Management of Abnormal Cervical Cancer Screening Tests in Pregnancy

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Pregnancy does not change the natural history of human papilloma virus (HPV) and pregnant patients are considered to have similar rates of progression to cancer as their nonpregnant counterparts. Abnormal screening results should be managed using the same risk/clinical action thresholds as those established for nonpregnant individuals.

In pregnancy, colposcopy is recommended for those with an immediate risk of cervical intraepithelial neoplasia 3 (CIN3) ≥4%. Expedited treatment is not recommended in pregnancy. Colposcopy is recommended in pregnant patients in cases with a risk of CIN3+ >25% where expedited treatment is acceptable in nonpregnant patients and in cases with a risk of CIN3+ >60% where expedited treatment is preferred in nonpregnant patients. Excision is only recommended in pregnant patients in cases where cancer is suspected.

Colposcopy with biopsy during pregnancy is a safe procedure and is not associated with adverse surgical or obstetric outcomes. Clinically indicated biopsies can be performed during pregnancy. However, colposcopy during pregnancy does present challenges to accurate diagnosis since pregnancy-related changes of the cervix may be challenging to distinguish from cancers, increasing the risk of a missed cancer diagnosis. For these reasons, it is preferred that a colposcopist experienced in the examination of the cervix during pregnancy perform the exam. Pregnant patients are considered a 'special population' since management and therapeutic options must weigh the potential risks to the pregnant person and fetus versus risk of a potential missed cancer diagnosis.

Fortunately, spontaneous regression rates of CIN for pregnant patients are high and persistence of CIN and progression to malignancy are low.

Patients diagnosed with high grade lesions (CIN 2 or 3) or adenocarcinoma in situ (AIS) during pregnancy should undergo surveillance via colposcopy and age-based testing (cytology/HPV) every 12-24 weeks. The choice of surveillance interval is individualized based on the gestational age of the fetus, level of experience of colposcopist, and risk for loss of follow-up. Repeat biopsy is recommended if the lesion worsens or invasion is suspected. Deferring repeat colposcopy to postpartum is acceptable.

If AIS is diagnosed during pregnancy, referral to a gynecologic oncologist is preferred, but management by a gynecologist skilled in the colposcopic diagnosis and treatment of AIS is acceptable.

Postpartum colposcopy is recommended no sooner than 4 weeks after delivery. This allows time for the cervix to heal following delivery and time for the patient to complete the procedure prior to the end of the postpartum

insurance coverage window. If a lesion is found at the time of postpartum colposcopy, either an excisional procedure or full diagnostic evaluation (cytology, HPV testing, colposcopy, and biopsy) is recommended. If no visible lesions are seen, a full diagnostic evaluation is recommended.

Further reading:

Perkins RB, Guido RS, Castle PE, Chelmow D, Einstein MH, Garcia F, et al. 2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors. J. Low Genit Tract Disease 24(2): 102–131.