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Clinical practice guidelines obstetrics gynecology philippines

I share with you my diaposition bouquet for the lesson I held on the Clinical Practical Guidelines of the Obstetric Society and Gynaecology on the AUB: AUB_POGS_CPG The cancer of the cervix is the third most common cancer among women worldwide with about 569,847 new cases and 311,365 dead in 2018. Approximately 85% of new cases and 90% of deaths occur in low-resource regions or socio-economically weaker sections of society. (1) Cervical cancer is the second most frequent cancer in the Philippines and the second most frequent cancer among women between 15 and 44 years of age. In 2018, about 7,190 new cases of cervical cancer were diagnosed each year while 4,088 cases led to death.(2) According to the facts and estimates of Philippines cancer, the incidence of cervical cancer among Filipino women begins to rise steeply to 30 years with a standardized incidence of 16-year-oldness for 100,000 women and mortality rate of 7.5 for 100,000.(3) In addition, a significant percentage of non-competitive patients A. What are the recommended screening methods to decrease the incidence of cervical cancer? RECOMMENDATION: Women must be projected through regular gynecological examinations and cytologic tests (Papanicolaou smear). Women must sufferof precancerous abnormalities to decrease the incidence and mortality of cervical cancer. Liquid-based cytology can be offered as this has the advantage of making HPV tests on the same preparation with a lower rate of unsatisfactory results than conventional banners. Test quality: 2aStrength of recommendation: BRECOMMENDATION: DNA HPV The test should be used as part of co-testing for cervical cancer among women over the age of 30. Test quality: 2bStrength of recommendation: BRECOMMENDATION: In low resource settings, visual inspection with acetic acid (VIA) can be performed as an acceptable alternative for pap smear. Test quality: 1aStrength recommendation: A B. Do cervical cancer screening recommendations differ between women at different age groups? RECOMMENDATION: The degree should not be made between women under 21 years. Quality of tests: 1 aStrength recommendation: AWomen of age 21-29 should have a Pap test every 3 years. Test quality: 1aStrength of recommendation: RECOMMENDATION: Women aged 30-65 should be co-tested with Pap Test and HPV Test every 5 years. Another option for projection of this age group is a pap test every 3 years. Test quality: 1 aStrength recommendation: ARECOMMENDATION: The screening of cervical cancer should be interrupted between 65 years and 70 years of age in women who have three or more negative results of cytology tests in a row and no result of abnormal tests in the last 10 years. Test quality: 2aStrength ofbtl 1 Guidelines for cervical cancer screening for middle-risk women. These recommendations do not apply to HIGH-RISK special populations who may need more intensive screening such as those with cin2, cin 3 history, cervical cancer, HIV infection or immunocompromised women. * Co-testing: cytology plus hpv dna testpscpc — Filipino society for cervical pathology and co-scopyacs — american cancer societyasccp — american society for co-scopy and cervical pathologyascp — american society for clinical pathology c. can vaccination with hpv vaccines prevent cervical cancer? RECOMMENDATION:Vaccination should be recommended against hpv 16/18 as this is proven effective against persistent hpv infection and cin2+ quality of testing: 1 a force of recommendation: avaccination against hpv 16/18 should not be given during pregnancy. quality of tests: 1st strength of recommendation: a d. should women who have completed the discount hpv vaccine in cervical cancer screening? Recommendation: Women who have been immunized against the hpv must be projected by the same regime as unimmunized women. vaccination does not eliminate the need to undergo screening of recommended cervical cancerquality of tests: 1 a force of recommendation: be. among high-risk women for cervical cancer development, how often should cervical cancer screening be done? Recommendation: HIV seropositive women, cytology should be made at the time of diagnosis, so every 6 months at onelater. After 3 consecutive normal cytology tests, the follow-up cervical cytology should be done every 3 years. For 30-year-old seropositive women, cervical cytology tests and HPV tests can be performed every 3 years until the results are negative. The projection should continue throughout the life of a seropositive woman. Quality of tests: 3rd Recommendation force: CTable 2. Guidelines for cervical cancer screening for high-risk women (HIV Positive Women). The following table summarizes the recommendations on cervical cancer screening for seropositive women from the following institutions: CDC — Center for Disease Control and PreventionNIH – National Institute for Health (US)ACOG — American College of Obstetrics and GynecologyHIV Medical Association RECOMMENDATION: immunocompromising women from HIV-negative, the projection should start within 1 year of sexual debut and continued during their lives. Among immunocommitted women by HIV less than 30 years, cytology should be done annually. After 3 consecutive normal cytology tests, the follow-up cervical cytology should be done every 3 years. For immunocommitted women from HIV 30 years and beyond, co-testing with cervical cytology and HPV test should be done every 3 years until the results are negative. Cytology on an annual basis up to 3 consecutive normal tests followed by tests every 3 years can be done instead of co-testing. Quality of tests: 3rd Recommendation force: CTable 3.Guidelines for cancer screening for high-risk women (HIV Negative Immunocompromised Women). The following table summarizes the recommendations on cervical cancer screening for immunocompromised women by HIV: F. How should we handle women with abnormal papi? F1. Atypical squamous cells of undetermined meaning (ASC-US) RECOMMENDATION:For women with ASC-US cytology, HPV reflex testingQuality of tests: 1 a force of recommendation: BIf test HPV cannot be done, repeat cytology at 1 year should be done. The coup can be offered as another option. Quality of tests: 2nd Recommendation force: BRECOMMENDATION: For women aged between 21 and 24 with ASC-US, cytology alone at intervals of 12 months should be done. You can also recommend the reflex HPV test. Quality of tests: 2 a force of recommendation: BRECOMMENDATION: Women 65 years and older with ASC-US cytology should have reflex HPV test done. The coup should be done if HPV is positive. If the HPV test is negative, repeat co-testing (preferred,) or cytology alone (acceptable) in 1 year should be done. Quality of tests: 2nd Recommendation force: BRECOMMENDATION: Pregnant women with ASC-US must be handled as in the non-pregnant population, except by rescheduling the coup until 6 weeks after childbirth is acceptable. Quality of tests: 3rd Recommendation force: CEndocervica curattage should not be done for pregnant women. Quality of tests: 3rd Recommendation force: And F2. Low degreeIntraepitelial lesion (LSIL)RECOMMENDATION: The colonoscopy should be made for women with LSIL cytology and with HPV positive test or HPV test not done. If the HPV test is negative, repeat co-testing at 1 year is preferred management, but the co-testing is also acceptable. Quality of tests: 1 a force of recommendation: For women 21-24 years with LSIL, follow with cytology at intervals of 12 months should be done. Quality of tests: 2nd Recommendation force: BRECOMMENDATION: For pregnant mothers with LSIL, couphoscopy should be recommended. Quality of tests: 2 a force of recommendation: BRECOMMENDATION: The endocervic curettage should not be done in pregnant women. Quality of tests: 3rd Recommendation force: ERECOMMENDATION: For pregnant women 21 – 24 years with LSIL, the same recommendations of women not pregnant in the same age group must be followed. Defer coup after 6 weeks postpartum is acceptable. Quality of tests: 3rd Recommendation force: For postmenopausal women with LSIL, you can recommend the following options: Test HPV, repeat the cytology at 6 and 12 months, and coxcopy. Quality of tests: 3rd Recommendation force: C F3. Atypical squamous cells: It cannot evade high quality squamous intraepitelial lesions (ASC-H)RECOMMENDATION: For women with ASC-H cytology, couphoscopy, they must be performed independently of the HPV result. Quality of tests: 2 a force of recommendation: DF4. High quality squamous intraepitelial(HSIL) RECOMMENDATION: women with hsil cytology must undergo an immediate cycle electrosurgery excision (leep) or a coup. quality of tests: 2nd recommendation force: Brecommendation: for women between 21 and 24 years old with hsil, the coup should be made. quality of tests: 2 a force of recommendation: a f5. atypical glandular cells (agc,) adenocaronoma citological in situ (ais,) benign glandular changes for women with all agc subcategories and ais, except for atypical endometrial cells, the coxcopy with endocervic sampling should be made independently of the hpvqual state of evidence: 2 a force of recommendation: anendometric sampling must be done in combination with endocervical couphoscopy and sampling on women 35 years of age and older, and in those younger than 35 years, but with clinical indications suggesting that they can be at risk for endometrial neoplasia (unexplained vaginal bleeding, chronic anovulation, etc.) quality of evidence: 2nd recommendation force: Brecommendation: for women with atypical endometrial cells, endometrial and endocervical sampling should be done. couphoscopy can also be acceptable. quality of tests: 2 a force of recommendation: arecommendation: for pregnant women with agc, management should be identical to that of women not pregnant (level 3a, grade b,) except for endocervic curettage and endometrial biopsy are unacceptable (level 3a, grade e.) quality of tests: 3rd recommendation force: b; erecommendation:should be evaluated for post menopause women with benign endometrial cells. Quality of tests: 2nd Recommendation force: premenopausal BASymptomatic women with benign endometrial cells, endometrial or histiocyte stromal cells, should not be subjected to further evaluation. Quality of tests: 2nd Recommendation force: BRECOMMENDATION: Post-hysterectomy patients with a cytological relationship of benign glandular cells should not undergo further evaluation. Quality of tests: 2 a force of recommendation: B G. How should we manage women diagnosed with premaligne injuries? G1. CERVICA NEOPLASIA (CIN) 1 (also known as low-grade intraepitelial lesion/LSIL using the two-tier classification system) RECOMMENDATION: Women without lesions or CIN 1 preceded by ASC-US or LSIL, HPV 16+ or 18+ and HPV persistent, must be tested co-testing. If the CIN 1 is detected on the endocervic sampling, the management is equal, but an endocervic sampling repeated in 12 months should also be done. Quality of tests: 2 a Recommendation force: For women without injuries or CIN 1 preceded by the ASC-H or HSIL cytology, any of the following operations can be done: (1) Excision diagnostic procedure, or (2) co-testing at 12 and 24 months if the co-testing is adequate and endocervical sampling is negative, or (3) a revision of cytologic, histologic and co-sock results. Quality of tests: 2nd Recommendation force: RECOMMENDATION: For women aged 21 to 24with CIN 1 after the cytology ASC-US or LSIL, a cytology repeated at intervals of 12 months should be done. Quality of tests: 2 a force of recommendation: ERECOMMENDATION: For women aged between 21 and 24 years with CIN 1 after the ASC-H or HSIL cytology, both coup and cytology at 6 months intervals must be carried out for a maximum of 24 months, provided that the co-scopic examination is adequate and endocervica evaluation is negative. Quality of tests: 2nd Recommendation force: BRECOMMENDATION: For pregnant women with CIN 1, follow-up without treatment should be recommended. Quality of tests: 2nd Recommendation force: BG2. CIN 2, CIN 3 and CIN 2,3 (also known as High Grade Intraepitelial Lesion/HSIL using the two-tier classification system)RENDATION: For women to win CIN 2, CIN 3, or CIN 2,3 and adequate couphoscopy, both excision and ablation can be done, except in pregnant women and young women. Quality of tests: 1st Recommendation force: RECOMMENDATION: For the recurring CIN 2, CIN 3, or CIN 2,3 or insufficient coupscopy, or endocervical sampling showing CIN 2, CIN 3, or CIN 2,3 a diagnostic procedure must be performed. Quality of tests: 2 a force of recommendation: ARECOMMENDATION: For young women with CIN 2,3 not otherwise specified, or excission, ablation, or observation with couphoscopy and cytology at intervals of 6 months for a maximum of 12 months can be done, provided that the coup is adequate. When a diagnosis of CIN 2 is specified in young women,management is observation with coup and cytology every 6 months for 12 months. Treatment with ablation or excision can also be done. When the CIN 3 is specified or the coup is inadequate, excision or ablation must be done. Quality of tests: 2nd Recommendation force: BRECOMMENDATION: For pregnant women with CIN 2, CIN 3, or CIN 2,3 further phonic and cytologic examinations at no more frequent intervals than every 12 weeks should be carried out. The repeated biopsy during pregnancy is recommended only if the appearance of injury worsens, or if cytology suggests invasive cancer. However, defer revaluation to 6 weeks after childbirth is acceptable. A diagnostic excision procedure can only be done if the invasion is suspected. Quality of tests: 2nd Recommendation force: BG3. Adenocarcinoma-in-situ (AIS) RECOMMENDATION: For women who have completed child education and have the isthological diagnosis of AIS from a diagnostic procedure of excision, hysterectomy must be done. Quality of tests: 3rd Recommendation force: BRECOMMENDATION: If future fertility is desired, conservative management can be done. Quality of tests: 2nd Recommendation force: A This site uses cookies to improve your experience. Suppose you're okay, but you can opt for your desire. Cookie settings ACCETTATION Privacy and cookie policy

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