Section 11: Screening and colposcopy during pregnancy

Cervical screening in pregnancy

For some participants, pregnancy may be the first opportunity to participate in cervical screening. Approximately 5% of pregnant participants will have abnormal cervical cytology.[1,2]

Pregnant people have the same screening choices as non-pregnant participants and should be offered cervical screening if they are due for it, including follow-up testing. Vaginal swab and cervical samples are safe to perform during pregnancy. If a follow-up test is required a cervical sample may be needed. If a participant has vaginal bleeding during pregnancy, clinical assessment is required.

It is important screen takers discuss the options available to participants so they can make an informed decision about which HPV test is most suitable for their individual circumstances.

If a cervical sample is being taken a cervibroom is the recommended sampling instrument. A cytobrush or combi-brush should not be inserted into the cervical canal because of the risk of associated bleeding, which may be upsetting or cause unnecessary worry to participants.

Pregnant participants with HPV detected (any type) should follow the same clinical pathway as outlined in the management of participants after HPV testing in section four.

RECOMMENDATIONS – SCREENING IN PREGNANCY	
R11.01 Cervical screening in pregnancy	**Practice point** Routine antenatal care should include a review of the pregnant participants cervical screening history. Participants who are due or overdue for screening should be screened. A participant can be safely screened at any time during pregnancy.

RECOMMENDATIONS – SCREENING IN PREGNANCY	
R11.02 Bleeding during pregnancy	**Practice point** If there is vaginal bleeding during pregnancy, it is important to perform a speculum examination to exclude an obvious cervical cancer, or other cause for bleeding (eg polyp). If there is unexplained bleeding, or an abnormal cervical appearance, a co-test for both HPV and cytology should be performed. If there is uncertainty about the normality of the cervix on examination, review with a senior clinician should occur.
R11.03 Support for cervical screening during pregnancy	**Practice point** Ask all participants/ whānau whether they require assistance or support to attend for cervical screening. Consider transport, cultural support and where appropriate offer referral to Support to Screening Services.

RECOMMENDATIONS – MANAGEMENT OF PARTICIPANTS AFTER HPV TESTING	
R11.04 HPV not detected	**Evidence-based recommendation** Participants with a screening test result of HPV not detected should be re screened in five years. If a participant is immune deficient they should be rescreened in three years.
R11.05 HPV detected Other on vaginal swab	**Practice point** Participants with an HPV detected Other on vaginal swab should have a follow-up cytology performed. If the participant is asymptomatic and in the late stages of pregnancy (36 weeks+) cytology can be deferred to the postpartum period (6 weeks postpartum).
R11.06 HPV detected Other with negative, ASC-US or LSIL cytology results	**Evidence-based recommendation** Pregnant participants with HPV detected Other and a negative, ASC-US or LSIL cytology result should have a repeat HPV test in 12 months.
R11.07 HPV detected Other with cytology results of ASC-H or HSIL or any glandular abnormality in pregnancy	**Evidence-based recommendation** Pregnant participants with an HPV detected Other and ASC-H or HSIL cytology result or glandular abnormality should be referred for colposcopic assessment and seen within 30 working days and not deferred until the postpartum period.
R11.08 HPV detected 16 or 18 in pregnancy	**Evidence-based recommendation** Pregnant participants with an HPV detected 16 or 18 result should be referred for colposcopic assessment and seen within 30 working days of receipt of the referral and not

RECOMMENDATIONS – MANAGEMENT OF PARTICIPANTS AFTER HPV TESTING	
	deferred until the postpartum period. If the participant has HPV 16 or 18 detected on a vaginal swab sample, cytology will be performed at the time of colposcopy.
R11.09 Referral of pregnant participants with invasive disease	**Evidence-based recommendation** Pregnant participants with cytology or clinical examination suspicious for invasive disease should be referred and seen within two weeks from receipt of referral by an experienced colposcopist. **Colposcopy assessment should not be deferred.** Multidisciplinary colposcopy meeting review should occur. If there is histologically confirmed invasion (any type) referral should occur promptly to a gynaecologic oncology multidisciplinary meeting.
R11.10 Referral of pregnant participants to colposcopy	**Practice point** It can be a particularly anxious time for participants who are pregnant and are referred to colposcopy. It is important to reassure participants colposcopy is safe to perform during pregnancy. Ask all participants/ whānau whether they require assistance or support to attend their colposcopy appointment. Consider transport, cultural support and where appropriate offer referral to Support to Screening Services.
R11.11 Postpartum follow-up assessment	**Practice point** If a follow-up cervical HPV test or co-test is required postpartum, it should be performed at least six weeks after delivery. This interval is optimal to reduce the risk of unsatisfactory cytology or interpretation difficulties due to oestrogen deficiency. The HPV test or co-test could be taken at the time of a postpartum check.

References

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2. Origoni M, Salvatore S, Perino A, et al. 2014. Cervical Intraepithelial Neoplasia (CIN) in pregnancy: the state of the art. European Review for Medical and Pharmacological Sciences 18(6): 851-60. URL: www.ncbi.nlm.nih.gov/pubmed/24706310

Colposcopy during pregnancy

The aim of colposcopic assessment during pregnancy is to exclude the presence of invasive cervical cancer and reassure the participant/whānau that it is safe to continue with their pregnancy. [1,2] It is important to reassure participants it is safe to perform colposcopy during pregnancy.

Changes to the cervix during pregnancy make colposcopic assessment more challenging. A colposcopist experienced in examination of the cervix in pregnancy should perform the examination because of the difficulty in differentiating between changes that result from pregnancy and those due to cervical pathology.[3]

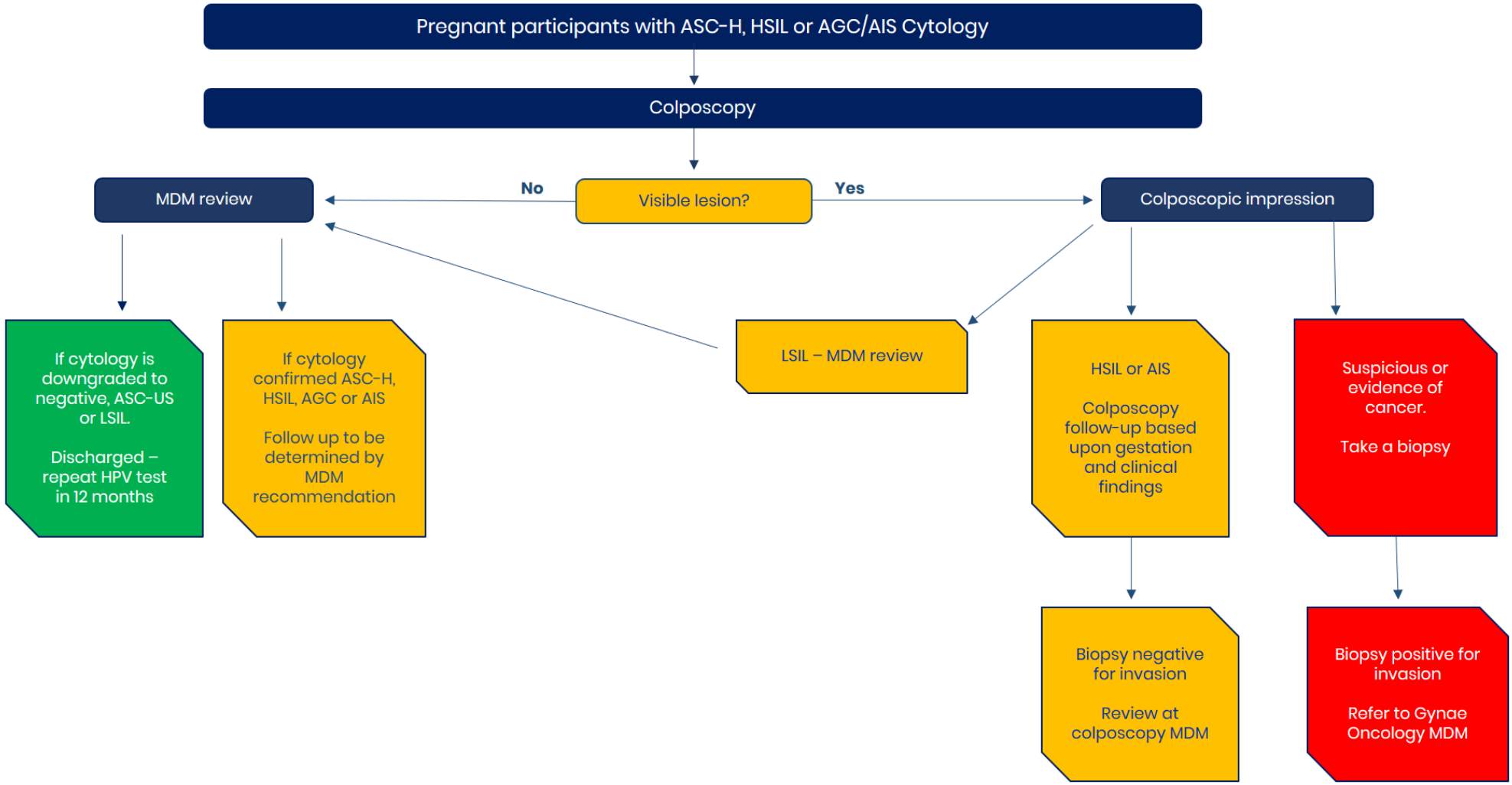
A biopsy is usually not indicated in pregnancy unless invasive disease is suspected. It is safe to biopsy the cervix during pregnancy and there may be a risk of increased bleeding. [4] The risk of an undiagnosed cervical cancer in pregnancy outweighs the risk of increased bleeding. When invasive disease is suspected or confirmed in pregnancy, expert management by a gynaecological oncologist is essential. Discussion regarding mode of birth should include input from a gynaecologic oncologist.

Because treatment is associated with an increased risk of pregnancy complications, HSIL diagnosed during pregnancy should be treated after delivery.[1] This approach is safe as HSIL progresses to invasive disease during pregnancy in only 0-3% of cases. [4-6] Almost all these cases are superficially invasive and amenable to curative treatment. HSIL may regress postpartum.[4,6,7]

RECOMMENDATIONS – COLPOSCOPY IN PREGNANCY	
R11.12 Colposcopy during pregnancy	**Consensus-based recommendation** The aim of colposcopy in pregnant participants is to exclude the presence of invasive cancer and to reassure the participant that their pregnancy will not be affected by the presence of an abnormal cervical screening test result.

RECOMMENDATIONS – COLPOSCOPY IN PREGNANCY	
R11.13 Colposcopy during pregnancy	**Practice point** Colposcopy during pregnancy should be undertaken by a colposcopist experienced in assessing participants during pregnancy.
R11.14 Cervical biopsy in pregnancy is usually unnecessary	**Consensus-based recommendation** Biopsy of the cervix is usually unnecessary in pregnancy, unless invasion is suspected colposcopically, or the cytology report suggests invasive disease.
R11.15 Defer treatment of HSIL until after pregnancy	**Consensus-based recommendation** Treatment of a suspected high-grade lesion can be deferred until the postpartum period. Repeat colposcopy should be considered if there has been a significant delay between histological confirmation of HSIL and treatment, taking into account individual circumstances.
R11.16 Postpartum follow-up assessment	**Practice point** If a follow-up colposcopy is required postpartum, it should be performed at least six weeks after the birth. This interval is necessary to reduce the risk of cytology and colposcopy interpretation difficulties due to unsatisfactory cytology, atrophy or the effect of lochia.
R11.17 Vaginal estrogen before postpartum colposcopy	**Practice point** Participants who are breastfeeding may experience vaginal atrophy. The use of estrogen before colposcopy can improve visualisation of the cervix and the quality of the cytology sample. Use nightly for two to three weeks stopping about two days before colposcopy is recommended.
R11.03 Support for colposcopy during pregnancy and post-partum	**Practice point** It can be a particularly anxious time for participants who are pregnant and are referred to colposcopy. It is important to reassure participants colposcopy is safe to perform during pregnancy. Ask all participants/ whānau whether they require assistance or support to attend for cervical screening. Consider transport, cultural support and where appropriate offer referral to Support to Screening Services.

Figure 1: Management of pregnant participants with ASC-H, HSIL or glandular cytology



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