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Success with LLETZ-Time to Initiate Universal Screening for Ca Cervix in India ?

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Summary

Large Loop Excision of Transformation Zone (LLETZ) has already been accepted as a favoured treatment option for women with cervical intraepithelial neoplasia (CIN). It has the inherent advantage of any excisional method of treatment namely the availability of tissue for further assessment by histology. A LLETZ procedure can be done under local anaesthesia saving on the cost of theatre time and anaesthesia. Presented here is my experience with 14 patients treated with LLETZ under local anaesthesia and in the outpatient department of the Ruby Hall Clinic, Pune.
Other advantages of this procedure are also discussed in trying to make a case that the acceptability and simplicity of this modality of treatment should help improve acceptance of the Pap smear test and hence the cancer screening programme itself in India.

Introduction

Effective use of the Pap smear test forms the basis of the screening programme for cancer of the cervix. A Pap smear test can detect cancer of the cervix in its preinvasive or early stage. The patient at this stage stands a good chance of a complete cure and hence cancer can be prevented.

It has been shown that in well screened population a shift in the age group of patients presenting with preinvasive disease is observed. This is not surprising as preinvasive disease predates the invasive disease by several years. The mean age of women presenting with CIN is 30 (Paraskevaidis et al, 1992). Therefore the treatment for CIN should also be one that is suitable for younger women.

LLETZ is associated with little immediate and long term morbidity (Moore EJ 1992). Successful pregnancy outcome has been documented after a LLETZ procedure (Briggs et al, 1991) and the rate of recurrence or residual disease is reported to be as low as 5% in the first year and 0.6% in the second year (Bigrigg et al, 1994). Thus making it an ideal and effective choice of treatment for younger women.

It was possible to set up the service using preexisting equipment in the hospital. We present here our experience with this procedure in terms of acceptability amongst women, complications observed and results at first follow up which reflect its effectiveness.

Technical aspects

All the procedures were successfully completed in the out patient department (OPD). The additional instruments required in the OPD were, an Olympus OCS 3 Colposcope, a unipolar diathermy instrument,

standard suction machine, pencil switch with reusable loop shaped electrodes and stirrups at the end of examination bed to put the patient into lithotomy position. Local anaesthetic, 2% lignocaine with or without 1 in 80000 adrenaline was used. An antiseptic cream was routinely applied after the procedure and oral antibiotics prescribed as the cases were all done in out patient set up.

Method

A colposcopic examination was done to assess the extent of lesion using acetic acid and/or Lugol's iodine to enhance the findings. Local anaesthetic was infiltrated, 1ml in each quadrant of the ectocervix with a 24 No. needle. A LLETZ cone was done when CIN was suspected whether on smear or on colposcopy. In several cases it was felt necessary to remove the suspected area not as cone but in two sections one covering the anterior lip & other the posterior lip. This allowed me to use a smaller size loop instead of one large loop that may have covered the entire area of abnormality. This was better tolerated by the patient as injury to vaginal wall was less likely when smaller loop was used. The base of the cone was cauterized using ball cautery. Antiseptic cream was applied and oral antibiotics were prescribed. The patient was reviewed in the clinic after two months whenever possible and a smear repeated if indicated.

Results

The results are presented here in table I. All women found to have any degree of dysplasia on either the smear or colposcopy had a LLETZ biopsy done instead of a directed biopsy alone. Overall a correlation between cytology and histology was obtained only in half the cases. On at least two occasions a higher grade lesion was diagnosed on histology than the one on corresponding cytology. This is not surprising as a higher prevalence of CIN has been demonstrated on LLETZ than on directed biopsy alone (Chia et al, 1993). Of these two positive cases one was found to have moderate dysplasia and the other adenocarcinoma in situ (AIS). In the latter case colposcopy was done in the presence of normal smear when a high degree of clinical suspicion was raised. Colposcopic assessment of this patient led to the diagnosis of CIN 3 and AIS was diagnosed on LLETZ. It is not unusual to miss a glandular intraepithelial lesion on cytology (Christopherson et al, 1979). It has also been observed that there are no colposcopic features that allow clear distinction between CIN and AIS and most often the diagnosis made on histology as in the case described (Luesly, 1987).

A number of women were referred with persistent erosion or leucorrhoea with or without an

Table I

Sr. No.	Index Smear or Ind.	Colpo. Imp	Proc. Done	Histology	Compli-cation	Follow Up Smear
1.	Mild Dysplasia	CIN 1	LLETZ	Moderate Dysplasia	Nil	Awaited
2.	Leuco.* & Erosion	CIN 1	LLETZ	CEC**	Nil	Normal
3.	Leuco & Erosion	CIN 1	LLETZ	CEC	Nil	Normal
4.	Mild Dysplasia	CIN 1	LLETZ	Mild Dysplasia	Nil	Awaited
5.	Warts and HPV***	CIN 1	LLETZ	Mild Dysplasia	Bleeding	No FU
6.	Severe Dysplasia	CIN 1	LLETZ	CEC	Nil	Normal
7.	Leuco & Erosion	Inflamm.$	Biopsy	CEC	Nil	Awaited
8.	Leuco & Erosion	CIN 1	LLETZ	CEC	Nil	Awaited
9.	Mild Dysplasia	CIN 1	LLETZ	CEC	Nil	Normal
10.	HPV Changes	Inflamm.	LLETZ	CEC	Nil	Normal
11.	Mild Dysplasia	Metaplasia	LLETZ	CEC	Nil	Normal
12.	Erosion & PMB$$	CIN 1	LLETZ	CEC	Nil	Hysterectomy
13.	Erosion & I PCB$$$	CIN 3	LLETZ	AIS	Nil	Hysterectomy
14.	Mild Dysplasia	CIN 1	LLETZ	Mild Dysplasia	Syncopal Attack	Normal

*Leuco=Leucorrhoea, **CEC=chronic nonspecific endocervicits, ***HPV=Human Papillom, $Inflam.=Inflammation, $$PMB =post menopausal bleeding, $$$PCB=post coital bleeding, AIS=adenocarcinoma in situ

abnormal smear. If colposcopic assessment diagnosed CIN then LLETZ was undertaken. Such a "see and treat" policy does lead to over treatment as evident from our results. Six women diagnosed to have CIN on colposcopy alone were found to have chronic endocervicitis only on histology. However, besides the fact that this policy led to the diagnosis of one high grade lesion and an adenocarcinoma in situ it was also my observation that all these women experienced satisfactory cure from leucorrhoea and were left less anxious from fear of cancer without having to undergo any major surgery.

All women who had any grade of dysplasia on the index smear were recalled for follow up (FU) smear after two months and 4 out of 6 of these smears after LLETZ procedure were reported to be negative, two did not come follow up. Women with negative smears prior to treatment were also recalled for FU. Local healing was satisfactory and they have been advised to have repeat smear after 6 months with the referring Gynaecologist.

Only one woman complained of persistent bleeding for longer than two weeks but was managed satisfactorily with a repeat course of oral antibiotics. One woman suffered from a syncopal attack soon after the procedure but could be revived with oral fluids and rest. Two of our patients underwent hysterectomy. One immediately after having found to have adenocarcinoma in situ and the other at a later date for complaints of post menopausal bleeding and was found to have an endometrial cancer.

Discussion

It has already been demonstrated that visual inspection is both an insufficient and inaccurate method of screening for cancer of cervix (Sunanda et al, 1995). Inspite of this gynaecologists choose to do smears only when the cervix looks abnormal on inspection or when a patient presents with menstrual irregularities.

It is possible that lack of availability of a suitable form of treatment acts as a deterrent when it comes to advocating a smear test routinely. As a matter of fact so far the only treatment easily available for women found to have abnormal smears was to undergo a cone biopsy or hysterectomy, often even before a colposcopic assessment. Successful as this policy maybe in treatment of CIN, it is not an option suitable for younger women who have yet to complete their families.

Also considering that only 22% of the women with even severe dysplasia or CIN3 will go on to develop cancer (Mc Indoe et al, 1984), most are being treated unnecessarily and often with huge consequences. Premature ovarian failure occurs in 26% of the women who undergo hysterectomy (Siddle et al, 1987), putting these women at an increased risk of cardiovascular disease and osteoporosis. Cone Biopsy was associated with higher rates of postoperative haemorrhage, infections and stenosis when compared with laser treatment (Larsson et al, 1983).

In contrast to this a large study has shown that women who underwent LLETZ treatment experienced less of postoperative haemorrhage and discomfort when compared with laser, besides having the advantage of less capital expenditure (Gunasekara et al, 1990). LLETZ is also a safe and effective procedure with no effect on menstruation or fertility (Bigrigg et al, 1994).

I hope that availability of LLETZ will lead to wider use of the screening test. Long term follow up in our circumstances has yet to be seen and will unfold with time. What is apparent is that the procedure is associated with minimal immediate morbidity, is well tolerated by patients and effective in treatment of preinvasive disease. Our experience at Ruby Hall's Well Women's clinic has been very encouraging. The technique is simple, the service not at all capital intensive to set up and more importantly the procedure was well tolerated by the patients and effective in treating the disease.

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