ECRONICON OPEN ACCESS

EC GYNAECOLOGY
Opinion

Can We Prevent Cervical KC?

Atika Bendrama*

Gynecologue Obstetrician Liberal, Algeria

***Corresponding Author:** Atika Bendrama, Gynecologue Obstetrician Liberal, Algeria.

Received: March 27, 2023; **Published:** April 27, 2023

Cervical KC is a major public health problem worldwide.

Its incidence is estimated at 570,000 new cases/year (2018 figure). It is the 4th female KC in incidence. Cervical KC mortality is 312,000 deaths/year.

This KC can be avoided or prevented by 1) Vaccination which plays an important role in prevention. 2) Screening of preneoplasic lesions and their treatment to avoid evolution towards invasive KC. Which explains the heterogeneous geographical distribution in the world (80% of deaths are recorded in developing countries. Varies between 2.5 to 55 cases per 100,000 women). The risk for a woman to develop cervical KC during her lifetime is 1% in France against 5% in developing countries. This reflects the different screening policies.

80 - 90% of cervical KC is epidermoid carcinoma developed from the malpighian epithelium of the exocol, and in 20% an adenocarcinoma developed from the cylindrical epithelium of the endocol.

The cause agent is the human papilloma virus; infection transmittable through sexual contact, cofactors are essential for the development of a KC of the cervix such as precocity of sexual intercourses, multiple sexual partners, multiparity, immunodeficiency, smoking, the existence of other sexually transmitted infections associated with HPV 18 and 16 particularly HIV virus herpes virus and *chlamydia*….

Invasive cervical KC takes an average 5 to 20 years to develop after persistence of a high-risk HPV infection.

Prevention:

1. Vaccination: Young girls must be vaccinated from the age of 11 to 14 years with a reminder between 15 and 19 years.
2. Screening: Is done by cytology or oncogenic DHPV research at the cervical level.

A negative HPV test eliminates the risk of neoplasic or preneoplasic lesions. Allows to reassure the patient and her attending doctor. Thus, it is redone every 5 years.

Cytology also allows screening of preneoplasic lesions which are classified according to the 2001 Bethesda classification.

WHO classifies the cervix in

- Normal appearance
    a) Benign cellular modifications: Trichomonas infection, mycosis, herpes, actinomycosis
        - Reactional modifications: Inflammation, atrophy; radiation; IUD.

b) Abnormalities of epithelial cells: 1- Malpighian cells: - of undetermined significance ASCUS

- Lesions malpighian low grade intraepithelial LSIL HPV/mild dysplasia/CIN1.
- Lesions high-grade HSIL intraepithelial: Medium dysplasia, severe dysplasia, CIN2; CIN3; carcinoma *in situ*.
- Malpighian carcinoma.

- Glandular cells: Glandular atypia of undetermined significance AGCUS
- Adenocarcinoma indicate likely site of origin; endocervical - endometrial - extrauterine - not specified (NOS).

In case of discovery of cytological abnormalities, cytological monitoring coupled with the HPV test in the ascus is recommended.

A colposcopy with HPV test in grade 1, 2, or 3 atypia.

Diagnostic and therapeutic conization; with monitoring by HPV test until the test is negative.

An appropriate treatment for each case in *in situ* and invasive carcinomas.

Volume 12 Issue 5 May 2023