

Further advice

We hope you have found the information in this leaflet helpful. If you require any further advice regarding any aspect of your care please contact:

Harbourside Gynaecology Centre

Main reception: **0300 019 2584**

Unit secretary: **0300 019 3107**

Colposcopy Department, first floor Jigsaw

Tel: **0300 019 4672**

You can leave a message on the answer phone and your call will be returned as soon as possible. Staff are there to support you and are happy to help with any concerns or anxieties.

Useful websites for further information:

The British Society for Colposcopy and Cervical Pathology:
www.bsccp.org.uk

MacMillan Cancer Support:

www.macmillan.org.uk Support Line: **0808 808 00 00**

Eve Appeal:

eveappeal.org.uk Ask Eve Helpline: **0808 802 0019**

Management options for cervical intraepithelial neoplasia grade 2 (CIN2)

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Women's Health Outpatient Investigation Unit
Patient Information

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Introduction

This information sheet gives more information on the treatment choices for CIN2 (cervical intraepithelial neoplasia grade 2).

It is important to remember that CIN is not cancer, but it is a precancerous condition that requires either watching (surveillance) or treatment to make sure cancer does not develop in the future.

The nurse or doctor looking after you in colposcopy will discuss your treatment options and recommendations based on your individual circumstances and wishes.

What is CIN2?

The cervix is lined by cells called squamous cells. These cells are on the outside of the cervix and come into contact with the environment inside the vagina. The Human Papilloma Virus (HPV) is a very common virus with more than one hundred different subtypes. Some of these subtypes can cause changes to the squamous cells of the cervix.

If the cells undergo change and become abnormal this can lead to cervical intraepithelial neoplasia (CIN). They are graded as CIN1, CIN2 and CIN3. CIN2 means there is a moderate abnormality of the cells on the cervix. This means that these abnormal cells may spontaneously go back to normal without treatment but have a potential to develop into cancer if they are not treated or if they do not resolve.

Summary of treatment options

	Procedure	Success rate	Advantage	Disadvantage
LLETZ (Large loop excision of transformation Zone)	Excises (cuts out) the abnormal cells	95-96%	Histology (analysis of removed tissue) available to confirm if excision complete	Risk of preterm labour and mid-trimester miscarriage
Ablation (cold-coagulation)	Burns the abnormal cells	90% (initial clearance)	Reduce risk of scarring Reduces risk related to LLETZ treatment	Histology (analysis removed tissue) not available.
Surveillance	Active monitoring with smear and colposcopy every 6 months for 2 years	50%	Reduces risk related to LLETZ treatment	Risk of progression to high grade disease 1 in 5 Progression to CIN3 in 2 years 1 in 200 may progress to cervical cancer after 2 years.

What else can I do?

We know that in women who smoke, CIN2 cells are more likely to get worse so that they need treatment. If you smoke, we would encourage you to stop as this will make it more likely that the CIN2 cells go back to normal. A leaflet titled 'Smoking and Cervical Cancer, the facts' is available on request which gives further information and useful contacts to help you quit.

Using condoms, also helps increase the clearance rate of HPV and CIN2 (especially if they are used every time you have intercourse).

This treatment has no effect on your ability to conceive or your fertility.

Cold coagulation (thermo-coagulation)

This procedure involves application of a heated probe to the cervix. This burns away the abnormal cells from your cervix. It usually takes only a few minutes and is performed in the colposcopy clinic under local anaesthesia.

It is only suitable for some women with small and fully visible lesions and the doctor or nurse caring for you will recommend if it is the right treatment for you.

The cure rate of CIN2 with this treatment is similar to LLETZ. You will have a repeat smear in six months to ensure all the abnormal cells have been removed.

The main complications are period like cramp during the procedure, and watery, blood-stained discharge and infection afterwards.

There is no increase in the risk of premature birth/mid-trimester miscarriage or of infertility.

Active surveillance

This involves regular monitoring with repeat cervical screening tests (smears), visits to the colposcopy clinic and/or cervical biopsies (small piece of tissue removed from the cervix).

This treatment option is offered as studies have shown that in time, CIN2 can return to normal in half of women (50% of women) even without treatment, and in up to 60% (60 out of 100) of women who are less than 30 years old. This helps avoid the risks associated with other active treatment options as mentioned previously.

In more recent years, studies have also shown that surveillance does not have a significant effect upon a woman's reproductive health.

In women who have not yet had any children, or wish for a further future pregnancy, surveillance can potentially avoid the risk of premature birth / mid-trimester miscarriage (between 13-26 weeks gestation).

Is active surveillance of CIN2 a suitable option for me?

It is important to understand that surveillance of CIN2 is not suitable for all women. The colposcopy team will take into account your individual circumstances before making a recommendation for your management.

Surveillance for CIN2 is more likely to be suitable for younger women in whom a small area of CIN2 is seen on the cervix.

It is very important that you attend the colposcopy clinic for your appointments. If you feel that you are not able to attend the colposcopy clinic at six monthly intervals then surveillance is not an appropriate option for you and we would recommend that you have a LLETZ or cold coagulation.

What does surveillance of CIN2 involve?

You will usually need to be seen in the colposcopy clinic every 6 months for a smear test and colposcopy and/or biopsy until the cells return to normal.

If CIN2 is still present after two years, we suggest active treatment with a LLETZ or cold coagulation.

If at any time during the two years, the cells become worse in grade or size then we would recommend LLETZ treatment at that point.

It is very important that you attend the colposcopy clinic when any appointment is made for you. If you cannot attend, for any reason, please let us know so the appointment can be used by someone else and we can arrange another appointment for you.

What are the risks of active surveillance?

One in five women under surveillance for CIN2 will progress to a higher grade of CIN within two years, but at this time they will be offered a LLETZ.

Less than 1 in 200 women with CIN2 will develop cervical cancer in a two year surveillance period.

What if I change my mind about active surveillance?

You can change your mind at any time. You can contact the colposcopy clinic if you are feeling worried or concerned about your treatment and speak to a member of the specialist team.

What are the treatment options for CIN2?

Until recently, in most cases women with CIN2 would have been offered treatment called 'Large Loop Excision of the Transformation Zone' (LLETZ). Alternatively, some women have treatment called cold coagulation. The aim of both treatments is to treat the abnormal cells. However, there is now evidence to support surveillance of CIN2 and only proceed with treatment if the abnormality does not get better of its own accord.

LLETZ

This is a common treatment used to remove abnormal cells from the cervix. It is usually performed in the colposcopy clinic with a local anaesthetic. It is a small procedure that is used to remove a small area of skin from the cervix using a hot wire loop.

The benefit of this treatment is that it removes the abnormal cells from the cervix and allows normal cells to grow back in their place. You will have a repeat smear in six months to ensure all the abnormal cells have been removed.

The main complications following this treatment are heavy vaginal bleeding and infection.

This treatment can create a potential risk of having a premature birth /mid-trimester miscarriage (between 13-26 weeks gestation) in women who have not yet had any children or wish for a further future pregnancy, as removing the abnormal cells can in some cases weaken the cervix. The risk is usually determined by the amount of cervix removed during the treatment. It can be up to 2 to 2.5 fold (or 10-15%). The doctor or clinical nurse specialist will discuss this with you when discussing the treatment options.