C4.2 – ABNORMAL CERVICAL CANCER SCREENING TESTS (Excluding Adolescents)

Policy

SRs must implement policies that reflect current national standards of care for the management of abnormal cervical cancer screening tests. The national standards may include USPSTF, ACOG or American Society for Colposcopy and Cervical Pathology (ASCCP).

Procedure

The cervical cancer screening measure for cervical cancer is not diagnostic. **Abnormal results must be further evaluated.** An endometrial tissue biopsy or some other diagnostic procedure would be necessary to identify endometrial cancer.

Risk Factors

Human Papillomavirus (HPV)	HPV is a group of viruses that can infect the cervix. An HPV infection that doesn't go away can cause cervical cancer in some women. HPV is the cause of nearly all cervical cancers.
Lack of Regular Cervical Cancer Screening Tests	Cervical cancer is more common among women who don't have regular cervical cancer screening tests.
Other Factors	These include smoking, immunocompromised, multiple sexual partners or having a male sexual partner who has had multiple sexual partners, personal or family history of cervical dysplasia or cancer, early sexual debut, and certain STIs (such as Chlamydia).
DES (Diethylstilbestrol)	DES may increase the risk of a rare form of cervical cancer in daughters exposed to this drug before birth. DES was given to some pregnant women in the United States between about 1940 and 1971. It is no longer given to pregnant women but is currently used in the treatment of prostate cancer and occasionally, breast cancer.

Terminology

There are multiple categories of epithelial cell abnormalities identified on a cervical cancer screening test, including unsatisfactory, atypical squamous cells (ASC), low-grade or high-grade squamous intraepithelial lesions (LSIL or HSIL), atypical glandular cell abnormalities (AGC), and adenocarcinoma in situ (AIS). The histological diagnosis of cervical cell abnormalities are reported as cervical intraepithelial neoplasia (CIN) categories from 1-3.

Follow-Up on Abnormal Findings

ASCCPs 2019 guidelines (below box) include the following guiding principles for individuals with current or previous abnormal screening results:

1. HPV–based testing is the basis for risk estimation. The term HPV-based testing is used throughout this document and refers to use of either primary HPV testing alone or HPV testing in conjunction with cervical cytology (cotesting).
2. Personalized risk-based management is possible with knowledge of current results and past history
3. Guidelines must allow updates to incorporate new test methods as they are validated, and to adjust for decreasing CIN3+ risks as more patients who received HPV vaccination reach screening age.
4. Colposcopy practice must follow guidance detailed in the ASCCP Colposcopy Standards.
5. The primary goal of screening and management is cancer prevention through detection and treatment of cervical precancer.
6. Guidelines apply to all individuals with a cervix.
7. Discussion regarding balancing benefits and harms essential in shared decision-making.
8. Guidelines apply to asymptomatic patients that require management of abnormal cervical screening test results.
9. Guidelines are intended for use in the United States.

Box 1. Essential Changes From Prior Management Guidelines

1) Recommendations are based on risk, not results.

- Recommendations of colposcopy, treatment, or surveillance will be based on a patient's risk of CIN 3+ determined by a combination of current results and past history (including unknown history). The same current test results may yield different management recommendations depending on the history of recent past test results.

2) Colposcopy can be deferred for certain patients.

- Repeat HPV testing or cotesting at 1 year is recommended for patients with minor screening abnormalities indicating HPV infection with low risk of underlying CIN 3+ (*e.g.,* HPV-positive, low-grade cytologic abnormalities after a documented negative screening HPV test or cotest).

3) Guidance for expedited treatment is expanded (*i.e.,* treatment without colposcopic biopsy).

- Expedited treatment was an option for patients with HSIL cytology in the 2012 guidelines; this guidance is now better defined.
- For non-pregnant patients 25 years or older, expedited treatment, defined as treatment without preceding colposcopic biopsy demonstrating CIN 2+, is preferred when the immediate risk of CIN 3+ is ≥60%, and is acceptable for those with risks between 25% and 60%. Expedited treatment is preferred for nonpregnant patients 25 years or older with high-grade squamous intraepithelial lesion (HSIL) cytology and concurrent positive testing for HPV genotype 16 (HPV 16) (*i.e.,* HPV 16–positive HSIL cytology) and never or rarely screened patients with HPV-positive HSIL cytology regardless of HPV genotype.
- Shared decision-making should be used when considering expedited treatment, especially for patients with concerns about the potential impact of treatment on pregnancy outcomes.

4) Excisional treatment is preferred to ablative treatment for histologic HSIL (CIN 2 or CIN 3) in the United States. Excision is recommended for adenocarcinoma in situ (AIS).

5) Observation is preferred to treatment for CIN 1.

6) Histopathology reports based on Lower Anogenital Squamous Terminology (LAST)/World Health Organization (WHO) recommendations for reporting histologic HSIL should include CIN 2 or CIN 3 qualifiers, *i.e.,* HSIL(CIN 2) and HSIL (CIN 3).

7) All positive primary HPV screening tests, regardless of genotype, should have additional reflex triage testing performed from the same laboratory specimen (*e.g.,* reflex cytology).

- Additional testing from the same laboratory specimen is recommended because the findings may inform colposcopy practice. For example, those HPV-16 positive HSIL cytology qualify for expedited treatment.
- HPV 16 or 18 infections have the highest risk for CIN 3 and occult cancer, so additional evaluation (*e.g.,* colposcopy with biopsy) is necessary even when cytology results are negative.
- If HPV 16 or 18 testing is positive, and additional laboratory testing of the same sample is not feasible, the patient should proceed directly to colposcopy.

8) Continued surveillance with HPV testing or cotesting at 3-year intervals for at least 25 years is recommended after treatment and initial post-treatment management of histologic HSIL, CIN 2, CIN 3, or AIS. Continued surveillance at 3-year intervals beyond 25 years is acceptable for as long as the patient's life expectancy and ability to be screened are not significantly compromised by serious health issues.

- The 2012 guidelines recommended return to 5-year screening intervals and did not specify when screening should cease. New evidence indicates that risk remains elevated for at least 25 years, with no evidence that treated patients ever return to risk levels compatible with 5-year intervals.

9) Surveillance with cytology alone is acceptable only if testing with HPV or cotesting is not feasible. Cytology is less sensitive than HPV testing for detection of precancer and is therefore recommended more often. Cytology is recommended at 6-month intervals when HPV testing or cotesting is recommended annually. Cytology is recommended annually when 3-year intervals are recommended for HPV or cotesting.

10) Human papillomavirus assays that are Food and Drug Administration (FDA)-approved for screening should be used for management according to their regulatory approval in the United States. (*Note:* all HPV testing in this document refers to testing for high-risk HPV types only).

- For all management indications, HPV mRNA and HPV DNA tests without FDA approval for primary screening alone should only be used as a cotest with cytology, unless sufficient, rigorous data are available to support use of these particular tests in management.

Reference the 2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors for further details and full clinical decision-making 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	Perkins RB, Guido RS, Castle PE, Chelmow D, Einstein MH, Garcia F, et al. 2019 ASCCP risk-based management consensus guidelines for abnormal cervical cancer screening tests and cancer precursors. 2019 ASCCP Risk-Based Management Consensus Guidelines Committee. J Low Genit Tract Dis 2020;24:102-31 Update to Cervical Cancer Screening and Management: https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/10/updated-guidelines-for-management-of-cervical-cancer-screening-abnormalities