CLINICAL PRACTICE GUIDELINES

CERVICAL CANCER

VISION

To provide a complete strategy to appropriately screen for cervical cancer in females of Northeast Nebraska.

GOAL

To ensure the patient receives the right test at the right time. This will decrease the number of unnecessary screenings and colposcopies that provides no statistical improvement in cancer detection, stage of disease at presentation, or survival rates of this disease.

OVERVIEW

Cervical Cancer used to be the leading cause of cancer deaths for women in the United States. However, cervical cancer is the easiest gynecological cancer to prevent with screening, and is highly curable. New technologies for cervical cancer screening continue to evolve as do recommendations for managing the results. In addition, there are different risk-benefit considerations for women at different ages, as reflected in age-specific screening recommendations. The ACS, the American Society for Colposcopy and Cervical Pathology (ASCCP), and the American Society for Clinical Pathology (ASCP) have recently updated their joint guidelines for cervical cancer screening, and an update to the U.S. Preventive Services Task Force recommendations also has been issued.

Development Team

Dr. Keith Vrbicky
Dr. Mark Davis
Dr. Renee Albin
Dr. Jim Albin
Dr. Alex Laudenklos
FRHS PHO Board

FAITH REGIONAL HEALTH SERVICES

Provider-Hospital Organization

FREQUENTLY ASKED QUESTIONS

WHAT ARE THE RISK FACTORS FOR CERVICAL CANCER?

HPV is so common that most people get it at some time in their lives. HPV usually causes no symptoms so you can't tell that you have it. For most women, HPV will go away on its own; however, if it does not, there is a chance that over time it may cause cervical cancer.

Other things can increase your risk of cervical cancer:

- Smoking.
- Having HIV (the virus that causes AIDS) or another condition that makes it hard for your body to fight off health problems.
- Using birth control pills for a long time (five or more years).
- Having given birth to three or more children.
- Having several sexual partners.

WHAT CAN I DO TO REDUCE MY RISK OF CERVICAL CANCER?

The Pap test (or Pap smear) looks for precancers, cell changes on the cervix that may become cervical cancer if they are not treated appropriately. You should start getting Pap tests at age 21.

- How to Prepare for Your Pap Test
  - You should not douche (rinse the vagina with water or another fluid).
  - You should not use a tampon.
  - You should not have sex.
  - You should not use a birth control foam, cream, or jelly.
  - You should not use a medicine or cream in your vagina.
- The human papillomavirus (HPV) test looks for the virus that can cause these cell changes.
- The HPV vaccine protects against the types of HPV that most often cause cervical, vaginal, and vulvar cancers
- Don't smoke.
- Use condoms during sex.*
- Limit your number of sexual partners.

WHAT ARE THE SYMPTOMS OF CERVICAL CANCER?

Early on, cervical cancer may not cause signs and symptoms. Advanced cervical cancer may cause bleeding or discharge from the vagina that is not normal for you, such as bleeding after sex. If you have any of these signs, see your doctor. They may be caused by something other than cancer, but the only way to know is to see your doctor.

HOW IS CERVICAL CANCER DIAGNOSED AND TREATED?

Cervical cancer is treated in several ways. It depends on the kind of cervical cancer and how far it has spread. Treatments include surgery, chemotherapy, and radiation therapy.

- Surgery: Doctors remove cancer tissue in an operation.
- Chemotherapy: Using special medicines to shrink or kill the cancer. The drugs can be pills you take or medicines given in your veins, or sometimes both.
- Radiation: Using high-energy rays (similar to X-rays) to kill the cancer.

Different treatments may be provided by different doctors on your medical team.

- Gynecologic oncologists are doctors who have been trained to treat cancers of a woman's reproductive system.
- Surgeons are doctors who perform operations.
- Medical oncologists are doctors who treat cancer with medicine.
- Radiation oncologists are doctors who treat cancer with radiation.

TEAM MEMBERS

The goal of the provider-hospital organization (PHO) is to standardize treatment across our health systems and providers. Clinical Practice Guidelines (CPGs) and resources are developed to implement evidence-based care and best practice standards within our network.

TEAM ROLES

There is an ongoing commitment from the Faith Regional Provider-Hospital Organization (PHO) to develop and implement current evidence-based CPGs. Educating yourself and your patients on these best practice guidelines helps your office.

TEAM RESOURCES

Patient-centered teams work more efficiently and effectively to provide high quality care that is known to improve health outcomes and patient satisfaction.

DISCLAIMER

FRHS PHO clinical practice guidelines are developed to assist clinicians by providing an analytical framework for the evaluation and treatment of selected common problems encountered in patients. They are not intended to establish a protocol for all patients with a particular condition. Clinicians must exercise independent judgment and make decisions based upon the situation presented. While great care has been taken to assure the accuracy of the information presented, the reader is advised that FRHS PHO cannot be responsible for continued currency of the information, for any errors or omissions in this guideline, or for any consequences arising from its use. This clinical practice guideline should not be used or reprinted without written consent from the FRHS PHO.

WHAT TO DO FOR ABNORMAL PAPS

ASCCP guidelines can be referenced at: http://www.asccp.org/asccp-guidelines

WHEN TO DO COLPOSCOPY

ASCCP guidelines can be referenced at: http://www.asccp.org/asccp-guidelines

OTHER:

Individuals and clinicians can use the annual Pap test screening visit as an opportunity to discuss other health problems and preventive measures. Individuals, clinicians, and health systems should seek effective ways to facilitate the receipt of recommended preventive services at intervals that are beneficial to the patient. Efforts also should be made to ensure that individuals are able to seek care for additional health concerns as they present.

Annual visits are still necessary; but less frequent testing and more-in-depth testing is recommended.

HPV is the main cause of cervical cancer.

Have your first Pap test when you're 21! IF your test results are normal, you can wait 3 years for your next Pap test. This does not mean other tests are to be delayed three years. Continue to keep your annual wellness visit with your Provider for other health related problems.

REFERENCES

1. American College of Obstetricians and Gynecologists committee on Practice Bulletins – Gynecology. ACOG Practice Bulletin 131: Screening for cervical cancer. Obstet Gynecol Nov 2012; 120(5): 1222-38.
2. The American College of Obstetricians and Gynecologists: Patient Education – Cervical Cancer Screening FAQ https://www.acog.org/-/media/For-Patients/faq085.pdf?dmc=1&ts=20180530T2007491248
3. Center for Disease Control and Prevention. Gynecological Cancers – What Should I Know About Screening? https://www.cdc.gov/cancer/cervical/basic_info/screening.htm
4. Center for Disease Control and Prevention. Inside Knowledge: Get the Facts About Gynecologic Cancer https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf
5. Center for Disease Control and Prevention. What Should I know About Screening? https://www.cdc.gov/cancer/cervical/pdf/cervical_infographic_print.pdf
6. U.S. Preventive Services Task Force. Recommendations for Cervical Cancer: Screening. Sept 2017. https://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement/cervical-cancer-screening2
7. USPSTF. Screening for Cervical Cancer. 2012. Available at http://www.uspreventiveservicestaskforce.org/uspstf11/cervcancer/cervcancerrs.htm. These recommendations apply to women who have a cervix, regardless of sexual history.

CERVICAL CANCER SCREENING GUIDELINES FOR AVERAGE-RISK WOMEN[a]

		American College of Obstetricians and Gynecologists (ACOG)[3] 2012
When to start screening[b]		Age 21 regardless of the age of onset of sexual activity. Women aged <21 years should not be screened regardless of age at sexual initiation and other behavior-related risk factors *(Level A evidence)*.
Statement about annual screening		In women aged 30–65 years, annual cervical cancer screening should not be performed. *(Level A evidence)* Patients should be counseled that annual well-woman visits are recommended even if cervical cancer screening is not performed at each visit.
Screening method and intervals		
Cytology (conventional or liquid based)[c]	21–29 years of age	Every 3 years *(Level A evidence)*.
	30–65 years of age	Every 3 years *(Level A evidence)*.
HPV co-test (cytology + HPV test administered together)	21–29 years of age	HPV co-testinge should not be performed in women aged <30 years. *(Level A evidence)*
	30–65 years of age	Every 5 years; this is the preferred method *(Level A evidence)*.
Primary hrHPV testing[d] (as an alternative to cotesting or cytology alone)[e]		Not addressed.
When to stop screening		Aged >65 years with adequate negative prior screening* results and no history of CIN 2 or higher[f] *(Level A evidence)*.
When to screen after age 65 years		Women aged >65 years with a history of CIN2, CIN3, or AIS should continue routine age-based screening[g] for at least 20 years *(Level B evidence)*.
Screening post-hysterectomy		Women who have had a hysterectomy (removal of the cervix) should stop screening and not restart for any reason[h,i] *(Level A evidence)*.
The need for a bimanual pelvic exam		Addressed in 2012 well-woman visit recommendations.[j] **Aged <21 years**, no evidence supports the routine internal examination of the healthy, asymptomatic patient. An "external-only" genital examination is acceptable. **Aged ≥21 years**, no evidence supports or refutes the annual pelvic examination or speculum and bimanual examination. The decision whether or not to perform a complete pelvic examination should be a shared decision after a discussion between the patient and her health care provider. Annual examination of the external genitalia should continue.[k]
Screening among those immunized against HPV 16/18		Women who have received the HPV vaccine should be screened according to the same guidelines as women who have not been vaccinated *(Level C evidence)*.

CERVICAL CANCER SCREENING GUIDELINES FOR AVERAGE-RISK WOMEN[a]

HPV = human papillomavirus; CIN = cervical intraepithelial neoplasia; AIS=adenocarcinoma in situ; hrHPV = high-risk HPV.

[a] These recommendations do not address special, high-risk populations who may need more intensive or alternative screening. These special populations include women with a history of CIN2, CIN3, or cervical cancer, women who were exposed in utero to diethylstilbestrol, women who are infected with HIV, or women who are immunocompromised (such as those who have received solid organ transplants).

[b] Since cervical cancer is believed to be caused by sexually transmissible human papillomavirus infections, women who have not had sexual exposures (e.g., virgins) are likely at low risk. Women aged >21 years who have not engaged in sexual intercourse may not need a Pap test depending on circumstances. The decision should be made at the discretion of the women and her physician. Women who have had sex with women are still at risk of cervical cancer. 10–15% of women aged 21–24 years in the United States report no vaginal intercourse (Saraiya M, Martinez G, Glaser K, et al. Obstet Gynecol. 2009;114(6):1213-9. doi: 10.1097/AOG.0b013e3181be3db4.). Providers should also be aware of instances of non-consensual sex among their patients.

[c] Conventional cytology and liquid-based cytology are equivalent regarding screening guidelines, and no distinction should be made by test when recommending next screening.

[d] Primary hrHPV testing is defined as a stand-alone test for cervical cancer screening without concomitant cytology testing. It may be followed by other tests (like a Pap) for triage. This test specifically identifies HPV 16 and HPV 18, while concurrently detecting 12 other types of high-risk HPVs.

[e] Because of equivalent or superior effectiveness, primary hrHPV screening can be considered as an alternative to current US cytology-based cervical cancer screening methods. Cytology alone and cotesting remain the screening options specifically recommended in major guidelines.

[f] Once screening is discontinued it should not resume for any reason, even if a woman reports having a new sexual partner.

[g] Routine screening is defined as screening every 5 years using cotesting (preferred) or every 3 years using cytology alone (acceptable).

[h] And no history of CIN2 or higher in the past 20 years.

[i] Women should continue to be screened if they have had a total hysterectomy and have a history of CIN 2 or higher in the past 20 years or cervical cancer ever. Continued screening for 20 years is recommended in women who still have a cervix and a history of CIN 2 or higher. Therefore, screening with cytology alone every 3 years for 20 years after the initial post-treatment surveillance for women with a hysterectomy is reasonable (Level B evidence).

[j] ACOG Committee Opinion No. 534: Well-Woman Visit. Committee on Gynecologic Practice. Obstet Gynecol. 2012;120(2)1:421–24. doi: 10.1097/AOG.0b013e3182680517.

[k] For women aged ≥21 years, annual pelvic examination is a routine part of preventive care even if they do not need cervical cytology screening, but also lacks data to support a specific time frame or frequency of such examinations. The decision to receive an internal examination can be left to the patient if she is asymptomatic and has undergone a total hysterectomy and bilateral salpingo-oophorectomy for benign indications, and is of average risk.

References:

1. ACOG Practice Bulletin No. 131: Screening for Cervical Cancer. ACOG Committee on Practice Bulletins-Gynecology. Obstet Gynecol. 2012;120(5):1222–38. doi: http://10.1097/AOG.0b013e318277c92a.

CERVICAL CANCER SCREENING GUIDELINES (PG. 2)

	American College of Obstetricians and Gynecologists (ACOG)
Guideline committee	ACOG Committee on Practice Bulletins-Gynecology.[a]
Methods used to analyze the evidence	Review of published meta-analyses and systematic review. Analysis of available evidence. When reliable research not available, consulted with experts.
Methods used to formulate recommendations	Not stated.
Definitions of level of recommendation or evidence assigned	*Level A evidence:* recommendations are based on good and consistent scientific evidence. *Level B evidence:* recommendations are based on limited or inconsistent scientific evidence. *Level C evidence:* based primarily on consensus and expert opinion.
Source of funding	American College of Obstetricians and Gynecologists
Disclosures of conflict	Not stated.[a]
Reference	National Guideline Clearinghouse. Website: www.guidelines.gov. ACOG Practice Bulletin Number 131: Screening for cervical cancer. Obstet Gynecol. 2012;120(5):1222-38.

[a] Individual members of the committees were not identified and no comment was made about conflicts of interest. (Volerman A and Cifu AS. Cervical cancer screening. JAMA. 2014;312(21):2279-80. doi: 10.1001/jama.2014.14992)