

the exocervical extension of the pathological areas observed on the exo-cervix using conventional colposcopy.

Unfortunately, this procedure can have two drawbacks: the macroscopic observation of the external limits of the observed lesion cannot have the same accuracy as the microscopic vision, capable of establishing the external limits of the cellular alterations to be removed, and secondly the colposcopic observation does not can accurately determine the endocervical extent of the lesion.

As a consequence, it is not uncommon to obtain an incomplete excision of the pathological tissue, with the risk of having to repeat the treatment again due to the persistence of the disease.^{17,18}

On the contrary, especially in initial high-grade lesions, standardized excisional treatment can remove an excessive amount of tissue, and this is not desirable in young subjects with the desire to become pregnant.


Personalization of treatment is the solution to the problem. Immediately before choosing the size and shape of the loop, an accurate micro-colpo-hysteroscopy is carried out, with the patient on the operating bed. Once the external and endocervical margins have been established, the loop is chosen. The excision takes place with a decisive and progressive passage of the loop in an antero-posterior or lateral-lateral direction, depending on one's habits, and immediately after the removal of the fragment of cervix, a new microcolpohysteroscopic check is carried out on the margins of the residual cervix, and on the removed piece, applying Waterman's blue solution again, to be able to observe the cells. If pathological cellular elements are observed on the margins of the uterine cervix

or of the removed cervical cone, it will be possible to proceed with a slight enlargement of the excision, thus avoiding learning of the incomplete excision only following the histology report, having to repeat a new hospitalization for the patient to complete the surgical treatment.

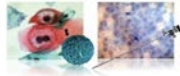
While the advantages of this method appear evident, the only disadvantage is linked to the difficulty of acquiring the instrument or learning the technique, which unfortunately is still reserved for a few specialists today.

Conclusion:

The use of preoperative micro-colpo-hysteroscopy to precisely identify the tissue to be removed allows for a "therapeutic" conization to be obtained, enormously reducing the risk of carrying out an incomplete or excessive excision. Furthermore, the immediately postoperative micro-colpo-hysteroscopic control on the margins of the uterine cervix allows an immediate evaluation of the total removal thus reducing the risk of persistence of the lesion.

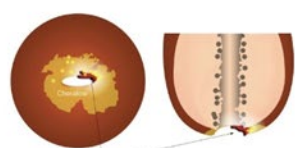


Dott. Luigi Montevocchi
Diagnostica e Terapia Endoscopica
in Ginecologia



MICROCOLPOSCOPIA

Name of the patient: _____ Date: _____
 Sent by Dr: _____ LMP: _____
 Indication: **ASCUS HPV 51 & 53** Date of birth: _____



**Focal area of CIN 2
on squamous metaplasia**

Squamo-columnar junction:
Type I: entirely endocervical
Type II: Partially endocervical
Type III: entirely endocervical

Normal microcolposcopy aspects

Mature original squamous epithelium yes No
 Atrophic squamous epithelium yes No
 Cylindrical epithelium yes No
 Squamous metaplasia yes No
 Nabothian cyst yes No
 Glandular orifices or crypts yes No
 Deciduous gravidarum yes No
 Squamo-columnar junction Type I Type II

Non-specific aspects

Polipo yes No
 Cheratosi yes No

Abnormal microcolposcopy aspects

VCE (Viral Cytopathic Effects) yes No
 CIN 1 or structured condyloma yes No
 Invasive Carcinoma yes No
 Lesion localized to the 1st quadrant yes No
 Lesion localized to the 2nd quadrant yes No
 Lesion localized to the 3rd quadrant yes No
 Lesion localized to the 4th quadrant yes No

Size of the Lesion: _____

Diagnosis: **High Grade focal Lesion, associated with HPV (= CIN 2 on superficial squamous metaplasia?)**

Suggestions: **Excision of pathological areas**

dott. Luigi Montevocchi

CYTOHISTOLOGICAL REPORT

■ Acceptance No: _____
 ■ Report Date: _____
 ■ Date of birth: _____
 ■ Surgery Date: _____
 ■ Patient: _____
 ■ Doctor: Dott. Montevocchi
 ■ Clinic: Ars Medica
 ■ Department: Ricoveri

Material received marked as:


Cone of uterine cervix

Macro - Microscopic findings

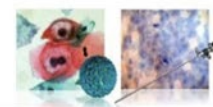
We receive a cervical cone measuring 1.5x1x0.5 cm

Diagnosis:

Sections of uterine cervix with a high-grade intraepithelial lesion, with moderate dysplasia (HSIL-CIN2).
 Surgical excision margins free from disease
 Immunohistochemical staining performed: p16+


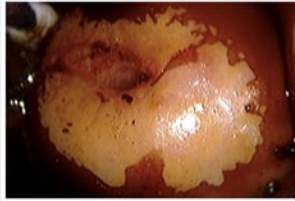


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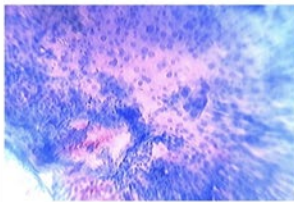
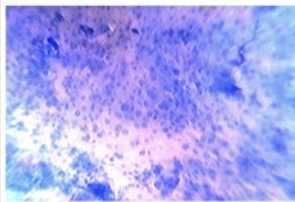


IMMAGINI

Name of the patient: _____ Date: _____
 Sent by Dr: _____ LMP: _____
 Indication: **ASCUS HPV 51 & 53** Date of birth: _____

Uterine cervix without preparation... ...and after Lugol's application

At 150x focal area of HSIL on superficial squamous metaplasia... ...The same, on the anterior lip

Diagnosis: **High Grade focal Lesion, associated with HPV (= CIN 2 on superficial squamous metaplasia?)**

dott. Luigi Montevocchi

CYTOHISTOLOGICAL REPORT

■ Acceptance No: _____
 ■ Report Date: _____
 ■ Date of birth: _____
 ■ Surgery Date: _____
 ■ Patient: _____
 ■ Doctor: Dott. Montevocchi
 ■ Clinic: Ars Medica
 ■ Department: Ricoveri

Material received marked as:

Cone of uterine cervix

Macro - Microscopic findings

We receive a cervical cone measuring 1.5x1.5x0.6 cm

Diagnosis:

Sections of uterine cervix with a high-grade intraepithelial lesion (HSIL-CIN2) of the superficial epithelium
 Present foci of Low Grade Squamous Intraepithelial Lesion with koilocytotic aspects.
 Surgical excision margins free from disease

Dott. Luigi Montevicchi
 Diagnosta e Terapeuta Endoscopico
 in Ginecologia

MICROCOLPOSCOPIA

Name of the patient _____ Date _____
 Sent by Dr _____ LMP _____
 Indication **LSIL - HPV 31, 51** Date of birth _____

■ Area periorificiale di HSIL (= CIN 2 su metaplasia squamosa)
 ■ LSIL

Squamo-columnar junction:
 Type I: Entirely endocervical
 Type II: Partially endocervical
 Type III: Entirely ectocervical

Normal microcolposcopy aspects

Mature original squamous epithelium yes No
 Atrophic squamous epithelium yes No
 Cylindrical epithelium yes No
 Squamous metaplasia yes No
 Nabothian cyst yes No
 Glandular orifices or crypts yes No
 Deciduous gravidarum yes No
 Squamo-columnar junction

Abnormal microcolposcopy aspects

VCE (Viral Cytopathic Effects)
 CIN 1 or structured condyloma yes No
 Invasive Carcinoma yes No
 Lesion localized to the 1st quadrant yes No
 Lesion localized to the 2nd quadrant yes No
 Lesion localized to the 3rd quadrant yes No
 Lesion localized to the 4th quadrant yes No

Size of the Lesion

Non-specific aspects

Polipo yes No
 Cheratosi yes No

Diagnosis **High Grade focal Lesion, associated with HPV (= CIN 2 on superficial squamous metaplasia?)**

Suggestions **Excision of pathological areas**

dott. Luigi Montevicchi

Dott. Luigi Montevicchi
 Diagnosta e Terapeuta Endoscopico
 in Ginecologia

IMMAGINI

Name of the patient _____ Date _____
 Sent by Dr _____ LMP _____
 Indication **LSIL - HPV 31, 51** Date of birth _____

Uterine cervix without preparation...

...and after Lugol's application

At 150x focal area of HSIL on superficial squamous metaplasia...

...The same, on the posterior junction, about 6 mm inside the cervical canal

Diagnosis **High Grade focal Lesion, associated with HPV (= CIN 2 on superficial squamous metaplasia?)**

dott. Luigi Montevicchi

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