

# SCREENING FOR CANCER OF THE CERVIX

**An Office Manual for Health Professionals** 

This manual has been prepared by the Cervical Cancer Screening Program of the BC Cancer Agency to support effective use of the screening program.

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## Introduction

The Cervical Cancer Screening Program (CCSP), operated by the BC Cancer Agency (BCCA) is a coordinated program of cervical cancer control. The CCSP is available to all women in the province.

## Components of the Cervical Cancer Screening Program

#### **Recruitment, Recall and Follow-up**

In a true "population-based" screening program, all at-risk women are personally invited to participate. At this time, recruitment to the CCSP is "opportunistic," i.e.; family doctors and other health professionals initiate the collection of a Pap smear from their patients. The Program's centralized computer system provides a coordinated system of recall and follow-up by sending reminders to the woman's care provider.

#### **Centralized Laboratory Services**

All Pap smears collected around the province are forwarded to a central cytology laboratory operated by the Provincial Health Services Authority. Approximately 600,000 smears are interpreted annually. As part of the central service, the laboratory distributes Pap smear supplies to physicians at no cost to them.

#### **Quality Assurance and Quality Control**

Quality assurance and quality control systems are based on recommendations provided by the Canadian Society of Cytopathology. The ability to decrease cervical cancer mortality through screening depends on four factors:

- Women's participation
- The quality of the Pap smear
- The performance of the laboratory
- Adequate management/treatment of a detected abnormality

To optimize these factors the Program provides:

- Recruitment initiatives to encourage participation
- Educational material to doctors and other care providers to enhance smear quality
- A system of regular work reviews and continuing education for the cytotechnologist to enhance smear interpretation quality
- The linked Provincial Colposcopy Program

#### **Evaluation**

Data is collected and analyzed on an ongoing basis to understand the Program's effectiveness and to identify areas for improvement.

#### **Colposcopy Service**

The linked provincial colposcopy service investigates women with abnormal Pap smears. (If recommended, women should be referred promptly for colposcopy and a copy of the cytology result must accompany the referral letter).

# **Limitations of Screening**

## Screening Tests are not Diagnostic Tests

Screening programs aim to reduce morbidity and mortality from cancer. Their goal per se is the "application of a relatively simple, inexpensive test to a large number of persons in order to classify them as likely, or unlikely, to have the cancer."<sup>1</sup>The emphasis on likelihood underscores the limitations of screening (screening tests are not diagnostic tests). A person with an abnormal screening test does not have a definitive diagnosis until additional, more sophisticated diagnostic tests are completed. Screening test accuracy varies according to cancer site and individuals' characteristics. Although most screening interpretations are accurate, it is inevitable that some individuals are identified as possibly having cancer when they do not (false positive screens)<sup>2</sup>, whereas others with disease are not identified (false negative screens).

## Facts About Screening and Cervical Cancer

The Papanicolaou (Pap) smear is a screening test for cervical squamous dysplasia and early invasive squamous carcinoma of the cervix. Glandular atypia can be detected in advanced pre-malignant lesions or in early adenocarcinomas. Some interesting facts about cervical cancer include:

- In many countries where effective cervical screening is not available, the incidence rate of cervical cancer is high and increasing.
- Most women diagnosed with cervical cancer in BC in the year 1999 had not had a Pap test in the past 3 years.
- Despite the benefits of Pap testing, not all women take advantage of it.
- The Pap smear is used to sample the asymptomatic woman who has a clinically normal appearing cervix. Those who are symptomatic require further investigation such as a biopsy, regardless of the result of the Pap smear test. Smears taken in the presence of symptoms are often unsatisfactory or have a higher false negative rate.
- Cervical cancer behaves like a sexually transmitted

disease. Human Papilloma Viruses (HPV), such as types 16, 18 and 45 are present in over 95% of cervical cancers. However, the majority of women who become infected with HPV, including those infected with high-risk subtypes, do not go on to develop invasive cervical cancer.

- Other risk factors include:
  - commencement of sexual activity at a young age
  - multiple sexual partners or a partner who has had multiple sexual partners
  - history of other sexually transmitted diseases
  - immunosuppression or deficiencysmoking
- Women who have never been sexually active have a low probability of developing cervical cancer. The health care professional should develop a rapport with these patients in order to feel confident that they have, in fact, never been sexually active. If there is any doubt, a Pap smear program should be initiated.
- Evidence shows that women who have been screened regularly up to age 69 with negative smears will have a very low risk of developing cervical cancer.

<sup>&</sup>lt;sup>1</sup> Cole P, Morrison AS: Basic issues in cancer screening. In Miller AB (Ed): Screening in Cancer. Geneva, International Union Against Cancer, 1978, page 7.

<sup>&</sup>lt;sup>2</sup>Miller, AB: Fundamentals of screening: In Screening for Cancer, Orlando, Academic Press, 1985, page 3.

# BC Cancer Agency Screening Recommendations

Criteria	Recommended Action		
Onset of sexual activity or soon after	Start regular Pap smear screening		
Negative or benign changes	Repeat smear every 12 months until there are 3 consecutive normal smears then continue at 24-month intervals		
Mild dyskaryosis (squamous and/or glandular)	Repeat in 6 months Colposcopy examination is recommended, if mild atypia persists for 2 years		
Moderate or higher dyskaryosis	Colposcopic examination is recommended		
After age 69	Stop screening, if there are 3 or more normal smears in the last 10 years and no history of previous significant abnormality (moderate atypia or higher)		
Pregnant Women	If no history of previous Pap smear, do Pap smear, otherwise follow guidelines as indicated in non-pregnant women		
HIV Positive Women	Repeat smear in 6 months until there are 2 consecutive normal smears then continue at 12-month intervals		

## **POST-HYSTERECTOMY SCREENING GUIDELINES**

### I. AFTER TOTAL HYSTERECTOMY (UTERUS AND CERVIX COMPLETELY EXCISED)

- Women with no history of moderate or higher abnormality and benign hysterectomy pathology can discontinue screening.
- If no previous pap smear record is available and hysterectomy pathology is benign, the patient should have two consecutive negative smears one year apart before discontinuing screening.
- Women with a history of moderate or higher abnormality (CIN II, CIN III or carcinoma *in situ* on histology), but no history of invasive cervical carcinoma should have three documented consecutive, technically satisfactory normal / negative vaginal smears one year apart over a 3year period before discontinuing screening.
- Women with a history of invasive cervical carcinoma should follow the recommendation provided by the BC Cancer Agency Gynecological Tumor Group.
- Women with a history of i*n utero* DES exposure should continue screening as long as this is clinically feasible.

### 2. AFTER SUB-TOTAL HYSTERECTOMY (uterine corpus removed, cervix in place)

• Women who have had a subtotal hysterectomy should continue cervical cancer screening as per the Screening Program guidelines.

## **Screening Recommendations continued**

### LESBIANS

Research suggests that cervical cancer is found at a later stage among lesbians due to the widespread belief that lesbians don't need Pap smears. This belief is untrue because:

- Lesbians or their partners may have had consensual or non-consensual intercourse with men at some time
- HPV in lesbians may be as prevalent as it is in heterosexual women

# **Role of the Smear Taker**

All Pap smears submitted to the Cervical Cancer Screening Program (CCSP) must be accompanied by the name of a licensed health care provider in British Columbia to whom the Pap smear result and follow-up letters can be sent. A "licensed health care provider" is a member in good standing of the BC College of Physicians and Surgeons, the Association of Naturopathic Physicians of BC or a registered midwife designated by a woman as her primary health care provider. Certain nursing health stations in rural areas will also be acceptable if designated as primary health care providers.

# Smear takers play a key role in the CCSP and are responsible for:

- Identifying women for whom screening is recommended and maintaining appropriate call and recall systems.
- Educating women about the benefits of screening while ensuring the limitations of screening are understood.
- Educating women about the importance of regular smears.
- Informing women of the need to seek medical attention for abnormal vaginal bleeding regardless of a normal smear result.

- Ensuring women are referred for specialist assessment and investigation when required and coordinating their ongoing care.
- Forwarding copies of smear results to a woman's primary care giver (with her consent).

#### The responsibility to follow up with individual women rests with primary care providers and should include:

- Mechanisms to ensure a result is received for each smear taken.
- Mechanism to inform the woman of the results, including normal results.
- Protocols to ensure women are recalled as appropriate, for regular smears.
- Protocols to ensure women with abnormal smears receive appropriate follow-up.

## The Patient

The goal of an effective screening program is to screen all women at risk.

- The single most powerful motivator for a woman to be screened is an invitation/suggestion by her health care provider. This is especially true for women over the age of 40 years.
- Barriers or discouraging experiences preventing women from being screened need to be addressed by the health professionals involved.

Women often describe the Pap smear experience as awkward, invasive, uncomfortable, embarrassing and traumatic. Some women, after their first Pap smear, never return for subsequent smears, and in many cases this failure to return has been attributed to a negative first experience. Therefore, it is imperative that health care professionals do all they can to provide a positive, sensitive and caring experience for the patient including comfortable, pleasant surroundings and an organized and informative environment.

Whenever possible, the patient should be given the following information (see box below) prior to the Pap smear visit. Should these conditions not be met, however, it is still acceptable to proceed with the Pap smear.

### **IDEAL PATIENT CONDITIONS FOR SCREENING**

Patient has not douched the vagina for 48 hours before the examination.

Patient has avoided use of contraceptive creams or jellies for 48 hours before the examination.

Smears are not recommended during menstruation. A mid-cycle smear is optimal. The patient should be informed that the date of her last menstrual period (LMP) will be required.

# Pap Smear Technique

## SLIDE LABELING IS MANDATORY

On the **frosted end** of the slide using a **lead pencil**, print **patient's surname** (include at least the first 7 letters), must be legible, spelled correctly and match the name on the requisition.

#### A major cause of a false negative cervical smear is failure of the smear collector to sample the transformation zone (squamocolumnar junction).

The transformation zone is the region lying between the columnar epithelium of the endocervix and the

## Single Slide Method

Please use the single slide method. Multiple slides from one patient are neither necessary nor cost effective. Patients with a double cervix are the obvious exception.



mature squamous epithelium of the ectocervix. It is here that carcinogens act upon the squamous metaplastic cells of the transformation zone to cause squamous dysplasia and squamous carcinoma.

Generally, during the reproductive years, the transformation zone lies on the ectocervix. Postmenopausally, it recedes within the endocervix.

If two sites are sampled, i.e. cervix and endocervix, they can be applied to two different areas of the same side of the slide.

### VARIATIONS IN CERVICAL TRANSFORMATION ZONE



The location of the squamocolumnar junction is dependent on the patient's age, parity, hormonal status and any previous surgery. If squamocolumnar junction is visible, sample with a spatula. If not visible, i.e. in the canal, sample with elongated end of spatula or cytobrush.

- a) Reproductive age group, nulligravida; squamocolumnar junction often visible on ectocervix lateral to os. Os (small, round or oval). Sample with spatula.
- b) Reproductive age group, parous; squamocolumnar junction often at or near external os. Sample with spatula.
- c) Post menopause. Squamocolumnar junction often in canal. Cervical os often smaller. Sample with elongated end of spatula and cytobrush.

## BASIC EQUIPMENT AND SUPPLIES

- examination table
- good illumination
- bi-valve speculum (various sizes)
- pencil for labeling slide
- endocervical brush (call 604-876-4186 in the Lower Mainland or toll free 1-800-667-5770 to order)

\*Supplied free of charge by the BC Cancer Agency Fax request to 604-660-3122

## **Obtaining the Smear**

- 1. Gently insert a pre-warmed speculum to visualize cervix. DO NOT USE lubricant jelly on speculum. Lubricant can obscure cellular detail, interfere with cellular adherence and cause bacterial over-growth on the slide.
- 2. Gently cleanse the cervix with cotton pledget if obscured with discharge or secretions.
- 3. Identify extent of transformation zone and probable squamocolumnar junction.

### If Squamocolumnar Junction is Visible



Rotate a spatula through 360° once to obtain a single specimen. Fixation is not necessary.

### If Not Visible

If squamocolumnar junction is not visible, first use a spatula for the exocervical specimen; then use a cytobrush or the elongated end of the spatula for the endocervical sample. Rotate cytobrush 180° only. Place both specimens on a single slide and fix immediately.

# If cytobrush is used, prompt fixation of the sample is necessary



- cytology spray fixative e.g. cytospray (call Surgipath toll free 1-800-665-7425 to order)
- extended-tip spatula\*
- glass microscope slide with frosted end\*
- container\* for transporting slide to laboratory
- requisition form\*

### CAUTIONS

- The use of the cytobrush is not recommended in pregnant patients.
- If a clinically suspicious lesion is seen, biopsy immediately.
- If the patient is menstruating or infection is present reschedule exam.
- Irregular bleeding may be a symptom of gynecological malignancy. Pelvic examination with lower genital tract and appropriate investigation is indicated.

The use of cotton swabs for sampling is associated with cellular trapping and distortion and is no longer recommended.

## **Completing the Requisition Form**

# To ensure the patient demographics are up-to-date, the laboratory requires:

- The patient's current and all previous surnames. Ensure correct spelling and enter first and middle names, if applicable. The name on the Requistion Form and the name on the slide must match exactly.
- The patient's PHN number.
- Date of birth (day/month/year).

## To ensure accurate report delivery, the laboratory requires:

- Smear taker's full address, including postal code and telephone number.
- Physician or Midwife MSP number

## To ensure optimum evaluation of specimens, the laboratory requires:

- Date of the patient's last menstrual period (LMP).
- Relevant clinical history e.g., discharge, bleeding, medications.
- Relevant past history and the reason for the hysterectomy, previous abnormal Pap smears, malignancy, or cervical treatment. This information helps determine appropriate follow-up recommendations.

## **Transporting the Specimen**

## To ensure that the slides arrive at the BC Cancer Agency laboratory:

- Labeled slides should be placed in the mailing containers provided by the BC Cancer Agency laboratory.
   For supplies, fax request to 604-660-3122.
- The completed requisition should be folded and wrapped around each slide-mailing container and secured with an elastic band. There is no need to apply a patient identification label to the mailing container.
- The slide and requisition should be sent by courier or Canada Post addressed to the BCCA:

Slides may be collected and sent in weekly batches.

Cervical Cancer Screening Laboratory c/o Central Processing and Receiving – Lane Level Laboratory 655 West 12th Avenue Vancouver, BC V5Z 4R4 Phone: 1-877-747-2522 (1-877-PHSA LAB)

## **Specimen Rejection Policy**

Inadequately labeled or unlabeled specimens have been identified as a significant source of laboratory error worldwide and for this reason the Cervical Cancer Screening Laboratory (CCSL) must accurately identify all slides that are processed in the laboratory. The CCSL will not process unlabeled, insufficiently labeled or mislabeled slides, a new specimen will have to be collected.

# **Optimal and Unsatisfactory Smears**

### What is an optimal cervical smear?

The presence of endocervical cells, metaplastic cells, and squamous cells suggest a high probability that the transformation zone has been sampled, which is necessary for a cervical smear to be considered optimal.

Cytologists continue to debate the criteria necessary to ensure that the transformation zone has been sampled. The presence of squamous metaplastic cells and endocervical cells and/or atypical cells is generally regarded as evidence of adequate sampling of the transformation zone.

### What is an unsatisfactory smear?

Smears can be considered unsatisfactory for either technical or interpretative reasons.

#### Technical Reasons

- Slide was received broken or slide was broken during handling in the laboratory and is beyond possible repair
- Slide not labeled with patient's name
- Mis-match between the name on the slide and the name on the requisition
- Improperly or illegibly labeled slide

#### Interpretative Reasons

- 75% or more of the smear is obscured by inflammatory exudate or blood
- Too few cells are present on the smear (generally less than one thousand)
- Smear is too thick (cells are piled up on the top of each other so technologist is unable to examine individual cells)
- Smear consists mainly of endocervical glandular cells (smear comes only from endocervical canal and there is no representation of the transformation zone)
- Cells are too poorly preserved for adequate interpretation

## Human Papilloma Virus and Cervical Cancer

The detection of Human Papilloma Virus (HPV) in the majority of cervical cancer precursor lesions and invasive cervical carcinomas supports the assertion that this agent is an essential factor in the development of cervical cancer. More than 80 types of HPV have been identified. Approximately 30 types are transmitted principally by skin-to-skin contact (commonly during sexual activity). About half of this group have been linked to cervical cancer, and two (types 16 and 18) account for 70% of this association in North America. While HPV infection is very common, only a small percentage of infected women will develop cervical cancer. Of note is that the HPV types associated with visible gential warts do not predispose to invasive cancer. At present the role of HPV testing for cervical cancer prevention is being evaluated in British Columbia in a large study due to start in 2007.

In late 2006, an HPV vaccine protecting against the most common HPV types associated with cervical cancer became available in Canada. This for the first time allows us to move in the direction of preventing this common infection in the hopes of further reducing the incidence of cervical cancer.

## **New Technologies**

Recent advances in gynecological cytology have focused on improving specimen preparation and processing and on the interpretation of cytological findings. They will lead to an increase in screening accuracy and subsequently improve the detection rate of pre-invasive and invasive cervical malignancies.

#### Liquid-Based Cytology (Thin-Layer Cytology)

The sample is collected with a spatula ± brush in the same way as for the conventional Pap smear. Instead of smearing the sample on the slide, the specimen is washed directly into a vial containing liquid fixative. Slide preparations are made from the liquid sample. The cells are fixed more uniformly, mucus is dissolved, large cell clusters are dispersed and debris and excessive blood are removed. Random cell disbursement allows for easier interpretation. Studies show that liquid-based cytology improves the detection of atypical cells and reduces the number of inadequate samples. However, it may increase the number of false positives. This method of specimen collection is more costly and transport is difficult.

It is not currently available in British Columbia.

#### **Machine-Assisted Screening**

Computerized screening devices are algorithm-based decision making instruments. Some automated screening devices require specially prepared and/or stained slides, while others can use routinely stained smears. These machines can be used for primary screening or as re-screening devices. In the United States, where 10% of all negative slides must be re-screened, an automated device was shown to detect 2 - 3 times more false-negatives than manual interpretation. In a primary screening mode, up to 25% of all slides from women with a low probability of having cervical precancerous lesions can be scanned by machine only without further intervention by a cytotechnologist.

# Appendix I

### CURRENT BC CANCER AGENCY GUIDELINES FOR THE Investigation and Management of Women with Screen Detected Abnormalities

### Low–Grade Epithelial Abnormalities

Pap Smear Report	Investigation	Management	
Mild squamous dyskaryosis Mild endocervical glandular atypia	Repeat smear at 6 month intervals if abnormal cytology persists for 2 years, refer to colposcopy	If mild dysplasia (CIN 1) confirmed at colposcopy follow with repeat Pap in 6 months	

### **High-Grade Epithelial Abnormalities**

Pap Smear Report	Investigation	Management	
Moderate squamous dyskaryosis	Refer to colposcopy & directed biopsy	<ul> <li>If moderate dysplasia/ severe dysplasia/Ca in</li> </ul>	
Marked squamous dyskaryosis		Situ, (CIN 2-3) confirmed, treatment by gynecologist	
Suspicious for squamous cell carcinoma in situ		with appropriate expertise	
Malignant squamous cells		If microinvasion present, refer to gynecologist with	
Moderate endocervical glandular atypia		appropriate expertise or gynecologic oncologist	
Marked endocervical glandular atypia		If frank invasion present, refer to gynecologic	
Cells suspicious for endocervical carcinoma seen		Uncologist at BOOA	
Malignant glandular cells seen			

# Appendix II

### Management of Women with Low Grade Epithelial Abnormalities (Mild Dysplasia or CIN 1)

#### **Observation Management**

If CIN 1/Mild Dysplasia has been confirmed by colposcopy and biopsy, cervical smears should be taken at 6-month intervals until the abnormality either regresses or progresses. After 2 consecutive negative optimal smears, smear should be taken at 24-month intervals.

#### **Active Management**

Treatment by ablative or excisional methods is not generally recommended for low-grade lesions.

## Special Categories

Post Treatment Follow-up (CIN 2/3)	Colposcopy in 4-6 months		
<ul> <li>Ablative therapy: cryotherapy, laser vaporization,</li> </ul>	• Complete excision: colpo +/- ECC (depending on whether satisfactory or not). If all negative, discharge for follow up Pap smear with GP in 6 months		
Excision therapy: cone biopsy, loop excision	• Excision incomplete or ablative therapy: repeat colposcopy with ECC every 6 months times two. If ECC abnormal, manage per guidelines. If ECC negative both times, discharge for follow up with GP in 6 months.		
Abnormal smears in pregnancy (moderate atypia or higher)	Refer to immediate colposcopy to exclude invasive disease. Repeat colposcopy in 8-12 weeks during pregnancy to rule out progression. Reassess lesions with colposcopy and biopsy 8 weeks post-partum		
Total Hysterectomy for Benign Disease	No further smears required if previous smears showed no significant squamous abnormality		

### **Further Investigation**

When "further investigation" is recommended for abnormal endometrial cells, then the selection of the methods of investigation rests with the clinician. The method of investigation may consist of endometrial biopsy, hysteroscopy, ultrasound or dilatation and curettage.

## Appendix III

### **UNDERSTANDING FALSE NEGATIVE RATES**

Many epidemiologic definitions of false negative, sensitivity and other similar concepts utilize absolute (gold standard) knowledge of the true state of the individual. When dealing with clinical cancer, this state will most likely be known (e.g., we know whether someone has symptomatic cancer). The same definition cannot be used when considering preneoplastic conditions (dysplasia) since the true state is only known in individuals who undergo a clinical investigation. Individuals with normal Pap smears are not routinely investigated. For these reasons, determining the precise number of false negatives is not possible.

In Pap smears and other screening tests, a false negative rate is often used to refer to what would be more accurately described as a reclassification rate for initially negative smears, i.e., what proportion of smears initially classified as negative are reclassified as non-negative upon re-screening. Of the 1998 "negative" smears reviewed, 4.5% were reclassified as "non-negative." The cases reviewed were selected because of their current cytologic abnormality. Thus, this sample is not representative of the general "negative" smears. Furthermore, reviewers had knowledge of the current smear result at the time of re-screening. These factors contribute to an over-estimation of the true misclassification rate.

An alternative statistic that has been calculated in the literature is the false-negative fraction. In this case, the number of "negatives" reclassified as "non-negative" is expressed as a percentage of the total "non-negatives" (i.e., "non-negatives" that were initially classified, or subsequently reclassified as such). CCSP has a false-negative fraction estimate of 2.6% of 1998 smears. This is likely to be an underestimation of the true false-negative rate, as not all slides have been reviewed.

# **Appendix IV**

## **Results Terminology**

BC Cervical Cancer Screening Program	CIN/Dysplasia System	The Bethesda System		
Unsatisfactory: state reason	Unsatisfactory: state reason	Unsatisfactory: state reason		
Negative, no atypical cells are seen	No abnormal cells; metaplasia noted	Negative for Intraepithelial Lesion or Malignancy		
Benign changes Trichomonas vaginalis Monilia (Candida species) Cellular changes suggestive of Herpes simplex viral infection	Abnormal cells consistent with reactive atypia. (non-dysplastic)chomonas vaginalisTrichomonas effectonilia (Candida species)Yeast effectellular changes suggestive of erpes simplex viral infectionViral effect (Herpes type)			
Benign changes       Abnormal cells consistent with reactive at (non-dysplastic)         Radiation effect       Inflammatory effect         Irradiation effect       Other		Benign cellular changes Reactive cellular changes associated with: Inflammation Radiation Other		
	Abnormal cells consistent with reactive atypia (possibly dysplastic) Atypical metaplasia Atypical parakeratosis Other (add comment)	ASC-US⁵ ASC-H <sup>6</sup>		
Mild squamous dyskaryosis     Abnormal cells consistent with condyloma       (+HPV¹ effect)     (HPV) effect       Mild squamous dyskaryosis     Mild dysplasia/ <sup>3</sup> CIN 1		LSIL 7 LSIL 7		
Moderate squamous dyskaryosis Marked squamous dyskaryosis/ Suspicious squamous cells	Moderate dysplasia/ <sup>3</sup> CIN 2 Severe dysplasia/ <sup>4</sup> CIS/ <sup>3</sup> CIN 3	HSIL <sup>8</sup> HSIL <sup>8</sup>		
MalignantAbnormal cells consistent with malignancyMalignant squamous cellsConsistent with invasive squamousMalignant glandular cellscarcinomaConsistent with adenocarcinomaType unspecified		<u>Carcinoma</u> Squamous cell carcinoma Adenocarcinoma Unspecified		
Mild glandular atypia Moderate glandular atypia Marked glandular atypia/Suspicious glandular cells		AGC – NOS <sup>9</sup> , AGC – favor neoplastic AIS <sup>10</sup>		
Other <sup>2</sup> Abnormal cells not specifically classified (add comment)		Other		

Human papilloma virus
 Inconclusive for squamous or glandular differentiation

3. Cervical intraepithelial neoplasia

4. Squamous Carcinoma in situ

5. Atypical squamous cells of undetermined significance

Atypical squamous cells – cannot exclude high-grade lesion
 Low grade squamous intraepithelial lesion

High grade squamous intraepithelial lesion
 Atypical glandular cells (NOS – not otherwise specified)

10. Adenocarcinoma in situ

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## Footnotes

<sup>1</sup>Cole P, Morrison AS: Basic issues in cancer screening. In Miller AB (Ed): Screening in Cancer. Geneva, International Union Against Cancer, 1978, page 7.

<sup>2</sup>Miller, AB: Fundamentals of screening: In Screening for Cancer, Orlando, Academic Press, 1985, page 3.

## **Educational Materials Order Form**



Cervical Cancer Screening Program Material Requests 8th Floor 686 West Broadway Vancouver, BC V5Z 1G1 Fax: 604-660-3645

Please fax this form to the CCSP to receive copies of the following free of charge:

Number Requested:	Item Requested:
	Technique for Obtaining Cervical Smears – Laminated Instruction Card
	Speculum Exam & Pap Smears – Video or DVD
	Cervical cancer: protect yourself with regular pap tests - Brochure
	HPV & cervical cancer: what you should know, and do – Brochure
	Preventing cervical cancer – Booklet
	Abnormal pap smear: causes and proper followup – Booklet
	Annual Report (most current year)
Name:	

Address:					
MSC#					

## Feedback

It is important that we receive your feedback to ensure that this Manual meets your needs and the needs of the Cervical Cancer Screening Program.

Please use this sheet to forward any comments/ suggestions you may have after using the Seventh Edition of the Office Manual. Thank you.

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### Content

### Format

Size:

#### **Binding:**

Other:

### LAYOUT

**Design:** 

**Order of Topics:** 

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