



THE EUROPEAN FEDERATION FOR COLPOSCOPY & PATHOLOGY OF THE LOWER GENITAL TRACT

2nd EFC NEWSLETTER
August 2005

Officers

President - Professor E Diakomanolis (*Greece*)
Secretary - Professor T Löning (*Germany*)
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EUROPEAN FEDERATION FOR COLPOSCOPY & PATHOLOGY OF THE LOWER GENITAL TRACT (EFC)

NEWSLETTER – AUGUST 2005

Letter from the President

Dear Member Societies

As I write this letter halfway through my tenure as President of the EFC, I cannot help but reflect back to the origins of the society and the people that made this idea possible.

The thought was older, but it was at the European Colposcopy Meeting in Dublin, Ireland in 1998 when representatives from each of the European Colposcopy Societies met and agreed that a pan-European group should be established.

Then in 1999 at the IFCCP Meeting in Buenos Aires, Argentina, the European Federation for Colposcopy (EFC) formally came into being and it then had its first official congress on the island of Rhodes, Greece in October 2001. At that meeting the National European Societies' Presidents met to elect officers for the European Federation and Joe Jordan was officially elected as the first EFC President. Joe provided clear leadership and vision and played an enormous role in moving our objectives forward.

There were many challenges against a background of limited resources but there was also a vision and commitment by many people from many European Countries who offered their knowledge and support to the new European Society.

Colposcopy Training Programmes in Europe

The first objective was to provide the best possible standards of Training in Colposcopy throughout Europe.

To this end a Committee under the Chairmanship of Charles Redman (UK) developed a competence based Colposcopy Curriculum using the Delphi Technique. Today there is a Consensus by all member societies for the introduction of a minimum Standard of Training and for a basic core curriculum as this was identified by the Delphi exercise. As there is greater opportunity today for doctors within the EFC to receive training in one country and to be employed in another, the need for uniformity in training and practice is obvious and the results of this effort I am sure will be apparent in the future.

European Treatment Quality Standards

The next priority, when I took over as President of the Society at the EFC Meeting in Paris 2004, was the development of standards of treatment.

A Committee under the chairmanship of Moody Shafi in Cambridge was set up and he did a wonderful job in providing evidence-based guidelines for the treatment of precancerous lesions of the uterine cervix in Europe and Katja Behrens from the University of Hamburg, Germany helped analyze the questionnaire from 31 centers in 16 European Countries. Using the Delphi technique a Consensus agreement for minimum standards of treatment of CIN in Europe will be reached soon and hopefully will be adapted by all Member Societies and corresponding European States in the future. I would like to congratulate them and thank them for their contribution.

In the next two years of my tenure as President of the EFC I shall try to consolidate the achievements of my predecessor mainly focusing upon education and training and pressing forward to implement the common standards of training and treatment for as many European Countries as possible, and in the process maintaining the momentum the society can be justly proud of.

That of course will be ultimately the responsibility of each individual Society/Country and the final programme will depend on local circumstances, needs and facilities.

A good example is the Spanish Society (AEPCC), which has already accepted the principle of the EFC guidelines and took the decision to implement them as they are presented in this Newsletter by Professor Javier Cortéz, who should also be congratulated.

EFC Website

Communication is obviously one of the highest priorities of our society and therefore a website (www.e-f-c.org) has been created for the EFC to disseminate information quickly and easily and to keep everyone up to date with the development of the society. The infrastructure of the EFC website has been designed so as to enable all members to potentially have the ability to add information, irrespective of their location, and has been developed with content flexibility in mind, in order to adapt to the EFC's future

communications and training needs. I particularly should like to thank Alexander Diakomanolis for his contribution in creating this website on our behalf. Having done the first step we are now trying to find the best way to maintain and keep it updated.

Association with other Organizations

I am also very pleased to announce that we have recently been recognized by other European bodies, under the banner of gynaecological oncology. Joe Jordan and I were invited to Brussels in October 2004 for a meeting with EBCOG where we presented the history of the EFC and its objectives and the EFC was accepted as a member of the EBCOG Standing Committee on Training and Assessment (SCTA). An important step, which will greatly facilitate our aims in teaching and training issues.

The EFC has already been invited to organize a colposcopy training course during the works of the European Congress of Obstetrics and Gynaecology organized by EBCOG in Torino, Italy in April 2006. Joe Jordan has been assigned to prepare the course and the EFC has also been invited to Joint Meetings by the German Society in September 2005 in Freiberg, Germany and by the Spanish Society in Bilbao, Spain in November of this year.

Our Federation already has an affiliation with WHO and IFCPC and we are making efforts to be linked with other Scientific and Professional Organizations.

EFC Sub-committees

We would also like to get more people from other European Societies involved and I would like to invite nominations for membership in three main sub-committees, which we would like to establish in order to assist in the smooth running of the Federation. These sub-committees will be as follows:

- a) Quality Standards and Development Committee
- b) Scientific Advisory Committee (responsible for future Scientific Meetings)
- c) IT Committee (responsible for the website and Communication).

I think there is scope for the Society to collaborate with persons and groups who could offer their skills and support. If we can get more people involved then the future of the EFC is secure and bright.

EFC Training Courses

There has been a wide-ranging debate among the members of the Society for sometime now on the possibility of organizing EFC Courses for the two following reasons:

- a) Educational
- b) To raise income for the EFC.

Such courses if they are organized by the EFC in co-operation with an academic centre of a European Country could perhaps be financed by the EU with grants made available to sponsor speakers.

The idea was also put forward for a Colposcopy Diploma modeled on the Current European Diploma for Ultrasound. In other words, it would be possible for the EFC to take the initiative in introducing a European Diploma for Colposcopy. These two ideas are delicate matters which we are going to explore with caution.

EFC Future Meeting

The last European Congress organized by Christine Bergeron in Paris, France on 23rd January 2004 was a great success and was attended by more than 800 people from many European countries and elsewhere in the world. She deserves our warmest congratulations.

Our next European meeting is going to be in Belgrade, Serbia in September 19th -21st 2007 and Vesna Kestic is well into the organization of it, and Santiago Dexeus as President Elect has been invited to chair the Scientific Committee for this meeting. The next EFC Meeting after Belgrade will take place in Berlin, Germany in 2010. So the future is planned and exciting.

Dear friends, the European Federation for Colposcopy owes much of its achievements, which have been accomplished in the short time of its existence, to the individual efforts of many people who I would like to mention in this Newsletter.

Joe Jordan, as the first President, steered the EFC through the initial uncharted pathways with his vision, prestige and experience. The Society was also lucky to have a President Elect since the Paris Meeting in 2004 a person with the International Status of Santiago Dexeus, whose contribution to the running of the Society has been invaluable.

Thomas Loening and Jurgen Heinrich from Germany, Antoni Basta from Poland, Theo Helmerhorst from Holland and Tiziano Maggino from Italy, have also been with us from the beginning willingly advising and supporting our efforts.

I would like to express my sincerest thanks and appreciation for their help and to thank all of them for their efforts in helping accomplish the aims of the society.

Many thanks also to the British Society for Colposcopy & Cervical Pathology, who gave us a grant of 16,000 Euro to begin our work, and which from the outset provided clear leadership for the other European Societies and offered its expertise to see our objectives move forward.

I should also like to thank everyone who so willingly has given their time and knowledge to help realize the ideas of EFC.

Last, but not least, many thanks to Liz Dollery who has done a magnificent job keeping everything going.

I wish you all a very pleasant summer holiday and I am looking forward to working with all of you during the next two years.

Professor E. Diakomanolis
President EFC

Survey of Colposcopy Training Programmes in Europe

Introduction

In 2000, as part of the EFC's mission to improve standards in colposcopy training, a baseline survey of colposcopy training in Europe. At that time, there were only four formal training programmes in Europe, two of which were full-time. Since then, the EFC membership has increased and it has convened two large scientific meetings, a core curriculum has been developed and ratified and the basic structure of colposcopy training programmes agreed. In order to review the current situation a repeat educational survey was undertaken in late 2004.

Results

All 25 member societies of the EFC were approached. There were 14 respondents from 12 countries. Seven countries now had a formal colposcopy training programme, all of which used the EFC core curriculum. With a single exception, all countries without a training programme had plans for one to be introduced.

Comment

Although this was a limited survey, there has been a marked increase in the number of countries with a training programme. As it is known that at least one of the non-responding societies has a training programme (Belgium), there are now at least 8 European countries with a training programme, six of which use the EFC core curriculum.

Focus on those countries planning to introduce a national programme is probably a cost effective strategy.

Countries with a national Training Programme:-

United Kingdom and Ireland, Serbia, Croatia, Germany, Holland, Slovenia, (Belgium)

Countries with plans for a national Training Programme:-

Austria, Finland, Portugal, Spain

Country with no plans for a national Training Programme:-

France

Charles Redman

EFC Training Committee

European Treatment Quality Standards for Cervical Intraepithelial Neoplasia (CIN)

A committee chaired by Mr Mahmood I Shafi (UK) working closely with Katja Behrens from Germany have been developing a consensus document in relation to treatment standards for CIN. This is based on guidance from one of the national screening programmes (NHSCSP) but was refined taking into consideration comments from member federations. Of the 10 standards being assessed, there was initial good agreement in relation to six of these. The other four guidelines have been revised and good agreement achieved from respondents. These now form the EFC approved standards for treatment. It is hoped that these guidelines will form the basis of an audit into quality standards across the EFC.

1. Whereas there is no obviously superior conservative surgical technique for treating and eradicating cervical intra-epithelial neoplasia (CIN), excision is preferred because of better histopathological assessment.
2. Ablative techniques are only suitable when:
 - The entire transformation zone is visualised
 - There is no evidence of glandular abnormality
 - There is no evidence of invasive disease
 - There is no discrepancy between cytology and histology
3. Cryocautery should only be used for low grade CIN and a double freeze thaw freeze technique should be used.
4. When excisional techniques are used for treatment, every effort should be made to remove the lesion in one specimen. The histology report should record the dimensions of the specimen and the status of the resection margins with regard to intraepithelial or invasive disease.
5. For ectocervical lesions, treatment techniques should remove tissue to a depth of 6 mm.
6. A see and treat policy at first visit can be used where audit has identified that CIN is present in the majority of the excised specimens. A target of CIN in $\geq 90\%$ of the excised specimens should be achieved. Treatment at first visit for a referral of borderline or mild dyskaryosis should only be used in exceptional cases to minimise the possibility of over-treatment.
7. CIN extending to the resection margins at LLETZ excision results in a higher incidence of recurrence but does not justify routine repeat excision as long as:
 - The entire transformation zone is visualised
 - There is no evidence of glandular abnormality
 - There is no evidence of invasive disease
 - The women are under 50 years of age
8. Women over the age of 50 years with incomplete excision of CIN at the endocervical margin are at high risk for residual disease. Careful and adequate follow-up endocervical cytology is a minimum requirement. Re-excision is an alternative.
9. Women with adenocarcinoma in situ / CGIN can be managed by local excision for women wishing to retain fertility. Incomplete excision at the endocervical margin requires a further excisional procedure to obtain clear margins and exclude occult invasive disease.
10. Microinvasive squamous cancer FIGO stage Ia₁ can be managed by excisional techniques if:
 - the excision margins are free of CIN and invasive disease.

If the invasive lesion is excised but CIN extends to the excision margin then a repeat excision should be performed to confirm excision of the CIN and to exclude further invasive disease. This should be performed even in those cases planned for hysterectomy to exclude an occult invasive lesion requiring radical surgery.

 - the histology has been reviewed by a specialist gynaecological pathologist

Mahmood Shafi
EFC Training Committee

AN INITIATIVE FOR ACCREDITATION IN COLPOSCOPY IN SPAIN

The general idea is to create a dual purpose academic instrument:

1. To guarantee quality when practicing Colposcopy
2. To provide content to the AEPCC in order to stimulate its social body and create incentives for the affiliation.

The AEPCC (*Spanish Society for Colposcopy*) has maintained a firm working relationship with SEGO (*Spanish Society for Gynaecology & Obstetrics*) for many years, and the development of this instrument will also form a strong part of this relationship. The joining together of both societies will strengthen the project.

Accreditation Committee

S. Dexeus, LM. Puig-Tintoré, JA. Vidart, F. Hernández, A. Torné
Co-ordinator: X. Cortés

Accreditation Application:

There are two requirements needed to formulate an application:

1. Previous Affiliation of the AEPCC for a minimum of 2 years.

This is an objective way of demonstrating that the applicant is actually involved in the practice of Colposcopy

2. Specialist in Gynaecology and Obstetrics

The received application must be accompanied by the applicants CV which will be subject to an assessment according to the following points:

Basis for Comparison/ Criterion

1. Doctor with a Thesis on Pathology of the Inferior Genital Tract (PTGI) 20 pts
2. Study period in exercises related to the PTGI, 1 point for each year up until a maximum of 10 10 pts
3. Practical help in exercises devoted to PTGI, 1 point per year up until a maximum of 10 pts
4. Affiliation to the AEPCC: 0,5 points per year up until a maximum of 5 pts
5. Attending PTGI courses and conferences: as many points as credits granted
6. Papers/ posters at conferences related to PTGI: 1 point for each one
7. Reports at PTGI courses or conferences: 2 points for each one
8. Publications related to the PTGI:
 - a) Magazine with Impact factor: 5 points per publication
 - b) Magazine without impact factor: 2 points per publication
 - c) Author of a book on the PTGI: 20 points
 - d) Editor of a book on the PTGI: 5 points
 - e) Chapter of a book on the PTGI: 3 points
9. Organization and management of PTGI conferences, meetings or courses:
 - a) President, Director, Secretary: 3 points per event
 - b) Other members: 1 point per event
10. Prizes, grants and distinctions in the area of PTGI: 2 points for each one.
11. Belonging to the Directive Organs of any PTGI societies:
 - a) President: 10 points
 - b) Secretary: 5 points
 - c) Other members: 3 points

The accreditation in Colposcopy will be granted with a score of ≥ 25 points

The title of Accreditation in Colposcopy will be valid for 5 years.

The renewal of the title of Accreditation of Colposcopy can be obtained after demonstrating curricular activity over the 5 year period with a value of ≥ 7 points.

All cases which have been unsuccessful in their application for accreditation in the PTGI and Colposcopy, or in their renewal application through curricular activity, will have the opportunity to sit a specific exam prepared and marked by the Accreditation Committee.

Access to the Accreditation exam: A minimum score of 5 points.

The exam will consist of a 1 hour theoretical/ practical assessment of 60 multiple choice questions, covering all aspects of Colposcopy and will have a pass mark of a score equal to or more than 85%.

Javier Cortés
Co-ordinator

Views of a Gynecopathologist: time to implement molecular findings into routine histopathology

Histopathology is often addressed as being the gold standard in diagnosis of precancer and cancer of the lower genital tract, and as such regarded to be not only superior to colposcopy and cytology, but also the ultimate basis for clinical decision making. Indeed, kappa values are high for most cervical and vaginal high grade SIL's (more than 0.9) and for most „ordinary“ squamous cell carcinomas, and in fact, quick and “clean“ Hematoxylin-Eosin (HE)-based work-up of these lesions meet the current quality standards in diagnostic pathology in most instances, although both in the high grade SIL group (e.g. atypical immature metaplasia), and in the carcinoma group (e.g. verrucous leukoplakia) mimics of (pre-)cancer and thereof major pitfalls may occur. Yet, older literature, and more recent results from the Hanover-Tuebingen Trial (so called HAT study, histopathology controlled by two reference laboratories) show that the risk of diagnostic failure is much higher in low grade SIL's with kappa values dropping down to 0.6. The same holds true for the field of glandular (pre-) neoplasias of the cervix uteri, and for vulvar precancer (especially the simplex type VIN's). It is this diagnostic hazard which calls for expert gynecopathology as integral part of a certified colposcopy and cervical pathology outpatient unit (so called dysplasia centre in Germany). The Guidelines for Colposcopy and Treatment of SIL's put forward by the European Federation of Colposcopy are already important steps to improve the management of patients under question. In collaboration with Working Groups of the European Societies of Cytology and Pathology, further efforts are needed to follow these lines and to define technical prerequisites for morphological diagnosis of lower genital tract precancer and cancer, including state of the art immunohistochemistry and molecular pathology. Questions to answer from any dysplasia centre are:

- 1) Certification of collaborating cytologists and histopathologists?
- 2) Routine work-up of cytological material (conventional, thin-prep) and tissue specimens (fixation, cutting, storage)?
- 3) Quality control and documentation?
- 4) Immunohistochemical and molecular facilities to test (directly or indirectly) for HPV infection (hybrid capture, PCR techniques, p16-immunohistochemistry)?
- 5) Current practice of using these ancillary methods?

At the dysplasia centre of the University Clinics of Hamburg-Eppendorf, it is our practice to test for HPV by hybrid capture II in all equivocal cytologies, and by p16-immunohistochemistry (ev. using HPV-genus-/type-specific PCR and/or RNA in situ hybridization as confirmatory tests) in all equivocal histologies. As Reference Laboratory, we also offer these tests to outside pathologists all over Europe. Results of our work have been repeatedly published (partly in cooperation with the group of C. Crum of the Women and Children Clinics, Harvard University, Boston, US) giving evidence of the value of this strategy in general, and of the special weight of this combined immunohistochemical and molecular approach for the differential diagnosis of glandular (pre-) neoplasias of the cervix, and for vulvar lesions.

What we should be aware of is that by starting to implement the molecular repertoire into diagnostics, we will also get ready for the challenge to better predict prognosis and therapeutic benefits. Since HPV detection (and/or detection of p16 overexpression as surrogate marker of active high risk HPV) per se is not a reliable prognosticator, HPV driven cellular gene clusters (e.g. “cervical cancer proliferation cluster“) have been already tested, and others will be tested for HPV-independent oncogenic pathways, in order to find a molecular signature related to the malignant, invasive and metastatic phenotypes of lower genital tract cancer and precancer. Ongoing array studies need the help of European Societies and Networks, and even more important the local support of European dysplasia centres to recruit patients and cell and tissue material (for further information see our general websites: www.ukc.uni-hamburg.de). Also, contact us under loening@uke.uni-hamburg.de or kbehrens@uke.uni-hamburg.de

Professor Th. Loening
Secretary, BSCCP

European Guidelines on Quality Assurance for Cervix Cancer Screening

New guidelines have been commissioned by the European Commission and should be available by the end of 2005/beginning 2006. The Senior Editor is Dr. Marc Arbyn, Scientific Institute of Public Health, Brussels.

Each year in Europe approximately 68,000 new cases of cervical cancer are diagnosed. In the European Union 27,000 cases are diagnosed each year and 11,000 women will die from it.

The new guidelines will cover all aspects of cervical screening and will provide guidelines which will be applicable to all European countries. The following topics will be covered as individual chapters:

- 1) Epidemiological guidelines for quality assurance and cervical cancer screening.
- 2) Methods for screening and diagnosis of cervical cancer precursors.
- 3) Quality assurance guidelines for cytology.
- 4) Quality assurance guidelines for pathology.
- 5) Guidelines for management of women with cervical cytological abnormalities.

- 6) Data collection on treatment and follow-up of screen-detected lesions.
- 7) Guidelines for training.
- 8) Summary table of key performance indicators.
- 9) Summary table of the screening programme.

The Scientific Secretariat working with Marc Arbyn is:

- Athi Antilla (Mass Screening/Finnish Cancer Registry, Helsinki)
- Joe Jordan (European Federation for Colposcopy, Birmingham)
- Gugliema Ronco (Centro per la Prevesione Oncol. Piemonte, Turin)
- Helene Wiener (Klinisches Institut für Pathologie, Vienna)

Expert Reviewers are Epidemiologists:

- Elsebeth Lynge (Copenhagen)
- Peter Sasieni (London)
- Maja Zakelj (Ljubljana)
- Nereo Segnan (Turin)

Gynaecologists:

- Santiago Dexeus (Barcelona)
- Pekka Nieminen (Helsinki)

Cytopathologists:

- Christine Bergeron (Paris)
- Amanda Herbert (London)

A great deal of work has gone into preparing these guidelines and the authors are confident that all relevant aspects of a mass cervical screening programme will be covered. Currently some countries, like Finland and U.K., have a well organised cervical screening programme based on cervical cytology and these programmes have been shown to reduce significantly the incidence of cervical cancer and mortality from cervical cancer. The guidelines will cover not only cervical cytology screening but all aspects of HPV testing and the future role of HPV vaccines.

An effective screening programme should define a screening policy, namely the target population and screening interval. Evidence shows that a population based screening programme is more likely to be successful (and less expensive) than a programme based on opportunistic/self referral screening. Europe Against Cancer Recommendations state that cervical cancer screening should be offered at least every 5th year and if resources are available, every 3rd year. Screening more frequently than every 3 years should be discouraged as it is not cost effective. The Europe Against Cancer programme recommends screening for the age groups 25-30 to 65 years but if screening resources are limited, the resources should be concentrated at the age range from 30-35 to 60 years.

It is important that cervical cancer screening should be planned within the context of national planning, and public health specialists consulted from the onset to confirm that the programme includes a population-based information system which will then monitor each step of the screening process and assess its effectiveness.

Trained colposcopists are essential for the management of women with abnormal cervical cytology. The European Federation for Colposcopy has identified minimum standards of training required before any clinician can be classified as a trained colposcopist. These recommendations are identified on the EFC website.

The authors are confident that by identifying the standards which ideally should be met by any country wishing to introduce cervical screening, pressure can be brought to bear on national governments to

ensure that the programme is properly planned, properly implemented, properly funded, and properly audited.

Joe Jordan
Past President, EFC

International Federation for Cervical Pathology and Colposcopy (IFCPC)

The 13th meeting of IFCPC took place in Cancun, Mexico, 5-9th June 2005. Over 1,000 delegates were present.

There was much discussion about the future role of IFCPC as a result of which there was a renewed sense of optimism about the future. The new President is Howard Jones (USA), the new President-Elect is Roberto Testa (Argentina) and the new Secretary General is Patrick Walker (UK.)

The changes which have been decided will make a significant difference:

- 1) The Secretarial budget will be doubled and there will be a move to a full-time Secretariat.
- 2) The website will be upgraded. The budget for the website will be doubled and a new IT sub-committee will be established. A web page will be established for each national society. IFCPC will cover the costs of establishing a web page for those countries which do not have the financial resources to do so themselves. The website for each member country will contain membership and numbers, their contact addresses, their mission statement, the incidence of invasive cancer in their country, their screening and educational programmes and their aspirations. If any country has any guidelines these will be made available.
- 3) The Scientific Committee will be strongly supported by the Executive and members of the Scientific Committee will have prime responsibility of organising the next World Congress. Members of the Scientific Committee will be chosen by their academic track record and willingness to input to the process. In addition there will be a new Scientific and Investigations Sub-Committee to work on co-ordinating research between the Congresses – the aim will be to put those with research aspirations in touch with others but most notably with international funding agencies such as NCI etc.
- 4) Key opinion leaders will be sought to establish an outreach committee and advice will be sought as to how best to help developing countries benefit from first world research and resources. There will be a 2-day retreat in the next 8 months involving key board members, chairs of standing committees and other key opinion formers to examine the current constitution, mission, focus and specific goals of IFCPC. The election processes will be brought up to date and will be transparent and accountable. The new proposed constitution will reflect the new values and goals of IFCPC.
- 5) Care will be taken with the choice of the venue of future Congresses. Each society submitting itself to host a future Congress will have to include a full proposed budget and if successful details of the budget will be reported to the Board at each Board Meeting. The IFCPC will underwrite each Congress for either 30% or 50% of the budget in return to the equivalent percentage of profits. The national society at the bidding conference will demonstrate the precise areas of women's healthcare into which any profit they make from their conference will be invested.
- 6) All Standing Committees will report annually to the Board and details of the reports will be published on the website.
- 7) Over time additional sources of income for IFCPC (currently only \$32,000 a year from subscription income) will be sought. The current reserves are on \$425,000.

Following the Cancun meeting everyone felt very happy that IFCPC was again moving towards its original goal envisaged at the time of its inception in Mar del Plata in 1972, namely to encourage screening programmes to reduce deaths from cervical cancer, and in particular to promote the best possible standards of colposcopy worldwide.

The next World Congress will be held in New Zealand in 2008 and the 2011 meeting will be in Salvador, Brazil.

Patrick Walker

Secretary General IFCPC

Belgrade Meeting – 19-21 September 2007

Dear Colleagues

It gives us a great pleasure to invite you to the 4th Congress of European Federation for Colposcopy (EFC), which is going to be held in Belgrade, in 2007. Never before has any European colposcopy meeting been organized in Eastern Europe which is the part of the world with high incidence and mortality of cervical cancer. On the other hand, this region has its own economic, organizational and educational problems, which often result in lack of organized screening, delay in early diagnosis and insufficient management of this disease. In our attempts to improve *cervical cancer control* in this area, the help and support by EFC is needed very much.

Belgrade is the capital of Serbian culture, education and economy, and one of the oldest cities in Europe which, since the ancient times, has been on intersection of roads of Eastern and Western Europe. European Federation brought colposcopy congress to Belgrade, thus giving a great opportunity to all gynecologists from this region, to learn the latest information from our field, share their ideas, discuss the various problems and work together in a stimulating forum.

Local Organizing Committee will be fully committed to work closely with the EFC and the Scientific Advisory Committee of the Society. A great deal of thought will go into formulating not only a stimulating scientific program, but also the preparation of most enjoyable social program, which will give participants and their partners the opportunity to experience Serbian culture and its wonderful scenery.

We look very much forward to welcoming you in Belgrade
Prof. Dr Vesna Kesic
President of the Organizing Committee

Financial Report

I am sorry to have to report that the finances of the EFC are rather fragile. The Federation did not receive a European grant in either year 2004 or 2005 and we are now existing on the monies left in the EFC account from the previous EU grants. The amount remaining is approximately 14,000 Euro. Only 8 member countries have paid their dues, which amounts to 4300 Euro, despite the fact that the Federation has kept the subscriptions low at only 2 euro per head for each member of the national society.

Despite the financial problems I am glad to report that everybody has been most kind in helping us to maintain our activities. The cost of the website has been kept to a minimum, and others who are owed money have not claimed it as yet. In addition, several of our member societies have very kindly allowed us to hold our Training Meetings at the same time as their Annual Scientific Meeting. Members of the Training Committee have participated in the local meetings by giving lectures, and the National Society has funded their travel and accommodation. This has enabled us to meet to discuss EFC matters on a fairly regular basis.

I believe that there is an outstanding EU payment due to the Federation, being the final payment from the 2003 grant. I calculate that this is approximately 30,000 Euro. However, whether we actually get this money is totally dependent upon the EU Commissioners allowing its release, and so far I have not been successful in accessing it. If we receive this sum of money it will be the last tranche of money which we receive from the European Commission. The Federation will then be in a position whereby it must fund itself and we need to think of ways in which we can raise funds. **ANYBODY GOT ANY IDEAS PLEASE???**

Liz Dollery
Treasurer, EFC

EFC Links with other Organisations

- > WHO International Network on Control of Gynaecological Cancer
- > WHO Collaborating Center for Research in Human Reproduction
- > European Cervical Cancer Screening Network
- > European Board and College of Obstetrics & Gynaecology (EBCOG)

Future Meetings

2007 – Belgrade, Serbia & Montenegro
4th European Congress of Colposcopy & Lower Genital Tract Pathology
19-21 September 2007
Contact: Congress Secretariat
Sava Centar – Congress Department
Str. Milentija Popovica 9
11070 Novi Beograd
Email: pco@scentar.co.yu
Tel: +381 11 2139 840
Fax: +381 11 135 919

2010 – Germany. Venue and further details to follow

2013 – to be decided in Belgrade in September 2007. Nominations for the 2013 meeting should be submitted to the Secretary of the EFC prior to that meeting

WHAT DO YOU THINK OF THE EFC WEBSITE (www.e-f-c.org)?

We have to thank Alex Diakomanolis, son of the President, for all the hours he has dedicated to designing an excellent Website. Without his help we would not have been in a position to own

such a website. I hope you will find it useful and informative. If you have any helpful comments or suggestions for the website please do not hesitate to contact me and I will pass them on to the Committee.

Liz Dollery
EFC

Publications - 2002 - 2005

'European Colposcopy Certificate – How to achieve Accreditation'

CWE Redman
Hungarian Journal of Oncology 7, 2002: 152-155

'L'Appredimento della colposcopia: Il sistema European'

CWE Redman
Giornale Italiano di Obstetricia & Ginecologica 2002, 24, 56-61

'Colposcopy: Education, Training and Accreditation'

CWE Redman, In: Bosze P, and Luesley DM
Ed. European Academy of Gynaecological Course Book on Colposcopy Primed-X
Press, Budapest 2003: 183-188

'Colposcopy – Standards of Training for Colposcopy and Management of CIN in Europe'

Jordan JA, Redman CWE, Dollery E, Diakomanolis E
In: MonsonegoJ, ed. Eurogin 2003. Miland: Monduzzi Editore, 2003: 121-124

'Development of the European Colposcopy Core Curriculum: Use of the Dephi Technique'

Redman CWE, Dollery E, Jordan JA
Journal of Obstetrics & Gynaecology 2004 Oct:24(7): 780-4

Affiliated Member Countries

- | | | |
|------------------|------------------|----------------------|
| • UK | • Poland | • Hungary |
| • Irish Republic | • Greece | • Switzerland |
| • France | • Finland | • Lithuania |
| • Spain | • Malta | • Sweden |
| • Portugal | • Israel | • Denmark |
| • Italy | • Slovenia | |
| • Austria | • Romania | Application to join: |
| • Germany | • Yugoslavia | • Turkey |
| • Belgium | • Croatia | |
| • Netherlands | • Czech Republic | |

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