

Colposcopy Today

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Since Hinselmann introduced Colposcopy as a useful tool in the study of the lower genital tract in 1925, the technique has experienced different avatars [1,2].

Being a German technique, after World War II its use was limited to those countries under the scientific influence of Germany.

Two pathologists De Brux from France [3] and Richart from USA [4] discovered the real significance of the so called dysplasias, and demonstrated that it was the same disease with the capacity to progress to carcinoma. Richart introduced new terminology CIN (cervical intraepithelial neoplasia) grades 1, 2, 3.

National cervical cancer screening programs have been cytology based. More recently, the knowledge of the etiopathogenic role of HPV persistent infection in the development of cervical preinvasive and invasive lesions has added new useful screening tools such as HPV tests.

Nowadays it is relatively well defined the role of colposcopy as an aid to diagnosis instead of a diagnostic test itself in patients with abnormal cytology in the absence of a grossly visible lesion. This fact has classically limited its practice to experienced colposcopists who work in specialized units, where most of them will limit the use of the technique by just nearly describing extension and morphology of the lesion. The usefulness of colposcopy should not be limited to the approach of premalignant or malignant diseases of the cervix, because it is a dynamic instrument that allows clinicians to detect, describe, interpret and even predict severeness and grading of the observed lesions, benign or not, that otherwise would be misdiagnosed or not diagnosed at all by the naked eyes. Moreover colposcopy helps in this same way when we talk about vulva, vagina, perineum and perineal regions. This article it is not intended to have a comprehensive listing of all known dermatological or pathological disorders that may be diagnosed by using the colposcope in vulva or vagina, but to notice that there are a lot of common disorders that could be identified [5]. There is also some concern on the fact that postponing the colposcopy to be done in a specialized unit and the drawbacks that this kind of practice could bring to the patients' personal (psychologically) and social/working live (due to the need to book two appointments), every time that a patient is encouraged to go to a specialized unit to have a colposcopy fear and anxiety could affect her, knowing that there is a need for further investigation.

As for cost - effectiveness, when colposcopy is part of the routine gynecological examination, there is no extra charge. The expense of a colposcope is covered by indirect ways including no need to reassure the patient in another visit, reduction of naked eyes' misdiagnosis or underdiagnosis, precise application of topical treatment and thereby decreasing complications and avoiding

insufficient therapy, patients anxiety related to the colposcopy itself is completely reduced and almost nonexistence [6,7].

Talking about the uterine cervix evaluation we also dear to recommend the routine use of colposcopy during the annual gynecological check in. It is quite clear that such proposal implies some problems: Increases the time of the consultation, requires some knowledge of the technique but also has some other clear advantages than those stated before: As the technique obliges to introduce the speculum in order to visualize the entire cervix, the number of cytologies without glandular component decreases and the colposcopy would help the clinicians identify if there is any extension of the lesion to the endocervix or vagina. In some cases, as we know the expert colposcopist had diagnosed a severe lesion, and cytology gave a false negative diagnosis [8].

In the past recent years the LASER(light amplification by the stimulated emission of radiation) with CO₂ technology had become an important and excellent tool to treat vulvar, perineal, perianal, vaginal and cervical disorders, because of its major advantages when compare with traditional techniques (scalpel, electrosurgical excision procedures, etc.) such as: High degree of clinical efficacy, bloodless field, sparing of normal tissue, rapid healing with minimal scar formation, small number of complications and microscopic precision due to the possibility to coupled the LASER beam equipment to the colposcope. If this technology really came to the gynecological field to stay longer, as it seems to be, colposcopy will be an important partner in order to let the LASER energy reach this goal.

On the other hand, it is quite surprising the rapid spread of ultrasounds used by the "general" gynecologist giving a definitive diagnostic, in spite of the imaging specialists that normally have better tools and the responsibility of the accurate diagnostic.

With this article, we as a group with enough experience in colposcopy want to encourage other groups similar to us and general gynecologists themselves to rethink and argue about this great an useful gynecological technique [9,10].

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