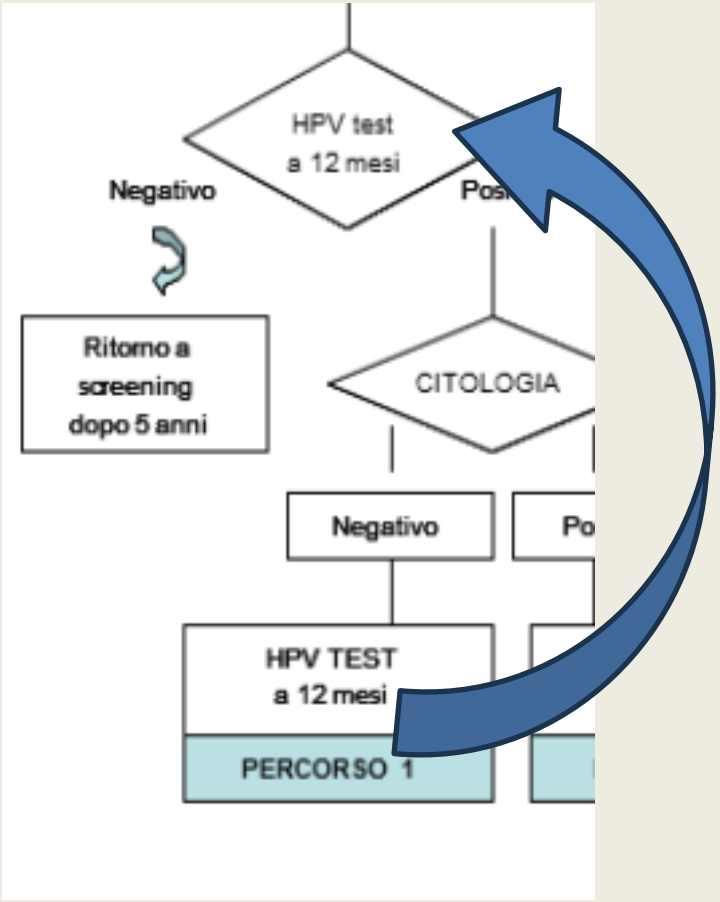
SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA

SURVEY DEL CERVICOCARCINOMA DELLA REGIONE EMILIA – ROMAGNA 2024

Gestione clinica e comunicativa delle donne con HPV persistente

Germana Gotti
Responsabile percorso screening cervicocarcinoma provincia di Ferrara
Ausl Ferrara



Per quante volte?

IMPLICAZIONI

Aspetti organizzativi e sanitari:

Liste di attesa lunghe
Aumento donne in follow up
Non sempre corretta comunicazione dei dati
Rischio di sovratrattamento
Rischio di sottotrattamento

Effetti sulla utente:

Ansia
Perdita di ore di lavoro
Tempi attesa lunghi con fuga nel privato
Rischi di sovrattamento
Rischi di sottotrattamento

Sono malata?

Perche' sono sempre positiva?

Sara' pericoloso per il mio partner?

- Cosa si chiede al colposcopista?
- Quale rischio ha la persistenza?
- Quali strategie si potrebbero utilizzare?

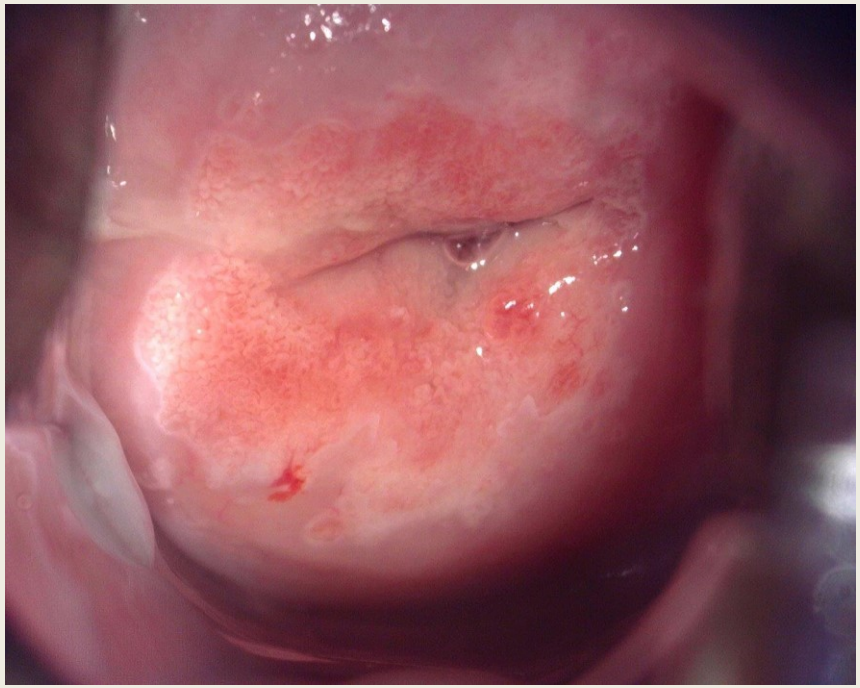
La storia naturale dell'infezione cervicale da HPV dipende dal tipo di HPV e dalla risposta immunitaria dell'ospite:

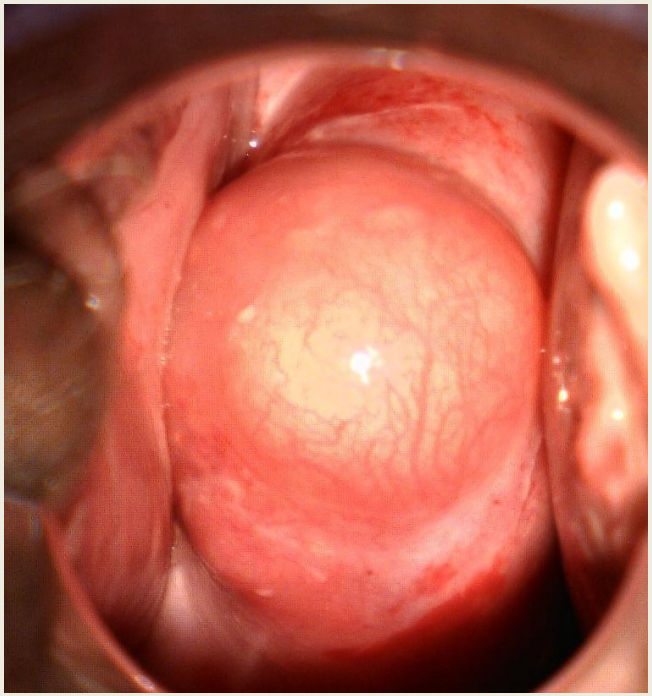
- l'esito più frequente è la clearance
- la persistenza deriva da un mancato controllo immunitario
- la latenza può verificarsi per controllo immunitario parziale

La riattivazione di una infezione latente è possibile anche a distanza di (molti) anni e può determinare lo sviluppo di lesioni

La pericolosità della persistenza dipende da diversi fattori:

1. Performance colposcopica
2. Storia cito-colposcopica
3. Tipo di HPV





Al colposcopista viene chiesta **accuratezza diagnostica**

Fattori che influenzano l'accuratezza:

Sede endocervicale della lesione	sensibilità 68% vs 78% esocervice
Età della donna	sottostima 20% vs 10% <50 anni
Stato post menopausale	sottostima 27% vs 7% premenopausa
Esperienza del colposcopista	sensibilità 68% vs 80% > 5 anni
Numero di biopsie	1 biopsia sensibilità 65% 2 biopsie 90-100%

Qin et al. BMC Cancer (2023) 23:107
https://doi.org/10.1186/s12885-023-10648-1

BMC Cancer

RESEARCH Open Access

2023

Colposcopic accuracy in diagnosing squamous intraepithelial lesions: a systematic review and meta-analysis of the International Federation of Cervical Pathology and Colposcopy 2011 terminology

Dongxu Qin[†1], Anying Bai[†1], Peng Xue[1*], Samuel Seery[2], Jiaxu Wang[3], Maria Jose Gonzalez Mendez[3], Qing Li[4], Yu Jiang[1*] and Youlin Qiao[1*]

Come cambia l'accuratezza in base a impressione colposcopica

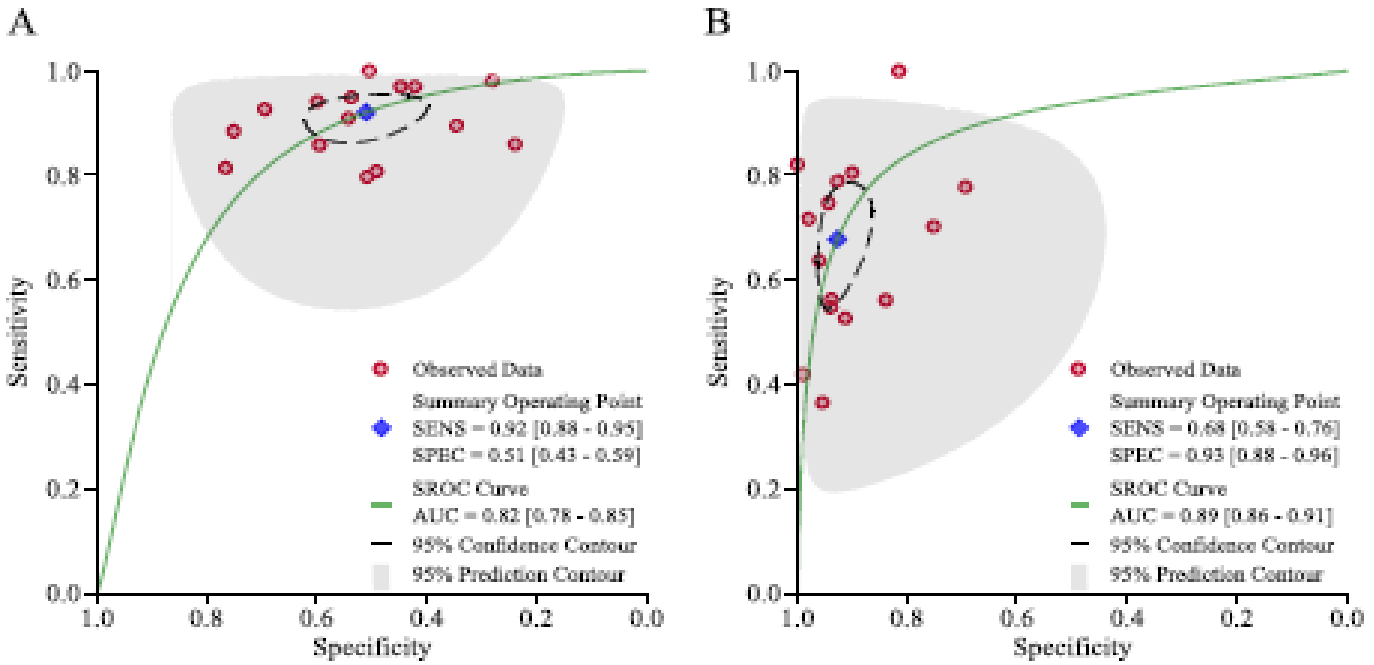
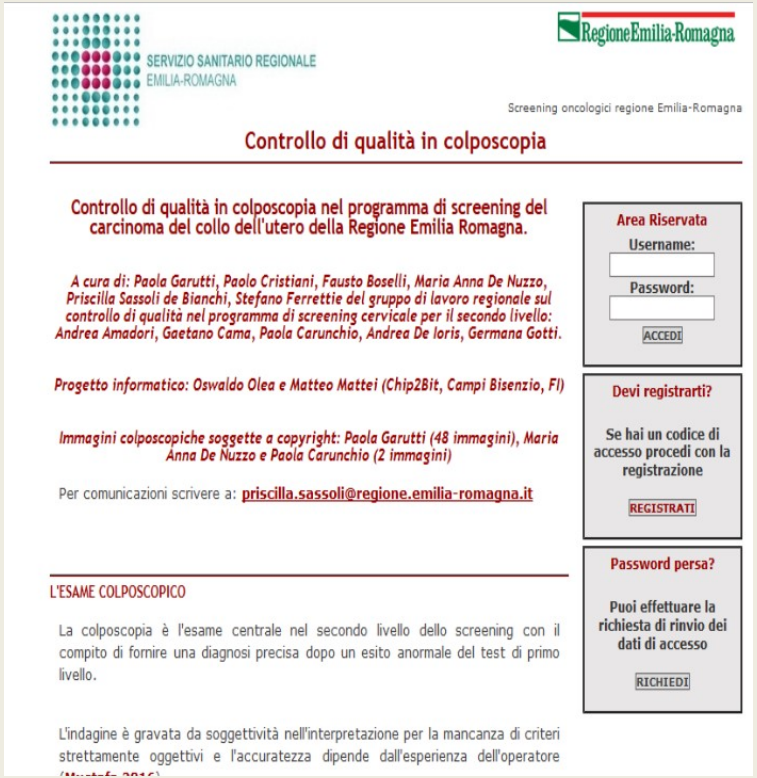


Fig. 2 Sensitivity and specificity reported for diagnostic colposcopic impression in 14 studies (each study represented by a point in the figure) relative to the gold standard of biopsy for distinguishing **A** <LSIL from LSIL+; **B** <HSIL from HSIL+. The solid line in the graph shows the receiver operating characteristic curve determined from regression analysis

Dati corso colposcopisti ER



SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA

RegioneEmilia-Romagna

Screening oncologici regione Emilia-Romagna

Controllo di qualità in colposcopia

Controllo di qualità in colposcopia nel programma di screening del carcinoma del collo dell'utero della Regione Emilia Romagna.

A cura di: Paola Garutti, Paolo Cristiani, Fausto Boselli, Maria Anna De Nuzzo, Priscilla Sassoli de Bianchi, Stefano Ferrettie del gruppo di lavoro regionale sul controllo di qualità nel programma di screening cervicale per il secondo livello: Andrea Amadori, Gaetano Cama, Paola Carunchio, Andrea De Ioris, Germana Gotti.

Progetto informatico: Oswaldo Olea e Matteo Mattei (Chip2Bit, Campi Bisenzio, FI)

Immagini colposcopiche soggette a copyright: Paola Garutti (48 immagini), Maria Anna De Nuzzo e Paola Carunchio (2 immagini)

Per comunicazioni scrivere a: priscilla.sassoli@regione.emilia-romagna.it

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REGISTRATI

Password persa?
Puoi effettuare la richiesta di rinvio dei dati di accesso
RICHIEDI

L'ESAME COLPOSCOPICO

La colposcopia è l'esame centrale nel secondo livello dello screening con il compito di fornire una diagnosi precisa dopo un esito anormale del test di primo livello.

L'indagine è gravata da soggettività nell'interpretazione per la mancanza di criteri strettamente oggettivi e l'accuratezza dipende dall'esperienza dell'operatore

RISULTATI DEL TEST

	2011 %	2017 %
K per diagnosi	69	73
Conc osservata	78	81

SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA

Corso 2025 sul controllo di qualità dei colposcopisti

24 gennaio 2025

AULA MAGNA - VIALE ALDO MORO 30, BOLOGNA

Performance of standardised colposcopy to detect cervical precancer and cancer for triage of women testing positive for human papillomavirus: results from the ESTAMPA multicentric screening study

2023

Joan Valls, Armando Baena, Gino Venegas, Marcela Celis, Mauricio González, Carlos Sosa, Jorge Luis Santin, Marina Ortega, Ana Soilán, Elmer Turcios, Jacqueline Figueroa, Margarita Rodríguez de la Peña, Alicia Figueredo, Andrea Verónica Beracochea, Natalia Pérez, Josefina Martínez-Better, Oscar Lora, Julio Yamil Jiménez, Diana Giménez, Laura Fleider, Yuly Salgado, Sandra Martínez, Yenny Bellido-Fuentes, Bettsy Flores, Silvio Tatti, Verónica Villagra, Aurelio Cruz-Valdez, Carolina Terán, Gloria Inés Sánchez, Guillermo Rodríguez, Maria Alejandra Picconi, Annabelle Ferrera, Laura Mendoza, Alejandro Calderón, Raul Murillo, Carolina Wiesner, Nathalie Broutet, Silvana Luciani, Carlos Pérez, Teresa M Darragh, José Jerónimo, Rolando Herrero, Maribel Almonte, on behalf of the ESTAMPA study group*

Come cambia l'accuratezza in base a età

By age					
Sensitivity for CIN3+	..	..	..	..	p<0·0001
30–49 years	534	1616	37	1191	93·5% (91·3–95·3)
50–65 years	76	410	22	613	77·6% (68·6–85·0)
Specificity for less than CIN2	..	..	..	..	p<0·0001
30–49 years	763	1387	61	1167	45·7% (43·8–47·6)
50–65 years	113	373	32	603	61·8% (58·7–64·8)

diagnostics
2023
MDPI

Article

Colposcopy Accuracy and Diagnostic Performance: A Quality Control and Quality Assurance Survey in Italian Tertiary-Level Teaching and Academic Institutions—The Italian Society of Colposcopy and Cervico-Vaginal Pathology (SICPCV)

Massimo Origoni [1,*], Francesco Cantatore [1], Francesco Sopracordevole [2], Nicolò Clemente [2], Arsenio Spinillo [3], Barbara Gardella [3], Rosa De Vincenzo [4,5], Caterina Ricci [5], Fabio Landoni [6], Maria Letizia Di Meo [6], Andrea Ciavattini [7], Jacopo Di Giuseppe [7], Eleonora Preti [8], Anna Daniela Iacobone [8,9], Carmine Carriero [10], Miriam Dellino [10], Massimo Capodanno [11], Antonino Perino [12], Cesare Miglioli [13], Luca Insolia [13], Maggiorino Barbero [14] and Massimo Candiani [1]

Come cambia l'accuratezza in base a esperienza del colposcopista e a GSC

Table 2. SCJ assessment (2011 IFCPC terminology [14]).

Experts Panel	Colposcopists	*All*	Experience in Colposcopy		
			Seniors	Juniors	
fully visibile	**fully visibile #**	**81.2%**	**80.3%**	**82.6%**	p = NS
	*not fully visibile **	*12.9%*	*13.4%*	*12.1%*	
	not visibile	*5.9%*	*6.3%*	*5.3%*	
not fully visibile	*fully visibile*	*29.3%*	*28.2%*	*31.2%*	p = NS
	not fully visibile	**51.4%**	**51.9%**	**50.5%**	
	not visibile	*19.3%*	*19.9%*	*18.3%*	
not visibile	*fully visibile*	*15.2%*	*12.5%*	*19.6%*	p = 0.011
	not fully visibile	*19.9%*	*20%*	*19.7%*	
	not visibile	**64.9%**	**67.5%**	**60.7%**	

All colposcopists: $p < 2.2^{-16}$; Cohen's *kappa* correlation coefficient = 0.49 CI 95% [0.47–0.51]. Seniors: $p < 2.2^{-16}$; Cohen's *kappa* correlation coefficient = 0.49 CI 95% [0.47–0.52]. Juniors: $p < 2.2^{-16}$; Cohen's *kappa* correlation coefficient = 0.48 CI 95% [0.45–0.51]. # block letters = colposcopists vs. panel full agreement; * italics = incorrect SCJ judgment by colposcopists; SCJ = squamocolumnar junction; NS = not significant.

Current Problems in Cancer
Volume 42, Issue 5, September 2018, Pages 521-526

The next generation of cervical cancer screening programs: Making the case for risk-based guidelines ☆

Rebecca B. Perkins MD, MS [a], Mark Schiffman MD, MPH [b], Richard S. Guido MD [c]

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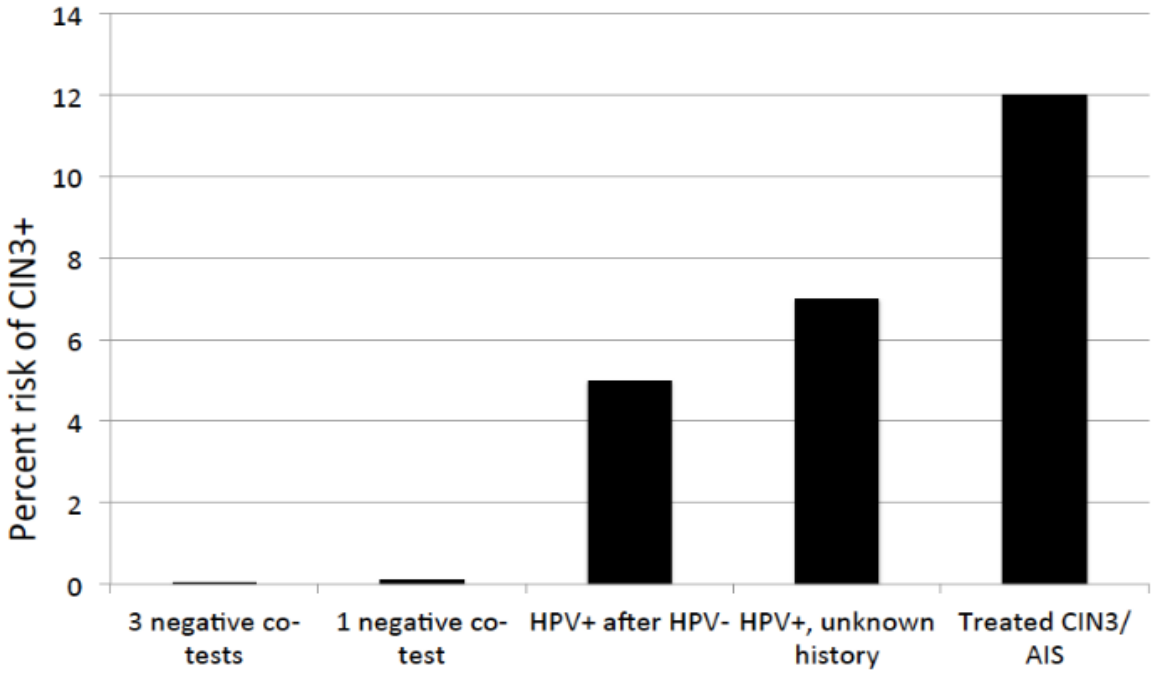
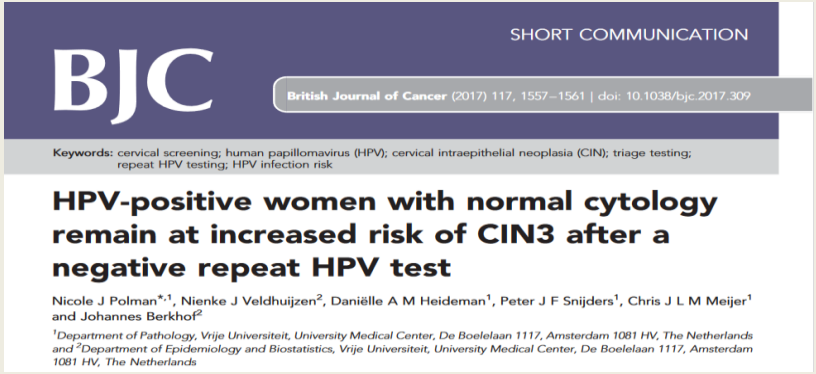
Rischio di cin3 in base alla storia di screening precedente

Figure 1. CIN3+ risk at 5 years





SHORT COMMUNICATION

BJC

British Journal of Cancer (2017) 117, 1557–1561 | doi: 10.1038/bjc.2017.309

Keywords: cervical screening; human papillomavirus (HPV); cervical intraepithelial neoplasia (CIN); triage testing; repeat HPV testing; HPV infection risk

HPV-positive women with normal cytology remain at increased risk of CIN3 after a negative repeat HPV test

Nicole J Polman*,[1], Nienke J Veldhuijzen[2], Daniëlle A M Heideman[1], Peter J F Snijders[1], Chris J L M Meijer[1] and Johannes Berkhof[2]

[1]Department of Pathology, Vrije Universiteit, University Medical Center, De Boelelaan 1117, Amsterdam 1081 HV, The Netherlands and [2]Department of Epidemiology and Biostatistics, Vrije Universiteit, University Medical Center, De Boelelaan 1117, Amsterdam 1081 HV, The Netherlands

Il rischio cumulativo cin3+ in donne con HPV test positivo (citologia negativa) e hpv test negativo al primo controllo risulta del 2%, significativamente superiore allo 0.2% delle donne con doppio HPV test negativo

Table 2. Risk of CIN3+/2+ in HPV-pos/cyt-neg women and in HPV-neg/cyt-neg women

			CIN3+			CIN2+		
Baseline	**Repeat test result** Dopo 5 anni	**Total**	***n***	**%**		***n***	**%**	
HPV-pos/cyt-neg	HPV-negative test result at first repeat test	199	4	2.0	Sign ($P=0.001$)	11	5.5	Sign ($P<0.001$)
HPV-pos/cyt-neg	HPV-negative test result at first or second repeat test	256	9	3.5	Sign ($P<0.001$)	18	7.0	Sign ($P<0.001$)
HPV-neg/cyt-neg	–	18 562	41	0.2	–	88	0.5	–

Abbreviations: CIN3/2+ = cervical intraepithelial neoplasia grade 3/2 or worse; HPV = human papillomavirus; NS = not significantly different when compared with HPV-neg/cyt-neg women; sign = significantly different when compared with HPV-neg/cyt-neg women.

CANCER EPIDEMIOLOGY, BIOMARKERS & PREVENTION | RESEARCH ARTICLE

Risk of Cervical Intraepithelial Neoplasia Grade 3 or Worse in HPV-Positive Women with Normal Cytology and Five-Year Type Concordance: A Randomized Comparison

Federica Inturrisi[1], Johannes A. Bogaards[1,2], Daniëlle A.M. Heideman[3], Chris J.L.M. Meijer[3], and Johannes Berkhof[1]

Table 1. CIN3+ and CIN2+ in HPV-positive women in the baseline round (intervention group) versus next round (control group, in bold).

18 mesi

Baseline round	Next round	N	CIN3+ n	CIN3+ %	CIN3+ RR (95% CI)	CIN2+ n	CIN2+ %	CIN2+ RR (95% CI)
HPV-pos		1,066	164	15%	1.0 (ref)	249	23%	1.0 (ref)
HPV-pos/cyt-neg		730	32	4%		66	9%	
HPV-pos/cyt-neg	**HPV-pos**	**111**	**40**	**36%**	**2.3 (1.8–3.1)**	**48**	**43%**	**1.9 (1.5–2.4)**
	type concordance	**91**	**36**	**40%**	**2.6 (1.9–3.4)**	**43**	**47%**	**2.0 (1.6–2.6)**
	type switch	**20**	**4**	**20%**	**1.3 (0.5–3.2)**	**5**	**25%**	**1.1 (0.5–2.3)**

Abbreviations: cyt, cytology; HPV, human papillomavirus; neg, negative; pos, positive.

Table 2. CIN3+ and CIN2+ in women with HPV type(s) 16, 16/18, 16/18/31/33/45 or other high-risk type(s) infection in the baseline round (intervention group) versus type concordant infection in the next round (control group, in bold).

Baseline round	Next round	N	CIN3+			CIN2+		
			n	%	RR (95% CI)	*n*	%	RR (95% CI)
HPV16-pos		343	103	30%	1.0 (ref)	140	41%	1.0 (ref)
HPV16-pos/cyt-neg		211	24	11%		40	19%	
HPV16-pos/cyt-neg	**HPV16-pos**	**38**	**23**	**61%**	**2.0 (1.5–2.7)**	**24**	**63%**	**1.5 (1.2–2.0)**
hrHPV-pos and HPV16-neg		723	61	8%	1.0 (ref)	109	15%	1.0 (ref)
hrHPV-pos/cyt-neg and HPV16-neg		519	8	2%		26	5%	
hrHPV-pos/cyt-neg and HPV16-neg	**At least one concordant type and HPV16-neg**	**49**	**11**	**22%**	**2.7 (1.5–4.7)**	**16**	**33%**	**2.2 (1.4–3.4)**
HPV16/18-pos		427	113	26%	1.0 (ref)	161	38%	1.0 (ref)
HPV16/18-pos/cyt-neg		263	27	10%		48	18%	
HPV16/18-pos/cyt-neg	**At least one concordant type**	**49**	**25**	**51%**	**1.9 (1.4–2.6)**	**27**	**55%**	**1.5 (1.1–1.9)**
hrHPV-pos and HPV16/18-neg		639	51	8%	1.0 (ref)	88	14%	1.0 (ref)
hrHPV-pos/cyt-neg and HPV16/18-neg		467	5	1%		18	4%	
hrHPV-pos/cyt-neg and HPV16/18-neg	**At least one concordant type and HPV16/18-neg**	**39**	**10**	**26%**	**3.2 (1.8–5.8)**	**14**	**36%**	**2.6 (1.6–4.1)**
HPV16/18/31/33/45-pos		697	147	21%	1.0 (ref)	214	31%	1.0 (ref)
HPV16/18/31/33/45-pos/cyt-neg		456	31	7%		60	13%	
HPV16/18/31/33/45-pos/cyt-neg	**At least one concordant type**	**76**	**29**	**38%**	**1.8 (1.3–2.5)**	**34**	**45%**	**1.5 (1.1–1.9)**
hrHPV-pos and HPV16/18/31/33/45-neg		369	17	5%	1.0 (ref)	35	9%	1.0 (ref)
hrHPV-pos/cyt-neg and HPV16/18/31/33/45-neg		274	1	0.4%		6	2%	
hrHPV-pos/cyt-neg and HPV16/18/31/33/45-neg	**At least one concordant type and HPV16/18/31/33/45-neg**	**11**	**5**	**45%**	**9.9 (4.4–21.9)**	**6**	**55%**	**5.8 (3.1–10.7)**

Abbreviations: cyt, cytology; HPV, human papillomavirus; hr, high-risk; neg, negative; pos, positive.

Contents lists available at ScienceDirect

EClinicalMedicine

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Research Paper

A study of type-specific HPV natural history and implications for contemporary cervical cancer screening programs

Maria Demarco[a,b,1,*], Noorie Hyun[a,c,1], Olivia Carter-Pokras[b], Tina R. Raine-Bennett[d], Li Cheung[a], Xiaojian Chen[a], Anne Hammer[e,f], Nicole Campos[g], Walter Kinney[b], Julia C. Gage[a], Brian Befano[i], Rebecca B. Perkins[j], Xin He[b], Cher Dallal[b], Jie Chen[b], Nancy Poitras[k], Marie-Helene Mayrand[l,m], Francois Coutlee[n], Robert D. Burk[o], Thomas Lorey[k], Philip E. Castle[o], Nicolas Wentzensen[a], Mark Schiffman[a]

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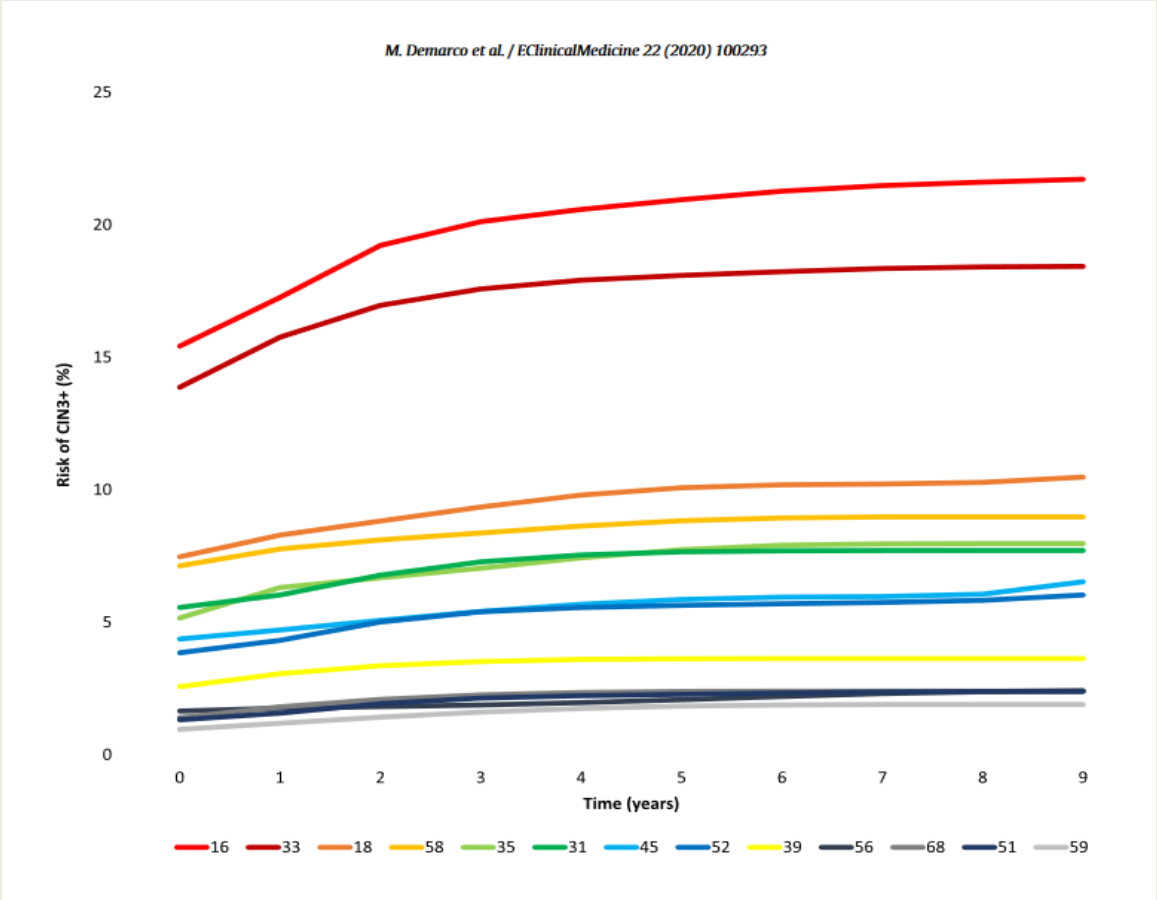
[m] Department of Social and Preventive Medicine, Université de Montréal and Centre de recherche du Centre hospitalier de l'Université de Montréal (CRCHUM), Montreal, Canada
[n] Department of Microbiology, Université de Montréal and CRCHUM, Montreal, Canada
[o] Albert Einstein College of Medicine, Bronx, NY, United States

Hpv 16 e 33 hanno un rischio aumentato di progressione a 7 anni



Rischio CIN3 dopo 10 anni di follow up (donne HPV positive citologia neg/basso grado):

Hpv 16 **19**%
Other 0.3%

DOI: 10.1111/1471-0528.15957
www.bjog.org

Epidemiology

Triaging women with human papillomavirus infection and normal cytology or low-grade dyskaryosis: evidence from 10-year follow up of the ARTISTIC trial cohort

24,496 donne

C Gilham,[a] A Sargent,[b] J Peto[a]

[a] London School of Hygiene & Tropical Medicine, London, UK [b] Clinical Virology, Manchester University NHS Foundation Trust, Manchester, UK
Correspondence: C Gilham, London School of Hygiene & Tropical Medicine, Keppel Street, London WC1E 7HT, UK.
Email: clare.gilham@lshtm.ac.uk

Accepted 12 September 2019. Published Online 7 November 2019.

Objectives To estimate long-term cervical intraepithelial neoplasia grade 3 (CIN3) risks associated with different triage strategies for human papillomavirus positive (HPV+) women with a view to reducing unnecessary referrals.

Design The ARTISTIC trial cohort was recruited in Manchester in 2001–03 and was followed up for CIN3 and cancer notification through national registration until December 2015.

Results The 10-year cumulative risk of CIN3+ was much higher for women with HPV16/18 infection (19.4%, 95% CI 15.8–23.8% with borderline/low-grade cytology and 10.7%, 95% CI 8.3–13.9% with normal cytology) than for those with other HPV types (7.3%, 95% CI 5.4–9.7% with borderline/low-grade cytology and 3.2%, 95% CI 2.2–4.5% with normal cytology). Among the 379 women with normal to low-grade cytology and new HPV infection, the 10-year cumulative CIN3+ risk was 2.9% (95% CI 1.6–5.2%).

Conclusions The CIN3 risk is confined to women with persistent type-specific HPV so partial genotyping test assays identifying HPV16/18 as a minimum are essential for efficient risk stratification. Immediate referral to colposcopy for HPV+ women with borderline or low-grade cytology and referral after a year if still HPV+ with normal cytology may be unnecessary. Low-grade lesions can safely be retested to identify those with persistent HPV. Recall intervals of 1 year for HPV16/18 and 2 years for other high-risk HPVs are justified for women with normal cytology and might also be considered for women with borderline/low-grade cytology. The minimal risk of invasive cancer that has progressed beyond stage 1A must be weighed against the advantages for patients and the NHS of reducing the number of referrals to colposcopy.

Keywords Cervical cancer, cervical screening, cervical intrapepithelial neoplasia grade 3, cytology, human papillomavirus, triage.

Tweetable abstract Cervical screening would be better for women and cheaper for the NHS if women with HPV and normal to low-grade cytology were retested after a year or two when many infections will have cleared.

Linked article This article is commented on by B Böttcher and S Abdel Azim, p. 69 in this issue. To view this mini commentary visit https://doi.org/10.1111/1471-0528.15983.

Cumulative risk of cervical intraepithelial neoplasia for women with normal cytology but positive for human papillomavirus: systematic review and meta-analysis

Talía Malagón[1], Karena D. Volesky[1,2], Sheila Bouten[1], Claudie Laprise[1,3], Mariam El-Zein[1], Eduardo L. Franco[1,2]

[1] Division of Cancer Epidemiology, Gerald Bronfman Department of Oncology, McGill University, Montreal, Canada

[2] Department of Epidemiology, Biostatistics and Occupational Health, McGill University, Montreal, Canada

[3] Division of Oral Health and Society, Faculty of Dentistry, McGill University, Montreal, Canada

Persistenza dello stesso ceppo virale
Rischio CIN3:

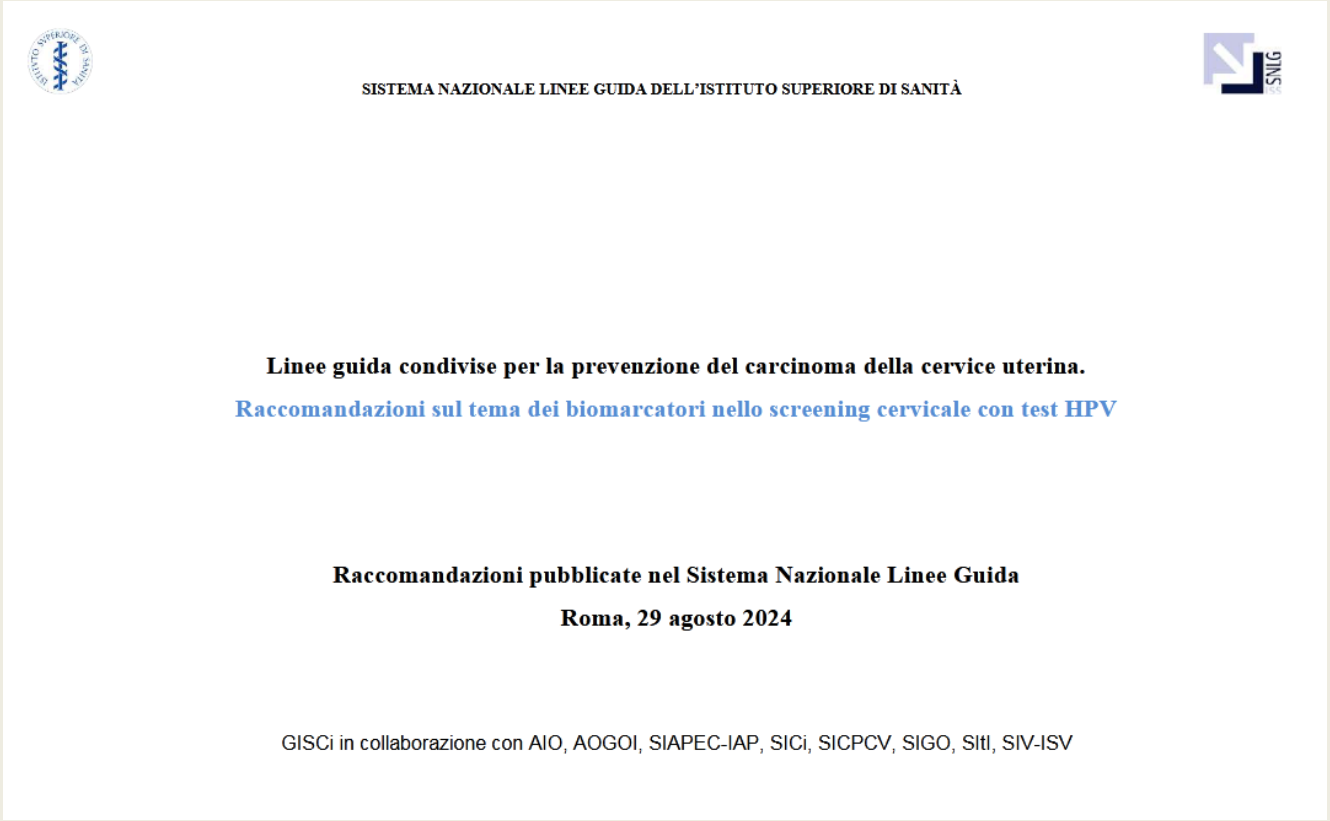
	cumulativo	hpv16/18
1 anno	2.1 %	3.5%
2 anni	4.3 %	8.1%
5 anni	6.4 %	12.6%

Table 3. Model-predicted average cumulative risk of CIN2+, CIN3+, and cancer for women who were cytology/histology normal but HPV-positive at baseline, with 95% prediction intervals.

HPV type	1 year (95% prediction interval)	3 years (95% prediction interval)	5 years (95% prediction interval)
	Cumulative CIN2+ risk (%)*		
HR-HPV	3.9 (0.0 to 11.2)	7.0 (0.0 to 14.0)	9.9 (2.5 to 16.8)
HPV16/18	5.1 (0.0 to 12.3)	10.4 (3.1 to 17.2)	15.4 (8.5 to 21.9)
HR excluding 16/18	2.8 (0.0 to 10.2)	3.7 (0.0 to 11.0)	4.6 (0.0 to 11.8)
HPV16	5.0 (0.0 to 12.2)	10.2 (2.8 to 17.0)	15.1 (8.1 to 21.6)
HPV18	2.6 (0.0 to 10.0)	3.1 (0.0 to 10.4)	3.5 (0.0 to 10.8)
HPV31	4.1 (0.0 to 11.4)	7.5 (0.0 to 14.6)	10.8 (3.2 to 17.8)
HPV33	4.3 (0.0 to 11.6)	8.1 (0.3 to 15.2)	11.7 (4.0 to 18.8)
HPV35	3.0 (0.0 to 10.4)	4.5 (0.0 to 11.7)	5.8 (0.0 to 13.1)
HPV45	3.2 (0.0 to 10.5)	4.8 (0.0 to 12.1)	6.4 (0.0 to 13.6)
HPV51	3.1 (0.0 to 10.4)	4.6 (0.0 to 11.8)	6.0 (0.0 to 13.2)
HPV52	3.3 (0.0 to 10.6)	5.2 (0.0 to 12.4)	7.1 (0.0 to 14.2)
HPV58	3.3 (0.0 to 10.6)	5.2 (0.0 to 12.5)	7.1 (0.0 to 14.3)
HPV59	3.1 (0.0 to 10.4)	4.5 (0.0 to 11.8)	6.0 (0.0 to 13.2)
	Cumulative CIN3+ risk (%)*		
HR-HPV	2.1 (0.0 to 9.5)	4.3 (0.0 to 11.5)	6.4 (0.0 to 13.5)
HPV16/18	3.5 (0.0 to 10.8)	8.1 (0.5 to 15.1)	12.6 (5.3 to 19.3)
HR excluding 16/18	1.5 (0.0 to 9.0)	2.5 (0.0 to 9.9)	3.4 (0.0 to 10.7)
HPV16	3.3 (0.0 to 10.6)	7.6 (0.1 to 14.6)	11.8 (4.5 to 18.5)
HPV18	2.3 (0.0 to 9.7)	4.9 (0.0 to 12.1)	7.3 (0.0 to 14.4)
HPV31	2.6 (0.0 to 9.9)	5.5 (0.0 to 12.7)	8.4 (0.9 to 15.4)
HPV33	2.7 (0.0 to 10.1)	6.1 (0.0 to 13.2)	9.3 (1.8 to 16.2)
HPV35	2.2 (0.0 to 9.6)	4.4 (0.0 to 11.7)	6.6 (0.0 to 13.9)
HPV45	2.0 (0.0 to 9.5)	4.0 (0.0 to 11.3)	6.0 (0.0 to 13.1)
HPV51	2.0 (0.0 to 9.5)	4.0 (0.0 to 11.3)	6.0 (0.0 to 13.1)
HPV52	2.1 (0.0 to 9.5)	4.2 (0.0 to 11.5)	6.3 (0.0 to 13.4)
HPV58	2.0 (0.0 to 9.4)	4.0 (0.0 to 11.3)	5.8 (0.0 to 13.1)
HPV59	2.1 (0.0 to 9.5)	4.1 (0.0 to 11.3)	6.0 (0.0 to 13.2)
	Cumulative cervical cancer risk (%)*,†		
HR-HPV	0.8 (0.0 to 8.3)	1.2 (0.0 to 8.7)	1.6 (0.0 to 9.1)
HPV16	1.2 (0.0 to 8.7)	2.5 (0.0 to 9.9)	3.7 (0.0 to 11.0)

CIN=cervical intraepithelial neoplasia; HPV=human papillomavirus; HR=high risk.
*Negative risks predicted by the model are truncated at 0.0 for coherence.
†Results reported only for HPV types assessed in more than one study.

Quanto è importante oggi la genotipizzazione!



SISTEMA NAZIONALE LINEE GUIDA DELL'ISTITUTO SUPERIORE DI SANITÀ

Linee guida condivise per la prevenzione del carcinoma della cervice uterina.

Raccomandazioni sul tema dei biomarcatori nello screening cervicale con test HPV

Raccomandazioni pubblicate nel Sistema Nazionale Linee Guida

Roma, 29 agosto 2024

GISCi in collaborazione con AIO, AOGOI, SIAPEC-IAP, SICi, SICPCV, SIGO, SItI, SIV-ISV

Nello screening i biomarcatori e/o la genotipizzazione possono aiutare nella gestione:

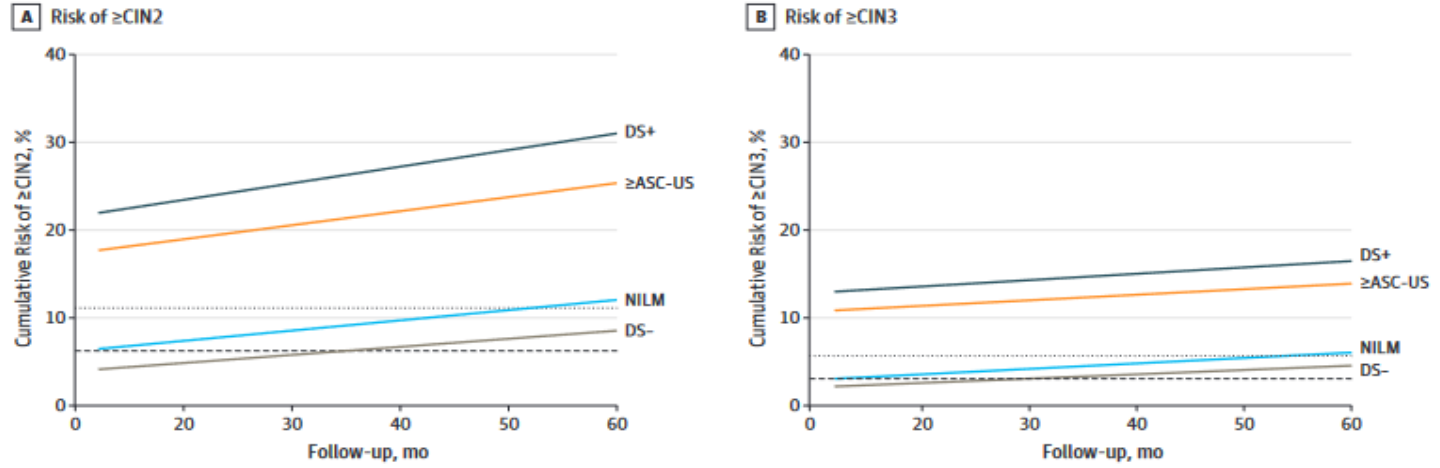
- per decidere invio immediato in colposcopia o richiamo a breve/medio termine in HPV positivo
- per migliorare il follow up nei casi di colposcopia negativa per cin2+
- per garantire tempi ottimali di follow up dopo il trattamento di lesioni alto grado
- gestione delle donne CIN2+ (?)

JAMA Oncology | Original Investigation

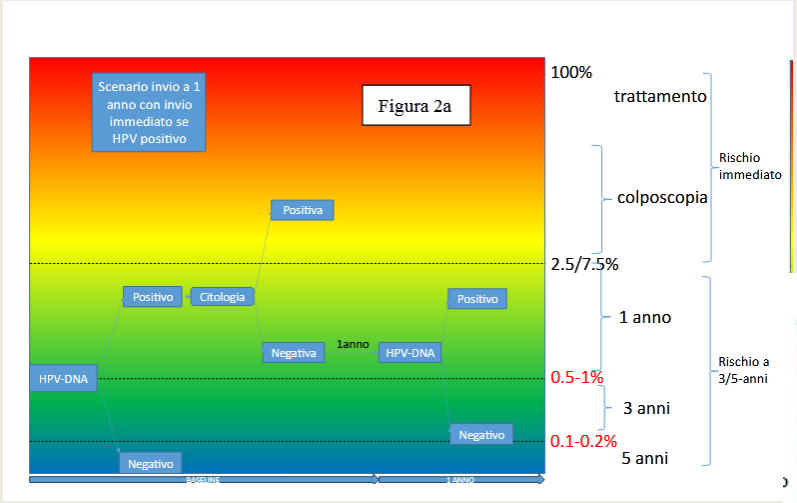
Five-Year Risk of Cervical Precancer Following p16/Ki-67 Dual-Stain Triage of HPV-Positive Women

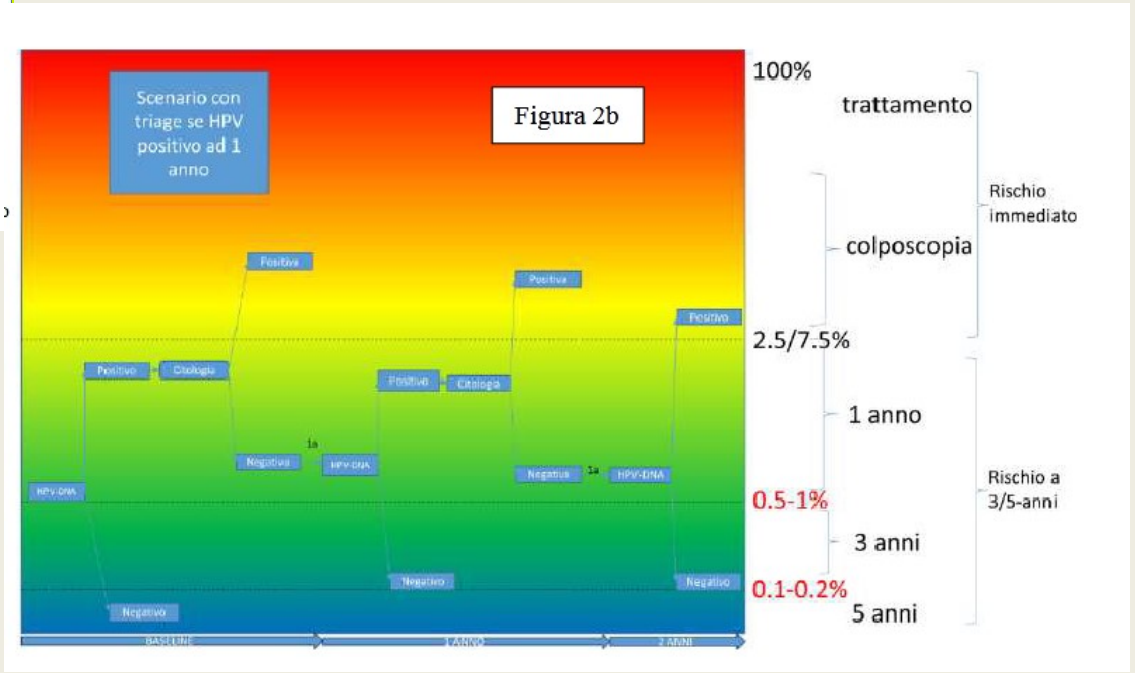
Megan A. Clarke, PhD, MHS; Li C. Cheung, PhD; Philip E. Castle, PhD, MPH; Mark Schiffman, MD, MPH; Diane Tokugawa, MD; Nancy Poitras, BS; Thomas Lorey, MD; Walter Kinney, MD; Nicolas Wentzensen, MD, PhD, MS

Figure 2. Cumulative Risk of ≥CIN2 and ≥CIN3 by p16/Ki-67 Dual-Stain Testing (DS) and Papanicolaou Cytology (Pap) Results



The 5-year cumulative risk curves were generated using the logistic Weibull model. The dashed line corresponds to the threshold for a 1-year return, and the dotted line corresponds to the threshold for immediate colposcopy referral in this study population. Plus sign indicates positive; minus sign, negative; ASC-US atypical squamous cells of undetermined significance; CIN2, cervical intraepithelial neoplasia grade of 2; CIN3, CIN grade of 3; NILM, negative for intraepithelial lesion or malignancy.


Scenario invio a 1 anno con invio immediato se HPV positivo
Figura 2a
Positiva
Positivo
Citologia
Negativa
1anno
HPV-DNA
Positivo
HPV-DNA
Negativo
Negativo
BASELINE
1 ANNO
100%
trattamento
colposcopia
Rischio immediato
2.5/7.5%
1 anno
Rischio a 3/5-anni
0.5-1%
3 anni
0.1-0.2%
5 anni


Scenario con triage se HPV positivo ad 1 anno
Figura 2b
Positiva
Positivo
Citologia
Negativa
1a
HPV-DNA
Positiva
Positivo
Positivo
Citologia
Negativa
1a
HPV-DNA
HPV-DNA
Negativo
Negativo
Negativo
BASELINE
1 ANNO
2 ANNI
100%
trattamento
colposcopia
Rischio immediato
2.5/7.5%
1 anno
Rischio a 3/5-anni
0.5-1%
3 anni
0.1-0.2%
5 anni

quanto rischio con HPV positivo?

Perche' sono sempre positiva?

Sara' pericoloso per il mio partner?

Importante non solo conoscere per saper rispondere ma anche come rispondere....

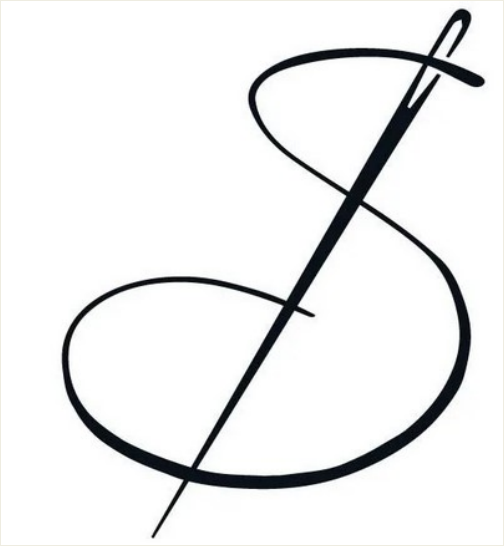
Corso:

la sfida comunicativa nello screening cervicale

8 aprile 2025

Aula Magna Ospedale Maggiore di Bologna

Lo screening non è più uguale per tutte!



grazie