Addressing patient concerns around changes in cervical cancer screening

Commentary by:
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A young woman is due for her next follow-up cervical screening in late 2017 after surgery for a high-grade cervical lesion but is concerned about how the changes to the screening program due to be implemented on 1 December 2017 will affect her. What can you tell her about the new screening program?

Case scenario

Lucy, aged 26 years, had a large loop excision of the transformation zone (LLETZ) for cervical intraepithelial neoplasia grade 2 (CIN2) in mid-December 2014. Her last two Pap smears since the procedure have been reported as normal. She is due for follow up in late 2017 and is concerned as she has heard that the Pap test system is changing.

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Commentary

From 1 December 2017 the National Cervical Screening Program, a joint initiative of the Australian and state and territory governments, is changing. The two-yearly Pap test is being replaced by a five-yearly cervical screening test – an oncogenic human papillomavirus (HPV) test with partial genotyping. Women will be invited to commence screening at age 25 years, with an exit test at age 70 to 74 years. All women who have oncogenic HPV types detected will have 'reflex' liquid-based cytology (LBC) performed on the cervical sample, to guide further management. Women who have HPV types 16 and/or 18 detected (the types most commonly associated with cervical cancer) will be referred directly to colposcopy; the reflex LBC will inform that assessment. Women who have oncogenic HPV types other than 16 or 18 detected will be triaged according to the LBC result. Women who do not have oncogenic HPV detected will be invited to re-screen in five years. The management of test results is detailed in the National Cervical Screening Program 2016 clinical management guidelines for cervical cancer screening (available at http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening).[1]

The National Cervical Screening Program 2016 guidelines also include recommendations for women transitioning to the new program, either following routine screening or after treatment or follow up for a screen-detected Pap test abnormality.

What advice should you give Lucy about testing after 1 December 2017? Will the way in which she is tested change?

Lucy's high-grade cervical lesion was treated with a LLETZ in December 2014. Post-treatment management recommendations at that time were based on the 2005 NHMRC guidelines, which recommended colposcopy and cervical cytology at four to six months, followed by a Pap and HPV test at 12 months, with dual

Pap and HPV testing continued annually until both tests had negative results on two consecutive occasions.[2] This annual testing is called Test of Cure (ToC), and once completed women were able to return to routine screening.

For women who undergo treatment for a high-grade lesion (CIN2/3) after 1 December 2017, the updated guidelines recommend a Test of Cure with annual co-testing (HPV test and LBC) starting 12 months post-treatment until results of two consecutive co-tests are negative.[1] After review with the treating specialist at four to six months, Test of Cure will generally be carried out by the woman's GP. Both tests (HPV and cytology) will be performed on the same liquid-based sample; a glass slide will not be made.

During transition to the renewed program, women whose most recent Pap test (prior to December 2017) was negative will be invited to have the new cervical screening test (primary HPV test for oncogenic HPV types) at their next scheduled date for screening, two years after their last Pap test. The cervical screening test involves taking a cervical cell sample from the transformation zone, in the same way as a Pap smear is taken, but instead of putting the cells on a glass slide the sample is placed into a liquid-based medium before sending to the laboratory. Women who are post-treatment and are under surveillance with, or were due to commence, Test of Cure prior to December 2017 should continue to have annual co-testing (HPV and LBC) until they have tested negative by both tests on two consecutive occasions, when they can then return to routine five-yearly screening.

What tests should Lucy have and how often should she be tested in future?

It appears that Lucy has not completed the recommended Test of Cure, as she has had Pap tests only without the recommended HPV tests. She should therefore be advised that she will need to complete the Test of Cure and that you will perform a co-test (HPV and LBC) in December 2017 and again in December 2018. If results of both co-tests are negative then she will be able to return to routine screening with a cervical screening test in five years (i.e. in 2023).

You can reassure Lucy that this course of action is very safe, given the high negative predictive value of consecutive HPV tests coupled with cytology testing. Lucy should also be advised to return if she develops abnormal vaginal bleeding, particularly postcoital or intermenstrual bleeding, which could be suggestive of cervical cancer. After consideration of other possible causes of bleeding such as pregnancy or chlamydia infection, HPV and LBC co-testing should be performed and referral for appropriate investigation to exclude genital tract malignancy should be considered.

Some concern has been expressed that increasing the age of commencement of screening to 25 years may lead to an increase in cervical cancer in young women

Routine screening is not recommended in the new National Cervical Screening Program for women under 25 years of age. This change is based on several factors, including:

- the incidence of cervical cancer in women under 25 years is extremely low, and has remained stable over the past two decades despite intensive screening of this age group as part of the introduction of the National Cervical Screening Program
- although HPV infections are very common in young women, most are transient and cleared without detection of cervical neoplasia
- if infection persists, the time frame for the development of invasive cancer is generally about 10 to 15 years
- the National HPV Vaccination Program (which commenced in 2007) has resulted in a steady decline in high-grade abnormalities in women under 20 years and more recently in women up to 25 years of age, and the prevalence of HPV types 16/18/6/11 is now very low in young vaccinated and unvaccinated women
- raising the age of screening will reduce significant possible anxiety and harms (including infection, haemorrhage and cervical incompetence in future pregnancies) associated with treatment of lesions that are, in fact, very likely to regress.

Although the screening age has been raised, it is essential that women of any age with signs or symptoms suggestive of cervical cancer or its precursors are assessed with a co-test (HPV and LBC) and referral for appropriate investigation to exclude genital tract malignancy is considered.

Furthermore, for women who experienced first sexual activity below age 14 years and who had not received the HPV vaccine before sexual debut, a single HPV test between 20 and 24 years of age can be considered on an individual basis.

Conclusion

GPs can feel reassured that streamlined comprehensive guidance will be provided for every possible scenario to ensure that women are managed safely during the period of transition from the existing to the new cervical screening program. MT

References

1. Cancer Council Australia Cervical Cancer Screening Guidelines Working Party. National Cervical Screening Program: guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. Sydney: Cancer Council Australia; 2016. Available from: http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening (accessed March 2017).
2. National Cervical Screening Program. Screening to prevent cervical cancer: guidelines for the management of asymptomatic women with screen-detected abnormalities. Canberra: Commonwealth of Australia; 2005.

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