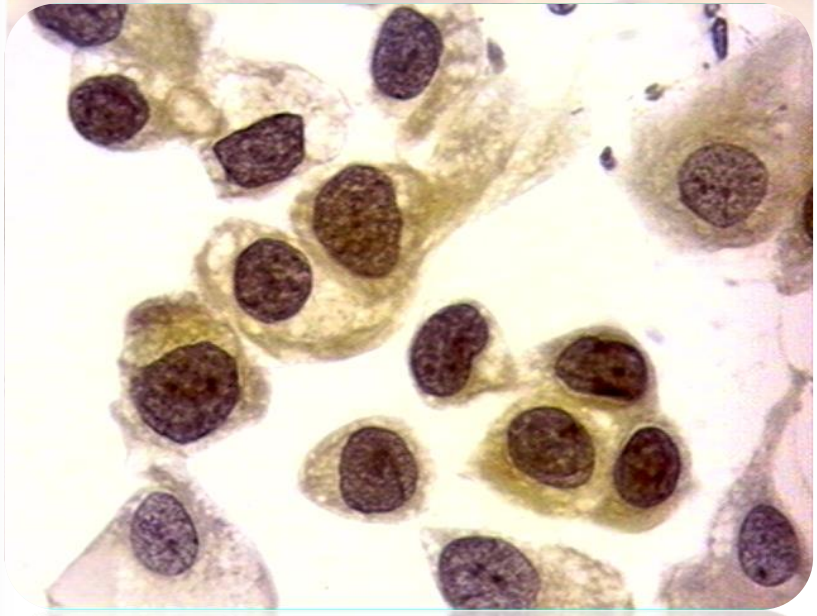

Increasing Cancer Risk
CIN3
High-Grade SIL
CIN2
p16 IHC
+
−
CIN1
Low-Grade SIL
Histologic Interpretation
LAST Terminology Diagnosis
Treatment
Follow-up
Clinical Management

Diretrizes Brasileiras para o Rastreamento do Câncer do Colo do Útero

2011

Ministério da Saúde
Instituto Nacional de Câncer





Prevenção Carcinoma Cervical

NIC 2/3

- **≤ 25 ANOS** → CP 6/6 meses (2 anos)
- **> 25 ANOS** → Excisão
- **GESTANTE** → CP + Colposcopia 3 meses pós-parto
- **IMUNOSSUPRIMIDA** → Excisão

Diretrizes Brasileiras para o Rastreamento do Câncer do Colo do Útero. Ministério da Saúde, Instituto Nacional de Câncer (INCA), Rio de Janeiro, 2011/**2014**.

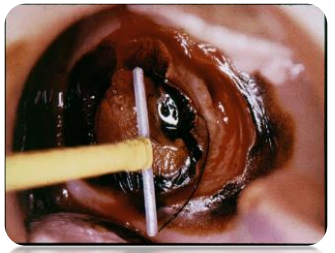
Cirurgia de Alta Freqüência

(LEEP – Loop Electrosurgical Excisional Procedure)

Exérese Ampla da Zona de Transformação ***(LLETZ – Large Loop Excision of the Transformation Zone)***

"Excisão do revestimento epitelial ectocervical, retirando a última glândula e a JEC, sem retirada do Canal Endocervical"

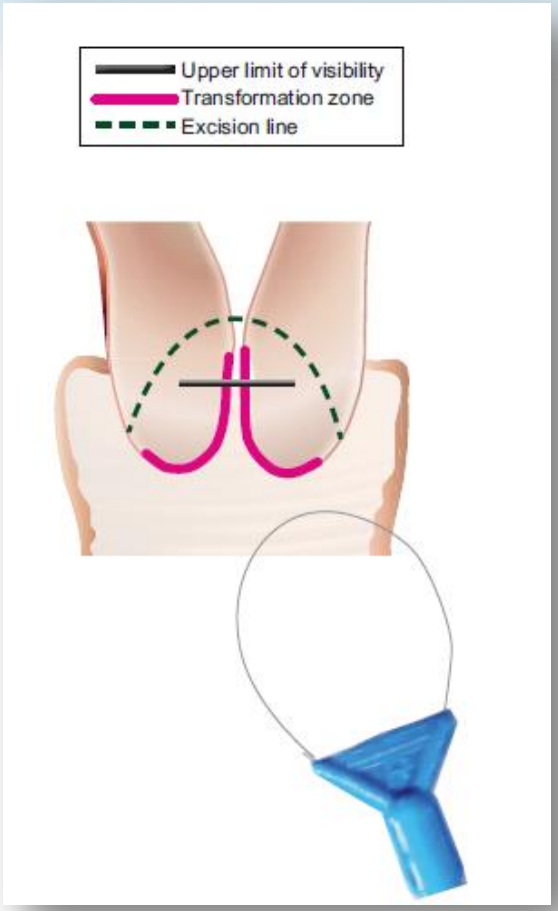
→ ***Pressupõe JEC visível***

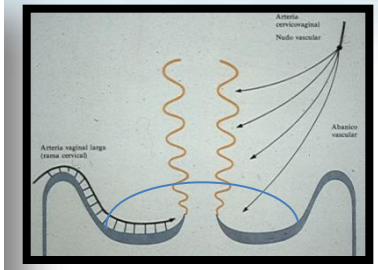


Conização ***(LEC – Loop Electrosurgical Conization)***

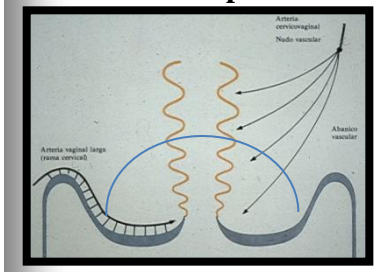
"Excisão de segmento do Canal Endocervical, de qualquer tamanho, em uma ou mais passagem da alça"

Reunião de Consenso – I Simpósio Regional de Genitoscopia – Brasília / 2005

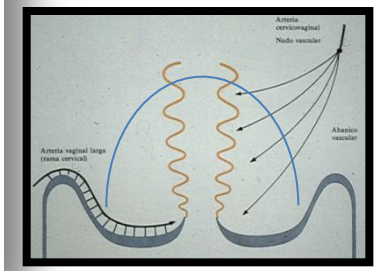




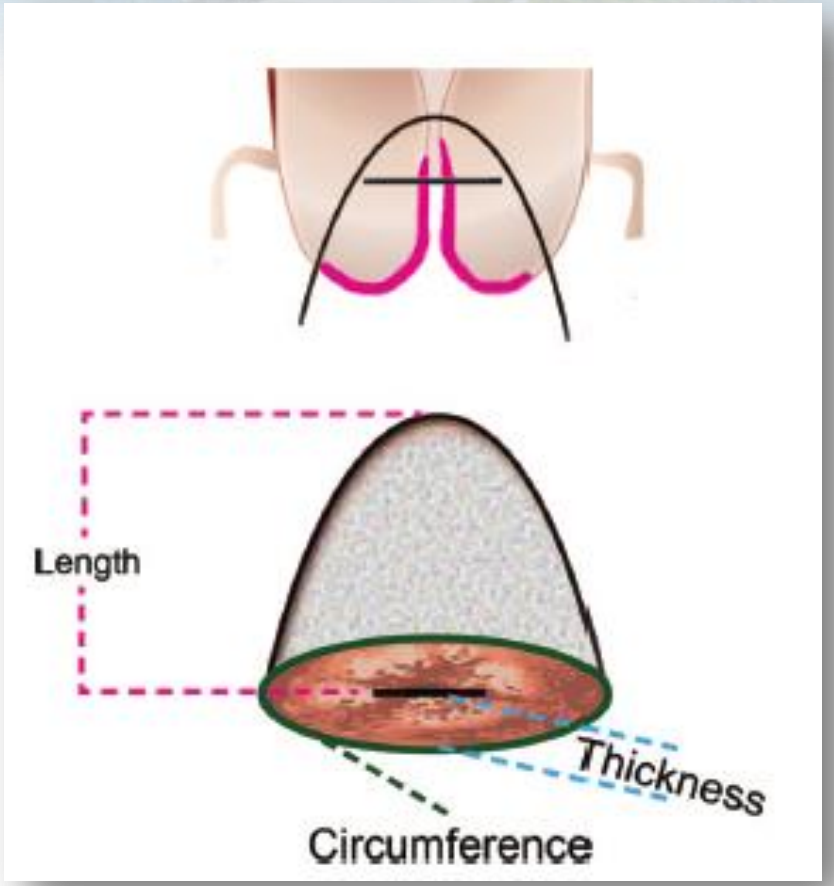
EZT Tipo 1

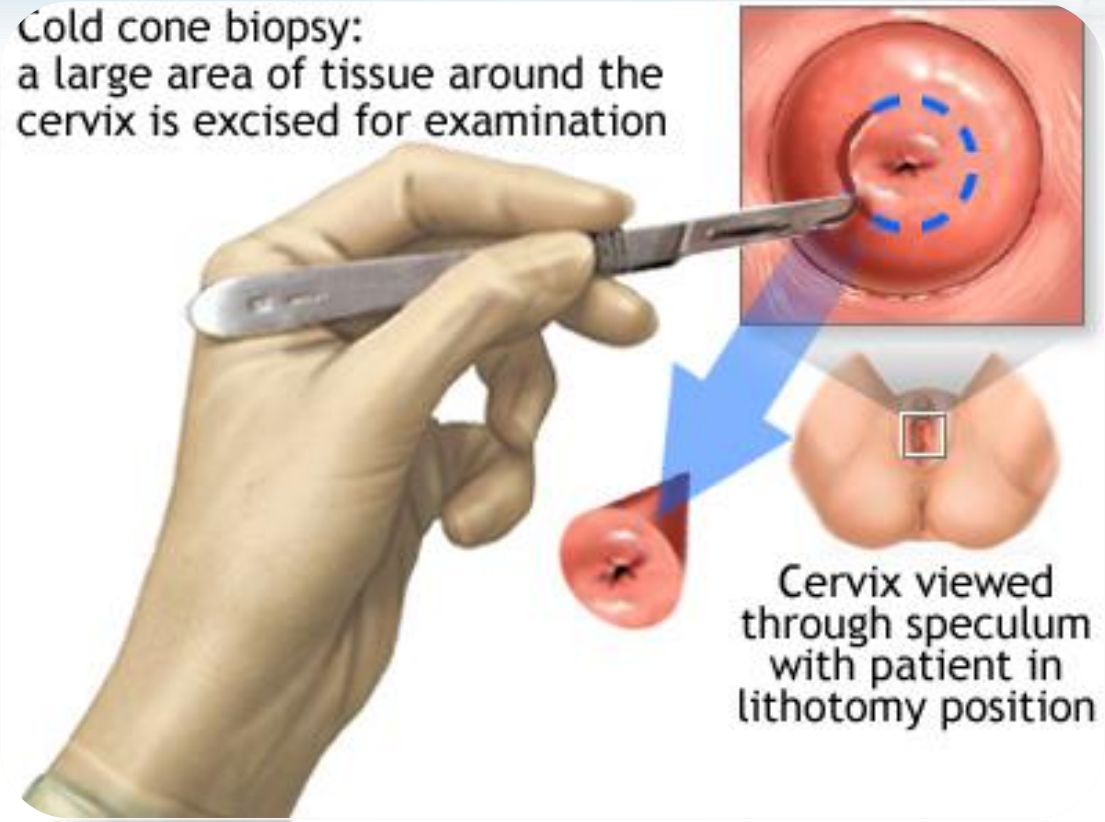


EZT Tipo 2



EZT Tipo 3



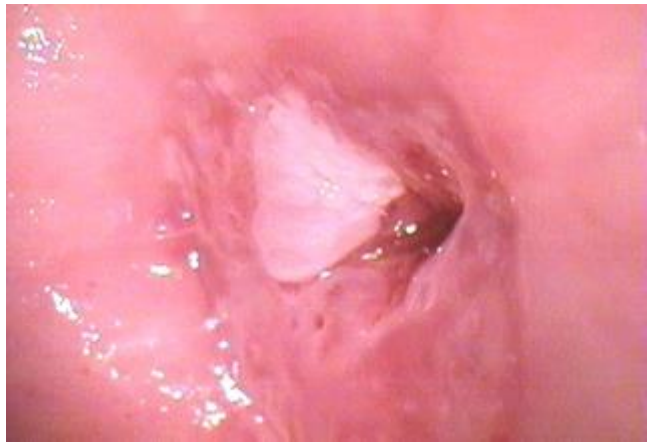

Cold cone biopsy:
a large area of tissue around the cervix is excised for examination
Cervix viewed through speculum with patient in lithotomy position

CAF x CONE

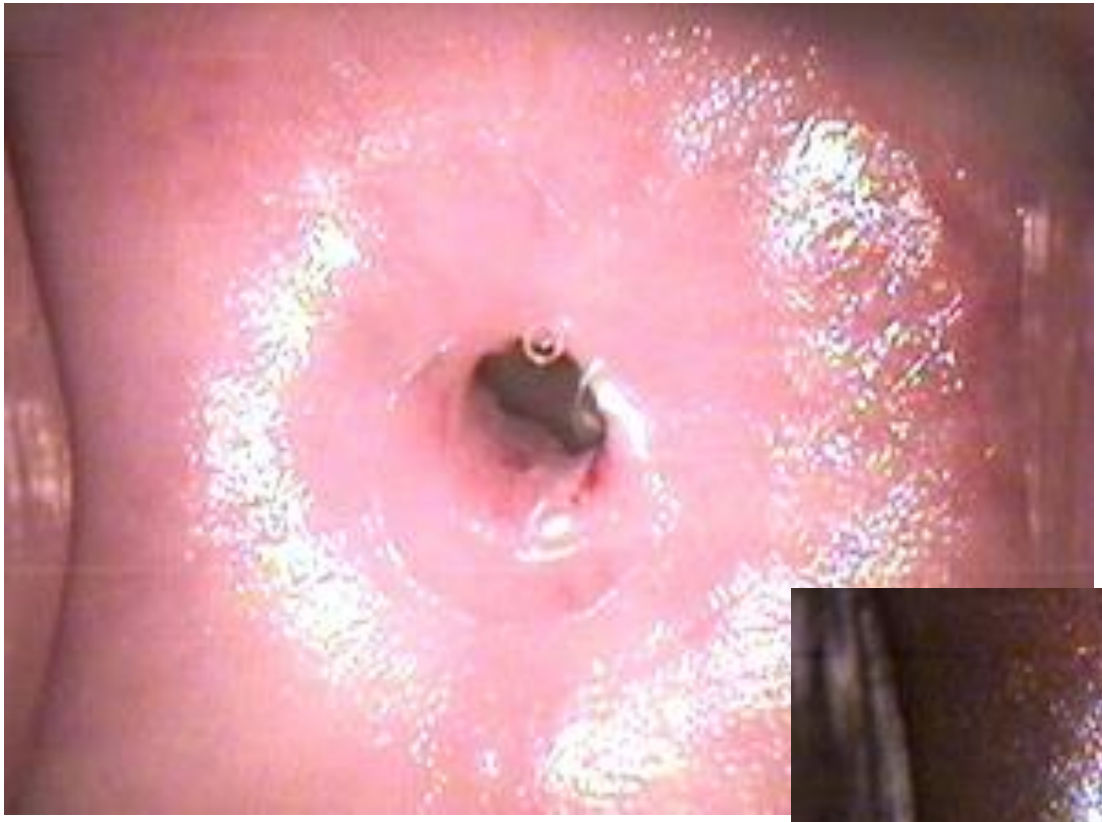
Indicação da Técnica

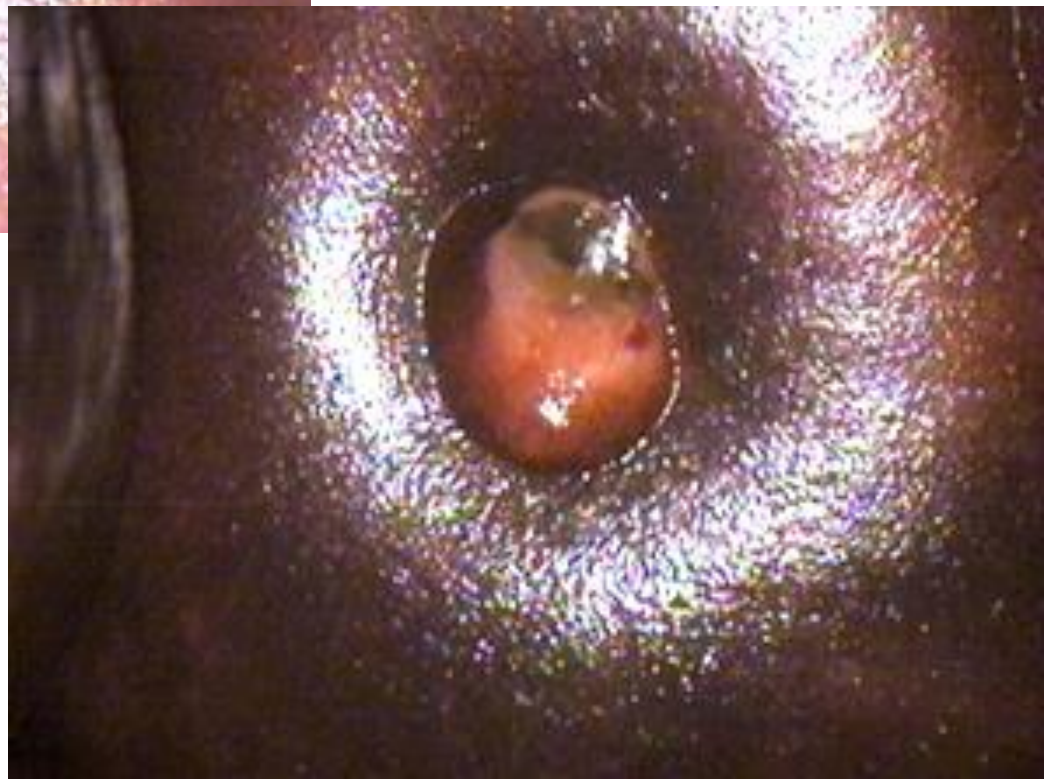
A) *Lesão Totalmente Visível*

- ***Cirurgia de Alta Frequência***
  - *Exérese Ampla da Zona de Transformação*
  - *Conização*
- *Alça de Fischer*
- *Laser*
- *Bisturi Frio*



Reunião de Consenso – I Simpósio Regional de Genitoscopia – Brasília / 2005



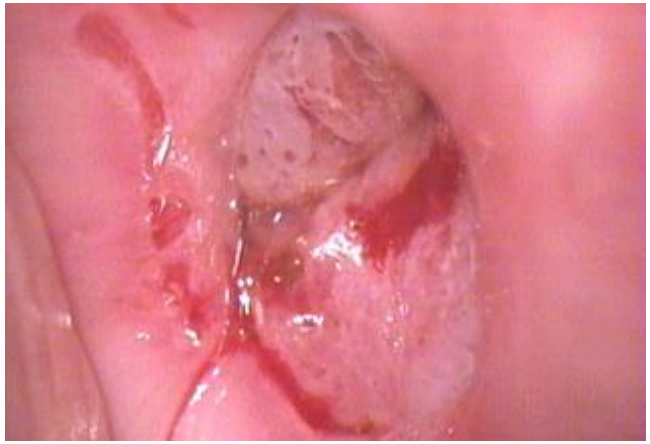


CAF x CONE

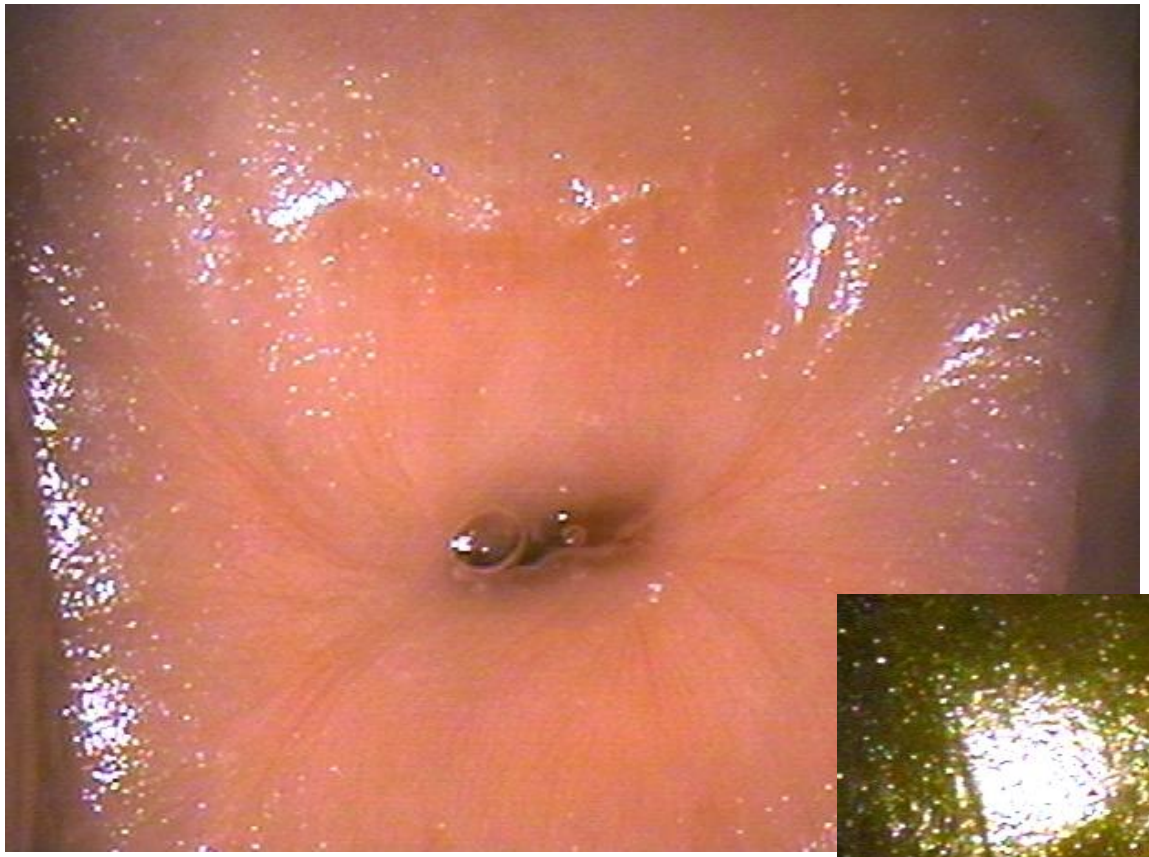
Indicação da Técnica

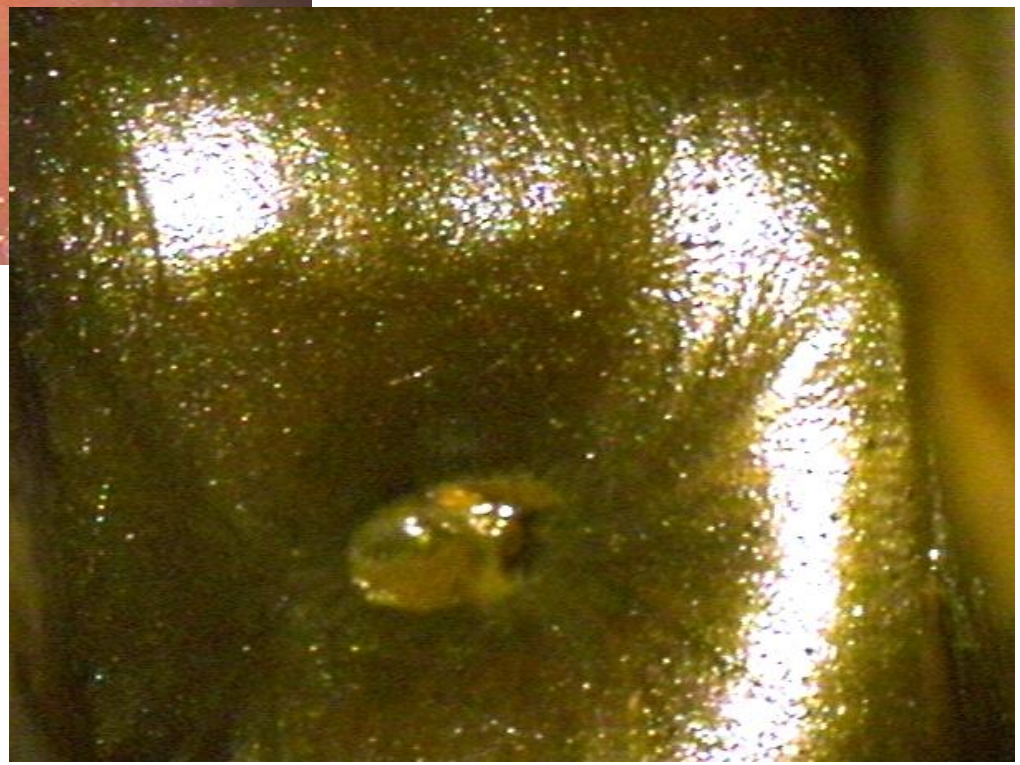
B) *Lesão Parcialmente Visível*

- ***Cirurgia de Alta Frequência***
  - *Conização*
- *Alça de Fischer*
- *Laser*
- *Bisturi Frio*



Reunião de Consenso – I Simpósio Regional de Genitoscopia – Brasília / 2005



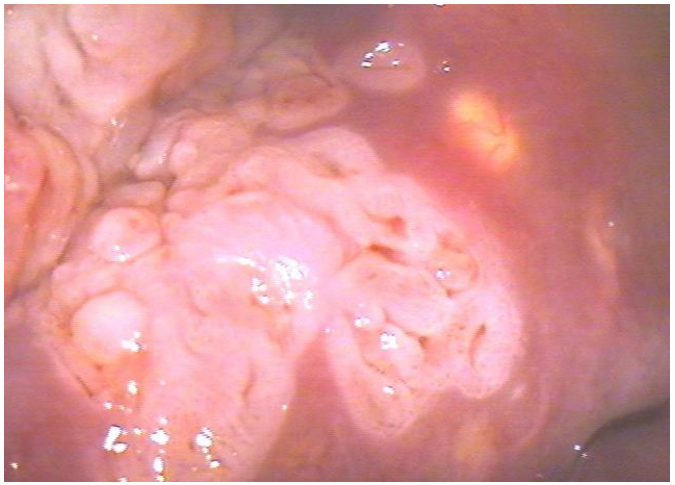


CAF x CONE

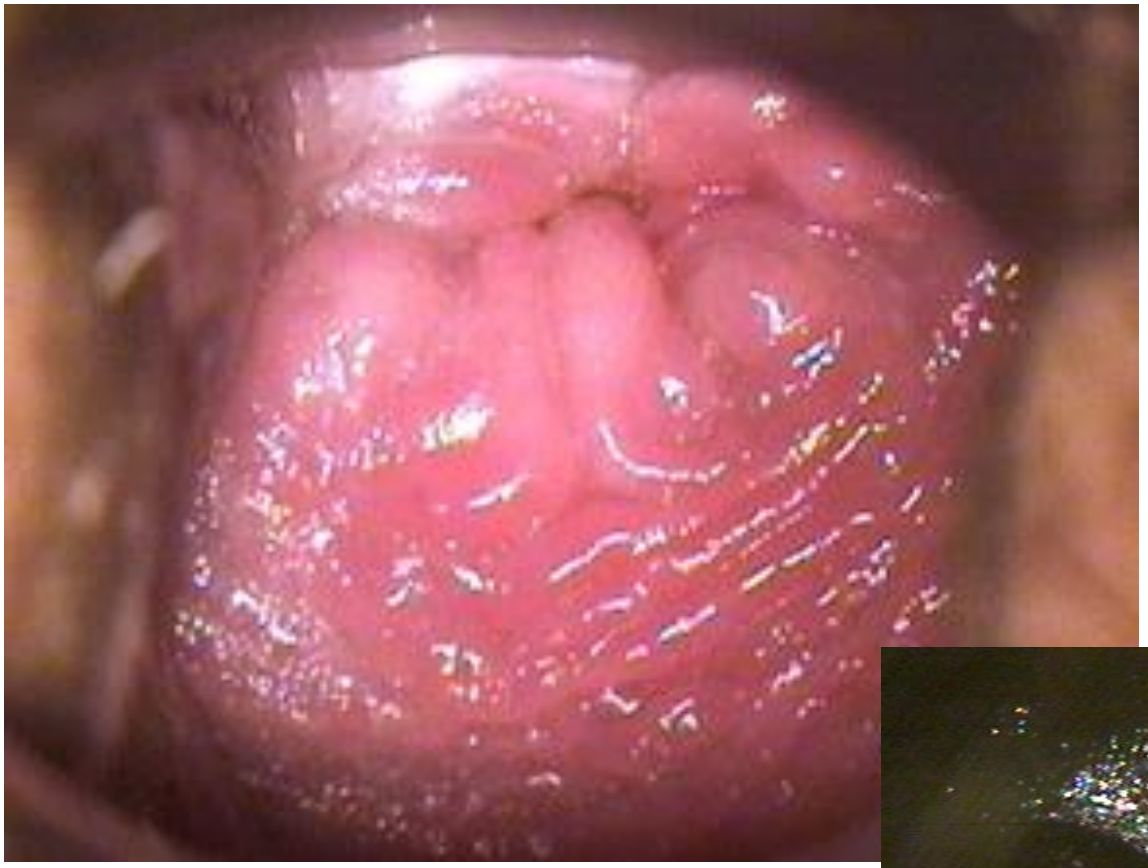
Indicação da Técnica

C) *Adenocarcinoma "in situ"*

- *Cirurgia de Alta Frequência*
  - *Conização*
- *Alça de Fischer*
- *Laser*
- ***Bisturi Frio***



Reunião de Consenso – I Simpósio Regional de Genitoscopia – Brasília / 2005

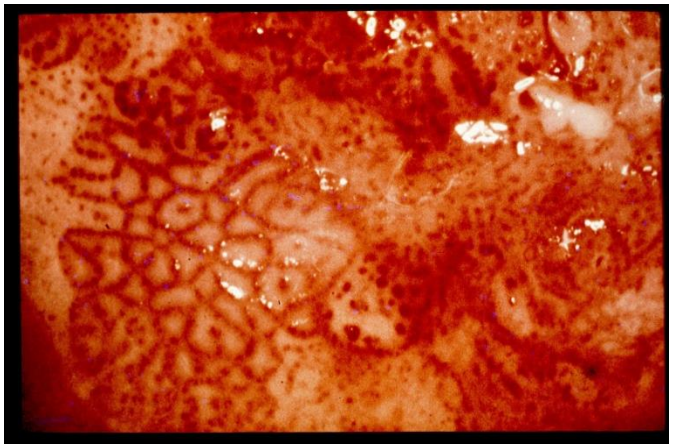


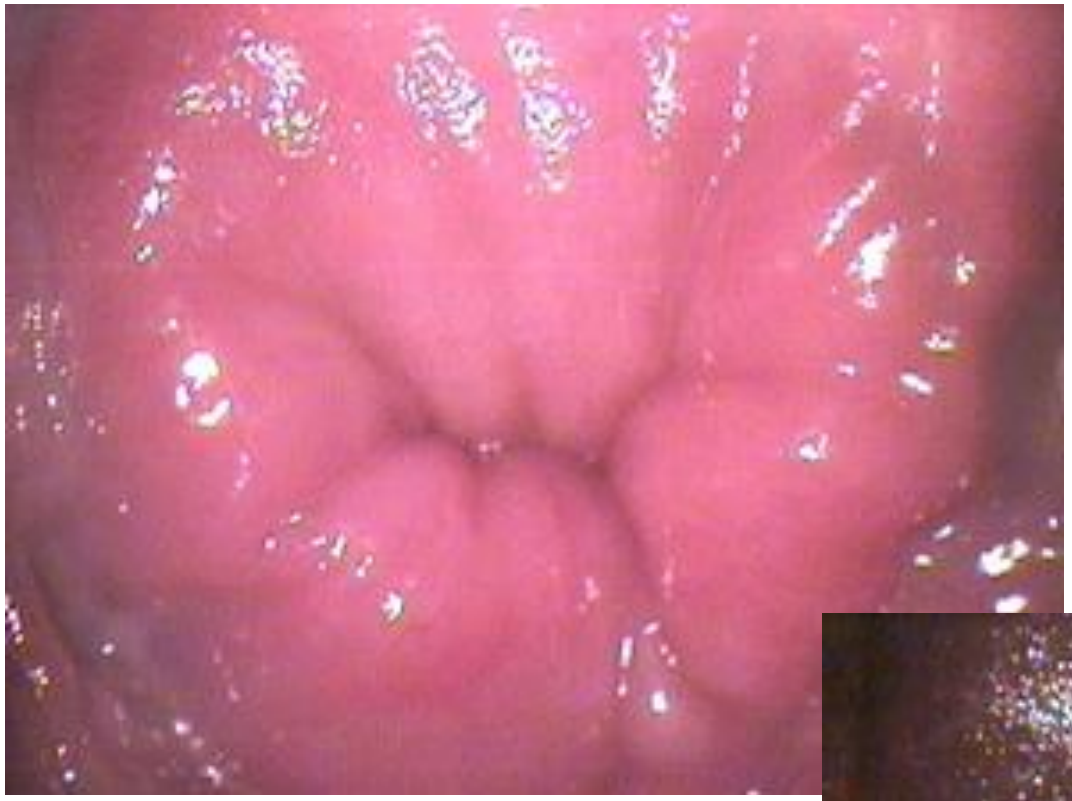
CAF x CONE

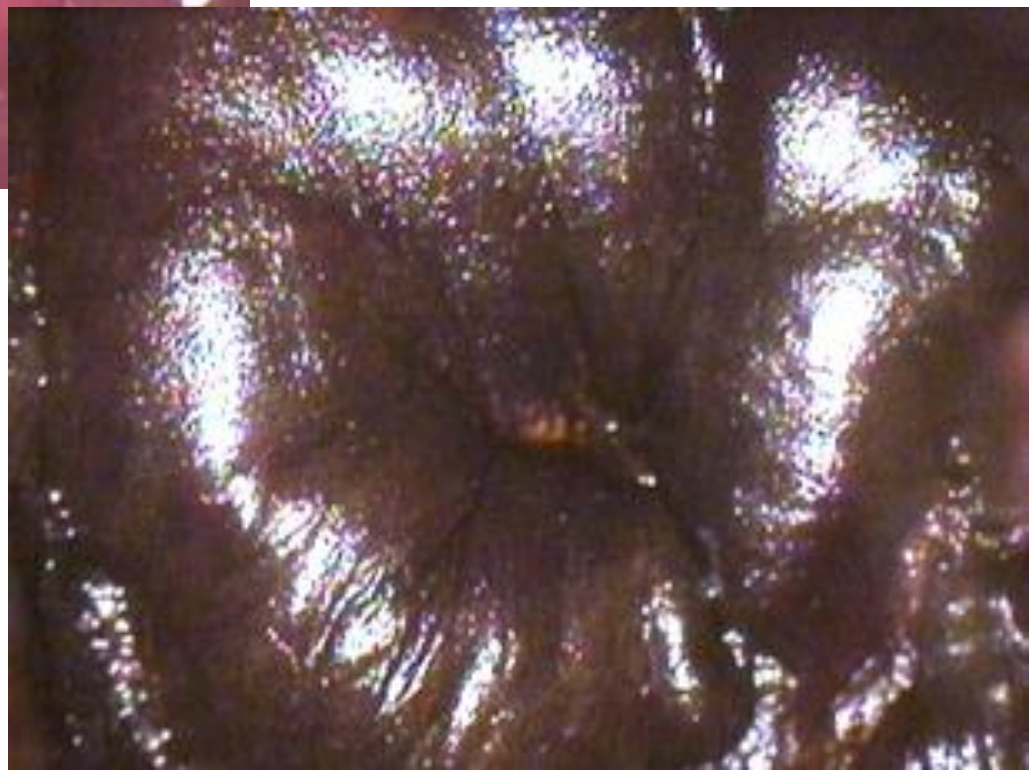
Indicação da Técnica

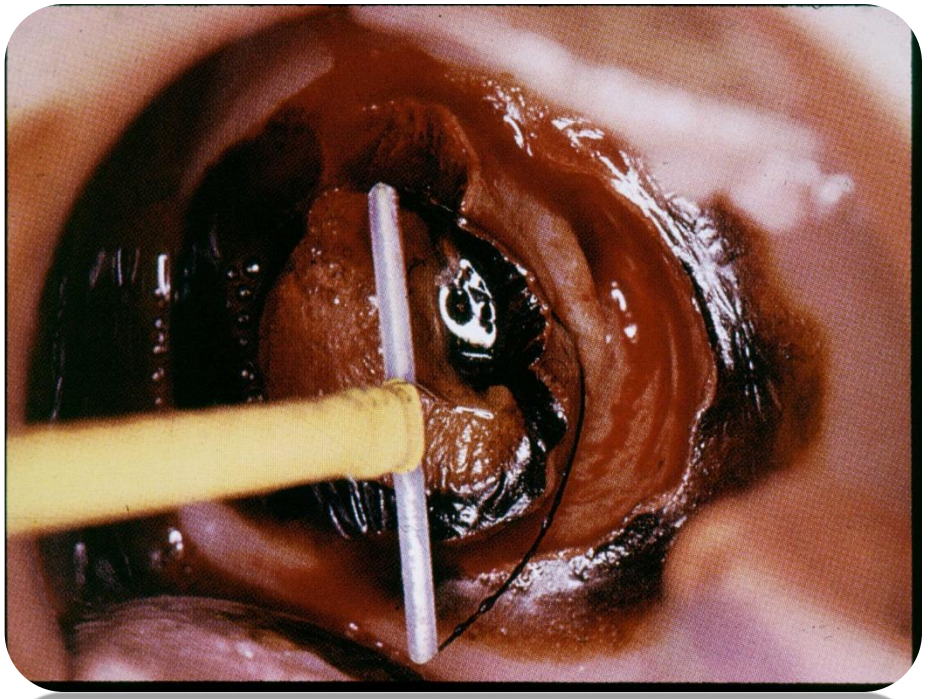
D) ***Suspeita de Microinvasão***

- ***Cirurgia de Alta Frequência***
  - *Conização*
- ***Alça de Fischer***
- ***Laser***
- ***Bisturi Frio***



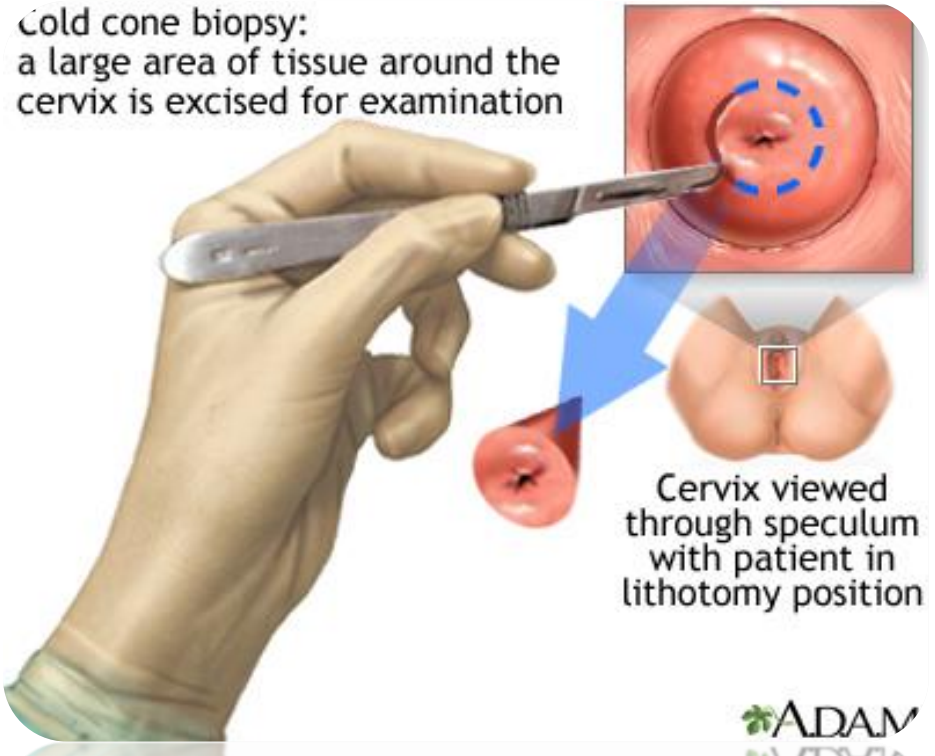






Experiência

Desejo Gestar



Prevenção Carcinoma Cervical

NIC 2/3

- **MARGEM (+)**
  - CP + Colposcopia 6/6 meses (2 anos)
    - CP Anual (5 anos)
- **MARGEM (-) NIC 1**
  - CP + Colposcopia 6/6 meses (1 ano)
    - CP Anual (5 anos)
- **Independente da Margem**
  - CP + Colposcopia após 3 meses
    - DNA HPV após 6 meses

Diretrizes Brasileiras para o Rastreamento do Câncer do Colo do Útero. Ministério da Saúde, Instituto Nacional de Câncer (INCA), Rio de Janeiro, 2011/**2014**.

PROJETO HPV

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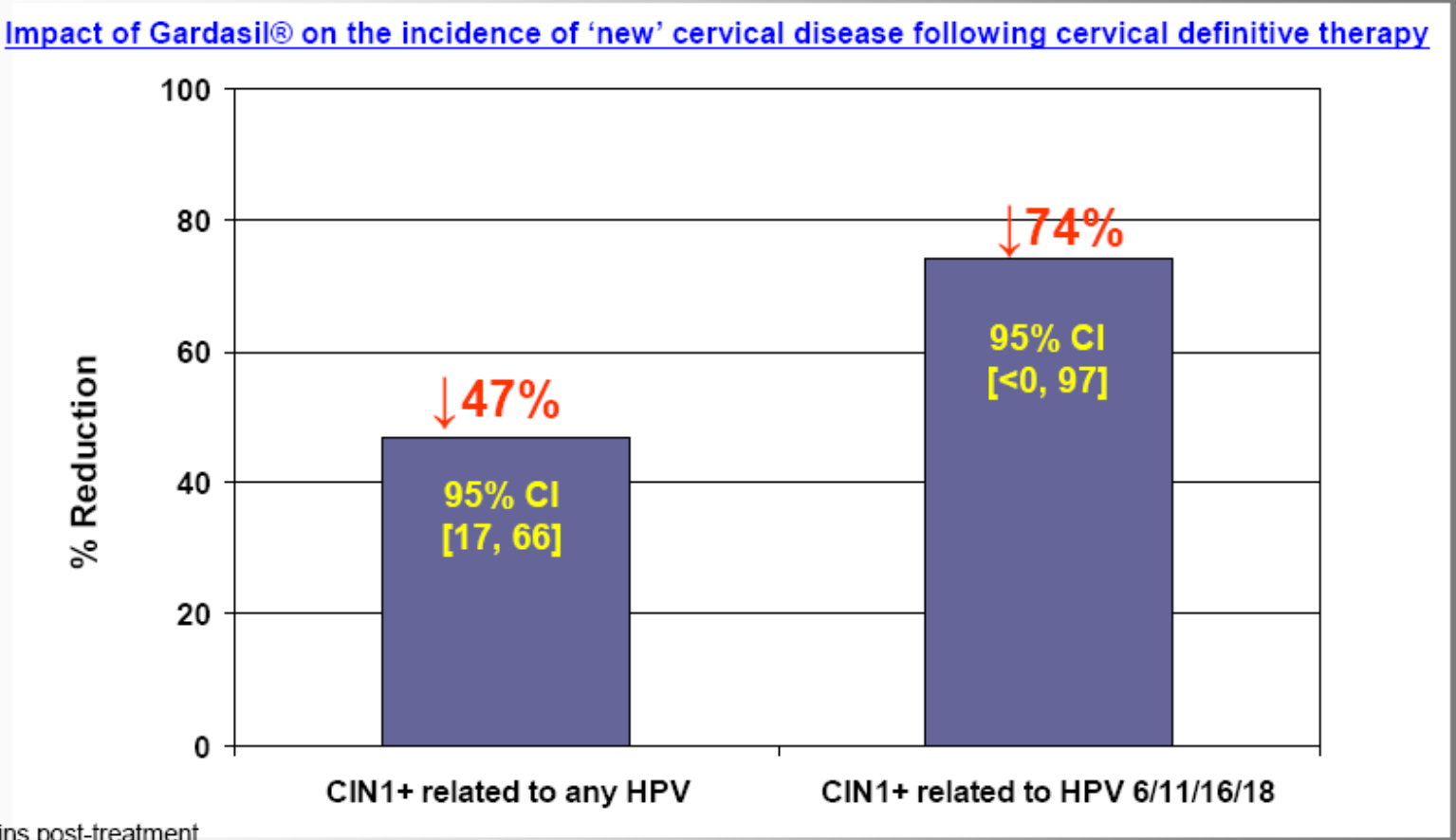
Prevenção das Recidivas

Reduction of 'new' cervical disease after cervical definitive therapy

Combined results from FUTURE I and II



Case counting begins post-treatment
Average follow-up post-treatment was ~ 2 years
Women aged 16–26 years received either Gardasil or placebo at day-1, month-2 and month-6; ITT analysis identified women who underwent surgery for
N (Gardasil) = 587, N (Placebo) = 763
Pap screening was given at day 1 and at 6-12 month intervals thereafter.

Joura E et al. Abstract presented at ESGO, Belgrade, Serbia Oct. 2009

VACINA DE HPV E USO EM MULHERES COM HISTÓRICO DE INFECÇÃO PRÉVIA OU ATUAL POR HPV [1]

RECIDIVA DE NIC 2/3 APÓS EXÉRESE DA ZT POR NIC DE ALTO GRAU
n=737

NIC 2/3 relacionada ao HPV 16 e 18

Grupo vacinado quadrivalente contra HPV	Grupo não vacinado
n=163	n=211
2,5%	8,5%
5 casos	18 casos

Recidiva de NIC 2/3 por HPV 16 e 18

P<0,05

NIC 2/3 relacionada a outros tipos de HPV

Grupo vacinado quadrivalente contra HPV	Grupo não vacinado
n=163	n=166
2,5%	5,4%
4 casos	9 casos

Recidiva de NIC 2/3 por outros tipos de HPV

P<0,257

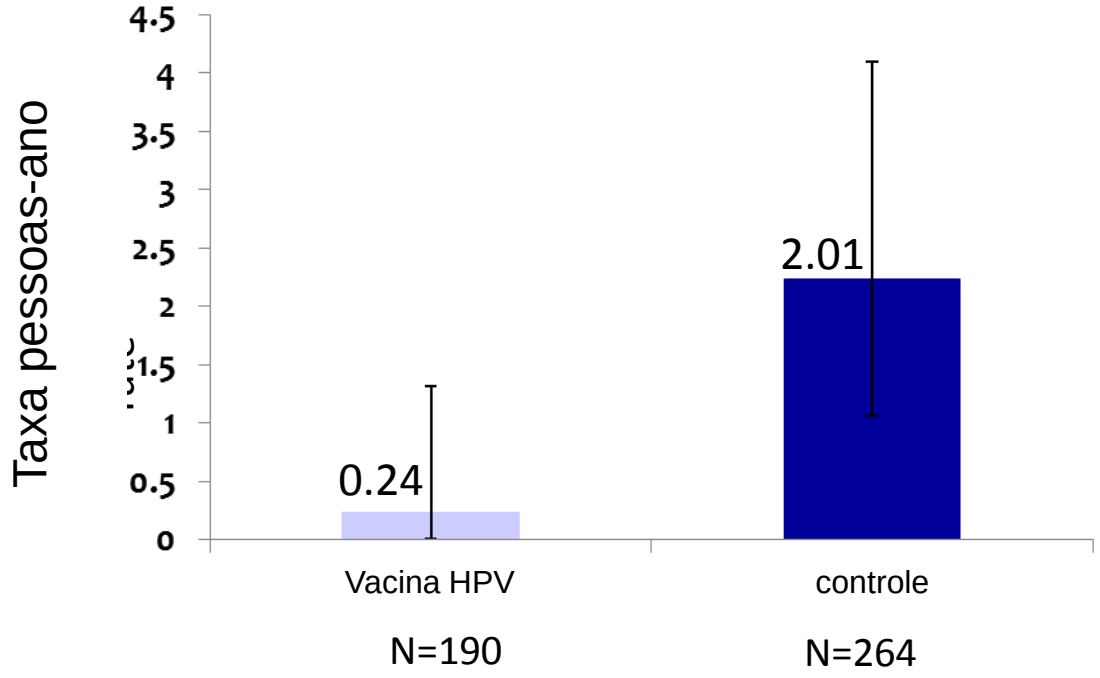
Redução de 70% de 20 a 45 anos (Coréia)

Adaptado de kang et al 2012.

1.Kang et al. Is vaccination with quadrivalent HPV vaccine after Loop Electrosurgical Excision Procedure effective in preventing recurrence in patients with High-grade Cervical Intraepithelial Neoplasia (CIN2-3)? Gynecol Oncol. 2013 Apr 25.

Taxa de incidência de NIC2+ após terapia cervical na coorte TVC do estudo PATRICIA (independente do tipo de HPV)

Taxa de incidência (por 100 pessoas-ano de seguimento) de sujeitos relatando pelo menos um evento de NIC2+ ≥60 dias após o 1º. tratamento da lesão cervical



Eficácia vacinal contra NIC2+:
88,2%
(14,8–99,7)

Numero de NIC2+	1	9

N = numero de mulheres submetidas a terapia cirúrgica; EV = eficácia vacinal; NIC = neoplasia intraepitelial cervical; TVC = coorte total vacinada

Garland et al. Eurogin 2011

Vacina de HPV
Hipótese para redução de recorrência

- Remoção da área alterada com células com DNA de HPV integrado[1,2]
- Células infectadas pelo HPV na forma episssomal, liberaram partículas capazes de infectar novas células[1,2].
- Os anticorpos gerados pela vacina de HPV evitariam à reinfecção[1,2]

Pode não prevenir todas as recorrências:

- presença de células residuais com DNA de HPV integrado[1,2],
- infecção simultânea por tipos de HPV não incluídos na vacina[1,2]

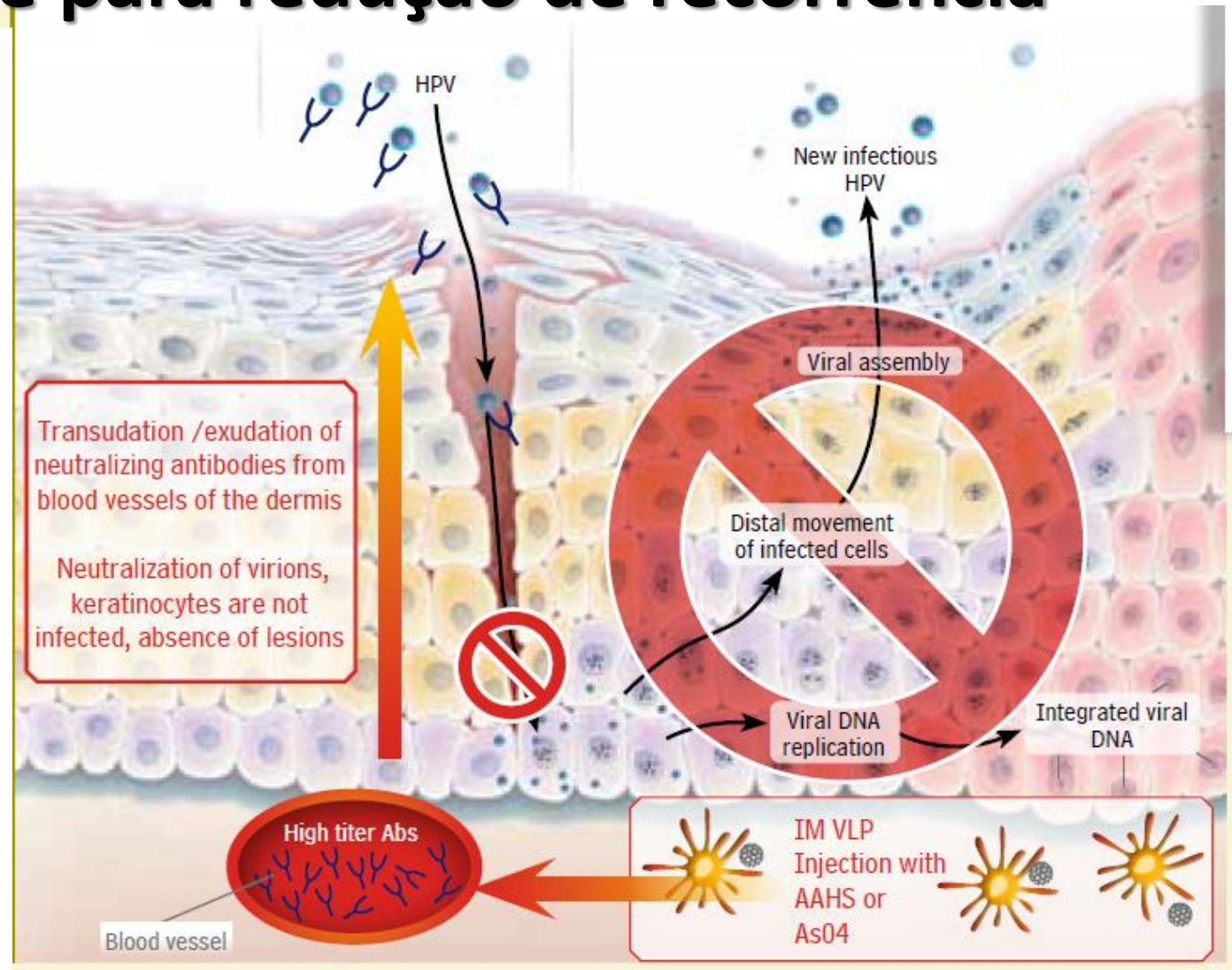


Imagem reproduzida do HPV Today n26

Joura EA, et al. BMJ. 2012;344:e1401. Swedish KA, et alClin Infect Dis. 2012;54(7):891-8.

Vacina Anti-HPV

"Vacina Anti-HPV pode prevenir a recorrência ou reativação da doença HPV induzida"

Olsson SE. Quadrivalent HPV 6/11/16/18 Vaccine Efficacy against Cervical and External Genital Disease in Subjects with prior Vaccine HPV type Infection. EUROGIN 2008;SS 1-3; Olsson et al. Human Vaccines 2009, 5:10, 696-704.

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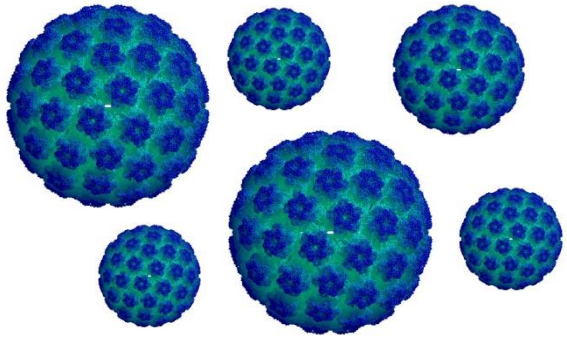
3º Encontro de Experts em HPV



Florianópolis, 20 a 22 de Agosto de 2015

Hotel Quinta da Bica D'Água

Informações: (48) 3233-6798 / 3721-9082