החברה הישראלית לרפואת האם והעובר
Israeli Society of Maternal-Fetal Medicine

החברה הישראלית לקולפוסקופיה
ופתולוגיה של צוואר הרחם והעריה
Israeli Society of Colposcopy and
Cervical and Vulvar Pathology

CIN 2-3 בהריון - מה עושים עם זה , ומה הנתונים בישראל ?

דר אפרים סיגלר
יו"ר
החברה הישראלית לקולפוסקופיה
ופתולוגיה של צוואר הרחם והעריה

במשך 15 שנה אני אוסף נתונים של נשים בהריון
שאובחנו עם ממצא של CIN 2-3 בביופסיה.
כמובן שזה לא מדגם מיצג , אבל הנתונים תואמים את הספרות

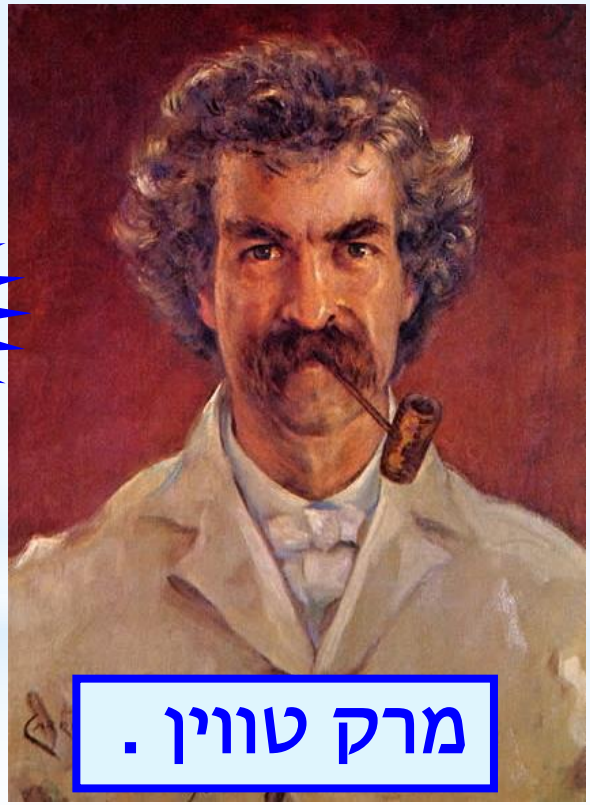
153 women were diagnosed
with CIN 2-3 lesion on cervical biopsy
during pregnancy

INVASIVE CANCER WAS DIAGNOSED IN 9 women (5.9%)

קודם תלמד את העובדות.

אחר כך אתה יכול לסלף אותן כאוות נפשך."

95%



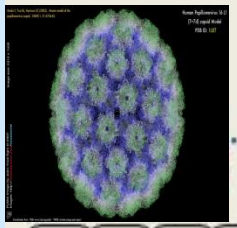
מרק טווין .

5%

סמיואל לנגהורן קלמנס

30 בנובמבר 1835 - 21 באפריל 1910

Progression of cervical disease after HPV infection



5%

Progression*

Months

Years

Normal epithelium

HPV infection koilocytosis

CIN1

CIN2

CIN3

Invasive carcinoma

Low-grade squamous intraepithelial lesion (ASCUS/LSIL)

High-grade squamous intraepithelial

Regression

30-50%

* Probability increases with viral DNA integration. CIN: cervical intraepithelial neoplasia; ASCUS: atypical squamous cells of undetermined significance

Burd EM. *Clin Microbiol Rev* 2003; **16**:1–17; Solomon D, *et al. JAMA* 2002; **287**:2114–2119.

2021

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ELSEVIER

Review article

European consensus statement on essential colposcopy

C.W.E. Redman[a], V. Kesic[b], M.E. Cruickshank[c,*], M. Gultekin[d], X. Carcopino[e], M. Castro Sanchez[f], M. Grigore[g], M. Jakobsson[h], V. Kuppers[i], A. Pedro[j], O. Reich[k], S. Leeson[l], U. Tabuica[m], J. Zodzika[n], A. Ciavattini[o], R. Jach[p], M. Katsyuba[q], R. Koiss[r], P. Martin-Hirsch[s], W.A. Tjalma[t], P. Nieminen[u], On behalf of the European Federation for Colposcopy and Pathology of the Lower Genital Tract (EFC) and the European Society of Gynecologic Oncology (ESGO)

Initial management of women with HSIL

Biopsies should be taken in non-pregnant women.

- If histological HSIL is confirmed, then treatment should usually be performed but expectant management can be considered in young women (≤30 years) with a small area HSIL/CIN 2 lesion, with a fully visible transformation zone [9]
- If treatment is not undertaken, then close surveillance with colposcopy and cytology is recommended with 6 monthly intervals. If at follow-up HSIL cytology persists over 24 months, then excisional treatment is recommended

2019

ORIGIN ASCCP VIX AND HPV

2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors

Rebecca B. Perkins, MD, MSc,[1] Richard S. Guido, MD,[2] Philip E. Castle, PhD,[3] David Chelmow, MD,[4] Mark H. Einstein, MD, MS,[5] Francisco Garcia, MD, MPH,[6] Warner K. Huh, MD,[7] Jane J. Kim, PhD, MSc,[8] Anna-Barbara Moscicki, MD,[9] Ritu Nayar, MD,[10] Mona Saraiya, MD, MPH,[11] George F. Sawaya, MD,[12] Nicolas Wentzensen, MD, PhD, MS,[13] and Mark Schiffman, MD, MPH[14] for the 2019 ASCCP Risk-Based Management Consensus Guidelines Committee

I.2 Management of Histologic HSIL (CIN 2 or CIN 3)

Guideline: In all nonpregnant patients with a diagnosis of histologic HSIL (CIN 3), treatment is recommended and observation is unacceptable (AII). In nonpregnant patients with histologic HSIL (CIN 2), treatment is recommended, unless the patient's concerns about the effect of treatment on future pregnancy outweigh concerns about cancer (BII). Observation is unacceptable when the squamocolumnar junction or the upper limit of the lesion is not fully visualized or when the results of an endocervical sampling, if performed, is CIN 2+ or ungraded (EIII) (see Figure 7).[3]

ACOG Management of Abnormal Pap & CIN in pregnancy(2008)

Hunter M. & al ; CIN in Pregnancy AMJOG July 2008 ;

TREAT, ONLY IF INVASION IS SUSPECTED

Perkins RB & al ; JLGTD : Vol 24 ;No 2 : APRIL 2020 ;

2019

2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors

Rebecca B. Perkins, MD, MSc,[1] Richard S. Guido, MD,[2] Philip E. Castle, PhD,[3] David Chelmow, MD, Mark H. Einstein, MD, MS,[5] Francisco Garcia, MD, MPH,[6] Warner K. Huh, MD,[7] Jane J. Kim, PhD, Anna-Barbara Moscicki, MD,[9] Ritu Nayar, MD,[10] Mona Saraiya, MD, MPH,[11] George F. Sawaya, MD, Nicolas Wentzensen, MD, PhD, MS,[13] and Mark Schiffman, MD, MPH[14] for the 2019 ASCCP Risk-Based Management Consensus Guidelines Committee

worsens (BII). Treatment of histologic HSIL (CIN 2 or CIN 3) during pregnancy is not recommended (DII). If AIS is diagnosed dur-

thelial lesion: LSIL, low grade SIL

t Gynecol 2008.

2021

European Journal of Obstetrics & Gynecology and Reproductive Biology

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Review article

European consensus statement on essential colposcopy

C.W.E. Redman[a], V. Kesic[b], M.E. Cruickshank[c,*], M. Gultekin[d], X. Carcopino[e].

Colposcopy in pregnancy:

- Should only be undertaken by an experienced, trained colposcopist
- Should be performed, if indicated, and not deferred because pregnancy
- Primarily aims to detect or exclude invasive disease. If invasive disease is not suspected, then punch biopsy or treatment deferred until post-partum
- Should not include endocervical curettage
- Enables excisional biopsy/ LLETZ if invasion is suspected
- If colposcopy has been performed for an abnormal cytology

מדוע ההמלצות השגויות ?

- כ95% מ CIN 2-3 תוך שנה **לא** הופך לסרטן פולשני.
  (הבעיה -5% מהנשים שכן יפתחו סרטן פולשני !)
- ערבוב בין מטופלות בגילים שונים ?
- בלבול בין הדרגות השונות של CIN-1-2-3 ?
- אחוז גדול של סיבוכים מעבודות ישנות [KNIFE CONE]
- ערבוב תוצאות CONE מכל תקופת ההיריון ?
- ***כיון שרופאים הפסיקו לבצע קוניזציה- אין להם ניסיון והם מצטטים את הסיבוכים / ההמלצות מהעבודות הישנות !***

ACOG Management of Abnormal Pap & CIN in pregnancy(2008)

Hunter M. & al ; CIN in Pregnancy AMJOG July 2008 ;

Why delay Treatment ?

1.CIN 2-3 doesn't progress to Invasion during pregnancy !

2.The treatment has many complications!
(Abortions,severe bleeding, premature delivery)

thelial lesion; *LSIL*, low grade SIL.

Hunter. Cervical neoplasia in pregnancy. Am J Obstet Gynecol 2008.

CIN Lesions during Pregnancy

Mailath-Pokorny *et al. BMC Pregnancy and Childbirth* (2016) 16:74

Mean age 24 years

??

CIN 1 ⇨ CIN 2

Table 4 Review of the literature and pooled analysis of studies with report histo-pathological outcome

Author, Date	N	Population	Analysis	Regression	Persistence	Progression
Lurain [19]	53	Pregnant women with CIN I–III	Retrospective	77.4 %	22.6 %	0 %
Yost [7]	153	Pregnant women with CIN II–III	Retrospective	69.3 %	26.8 %	3.9 %
Palle [16]	142	Pregnant women with CIN I–III	Retrospective	25 %	47 %	28 %
Vlahos [8]	78	Pregnant women with CIN II–III	Retrospective	61.6 %	38.4 %	0 %
Paraskevaides [9]	64	Pregnant women with CIN II–III	Retrospective	37.5 %	59.4 %	3.1 %
Serati [15]	36	Pregnant women with CIN II–III	Prospective	47.3 %	52.7 %	0 %
Coppolillo [11]	30	Pregnant women with CIN II–III	Retrospective	16.7 %	70.0 %	13.3 %
Kärrberg [17]	163	Pregnant women with CIN I–III	Prospective	33.1 %	54.6 %	12.3 %
This study	51	Pregnant women with CIN I–III	Retrospective	56.9 %	39.2 %	3.9 %
Pooled analysis	770	Pregnant women with CIN I–III	Pooled	46.8 %	43.6 %	9.6 %

28 % according to different reports. Ackermann et al. limitation of the present study. We did not consider cy-

CIN Lesions during Pregnancy

The risk of CIN 1 to progress to CIN 2-3

or

The risk of CIN 2-3 to progress to

Invasive Cancer ?

COMPLICATION OF CONE during PREGNANCY

- *High Complications Rate , -* *Hannigan 1982, Coppola 1997*
- *High rate of Residual disease*
- *(52-86%)* *Devereux 1967,Richart 1966*
- *Excess Hemorrhage -8.9%*
- *(range 5.2-13.9)* *Hannigan 1982*
- *Spontaneous Miscarriage - 33%* - *Hacker 1982*

Cone Biopsy During Pregnancy

EDWARD V. HANNIGAN, MD, HENRY H. WHITEHOUSE III, MD, WILLIAM D. ATKINSON, BS, AND STEVEN N. BECKER, MD

Obs & Gyn Vol 60 No4 Oct 1982:450-55

Under a diagnostic schema that used cervical conization liberally for evaluating women with abnormal Papanicolaou smears, 82 pregnant patients underwent conization. Fifteen had significant morbidity related to cervical bleeding. The uncorrected perinatal mortality was 44.1/1000. Sixty-one cone biopsies, performed before colposcopy was introduced into the schema, uncovered 2 cases of previously undiagnosed invasive carcinoma. Among 21 patients who under-

of invasive carcinoma, and then, after review of the relative risks and benefits of the procedure, to redefine the proper role of diagnostic conization for pregnant patients who have been evaluated colposcopically.

Materials and Methods

Conization and Duration of Pregnancy

The duration of pregnancy after conization is summarized in Table 2. All infants delivered after 36 weeks of pregnancy were alive. No patients subjected to a cone biopsy in the first trimester had a spontaneous abortion or premature onset of labor.

inal cervical smears in an attempt to reduce the chance of missing the diagnosis of invasive carcinoma during pregnancy. As a consequence of this policy, the authors have a large series of pregnant patients who underwent cone biopsy after a colposcopically directed punch biopsy.

The purpose of the study is threefold: to quantitate maternal and fetal risks in a large series of patients undergoing diagnostic conization during pregnancy, to quantitate the yield of previously undiagnosed cases

From the Departments of Obstetrics and Gynecology and of Pathology, The University of Texas Medical Branch at Galveston, Texas.

Submitted for publication November 13, 1981.

opsy, and 21 underwent it after colposcopic examination. Neither an endocervical speculum nor ring forceps was used to assist in visualizing the upper limits of the transition zone in patients evaluated by colposcopy, and endocervical curettage was not performed. The indications for conization and the results of examination of the specimen are summarized in Table 1 for the 21 patients evaluated by colposcopy.

Thirteen patients underwent conization in the first 14 weeks of pregnancy, 50 during the second trimester, and 19 after 28 weeks of pregnancy. No standardized technique was employed in obtaining the cone specimen; the cervix was injected with epinephrine in

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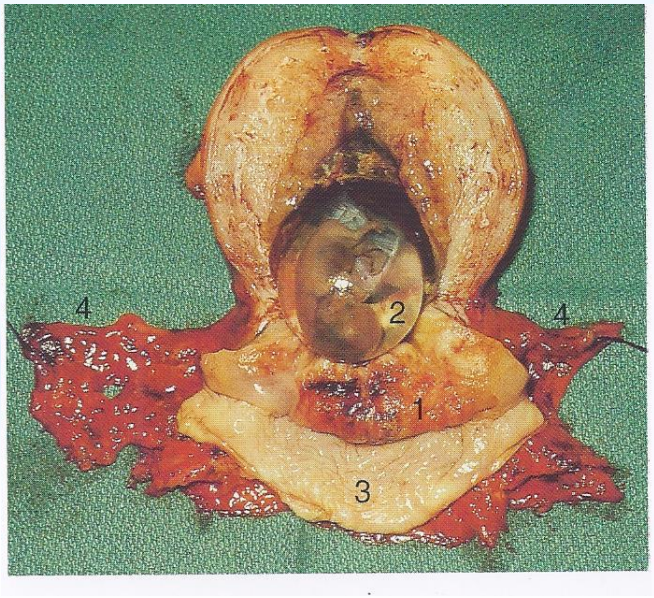
Why are we treating CIN 2-3 ?

1. Diagnose Cervical Cancer

2. Prevent Cervical Cancer



Why are we treating CIN 2-3 ?

Diagnose Cancer

CX Cancer is found in 5.4% of women with HSIL on PAP Test +HPV HR + .

Katki HA & al :JLGTD 2013;Vol 17;Issue 5, S50-S55

CX Cancer is found in 4.8% of women with HSIL on PAP Test +HPV HR + .

Demarco M & al :JLGTD 2018;Vol 22;Issue 2,p 97103.

CX Cancer was found in 7% PREGNANT women investigated because HSIL on PAP Test .

Karrberg C: Acta Obst Gynecol Scand ,2013 Jun :92(6) 692-9

Why are we treating CIN 2-3 ?

Diagnose Cancer

The same risks are in pregnant women

Invasive carcinoma diagnosed in excisional spec
of women treated because CIN 2-3 lesions

8% in women undergoing Hysterectomy
Due to CIN 2-3
ACOG Practice Bulletin:Obstet Gynecol. 2008 Dec; 112(6):1419-44.

6.4% in women undergoing LOOP CONE
Due to CIN 2-3
Cong Q –Bio Med Research Int 2018

2.3%

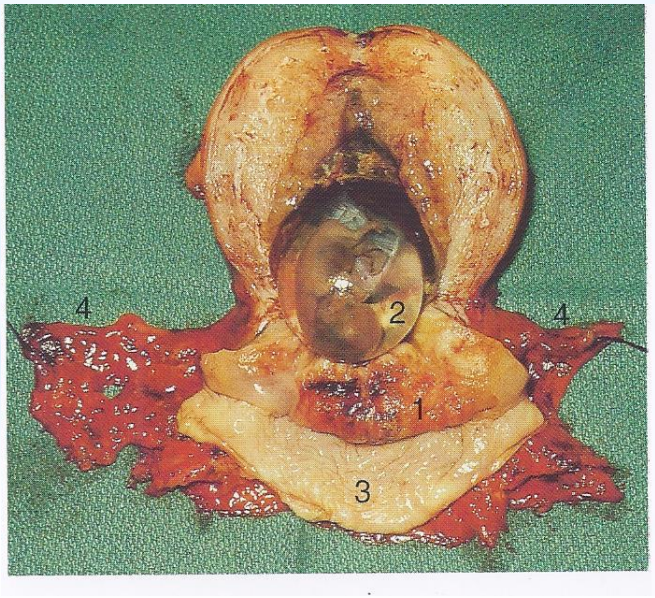
From 1683 LLETZ operations because CIN 2- 3

Siegler E, Bornstein J; LLETZ in Israel
Gynecologic And Obstetric Investigation 2011; Vol. 72 (2), pp. 85-9

Why are we treating CIN 2-3 ?

1. Diagnose Cervical Cancer

2. Prevent Cervical Cancer



CIN 3 Progression to Invasive Cancer

Prevent Cancer

See 1 citation found using an alternative search:

Br J Obstet Gynaecol. 1985 Feb;92(2):150-7.

The impact of screening on the incidence of cervical cancer in England and Wales.

Parkin DM, Nguyen-Dinh X, Day NE.

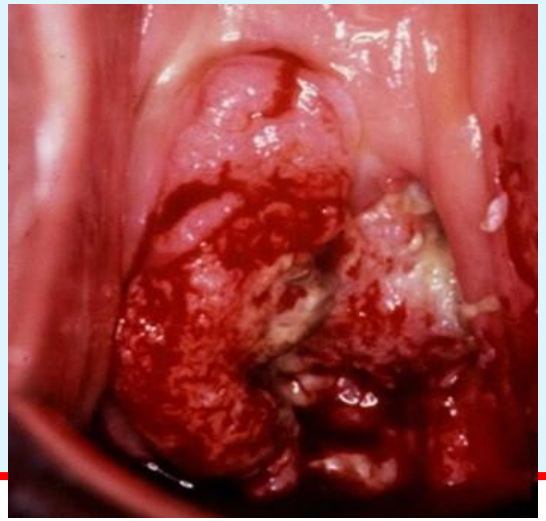
A mathematical model ..

the annual rate of progression from

***CIN 3* TO CERVICAL CANCER,4.33 %**

CIN Lesions during Pregnancy

The risk of CIN 2-3 to progress during pregnancy to Invasive Cancer ?



CIN 2- 3 in Pregnancy - Progression to Cancer > 25 years

NO	Name / Year	No Pat	Mean Age	Dig	Regres (%)	Persist (%)	Progr... (%)
1	LaPolla JP :J Reprod Med ;1988;33(3)301-6	16	27	CIN 3			4(25%)
2	Copolla A :Gyn Onc :67:162-165 (1997)	26	26	CIS		88	2(8%)
3	Giraud: J Gynecol Obstet Biol Reprod (Paris). 1997;	16	*	CIN 3			3(18%)
4	Pale C: Acta Obs Gyn Scand 2000 Apr ;79;(4) 306-10	97	28	CIN 2-3	8	89.6	2(2%)
5	Mitsushasi A ; Int J Obst & Gyn 71(2000) 237-239	9	29	CIN 2-3			2 (22.2%)
6	Sood Ak: Obst Gyn 2000;95;832-8	3	31.2	CIN3			3(100%)
7	Vlahos G :Gy Ob Inves 2002 :54:78-81	78	28	CIN 2-3	61	38.4	0
8	Kaplan K :Cancer Cytopathology 2004:102;228-32	28	26	HSIL		100	3(10.7%)
9	Robova H :Eur J Gynaecol Oncol. 2005;26(6):611-4.	85	28	CIN3/MIC			12(14.1%)
10	Ackerman S:Acta Ob GynScand. 2006;85(9):1134-7	77	31	CIS	34	63.1	2(2.6%)
11	Frega A:Anticancer Research 27:2743-2746(2007)	16	31	CIN 3	62.5	37.5	1(4.7%)
12	Fambrini M:Int J Gyn Cancer2007;17;127-131	26	32.3	CIN 3			2(7.7%)
13	Serati M:Acta Ob GynScand. 2008;87(12):1296-300.	36	30	CIN 2-3	47	52	0
14	Chung SU –Gyn Obs Invest 2011:72:234-8	29	32	CIN-2-3	77		4(13%)
15	Cubo-Abert M:JLGTD 16(1) Jan 2012:34-28	33	>25	HSIL	26	67	2(6.1%)
16	Schaefr K :Int J Gyn Obstet. 2012 Aug;118(2):141-4.	27	31	CIN 3		89	3(11%)
17	Coppolilo: Acta Obst Gyn Scan 2013:92;293-7	30	*	CIN 2-3	16	70	4(13.3%)
18	Karrberg C:Acta Ob GynScand. 2013 Jun;92(6):692-9	71	30	CIN 3			4(5.6%)
19	Wu YM: Arch Gyn Obs 2014	65	30	CIN 3			4(6.1%)
20	Mailath-Pokorny :BMC Preg Childbirth 2016;16;74	27	29	CIN 3	37	63	0
21	Grimm : Arch Gyn Obs 2020	60	30				1(1.7%0
22	Siegler E : JLGTD Vol 21 No 4, 2017:299-303	93	32.5	CIN 2			5 (5.4%)
23	Mazzoni SE: J Low Gen Tract Dis 2015:19:329-332		26	CIN 2			1(4%)
24	Da Kyung Hong:Eur J Obs Gyn 236(2019) 173-6		30.4	CIN			3(2.1%)

1113

67 [6%]

CIN 2- 3 in Pregnancy - Progression to Cancer over 25 years

NO	Name	No Pat	Mean Age	Dig	Regres (%)	Persist (%)	Progress (%)
1	LaPolla JP :J R						4(25%)
2	Copolla A :Gyn					88	2(8%)
3	Giraud: J Gyne						3(18%)
4	Pale C: Acta Ob					89.6	2(2%)
5	Mitsushasi A ;						2 (22.2%)
6	Sood Ak: Obst						3(100%)
7	Vlahos G :Gy C					38.4	0
8	Kaplan K :Can					100	3(10.7%)
9	Robova H :Eur						12(14.1%)
10	Ackerman S:Ac					63.1	2(2.6%)
11	Frega A:Antica					37.5	1(4.7%)
12	Fambrini M:Int						2(7.7%)
13	Serati M:Acta O					52	0
14	Chung SU –Gy						4(13%)
15	Cubo-Abert M:J					67	2(6.1%)
16	Schaefr K :Int J					89	3(11%)
17	Coppolilo: Acta					70	4(13.3%)
18	Karrberg C:Acta						4(5.6%)
19	Wu YM: Arch Gyn Obs 2014	65	30				4(6.1%)
20	Mailath-Pokorny :BMC Preg Childbirth 201		29				0
21	WU YM. Arc Gynecol Obstet 2014		29				4(6.1%)
22	Siegler E : JLGTD Vol 21 No 4, 2017:299-3		32.5				5 (5.4%)
23	Mazzoni SE: J Low Gen Tract Dis 2015:19		26				1(4%)
24	Da Kyug H:Eur J Obs Gyn 236(2019) 173-		30.4				3(2.1%)

1113 Pregnant women over the age of 25 years with CIN 2-3 lesion

6 % were diagnosed with INVASIVE CANCER

1113

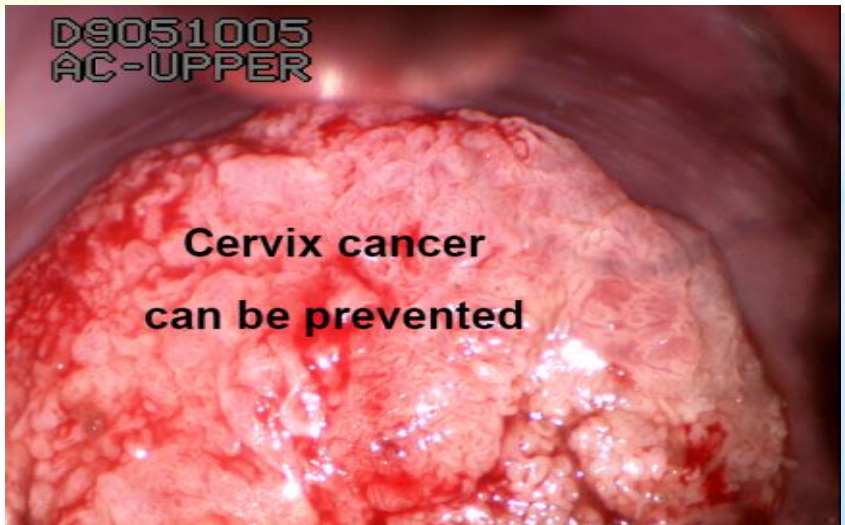
67 [6%]

Cancer in pregnancy: a challenging conflict of interest

Great and sacred are the thoughtful deliberations required of progression. For particular cancers treatment can See Perspectives page 511

Morice P ,Uzan C ,Gouy S –The Lancet
Volume 379, Issue 9815,Pages 558-9,11.2 2012

The main goal is to offer pregnant patients the same optimum management (and therefore similar predicted survival) as non-pregnant patients. Overall survival and



CIN 2-3 diagnosed during pregnancy
Data from ISRAEL registry 2006-2021

Objective :

1. To describe the outcome of women diagnosed with CIN 2 or CIN 2-3 during pregnancy .

2. To describe the outcome of women who had LLETZ during the first 15 weeks of pregnancy

CIN 2-3 diagnosed during pregnancy
Data from ISRAEL registry 2006-2021

החברה הישראלית לקולפוסקופיה ופתולוגיה של צוואר הרחם והנרייה

Israeli Society of Colposcopy and Cervical and Vulvar Pathology

A questionnaire was sent to members of the Israeli Society of Colposcopy

- **155 women : Lin / Carmel Medical Center ,**
- **32 women : Other Doctors, Clinics ,Medical Centers**

187women were diagnosed with

CIN 2 or CIN 2-3 on cervical biopsy

- **34 women CIN 2 only [Only Observation]**
- **153 women CIN 2-3**

CIN 2-3 in Pregnancy
Observation or LLETZ till 15 weeks

153 women diagnosed during pregnancy with CIN 2-3 lesion on cervical biopsy

INVASIVE CANCER WAS DIAGNOSED IN 9 women (5.9%)

CIN 2-3 during PREGNANCY- Observation Group

90 women - observation only
Investigation & treatment after delivery

CANCER	6(6.6%)
CIN 2-3/AIS	58 (64.5%)
CIN 1/ NORMAL	24 (26.6%)
Lost FU	2(1.3%)
TOTAL	90

5/6 נשים שאובחנו עם סרטן עברו כריתת רחם/ כריתת רחם רדיקלית

CIN 2-3 during PREGNANCY
LLETZ Treatment Group

63 women underwent LLETZ till 15 weeks

LLETZ was offered individually (Personalized Medicine) :

* **Colposcopic impression of HSIL**

  (Large lesions ,dense AWE ,mosaic, punctations, erosion)

* **Risk Factors (HPV 16,18, 45)**

* **Pathological report of the cervical biopsy (positive ECC,AIS)**

* **History of persistent CIN lesion, abnormal PAP**

* **Women preference (Fear of cancer) .**

CIN 2-3 in Pregnancy
Observation or LLETZ till 15 weeks

	Observation 90 women	LLETZ Treatment 63 women	Total 153 women
CANCER	6(6.6%)	3(4.8%)	9 (5.9%)
CIN 2-3/AIS	58 (64.5%)	57(90.4%)	115(75.2%)
CIN 1/ NORMAL	24 (26.6%)	3(4.8%)	27(17.6%)
Lost FU	2(1.3%)	-	2 (1.4%)
TOTAL	90	63	153

CIN 2-3 in Pregnancy
Observation or LLETZ till 15 weeks

Total 153 Women	Observation 90 women	LLETZ Treatment 63 women	P VALUE
CANCER	6(6.6%)	3(4.8%)	0.890
CIN 2-3/AIS	58 (64.5%)	57(90.4%)	<0.001
CIN 1/ NORMAL	24 (26.6%)	3(4.8%)	<0.001
Lost FU	2(1.3%)	-	
TOTAL	90	63	

CIN 2-3 during PREGNANCY
LLETZ Treatment Group

63 women underwent LLETZ till 15 weeks

9 women underwent LLETZ and D+C

- 3 women (4.8%) - Missed Abortion before LLETZ .
- 6 women (9.2%) -- Termination of Pregnancy .

54 women continued their pregnancy

- ***49 women (90.7%) Term delivery***
- 2 women (3.7%) Late preterm delivery (34,36 W)
- 2 women (3.7%) Early/Late Missed Abortion
- 1 women (1.7%) Ongoing pregnancy

CIN 2-3 in Pregnancy
Observation –LLETZ till 15 weeks

'	Observation 90 women	LLETZ Treatment 63 Women	Total 153 Women
Early Missed Abortion – PRE LLETZ	4(4.4%)	3(5.7%)	12(7.8%)
IUFD / Late Abortion	5(5.5 %) ?		
Abortion/Late POST LLETZ		2(3.8%)	
TOP	1 (1.1%)	6 (11.3%)	
CX Suture	1(1.1%) 22 weeks	1(1.8%) 21 weeks	

BLEEDING :

Our Experience with 63 LLETZ operations during first 15 weeks of pregnancy

- Diagnosed Invasive Cancer in 4.8% of the women .
- Low Rate of Complications

  (1- severe bleeding ,1-early abortion ,

  1- late abortion, 1- Cervical suture)
- Term delivery (Late preterm) - (94.4%) .
- Two cases of recurrence after delivery (3.1%)

LLETZ /LASER CONE till 19 weeks

	Author (year)	NO	WEEKS of LLETZ /KNIFE CONE LASER CONE	Cancer/ MIC	SEVERE BLEEDING	ABOR TIONS	PRE TERM DELIVERIES	Term deliveries
1	Hannigan 1982 *(Knife Cone)*	7	13	1				7/7 (100%)
2	Robinson 1996	4	9-16					2(100%)
3	Penna -1998 (Laser)	8	16		1			8/8(100%)
6	Mitsuhashi 2000	9	14	2			1	9/9 (100%)
4	Lacour 2005	5	19					5/5 (100%)
5	Fambrini 2007 (Laser)	26	10-18	2	6		1	25/26(96%)
7	Frega 2007	5	16	1				5/5(100%)
8	Schaefer 2012	21	16	3		1	2	18/21 (86%)
9	Siegler 2021	55	4-15	3	1	2	2	44/48(91%)
	TOTAL	141	4-19	12 (8.5%)				86-100%

Based on that data :

LLETZ in the first trimester should be performed based on personalized medicine !

- ✓ The benefit of diagnosing Cervical Cancer in 5-6% of the women should be considered against the risk of complications .
- ✓ LLETZ during the first trimester appears to be a safe procedure with few complications.
- ✓ In each woman - personalized treatment should be selected according to pathological results, colposcopic results ,risk factors and patient preferences.

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Based on that data :

- ✓ The benefit of diagnosing Cervical Cancer in 5-6% of the women should be considered against the risk of complications .
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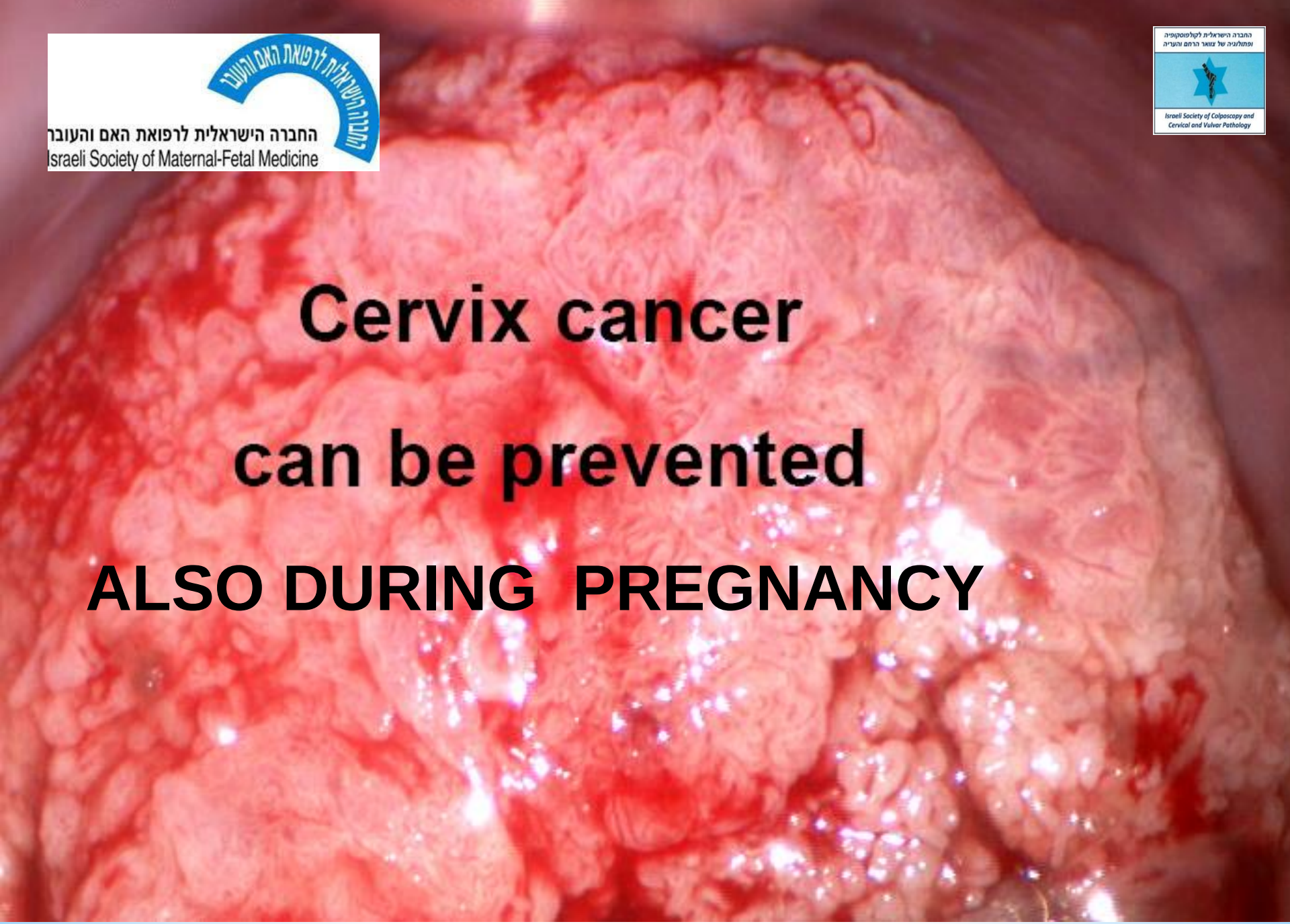
- ✓ In each woman - personalized treatment should be selected according to pathological results, colposcopic results ,risk factors and patient preferences.

Take PAP test in the first visit of the pregnant woman


החברה הישראלית לרפואת האם והעובר
Israeli Society of Maternal-Fetal Medicine
החברה הישראלית לקולפוסקופיה ופתולוגיה של צוואר הרחם והעריה
Israeli Society of Colposcopy and Cervical and Vulvar Pathology
Cervix cancer
can be prevented
ALSO DURING PREGNANCY