



**VII CONGRESSO CATARINENSE  
DE OBSTETRÍCIA E GINECOLOGIA**  
II Congresso Catarinense de Perinatologia

25 a 27 de junho de 2015 | Expoville | Joinville | SC

**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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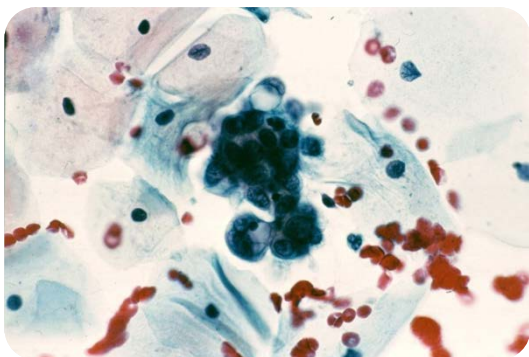


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## Lesões do Colo Uterino

- Alto Grau -



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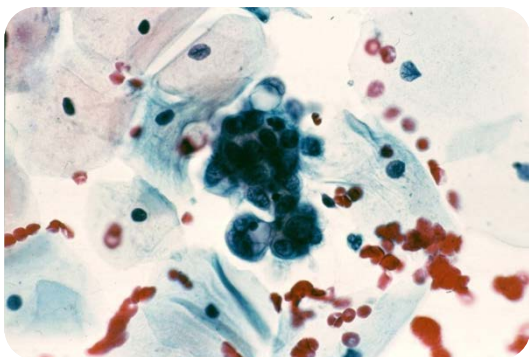


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## Lesões do Colo Uterino

- Alto Grau -



Potencial Conflito de Interesse

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

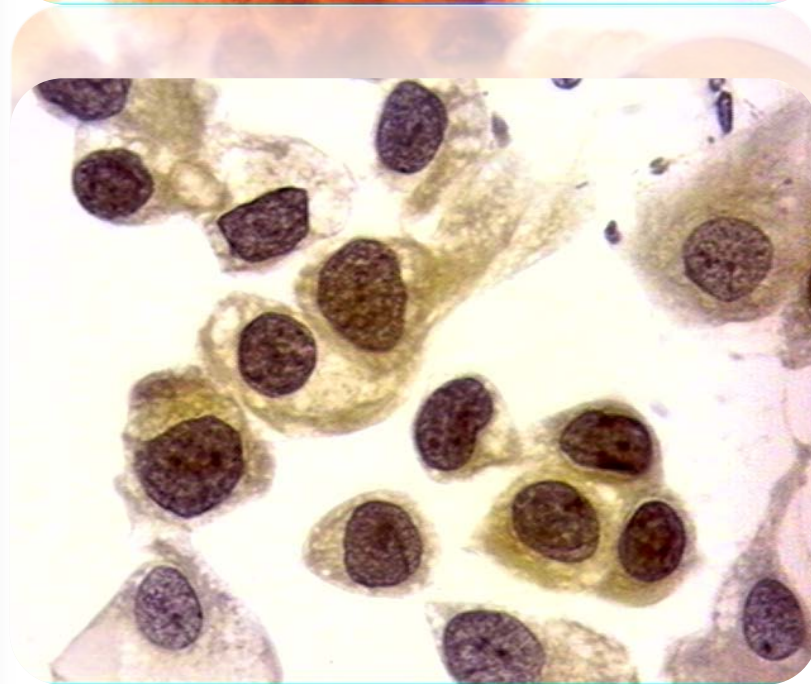
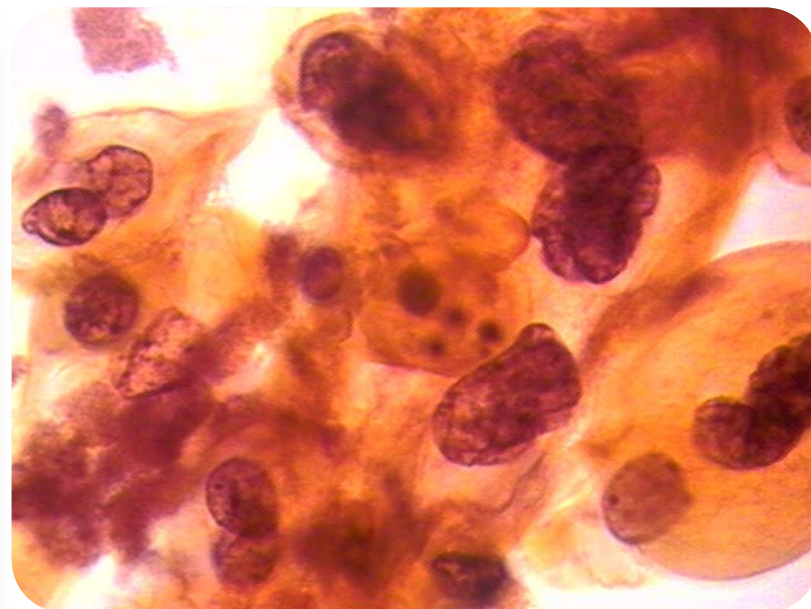
**Pesquisador dos Ensaios Clínicos da Vacina Quadrivalente e  
Nonavalente Anti-HPV**



# **Diretrizes Brasileiras para o Rastreamento do Câncer do Colo do Útero**

**2011**

Ministério da Saúde  
Instituto Nacional de Câncer



# PROJETO HPV

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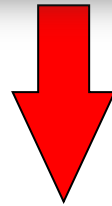
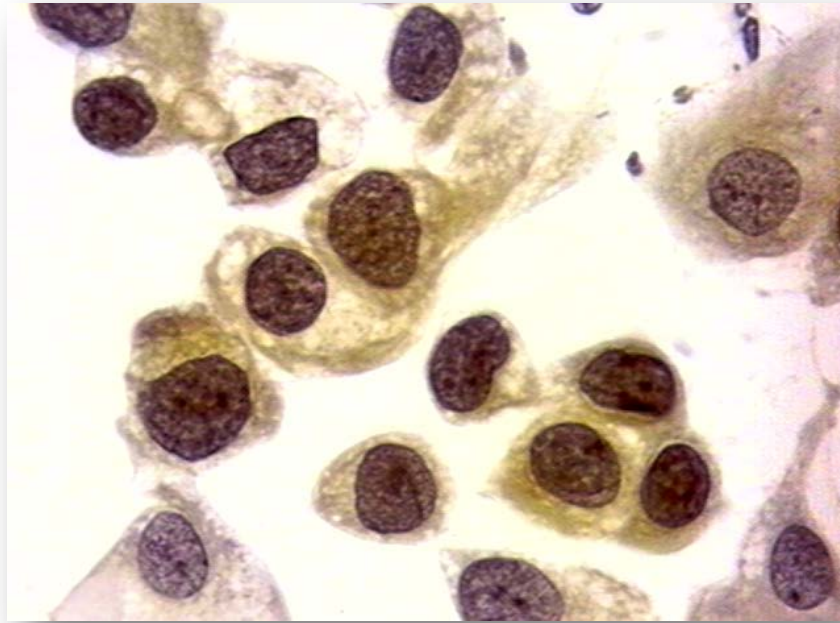


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## **Lesão Intraepitelial Escamosa de Alto Grau - LIEAG**

*“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”*

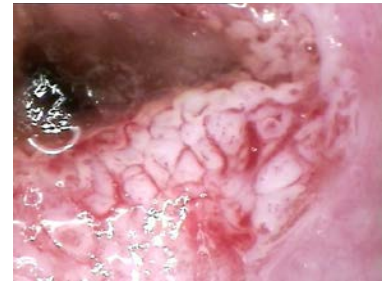
# Conduta nas LIEAG



**Colposcopia**



# Manejo das HSIL

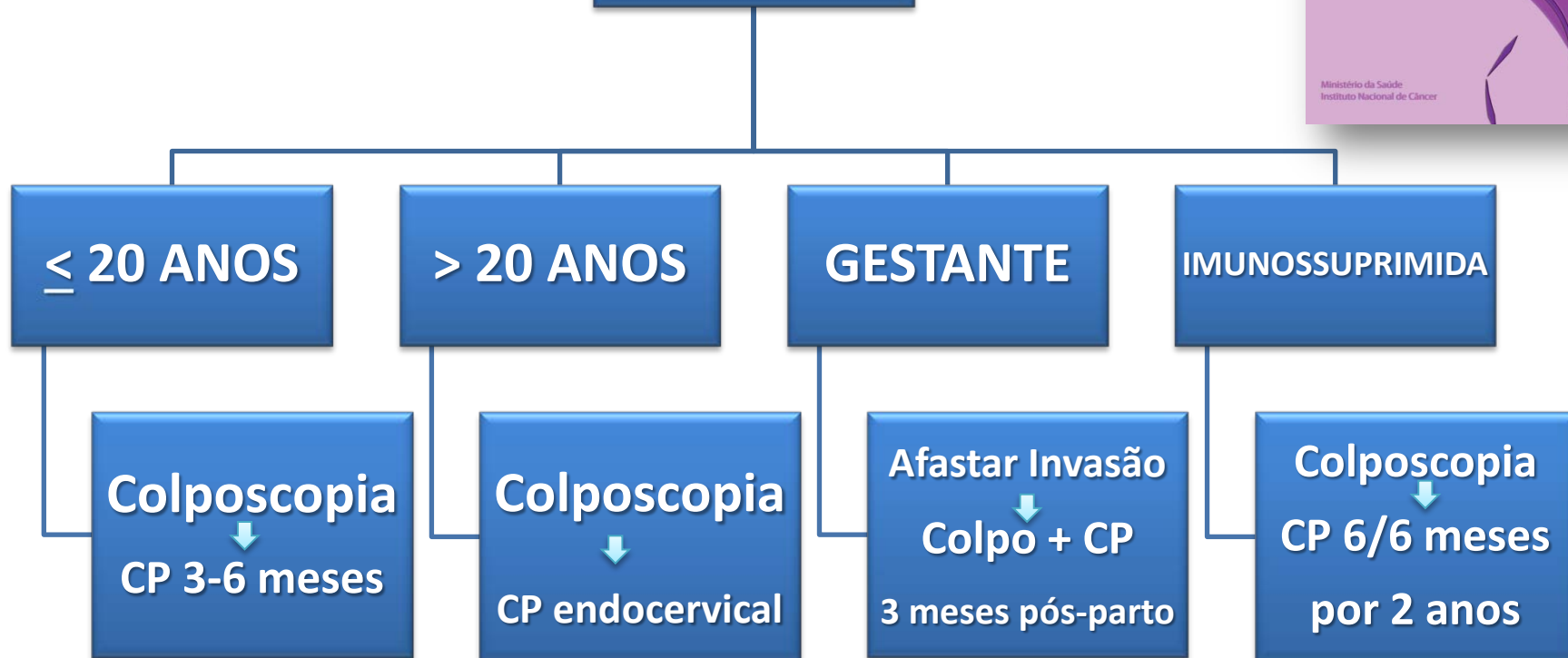


**“ Cerca de 70-75% das mulheres com diagnóstico de Lesão Intraepitelial de Alto Grau à citologia, apresentam confirmação do diagnóstico à histopatologia e 1-2% terão um carcinoma invasor “**

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

# Prevenção Carcinoma Cervical

## HSIL



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**

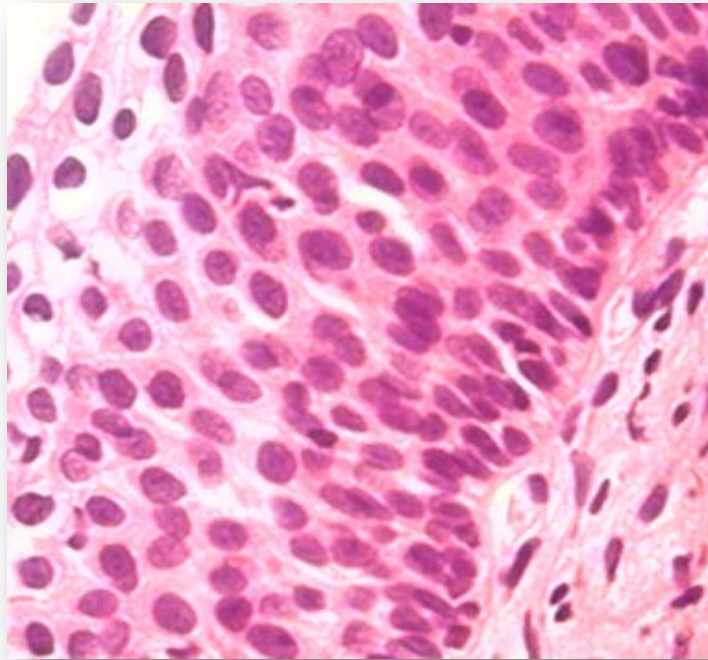
Diretrizes  
Brasileiras  
para o  
Rastreamento  
do Câncer  
do Colo do Útero

Ministério da Saúde  
Instituto Nacional de Câncer

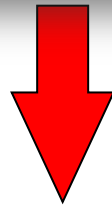


Diretrizes Brasileiras para o Rastreamento do Câncer do Colo do Útero. Ministério da Saúde, Instituto Nacional de Câncer (INCA), Rio de Janeiro, 2011/**2014**.

# 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% “*

# *História Natural das NIC*

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

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

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.<sup>1</sup> 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.<sup>2</sup>

## 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.<sup>3-5</sup> 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

<sup>1</sup>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; <sup>2</sup>Senior Investigator, Division of Cancer Prevention, National Cancer Institute, National Institutes of Health, Rockville, MD, on behalf of the Steering Committee; <sup>3</sup>Adjunct Associate Professor, Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, GA, on behalf of the Data Group; <sup>4</sup>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; <sup>5</sup>Assistant Professor, Division of Epidemiology and Community Health, University of Minnesota, Minneapolis, MN, on behalf of Working Group 1; <sup>6</sup>Professor and Vice Chair, Department of Obstetrics and Gynecology, University of Massachusetts School of Medicine, Worcester, MA, on behalf of Working Group 2; <sup>7</sup>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; <sup>8</sup>Director, Department of Esoteric Testing, AmeriPath Indiana, Indianapolis, IN, on behalf of Working Group 6; <sup>9</sup>Professor, Department of Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque, NM, on behalf of Working Group 3a; <sup>10</sup>Professor of Pathology, Department of Pathology, Massachusetts General Hospital, Harvard Medical School, Boston, MA, on behalf of Working Group 3b; <sup>11</sup>Investigator, Division of Cancer Epidemiology and Genetics, National Cancer Institute, National Institutes of Health, Rockville, MD; <sup>12</sup>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; <sup>13</sup>Professor of Clinical Obstetrics and Gynecology, Weill Medical College of Cornell University, New York, NY, on behalf of Working Group 4; <sup>14</sup>Professor, Department of Pediatrics, University of California at San Francisco, San Francisco, CA, on behalf of Working Group 5; <sup>15</sup>Professor, Departments of Oncology and Epidemiology, McGill University, Montreal, Quebec, Canada; <sup>16</sup>Professor of Pathology and Clinical Gynecology, Associate Director of Surgical and Cytopathology, Surgical Pathology, Department of Pathology, University of Virginia Health System, Charlottesville, VA; <sup>17</sup>Senior Investigator, Clinical Genetics Branch, Division of Cancer Epidemiology and Genetics, National Cancer Institute, National Institutes of Health, Bethesda, MD; <sup>18</sup>Executive Director, American Society for Clinical Pathology Institute, Washington, DC, on behalf of the Writing Committee; <sup>19</sup>Professor, Department of Obstetrics and Gynecology, Duke University Medical Center, Durham, NC; <sup>20</sup>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.

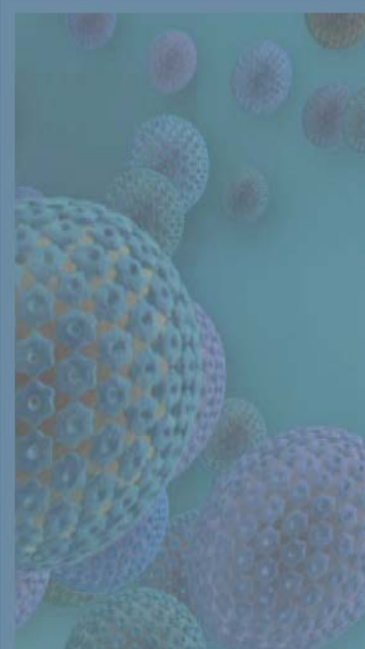
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August • août 2007

Supplement 3 • supplément 3



## 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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## 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 $\geq$ 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)

## 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

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](mailto: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.

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. ■

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

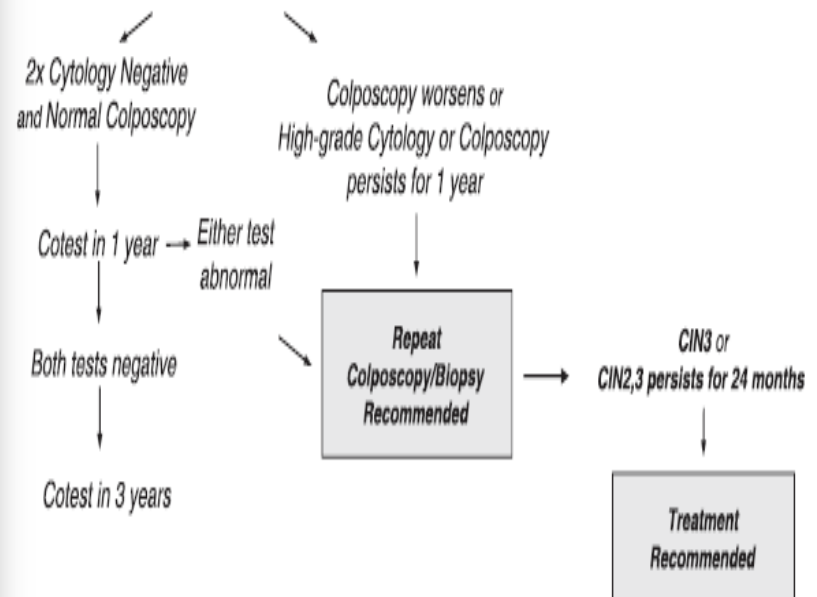
Young Women with CIN2,3

*Either treatment or observation is acceptable, provided colposcopy is adequate. When CIN2 is specified, observation is preferred. When CIN3 is specified, or colposcopy is inadequate, treatment is preferred.*

**Observation - Colposcopy & Cytology**

@ 6 month intervals for 12 months

**Treatment using Excision  
or Ablation of T-zone**



# 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*

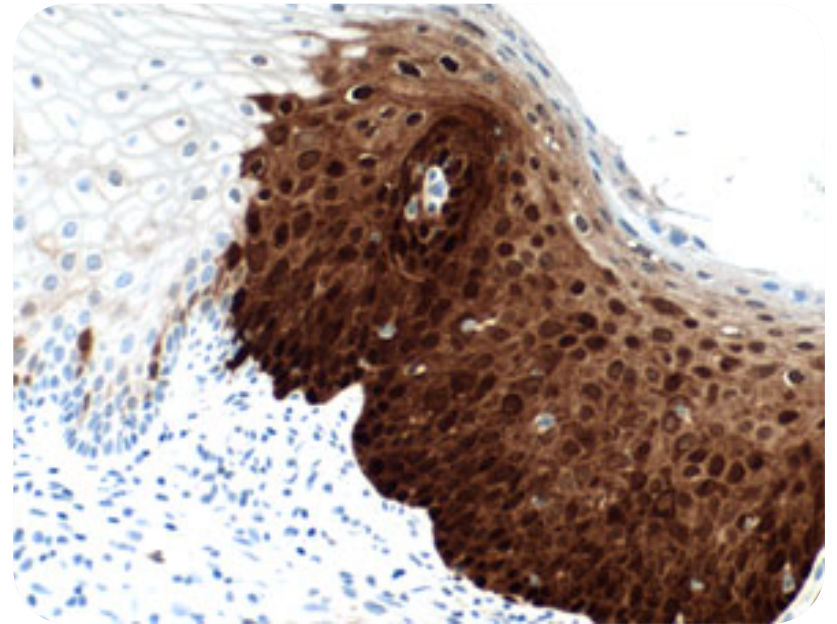
★ *PCNA e Ki-67*

➔ ★ *p16*

★ *Tipo / Variante HPV*

★ *E6 e E7 RNAm*

★ *Mcm e cdc6*



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.

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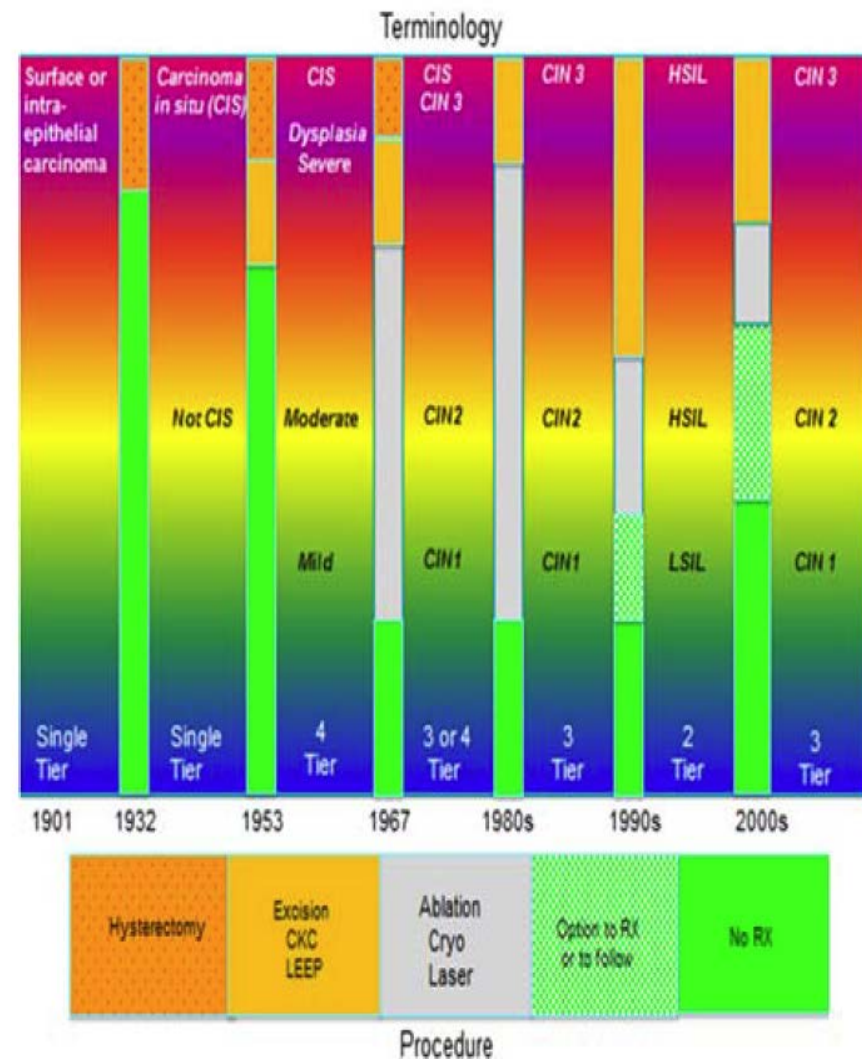
Disclosure: ASCCP and the CAP provided the funding for this project; no industry funds were used in the development of the consensus statements and recommendations.

The authors declare no conflict of interest.

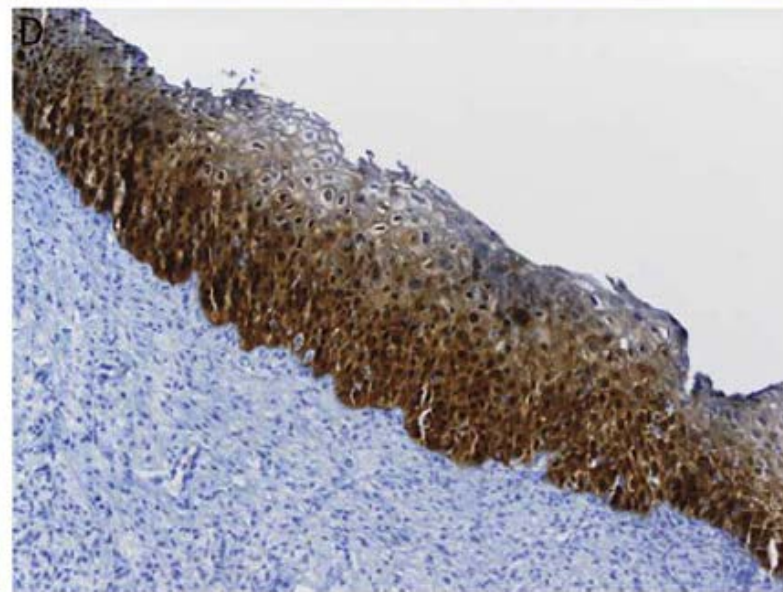
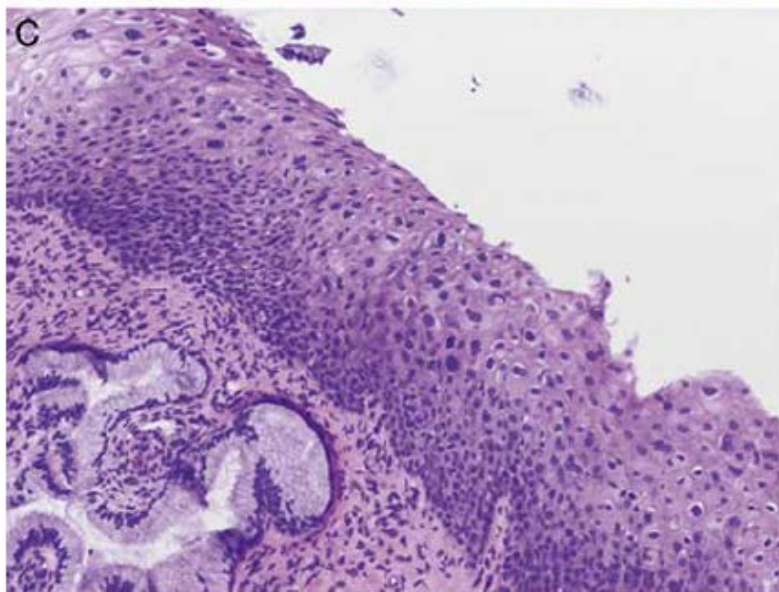
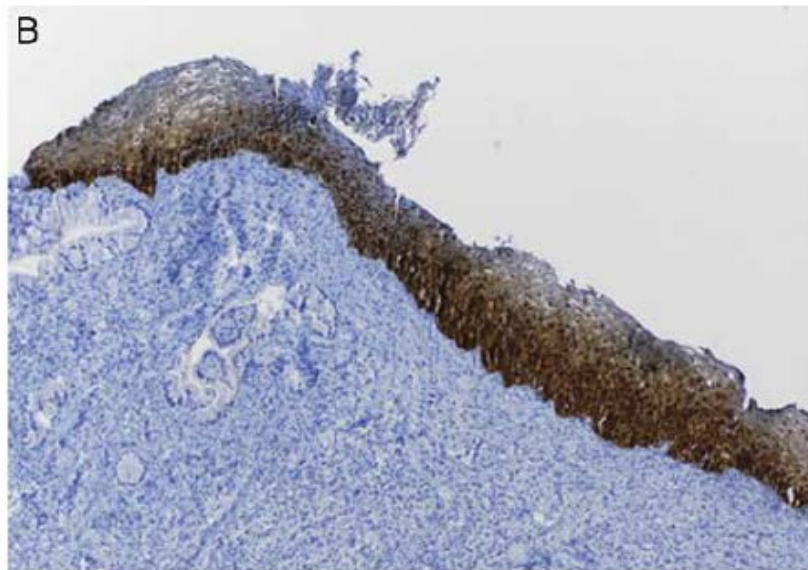
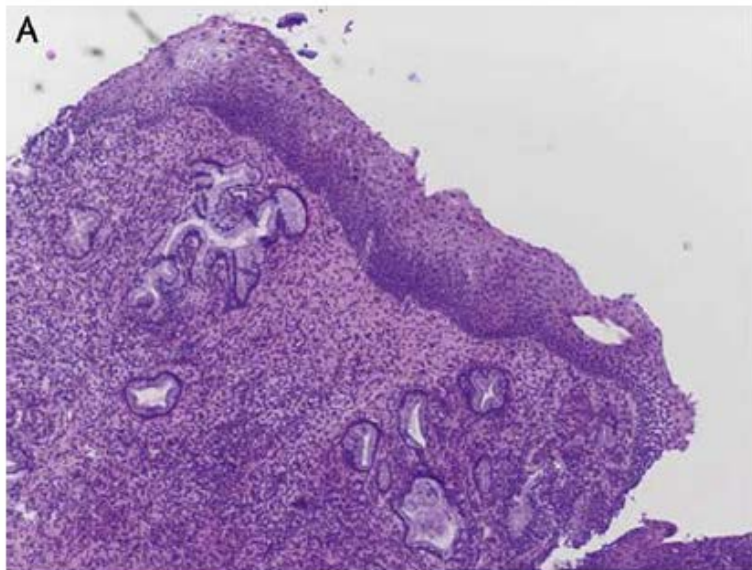
**Précis:** The CAP-ASCCP LAST project provides recommendations for a unified terminology for HPV-associated squamous intraepithelial lesions and superficially invasive squamous carcinomas of the lower anogenital tract.

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Supplemental Digital Content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Website, [www.intjgynpathology.com](http://www.intjgynpathology.com).



**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 parabasaloid 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

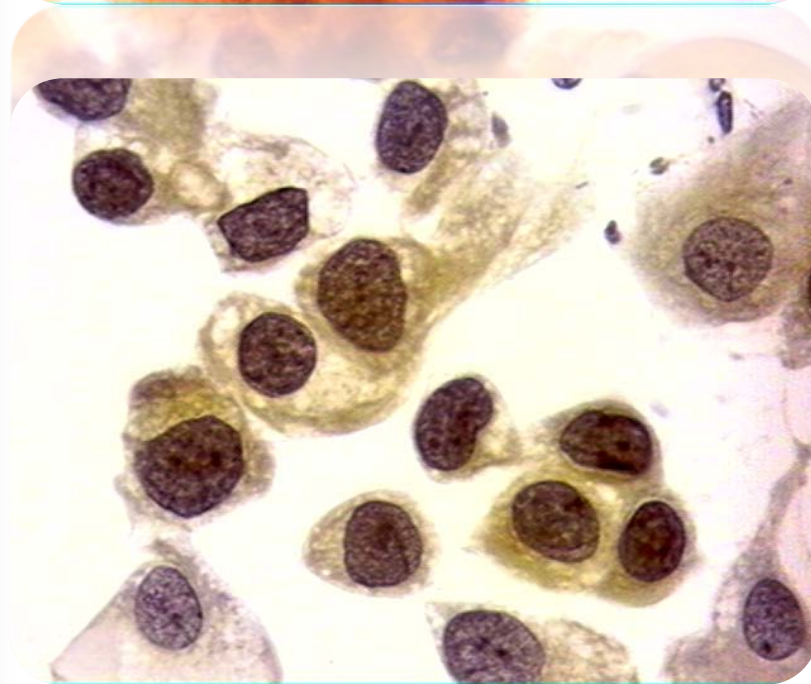
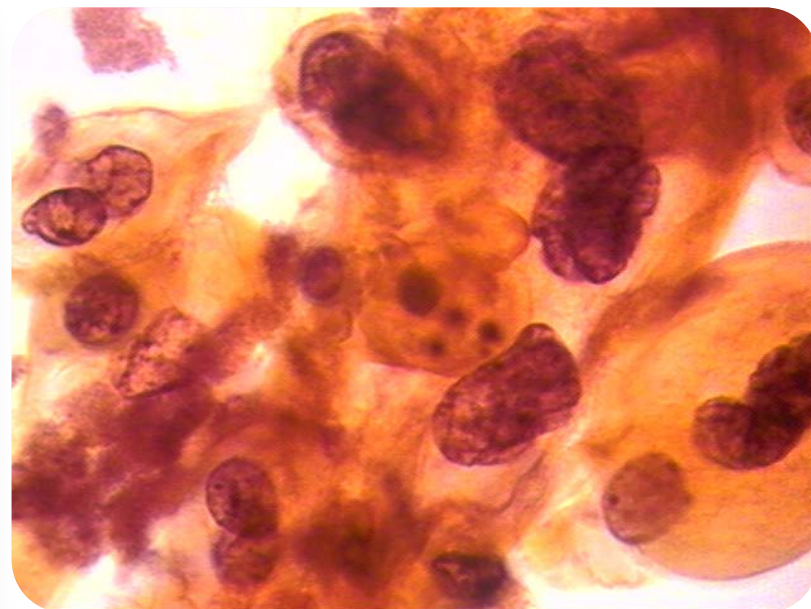
Clinical Management



# **Diretrizes Brasileiras para o Rastreamento do Câncer do Colo do Útero**

**2011**

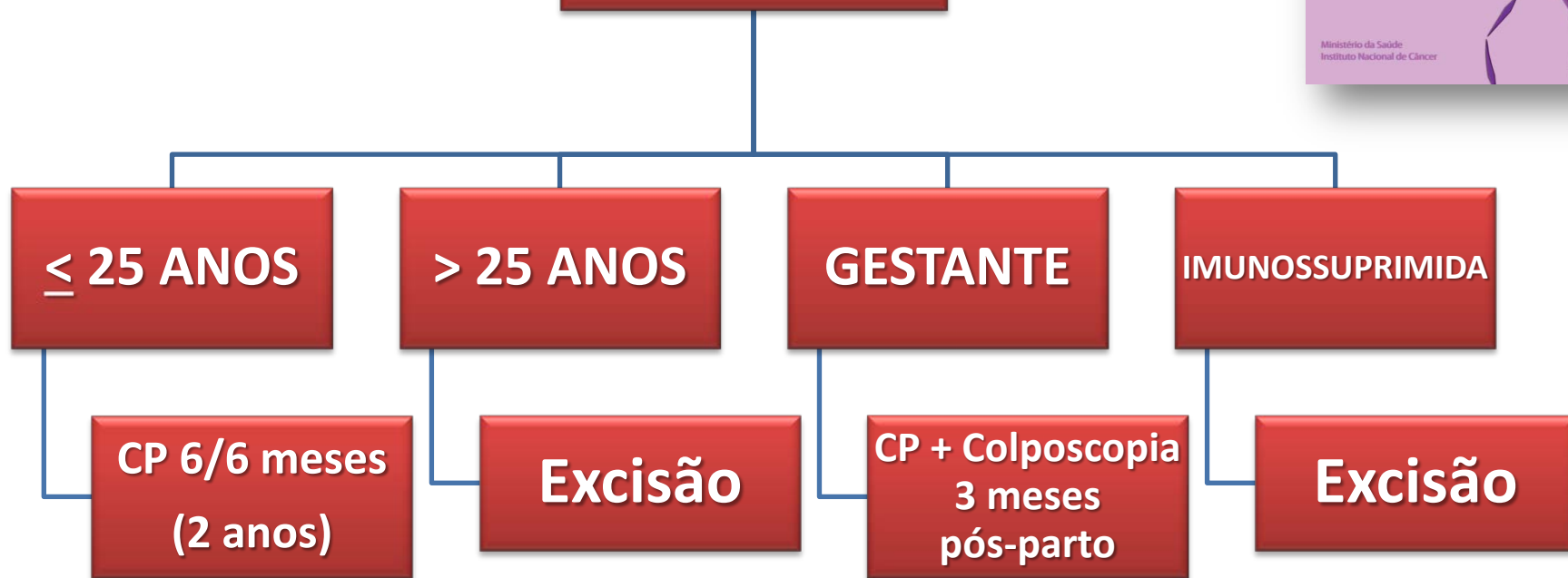
Ministério da Saúde  
Instituto Nacional de Câncer



# Prevenção Carcinoma Cervical



**NIC 2/3**



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 Frequência

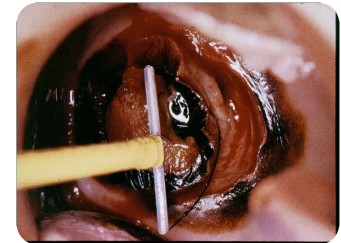
**(LEEP – Loop Electrosurgical Excisional Procedure)**

***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***

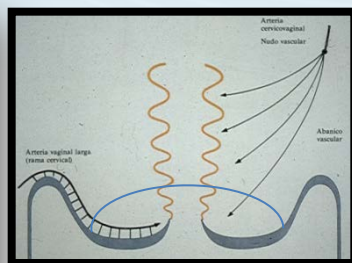
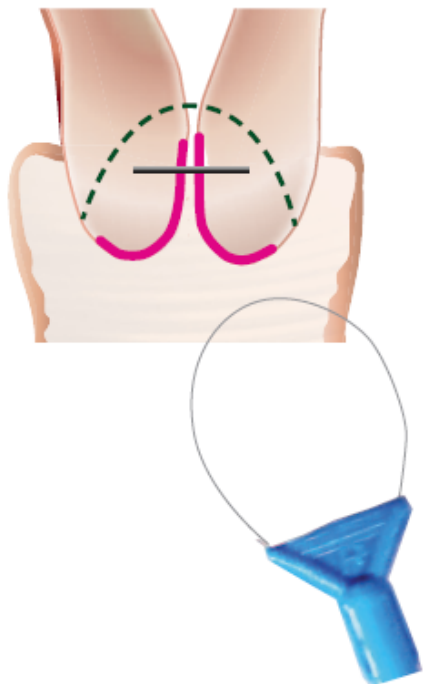
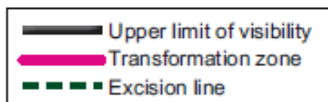
# PROJETO HPV

Centro de Pesquisa Clínica

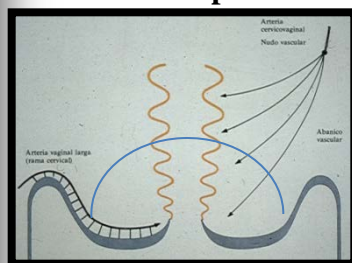
Universidade Federal de Santa Catarina • Hospital Universitário



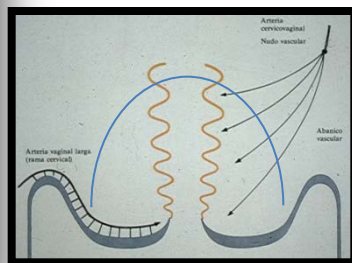
[www.projeto HPV.com.br](http://www.projeto HPV.com.br)



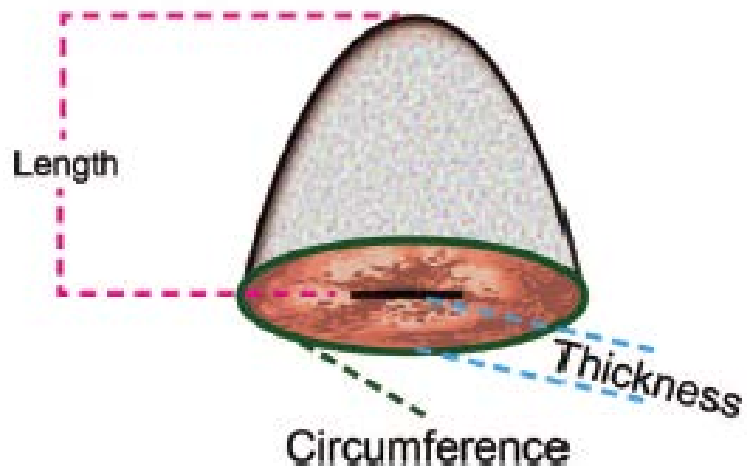
**EZT Tipo 1**



**EZT Tipo 2**



**EZT Tipo 3**



# PROJETO HPV

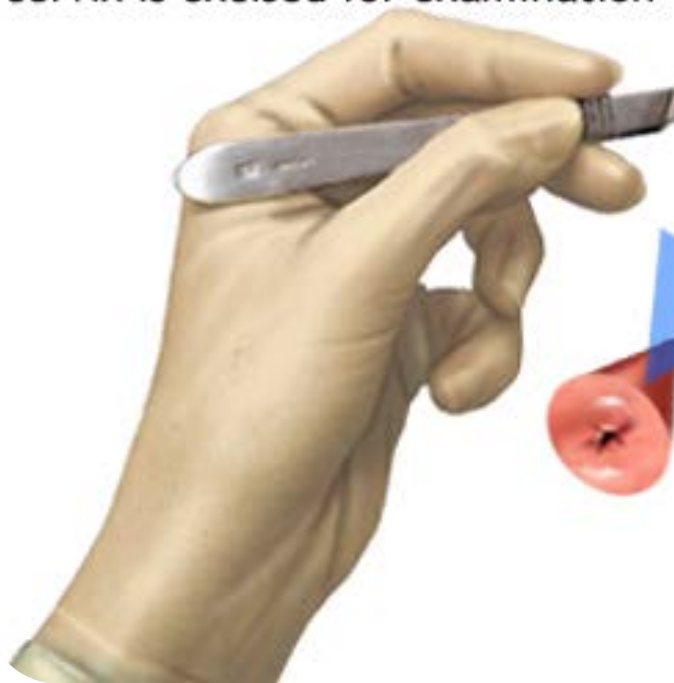
Centro de Pesquisa Clínica

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[www.projeto HPV.com.br](http://www.projeto HPV.com.br)

**Cold cone biopsy:**  
a large area of tissue around the  
cervix is excised for examination



Cervix viewed  
through speculum  
with patient in  
lithotomy position

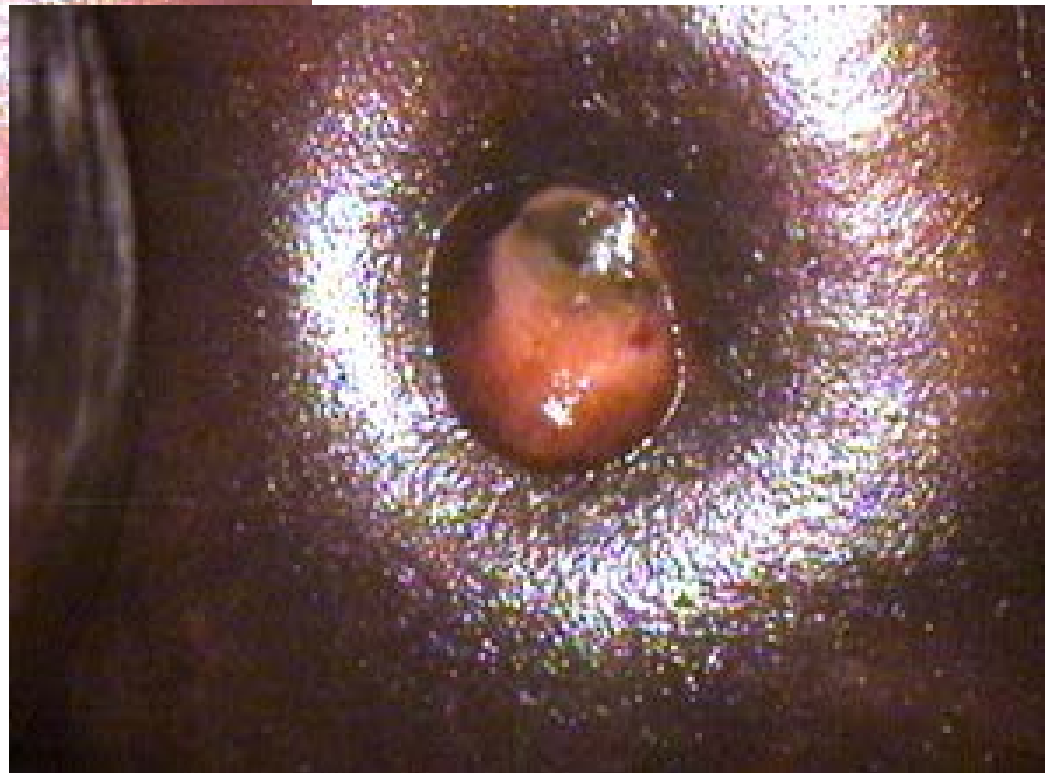
# CAF x CONE

## *Indicação da Técnica*

### *A) Lesão Totalmente Visível*

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





# CAF x CONE

## *Indicação da Técnica*

### *B) Lesão Parcialmente Visível*

- *Cirurgia de Alta Frequência*

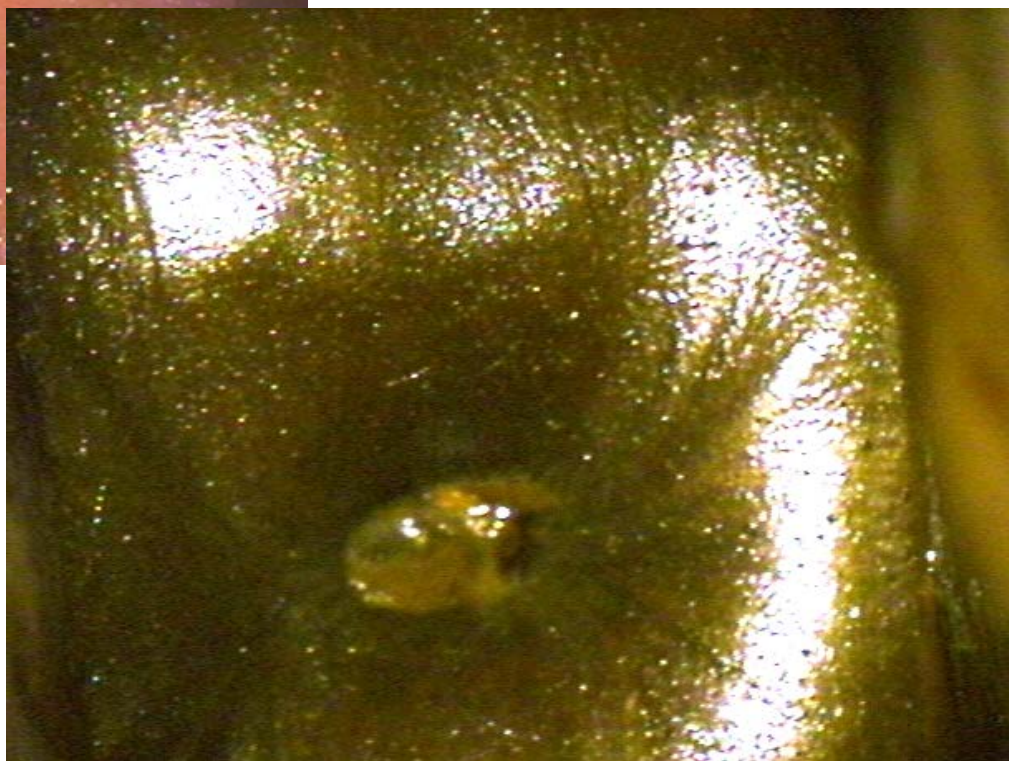
- *Conização*

- *Alça de Fischer*

- *Laser*

- *Bisturi Frio*



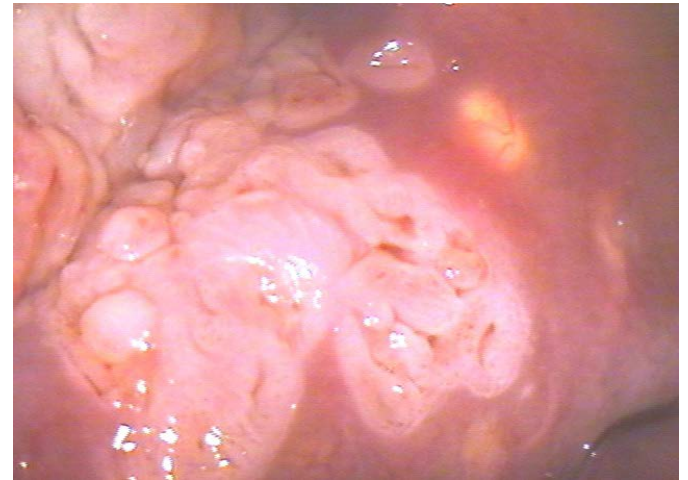


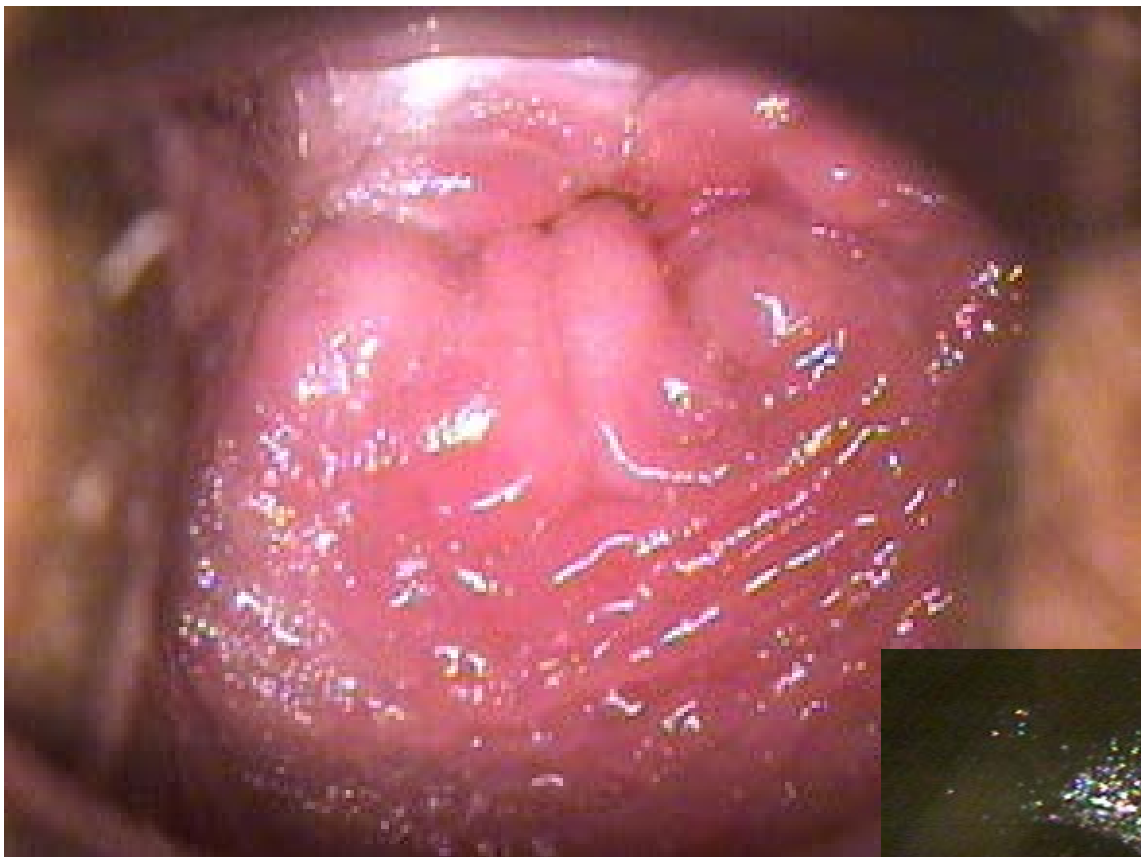
# *CAF x CONE*

## *Indicação da Técnica*

### *C) Adenocarcinoma “in situ”*

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



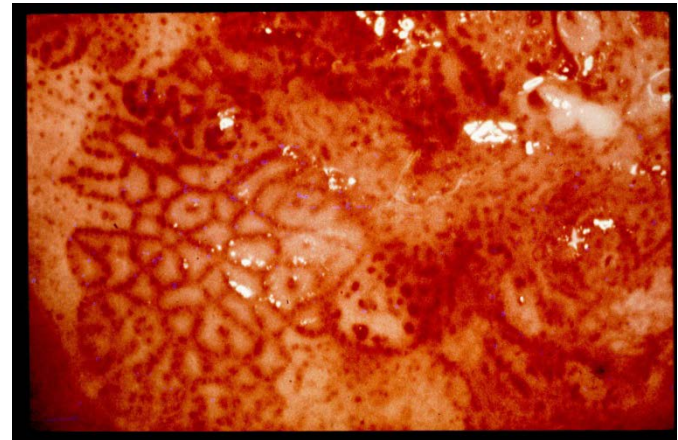


# CAF x CONE

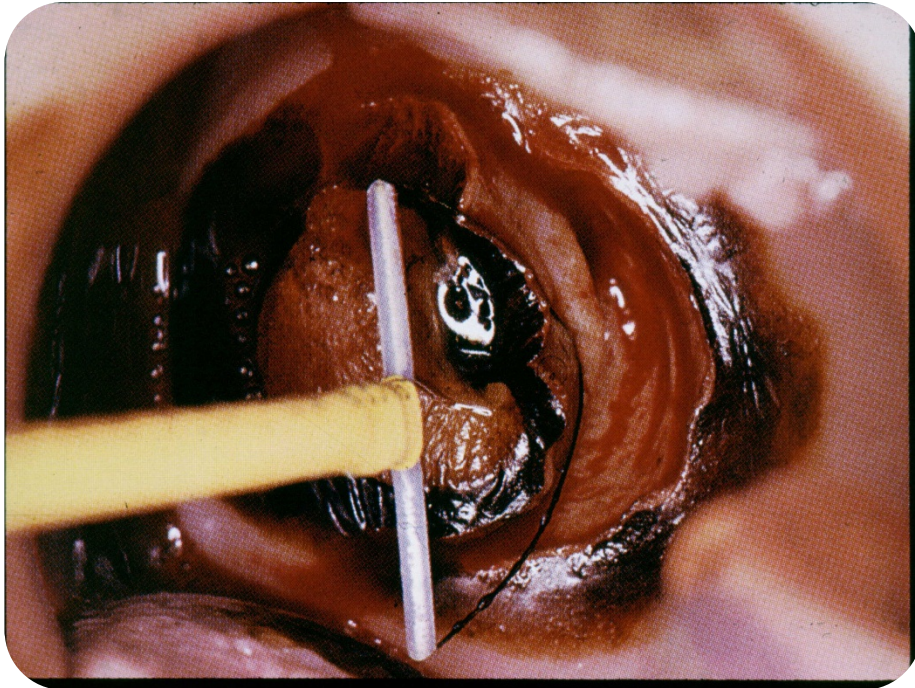
## *Indicação da Técnica*

### *D) Suspeita de Microinvasão*

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

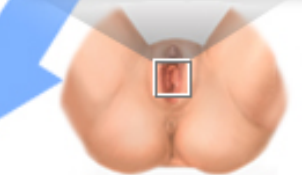
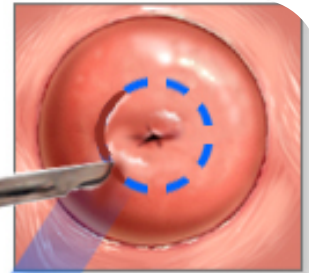






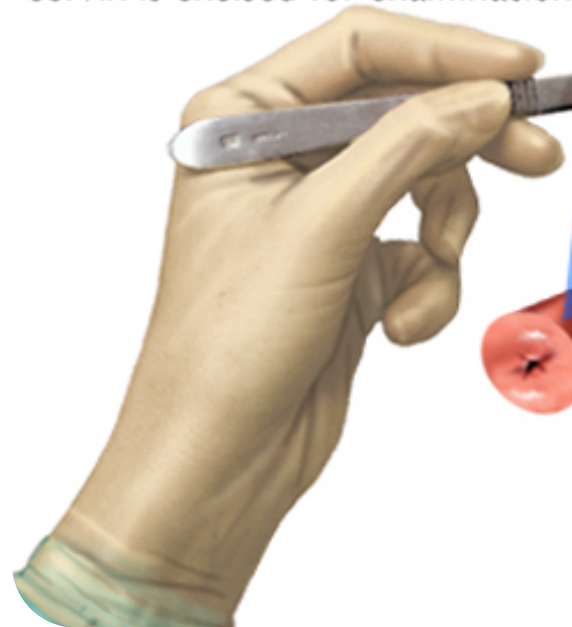
# Experiência

Cold cone biopsy:  
a large area of tissue around the  
cervix is excised for examination



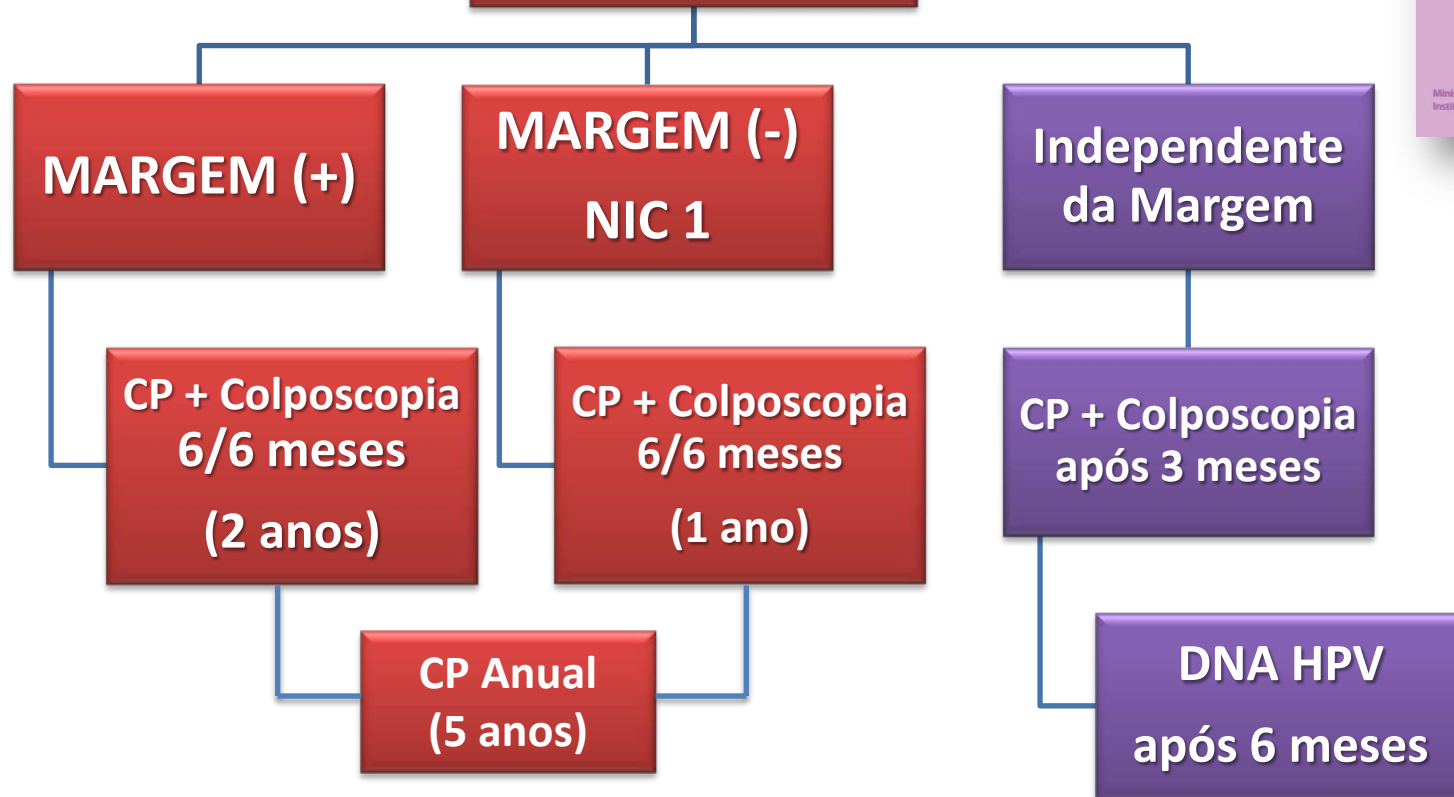
Cervix viewed  
through speculum  
with patient in  
lithotomy position

# Desejo Gestar



# Prevenção Carcinoma Cervical

**NIC 2/3**



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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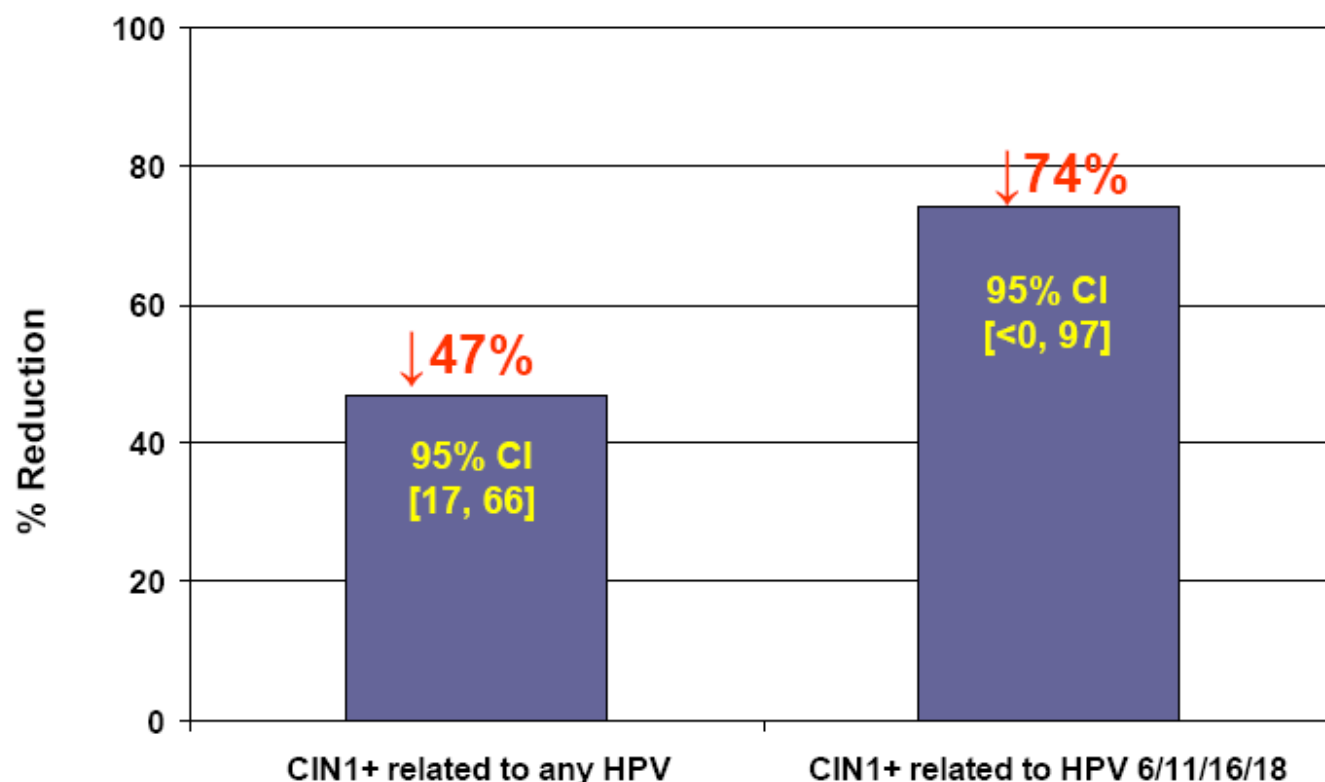


## Prevenção das Recidivas

# Reduction of 'new' cervical disease after cervical definitive therapy

Combined results from FUTURE I and II

Impact of Gardasil® on the incidence of 'new' cervical disease following cervical definitive therapy



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.

# VACINA DE HPV E USO EM MULHERES COM HISTÓRICO DE INFECÇÃO PRÉVIA OU ATUAL POR HPV <sup>1</sup>

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  
n=163

Grupo não  
vacinado  
n=211

NIC 2/3 relacionada a outros  
tipos de HPV

Grupo vacinado  
quadrivalente  
contra HPV  
n=163

Grupo não  
vacinado  
n=166

Recidiva de NIC 2/3 por HPV 16 e 18

2,5%

5 casos

8,5%

18 casos

P<0,05

**Redução de 70%**

Recidiva de NIC 2/3 por outros tipos de HPV

2,5%

4 casos

5,4%

9 casos

P<0,257

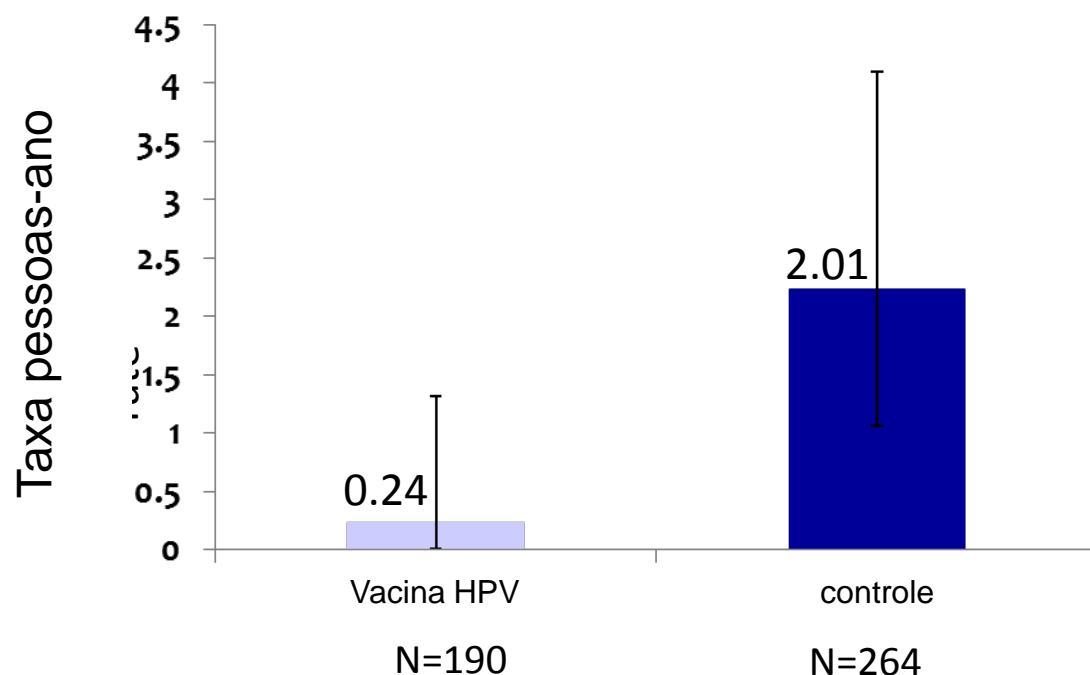
‡ de 20 a 45 anos (Coréia)

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+  $\geq 60$  dias após o 1º. tratamento da lesão cervical



Numero de NIC2+

1

9

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

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<sup>1,2</sup>
  - Células infectadas pelo HPV na forma epissomal, liberaram partículas capazes de infectar novas células<sup>1,2</sup>.
  - Os anticorpos gerados pela vacina de HPV evitariam a reinfeção<sup>1,2</sup>
- Pode não prevenir todas as recorrências:
- presença de células residuais com DNA de HPV integrado<sup>1,2</sup>,
  - infecção simultânea por tipos de HPV não incluídos na vacina<sup>1,2</sup>

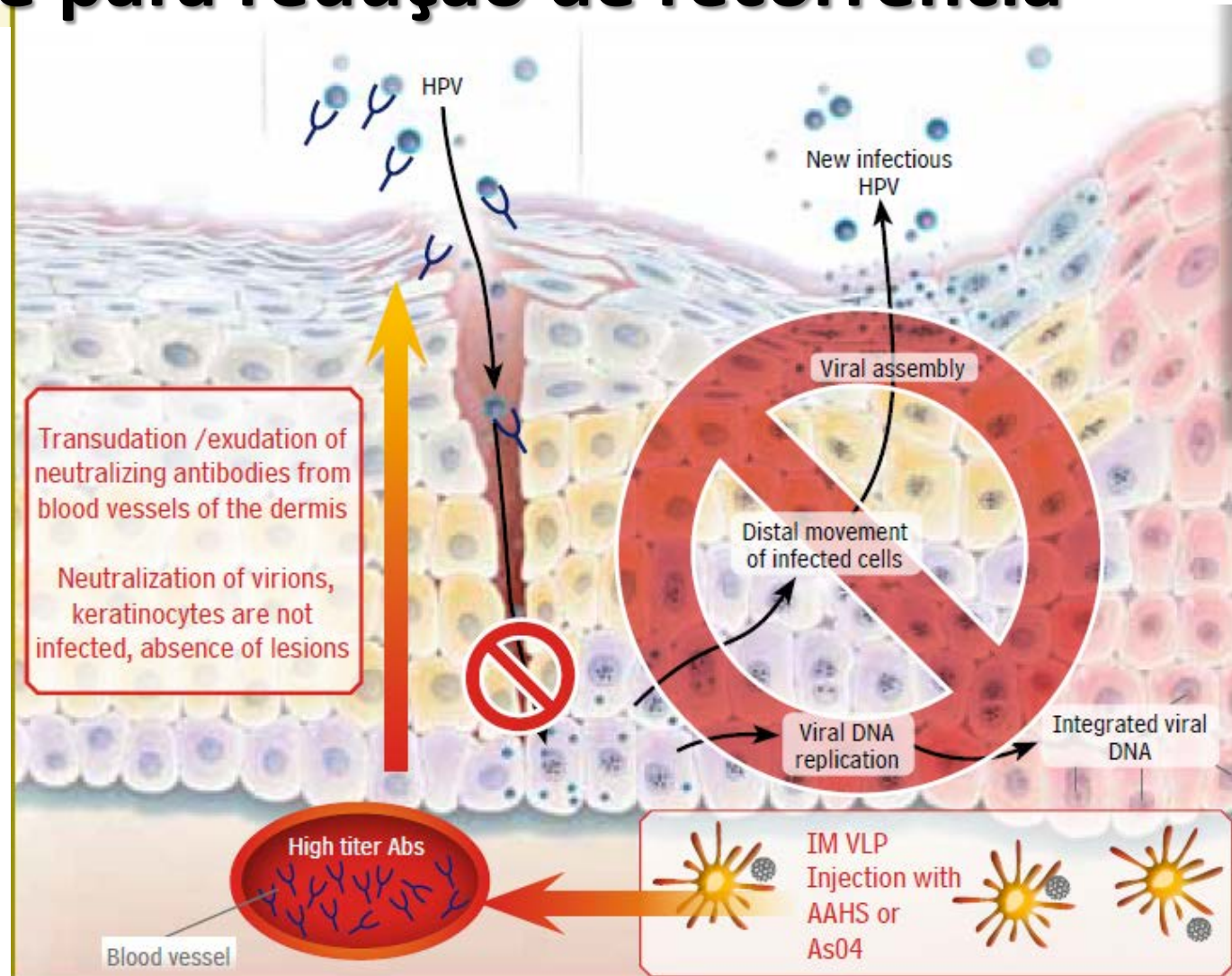


Imagem reproduzida do HPV Today n26

# *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.*

# PROJETO HPV

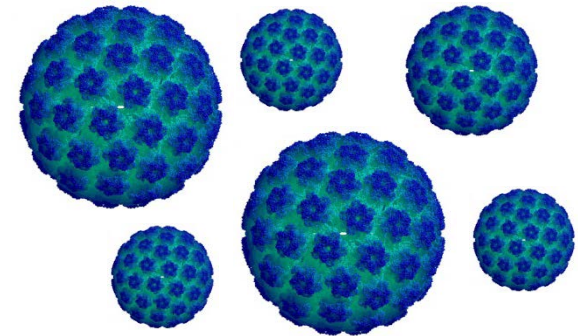
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[www.projeto HPV.com.br](http://www.projeto HPV.com.br)

## 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

