

Recurrent smear abnormalities where repeat loop treatment is not possible: Is hysterectomy the answer?

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Received 1 June 2004

Abstract

Objective. The objective of this study was to determine the outcome of women who underwent hysterectomy for recurrent cytological abnormalities where repeat loop treatment was considered not to be technically possible because of insufficient remaining cervical tissue.

Methods. Women undergoing a hysterectomy for the above indication at the Northern Gynaecological Cancer Centre over a period of 10 years (1992–2001) were identified from a prospectively collected database. Case notes were then reviewed and women undergoing hysterectomy for other indications were excluded. Relevant demographic and clinical data were then extracted.

Results. 33 patients meeting the above criteria were identified. The overall hysterectomy rate for this indication was 0.73%. 20 out of the 33 women had significant pathology on the hysterectomy specimen. 95% of these had high-grade disease with one having a Stage 1A₁ squamous carcinoma. None of the patients required more radical treatment than a simple hysterectomy. There were no major complications following the hysterectomy. Positive endocervical margins on the previous loop specimen ($P = 0.05$) was an important correlating factor predicting the presence of CIN on the hysterectomy specimen. One out of the thirty hysterectomies (3.3%) performed using the vaginal route had incomplete excision compared to one of three (33%) using the abdominal route. Hysterectomy was successful in treating 85.2% of the women; only 4 women subsequently developed vaginal intraepithelial neoplasia.

Conclusion. Simple hysterectomy appears to be a suitable diagnostic and treatment option for women with recurrent high-grade cytological abnormalities where further loop treatment is technically not possible. Incomplete excision at the endocervical margin on the previous loop specimen was the main factor associated with the presence of cervical intraepithelial neoplasia at hysterectomy.

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Keywords: Hysterectomy; Cytological abnormality; Loop treatment

Introduction

Large loop excision of the transformation zone (LLETZ) is currently the standard treatment for high-grade cervical intraepithelial neoplasia (CIN) in the UK [1]. The value of LLETZ as a procedure is in the fact that it is a simple outpatient procedure providing tissue for histological diagnosis in addition to therapy. It is effective in about 95%

of cases with less than 5% of women requiring further treatment [2]. In cases with recurrent high-grade smear abnormalities where there is minimal to no cervical tissue accessible vaginally, repeat loop procedures can be technically more difficult and associated with a greater risk of injury. This also results in a poor quality specimen preventing adequate histological diagnosis. In this situation, the clinician is faced with the option of either managing these women conservatively with regular cytology and colposcopy or alternatively proceeding to hysterectomy. The objective of this study is to determine the outcome of those women who underwent hysterectomy for recurrent cyto-

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logical abnormalities where repeat loop treatment was considered not to be possible.

Material and methods

All hysterectomies performed during a 10-year period (1992–2001) for preinvasive disease of the cervix or abnormal cervical cytology were identified from a prospectively collected database at the Northern Gynaecological Oncology Centre (NGOC). The case notes were then reviewed manually to confirm that the patient had previously undergone loop treatment and the decision for hysterectomy was taken because a recent smear showed high-grade or glandular abnormalities and that further loop treatment was not felt to be technically possible because of insufficient remaining cervical tissue. Hysterectomy performed for all other indications was excluded. Relevant demographic and clinical details were then extracted including patients' age, parity, menopausal status, number of previous loop treatments and their histology, margin status on the previous loop specimen, recent smear result, colposcopic findings, route of hysterectomy, peri-operative complications, hysterectomy histology result and subsequent cytological or histological outcome. Data were analyzed using SPSS version 11. In an effort to avoid missing preinvasive or invasive disease (keep false-negative low), $P < 0.1$ was considered as significant. Univariate and multivariate analysis were performed to explore any association between the above variables and the presence of cervical intraepithelial neoplasia in the hysterectomy specimen. For univariate analysis, we calculated the odds ratio and 95% confidence intervals for the relevant variables, and multivariate analysis was performed using the stepwise forward likelihood ratio statistic.

Results

Thirty-three patients were identified who met the above criteria. During this 10-year period 4509 LLETZ/loop biopsies were performed at the NGOC, with the overall hysterectomy rate for the above indication being 0.73% (33/4509). The median age of the patients at the time of hysterectomy was 45 years. (Range 24–72 years). 14 of the 33 women (42.4%) in this study were postmenopausal. While most of the women in this cohort were multiparous (55.8%), five of the women (15.1%) were nulliparous. Although the total number of previous loops performed ranged from 1 to 5 (median 2), the majority of women (72.7%) in this study had undergone two or more loop excisions.

Table 1 shows the distribution of the referral smear and histological details of the most recent loop excision. The CIN-free period from previous loop to abnormal smear ranged from 3 months to 10 years. (Median: 6 months, SD: 32 months). The hysterectomy was performed via the laparo-

Table 1

Referral smear and histology of most recent loop excision (CGIN: cervical glandular intraepithelial neoplasia, CIN: cervical intraepithelial neoplasia)

Pre hysterectomy smear	Previous loop histology				
	Cervical CA Stage 1A ₂ *	Cervical CA Stage 1A ₁ *	CGIN	CIN III	CIN II
Severe ($n = 19$)	1	1	1	14	2
Moderate ($n = 12$)	0	3		8	1
Abn.Glandular ($n = 2$)	0	1	1	0	0

* Denotes FIGO staging of cervical cancer.

vaginal route in 22 cases, vaginal route in 8 cases, and open abdominal route in 3 cases. None of these women underwent any additional pre-operative investigations, including CT or MRI to exclude the presence of invasive disease prior to the hysterectomy. Table 2 shows the presence of CIN in the hysterectomy specimen and distribution of margin status at the most recent loop excision. The positive predictive value (ppv) of an abnormal cervical smear in this clinical scenario based on the histology of the hysterectomy specimen was 61%. Table 3 summarizes the Odds Ratio for the presence of cervical intraepithelial neoplasia at hysterectomy with the collated variables.

Involvement of the endocervical margin at previous loop excision correlated with the presence of CIN on hysterectomy with a coefficient of 0.337 (Pearson r) and $P = 0.05$ (OR 4.1, 95% CI 0.9, 18.6). On multivariate analysis using logistic regression with the above factors, the presence of involved endocervical margins appeared to be the only independent risk factor associated with the presence of cervical intraepithelial neoplasia.

The distribution of the pre-hysterectomy smear and histology of hysterectomy specimen is shown below in Table 4.

There were no cases of invasive disease where more radical primary treatment would have been considered appropriate, that is, no cases were under treated by simple hysterectomy.

There were no major complications associated with the hysterectomy, only two minor complications, one pelvic and one urinary infection (both treated with antibiotics) and only one patient required a blood transfusion.

Follow up data were available for 27 of the 33 patients. Four of the 27 women (14.8%) subsequently developed vaginal intraepithelial neoplasia (VAIN) on follow up. Two of these women had incompletely excised margins at hysterectomy and were found to have persistent VAIN on their first follow up visit. While the other two, who had completely excised preinvasive disease on hysterectomy, developed VAIN more than a year later while on follow up. As regards the route of hysterectomy, only one out of the 29 (3.4%) hysterectomies performed involving the vaginal route had margins involved with preinvasive changes. Two of the four women developing VAIN required an

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