NHS Cervical Screening Programme

NHS Cancer Screening Programmes

Audit of invasive cervical cancers: colposcopy review 2013-14

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Document objective	Produced on behalf of the NHSCSP to outline measures for the inclusion of colposcopy in the audit of invasive cervical cancers from April 2013.
Clinical/healthcare/social questions covered	How to include data on colposcopy into the audit of invasive cervical cancers.
Population affected	Women diagnosed with invasive cervical cancer after screening in the NHSCSP
Target audience	Colposcopy clinics, QA Coordinators and Directors
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CONTENTS

1. INTRODUCTION

The audit of invasive cervical cancers aims to understand the reasons that cervical cancers occur, despite the existence of an excellent screening programme. The overall purpose of the exercise is to identify modifications that might reduce the incidence of invasive cervical cancer. There is also an educational element to the audit, since it offers an opportunity to review the original management of each case of invasive cancer, and to determine whether it was appropriate.

Fulfilling this objective necessitates the collation of data from different sources: screening invitations, cytology results, colposcopy attendance, and histology. **From April 2013**, more data will be collected on the performance of colposcopy services to enable fuller audit of this element of the programme. Providing this data is a mandatory requirement of all colposcopy services participating in the NHS Cervical Screening Programme (NHSCSP).

New forms will be made available to ensure that the appropriate data is collected for each case.

1.1 Review of prior colposcopy on diagnosis of invasive cervical cancer

Any colposcopic examinations that predate the index referral by up to five years should be reviewed, since these examinations (and associated management) may have impacted on the development of cervical cancer.

Since the aim of this part of the review is to improve education through assessment of potential errors, any colposcopic examinations associated with the index referral cytology and made within 18 weeks of the subsequent diagnosis of cervical cancer do **not** require routine review.

1.2 Who should do the review?

In most cases, the lead colposcopist at the unit where the diagnosis of the cancer was made should undertake the review. She or he must include notes from other clinics where necessary. However, if the lead colposcopist participated in the management of the women, another British Society for Colposcopy and Cervical Pathology (BSCCP) certified colposcopist from the same unit should undertake the review.

1.3 What should be reviewed?

The reviewer must check whether the coloscopic management of the woman reflected the NHSCSP guidelines pertaining at the time.

With all colposcopic examinations under review, the reviewer should check the following:

1. Was a record made that the squamocolumnar (SCJ) junction was identified? If the SCJ junction was not identified, was this recorded in a clear manner?

2. Was there a record of the colposcopic impression of any lesions identified?

3. Was a record kept of the grade of colposcopist conducting the examination (e.g. ‘BSCCP certified’ or ‘in training’)?

One or more of the following sets of questions should be answered at the time of the review, according to the index referral cytology that initiated the colposcopic examination (or series of examinations).

Where the woman was first referred with low-grade cytology:

1. If the woman was discharged after colposcopic examination, was the SCJ completely visualised and no lesion identified?

2. If a lesion was identified, was it biopsied (within the preceding two years) prior to discharging the woman back to cytological surveillance?

3. If CIN1 was present either on biopsy or colposcopic impression, were arrangements made to recall the women for either follow-up colposcopy at 12 months or community-based cytological surveillance?

Where the woman was first referred with high-grade cytology:

1. If the woman was managed conservatively, was the SCJ completely visualised and the upper limit of any lesion identified?

2. If CIN1 or less was present either on biopsy or colposcopic impression, were arrangements made to review the woman with follow-up colposcopy at 6 months?

3. If any lesion was identified, was it biopsied prior to discharging the woman back to cytological surveillance?

4. If CIN1 or less was present on biopsy, following referral with severe dyskaryosis, was the case reviewed by the multi-disciplinary team (MDT) prior to discharge to cytological follow-up? If so, what was the outcome of the MDT review?

5. If the woman was discharged at the follow-up colposcopic examination, was the SCJ completely visualised, and no lesion identified?

If the woman was subsequently treated for CIN:

1. Was the lesion biopsied prior to ablative treatment?

2. Was the upper limit of the lesion identified prior to ablative treatment (i.e. was invasion excluded on colposcopic examination)?

3. If the woman had undergone a previous ablative treatment, was the retreatment by excision?

4. If the lesion was excised, what was the depth (height) of the cone specimen?

5. Was the specimen removed in one piece?

6. Was the lesion completely excised? If this cannot be determined, was this because the specimen was in more than one piece?

7. If the lesion was not completely excised, which margins were involved (e.g. ecto/endo/deep)?

8. If the endo or deep margins were involved, and the woman was over 50 years of age, was re-excision offered?

9. Did the definitive treatment of high-grade CIN take place within 8 weeks of diagnosis? If not, was this because the woman was pregnant?

Where the women was first referred with glandular neoplasia:

1. Was an excisional procedure performed or arranged at the first visit?

2. If margins were involved, was re-excision offered?

3. If no treatment was arranged and follow-up was by colposcopy, was the case discussed at the MDT? What was the outcome of the MDT review?

4. Did the definitive treatment take place within 8 weeks of diagnosis? If not, was this because the woman was pregnant?

If the woman was treated for CIN or CGIN:

1. Were appropriate follow-up arrangements made? (At minimum, follow-up cytology should be conducted 6 months after treatment.)

Summary conclusions

For **all** cases, the following four questions must be answered:

1. Was the colposcopic management of the woman appropriate?

2. If not, could this have resulted in a failure to prevent the development of cervical cancer, or led to a delay in the diagnosis of cervical cancer?

3. Was there an inappropriate delay in treatment of high-grade CIN or high-grade CGIN?

4. If there was, was the colposcopy clinic responsible for this delay?

2. CASES WHERE MANAGEMENT HAS BEEN LESS THAN APPROPRIATE

Where colposcopic management of a woman is determined to have been inappropriate, or less than appropriate, the case should be reviewed by the QARC lead for colposcopy. In the event of the case being in the lead's own unit, the lead from another QARC should undertake this role.

Findings should be fed back as soon as possible to the colposcopist(s) and unit concerned.

The lead should identify the educational issues pertaining to the case, and present these on an annual basis at a relevant QARC colposcopy meeting for the area to which the learning points apply.

3. NATIONAL CLINICAL AND STATISTICAL AUDIT

In addition, all QARCs must aggregate the data from each case, and summarise it in an annual report for the National Colposcopy Quality Assurance Group. The Group will conduct a clinical audit of these cases, to determine any nationally relevant learning points. All QARC leads should be informed of the results of this clinical audit, and must inform their local services of its conclusions.

Summary data from the audit form will also be used to produce statistics that will allow review of colposcopic services to be incorporated into the national audit of invasive cervical cancers.

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