CLINICAL PRACTICE

ALERT

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Family PACT
Planning • Access • Care • Treatment

OFFICE OF FAMILY PLANNING
DEPARTMENT OF HEALTH CARE SERVICES

UPDATE: CERVICAL CANCER SCREENING

Between the 1940s and 2002, women in the United States (U.S.) were advised to have cytology screening for cervical cancer performed annually at the time of their well woman visit. Over the past decade, national guidelines have changed substantially, such that routine screening is started later, completed earlier, and intervals extended to every three to five years for most women. The Family Planning, Access, Care, and Treatment (Family PACT) program has adopted the 2012 guidelines of the U.S. Preventive Services Task Force[1] (USPSTF) with additional recommendations from the multidisciplinary partnership among the American Cancer Society, American Society for Colposcopy and Cervical Pathology, American Society for Clinical Pathology,[2] and the American College of Obstetricians and Gynecologists (ACOG).[3]

KEY RECOMMENDATIONS

- **Cervical cancer screening is started at 21 years of age and should be performed every three years. As of May 1, 2013, Family PACT no longer covers cervical cytology in women under 21 years of age, unless criteria are met (see below).**
- **An alternative strategy for women ages 30 years and older is to screen with cytology and a human papillomavirus-deoxyribonucleic acid (HPV-DNA) test (co-testing) every five years. *NOTE: Co-testing is not a Family PACT benefit.***
- **Women younger than 21 who have a history of an abnormal cytology test should continue in a surveillance pathway recommended by the ACOG Committee of Adolescent Health Care.[4]**
- **Immune compromised women (human immunodeficiency virus [HIV]-positive women, major organ transplant recipients, or long term steroid users) and women who were exposed to diethylstilbestrol (DES) in-utero should receive cervical cytology screening annually.**

Based upon these guidelines, each client *must* be advised of the screening interval that applies to her.

QUESTIONS AND ANSWERS

How often should cervical cytological screening (Pap smears) be performed?

- Cytology screening begins at 21 years of age, regardless of the age at first intercourse. Screening women younger than 21 for cervical cancer lacks proven benefit and is harmful to some women because of overdiagnosis and overtreatment.
- Women 21-30 years of age should have cytology screening every three years and women between 30 and 65 years of age may opt either for cytology every three years or co-testing every five years.
- Women with HIV infection should be screened twice in the first year after diagnosis (even if under 21) and annually thereafter.[5]
- Women who were DES-exposed in utero or who have had a major organ transplant should be screened annually.
- Women treated in the past for a high grade cervical lesion remain at risk for recurrent disease for at least 20 years after treatment. Women who have been treated for CIN 2,3 or adenocarcinoma in situ (AIS) must be *regularly screened* for 20 years, even if 65 years of age or older, either with cytology every three years or co-testing every five years.

If a woman younger than 21 has had cervical screening according to the prior guidelines, what should be done now?

According to a 2010 Committee Opinion by the ACOG Committee on Adolescent Health Care:[4]

- An adolescent with a history of normal cervical cytologic screening in the past should not be rescreened until age 21.
- If she had a cytology result of ASC-US or LSIL, or a biopsy result of CIN 1,2, but has had two subsequent normal cytology test results, rescreening can be delayed until age 21 years.
- ASC-H is managed with colposcopic evaluation. If no CIN 2,3 is identified histologically, cytologic evaluation should be repeated at six-month intervals. If any abnormality is found (ASC-US or worse), colposcopy is repeated. When the client has two consecutive normal cytology test results, screening can be reinitiated at age 21 years.
- HSIL requires a colposcopic evaluation with endocervical assessment. Use of the “see and treat” LEEP for clients with HSIL who are younger than 21 years is considered unacceptable. If on biopsy no CIN 2,3 is found, observation with colposcopy and cytology at six-month intervals is recommended for up to two years provided the result of the endocervical sampling is negative.

Do virginal women need to be screened?

Virginal women of any age should be advised that their risk of cervical cancer is extremely low, but not zero. Once counseled, either a woman may decline cervical cancer screening entirely or opt to be screened routinely.

Are the screening intervals any different for women with multiple sexual partners?

No. While women with multiple sexual partners are at an increased risk for acquiring HPV infection and are more likely to develop a pre-invasive cervical lesion or cancer, they do not have faster time of progression if a lesion does develop.

Are there any chronic medical conditions that necessitate cervical cancer screening more often than every 3-5 years?

Women who have a compromised immune system may develop lesions more rapidly than women who are immunocompetent and therefore must be screened more often in order to detect an interval cancer. This includes women with HIV infection, a major organ transplant with the use of an anti-rejection drug, and long term corticosteroid use. The Centers for Disease Control and Prevention recommends that HIV-positive women start screening once diagnosed[5] and ACOG recommends that other immune compromised women start screening at 21 years of age.[3]

If the client has an abnormal cytology result, should hormonal contraception be limited or withheld?
No. There is no medical evidence that the use of hormonal contraceptives will adversely affect the diagnosis and treatment of cervical abnormalities. Having an abnormal result makes it even more important to provide effective contraception, as pregnancy would complicate, and in some cases delay, treatment for cervical abnormalities.

Some of my clients insist on having cervical cytology screening annually despite a history of prior negative results. What do I tell them now?
The client should be counseled that intervals are designed to balance benefits and risks of screening and that being screened too often actually may be harmful to her health. Over-screening results in an excess risk of false positive test results, which can lead to unnecessary colposcopy and biopsies, with attendant anxiety and inconvenience.

If cervical cytology screening is *not* scheduled or necessary, what about the need to perform a screening bimanual pelvic exam at the time of a well woman visit?
While a bimanual pelvic exam has been recommended for the detection of ovarian cancer, national guidelines differ on this topic. USPSTF states that there is no evidence that this practice improves ovarian cancer detection or outcomes and recommends against routine screening for ovarian cancer in low risk women.[6] ACOG guidelines state that a screening pelvic exam is not indicated in asymptomatic women under 21 years of age, but should be performed routinely in women 21 and older.[7] Family PACT Standards do not recommend a *screening* bimanual pelvic exam at any age.

APPLICATION OF FAMILY PACT POLICIES

Will Family PACT continue to cover cervical cytology for women younger than 21 years of age?
Family PACT covers cervical cytology screening when provided in conjunction with family planning services. As of May 1, 2013, routine cytology screening for women younger than 21 years of age *will no longer be covered* unless one of the criteria listed in Question 2, page 1 are met. The ordering provider must document on the cytology request form either "requires repeat cervical cytology to reevaluate prior ASC-US, LSIL, or a CIN1 biopsy result," "immunocompromised status," or "requires post-treatment surveillance."

For women 21 years of age and older, will Family PACT cover an annual cervical cytology test if a woman requests it or the clinician prefers this approach to the listed guidelines?
Family PACT covers cervical cytology screening when provided during a family planning visit. Acceptable clinical indications for screening more frequently than every three to five years include clients who:

- Have had a previously abnormal cytology result, and consequently, are in a surveillance pathway*
- Have had a result of "insufficient specimen adequacy" or unsatisfactory for evaluation at her last cervical cytology screen*
- Have received treatment with cryotherapy, LEEP, or a cone biopsy for a pre-invasive cervical lesion*
- Have HIV infection, a major organ transplant with the use of an anti-rejection drug, or long term corticosteroid use
- Are newly enrolled in a practice and have no documentation of their most recent cervical cytology result

Why doesn't Family PACT include co-testing as a benefit?
While co-testing is an evidence-based screening strategy for women 30 years of age and older, its success depends upon adherence to the recommendation that women who have a benign cytology and a negative HPV-DNA test must not be re-screened until five years later. Women screened more often than this will not have any additional benefit but may experience the harms of a false positive test. Co-testing works best in health delivery systems where prior tests results are immediately available to the clinician caring for a client. Because many Family PACT clients frequently change providers, it is unlikely a new provider will have documentation of a prior co-test result, which in turn can lead to over-screening.

Does Family PACT ever cover HPV-DNA testing?
Currently, HPV-DNA testing is limited to reflex testing for clients 21 years of age and older with a cervical cytology result of ASC-US or AGC, as well as certain follow up strategies after colposcopy or treatment (see Benefit Grid, Policies, Procedures, and Billing Instructions [PPBI]).

Providers should refer to the Family PACT PPBI manual for the complete text of the Family PACT Standards, official administrative practices, and billing information.

REFERENCES

1. Moyer VA. Screening for cervical cancer: USPSTF recommendation statement. *Ann Intern Med*. 2012 Jun 19; 156(12):880-91.
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3. ACOG. Screening for cervical cancer. Practice Bulletin No. 131. *Obstet Gynecol*. 2012; 120:1222-38.
4. ACOG Committee on Adolescent Health Care. ACOG Committee Opinion no. 463: Cervical cancer in adolescents: screening, evaluation, and management. *Obstet Gynecol*. 2010 Aug; 116(2 Pt 1):469-72.
5. Kaplan JE, et.al. Guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: *MMWR Recomm Rep*. 2009 Apr 10;58(RR-4):1-207.
6. USPSTF Ovarian Cancer Screening, 2012. Accessed at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsovar.htm.
7. ACOG Committee on Gynecologic Practice. Well Woman Visit. Committee Opinion No. 534. *Obstet Gynecol*. 2012;120:421-24.
8. Massad LS, et.al. 2012 Updated consensus guidelines for the management of abnormal cervical cancer screening tests and cancer precursors. *J Lower Gen Tract Dis*. 2013, S1-27. Available at: http://www.asccp.org/ConsensusGuidelines/tabid/7436/Default.aspx.

* For additional detail regarding follow-up after treatment or abnormal cytology results, see reference 8 or the appended tables in "Family PACT Clinical Practice Alert *Update: Management of Abnormal* or *Cervical Cytology*" at http://www.familypact.org/Providers/clinical-practice-alerts.