CERVICAL INTRA-EPITHELIAL NEOPLASIA (CIN) MANAGEMENT AND FOLLOW-UP IN AIN SHAMS UNIVERSITY MATERNITY HOSPITAL

Thesis

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بسم الله الرحمن الرحيم

"سبحانك لا علم لنا إلا ما علمتنا إنك انت العليم الحكيم"

صدق الله العظيم

سوره البقره

ايه رقم ٣٢

الله

بسم الله الرحمن الرحيم

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Dedicated To My Father

Contents

List of Tables

List of Figures

INTRODUCTION

Introduction

Better understanding of natural history of cervical cancer precursors in the past decade lead to the outpatient management of most women with cervical intraepithelial neoplasia **(Richart, 1980)**. Rigid diagnostic criteria including appropriate cytologic testing, colposcopy, endocervical curettage and multiple punch biopsies have been recommended to obtain good therapeutic results on one hand and to make sure that invasive carcinoma is not missed on the other hand **(Richart, 1980 and Ferenczy, 1981)**. The natural history of CIN remains a controversial subject. It is generally accepted that grade I and grade II cervical intraepithelial neoplasia will either regress or progress to grade III CIN even after several years of persistence a substantial percentage of CIN grade III will ultimately progress to invasive carcinoma **(McIndoe, 1984)**. Consequently, all patients with CIN III require treatment and in addition many surgeons in this field also treat CIN II in cases of abnormal cervical smear further investigations are necessary. In general management of these patients consists of destruction or complete excision of the entire transformation zone after invasive carcinoma has been excluded by means of histopathologic examination of one or more biopsy specimen **(Karel et al., 1992)**. Irrespective of the method of treatment, long term follow up after conservative management is essential to detect residual and recurrent disease or the development of invasive carcinoma **(Pearson et al., 1989)**. The appropriate means to follow up women treated for cervical cancer precursors are on an outpatients basis have not been as rigidity established and in fact the issue remains controversial. Two basic schools of thoughts exist with regard to methods used for post treamtent follow up, one recommends the patient to be evaluated by cytologic testing alone **(Greasman et al., 1984)**.

Whereas the others favour the combined use of cytologic testing and colposcopy at regular intervals at least during the first year after outpatients treamtent **(Baggish, 1982; Coppleson, 1982)**.

AIM OF THE WORK

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A retrospective study of cases of cervical intraepithelial neoplasia (C.I.N.) treated in the unit of early cancer detection of Obstetric and Gynecology department in Ain Shams University hospital in the last 5 years 1990-1994, aiming at reaching and evaluating different lines of treatment and follow-up.

REVIEW OF LITERATURE

Anatomy of The Cervix

Gross anatomy:

The cervix (term taken from latin, meaning neck) is the most inferior portion of the uterus, protruding into the upper vagina. The transition between the endocervix and the lower portion of the uterine corpus is termed the isthmus or lower uterine segment. The latter is used for descriptive purposes during gestation and labor and is an important landmark for pathologist when describing cancers of uterine corpus **(Ferenczy, 1994)**. The cervix projects through the anterior wall of vagina at the vaginal vault, as a result of which, there is an upper supravaginal portion and lower vaginal one approximately of the same length. The vaginal mucosa is reflected around the front, sides, and the back of the cervix forming the vaginal fornices **(Richard, 1984)**. The cervix is a cylinder of fibromuscular tissue with an average length of about 3.5 cm and average diameter of 2.5 cm **(Reid and Campion, 1989)**.

The vaginal cervix has both an anterior and posterior lip. The anterior lip is shorter than the posterior one due to the oblique line of reflection of the vaginal mucosa **(Ferenczy, 1994)**.

In the center of the exocervix is the external os which is spherical in nullipara but usually transverse and more gaping in multipara **(Mackay**