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How Likely Clinically Suspicious Looking Cervix is Cervical Cancer?

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***Abstract*— Clinically suspicious looking cervix does not always mean cervical intraepithelial neoplasia (CIN) or cervical cancer but it can be caused by other benign and inflammatory conditions. It was recommended that the patients should be initially seen urgently in the general gynaecology clinic rather than in the colposcopy unit because most of them will not have cancer. Consideration should be taken into account in those women who have risk factors for cervical cancer especially postcoidal bleeding (PCB).**

***Index Terms*— Clinically suspicious looking cervix, cervical intraepithelial neoplasia, cervical cancer, postcoidal bleeding**

I. INTRODUCTION

What is clinically suspicious looking cervix?

Suspicious looking cervix is a comprehensive term used to include all cervical lesions that have the potential for cervical cancer. Clinically suspicious looking cervix does not mean CIN but mostly it is caused by benign and inflammatory conditions. The potential cervical abnormalities include Nabothian cysts (mucous retention cysts), cervical ectropion, cervical polyp/ fibroid, leukoplakia, endometriosis, obstetric/ surgical trauma or scarring, DES (diethylstilbestrol) exposure related abnormalities and invasive cancer.[1]

Causes

1. Inflammatory
    a. Mechanical – tampons
    b. Traumatic – cervical laceration
    c. Infections – gonorrhea, chlamydia
2. Dystrophic
    a. Hormonal – oestrogen deficiency
3. Neoplastic
    a. Benign – fibroid
    b. Premalignant – CIN
    c. Malignant – clear cell carcinoma secondary to diethylstilbestrol (DES), adenocarcinoma

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Current UK standards dictate that if a clinically suspicious looking cervix is detected, prompt urgent referral for gynaecologist review should be made and the women should be seen within two weeks of referral.[2]

II. DISCUSSION

A question has arisen whether these women should be referred directly to colposcopy unit or triage to the general gynaecology unit? This can be challenging for the clinicians in the primary care settings to determine the most appropriate management when the cervix does not look classically normal. This will undoubtedly increase the workload in the colposcopy unit and increase the waiting time for routine referrals through national cervical screening programme if all women with clinically suspicious looking cervix need to be reviewed by the colposcopists.

Based on a study by Milingos et al, it was shown that 80% of the women who were referred to colposcopy unit with clinically suspicious looking cervix had a normal cervix, 16% of them had cervical intraepithelial neoplasia (CIN) and the rest of the 4% had invasive cancer.[3] This study has suggested that women who are referred with a clinically suspicious looking cervix should be assessed in a general gynaecology clinic rather colposcopy unit because most of them will not have cancer.[3] The small number of women with a clinical suspicious of cancer can then be referred onto colposcopy whereas women with benign pathological result can be treated appropriately in the general gynaecology clinic.[3]

However, demographic variables such as smoking, number of sexual partners, history of any sexually transmitted diseases or HPV (Human Papilloma Virus) infection, previous abnormal smears or symptoms of PCB should be taken into account for the risk assessment in triaging. About 11% of women with cervical cancer present with postcoidal bleeding.[4] In Rosenthal et al. (2001) study, 30% of women with cervical cancer or CIN had a negative smear and were referred because of PCB only.[5] Jha and Sabharwal (2002) reported that 11% of women presented with PCB and a negative cervical smear had CIN on histological examination of colposcopically directed biopsies.[6] Therefore clinicians should be aware that a normal smear history must not be regarded as reassuring in a woman with PCB.

III. CONCLUSION

Given the fact that only 4% of women with suspicious looking cervix were found to have cervical cancer and 16% of them had CIN in one of the studies, it was recommended that

the patients should be initially seen urgently in the general gynaecology clinic rather than colposcopy unit. However, women with risk factors for cervical cancer especially symptom of PCB should be taken into account in considering direct referral to colposcopy unit for further assessment. More investigations need to be done to look at the probability of cervical cancer in suspicious looking cervix in the high risk group of women.

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