## COLPOSCOPY, BIOPSY AND EVALUATION OF ENDOCERVICAL CANAL

### DEFINITION

Patients with significant abnormalities noted on cervical cancer screening test(s) require more definitive evaluation with colposcopy, biopsy(ies), with or without endocervical curettage. The sensitivity of colposcopy is increased with additional biopsy.

### SUBJECTIVE

Must exclude: History of in utero DES exposure (refer to MD or Specialty clinic).

Must include:
1. Age.
2. LMP.
3. Contraceptive method.
4. Unprotected intercourse since LMP.
5. Recent sexual history (new sex partner, other STD risks).

May include:
1. Recent abnormal vaginal bleeding, including post coital bleeding.
2. Vaginal discharge.
3. History of prior HPV infection (external genital warts (EGW), cytology test abnormality or prior treatments).
4. History of HPV vaccine.

### OBJECTIVE

Must exclude: Vaginal or cervical lesion(s) suspicion for carcinoma. Refer to MD or Specialty Clinic.

May include:
1. Vaginal discharge (refer to appropriate protocol).
2. Vulvar, perineal, perianal, vaginal EGWs or lesions.

### LABORATORY

Must include:
1. Abnormal cytologic result or HR-HPV result. See protocol 3.3.3 Management of Cervical Dysplasia.
2. Pregnancy test, if unexplained delayed menses or symptoms of pregnancy.
3. STD tests, if indicated by history or exam.

### ASSESSMENT

Candidate for colposcopy, biopsy(ies) with or without endocervical evaluation.

### PLAN

1. Candidates for advanced practice nurse/physician assistant evaluation include: non-pregnant patients requiring colposcopy for abnormal squamous cell cytology unless cytology test is suggestive of carcinoma or carcinoma in situ. Women with other cytological abnormalities (glandular cell) and pregnant women should be referred directly for MD or Specialty Clinic for colposcopy. These evaluations may be performed only by advanced practice nurses/physician assistants credentialed in these skills.
2. Written informed consent must be obtained from the patient.
3. Recommend HIV testing for women with ≥HSIL lesions, if not recently tested.
4. Measures that have been found to reduce patient anxiety during colposcopy include playing music, showing videos before the procedure and having the patient watch as her own procedure is being done (with provider explanation).
5. Prepare for possible complications.
   a. To reduce the risk of vasovagal reactions:
      1) Make sure patient is well hydrated and has eaten recently.
      2) Reassure her to reduce anxiety.
      3) Offer pain control measures, if appropriate. Remember the power of calm communications, “verbal analgesia,” verbicaine.”
      4) If patient high risk for vasovagal reaction, have her practice lower body skeletal muscle tensing (LBMT) during each step of the procedure.
### PLAN (Continued)

6. Steps of colposcopy:
   a. Repeat cytologic test, if none available in last 6 months.
   b. Examine cervix with green light filter.
   c. Perform colposcopy with white light after application of acetic acid.
   d. Document location of original and current squamocolumnar junction (SCJ) and describe all abnormalities seen and overall colposcopic impression.

7. Perform biopsy:
   a. Perform colposcopically directed biopsy of all lesions suspicious for CIN2 or higher or highest grade lesion seen if no ≥ CIN2 lesions seen.
   b. Consider additional random 4-quadrant biopsies (particularly if no lesions detected colposcopically)
   c. Obtain hemostasis

8. Endocervical curettage indicated only in nonpregnant women (contraindicated in pregnant women).
   a. Endocervical curettage is routine part of initial evaluation (unless excision is planned) for each of the following cytologies: ASC-H, ≥ HSIL
   b. Endocervical sampling preferred when
      1) Colposcopy is unsatisfactory
      2) No lesion seen on colposcopy
      3) Woman has history of prior excision or ablation
      4) If ablative treatment planned
   c. Endocervical curettage acceptable in all other conditions (satisfactory colposcopy, limits of lesion seen), but yield will be low.

9. Endocervical curettage techniques (Do not perform in pregnancy)
   a. Traditional sharp curettage (painful, no increase in detection).
   b. Combination sharp curettage to disrupt epithelium, cytobrush to collect specimen (more painful and more prolonged).
   c. Vigorous cytobrushing (less painful, more sensitive, fewer insufficient specimens, but more difficult to grade).
   d. Normally the ECC is done after the cervical biopsies are done. Perform ECC before doing cervical biopsies only if lesion is at edge of ectocervix. Examine again with colposcope after ECC to verify that no ectocervical lesions were inadvertently included in ECC specimen.

10. If patient develops vasovagal reaction during or following procedure:
    a. Stop procedure and call for help.
    b. Initiate lower body muscle tensing (LBMT), if patient not already performing.
    c. Turn patient to side to prevent aspiration.
    d. Provide oxygen.
    e. Monitor and record vital signs at least every 3-5 minutes.
    f. When patient regains complete consciousness, provide fluids and maintain in supine position for at least 15 minutes.
    g. If patient does not rapidly respond to these measures, call paramedics (if not already called).

11. Provide post procedure instructions:
    a. Advise pelvic rest for at least two weeks (or one week after the last day of spotting or discharge).
    b. Provide warning signs of complications following biopsy (bleeding or infection).
    c. Recommend correct and consistent condom use for at least 3 months.

12. Arrange follow-up visit to check pathology results and to determine need for treatment.

### PATIENT EDUCATION

1. Advise patient about the nature of her problem.
2. Post procedure counseling:
   a. Instruct patient to seek urgent medical care if she experiences heavy vaginal bleeding (especially if she has clots) or if she has severe lower pelvic pain, fever or chills.
### PATIENT EDUCATION (Continued)

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<td>b.</td>
<td>Instruct patient to avoid putting anything (including tampons) into her vagina for at least one week after bleeding and discharge stop following biopsy.</td>
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<td>c.</td>
<td>Recommend correct and consistent condom use for at least 3 months.</td>
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<td>3.</td>
<td>Advise and encourage safer sex practices in future.</td>
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<td>4.</td>
<td>Recommend smoking cessation and use of prenatal vitamins (or folate supplementation) for patients with low folate diets.</td>
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<td>5.</td>
<td>Encourage close adherence to planned follow-up schedule.</td>
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### REFER to MD or Specialty Clinic

1. Pregnant women requiring colposcopy.  
2. Women with AGC, AIS or carcinoma on cytology test.  
3. Women with suspicious vulvar, vaginal, perianal or cervical lesions.  
4. Women with known bleeding disorders, if they require biopsy.

### REFERENCES