What Is CIN 2 and How Should It Be Treated?

The debate over whether cervical intraepithelial neoplasia grade 2 is a real, distinct entity continues.

BY ROXANNE NELSON
Contributing Writer

Las Vegas — Experts are divided on how aggressively cervical intraepithelial neoplasia grade 2 should be treated, and on whether observation is an acceptable option, especially in low-risk populations.

Cervical intraepithelial neoplasia (CIN) has been regarded as a preinvasive condi-
tion, with progressively higher grades be-
ing associated with an increasing risk of cancer. As most CIN 1 lesions regress without treatment, it has been suggested that CIN 2 may also have limited potential to progress to a more invasive disease.

"The goal of treatment for CIN is to prevent cancer by eliminating lesions with true malignant potential," Dr. Mark Spitzer said at a meeting of the American Society for Colposcopy and Cervical Pathology. "And we also want to avoid un-
necessary treatment of lesions with little or no premalignant potential."

The data are mixed, said Dr. Spitzer of New York University, New York. Some studies show that CIN 2 is an intermedi-
ate entity that lies between CIN 1 and CIN 3 and has some premalignant potential al-
though not as great as that of CIN 3. Oth-
er studies show that it is much closer to CIN 1 or benign disease, so it does not have real premalignant potential.

"That raises the question, "Is the diag-
nosis of CIN 2 a reliable or reproducible diagnosis?" Dr. Spitzer said.

He pointed out that a few studies have assessed that question, and one conclud-
ed that interobserver variation is fair to good for the diagno-
sis of benign condi-
tions, CIN 3, or inva-
sive cancer, but poor for the diagnosis of CIN 1 or CIN 2. There is also poorer correlation between colposcopic and his-
tologic diagnosis with CIN 2, compared with CIN 1 and CIN 3.

"The problem with CIN 2 is that we don't really know what it is," Dr. Spitzer said. Any system of grading an intraep-
ithelial lesion, in which there is a lesional continuum, is essentially artificial. A grad-
ing system that is based on light mi-
croscopy is subject to inter- and intra-
observer variations in reporting, and treating all patients with CIN 2 will clearly result in the overtreatment of many of them.

There’s also a question of age, when making the decision to treat cervical le-
sions. CIN 2 in adolescents is different than it is in adults, he explained. Some prelimi-
nary results showed that after 1 year, the behavior of CIN 2 in adolescents was the same as that of CIN 1.

"If you're under 20 the risk of invasive cancer is zero," said Dr. Spitzer. "If you're in the cohort under age 25, it still is really very low. So not treating CIN 2 in younger patients really makes a lot of sense."

However, Dr. Ed-
ward John Mayeaux Jr., an associate pro-

fessor of family med-
icine and obstetrics and gynecology at Louisiana State Uni-
versity, Shreveport, disagreed with the assumption that CIN 2 isn’t a real entity.

"This has been debated before," he said, "And the data do show that it is different in its progression and regression potential than CIN 1. It has a biological activity that is different from both CIN 1 and CIN 3."

"In adolescents it is often transient and the risk of cancer is small, and our guide-
lines already say that observation for 1 year is acceptable for adolescents."

Dr. Mayeaux said. Dr. Mayeaux also pointed out that in the United States, CIN 2 and 3 are man-
aged in a similar fashion, primarily be-
cause the potential for progression is high-
er than that of CIN 1 and reliable histologic differentiation in CIN 2 and 3 is only moderate.

Overall, CIN 3 has about a 12% pro-
gression to cancer, but CIN 2 has about a 5% progression to cancer. These estimates do vary significantly, and at this time, most authors, guidelines, and profession-
als recommend treatment for both CIN 2 and 3 lesions.

"We do need a better way to tell who is going to progress, and I agree with that," said Dr. Mayeaux. "The difference in our point of view is that I don’t think we’re there yet. And until we get there, we don’t know what those changes are going to mean for patient outcome. We still need to treat it until we reach that point."

Given the current variations in equip-
ment and practice, and the greater po-
tential of CIN 2 to progress, compared with CIN 1, Dr. Mayeaux recommends no changes in current treatment proto-
ocols.

In rebuttal, Dr. Spitzer pointed out that while there is no doubt that CIN 2 has some premalignant potential, overtreat-
ment with the loop electrosurgical exci-
sion procedure can also have conse-
quen-
ces.

Drugs, Ultrasound May Be New Alternatives to Hysterectomy

BY GIANCARLO LA GIORGIA
Contributing Writer

Toronto — Treating uterine fibroids may eventually be as simple as prescribing a pill, or zapping the benign growths with high-intensity focused ultrasound—two of several promising nonsurgical alterna-
tives to the roughly 300,000 fibroid-relat-
ed hysterectomies performed annually in the United States.

"(Hysterectomy) is the gold standard in fibroid treatment. ... The problem is that it’s a big operation, and the patient loses her uterus. For some women, that just is not an acceptable solution," said Dr. R. Torrance Andrews in an interview after his presentation at an annual meeting of the Society of Interventional Radiology.

Uterine fibroids, or leiomyomas, may cause infertility or premature delivery and in rare cases may become malignant. They affect about 30% of reproductive-
age women, most commonly between the ages of 35 and 45 years, and particu-
larly African American women, whose incidence rate is up to nine times higher than that of white women.

Dr. Andrews, chief of vascular and in-
terventional radiology at the University of Washington Medical Center, Seattle, dis-
cussed mainstream fibroid treatments like hysterec-
tomy, laparoscopic myomectomy, and uterine fibroid embolization (UFE), as well as emerging techniques like high-
intensity focused ultrasound (HIFU), asopris-
nil, and other methods.

In terms of recommending one treat-
ment over the other, Dr. Andrews was frank: "I think it’s a big mistake for inter-
ventional radiologists to tell patients au-
thoritatively that they should have an em-
bolization, instead of (a surgical) treatment."

"Similarly, unless a gynecologist is re-
ed with the loop electro-
surgical excision procedure."

"This has been debated before," he said, "And the data do show that it is different in its progression and regression potential than CIN 1. It has a biological activity that is different from both CIN 1 and CIN 3."

"In adolescents it is often transient and the risk of cancer is small, and our guide-
lines already say that observation for 1 year is acceptable for adolescents with CIN 2," Dr. Mayeaux said.

"The beauty of HIFU is that it’s completely noninvasive. It’s the “Star Trek” of medical intervention ... and is going to have a very important role to play."

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