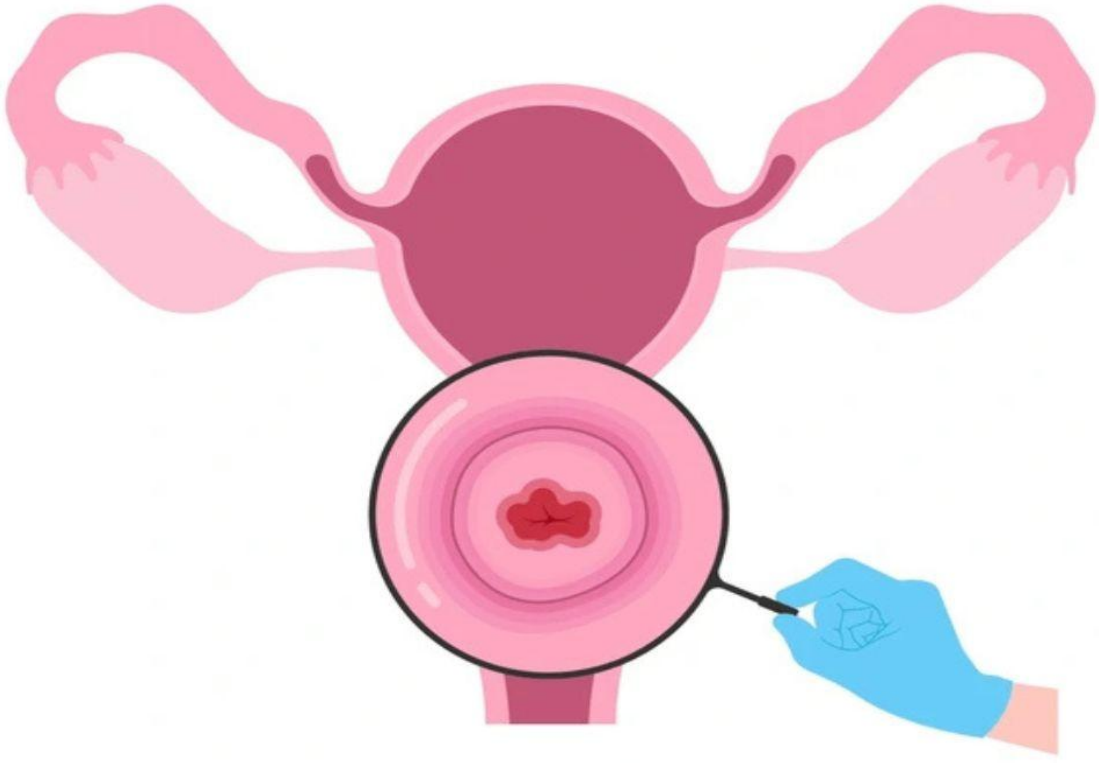
NATIONAL COLPOSCOPY GUIDELINE 2025



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Disclaimer:

This guideline provides national recommendations for the provision of colposcopy services in the Maldives. It is intended for use by licensed healthcare professionals involved in cervical cancer screening, diagnosis, and management. The guidance reflects current evidence and best practice at the time of publication and should be applied in conjunction with clinical judgment and local protocols.

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1. Background

1.1 Cervical Cancer Burden in Maldives

Cervical cancer is a significant public health concern in the Maldives. In 2022, there were 51 new cases and 26 deaths, making it the second most common cancer among women and overall, and responsible for over 10% of all cancer-related deaths [1].

Approximately 167,600 women aged 15 years and older are at risk in the Maldives. More than 80% of invasive cancers are attributed to HPV types 16 and 18 [2].

The South-East Asia region, including the Maldives, has one of the highest age-standardized incidence rates of cervical cancer (25 per 100,000 women), underscoring the need for strengthened screening and colposcopy services [3].

The Maldives has initiated a national cervical cancer screening programme, currently based on Pap smear cytology. While population coverage and follow-up mechanisms are still being strengthened, and coordination among stakeholders and treatment facilities continues to evolve, significant efforts are underway to expand and optimize the programme. Establishing an effective, well-organized screening and follow-up system remains a national priority, with ongoing work to improve coverage, streamline referral pathways, and ensure timely treatment for screen-positive women [3].

Although colposcopy is practiced by many clinicians (including advanced practice providers, primary care providers, gynaecologists, gynaecological oncologists, and others), standardization of the procedural process, necessary training, and continued development and maintenance of colposcopic skills are generally poor. It is also well-documented that colposcopy has significant inter-performer variability and poor reliability. In 2017, the American Society for Colposcopy and Cervical Pathology (ASCCP) published colposcopy standards to address these and other concerns.[4]

1.2 Colposcopy in Cervical Cancer Prevention

Colposcopy is a key diagnostic and management tool in cervical cancer prevention programmes. It is primarily used to assess the transformation zone epithelium, determine its type, identify abnormal areas, and facilitate directed biopsy or treatment [5]. Unlike visual inspection with acetic acid (VIA), colposcopy provides magnified visualization and more precise lesion characterization, which helps differentiate high-grade from low-grade abnormalities.

However, its higher cost, need for specialized equipment, and training requirements limit its use as a primary screening method [5].

In resource-limited settings, screening and treatment strategies should prioritize a balance between improving diagnostic accuracy and ensuring broader access to essential screening methods, such as VIA and pap smears. Colposcopy is recommended where available to ensure accurate diagnosis and appropriate treatment allocation. Global cervical cancer elimination efforts emphasise expanding basic screening coverage while selectively using colposcopy to improve management quality [6].

1.2.1 Role of Colposcopy in Cervical Cancer Screening, Diagnosis and Treatment:

- **Triage:** Used following a positive screening test (e.g., HPV DNA or cytology) to determine whether treatment is needed. Compared with a simple "screen-and-treat" approach using VIA, colposcopy offers higher specificity and helps reduce overtreatment [5].
- **Treatment:** Ranges from outpatient ablative or excisional procedures to surgical management for more advanced diseases; aim is complete removal of pre-cancer while preserving reproductive potential when possible.
- **Follow-up:** Post-treatment surveillance with HPV/cytology at defined intervals, may indicate colposcopy if High-Risk HPV (HR-HPV) persists, cytology is abnormal, or margins of a biopsy are incomplete, ensuring early detection of residual or recurrent disease. Clear pathways reduce loss of follow-up.

1.3 WHO-Recommended Screening Strategies

The World Health Organization (WHO) recommends two broad approaches (with 7 algorithms) to cervical cancer screening and treatment [6]:

1.3.1 Screen-and-treat approaches:

- VIA as the primary screening test, followed by treatment
- HPV DNA detection as the primary screening test, followed by treatment

1.3.2 Screen, triage and treat approaches:

- Cytology as the primary screening test, followed by colposcopy triage, followed by treatment
- HPV DNA detection as the primary screening test, followed by HPV16/18 triage (when already part of the HPV test), followed by treatment, and using VIA triage for those who screen negative for HPV16/18
- HPV DNA detection as the primary screening test, followed by VIA triage, followed by treatment

2. The Colposcope

2.1 History

The pioneer in the field of colposcopy was Hans Hinselmann, who is also known as the "father of colposcopy." He developed the first colposcope in 1924 (Hamberg, Germany) and reported his findings for the first time in 1925. He also coined the term "colposcopy." Acetic acid was used to identify squamocolumnar epithelium along with normal/abnormal transformation zone. He described his findings as punctations, leucoplakia, and diverse mosaic patterns which were termed matrix areas (potentially malignant lesions). He first used the colposcope to examine the cervix using a Leitz lens on top of a pile of books, the light source being the lamp used for usual gynaecological examinations which were positioned above the examining physician's head for illumination purposes. Later, he developed his first colposcope using fixed binocular lenses mounted on top of a tripod stand which was equipped with a light source and a mirror to collect the light [7].

2.2 The Colposcope

The colposcope is a dissecting microscope used to magnify cervical, vaginal, or vulvar tissue. There may be variations in features such as lens types, light filters, and integrated cameras.

Optical colposcopes were large and unhandy. These have been largely replaced with more compact digital and video colposcopes in recent years. There also has been an integration of colpo-photography which was subsequently digitalized via computerized software programs. It is now possible to store the colposcopic images and videos and transfer it remotely to expert physicians.

As a result of the endless efforts that have been made over time to make colposcopes more convenient and user-friendly, the reach of colposcopy has expanded outside of special colposcopy clinics into outpatient settings as well as for mass cervical screening programs. With the growth of colposcopy, its use is now not only limited to the examination of the cervix but also for the identification of vaginal and vulval pathologies through vaginoscopy and vulvoscopy.

Colposcopes should provide both low- and high-power magnification to evaluate lesions, with most offering interchangeable settings at 10× and 18×. Modern colposcopes incorporate white and green light filters to highlight vascular patterns that may indicate high-grade disease [8].

Digital video colposcopy, a newer technique, uses a built-in camera and powerful LED light source to provide magnification and illumination. Instead of binocular eyepieces, the colposcopic image is displayed on a high-resolution video monitor for viewing.

The advantages of a digital video colposcope includes easier image manipulation and the ability for multiple viewers—trainees as well as the patient—to observe the findings simultaneously. It also allows for a permanent record, capturing an exact replica of what the examiner sees [4].

2.3 Diagnostic accuracy

Colposcopy is a reliable tool for detecting cervical intraepithelial neoplasia (CIN) and directing histological confirmation. Its positive predictive value (PPV) is highest among women referred with high-grade cytology and lower among those referred solely for persistent HR-HPV with negative cytology [9–11]. UK guidelines recommend a PPV of at least 75% for high-grade impressions in high-grade cytology referrals, and at least 35% in other referral categories [12].

3. Indications for Referral for Colposcopy

The need for colposcopy is determined by individual risk. A woman's cytology results, HPV status (if available), and personal history of cervical dysplasia all contribute to her underlying risk for cervical precancer and guide referral decisions. When indicated, colposcopy is used to detect dysplasia and assess its severity.

3.1 Screening based indications

- Abnormal cytology results
- Positive HR-HPV DNA results
- Positive visual inspection with acetic acid (VIA) test
- Persistent inflammatory or unsatisfactory cervical cytology
- Persistent inconclusive HPV DNA tests
- Atypical endometrial, endo-cervical, and glandular cells on cytology or biopsy

3.2 Clinical indications

- Localization and mapping of existing lesions
- Selection of biopsy sites
- Examination of a suspicious cervix in cases of postcoital or postmenopausal bleeding, even with a negative cytology and/or negative HR-HPV DNA
- Investigation of unexplained abnormal lower genital tract bleeding
- Evaluation of persistent abnormal vaginal discharge not responding to standard treatments
- Conservative management of intraepithelial neoplasia
- Identification and treatment of vaginal extension of cervical neoplasia

- Post-treatment surveillance following intraepithelial neoplasia, invasive carcinoma, or radiation therapy

Not every abnormal Pap test requires immediate colposcopy. Low-risk abnormalities—such as LSIL or ASC-US with negative HPV—are less likely to reveal significant disease, and follow-up with repeat cytology in one year is usually appropriate. If abnormalities persist (e.g., LSIL or ASC-US with HPV positivity), colposcopy is recommended. Certain findings, such as HSIL or ASC-H, carry a higher probability of severe dysplasia or invasive cancer. In these cases, immediate colposcopy is warranted.

4. Colposcopy Clinic Requirements

4.1 Registration of Patients

All referred patients with appropriate clinical or screening indications shall be registered at the Colposcopy Clinic. Each case should undergo confirmation of indication and review of referral details prior to scheduling and further management. Proper registration ensures traceability, continuity of care, and data collection for monitoring service quality.

4.2 Consent Taking

Informed written consent must be obtained before performing colposcopy or any associated procedure. Patients should be informed about the purpose, potential findings, procedures such as biopsy or treatment, possible discomfort, and post-procedure care.

Refer to Appendix 1 for Sample Colposcopy Consent Form.

4.3 Colposcope, Instruments and Consumables

The clinic should be equipped with a functioning colposcope (preferably with variable magnification and green filter), appropriate examination instruments, consumables, and reagents.

The equipment needed to perform an adequate colposcopy includes a vaginal speculum, a colposcope, 5% acetic acid, Lugol's solution, biopsy forceps, an endocervical speculum, a Kevorkian curette or endocervical brush, and solutions or methods to stem bleeding.

An endocervical speculum may be needed to inspect the cervical os adequately. There is a variety of biopsy forceps available for cervical biopsy; the more common ones are Tischler cervical biopsy punch forceps, Burke biopsy forceps, or some variation of these.

Different haemostatic agents must be available for post-biopsy care. These include Monsell's solution, silver nitrate, as well as equipment for cauterization.

Refer to Appendix 2 for Table of equipment requirements for a Colposcopy Clinic.

4.4 Software for Video Colposcopy

Where available, video or digital colposcopy software should be used to capture, store, and manage high-quality images for documentation, follow-up, and teaching purposes. The system should be secure, ensuring patient confidentiality and integration with hospital record systems when possible.

4.5 Documentation and Provision of Colposcopy Images and Reporting

Each examination should be recorded in the colposcopy register or electronic system, including patient identifiers, indication, findings, impression, and management plan.

Where feasible, colposcopic images should be attached to the patient record and made available for audit and multidisciplinary review.

Refer to Appendix 3 for Sample Colposcopy Documentation Form.

4.6 Facilities for Colposcopy-Guided Biopsy and Treatment of Basic Dysplasia

The clinic must have facilities and equipment for performing directed biopsies and providing treatment for low-grade lesions, such as cryotherapy or thermal ablation, where indicated.

Sterile technique and appropriate infection prevention measures must be observed.

4.7 Histopathology Report Dispatch Facilities

A reliable system for specimen transport, processing, and timely receipt of histopathology reports should be established.

Results must be tracked and reviewed promptly to guide further management and follow-up.

4.8 Referral System

Clear referral pathways should exist for patients requiring higher-level care, including excisional treatment, oncology consultation, or multidisciplinary management.

A feedback mechanism should ensure continuity of care between referring and receiving centres.

4.9 Staffing and Infrastructure

A colposcopy clinic should be staffed by a trained gynaecologist responsible for clinical oversight, assisted by a designated nurse experienced in colposcopy procedures and infection control.

The facility must include a dedicated, well-ventilated procedure room with privacy, examination couch, lighting, emergency equipment, and hand hygiene facilities.

5. Colposcopic Examination

5.1 Scope of Examination

Colposcopic examination should include a thorough assessment of the **vulva, vagina, and cervix**, both **before and after the application of 5% acetic acid**.

The **entire cervix and squamocolumnar junction (SCJ)** must be visualized to ensure the adequacy of the procedure. Both **white light** and **blue or green filters** should be used to identify any abnormal lesions.[8]

5.2 Directed Biopsies

- **Directed biopsies** should be taken from **each abnormal finding**.
- If persistent bleeding occurs after biopsy, **Monsell's paste or silver nitrate** should be applied to control haemorrhage.
- If a **colposcopically directed biopsy** is reported as **inadequate for histological interpretation**, it should be **repeated at the earliest** if there is a residual colposcopic lesion. [12]

- All excisional procedures must be accompanied by **an endocervical curettage** (to rule out any abnormality in the endocervical canal **above the margin of excision**).

5.3 Documentation

Documentation of colposcopy must include the following:

- Extent of visibility and adequacy of examination
- Size, location, and description of each lesion (including colour, contour, border, and vascular changes)
- Presence or absence of **acetowhite areas**
- **Complete or incomplete** visualization of the SCJ
- **Type of transformation zone** (Type 1, 2, or 3)
- **Site and number** of directed biopsies
- **Colposcopic impression**: benign/normal, low-grade, high-grade, or cancerous lesion [4, 13]

Refer to Appendix 4 for Pictorial guide for identification of Transformation Zones.

5.4 Colposcopic Scoring and Interpretation

The **Swede Scoring System** is used to score the colposcopic findings and ensure uniformity in reporting. The total possible score is 10. (See *Table 1. Swede Scoring System*).

The performance and accuracy of colposcopic scoring are highly dependent upon the training and experience of the colposcopist.

The original study by Strander et al. reported the sensitivity to predict CIN grade 2 and higher (CIN2+) with a **Swede score ≥5** was **100%**, and the specificity was **90%** with a score ≥8. It was recommended that biopsy be reserved for a Swede score ≥5. [4, 14, 15]

For each characteristic, the score can be 0, 1, or 2. The scores for all five characteristics are added up to derive the final score. A provisional diagnosis can be made based on the total score.

Table 1. Swede Scoring System

Score	0	1	2
Aceto uptake	Zero or transparent	Shady, milky (not transparent; not opaque)	Distinct, opaque white
Margins/ surface	Diffuse	Sharp but irregular, jagged, "geographical" satellites	Sharp and even, the difference in surface level, including "cuffing"
Vessels	Fine, regular	Absent	Coarse or atypical
Lesion size	<5 mm	5 mm to 15 mm or 2 quadrants	>15 mm or 3-4 quadrants/endocervical undefined
Iodine staining	Brown	Faintly or patchy yellow	Distinct yellow

Table 2. Use of Swede Score to Predict Histology

Overall Swede Score	Colposcopic Prediction of Probable Histology
0-4	Low-grade/normal CIN1
5-6	High-grade/noninvasive cancer CIN2+
7-10	High-grade/suspected invasive cancer CIN2+

Refer to Appendix 5 for Pictorial Guide to Swede Scoring System.

5.5 Cytology and HPV Testing at Colposcopy

- **Cervical cytology should not be repeated** at the first colposcopy following a referral for cytological abnormality.
- **HPV DNA testing should not be repeated** at the first colposcopy for individuals referred with a previously positive HR-HPV DNA result.
- If the **initial cytology** is **inadequate**, the **repeat sample** should be taken **no less than three months** after the first. Repeating cytology within **three months** reduces test sensitivity and may affect colposcopy quality due to incomplete epithelial regeneration. [12, 16]
- A **minimum three-month interval** between cytology tests is therefore recommended to ensure diagnostic accuracy [12, 16]

- Evidence indicates that a **"see and treat"** approach in appropriate cases at the first colposcopy provides more effective management compared with performing only a directed biopsy. [17, 18]

5.6 Diagnostic Value

Colposcopy provides an **accurate method to diagnose CIN** and to differentiate **high-grade** from **low-grade** lesions, especially when used for **abnormal cytology assessment** rather than as a primary screening tool.

5.7 Indications for Biopsy

- **Biopsy must be performed** when cytology shows moderate or severe **high-grade dysplasia** or when a **recognisably atypical transformation zone** is seen.
- **Low-grade cytology** with a **low-grade or negative colposcopic exam** does **not require biopsy**, provided there is **no atypical transformation zone**.
- In deciding on treatment (particularly **destructive methods** such as thermal coagulation, laser ablation, cryocautery), **cytological and colposcopic findings** should be considered alongside biopsy results. [12, 19]

5.8 Excisional Biopsy

An **excisional form of biopsy** is recommended when:

- Most of the **ectocervix** is replaced by **high-grade abnormality**
- **Low-grade colposcopic changes** occur with **high-grade dysplasia**
- A **lesion extends into the endocervical canal**, in which case sufficient canal tissue must be removed to include the **endocervical extension** of the abnormality.

5.9 Minimum Data Recording Requirements

At every colposcopy examination, the following information **must be** recorded [12, 20]

- **Reason for referral**
- **Grade of cytological abnormality** – Knowledge of cytology improves the identification of high-grade CIN at colposcopy [21] and enhances diagnostic sensitivity when combined with colposcopic findings [22, 23].

- **HR-HPV result**
- **The presence or absence of a cervix**
- **Adequacy of examination**
- **Presence or absence of vaginal or endocervical extension**
- **Colposcopic features of any identified lesion** (IFCPC nomenclature) [14, 20]
- **Colposcopic impression** (with grade of any identified intraepithelial lesion)
- **Type of transformation zone** (TZ 1, TZ 2, or TZ 3)
- **Site and details of directed biopsies**

The use of the criteria from the International Federation of Cervical Pathology and Colposcopy (IFCPC) nomenclature committee is recommended when documenting colposcopic findings [14, 20].

5.10 Preparation and Counselling for Colposcopic Examination

- Ensure that every colposcopic examination is preceded by completion of the designated pre-procedure checklist.
- Provide appropriate counselling before the procedure, including the purpose of colposcopy, expected steps, potential discomfort, and possible outcomes.
- Use the standardised counselling and assessment checklist at each visit.
- Offer post-procedure counselling, including findings, recommended management, and follow-up instructions.
- Allow the woman to ask questions both before and after the examination and provide clear written or verbal information as required.

Refer to Appendix 6 for Sample Colposcopy Check-list for Pre- and Post-Procedure Tasks.

Refer to Appendix 7 for Sample Check-list for Pre- and Post-Procedure Counselling.

6. Management of Cervical Dysplasia

6.1 Overview

Cervical premalignant lesions (CIN) may be treated using ablative methods (cryotherapy or thermal ablation) or excisional methods, depending on defined clinical criteria.

6.2 Principles of Treatment

6.2.1 The entire **transformation zone** is at risk due to HPV-induced clonal changes. Therefore, the whole transformation zone should be treated (by destructive or excisional methods) regardless of lesion size.

6.2.2 High-grade CIN lesions may extend into crypts up to 5 mm deep.

- Ablative treatment must destroy tissue to a depth of 7–8 mm for complete clearance.
- Excisional treatment should remove the entire transformation zone, including crypts.

6.2.3 CIN1 and HPV-related changes do not routinely require treatment.

- Follow-up should not be less frequent than every 12 months.
- Discuss treatment options if lesions enlarge, persist beyond 24 months, or are associated with high-grade cytology.
- Treatment may be considered if reliable follow-up cannot be ensured.

6.2.4 CIN2 and CIN3 lesions should always be treated.

6.3 Low-Grade Dysplasia (CIN1)

- All women who are **HR-HPV positive with low-grade dysplasia** must be referred for colposcopy and **seen within 6 weeks** of result.
- All women with **inconclusive / unreliable HPV result** must be referred for colposcopy and **seen within 6 weeks** of result.
- Women who are **HPV positive with low-grade dysplasia** should undergo **colposcopic assessment**, but **not on a 'see and treat' basis** to prevent overtreatment.

6.4 High-Grade Dysplasia (CIN2/3)

- Women with **high-grade dysplasia (moderate and severe)** on cytology must be **referred directly for colposcopy** — HR-HPV testing is not required.
- Following direct referral, colposcopy must be performed **within 2 weeks** of result.
- The "see and treat" approach at first colposcopy visit is appropriate for CIN2/3, where immediate treatment is supported by the high likelihood of underlying high-grade disease.

6.5 Treatment Modalities

6.5.1 Destructive Techniques (thermal coagulation / laser ablation / cryocautery)

These techniques are suitable **only when** [12, 19]:

- The entire transformation zone is **fully visible and accessible**
- There is **no evidence or suspicion** of glandular abnormality or invasive disease.
- There is **no major discrepancy** between cytology and histology.
- There is no history of post-coital or intermenstrual bleeding
- There is no gland crypt involvement on punch biopsy
- There is no history of previous treatment of the cervix
- The patient should not be pregnant
- If the patient has recently delivered, she should be at least 3 months postpartum

Cryocautery should only be used for low grade CIN. A double freeze-thaw-freeze technique must be used. [12]

6.5.2 Excisional Techniques

- Excisional procedures should aim to remove the entire lesion as a **single, intact specimen** whenever possible.
- Fragmented excisions complicate histopathological interpretation, including defining completeness of excision and allocation of staging.
- The histology report must record **specimen dimensions** and **margin status**.
- The aim is **complete excision** of all abnormal epithelium.

6.5.3 Margins

- **CIN3 extending to excision margins** have a higher recurrence risk but **repeat excision not routinely required** if:
  - No glandular/invasive disease
  - Patient <50 years
  - Reliable follow-up is ensured
- **Women ≥50 years** with CIN3 at margins, repeat excision. [12]

6.6 Glandular Abnormalities

- **Colposcopic assessment** is mandatory for cervical glandular intraepithelial abnormalities, given the high risk of endocervical adenocarcinoma and CGIN.
- Colposcopy helps identify **coexistent CIN** and guides biopsy.
- Women with **suspected glandular neoplasia: CGIN, high-grade atypical glandular cytology and endocervical cells** on cytology must be referred directly for colposcopy — HR-HPV testing is not required.
- Following direct referral, colposcopy must be performed within 2 weeks of result.
- The "see and treat" approach at first colposcopy visit is appropriate for CGIN.
- **Primary excisional treatment** is recommended for **CGIN and high-grade atypical glandular cytology**, with further management based on histology and margins.
- Endometrial sampling is indicated in individuals referred to colposcopy with CGIN or high-grade atypical glandular cytology. [12]
- If margins of an initial excision are not free from CGIN, repeat excision. [12]
- Simple hysterectomy may be considered if [12]:
  - **Fertility is not required**
  - **Invasive disease has been confidently excluded**
  - There are positive margins after an adequate excisional procedure
  - High-grade abnormalities are found on follow up
  - There are other clinical indications for the procedure

6.7 Referral and Waiting Time Standards for Colposcopy

- Cytology or HPV DNA testing may be performed either at atoll hospitals or at tertiary centres, depending on service availability.
- All test results must be traced within 2 weeks (maximum allowable turnaround time for result tracing).
- Individuals requiring further evaluation must be referred immediately once results are available to a tertiary centre for appropriate assessment.
- Referral may be directed to regional centres with colposcopy services or directly to national referral centres, according to clinical need and local service capacity.
- Once results are available, patients should be referred without delay, in accordance with the cytology result identified.
- Colposcopy, along with any required treatment, must be performed **within the recommended time frames** from the time of obtaining results, for each indication.

Cytology Result	Recommended Time Frame for Colposcopy +/- Treatment
3 consecutive inadequate cytology or inconclusive HPV samples	Within 6 weeks of result
Borderline squamous change / HR-HPV positive	Within 6 weeks of result
Low-grade / HR-HPV positive	Within 6 weeks of result
High-grade (moderate)	Within 2 weeks of result
High-grade (severe)	Within 2 weeks of result
Borderline endocervical change / glandular intraepithelial abnormality	Within 2 weeks of result
Invasive glandular / squamous carcinoma	Within 2 weeks of result
Cells of other origin / abnormal cervix	Within 2 weeks of result

6.8 Follow-Up and Surveillance

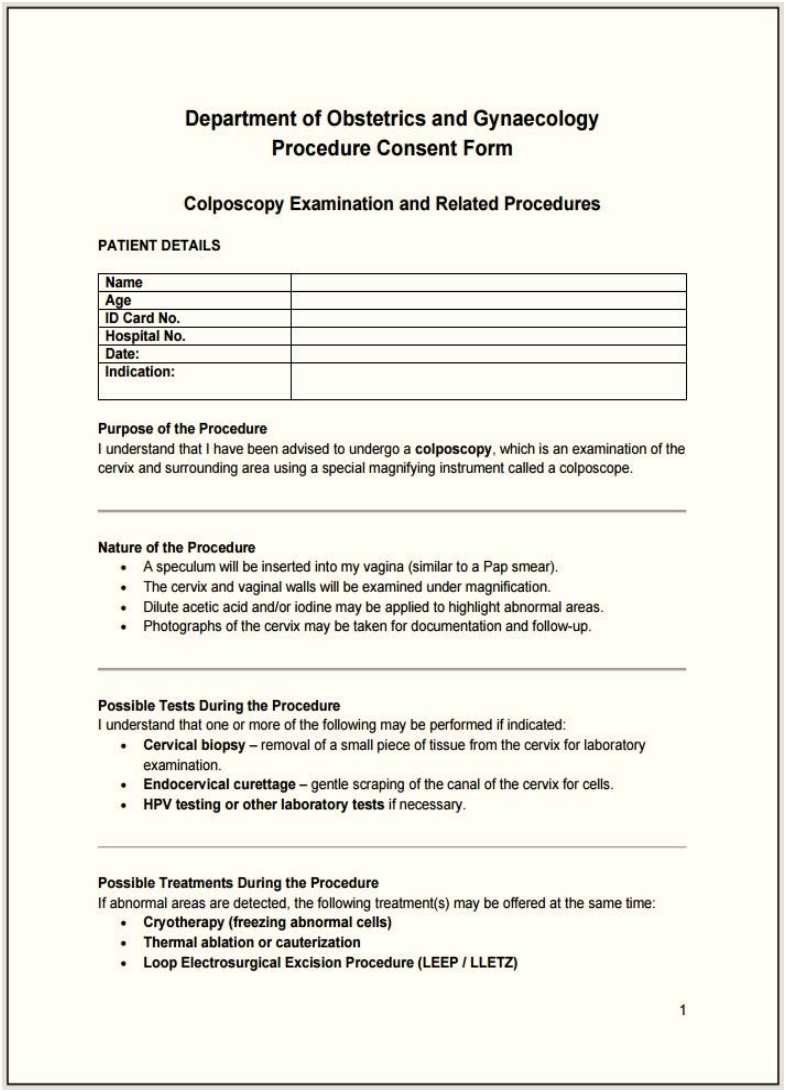
- Women treated for CIN remain **2–5 times more likely** to develop cervical cancer than the general population.
- **Poor follow-up compliance** accounts for many post-treatment cancers.
- Risk is increased in cases with **positive/endocervical margins** and **age ≥50 years**.
- All women should be recalled at **6 months post-treatment** for **test-of-cure cytology and HR-HPV testing**.
- Ongoing follow-up should be reinforced.

6.9 Colposcopy in Pregnancy

- An individual who meets the criteria for colposcopy should be examined in the colposcopy clinic even if they are pregnant. [12]
- Post-treatment or CIN1 follow-up colposcopy may be deferred until after delivery. [12]
- The primary aim of colposcopic examination of a pregnant individual is to exclude invasive disease and to defer biopsy or treatment until the individual has delivered. [12]
- Precancerous lesions are usually left untreated until about 3 months postpartum. [19]
- Biopsy may be deferred until 3 months postpartum if the suspected lesion does not appear invasive. [12, 19]
- For suspected invasive disease, diagnostic biopsy should be performed only in a setting with surgical backup due to the higher risk of bleeding. The risk of pregnancy loss must be informed at the time of consent for biopsy in such cases.

7. Appendix

APPENDIX 1: Consent Document



Department of Obstetrics and Gynaecology
Procedure Consent Form

Colposcopy Examination and Related Procedures

PATIENT DETAILS

Name	
Age	
ID Card No.	
Hospital No.	
Date:	
Indication:	

Purpose of the Procedure
I understand that I have been advised to undergo a **colposcopy**, which is an examination of the cervix and surrounding area using a special magnifying instrument called a colposcope.

Nature of the Procedure
- A speculum will be inserted into my vagina (similar to a Pap smear).
- The cervix and vaginal walls will be examined under magnification.
- Dilute acetic acid and/or iodine may be applied to highlight abnormal areas.
- Photographs of the cervix may be taken for documentation and follow-up.

Possible Tests During the Procedure
I understand that one or more of the following may be performed if indicated:
- **Cervical biopsy** – removal of a small piece of tissue from the cervix for laboratory examination.
- **Endocervical curettage** – gentle scraping of the canal of the cervix for cells.
- **HPV testing or other laboratory tests** if necessary.

Possible Treatments During the Procedure
If abnormal areas are detected, the following treatment(s) may be offered at the same time:
- **Cryotherapy (freezing abnormal cells)**
- **Thermal ablation or cauterization**
- **Loop Electrosurgical Excision Procedure (LEEP / LLETZ)**

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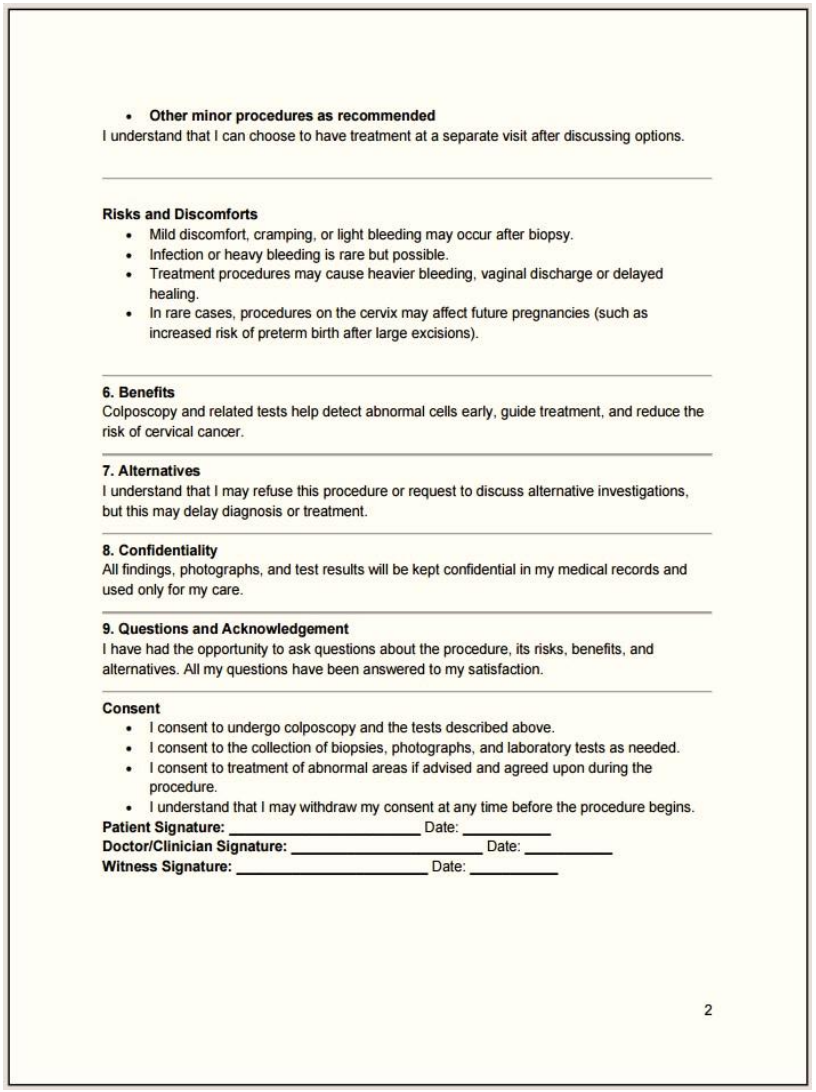


- **Other minor procedures as recommended**

I understand that I can choose to have treatment at a separate visit after discussing options.

Risks and Discomforts
- Mild discomfort, cramping, or light bleeding may occur after biopsy.
- Infection or heavy bleeding is rare but possible.
- Treatment procedures may cause heavier bleeding, vaginal discharge or delayed healing.
- In rare cases, procedures on the cervix may affect future pregnancies (such as increased risk of preterm birth after large excisions).

6. Benefits
Colposcopy and related tests help detect abnormal cells early, guide treatment, and reduce the risk of cervical cancer.

7. Alternatives
I understand that I may refuse this procedure or request to discuss alternative investigations, but this may delay diagnosis or treatment.

8. Confidentiality
All findings, photographs, and test results will be kept confidential in my medical records and used only for my care.

9. Questions and Acknowledgement
I have had the opportunity to ask questions about the procedure, its risks, benefits, and alternatives. All my questions have been answered to my satisfaction.

Consent
- I consent to undergo colposcopy and the tests described above.
- I consent to the collection of biopsies, photographs, and laboratory tests as needed.
- I consent to treatment of abnormal areas if advised and agreed upon during the procedure.
- I understand that I may withdraw my consent at any time before the procedure begins.

Patient Signature: _____ Date: _____
Doctor/Clinician Signature: _____ Date: _____
Witness Signature: _____ Date: _____

2

APPENDIX 2: Colposcopy Clinic Equipment Requirements

Item	Details / Examples
Colposcope (with Camera System)	Variable magnification, green filter preferred
Gynaecological Couch	Lithotomy or Semi-lithotomy position
Vaginal speculum	All standard sizes
Sponge forceps	For cleaning and for application of Acetic acid or Lugol's iodine to the cervix
Endocervical forceps	Kurihara and Desjardins forceps
Local analgesia syringes	Dental syringe
Lugol's iodine solution	For Schiller test
Biopsy forceps	Tischler-Morgan or Kevorkian punch biopsy forceps, or equivalent
Endocervical curette (Kevorkian) or Endocervical brush	For endocervical sampling
3-5% Acetic acid	For application during colposcopy
Monsell's solution	Haemostasis
Silver nitrate sticks	Haemostasis
Loops and diathermy electrode (ball)	LLETZ / LEEP and thermal ablation
Electrosurgical unit	Thermal coagulation or electrocautery / LLETZ
Cryosurgical unit (attached to a cylinder of either CO_2 or N_2O)	Cryotherapy
Consumables	Cotton swabs, gauze, gloves, specimen bottles

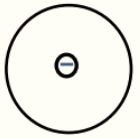
APPENDIX 3: Colposcopy Documentation Form

COLPOSCOPY FORM

Name of Colposcopy Center		
Patient's Name:		
ID Card no.:		
Contact number:		
Date of Colposcopy		(dd/mm/yyyy)
1.	Indication for Colposcopy	☐ HR HPV positive ☐ Abnormal cytology ☐ VIA positive ☐ Follow up after treatment ☐ Other: _____
History		
2.	Parity	
3.	On contraception	☐ No ☐ Yes Specify: _____
4.	Pregnant	☐ No ☐ Yes
5.	Menopause	☐ No ☐ Yes
6.	Hysterectomy status Cervix present	☐ No ☐ Yes ☐ Cervix present ☐ Cervix absent
7.	Previous history of treatment of cervix	☐ No ☐ Yes ☐ Ablative therapy ☐ Excisional therapy
8.	Smoker	☐ No ☐ Yes
9.	HIV status	☐ Negative ☐ Positive
Colposcopic Examination		
6.	Adequacy of colposcopic examination	☐ Adequate (the entire cervix and SCJ is visible) ☐ Inadequate Inadequate due to: _____
7.	Squamocolumnar junction (SCJ)	☐ Fully visible ☐ Partially visible ☐ Not visible
8.	Type of transformation zone	☐ Type 1 ☐ Type 2 ☐ Type 3
9.	Vaginal and / or endocervical extension	☐ No ☐ Yes ☐ Vaginal extension ☐ Endocervical extension
10.	Abnormal lesion present	☐ No ☐ Yes
If lesion is present:		
i	Location	☐ In the TZ ☐ Outside the TZ
ii	Percentage of cervix involved	☐ <25% ☐ 25-50% ☐ 50-75% ☐ >75%
iii	Acetowhite uptake	☐ Thin/ Transparent ☐ Dense
iv	Borders	☐ Diffuse / Irregular / Geographic ☐ Sharp
v	Mosaics	☐ No ☐ Fine ☐ Course
Vi	Punctations	☐ No ☐ Fine ☐ Course
vii	Inner border/ridge sign	☐ No ☐ Yes
viii	Cuffed crypt opening	☐ No ☐ Yes
ix	Iodine staining	☐ Stained ☐ Non-stained ☐ Not done
x	Erosion / leukoplakia	☐ No ☐ Yes
xi	Irregular surface of AW	☐ No ☐ Yes
xii	Atypical/fragile vessels	☐ No ☐ Yes
xiii	Frank growth / ulceration / necrosis	☐ No ☐ Yes
xiv	Miscellaneous (specify)	

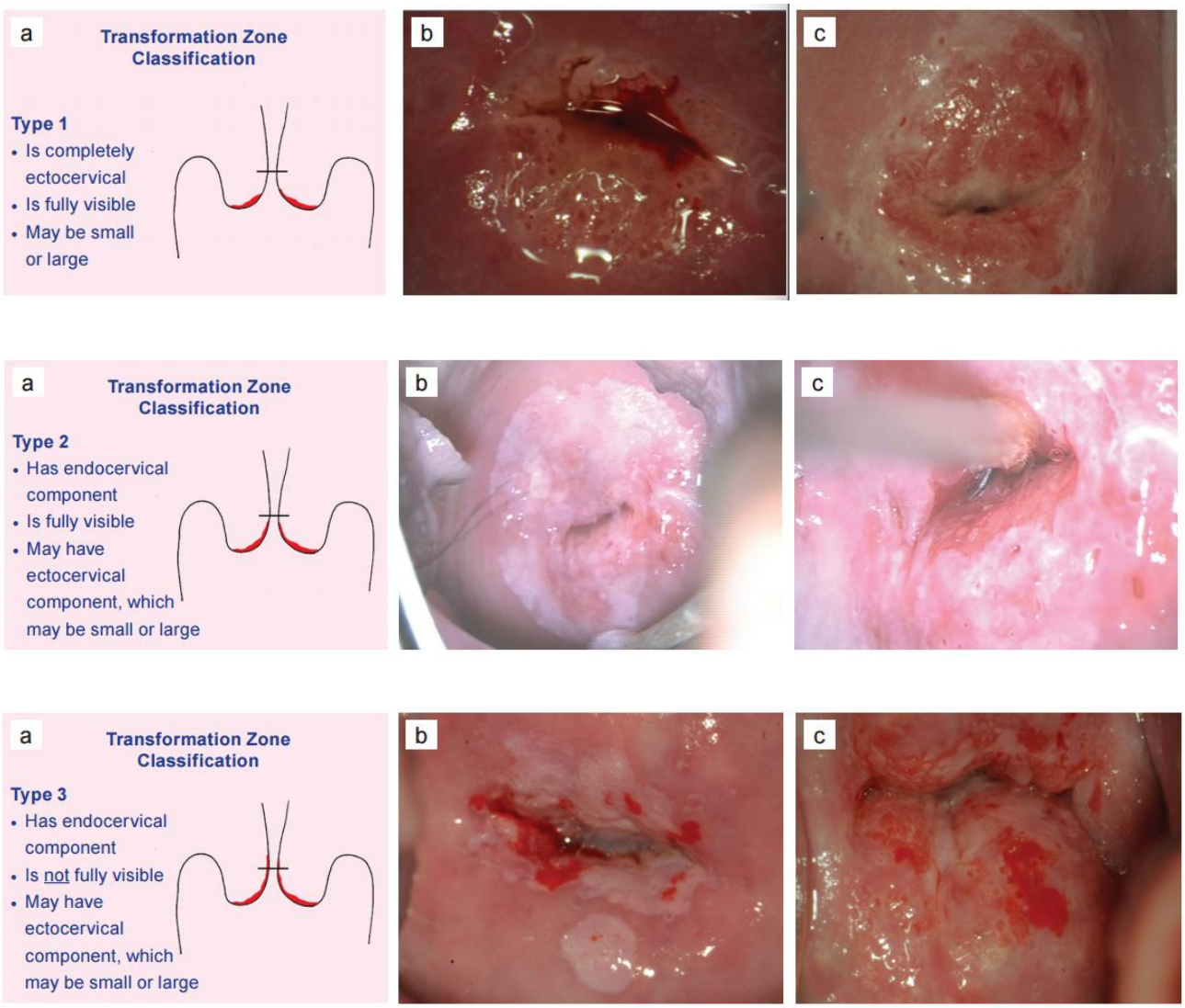
1

COLPOSCOPY FORM

11.	Swedes score	
12.	Colposcopy provisional diagnosis	☐ Normal ☐ Inflammation ☐ Leukoplakia ☐ Condyloma ☐ Low grade squamous intraepithelial lesions ☐ High grade intraepithelial lesions ☐ Suspicious for invasive cancer ☐ Other: _____
13.	Biopsy taken	☐ No ☐ Yes ☐ Refused ☐ Facility not available
14.	Mark the lesion Mark the biopsy site (X)	
15.	Endocervical biopsy taken	☐ No ☐ Yes
16.	Endometrial biopsy taken	☐ No ☐ Yes
17.	Histopathology report	☐ Normal ☐ Inflammation ☐ LSIL / CIN 1 / Atypia ☐ HSIL – CIN 2 ☐ HSIL – CIN 3 ☐ Adenocarcinoma in-situ ☐ Micro invasive carcinoma ☐ Squamous cell carcinoma ☐ Adenocarcinoma ☐ Other carcinoma (specify): _____ ☐ Inadequate / Inconclusive ☐ Other (specify): _____
18.	Treatment	☐ None ☐ Cryotherapy ☐ Cold coagulation ☐ LEEP ☐ Cold Knife Conisation ☐ Hysterectomy ☐ Refused treatment ☐ Referred (specify reason): _____
19.	Treatment date	(dd/mm/yyyy)
20.	Referred to	
21.	Follow-up date	
Name and signature/ stamp of Colposcopist:		Sign here

2

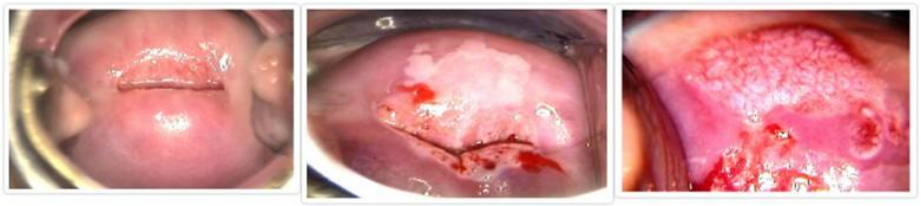
APPENDIX 4: Transformation Zone Pictorial Guide



Source: Prendiville W, Sankaranarayanan R. Colposcopy and Treatment of Cervical Precancer. Lyon (FR): International Agency for Research on Cancer; 2017. (IARC Technical Report, No. 45.)

APPENDIX 5: Pictorial Guide to Colposcopic Findings for Swede Scoring

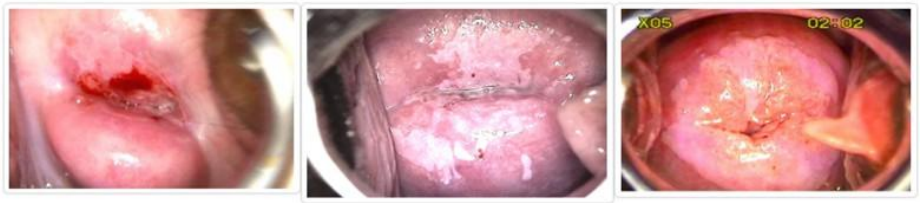
- **Margin and surface of the lesion**



0: Diffuse or no margin

1: Sharp but irregular, jagged, "geographical"; satellites

2: Sharp and even; difference in surface level, including "cuffing"

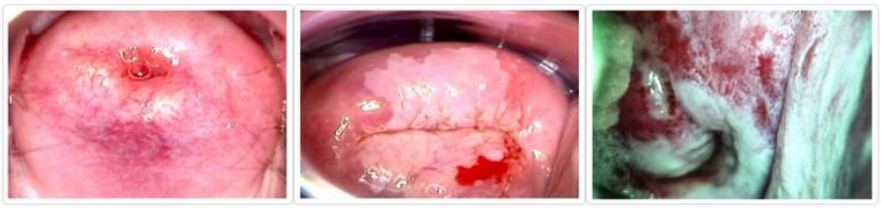


0: Diffuse or no margin

1: Sharp but irregular, jagged, "geographical"; satellites

2: Sharp and even; difference in surface level, including "cuffing"

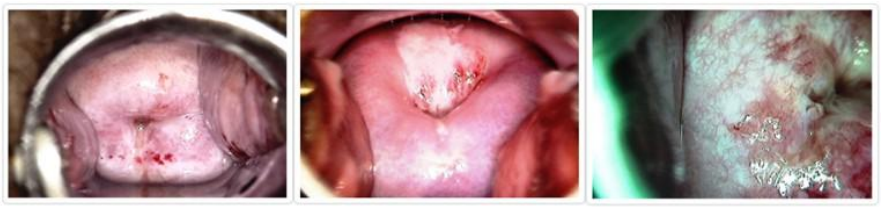
- **Characteristic of blood vessels**



0: Fine, regular

1: Absent

2: Coarse or atypical

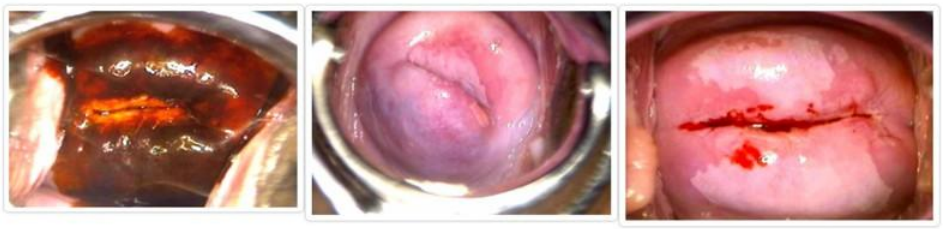


0: Fine, regular

1: Absent

2: Coarse or atypical

- **Size of the lesion**



0: < 5 mm

1: 5–15 mm or spanning 2 quadrants

2: > 15 mm or spanning 3–4 quadrants, or endocervically undefined

0: < 5 mm

1: 5–15 mm or spanning 2 quadrants

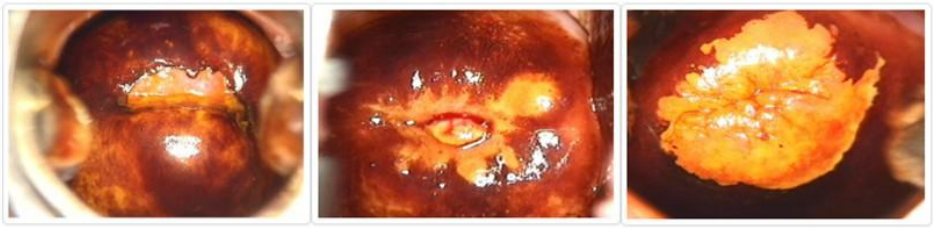
2: > 15 mm or spanning 3–4 quadrants, or endocervically undefined

- **Result of application of Lugol's iodine**

0: Brown

1: Faint or patchy yellow

2: Distinct yellow



0: Brown

1: Faint or patchy yellow

2: Distinct yellow

Source: *Basu P, Sankaranarayanan R (2017). Atlas of Colposcopy – Principles and Practice: IARC Cancer Base No.13, Lyon, France: International Agency for Research on Cancer.*

APPENDIX 6: Colposcopy Pre- and Post-Procedure Checklist

COLPOSCOPY CHECKLIST		
Steps		**Check**
Preparation for colposcopy		
1	Keep necessary instruments ready (see list of equipment)	
2	Check availability of consumables (see list of consumables)	
3	Ensure that the colposcope is functioning and is ready to use	
4	Position the colposcope and check for adequacy of intensity of light source	
5	Adjust the eye pieces to get well focused stereoscopic vision	
6	Arrange instruments and supplies on sterile tray or container	
History taking (Ask questions/check records)		
7	Personal information: Name, age, husband's name, address, telephone number and LMP	
8	Obstetric history	
9	History of past illness	
10	Check referral records and review the cause of referral	
11	Ask for any of the following symptoms: • Persistent foul smelling white discharge • Post-coital bleeding • Post-menopausal bleeding • Irregular menstrual bleeding	
12	Record all relevant information on a case record form	
Counseling and consent		
13	Follow the checklist for Counseling	
14	Obtain informed consent	
15	Step-wise colposcopy procedure	
16	Check that the woman has emptied her bladder	
17	Help her onto the examining table, to undress and drape her	
18	Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry	
19	Put one pair of new examination gloves on both hands	
20	Inspect external genitalia and check urethral opening for discharge	
21	Select speculum of appropriate size and lubricate the blades with lubricant jelly or saline	
22	Insert speculum and adjust it so that the entire cervix can be seen	
23	Fix the speculum blades in the open position so that the speculum will remain in place with the cervix in view	
24	Adjust the colposcope to bring the cervix in sharp focus using appropriate magnification (usually 6x or 8x)	
25	If the cervix cannot be exposed properly or is obscured by excessive inflammation or bleeding or scar the colposcopy is to be considered "inadequate"	
26	Examine the cervix for cervicitis, growth, ulcers or contact bleeding	
27	Apply normal saline to the cervix with cotton swabs to gently remove the mucus and discharge	
28	Identify the external os and the squamocolumnar junction (SCJ).	
29	Examine blood vessels with the help of a green (or blue) filter. Increase magnification if required	
30	Soak a clean swab in 5% acetic acid and apply it to the cervix	
31	Wait for 1 minute for any aceto-white change to appear	
32	Locate the SCJ again and determine the type of TZ	
33	Look for any new white patch (acetowhite area) appearing on the cervix	
34	If there is an aceto-white area, look for the following features: • Density • Margin characteristics • Location in relation to SCJ or external os • Number of quadrants involved • Vascular pattern	
35	Use an endo-cervical speculum to visualize the endo-cervix, if necessary	
36	After completion of the examination with acetic acid, use a fresh swab to remove any remaining acetic acid from the cervix and the vagina	
37	Apply Lugol's iodine and inspect for colour change	
38	Use Swede score for interpretation of colposcopy findings	
39	Perform cervical biopsies (or proceed for treatment) depending on the Swede score	
40	Obtain punch biopsy (s) from the worst identified lesion (s) close to the SCJ	
41	Apply Mosel's solution (paste) to biopsy site to control bleeding	
42	Remove the speculum	
43	Help the woman to get up from the examination table and sit comfortably. Tell her that you will explain the test findings soon	
Post-colposcopy tasks		
44	Dispose-off the swabs in appropriate disposal bags	
45	Immerse the speculum in 0.5% chlorine solution	
46	Immerse both gloved hands in 0.5% chlorine solution.	
47	Remove gloves by turning them inside out	
48	Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry	
49	Record the colposcopy findings in the woman's case record form	
50	i. If colposcopy test is normal, counsel the woman as per Skills Checklist for normal findings ii. If punch biopsy has been taken, label the specimen and fill up the lab requisition form and give post-biopsy instructions iii. If colposcopy is abnormal and immediate Cold coagulation or LEEP is planned proceed for treatment as per skills checklist for the same iv. If invasive cancer is suspected on colposcopy, counsel the woman as per Skills Checklist for the same	

APPENDIX 7: Counselling for Colposcopy - Checklist

Steps for counselling Normal Colposcopy		
Steps		**Check**
Counselling prior to Colposcopy		
1	Greet the woman respectfully and introduce yourself	
2	Explain the screening test result and its implication	
3	Explain the necessity of colposcopy to confirm the presence or absence of disease	
4	Describe how colposcopy will be done and the possible results	
5	Give information about the possibility of obtaining biopsy or treatment	
6	Explain the treatment options and treatment procedures that may be required	
7	Reassure the woman that the colposcopy procedure causes minimum discomfort	
8	Inform the woman that the procedure will take same time and the discomfort may be a little more if biopsy is done	
9	Explain the expected side effects and potential complications of treatment, in brief	
10	Respond to the woman's possible concerns	
Post-colposcopy Counselling: Colposcopy is Normal		
11	Help the woman to get up from the table and be comfortably seated	
12	Discuss the results of colposcopy and the significance of a normal test	
13	Tell the woman when and where to go for the next screening	
14	Assure her that she can return to the clinic for any medical advice or attention if required	
15	Maintain your record	

Score Achieved:
Facilitators Remarks:
Facilitator's Signature:

Steps for counselling Suspicion of Cancer		
Steps		**Check**
Counselling prior to Colposcopy		
1	Greet the woman respectfully and introduce yourself	
2	Explain the screening test result and its implication	
3	Explain the necessity of colposcopy to confirm the presence or absence of disease	
4	Describe how colposcopy will be done and the possible results	
5	Give information about the possibility of obtaining biopsy or treatment	
6	Explain the treatment options and treatment procedures that may be required	
7	Reassure the woman that the colposcopy procedure causes minimum discomfort	
8	Inform the woman that the procedure will take same time and the discomfort may be a little more if biopsy is done	
9	Explain the expected side effects and potential complications of treatment, in brief	
10	Respond to the woman's possible concerns	
Post-colposcopy Counselling: Cancer is suspected on colposcopy		
11	Help the woman to get up from the table and be comfortably seated	
12	Express concerns about the test findings and ask the woman if she would like to have any of her relatives or friends with her	
13	Inform the woman about the colposcopy findings and their implications	
14	Reassure the woman that appropriate treatment for the condition is available and arrangements will be made for that	
15	Emphasize the fact that early treatment is most crucial	
16	Give detailed and specific information on the referral centre that she needs to visit for treatment	
17	If a biopsy has been taken during colposcopy, inform the woman about the date and place from where the biopsy report needs to be collected	
18	Encourage the woman to ask questions and respond with care	

Score Achieved:
Facilitators Remarks:
Facilitator's Signature:

Steps for counselling Abnormal Colposcopy Requiring Cold-Coagulation or LEEP		
Steps		**Check**
Counselling prior to Colposcopy		
1	Greet the woman respectfully and introduce yourself	
2	Explain the screening test result and its implication	
3	Explain the necessity of colposcopy to confirm the presence or absence of disease	
4	Describe how colposcopy will be done and the possible results	
5	Give information about the possibility of obtaining biopsy or treatment	
6	Explain the treatment options and treatment procedures that may be required	
7	Reassure the woman that the colposcopy procedure causes minimum discomfort	
8	Inform the woman that the procedure will take same time and the discomfort may be a little more if biopsy is done	
9	Explain the expected side effects and potential complications of treatment, in brief	
10	Respond to the woman's possible concerns	
Post-colposcopy Counselling: Colposcopy is abnormal and the woman needs cold-coagulation or LEEP		
11	After completing colposcopy, ask the woman if she is more comfortable discussing the test results while lying down or sitting up on the table	
12	Inform the woman about the colposcopy findings and the significance of positive results	
13	Give her detailed information about how treatment will benefit her	
14	Give detailed information about the LEEP/coldcoagulation procedure	
15	Explain the side effects she may experience during and after the procedure	
16	Encourage the woman to ask questions and respond with care	
17	Give the woman some time to decide	
18	Obtain informed consent for cold-coagulation/ LEEP	
Post-LEEP / Cold-coagulation Counselling		
19	Provide the woman with instructions for self-care at home	
20	Inform her that she should seek medical attention if she experiences the following within 4 weeks of treatment: • Fever with shaking chills and/or >38 °C • Foul smelling purulent discharge • Severe lower abdominal pain/cramps • Vaginal bleeding >2 days or with clots otherthan expected menstrual bleeding	
21	Provide instructions for using condoms and sanitary pads (if supplied)	
22	Ensure that the woman has understood the instructions fully	
23	Answer any questions the woman may ask	
24	Schedule a follow-up visit	

Score Achieved:
Facilitators Remarks:
Facilitator's Signature:

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