C4.3 – MANAGEMENT OF ABNORMAL CERVICAL CYTOLOGY IN ADOLESCENTS

Policy

Routine cervical cytology screening is not recommended in women under 21 years of age.
Reference policy Management of Abnormal Cervical Cytology Results.

Procedure

If cervical cytology testing was completed for clinical indications, the following policy should apply:

ACOG and the USPSTF recommend that cervical cancer screening should only begin at age 21, unless sexually active and:

1. HIV positive
2. Organ transplant recipient or
3. Immuno-compromised.

In these instances, begin testing yearly after diagnosis and extend to every three years after three tests are negative.

The management of abnormal cervical cytology in adolescents and young women differs from that of the adult population. Cervical cancer is almost nonexistent in adolescents; yet HPV infection is very common in this population. Natural history studies of adolescents with newly acquired HPV infection show that HPV usually becomes undetectable after an average of 8 months. In most adolescent patients with an intact immune system, 90% of HPV infections will resolve within 24 months.

The ASCCP guidelines now advise against routine HPV testing in women under the age of 30 and recommend against treatment of low-grade squamous intraepithelial lesions or cervical intraepithelial neoplasia in those under the age of 25. These new guidelines were established to minimize the potential negative impact that treatment can have on future pregnancy outcomes, while taking advantage of the natural history of HPV in young women.

Each agency must have a policy in place for management and follow-up of abnormal cervical cytology results in adolescents.

ASCCP Pap Smear (Cervical Cytology) Screening Recommendations (2012)

POPULATION	RECOMMENDED SCREENING
Under 21	Should NOT be screened regardless of the age of sexual initiation or other risk factors.+
Age 21-29	Every 3 years with cervical cytology only (reflex HPV for ASCUS results in those 26-29 years old).
Age 30-65	Every 3 years with cervical cytology OR Every 5 years with cervical cytology and high risk HPV co-testing (preferred).
Age >65	No screening following adequate negative prior screenings.*

History of Hysterectomy	No screening if done for benign indications.*
History of HPV Vaccine	Follow age specific guidelines.

[†]Unless sexually active and HIV positive/immune compromised or organ transplant recipient.
*Those with a history of CIN 2 or more severe lesion should be screened for at least 20 years.

For abnormal cytology management recommendations, please see ASCCP guidelines (2020).

Abnormal Cervical Cytology Results

ASC-US: Atypical squamous cells of undetermined significance.
ASC-H: Atypical squamous cells, cannot exclude high-grade squamous intraepithelial lesion.
LSIL: Low squamous intraepithelial lesion.
HSIL: High squamous intraepithelial lesion.
AGC: Atypical glandular cells.

Management of Abnormal Findings

If cervical cytology screening is performed during adolescence for any reason indicated above, or screening, follow-up is dictated by the Pap smear result:

- If No Abnormality: No further testing is required until age 21.
- If ASCUS or LSIL:
  - Perform cervical cytology screening yearly for 2 years.
  - If followed by two normal cervical cytology screens, can halt further testing until age 21.
  - If ASC-US/LSIL persists for 2 years, refer for colposcopy.
  - If any single cervical cytology screening shows HSIL, colposcopy is indicated.
- If ASC-H: Follow with a six month repeat screening.
  - If negative x 2, no further testing until age 21.
- If HSIL: Refer for colposcopy with endocervical sampling.

Special Considerations

Pregnancy in adolescents does not alter screening and management of abnormal cytology. Endocervical curettage and excisional procedures should never be performed during pregnancy unless invasive cancer is highly suspected. Screening for pregnancy, therefore, should be performed before evaluation and management of abnormal cervical cytology in adolescents.

Consent

Minors undergoing a colposcopic examination may find it helpful to have parental involvement for the procedure. However, colposcopic examinations are considered evaluation for STIs, and minors are allowed to consent for diagnosis and treatment of STIs. For that reason, parental consent, although preferred, is not required to perform the procedure.

If parental consent is not obtained, consent for the examination should be obtained from the minor and indicated in the medical record. Any Clinical Service Provider who delivers such care should be fully informed of their state laws and established local standards of care. Even if the minor legally can consent, the law may not ensure confidentiality. Some states allow minors to consent for STI care, but give the Clinical Service Provider discretion to disclose information to parents, particularly if it is necessary to protect the minor's health. Colposcopy, biopsy and therapy for cervical dysplasia are likely to generate a bill, which can compromise confidentiality. These issues need to be considered when determining whether parental consent should be obtained, even if it is not legally required.

Screening for STIs

Having a non-HIV STI diagnosis is not an indicator for earlier cervical cytology screening. Because of high rates of STIs in adolescents, screening and treatment for Chlamydia trachomatis and Neisseria Gonorrhea before treatment for abnormal cervical cytology is strongly recommended. *Reference Sexually Transmitted Infections and HIV policy for further guidance.*

Date Revised	**September 2023**
References	Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of Population Affairs (QFP) [2014] (https://www.hhs.gov/opa/guidelines/clinical-guidelines/quality-family-planning/index.html)
Additional Resources	ACOG Updated Cervical Cancer Screening Guidelines, April 2021 (https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/04/updated-cervical-cancer-screening-guidelines