Managing low-grade cervical lesions

The optimal management of patients with low-grade squamous intraepithelial lesions (LSIL), many of whom have transient human papillomavirus (HPV) infections, is controversial. We applaud Susie Lau and Eduardo Franco for tackling this difficult issue.[1] However, we are concerned that Canadian practitioners will interpret their commentary and its algorithm as an endorsed guideline. Clinical practice guidelines should be based on thorough review of the evidence, expert review by a wide variety of stakeholders and practitioner feedback. Furthermore, recommendations should be clear, straightforward and clinically applicable. We believe their algorithm is unlikely to be accepted into clinical practice because of its complexity and its reliance on obtaining an accurate date of sexual debut.

The authors quote US guidelines[2] for cervical abnormalities but fail to recognize other consensus guidelines in Canada and abroad. The report of the Pan-Canadian Forum on Cervical Cancer Prevention and Control[3] was based on a consensus process that included a wide variety of stakeholders. That report did not provide specific guidelines for the management of LSIL, but recommended that a national consensus management algorithm be developed. Currently, the Cervical Cancer Prevention and Control Network, supported by the Public Health Agency of Canada, is developing strategies to achieve those recommendations.

A revised set of Ontario-based guidelines was recently released;[4] optimal management of women with LSIL was one of the most contentious issues. In the end, the review panel concluded that for the present there is insufficient evidence to recommend different management strategies for LSIL based on a specific patient age.

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In their article on management of LSIL in young women, Susie Lau and Eduardo Franco have provided an algorithm that if implemented would reduce unnecessary intervention and anxiety in women aged 24 years or less.[1] However, as they state, the incidence of invasive cervical cancer in women aged 20–24 years is 1.7 per 100 000 annually, far below the incidence of HIV seropositivity (16–34 per 100 000 in young women[2]) and diseases such as lymphoma (12.5 per 100 000 in people of all ages[3]), for which we do not routinely screen. Is there evidence that detection of cervical cytological abnormalities in this group reduces the risk of developing cervical cancer later? If not, it is illogical to recommend screening for women younger than 24 years of age.

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[The authors respond:]

We wish to respond to the thoughtful comments by Howlett and colleagues and Burn to our commentary.[1] We agree with Burn that cervical cancer risk among young women is very low. However, the finding of an LSIL smear in a young woman is a very common byproduct of existing cervical cancer screening guidelines. What we proposed is in line with the new knowledge concerning the relative performance of Pap cytology and oncogenic HPV testing and, contrary to what Howlett and colleagues suggest, it is based on a thorough review of the evidence by the American Society for Colposcopy and Cervical Pathology that included Canadian experts.[2] HPV testing has substantially greater sensitivity than cytology and it targets a period in the natural history of cervical neoplasia that is "upstream" from the appearance of cytological abnormalities, which provides a better margin of safety if the result is negative. Cytological follow-up every 6 months has been the management standard in Canada, but immediate colposcopy also occurs frequently. We rec-