AGC
management based on ASCCP 2020

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AGC

- AGC on cytology
  - poorly reproducible Dx category
- HPV pos, (es.18),
  - higher risk of CIN 2+
- **Colp is recommended for all**
  - **regardless of HPV result**

AGC

- AGC can be associated with
  - polyps
  - metaplasia
  - Adenoca of the cx;
  - Ca of the En, FT, Ov, other sites,
    - especially in older women with neg HPV

Cytology: AGC or AIS…

- Colp
  - recommended regardless of HPV test result
    - all ages
    - all subcategories of AGC and AIS,
      - except when AEC specified
- ECC
  - recommended at initial colp
    - except in preg

Cytology: AGC, AIS…

- triage by reflex HPV testing
  - not recommended
- triage by repeat cytology
  - unacceptable
- Endometrial sampling
  - Recommended if nonpregnant
    - ≥ 35 yrs; all categories of AGC & AIS
    - < 35 yrs at increased risk of En neoplasia
      - clinical indications (AUB, chronic anovulation, obesity)

Cytology: AGC or AIS …

- If atypical En cells specified
  - initial evaluation limited to En and Endocx sampling is preferred,
    - colp acceptable at the time of initial evaluation
  - If no endometrial pathology at the first En sampling
    - Colp recommended

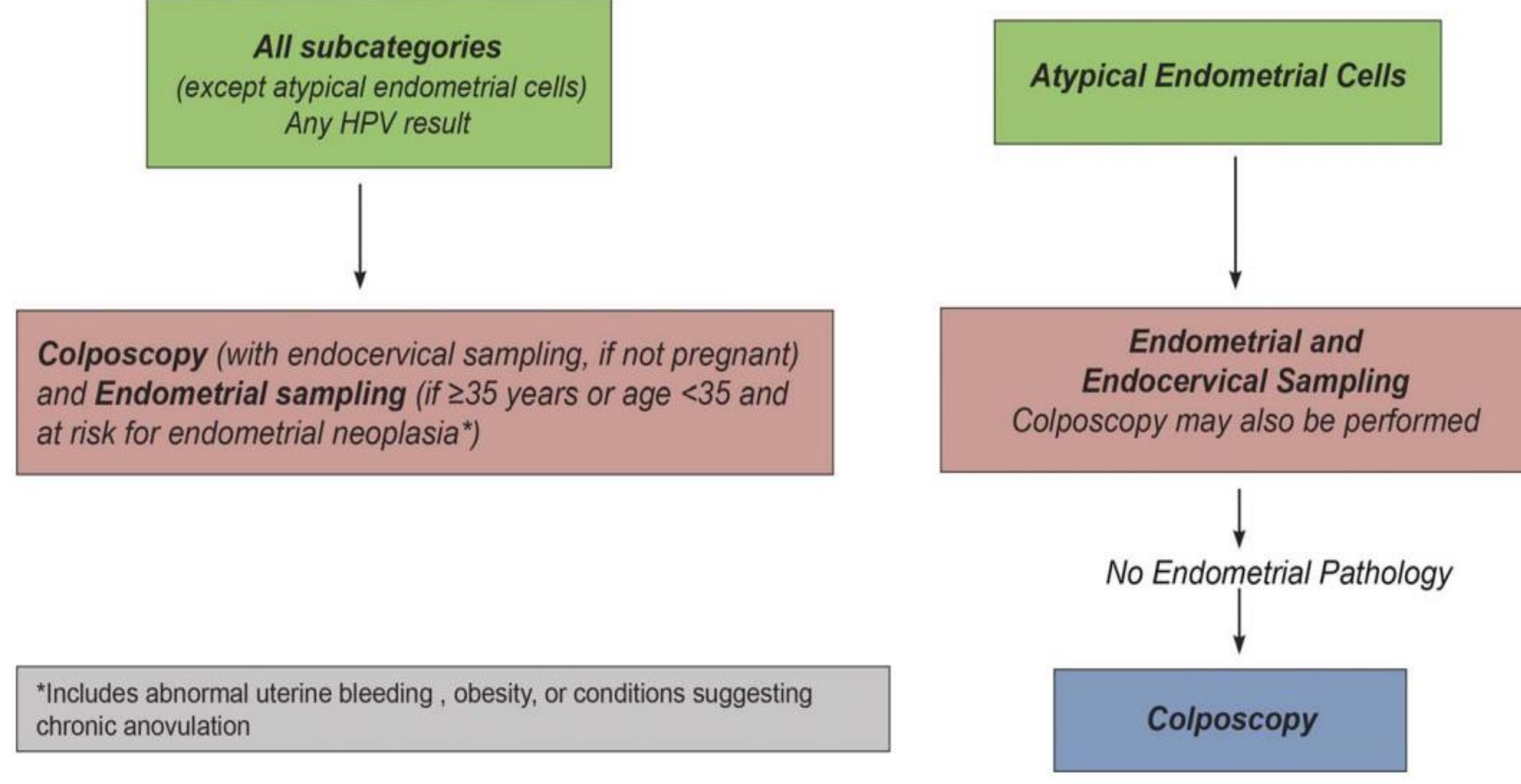

FIGURE 3. **This figure describes the initial workup of AGC found on cervical cytology.**

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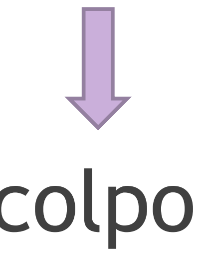
Cytology: AGC, AIS ⟶ colpo Bx

- Colp Bx: **No HSIL (CIN2+), no AIS, no ca:**
- If initial cytology: **AGC- NOS or AEC-NOS**

cotesting at 1&2 yrs

Any abnormality:



colpo

Cytology: AGC, AIS → colpo Bx

- Colp Bx: **CIN2+ but no glandular**
- If initial cytology: **AGC- NOS or AEC-NOS**

→ Manage per 2019 ASCCP guidelines

Cytology: AGC, AIS → colpo

- Colp Bx: No AIS or Ca

- If initial cytology: AGC (favor neoplasia), or AIS

Dx Excisional Procedure

(intact specimen+ interpretable margins)

(ECC above excision bed preferred)

The importance of
AGC(favor neoplasia), adeno ca…

- Why AGC (favor neoplasia), adenoca in cytology are so important
  - Frequently indicative of invasive or preinvasive disease
    - even if HSIL or AIS not been identified
- En ca is rare in premenopause without risk factors
- The prevalence of premenopausal En ca is increasing
- The importance of En sampling when indicated

The importance of AGC(favor neoplasia), adeno ca…

- Cytologic AGC results are associated with a histologic Dx of:
  - AIS in 3-4%,
  - CIN 2+ in 9%,
  - invasive ca in 2-3%.

The importance of AGC(favor neoplasia), adeno ca…

- In the KPNC data,
  - HPV-pos AGC (all categories):
    - immediate CIN 3+ risk of 26%
  - HPV-neg AGC:
    - immediate CIN 3+ risk of 1.1%.

The importance of AGC(favor neoplasia), adeno ca…

- Consistent with other literature,
  - HPV-pos AGC favor neoplasia or adenoca
    - immediate CIN 3+ risk of 55%,
  - other HPV-positive AGC categories
    - immediate CIN 3+ risks of 20%.

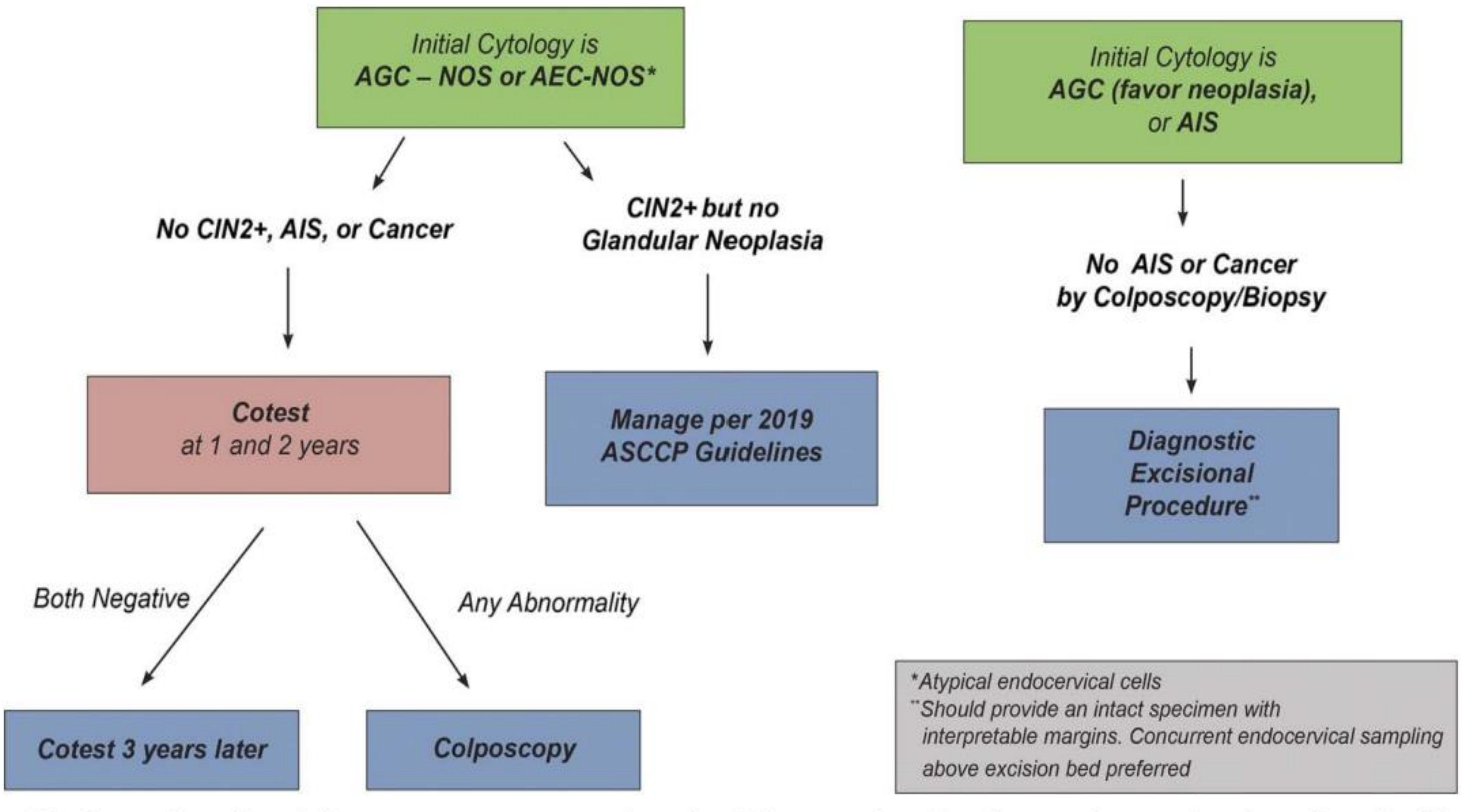


FIGURE 4. **This figure describes follow-up management that should occur after the diagnostic examinations described in Figure 3.**

Management of AIS
(SGO Recommendations)

- **For All patients with a Dx of AIS on Cx Bx**
- A Dx excisional procedure is recommended
  - To R/O invasive adenoca
  - even when definitive hysterectomy is planned.
- Excisional procedures should optimally remove an intact specimen
  - to facilitate accurate interpretation of margin status.
- no preference for CKC vs LEEP,
  - ***Unacceptable***
    - intentional disruption of the specimen by LEEP, “top hat” endocx excision

Management of AIS
(SGO Recommendations)

- An excisional specimen length of
  - at least 10 mm is preferred
  - 18-20 mm if completed family planning
    - Regardless of whether hysterectomy is planned.

Management of AIS
(SGO Recommendations)

- After the initial Dx procedure,
  - hysterectomy is the preferred management for all patients
  - who have a histologic Dx of AIS,
- Fertility-sparing management for appropriately selected patients is acceptable.

Management of AIS
(SGO Recommendations)

- If confirmed AIS on the excisional specimen,
  - with neg margins
    - simple hysterectomy is preferred.
  - with pos margins
    - re-excision to achieve neg margins is preferred
    - even if hysterectomy is planned.
  - with persistent pos margins & additional excisional procedures not feasible,
    - either a simple or modified rad hys is acceptable.

Management of AIS
(SGO Recommendations)

- In reproductive age, If desire future pregnancy:
  - 1- an excisional procedure is acceptable
    - provided neg margins have been achieved
    - the patient is willing/able to adhere to F/U recommendations.
  - 2-If neg margins not be achieved after max excisional attempts
    - **fertility-sparing management not recommended.**

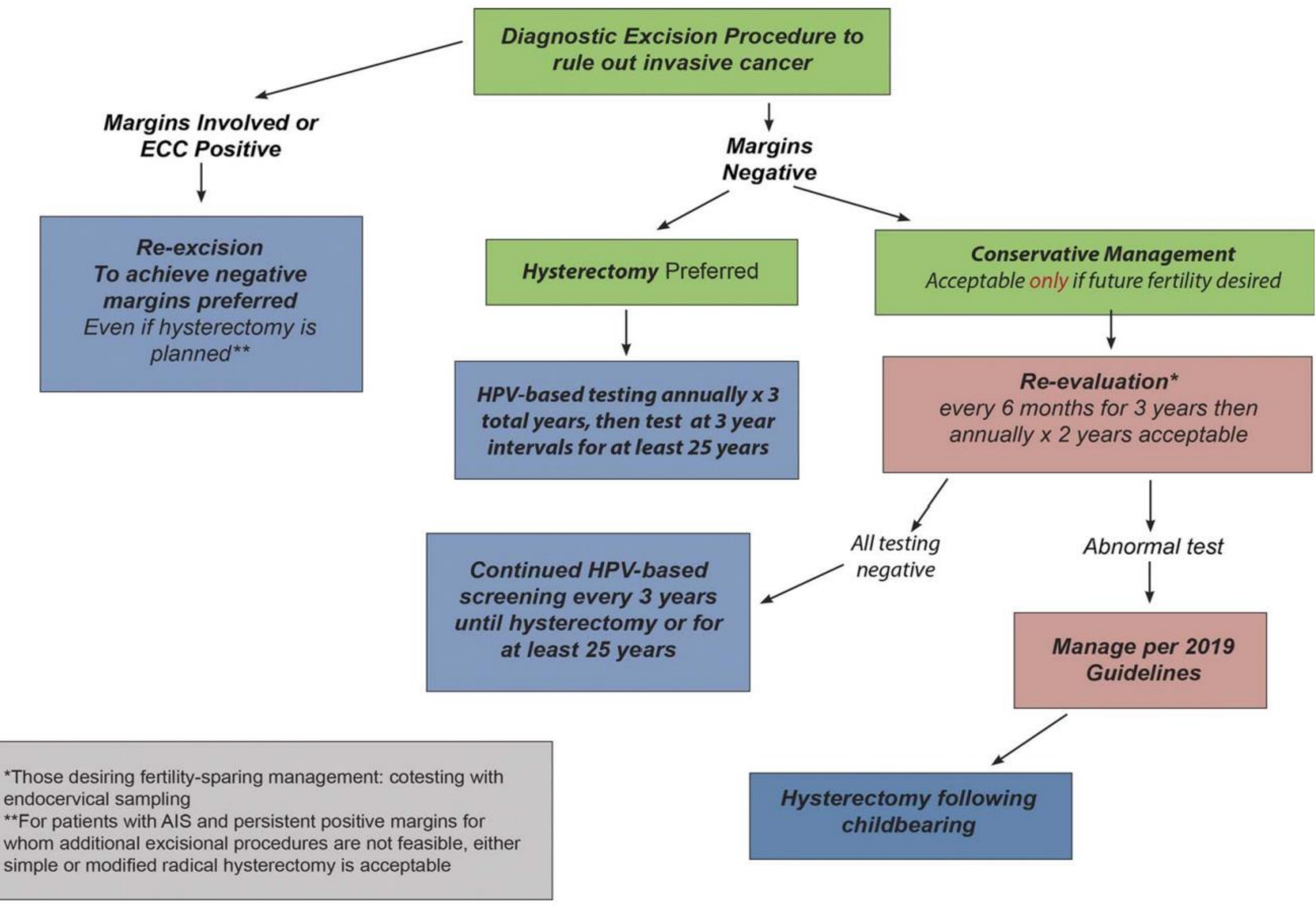


FIGURE 11. This figure describes management of AIS. This management algorithm was developed by the Society of Gynecologic Oncology and endorsed by the ASCCP Risk-Based Management Consensus process.

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Management of AIS Surveillance (SGO Recommendations)

- After hysterectomy
  - ASCCP guidelines for treated CIN 2+ is recommended
- If undergo fertility-sparing management,
  - Cotesting and ECC Q 6 mo for at least 3 yrs
  - then annually at least 2 yrs, or until hysterectomy performed.
  - If consistently neg cotesting and ECC for 5 yrs,
    - extending the surveillance interval to Q 3 yrs
      - starting in the sixth yr of surveillance is acceptable.

Management of AIS
(SGO Recommendations)

- Small retrospective studies have shown:
  - HPV test; the best predictor for recurrent disease.
    - If consistently neg cotesting and ECC
      - continued surveillance is acceptable after completion of childbearing
    - If pos HPV/abnormal cytology/histology surveillance,
      - hysterectomy at the completion of childbearing is preferred

Management of AIS; Why hysterectomy is the best
(if no desire for fertility preservation)

- 1-AIS is frequently located within the endocx canal
  - colpo changes may be minimal
  - determination of the necessary length of a cx excisional specimen may be difficult
- 2-AIS has a higher risk of being multifocal,
  - Even neg margins, do not ensure complete excision of disease
- 3-Importantly, in the setting of histologic AIS on Bx
    - invasive ca cannot be excluded without a Dx excisional
- 4- AIS is not SCC
  - In SCC: increased detection/tr of SCC precursors (CIN 3) decreases the incidence of SCC
- 5-Because of the challenges in Dx and monitoring AIS

Management of AIS; Why hysterectomy is the best (if no desire for fertility preservation)

- For patients desiring future pregnancy,
  - observation after an excisional procedure remains an option
    - but carries <10% risk of recurrent AIS,
    - a small risk of invasive ca even with neg margins.
  - Both margin status and ECC at the time of excisional procedure
    - predict residual disease/risk of invasive ca on hysterectomy specimen
  - After tr, HPV tests results are the strongest predictor for recurrent AIS

Case 1:37 yrs, NG, routine screening

- Cytology result
  - Atypical En Cell (AEC)
- Q1: Next step???
  - D&C
  - Colpo
  - ECC
  - HPV

Case 1: 37 yrs, NG, routine screening: AEC

- AQ1: D&C, ECC

- Q2: no En pathology, next step?
  - Cotest in 3 mo
  - Tr by progesterone for 3 mo
  - HPV reflex test
  - colpo

Case1: 37 yrs; NG; routine screening: AEC; D&C&ECC: no endometrial pathology

- AQ2: Colposcopy

- Q3: colpo result CIN 1, next step?
- CKC
- LEEP
- Cotest in 1 year
- Copo in 6 mo

Case 1: 37 yrs; NG; routine screening: AEC; D&C&ECC: no En path; colpo:CIN1

- **AQ3: Cotest in 1 year**

- **37yrs NG**
  - **Cytology: AEC**
    - **D&C, ECC: no tissue**
      - **Colpo: CIN1**
        - **Cotest in 1 year**

Case 2

- 31yr, NG, Mense reg, contraception WD,
- routine screening: AIS
- Colpo: No ca or AIS
- Excisional procedure
- AIS but margin neg and ECC pos
- Reexcision again margin pos
- Not possible for re excision, rad hys or simple hystrectomy