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Is cervical dysplasia a major concern in women with inflammatory bowel disease? A Spanish retrospective study

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Dear editor,
Cervical cancer (CC) is the fourth most common cancer affecting women worldwide. The risk of women immunosuppressed due to AIDS or organ transplantation is well documented, as most cases are caused by persistent human papillomavirus (HPV) infection and immunosuppression can prevent clearing HPV (1,2). Although European guidelines advise that inflammatory bowel disease (IBD) women under immunosuppression should be screened for CC as regularly as high-risk patients, quality evidence is lacking in our country (1,3,4).

We performed a retrospective case-control (2020-2021) study to analyse the risk factors associated with the appearance of low-grade (LSIL) or high-grade (HSIL) squamous intraepithelial cervical lesions in patients with IBD. We included all women aged 21-65 years, followed up at the University Hospital Fundación Alcorcón (Spain). Cases were defined as those patients with abnormalities in cervical cytology, while the control group consisted of the rest of the women. Disease characteristics, treatments and epidemiological data (smoking habit, sexual behaviour and reproductive history) were obtained. We recorded the results of cervical screening, and cervical abnormalities (CA) were grouped into precursor lesions and cervical cancer. We documented the evolution of abnormalities over time and compare data between women under immunosuppressive treatment or not.

A total of 269 IBD patients were included (53% Crohn’s disease (CD), 46% Ulcerative Colitis (UC). Imunosuppressive treatment was more frequent among CD than UC patients (61% vs 21%, p<0.001).

Cervical abnormalities were found in 20 patients (case group). No significant associations were found related with the type of disease, treatment or epidemiologic characteristics between cases and controls.

CA comprised 17 L-SIL and 3 H-SIL, which represented 9,5% in women under immunosuppression vs 5,6% in non-immunosuppressed, p=0,2. The regression rate in patients under immunosuppressive treatment was significantly lower vs non-immunosuppression (20% vs 90%, p=0.02). Five of those women indeed required surgical intervention (conization and/or hysterectomy).

The adherence to cervical screening was low, only 25% of the high-risk patients followed regular vigilance. Still, 52% had never performed a Pap smear or very
sporadically.

In conclusion, our study has not probed significant risk factors for cervical cancer in IBD patients. Although we have not found a higher percentage of cervical abnormalities among immunocompromised vs non-immunosuppressed women, it suggests a worse outcome. We have evidenced a low adherence to current guidelines, which should encourage physicians and patients in their surveillance (5). Women with cervical abnormalities and immunosuppressive treatments should be closely monitored.

REFERENCES: