WHO guidelines

Use of cryotherapy for cervical intraepithelial neoplasia
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Acknowledgements

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Declarations of interest

All experts who participated in the development of *World Health Organization guidelines: use of cryotherapy for cervical intraepithelial neoplasia*, were required to complete the WHO Declaration of Interests form. Out of all the experts who participated in this work, three experts declared an interest in the subject related to cervical cancer prevention, as follows:

Dr Lynette Denny: from 2006 to 2010, she has spoken on HPV vaccination at various speaker’s fora organized by the companies MSD and GSK. The total honorarium received by Dr Denny from both companies combined was approximately US$ 3000 per year.

Dr Swee Chong Queck: over the past four years, he has participated in medical advisory boards and speakers’ bureaux relating to cervical cancer prevention strategies, HPV vaccine efficacy studies and clinical relevance of HPV vaccination for the prevention of cervical cancer and other HPV related diseases. The total income received by Dr Queck from both companies combined was approximately 5000 Singapore dollars per year over the past four years.

Dr Vivien Tsu: her employer PATH, an international nonprofit organization operating in the field of health, has received large-scale donations of HPV vaccines and test kits, as well as equipment, for use in demonstration projects aimed at promoting public health, including in particular in low-resource countries.
Contents

Acknowledgements iii
Declarations of interest iv
Executive Summary vi
Specific recommendations and their strength and quality of available evidence vii
Introduction 1
Methods 1
Results 4
Recommendations 5
Use of cryotherapy for prevention of CIN 5
Lesion size 5
Lesions extending into the endocervical canal 5
Cryotherapy technique and procedure 6
Providers 6
Use of cryotherapy during pregnancy 7
Retreatment of CIN lesions with cryotherapy 7
Discussion 9
References 9
Appendix A: Search strategy for OVID MEDLINE 10
Appendix B: Summary tables for each recommendation 11
Appendix C: References used in creating the GRADE tables for the recommendations 23
Executive Summary

In 2008, cervical cancer was responsible for 275,000 deaths, of which about 88% occurred in low- and middle-income countries. In 2009, the World Health Organization (WHO) committed to updating the recommendations on the use of cryotherapy for cervical intraepithelial neoplasia (CIN), adhering to the WHO revision process of guideline development. This document summarizes the new evidence-based WHO recommendations about the use of cryotherapy in women with histologically confirmed CIN for low-, middle- and high-income countries.

The methods used to develop these guidelines follow the WHO handbook for guidelines development. An expert panel was established that included clinicians who provide cryotherapy services, researchers in cervical cancer prevention and treatment, programme directors and methodologists. An independent group of scientists at a WHO collaborating center conducted systematic reviews and produced evidence summaries following the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) approach.

GRADE evidence profiles were created for 16 key questions about the effects of cryotherapy in the presence of histologically confirmed CIN compared to no treatment and to loop electrosurgical excision procedure (LEEP), as well as the use of different techniques of cryotherapy. Conflict of interests were managed according to WHO rules.

The systematic reviews had very few randomized controlled trials or controlled observational studies, and therefore most of the recommendations are based on pooled results across observational studies in women receiving cryotherapy. Very few studies assessed outcomes that the expert panel had identified as critical to decision-making, including fertility and obstetrics outcomes, maternal morbidity, acceptability of the procedure to women or their health-care providers, referral rates for complications, and HIV acquisition and transmission. Thus, most of the resulting 14 recommendations are based on studies that included outcomes for recurrence rates of CIN, major and minor adverse events, and cervical cancer incidence and mortality rates.
<table>
<thead>
<tr>
<th>Context</th>
<th>Recommendation</th>
<th>Quality of evidence</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of cryotherapy for prevention of CIN</td>
<td>1a. The expert panel recommends cryotherapy over no treatment</td>
<td>☀️☀️☀️</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td>1b. In settings where LEEP is available and accessible, the expert panel suggests treatment with LEEP over cryotherapy</td>
<td>☀️☀️</td>
<td>Conditional</td>
</tr>
<tr>
<td>Lesion size</td>
<td>2. Among women with CIN lesions covering more than 75% of the ectocervix, or with lesions extending beyond the cryo tip being used, the expert panel suggests performing or referring for excisional therapy</td>
<td>☀️☀️</td>
<td>Conditional</td>
</tr>
<tr>
<td>Lesions extending into the endocervical canal</td>
<td>3a. In settings where LEEP is available and accessible, and women present with CIN lesions extending into the cervical canal, the expert panel suggests treatment with LEEP over cryotherapy</td>
<td>☀️☀️</td>
<td>Conditional</td>
</tr>
<tr>
<td></td>
<td>3b. In settings where excisional procedures (e.g. LEEP, laser or CKC) or referral to additional treatment are not available, the expert panel suggests that women with lesions extending into the endocervical canal be treated with cryotherapy</td>
<td>☀️☀️</td>
<td>Conditional</td>
</tr>
<tr>
<td>Cryotherapy technique and procedure</td>
<td>4. The expert panel suggests double freeze using a 3 minute freeze, 5 minute thaw, 3 minute freeze cycle over single-freeze cryotherapy</td>
<td>☀️☀️</td>
<td>Conditional</td>
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<tr>
<td></td>
<td>5. The expert panel recommends cryotherapy using either carbon dioxide (CO₂) or nitrous oxide (N₂O) gas</td>
<td>☀️☀️</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td>In settings where both gases are available, the expert panel suggests cryotherapy with CO₂ rather than with N₂O</td>
<td>☀️☀️ occasions</td>
<td>Conditional</td>
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<td></td>
<td>6. The expert panel recommends that the “cough technique” should not be used during cryotherapy</td>
<td>☀️☀️</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td>7. The expert panel suggests that prophylactic antibiotics should not be used when providing cryotherapy</td>
<td>☀️☀️</td>
<td>Conditional</td>
</tr>
<tr>
<td>Providers</td>
<td>8. The expert panel recommends that health-care workers (including non-physicians) trained in cryotherapy perform the procedure for women when it is indicated</td>
<td>☀️☀️</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td>The expert panel also suggests that trained nurses or trained midwives rather than physicians may perform cryotherapy</td>
<td>☀️☀️ occasions</td>
<td>Conditional</td>
</tr>
<tr>
<td>Use of cryotherapy during pregnancy</td>
<td>9a. In pregnant women, the expert panel suggests deferring cryotherapy until after pregnancy</td>
<td>☀️☀️</td>
<td>Conditional</td>
</tr>
<tr>
<td></td>
<td>9b. In women whose pregnancy status is unknown (or there is no clinical evidence of pregnancy), the expert panel suggests using cryotherapy</td>
<td>☀️☀️</td>
<td>Conditional</td>
</tr>
<tr>
<td>Retreatment of CIN lesions with cryotherapy</td>
<td>10a. The expert panel recommends cryotherapy over no treatment for women who screen positive after prior cryotherapy treatment</td>
<td>☀️☀️</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td>10b. In settings where LEEP is available and accessible, the expert panel suggests treatment with LEEP over cryotherapy for women who screen positive after prior cryotherapy treatment</td>
<td>☀️☀️</td>
<td>Conditional</td>
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</table>

See page 7 for full details of recommendations and remarks.
**Introduction**

In 2008, cervical cancer was responsible for 275,000 deaths, of which about 88% occurred in low- and middle-income countries. Cervical cancer is the third most common cancer in women worldwide and the most common cancer in many low- and middle-income countries (1). Because it has a typically slow progression, from atypical cells to cervical intraepithelial neoplasia (CIN) and to invasive carcinoma, precancerous lesions can be treated and invasive cervical cancer prevented. The screening methods currently available in a wide range of settings include cytological smears (Pap smear), visual inspection with acetic acid (VIA), and human papillomavirus (HPV) testing. A diagnosis of CIN can be confirmed by histological interpretation of biopsies, either with or without colposcopy. Furthermore, a variety of treatment methods are available, including cryotherapy, loop electrosurgical excision procedure (LEEP)/large loop excision of the transformation zone (LLETZ), cold knife conization (CKC), laser vaporization, cold coagulation, and hysterectomy. In 2004, the World Health Organization (WHO) and other international organisations, developed and published *Comprehensive cervical cancer control: a guide for essential practice* (C4-GEP), as a comprehensive guide to assist health-care providers at multiple levels of the health system to prevent, detect and treat cervical precancer and cancer (2).

In 2009, WHO committed to updating these guidelines following the WHO revised process for guideline development (3). The C4-GEP currently includes recommendations on major treatment procedures for precancer of the cervix: cryotherapy, LEEP and CKC. Since many countries are moving towards marked revisions in their national programmes based on “single-visit” or “screen-and-treat” approaches using cryotherapy following a positive screening test, and because of the widespread use and ready availability of cryotherapy and limited availability of confirmatory colposcopy diagnosis, recommendation on the use of cryotherapy was therefore deemed a priority for the update of the C4-GEP, to support programme managers and clinicians to scale-up national programmes.

This document presents recommendations for the use of cryotherapy compared to no treatment, and to LEEP in the presence of histological confirmation of precancer lesion, CIN (CIN1, CIN2 or CIN3). The document also addresses the use of different techniques of cryotherapy for CIN and provides recommendations for treatment of CIN in women who are pregnant, as well as for women who are HIV infected. In keeping with WHO guideline terminology, the recommendations are either “strong” or “conditional” (4). For strong recommendations, we use the words “we recommend”, and for conditional recommendations, “we suggest”. We offer suggested interpretations of “strong” and “conditional” recommendations in Table 1. Understanding the interpretation of these two grades – either strong or conditional – is essential for health-care decision-making.

**Methods**

The methods to develop these guidelines followed the WHO handbook for guidelines development (3).

**Formulating questions and determining outcomes**

In March 2009, experts invited by WHO drafted a list of 45 general questions about the effects of cryotherapy in women with CIN. These experts were then asked to rank the questions by priority.

**Expert guideline panel**

WHO selected a multidisciplinary expert guideline panel comprising clinicians with cryotherapy experience, researchers in cervical cancer prevention and treatment, programme directors, epidemiologists, public health offi-
Table 1. Interpretation of strong and conditional recommendations

<table>
<thead>
<tr>
<th>Implications</th>
<th>Strong recommendation</th>
<th>Conditional recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patients</td>
<td>Most individuals in this situation would want the recommended course of action, and only a small proportion would not.</td>
<td>The majority of individuals in this situation would want the suggested course of action, but many would not.</td>
</tr>
<tr>
<td></td>
<td>Formal decision aids are not likely to be needed to help individuals make decisions consistent with their values and preferences.</td>
<td></td>
</tr>
<tr>
<td>For clinicians</td>
<td>Most individuals should receive the intervention. Adherence to this recommendation according to the guideline could be used as a quality criterion or performance indicator.</td>
<td>Recognize that different choices will be appropriate for individual patients and that you must help each patient arrive at a management decision consistent with his or her values and preferences. Decision aids may be useful for helping individuals make decisions consistent with their values and preferences.</td>
</tr>
<tr>
<td>For policymakers</td>
<td>The recommendation can be adopted as policy in most situations.</td>
<td>Policy-making will require substantial debate and involvement of various stakeholders.</td>
</tr>
</tbody>
</table>

cers and methodologists. The methodologists (evidence review team) were based at the McMaster University WHO Collaborating Center and had expertise in guideline development and evidence synthesis. A steering group of seven members was then created from the expert guideline panel, to guide the process.

Following a review of the suitability of the initial 45 general questions, these questions were refined to 16 questions for which an evidence review was deemed necessary. The steering group also decided to assess the evidence for the effects of cryotherapy in women with histologically confirmed CIN, to provide the best estimate of the benefits and side-effects of cryotherapy without the potential for confounding the outcomes due to false-positive screening tests or diagnoses.

To determine the outcomes, a scoping review of cryotherapy studies was conducted by the evidence review team. The expert guideline panel was also consulted. A list of outcomes to be considered when making the recommendations was compiled. Nineteen members of the expert guideline panel independently and anonymously scored the outcomes by importance for decision-making, via an electronic survey (5). The mean and median importance of each outcome (scale: 1 – least important to 9 – critical) was calculated, and 16 outcomes were identified as important or critical (see Box 1).

Preparation of the evidence profiles and grading of the evidence

The evidence review team conducted a series of systematic literature reviews following the methods of the Cochrane Collaboration, and prepared GRADE (Grading of Recommendations, Assessment, Development and Evaluation) evidence profiles for each question (6). During this process, the steering group held conference calls to discuss issues about the available evidence, the presentation of the results, and their impact on making recommendations.

MEDLINE, Embase, LILACS, The Cochrane Library and the WHO Clinical Trials Search Portal were searched up to July 2009, using key subject and text words for cryotherapy and cervical cancer, depending on the database (see appendix A for the MEDLINE search strategy). The search was not limited by language or by study type. The evidence review
Box 1. Outcomes identified as important or critical to making recommendations

- Resource use (including cost, human resources and length of stay)
- CIN2–3
- Cervical carcinoma incidence
- Acceptability to women (e.g. satisfaction with process or provider)
- Referrals after cryotherapy for complications or follow-up treatment
- Acceptability according to providers
- HIV transmission (HIV acquisition, HIV shedding)
- All severe adverse events (including major bleeding, major infections, etc.)
- Mortality
- Fertility (e.g. conception)
- CIN (1 or 2–3)
- Spontaneous abortion
- Pain (requiring local treatment)
- Maternal morbidity
- Minor infection (requiring outpatient treatment only)
- CIN1

*In order of importance for cryotherapy versus no treatment or LEEP.*

Team screened titles, abstracts and full text of potentially relevant literature, in duplicate. The first screen was for controlled trials (randomized or non-randomized), but because only a few controlled trials were identified, observational studies without independent controls were also included as evidence. Authors in the field, and the expert guideline panel, were also contacted to identify missing studies, studies in progress or studies not yet published.

When possible, relative effects (such as relative risks and odds ratios of an event) were calculated from pooled data of controlled studies. When there were no data, indirect comparisons were made (e.g. randomized controlled studies of cryotherapy versus laser excision were compared to laser excision versus LEEP), and a network meta-analysis was conducted. In studies without independent controls, the risks of an event were pooled across studies (e.g. for cryotherapy and for LEEP), and a relative effect was then calculated to compare those pooled results. All results were normalized to effects over a period of one year, with the exception of adverse events, most of which would probably occur and be reported within one year. Cervical cancer rates in untreated CIN were obtained from McCredie et al. (2010), and annualized (7). It was assumed that these risks were constant over time.
Evidence summaries and profiles, which were based on the evidence of the systematic reviews, were prepared for each question using the GRADE profiler software (8). GRADE evidence profiles present the effect of the intervention on each outcome (e.g. number of women with recurrent CIN), and the quality of the evidence for each outcome. The quality of a body of evidence is assessed based on the following criteria: risk of bias, imprecision, inconsistency, indirectness, publication bias, magnitude of effect, dose–effect relations and an assessment of the effect of residual confounding and bias. Quality is categorized into four levels, ranging from ⊕⊕⊕⊕, being the lowest quality, to ⊕⊕⊕⊕⊕, being the highest quality. The GRADE evidence profiles allow the expert guideline panel to base its judgments on the same concisely summarized evidence when making recommendations. One week before the expert guideline panel met to develop the recommendations, panel members were able to review the evidence profiles for each question via a password-protected electronic SharePoint site.

Development of recommendations

The expert guideline panel met on 22 to 23 September 2010, to review the evidence and make recommendations. This meeting was chaired by a methodologist with experience in guideline development, and cochaired by a gynaecological oncologist. There were 32 panel experts, as well as WHO and International Agency for Research on Cancer (IARC) officers, who provided scientific input and guidance. The key objectives of the meeting were to formulate evidence-based recommendations for each of the priority questions, identify key research gaps and discuss a dissemination plan for the new guidelines.

During the September meeting, the panel developed recommendations based on the GRADE evidence profiles. For each recommendation, the panel considered and agreed on the following: the quality of the evidence; the balance of benefits and downsides; the assumptions about the values and preferences associated with the decision; and the extent of resource use. Recommendations were made by consensus. Before the meeting concluded, the panel used the evidence to classify each recommendation as “strong” or “conditional” and agreed on the wording and remarks for each recommendation.

Results

GRADE evidence profiles were created for 16 key questions about the effects of cryotherapy compared with no treatment or LEEP in women with histologically confirmed CIN1, 2 or 3 (see Appendix B for summary tables for each recommendation; GRADE tables are available from http://www.who.int/reproductivehealth/publications/cancers/9789241502856/en/index.html). The systematic reviews found only a few randomized controlled trials or controlled observational studies (such as cohort or case–control studies) that fulfilled the inclusion criteria. Therefore, most of the recommendations are based on pooled results across observational studies of women who received cryotherapy. For these analyses, results were pooled across all CIN grades (CIN1, 2, 3), and, when possible, tested for differences between outcomes for CIN1 and CIN2/3. However, cryotherapy outcomes stratified by CIN grade at diagnosis were not different enough to make separate recommendations based on CIN grade. For this reason, these recommendations can apply to any CIN grade. There were few studies measuring outcomes that the panel identified as critical to decision-making: fertility and obstetrics outcomes; maternal morbidity; acceptability of the procedure to women or their health-care providers; referrals rates for complications; and HIV acquisition and transmission. Therefore, the recommendations are based primarily on studies that measured cryotherapy treatment failures for CIN (i.e. included any evidence of disease after treatment); major and minor adverse events; and mortality.
Recommendations

Use of cryotherapy for prevention of CIN

1a. The expert panel recommends cryotherapy over no treatment (strong recommendation, ☑️️️️️ quality evidence)

Remarks: This recommendation is strong, despite the presence of very-low-quality evidence. The expected benefit of cervical cancer prevention is very high but there is uncertainty related to the occurrence of adverse outcomes. There was very low-quality evidence for the occurrence of spontaneous abortions and infertility but the risk appeared similar to that in the general population. Although neither the risk of HIV acquisition in HIV-negative women nor the risk of HIV transmission by HIV-infected women who undergo cryotherapy is known, the current limited data do not suggest that there is an increase in the risk of HIV acquisition/transmission. Additional data regarding the rate of HIV acquisition/transmission are pending and will need to be assessed in future. However, the panel agreed that the net benefit from cryotherapy outweighs the potential HIV risk.

1b. In settings where LEEP is available and accessible, the expert panel suggests treatment with LEEP over cryotherapy (conditional recommendation, ☑️️️️ quality evidence)

Remarks: This recommendation applies to women regardless of HIV status. The benefits of LEEP when compared to cryotherapy were greater, and harms fewer or similar; therefore, LEEP was suggested. However, the panel recognized that there are greater resource implications for LEEP than with cryotherapy and therefore LEEP is not available in all settings. When LEEP is unavailable, cryotherapy is recommended (see recommendation 1a). Although the risk of HIV seroconversion in HIV-negative women, and the risk of transmission after LEEP or cryotherapy are unknown, the benefits of LEEP were felt to outweigh the harms, and, therefore, this recommendation applies to women regardless of HIV status.

Lesion size

2. Among women with CIN lesions covering more than 75% of the ectocervix, or with lesions extending beyond the cryo tip being used, the expert panel suggests performing or referring for excisional therapy (conditional recommendation, ☑️️️️️ quality evidence)

Remarks: This recommendation includes considerations that cryo tips should cover the entire lesion and that the largest cryo tip typically only covers lesions that extend over up to 75% of the cervix. Since the quality of the evidence is low for recurrent CIN lesions and for lesions larger than 75% of the cervical surface, the panel made a conditional recommendation.

Lesions extending into the endocervical canal

In women with CIN lesions extending into the endocervical canal, prior guidelines recommend excisional procedures; this panel operated under this assumption (2).

3a. In settings where LEEP is available and accessible, and women present with CIN lesions extending into the cervical canal, the expert panel suggests treatment with LEEP over cryotherapy (conditional recommendation, ☑️️️️️ quality evidence)

Remarks: The benefits of LEEP were greater than those of cryotherapy, and the harms were fewer in these women. However, since there are greater resource implications for LEEP than cryotherapy, and thus LEEP is not available in all settings, a conditional recommendation was made.

3b. In settings where excisional procedures (e.g. LEEP, laser or CKC) or referral to additional treatment are not available, the expert panel suggests that women with lesions extending into the endocervical canal be treated with cryotherapy (conditional recommendation, ☑️️️️ quality evidence)

Remarks: The risk of treatment failure is higher in women with CIN lesions extending into the cervical canal than in women whose lesion
margins are clearly demarcated or do not extend into the cervical canal. The rationale for treating these women is that women left untreated may be lost to follow-up (i.e. they may not receive further treatment and are at risk for developing cervical cancer). This recommendation should be considered in the context of recommendation 3a.

Cryotherapy technique and procedure

4. The expert panel suggests double freeze using a 3 minute freeze, 5 minute thaw, 3 minute freeze cycle over single-freeze cryotherapy (conditional recommendation, ⊕⊕⊕⊕ quality evidence)

Remarks: The evidence stems from studies in which a single-freeze technique was performed for up to 3 minutes. This recommendation takes into consideration that during a cryotherapy procedure, the iceball should extend beyond the edge of the cryo tip. Data from trials regarding the benefits and harms of single-freeze versus double-freeze techniques are pending and will be assessed in the future. The panel commented that randomized controlled trials should be performed to specifically address this issue.

5. The expert panel recommends cryotherapy using either carbon dioxide (CO₂) or nitrous oxide (N₂O) gas (strong recommendation, ⊕⊕⊕⊕ quality evidence); in settings where both gases are available, the expert panel suggests cryotherapy with CO₂ rather than with N₂O (conditional recommendation, ⊕⊕⊕⊕ quality evidence)

Remarks: Due to the limitations in the available evidence, it is uncertain whether CO₂ provides better or worse health outcomes, but the existing evidence suggests that there is no difference. Laboratory studies suggest no difference in temperature at the cryo tip between different grades of CO₂ (e.g. medical or industrial). Although, N₂O gas is less available and requires more resources due to higher cost and additional requirements for ventilation, in settings where N₂O gas is more likely to be available or has other advantages, this conditional recommendation suggests that N₂O gas may be used. Studies addressing the use of CO₂ versus N₂O are being conducted.

6. The expert panel recommends that the “cough technique” should not be used during cryotherapy (strong recommendation, ⊕⊕⊕⊕ quality evidence)

Remarks: The “cough” or “freeze–clear–freeze” technique was historically used because of technical deficiencies in a particular cryotherapy device from a single manufacturer, which caused instrument clogging. This device has been removed from the market, and so this is a strong recommendation despite very low-quality evidence.

7. The expert panel suggests that prophylactic antibiotics should not be used when providing cryotherapy (conditional recommendation, ⊕⊕⊕⊕ quality evidence)

Remarks: While there may be fewer minor adverse events and fewer minor infections with prophylactic antibiotic use, there is a risk of increased antimicrobial resistance and allergic reactions that is unlikely to outweigh any potential benefits. Resources also appear to be increased with the use of antibiotics.

Providers

8. The expert panel recommends that health-care workers (including non-physicians) trained in cryotherapy perform the procedure for women when it is indicated (strong recommendation, ⊕⊕⊕⊕ quality evidence); the expert panel also suggests that trained nurses or trained midwives rather than physicians may perform cryotherapy (conditional recommendation, ⊕⊕⊕⊕ quality evidence)

Remarks: The importance of cryotherapy training of the health-care worker was considered when making this recommendation. There appear to be better health outcomes when cryotherapy is performed by trained nurses or trained midwives rather than physicians. However, values and preferences for
cryotherapy performed by physicians versus midwives or nurses differ across settings. In many settings, the resources required for nurses and midwives are lower than for physicians.

**Use of cryotherapy during pregnancy**

9a. In pregnant women, the expert panel suggests deferring cryotherapy until after pregnancy (conditional recommendation, ★★★★ quality evidence)

**Remarks:** Deferral means that cryotherapy is delayed until the postpartum period. The available limited evidence does not suggest that cryotherapy increases risk of adverse pregnancy outcomes when performed during pregnancy; however, an increased risk of pregnancy loss cannot be ruled out and evidence is required. If women with histologically confirmed CIN lesions are at a high risk of loss to follow-up, or if additional opportunities for treatment are unlikely, treatment during pregnancy may be considered. However, there is an opportunity for enforcing the need for postpartum visits (including opportunities for child vaccination) if lesions are identified during pregnancy. There also are possible negative perceptions if cryotherapy is (erroneously) associated with pregnancy loss by women.

9b. In women whose pregnancy status is unknown (or there is no clinical evidence of pregnancy), the expert panel suggests using cryotherapy (conditional recommendation, ★★★★ quality evidence)

**Remarks:** This is based on recommendation 1a.

**Retreatment of CIN lesions with cryotherapy**

10a. The expert panel recommends cryotherapy over no treatment for women who screen positive after prior cryotherapy treatment (strong recommendation, ★★★★ quality evidence)

**Remarks:** There was no evidence for use of cryotherapy over no treatment in women who screen positive after previous treatment with cryotherapy. Therefore, this recommendation is based on recommendation 1a.

10b. In settings where LEEP is available and accessible, the expert panel suggests treatment with LEEP over cryotherapy for women who screen positive after prior cryotherapy treatment (conditional recommendation, ★★★★ quality evidence)

**Remarks:** There was very-low-quality evidence for benefits of LEEP techniques over cryotherapy and no evidence for harm in women who screen positive after previous treatment with cryotherapy. This recommendation is directly related to recommendation 1b.

**Education**

As part of best practice, detailed counselling and education should be provided with informed consent, prior to performing cryotherapy. Specific involvement of a woman’s partner post-treatment should be given special attention, and, in particular, the use of condoms post-cryotherapy. The reviewed evidence was judged by the expert panel as too indirect to make a recommendation for additional education and counselling beyond what would be part of best practice. Evidence from future interventions may inform this question.
Discussion

This document summarizes the recent WHO recommendations for the use of cryotherapy in women with histologically confirmed CIN. The methods recommended by WHO for guideline development were followed, and a series of systematic reviews were conducted to inform these recommendations. The panel, comprising experts from around the world, developed 14 recommendations, while considering the international audience and application of these guidelines in low-, middle- and high-income countries.

These guidelines are directly applicable to women with histologically confirmed CIN, but may be applicable to women who have been screened positive without histological confirmation. However, this review and the recommendations did not address the issue of “single-visit” or “screen-and-treat” approaches. We recognize that in many cervical cancer prevention and control programmes, treatment is commonly offered on the basis of a screening test result alone, such as VIA, most often because histological confirmation is not available or is programmatically feasible. Thus, although not all women who screen positive will have CIN, treatment by cryotherapy according to these present guidelines can be provided. In addition, the recommendations for cryotherapy using the double-freeze techniques and different gases (CO₂ versus N₂O) are directly applicable to any populations of women receiving cryotherapy who have positive screening test results without confirmatory histology diagnosis. These cryotherapy recommendations are also essential for the forthcoming development of the WHO “technical specification and procurement of cryotherapy equipment”, and for programme managers wanting to scale-up national cervical cancer and prevention programmes.

As in most guidelines, many of these recommendations are conditional, due to the absence of moderate or high quality of evidence. Therefore, clinicians and policy-makers will need to consider available resources (including costs, equipment and human resources), and the presumed values and preferences of women presenting with precancerous lesions found at the time of screening. For suspicion of glandular disease, the evidence was considered too indirect or sparse to develop recommendations, and so the panel did not formulate recommendations. There is also little evidence for cryotherapy use among HIV-positive women and those who are pregnant. For recommendations in these populations, the panel agreed that the benefits of treatment to prevent cervical cancer outweighed the unknown or uncertain harms, but that future research will need to be considered for future updates of the recommendations.

A strength of these recommendations is the process used by the expert panel. Specifically, the recommendations were made considering the totality of the available evidence and using the transparent and rigorous methods recommended for all WHO guidelines. Thus, despite the frequently indirect evidence from studies that lacked independent control groups, the panel had at hand comprehensive evidence summaries when making decisions regarding recommendations. The WHO guideline process also provided a systematic approach to decision-making, and a method to transparently record the benefits, harms, values, preferences and resource use for each recommendation decision.

The limitations of these guidelines are inherent to the lack of available evidence to answer key questions. Guidelines in general, and for WHO in particular, should provide recommendations based on the best available evidence. Much of the best available evidence for these guidelines came from pooled data across observational studies, which did not include independent control or comparison groups. Because of this, the estimates of comparative effects were frequently based on indirect comparisons, that is, comparisons were made across studies rather than within studies, leading to considerable uncertainty about the best estimates of effect. More importantly, the efficacy estimates...
of cryotherapy compared to no intervention are based on observational data that were not properly controlled. While trials comparing cryotherapy to no treatment to determine the effectiveness of cryotherapy are not ethically sound or feasible, studies comparing different techniques or equipment (e.g. a trial comparing women randomized to receive cryotherapy with N₂O versus CO₂, or different-shaped cryo tips) could, and should, be conducted. Moreover, randomized trials comparing the effects of providing additional counselling and education to standard best-practice counselling have not been performed. While most providers might assume that detailed education and counselling would be inherently effective, the cost–benefit analysis of the additional time spent, and measurement of potential harms, such as increased anxiety or treatment refusal, need to be explored.

These guidelines provide recommendations on the use of cryotherapy for cervical cancer prevention, and will be incorporated into the next update of Comprehensive cervical cancer control: a guide for essential practice. WHO has committed to updating the guide and will focus the next steps on reviewing the evidence to make recommendations for (1) health education; (2) HPV vaccines; (3) use of screening tests, including HPV testing as a primary stand-alone test; (4) treatment of precancerous lesions other than with cryotherapy; (5) "screen-and-treat" or "single-visit" approaches based on VIA of the cervix with and without HPV testing, followed by cryotherapy; and (6) additional guidance on prevention and management of positive screening tests in HIV-infected women.

References


Appendix A: Search strategy for OVID MEDLINE

1. cervical intraepithelial neoplasia/
2. uterine cervical dysplasia/
3. uterine cervical neoplasms/
4. (precancer* or pre-cancer* or neoplas* or dysplasia or lesion* or premalignan* or malignan* or cancer*).tw.
5. cin.tw.
6. 4 or 5
7. 6 and cervi*.tw.
8. 1 or 2 or 3 or 7
### Appendix B: Summary tables for each recommendation

**Recommendation 1a.** Should cryotherapy versus no treatment be used in women with histologically confirmed CIN (cervical intraepithelial neoplasia)?

<table>
<thead>
<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>High or moderate evidence (is there high or moderate quality evidence?)</td>
<td>☐ Yes</td>
<td>The higher the quality of evidence, the more likely is a strong recommendation.</td>
</tr>
<tr>
<td></td>
<td>☒ No</td>
<td>There is low- to very-low-quality evidence from both randomized and observational controlled studies for recurrence rates and adverse events. In general estimates of effect are obtained from single arm studies with no independent control. Outcomes, such as some fertility outcomes and acceptability were not measured.</td>
</tr>
<tr>
<td>Certainty about the balance of benefits versus harms and burdens (is there certainty?)</td>
<td>☒ Yes</td>
<td>There is considerable benefit and relatively little harm</td>
</tr>
</tbody>
</table>
|                                                  | ☐ No     | • Recurrence rates of CIN from observational studies with no independent control show  
|                                                  |          |   • CIN II–III, 4%  
|                                                  |          |   • CIN I, 2%  
|                                                  |          |   • All CIN, 6% |
|                                                  |          | • Absolute risk reduction in cervical cancer with cryotherapy was calculated as 18% over 30 years for baseline risk of 1%; 9% over 30 years for 0.5%  
|                                                  |          |   • assumptions: from observational studies with no independent control the relative risk reduction with cryotherapy is 86%, but a spontaneous regression of 28% which gives the relative risk reduction with cryotherapy as 61% [86% – (28% × 86%)]. Using 1% baseline risk without cryotherapy, the absolute risk reduction with cryotherapy is 0.61% over 1 year or 18% over 30 years. Using 0.5% gives 0.3% over 1 year or 9% over 30 years.  
|                                                  |          |   • Major adverse effects occurred rarely with cryotherapy, but minor may occur more frequently.  
|                                                  |          |   • It is unclear whether cryotherapy affects fertility/obstetric outcomes, or whether cryotherapy is unacceptable to women.  
|                                                  |          |   • Risk of HIV shedding or acquisition is not known, but this risk is unlikely to outweigh the benefits. |
| Certainty in or similar values (is there certainty or similarity?) | ☒ Yes    | A high value was placed on avoiding CIN recurrence, avoiding serious adverse events and acceptability to the patient  
|                                                  | ☐ No     | A low value was placed on minor adverse events                           |
Resource implications

The lower the cost of an intervention compared with the alternative, and other costs related to the decision – that is, the fewer resources consumed – the more likely is a strong recommendation.

▲ Yes □ No

Resources required for cryotherapy but they are generally affordable

- There are resources required to provide cryotherapy to prevent cervical cancer but these resources are worth the expected benefits and downstream treatment costs for cervical cancer are avoided. The treatment of adverse outcomes is also considered worthwhile.

Overall strength of recommendation

Strong

References (see Appendix C)

4,4a,4b,6,7,8,10,11,15,16,16a,18,19,21–23,26,27,29–31,31a,31b,31c,34–38,40–44,48,52,53,55,57,58,63,64,66–70,72,75–77,81,82,82a,84–88,91–95

ADDITIONAL REFERENCES


Recommendation 1b. Should cryotherapy versus LEEP (loop electrosurgical excision procedure) be used in women with histologically confirmed CIN?

**Recommendation:** In settings where LEEP/LLETZ is available and accessible, the expert panel suggests treatment with LEEP/LLETZ over cryotherapy.

**Population:** Women with histologically confirmed CIN

**Intervention:** Cryotherapy versus LEEP

<table>
<thead>
<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
</tr>
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<tbody>
<tr>
<td>High or moderate evidence (is there high or moderate quality evidence?)</td>
<td>☐ Yes ☒ No</td>
<td>There is moderate quality evidence from both randomized and observational controlled studies for recurrence rates. However, there is low quality evidence for other outcomes which were considered critical and important for decision-making (e.g., severe adverse events, cervical cancer). There is uncertainty for fertility and other obstetrical outcomes, and HIV acquisition/transmission was not measured.</td>
</tr>
<tr>
<td>Certainty about the balance of benefits versus harms and burdens (is there certainty?)</td>
<td>☐ Yes ☒ No</td>
<td>Benefits of LEEP were greater, and harms were fewer or similar</td>
</tr>
<tr>
<td>Certainty in or similar values (is there certainty or similarity?)</td>
<td>☒ Yes ☐ No</td>
<td>Similar values across women</td>
</tr>
<tr>
<td>Resource implications (are resources worth expected benefits?)</td>
<td>☐ Yes ☒ No</td>
<td>More resources required for LEEP</td>
</tr>
</tbody>
</table>

**Overall strength of recommendation**

Conditional

**References (see Appendix C)**

2, 5, 11, 14, 17, 22, 23, 25, 33, 42, 47, 50, 54, 55, 58, 60, 63, 64, 66, 70, 77, 82, 82a, 83, 89, 95
Recommendation: In settings where LEEP/LLETZ is available and accessible, the expert panel suggests treatment with LEEP/LLETZ over cryotherapy.

Population: Women with histologically confirmed CIN who are HIV-positive

Intervention: Cryotherapy versus LEEP

<table>
<thead>
<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>High or moderate evidence (is there high or moderate quality evidence?)</td>
<td>□ Yes</td>
<td>There is low quality evidence for recurrence rates. But very-low-quality evidence for other outcomes which were considered critical and important for decision-making (e.g. severe adverse events, cervical cancer). There is uncertainty around acceptability, fertility and other obstetrical outcomes, and HIV acquisition/transmission was not measured.</td>
</tr>
<tr>
<td>The higher the quality of evidence, the more likely is a strong recommendation.</td>
<td></td>
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<tr>
<td>certainty?</td>
<td>□ Yes</td>
<td>Risks greater with cryotherapy</td>
</tr>
<tr>
<td>The larger the difference between the desirable and undesirable consequences and the certainty around that difference, the more likely a strong recommendation.</td>
<td></td>
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</tr>
<tr>
<td>certainty or similarity?</td>
<td>□ Yes</td>
<td>▪ Recurrence rates of CIN II–III and all CINs may be greater with cryotherapy</td>
</tr>
<tr>
<td>The more certainty or similarity in values and preferences, the more likely a strong recommendation.</td>
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<tr>
<td>certificate or similar values</td>
<td>□ Yes</td>
<td>▪ CIN II–III, OR 3.6 (0.85 to 15.32)</td>
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<tr>
<td>▪ All CIN, OR 3.89 (1.54 to 9.85)</td>
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<tr>
<td>▪ The difference between cryotherapy and LEEP is uncertain for prevention of cervical cancer.</td>
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<tr>
<td>▪ It is uncertain whether there are differences in major or minor adverse events between cryotherapy and LEEP.</td>
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<tr>
<td>▪ There is uncertainty about fertility/obstetric outcomes, acceptability and HIV transmission.</td>
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<td></td>
</tr>
<tr>
<td>certificate or similar values</td>
<td>□ Yes</td>
<td>▪ High value was placed on CIN recurrence, serious adverse events and acceptability to the patient</td>
</tr>
<tr>
<td>▪ Low value was placed on minor adverse events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource implications (are resources worth expected benefits?)</td>
<td>□ Yes</td>
<td>▪ Need for more skilled providers to perform LEEP</td>
</tr>
<tr>
<td>The lower the cost of an intervention compared to the alternative that is considered and other costs related to the decision – that is, the fewer resources consumed – the more likely is a strong recommendation.</td>
<td></td>
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<tr>
<td>▪ Need for more or expensive equipment/supplies for LEEP</td>
<td></td>
<td></td>
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<tr>
<td>▪ Need for local anaesthesia with LEEP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall strength of recommendation</td>
<td>Conditional</td>
<td></td>
</tr>
</tbody>
</table>
Recommendation 2. In women who have histologically confirmed CIN, are there differences in recurrence of CIN by lesion size?

Small lesion defined as <25% covered, 1 quadrant or 1 degree. Moderate lesion defined as 25 to 75% covered, 2 quadrants, 2 degree or <25 to 30mm. Large lesion defined as >75% covered, large lesion, >2 quadrants, >25 to 30mm.

Meta-analysis of the proportion of women who had recurrence/persistence of CIN at 1 year shows a significant interaction among different lesion sizes.

At 1 year post cryotherapy, recurrence rate was greatest in women who had a large lesion. Recurrence rate of all grades of CIN in women with a

- small lesion is 6% (from 5 to 7%);
- moderate lesion is 7% (from 6 to 8%);
- large lesion is 18% (from 13 to 23%).

See the evidence summaries on the evidence base document at http://whqlibdoc.who.int/hq/2012/WHO_RHR_12.11_eng.pdf?ua=1

Recommendation 3, a and b. In women who have histologically confirmed CIN, are there differences in recurrence of CIN when the lesion extends into the endocervical canal?

Summary

Meta-analysis of the proportion of women with a lesion that DOES or DOES NOT extend into the endocervical canal showed a significant interaction between these two groups for recurrence of all grades of CIN at 1 year.

At 1 year post cryotherapy, the recurrence rate in women was higher in women with endocervical canal extension. Recurrence of all grades of CIN at 1 year in women with a lesion that is:

- ECC positive is 16% (from 13 to 20%);
- ECC negative is 6% (from 5 to 6%).

There was however, inconsistency across studies in both groups of women which could not be explained and therefore decreases our confidence in these results.

References (see Appendix C)

- Extends into canal: 4,4a,4b,6,19,30,35,38,44,48,66.
- Does not extend into canal: 4,4a,4b,6,8,9,15–17,19,20,22,23,26,27,29,30,31,31a,31b,31c,34–38,40–44,48,52, 53,55,57,58,63,64,66–68,70,72,75,77,82,82a,84–88, 91–94.

See the evidence summaries on the evidence base document at http://whqlibdoc.who.int/hq/2012/WHO_RHR_12.11_eng.pdf?ua=1
**Recommendation 4.** Should cryotherapy using a double versus single freeze technique be used in women with histologically confirmed CIN?

**Recommendation:** The expert panel suggests double freeze using a 3 minute freeze, 5 minute thaw, 3 minute freeze cycle over single freeze cryotherapy.

**Population:** Women with histologically confirmed CIN

**Intervention:** Double versus single freeze

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<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>High or moderate evidence <em>(is there high or moderate quality evidence?)</em></td>
<td>☐ Yes ☒ No</td>
<td>☃ ☃ ☃ There is moderate to low quality evidence from both randomized and observational controlled studies for recurrence rates. There is low quality evidence for other outcomes which were considered critical and important for decision-making (e.g. severe adverse events, cervical cancer). There is uncertainty for fertility and other obstetrical outcomes, and HIV acquisition/transmission was not measured.</td>
</tr>
<tr>
<td>Certainty about the balance of benefits versus harms and burdens <em>(is there certainty?)</em></td>
<td>☐ Yes ☒ No</td>
<td>Risks may be reduced with double-freeze cryotherapy • Recurrence rates of CIN I, CIN II–III and all CINs may be reduced with double-freeze technique • CIN II–III, OR 0.40 (0.22 to 0.75) • CIN I, OR 0.70 (0.21 to 2.28) • All CIN, OR 0.37 (0.21 to 0.63) • There may be little difference in cervical cancer rates based on absolute risks • There may be little difference in serious adverse events between double and single freeze cryotherapy, but there may be fewer people experiencing pain with double-freeze cryotherapy and more minor infections • It is unclear whether there is little difference in fertility/obstetric outcomes</td>
</tr>
<tr>
<td>Certainty in or similar values <em>(is there certainty or similarity?)</em></td>
<td>☒ Yes ☐ No</td>
<td>• High value was placed on CIN recurrence, incidence of cervical cancer, serious adverse events, resource use, and acceptability to the patient and providers • Low value was placed on minor adverse events and fertility</td>
</tr>
<tr>
<td>Resource implications <em>(are resources worth expected benefits?)</em></td>
<td>☒ Yes ☐ No</td>
<td>More resources for double freeze but benefits worth the resources • Both interventions utilize the same equipment/supplies • Additional resources are required (provider time, patient time, more gas) for double freeze</td>
</tr>
</tbody>
</table>

**Overall strength of recommendation** | Conditional |

**References (see Appendix C)**

11,13,15,20,21,47,49,67,68,80,85,87,90,94
**Recommendation 5.** Should nitrous oxide versus carbon dioxide be used in cryotherapy to treat women with histologically confirmed CIN?

**Conditional Recommendation:** The expert panel recommends cryotherapy using either CO\(^2\) or N\(^2\)O gas.

**Population:** Women with histologically confirmed CIN

**Intervention:** Cryotherapy using N\(^2\)O versus Cryotherapy using CO\(^2\)

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<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>High or moderate evidence (is there high or moderate quality evidence?)</td>
<td><img src="x" alt="Yes" /> <img src="x" alt="No" /></td>
<td>There is very-low-quality evidence from observational controlled studies for recurrence rates, cervical cancer, and severe adverse events which were considered critical for decision-making. HIV acquisition/transmission as well as fertility and other obstetrical outcomes were not measured.</td>
</tr>
</tbody>
</table>
| Certainty about the balance of benefits versus harms and burdens (is there certainty?) | ![Yes](x) ![No](x) | It is uncertain whether recurrence rates of CIN I, CIN II–III and all CINs differ between nitrous oxide and carbon dioxide  
* CIN II–III, OR 0.67 (0.38 to 1.18)  
* CIN I, OR 1 (0.58 to 1.73)  
* All CIN, OR 1.2 (0.96 to 1.50)  
It is uncertain whether there is little or no difference in cervical cancer rates, as well as severe adverse events between nitrous oxide and carbon dioxide  
Minor infections may be lower with nitrous oxide, but this is uncertain. |
| Certainty in or similar values (is there certainty or similarity?) | ![Yes](x) ![No](x) | High value was placed on CIN recurrence, cervical cancer, and serious adverse events  
Low value was placed on minor adverse events |
| Resource implications (are resources worth expected benefits?) | ![Yes](x) ![No](x) | More resources required for nitrous oxide  
Nitrous oxide is more costly than carbon dioxide  
Nitrous oxide requires more safety measures <(e.g. ventilation) |

**Overall strength of recommendation**  
Conditional

**References (see Appendix C)**  
3,4,4a,4b,6,8–12a,15,17,19,21,26,29–31c,34,41,44,48,52,53,55,57,58,66,67,70,75,77,82,82a,85–87,92,94
**Recommendation 6.** Should cryotherapy using cough technique be provided to women with histologically confirmed CIN?

**Recommendation:** The expert panel recommends to **not** use cough technique during cryotherapy.

**Population:** Women with histologically confirmed CIN

**Intervention:** cryotherapy using cough technique

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<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>High or moderate evidence</td>
<td>☑ Yes ☐ No</td>
<td>There is very-low-quality evidence for outcomes such as recurrence rates and adverse events. Outcomes, such as acceptability to women or providers, and fertility were not measured or could not be compared between studies using cryotherapy with cough technique or cryotherapy.</td>
</tr>
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<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Certainty about the balance of benefits versus harms and burdens</td>
<td>☑ Yes ☐ No</td>
<td></td>
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<tr>
<td>The higher the quality of evidence, the more likely is a strong recommendation.</td>
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<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Certainty in or similar values</td>
<td>☑ Yes ☐ No</td>
<td></td>
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<tr>
<td>The more certainty or similarity in values and preferences, the more likely a strong recommendation.</td>
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<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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</thead>
<tbody>
<tr>
<td>Resource implications</td>
<td>☑ Yes ☐ No</td>
<td>Resource use may not be increased with use of the cough technique.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Overall strength of recommendation</td>
<td>Strong</td>
<td></td>
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</tbody>
</table>

References (see Appendix C)

4,4a,4b,6–12,15–17,19,21,23,26,27,29,30,31,31a,31b,31c,34–38,40–44,48,52,53,55,57,58,66,68,70,72,75,77,82,82a,84–88,91–95
**Recommendation 7.** Should antibiotics be provided prophylactically with cryotherapy in women with histologically confirmed CIN?

**Recommendation:** The expert panel suggests that prophylactic antibiotics *not* be used when providing cryotherapy.

**Population:** Women who have a histologically confirmed CIN and being treated with cryotherapy.

**Intervention:** Prophylactic antibiotics

<table>
<thead>
<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High or moderate evidence <em>(is there high or moderate quality evidence?)</em></td>
<td>☐ Yes ☒ No</td>
<td>☐☐☐ Indirect comparisons of observational studies with no control group provided very-low-quality evidence for the outcomes that were considered important for decision-making (e.g. major bleeding, major infection and minor adverse effects). Acceptability to providers or women was not measured.</td>
</tr>
<tr>
<td>Certainty about the balance of benefits versus harms and burdens <em>(is there certainty?)</em></td>
<td>☒ Yes ☐ No</td>
<td>Major risks similar with antibiotic, but minor risks appear to be lower with antibiotics</td>
</tr>
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<td></td>
<td>• It is uncertain whether there is little difference with risks of major adverse events with or without antibiotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• It is uncertain if the risk of minor infections, vaginal discharge and all minor adverse events are lower when prophylactic antibiotics are given</td>
</tr>
<tr>
<td>Certainty in or similar values <em>(is there certainty or similarity?)</em></td>
<td>☐ Yes ☒ No</td>
<td>Similar values</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Similar value was placed on major and minor adverse events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Burden to women may be a consideration</td>
</tr>
<tr>
<td>Resource implications <em>(are resources worth expected benefits?)</em></td>
<td>☒ Yes ☐ No</td>
<td>Increased cost with antibiotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additional costs of antibiotics and burden on staff</td>
</tr>
</tbody>
</table>

**Overall strength of recommendation** Conditional

**References**

8,9,11,17,22,23,26,27,30,37,55,58,66,64,67,70,77,82,82a,85,92,94
**Recommendation 8.** Should cryotherapy be provided by a non-physician for women with histologically confirmed CIN?

**Recommendation:** The expert panel recommends that health-care workers (including non-physicians) who are trained in cryotherapy perform the procedure in women when indicated.

**Population:** women who have a histologically confirmed CIN

**Intervention:** cryotherapy performed by a non-physician

<table>
<thead>
<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>High or moderate evidence (is there high or moderate quality evidence?)</td>
<td>☑ Yes ☐ No</td>
<td>There is very-low-quality evidence from observational studies (with no control) for the outcomes that were considered critical for decision-making (e.g. CIN 2-3, all severe adverse events, cervical carcinoma) or important for decision-making (e.g. minor infections and pain) Unacceptability to women or their providers, and HIV transmission were not measured.</td>
</tr>
</tbody>
</table>
| Certainty about the balance of benefits versus harms and burdens (is there certainty?) | ☑ Yes ☐ No | Appears to be benefits with non-physicians | It would appear that CIN recurrence rates are reduced when cryotherapy is provided by non-physicians:  
  • CIN II–III, OR 0.14 (0.05 to 0.38)  
  • CIN I, OR 0.5 (0.32 to 0.78)  
  • All CIN, OR 0.63 (0.49 to 0.73)  
  - It is uncertain if there is little or no difference in severe adverse events, or minor infections.  
  - Fewer women may have pain or minor infections when cryotherapy is provided by non-physicians, but this is uncertain.  
  - It is also unclear whether cervical cancer rates decrease when cryotherapy is provided by non-physician. |
| Certainty in or similar values (is there certainty or similarity?) | ☑ Yes ☐ No | Similar values | High value was placed on acceptability, recurrence of CIN II,III, severe adverse events and cervical cancer incidence.  
  - Low value was placed on fertility outcomes and minor adverse events. |
| Resource implications (are resources worth expected benefits?) | ☑ Yes ☐ No | Balanced costs | Need for professional training and monitoring  
  - Less cost with fewer physicians performing cryotherapy  
  - Training non-physicians may increase the availability of cryotherapy |

**Overall strength of recommendation**

Strong

**References (see Appendix C)**

6,16,16a,17,21,35,38,41,58,70,82,82a,84,88,93
**Recommendation 9.** Should cryotherapy be used in women with histologically confirmed CIN who are pregnant?

Recommendation: In women who are pregnant, the expert panel suggests to defer cryotherapy until after pregnancy.

**Population:** Women with histologically confirmed CIN who are pregnant

**Intervention:** Cryotherapy versus LEEP or no treatment

<table>
<thead>
<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High or moderate evidence (is there high or moderate quality evidence?)</td>
<td>☐ Yes ☒ No</td>
<td>☜وفقًا على دراسات مبكرة، يمكن أن يكون التبقي عند الأم حادثة من قبل التهاب الرحم.</td>
</tr>
<tr>
<td>Certainty about the balance of benefits versus harms and burdens (is there certainty?)</td>
<td>☐ Yes ☒ No</td>
<td>Suggests benefits over adverse effects</td>
</tr>
<tr>
<td>Certainty in or similar values (is there certainty or similarity?)</td>
<td>☐ Yes ☒ No</td>
<td>Uncertain</td>
</tr>
<tr>
<td>Resource implications</td>
<td>☐ Yes ☒ No</td>
<td>Lower resource use with cryotherapy versus LEEP</td>
</tr>
<tr>
<td>Overall strength of recommendation</td>
<td></td>
<td>Conditional</td>
</tr>
</tbody>
</table>

**References**

20,23,26,28,32,65,71,73,79,96,98
**Recommendation 10.** Should cryotherapy versus conisation be used for treatment failures diagnosed >12 months after first cryotherapy treatment?

**Recommendation:** The expert panel recommends cryotherapy over no treatment for women who screen positive after treatment for a previous diagnosis of histologically confirmed CIN lesions. In settings where LEEP is available and accessible, the expert panel suggests treatment with LEEP over cryotherapy for women who screen positive after previous cryotherapy treatment.

**Population:** women who have been already treated with cryotherapy but screen positive or histologically diagnosed CIN at follow-up testing (>12 months)

**Intervention:** retreatment with cryotherapy versus other intervention

<table>
<thead>
<tr>
<th>Factor</th>
<th>Decision</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| High or moderate evidence  
(is there high or moderate quality evidence?) | ☑ Yes  ☒ No | ⭐⭐⭐⭐ There is very-low-quality evidence from observational studies for recurrence rates between cryotherapy and conisation for retreatment. Other outcomes which are considered critical and important for decision-making (e.g. major adverse effects) were not measured in the studies. |
| Certainty about the balance of benefits versus harms and burdens  
(is there certainty?) | ☑ Yes  ☒ No | Risks may be greater with cryotherapy  
- It is uncertain whether the risk of CIN recurrence is greater with cryotherapy than conisation  
All CIN, OR 2.35 (0.82 to 6.7) |
| Certainty in or similar values  
(is there certainty or similarity?) | ☑ Yes  ☒ No | Uncertain  
- High value was placed on CIN recurrence, acceptability and severe adverse events  
- Low value was placed on minor events |
| Resource implications  
(are resources worth expected benefits?) | ☑ Yes  ☒ No | Fewer resources with cryotherapy  
- More resources needed for other follow-up treatment modalities |

**Overall strength of recommendation**  
Strong (cryotherapy to no treatment);  
Conditional (cryotherapy to LEEP)

References (see Appendix C)
7,11,15,19,29,37,38,43,53,86,92,94
Appendix C: References used in creating the GRADE tables for the recommendations


World Health Organization guidelines: use of cryotherapy for cervical intraepithelial neoplasia
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