The 2019 ASCCP Risk-based Management Guidelines: Updated Management for Abnormal Screening Tests

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shaping the future of sexual + reproductive health care™

Today's Speakers

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Polling Question

Please select the option that best describes you:

1. Colposcopist
2. Physician or advanced practice clinician, not a colposcopist
3. Registered Nurse
4. Clinical support staff, health educator, or social worker
5. Administrative role
6. I do not work in a clinical setting

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Disclosures

- Cason
  - ASCCP board of directors
  - Merck
- Policar
  - None related to this talk
- Planners
  - None

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Objectives

- Describe the risk-based paradigm for managing abnormal cervical cancer screening test results.
- Explain how risk-thresholds guide the clinical actions of immediate treatment, colposcopy, and short-interval follow up
- Demonstrate use of the ASCCP app to apply the new guidelines to patient care

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Outline

- Welcome and Introductions
- A Roadmap through the 2019 Guidelines
- Guideline content (emphasis on guiding principles and how the 2019 guidelines differ from the 2012 guidelines
- Obtaining and using the ASCCP APP
- Implementation of the 2019 Guidelines in your practice
- Questions and answers

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What's In the 2019 ASCCP Guidelines?

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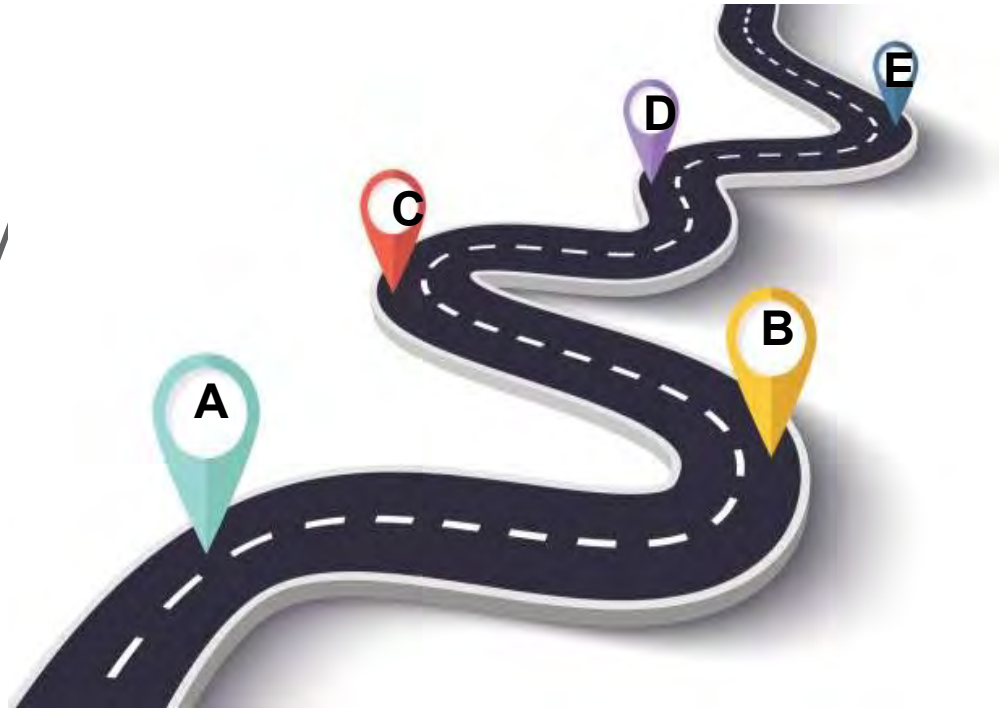
2019 ASCCP Risk-Based Management Consensus Guidelines

SECTION

A. Executive summary
B. Introduction
C. Guiding principles
D. Methods



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Section E. Paradigm Shift: Clinical Action Thresholds (CATs)

Recommendations for

E.1 Surveillance

E.2 Colposcopy

E.3 Treatment

E.4 Clinical situations leading to recommendation

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Section F: Updates Related to Pathology Reporting and Lab Tests

F.1 2-tier LAST terminology (histologic LSIL/HSIL)

F.2 Primary HPV screening (replaces 2015 interim guidance)

F.3 Statement on HPV tests

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Section G: Management of Rare Cytology Results

G.1 AGC or adenocarcinoma in situ (AIS)

G.2 Unsatisfactory cytology

G.3 Absent transformation zone on cytology

G.4 Benign endometrial cells in premenopausal patients or benign glandular cells post-hysterectomy

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Section H: Colposcopy Practice Standards and Exceptions to Colposcopy Clinical Action Threshold

H.1 ASCCP Colposcopy Standards

H.2 Exceptions to colposcopy threshold

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Section I: Management Based on Histology (Biopsy) Results

I.1 HSIL, not further specified

I.2 HSIL (CIN 2 or CIN 3)

I.3 CIN 2, and concerned about the potential effect of treatment on future pregnancy outcomes

I.4 LSIL (CIN 1) or less, preceded by ASC-H or HSIL cytology

I.5 LSIL (CIN 1) diagnosed repeatedly for at least 2 years

I.6 AIS (Adenocarcinoma in-situ)

Section J. Surveillance After Abnormalities

J.1 Tests and testing intervals when managing abnormal results (HPV-alone preferred)

J.2 Short-term follow-up after treatment for HSIL

J.3 Long-term follow-up after treatment for high-grade histology or cytology

J.4 Long-term follow-up after LSIL without evidence of histologic or cytologic high-grade abnormalities

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Section K: Management of Special Populations

K.1 Younger than 25 years old

K.2 During pregnancy

K.3 Immunosuppression

K.4 Older than 65 years with a history of prior abnormalities

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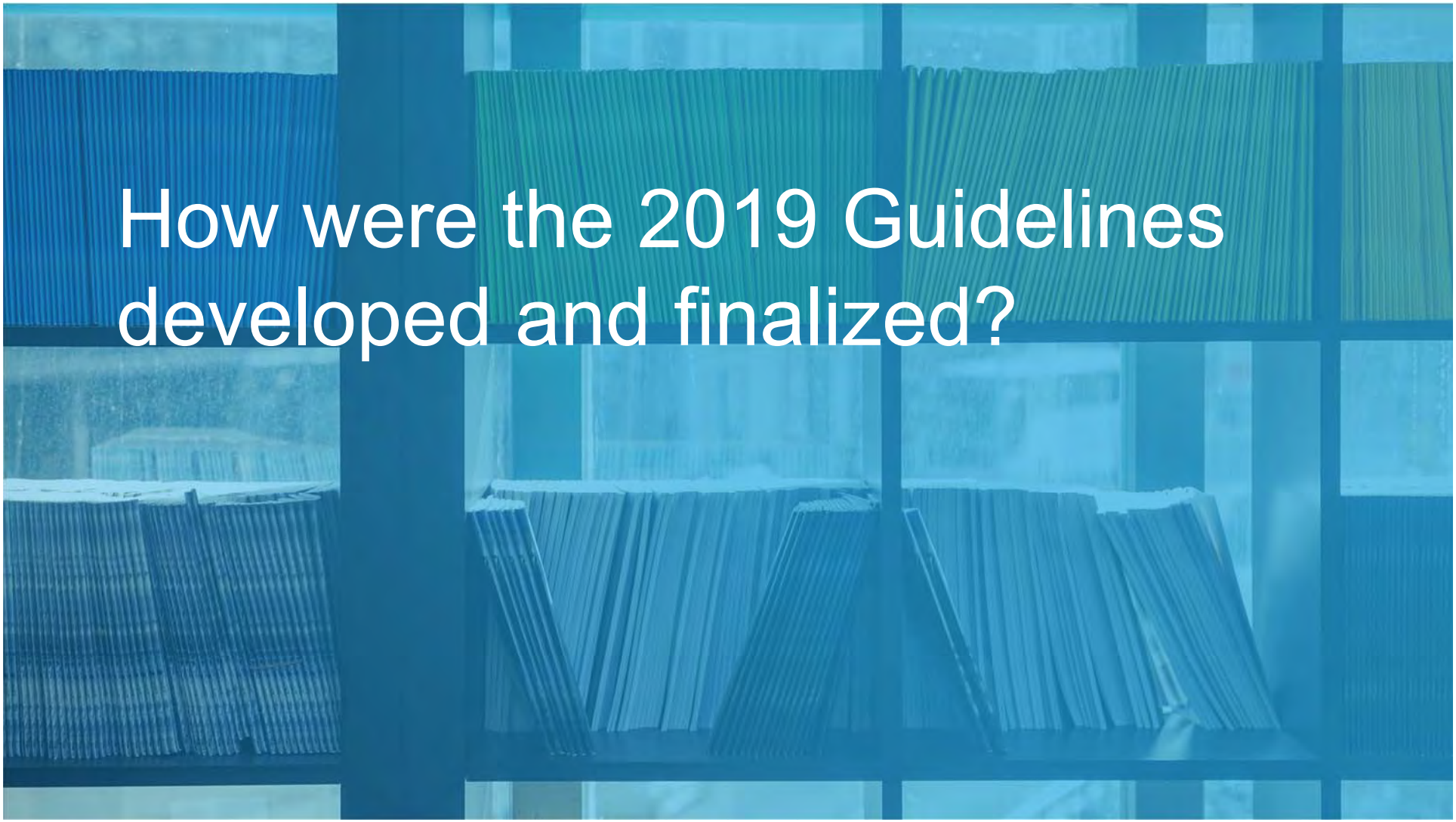

How were the 2019 Guidelines developed and finalized?

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19 Participating Organizations

Medical Professional Societies

- ASSCP
- American Academy Of Family Physicians
- American Cancer Society
- American College Of Nurse-Midwives
- American College Of Obstetricians and Gynecologists
- American Society For Clinical Pathology
- American Society Of Cytopathology
- College Of American Pathologists
- Nurses For Sexual And Reproductive Health
- Nurse Practitioners In Women's Health
- Papanicolaou Society Of Cytopathology
- Society Of Gynecologic Oncology
- Women Veterans Health Strategic Healthcare Group

Federal Agencies

- Centers for Disease Control & Prevention
- National Cancer Institute

Patient Advocacy Organizations

- American Sexual Health Association
- Cervivor
- Latino Cancer Institute
- Team Maureen

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What were the “fundamental concepts” used in 2019 Guideline development?

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Screening distinguishes normal from abnormal

Colposcopy with biopsy detects high grade disease Treating

prevents cancer

Goal of screening is to detect high grade disease

and *prevent* cervical cancer

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Definitions

- High grade disease/precancer: CIN 2, CIN 3, AIS
- Cotest: Hr HPV test **plus** cytology
- Cytology: Pap test, pap smear
- Primary HPV screening: Test for 14 high risk strains of HPV with one of two FDA licensed tests
  - Roche Cobas (Thin Prep or SurePath LB)
  - BD Onclarity (SurePath LB)
- HPV-based testing: Cotesting or primary HPV testing
- Diagnostic testing: Use the same test(s) as screening tests but done in response to abnormality

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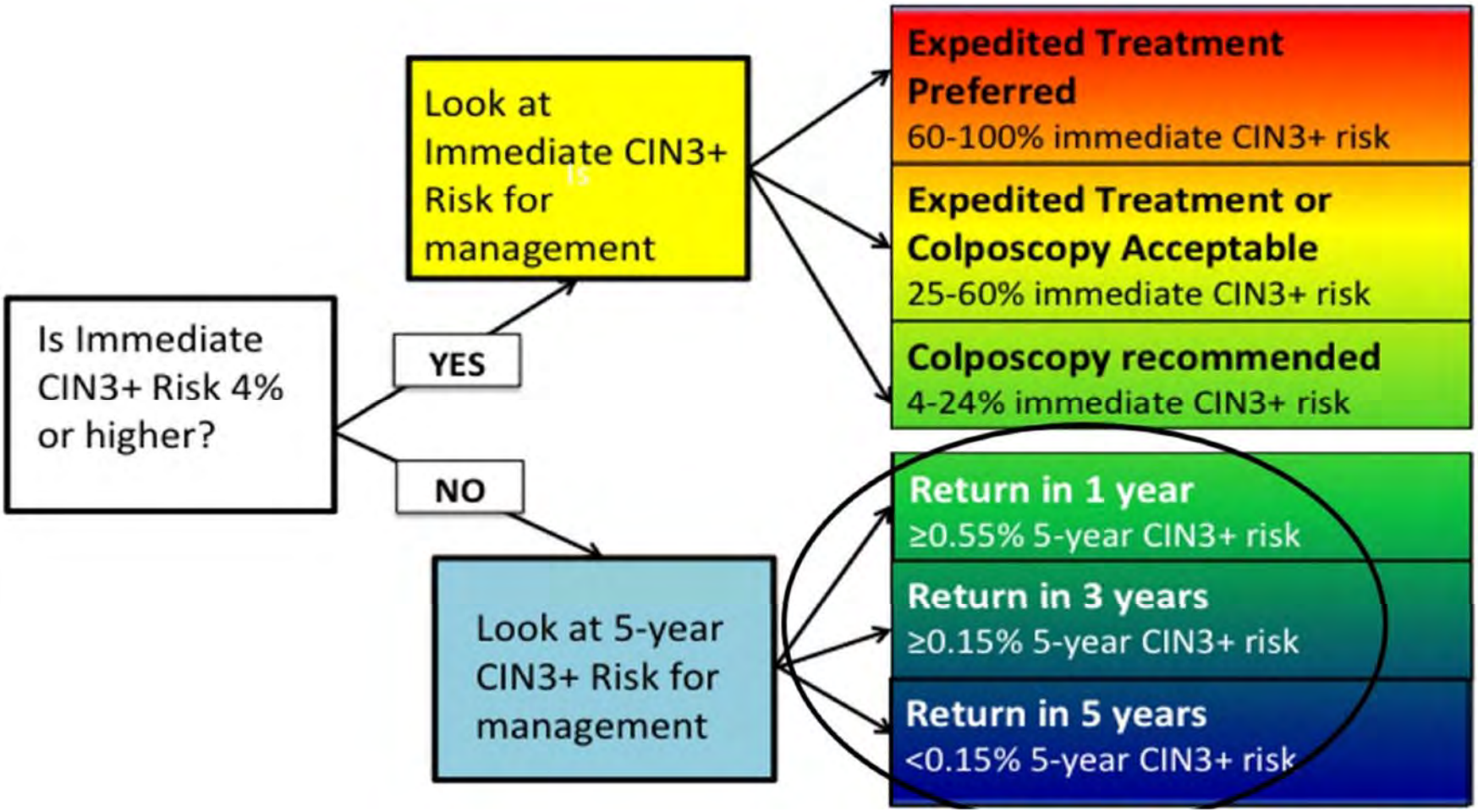
Patients Stratified into Risk Levels



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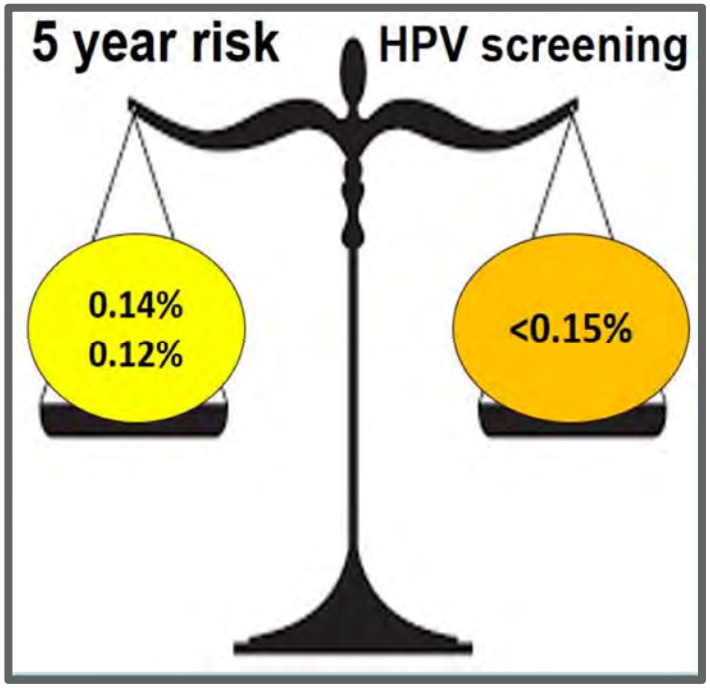
Five-Year Return CAT

- Risk should be similar to that of negative HPV test or cotest in a screening population
- Five-year CIN3+ risk based on the general population at KPNC
  - HPV alone = 0.14%
  - Cotesting = 0.12%



Egemen D, et al.. (2020). Risk Estimates Supporting the 2019 ASCCP Risk-Based Management Consensus Guidelines. *J Low Genit Tract Dis*; 24(2):132-143

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Five-Year Return CAT

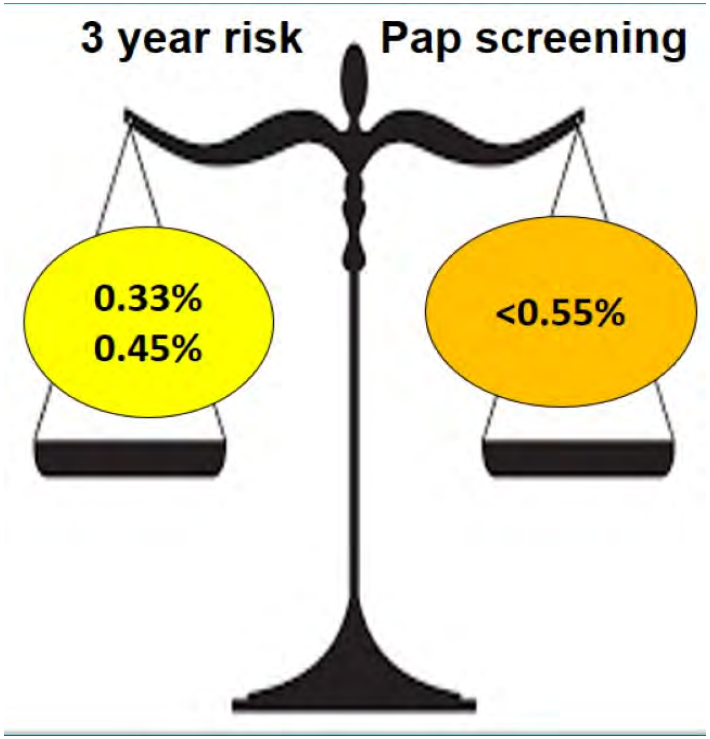
Guideline

- When patients have an estimated 5-year CIN3+ risk of <0.15% based on past history and current test results, return to routine screening at 5-year intervals using HPV-based testing is recommended

**Note: HPV-based testing is cotesting or primary HPV testing*

Three-Year Return CAT

- Risk should be similar to that of negative Pap test in a screening population
- Five-year CIN3+ risks:
  - 0.33% estimated in KPNC
  - 0.45% projected in CDC breast and cervical cancer screening program



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Perkins RB, et al. (2020) 2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors. *J Low Genit Tract Dis*; 24(2):102-131.

Three-Year Return CAT

Guideline

- When patients have an estimated 5-year CIN3+ risk ≥0.15% but <0.55% based on past history and current test results, repeat testing in 3 years with HPV-based testing is recommended

- *Note: HPV-based testing is cotesting or primary HPV testing*

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Clinical Examples: Three-Year Return

Result	CIN3+ risk at 5 years
HPV-negative ASC-US screening result	0.40%
HPV-negative LSIL → HPV-negative NILM cotest	0.40%
Low-grade cotest → Colposcopy CIN1 → HPV-negative NILM follow-up	0.42%
CIN2/3 treated with LEEP → 3 negative cotests	0.35%

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One-Year Return CAT

Guideline

- When patients have an estimated risk of CIN3+ that is below the threshold for immediate colposcopy
  - ≤4.0%
- and above the 3-year follow-up threshold
  - ≥0.55

repeat testing in 1 year with HPV-based testing

- *Note: HPV-based testing is cotesting or primary HPV testing*

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Clinical Examples of One-Year Return

Result	CIN3+ immediate risk %
HPV-positive NILM	2.1%
HPV-negative LSIL	1.0%

Egemen D, et al.. (2020). Risk Estimates Supporting the 2019 ASCCP Risk-Based Management Consensus Guidelines. *J Low Genit Tract Dis*; 24(2):132-143

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Post-Colposcopy Results → One-Year Return

Pre-colposcopy test result	Colposcopy result	Post-colposcopy test result	Immediate CIN3+ risk
Low-grade*	<CIN2	HPV-positive NILM	2.0%
Low-grade*	<CIN2	HPV-positive ASCUS/LSIL	3.1%

Low-grade defined as HPV+/NILM, ASC-US, or LSIL cytology

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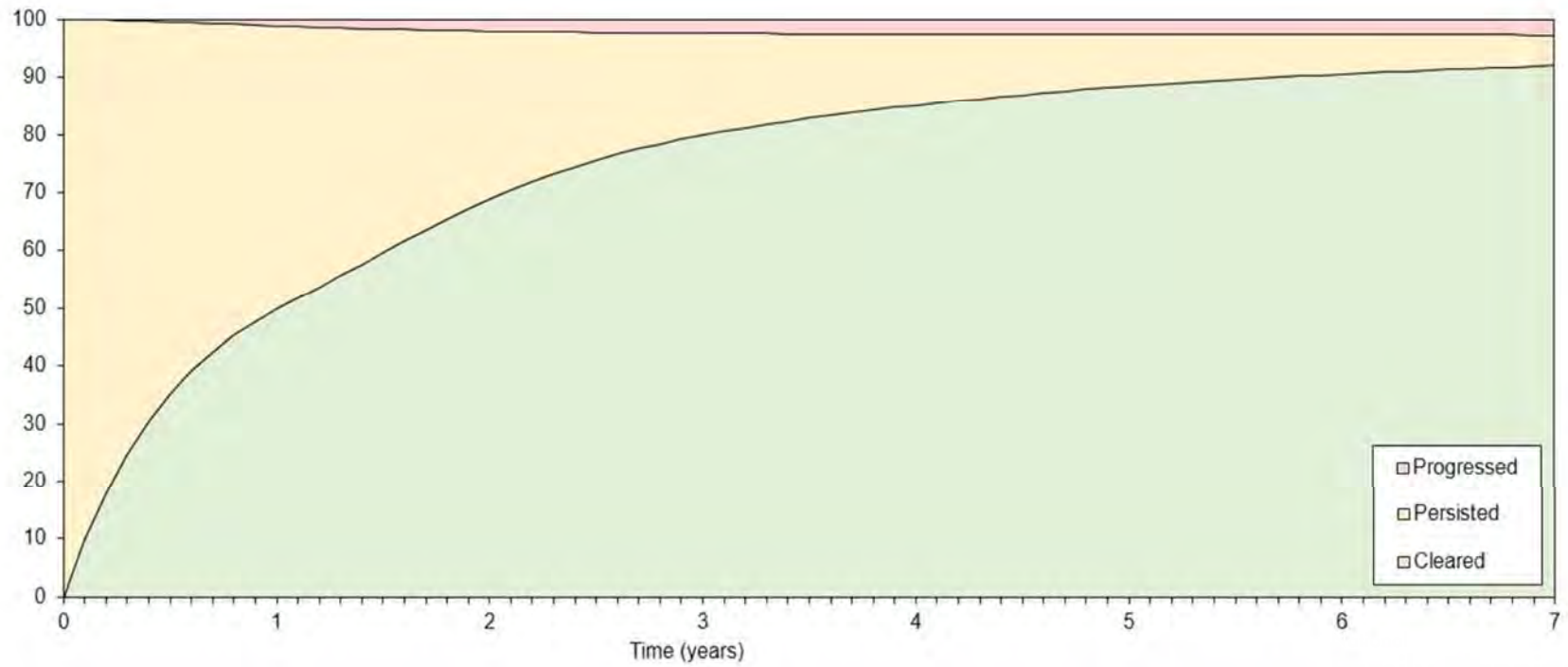
Egemen D, et al.. (2020). Risk Estimates Supporting the 2019 ASCCP Risk-Based Management Consensus Guidelines. *J Low Genit Tract Dis*; 24(2):132-143

Fundamental Concept #1: The longer an HPV infection has been present, the higher the risk of pre-cancer and cancer

- Time matters
- Type matters (HPV 16 and 18 are most dangerous)
- Other factors don't matter if you know about HPV

- *Clinical Tip:* Colposcopy is always needed following two consecutive positive HPV tests

Most HPV infections become undetectable in 1-3 years those that persist cause CIN3+ over time



Rodríguez AC, et al.. (2008) Rapid clearance of human papillomavirus and implications for clinical focus on persistent infections. *J Natl Cancer Inst*; 100(7):513-7.

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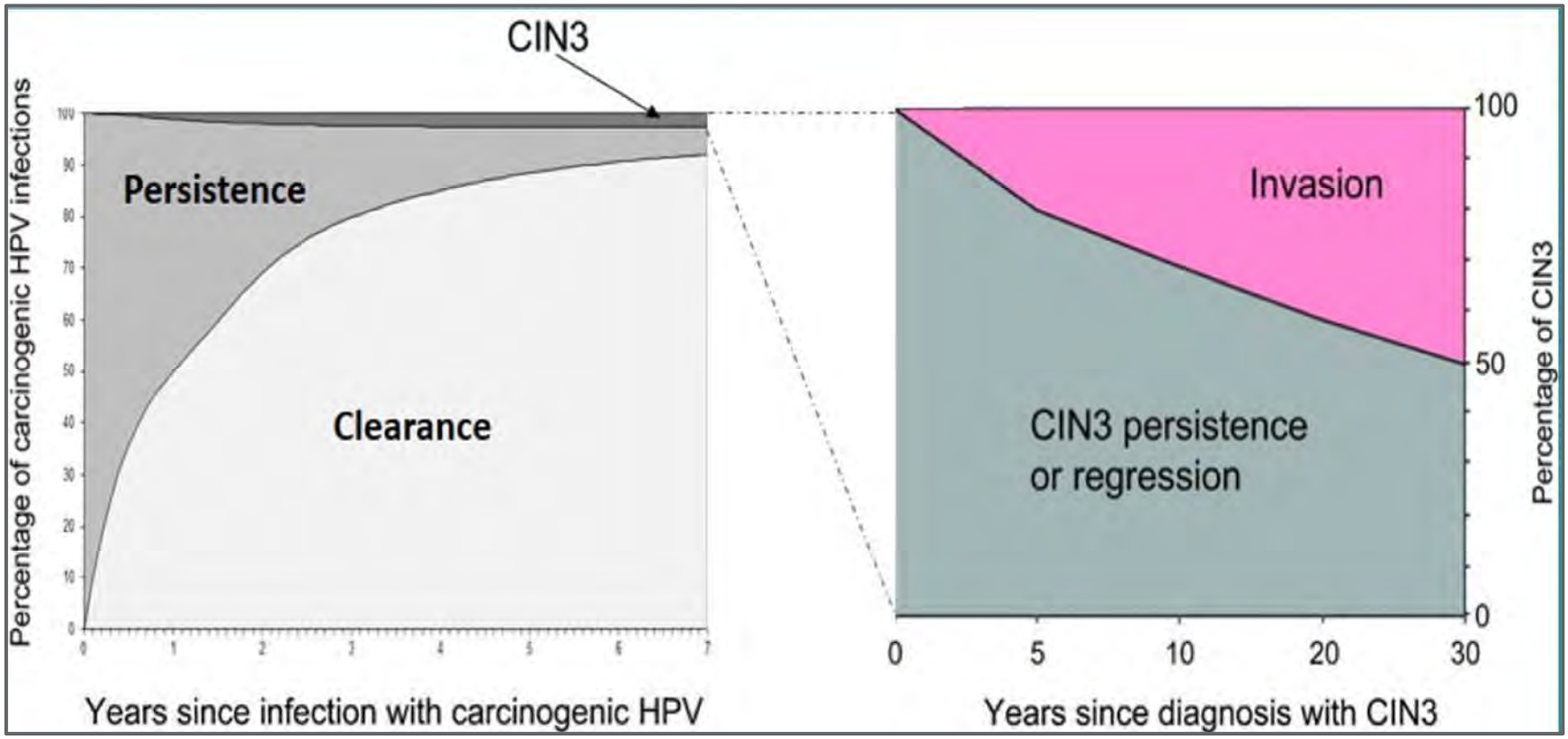
Precancer and Cancer Increase Markedly When Infections Persist for 5 Years or More



McCredie, M. R. et al.. Natural history of cervical neoplasia and risk of invasive cancer in women with cervical intraepithelial neoplasia 3: a retrospective cohort study. The Lancet. Oncology, 2008, 9(5), 425–434.

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New Guidelines Prefer HPV Testing for Follow Up

- Surveillance with cytology alone is acceptable *only if testing with HPV or cotesting is not feasible*
- Cytology is **less sensitive** than HPV testing

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New Guidelines Prefer HPV Testing for Follow Up

When testing with HPV or cotesting is recommended in 1 year → Cytology is recommended in 6 months

When 3-year intervals are recommended for HPV or cotesting → Cytology is recommended annually

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Fundamental Concept #2: Management Is Based on Risk, Not Results

- Recommendations are based on a patient's risk of CIN3+ 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 prior test results, recent results, and other risk factors

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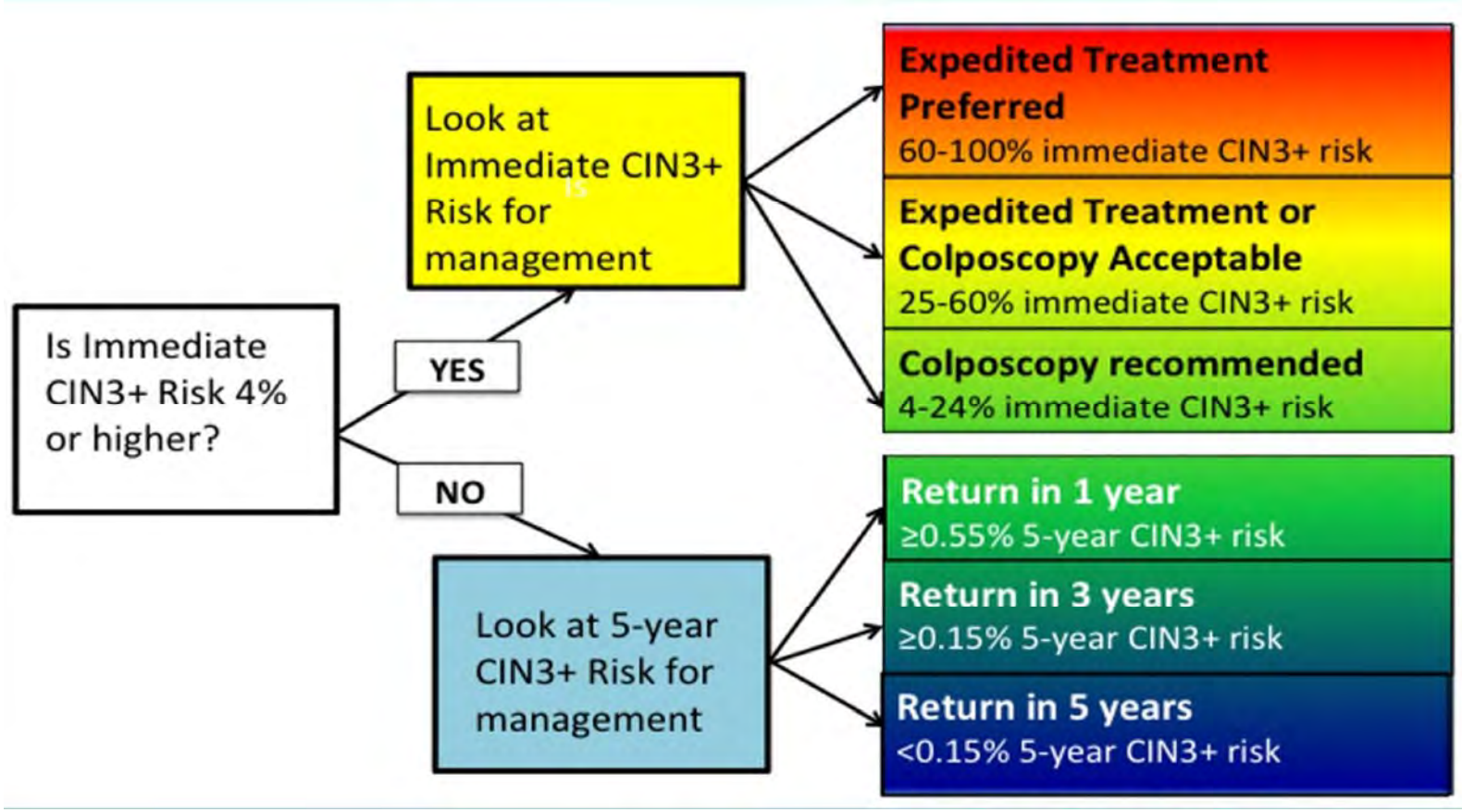
Patients Stratified Into Risk Levels



Perkins RB, Fuzzell LN, et al. (2020) Incorporating Stakeholder Feedback in Guidelines Development for the Management of Abnormal Cervical Cancer Screening Tests. *J Low Genit Tract Dis*; 24(2):167-177.

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Validation of Risk and Risk-based Management

- Kaiser Permanente Northern California (KPNC) cohort (~1.5m)
- New Mexico HPV Pap Registry (450k, previous study)
- CDC NBCCEDP – well-screened (~200k)
- CDC NBCCEDP – rarely/never/unknown screened (~150k)
- BD Onclarity Trial (~30k with genotyping)

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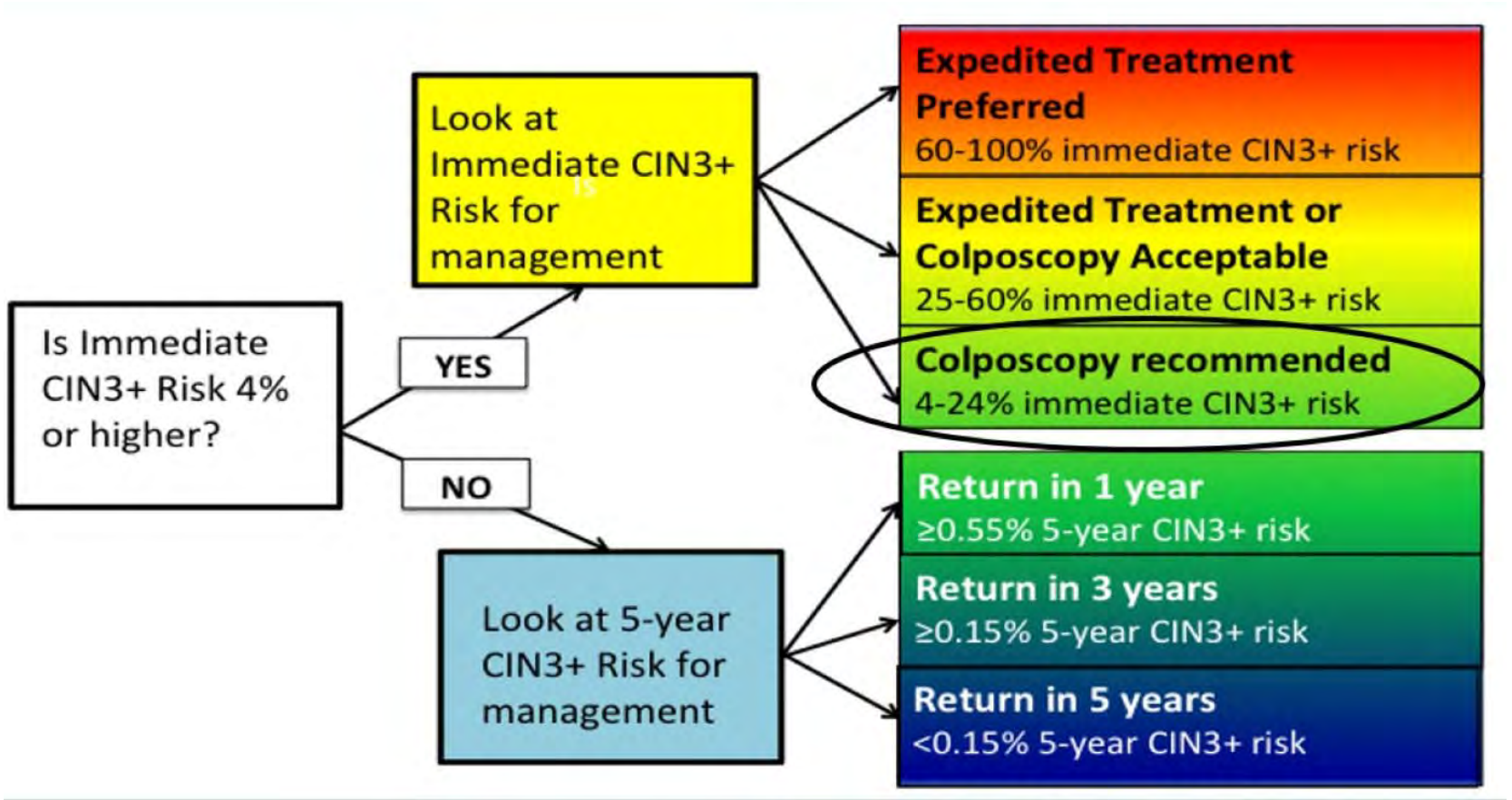
2019 Management Guidelines Colposcopy Threshold

- When individuals have an estimated immediate risk of CIN3+ of ≥4.0% based on prior history and current results, referral to colposcopy is recommended

Patients Stratified Into Risk Levels



Perkins RB, Fuzzell LN, et al. (2020) Incorporating Stakeholder Feedback in Guidelines Development for the Management of Abnormal Cervical Cancer Screening Tests. *J Low Genit Tract Dis*; 24(2):167-177.

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Immediate CIN3+ Risk by Co-test (KPNC)

HPV	Pap	N	%	Immediate risk (%)	Colposcopies per CIN3+ diagnosis
Pos	HSIL+	3980	0.3%	48.86	2.1
Pos	ASC-H	3766	0.2%	25.73	2.8
Neg	HSIL+	183	0.0%	25.21	2.8
Pos	ASC-US	30506	2.0%	4.45	8.6
Pos	LSIL	23659	1.5%	4.27	11.3
Pos	NILM	63541	4.1%	2.13	18.3
Neg	LSIL	3300	0.2%	1.05	19.0
Neg	ASC-US	25331	1.6%	0.04	22.6
Neg	NILM	1388153	89.8%	0.002	219.4

Cheung LC, Egemen D, Chen X, et al.. (2020) 2019 ASCCP Risk-Based Management Consensus Guidelines:Methods for Risk Estimation, Recommended Management, and Validation. *J Low Genit Tract Dis*; 24(2):90-101.

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Documented Prior Negative HPV (KPNC)

HPV	Pap	Immediate risk (%) after prior HPV neg	Immediate risk (%) no prior HPV test
Pos	HSIL+	32.28	48.86
Pos	ASC-H	13.56	25.73
Neg	HSIL+	13.80	25.21
Pos	ASC-US	2.10	4.27
Pos	LSIL	2.03	4.45
Pos	NILM	0.74	2.13
Neg	LSIL	0.44	1.05
Neg	ASC-US	0.014	0.04
Neg	NILM	0.001	0.002

LSIL/ASCUS no longer meets colposcopy threshold

Egemen D, et al.. (2020). Risk Estimates Supporting the 2019 ASCCP Risk-Based Management Consensus Guidelines. *J Low Genit Tract Dis*; 24(2):132-143

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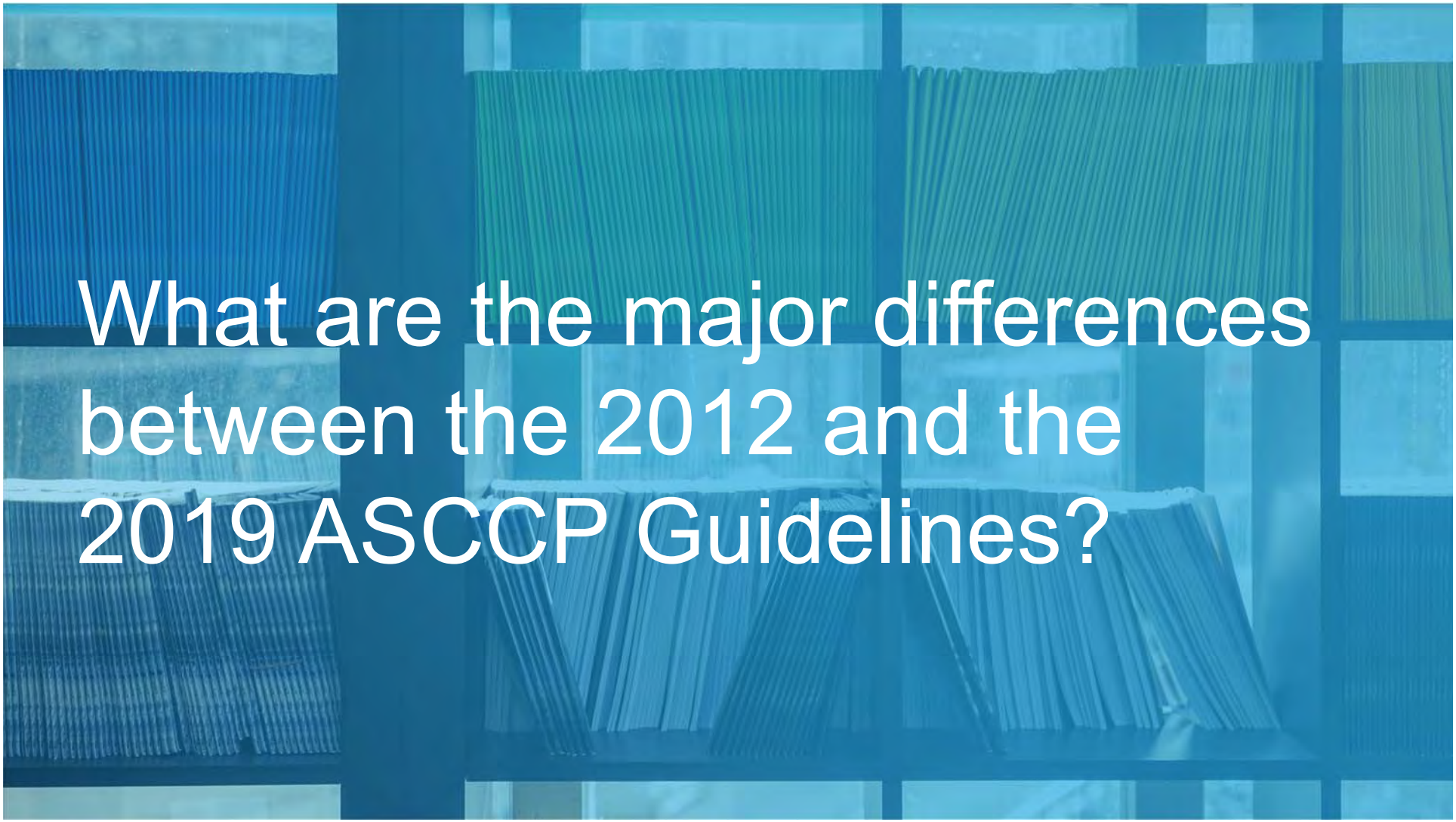

What are the major differences between the 2012 and the 2019 ASCCP Guidelines?

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Key Change: Colposcopy Can Be Deferred for Certain Patients

- Following minor screening abnormalities with low risk of underlying CIN3+ repeat HPV testing or cotesting at 1 year is recommended
- Low-grade cytologic abnormalities (ASCUS, LSIL) often reflect an incident HPV infection
- Low-grade abnormalities following a documented negative screening HPV test or cotest are highly likely to represent a transient HPV infection

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Impact of HPV Type With Prior Negative HPV Test (KPNC)

HPV Type	PAP Category	CIN3+ Immediate risk (%)	Cancer Immediate risk (%)
HPV 16+	ASC-US	5.34	0.33
HPV 16+	LSIL	6.70	0.89

***HPV-16 positive ASC-US and LSIL still exceed 4% threshold**

Cheung LC, Egemen D, Chen X, et al.. (2020) 2019 ASCCP Risk-Based Management Consensus Guidelines: Methods for Risk Estimation, Recommended Management, and Validation. *J Low Genit Tract Dis*; 24(2):90-101.

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Safer: Define High Risk Patients to Focus Resources

High-risk concepts similar to 2012 guidelines:

- Histologic HSIL (CIN2+) on biopsy remains the threshold for treatment in the general population
- CIN3 should always be treated (except in pregnancy)
- CIN2 has the option of treatment or observation with colposcopy/biopsy for those concerned with treatment effects on future pregnancy

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Safer: Define High Risk Patients to Focus Resources

High-grade cytology with HPV 16 are highest risk

- >75% risk of any precancer (histologic HSIL or CIN2+)
- >60% risk of highest-grade precancer (CIN3+)

Demarco M, Egemen D, Raine-Bennett TR, et al.. (2020) A study of partial human papillomavirus genotyping in support of the 2019 ASCCP Risk-Based Management Consensus Guidelines. *J Low Genit Tract Dis*; 24(2):144-147.

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CATs for Expedited Treatment Without Confirmatory Colposcopic Biopsy

Immediate risk of pre-cancer (CIN 3+)

- <25%: Level below which colposcopy and biopsy preferred
- ≥25-59%: Immediate excisional treatment or treatment after colposcopy with biopsy confirmation are acceptable
- >60%: Immediate excisional treatment is preferred, treatment after colposcopy with biopsy confirmation is acceptable

**Not recommended for patients age <25 and pregnant women*

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2019 Management Guidelines Highest Risk Patients Receive Expedited Treatment

- Excisional treatment for patients at high risk of pre-cancer without requiring confirmatory biopsy

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Changes to Follow-up After Treatment of CIN 2/3

- HPV-based testing at 6 months, then annually for 3 years
- Continued surveillance with HPV testing or cotesting at 3-year intervals for at least 25 years
- 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

Note: 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 return to risk levels compatible with 5-year intervals.

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Special Situations: HPV18, HPV-Negative AGC, and ASC-H

- Disproportionately important for invasive cancer
- Using medium-term risk of CIN3+ does not lead to colposcopy using CAT of 4% risk
- Consider absolute risk of cancer in addition to risk of precancer for **safety**

Enduring: Defined Risks for Referral to Colposcopy and Treatment

- 2019 Guidelines Framework designed to preserve cancer prevention while decreasing unnecessary colposcopy in the setting of:
- Decreasing CIN3+ prevalence as vaccinated populations age into screening cohorts
- Decreasing CIN3+ prevalence as populations undergo multiple rounds of HPV-based screening

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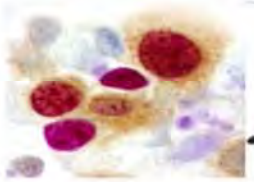
Enduring: Accommodates New Tests In Development

Cytology-based

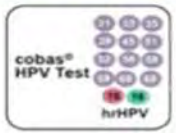
Cytology / Automation

p16/Ki-67 / Automation



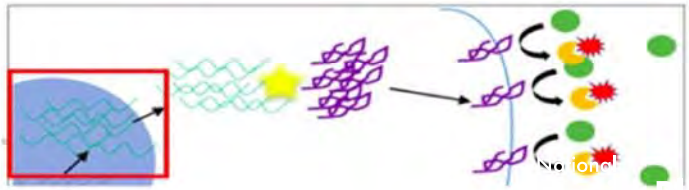
Molecular

HPV genotyping



Methylation

In-vivo imaging



Visual

VIA / Automation

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Enduring: Accommodates New Tests In Development

- Establishment of risk-based thresholds means that new tests can be elevated against existing thresholds instead of making new algorithms for each new test
- Test characteristics will be objectively compared to existing CATs
- Standardized, transparent clinical guidance will logically follow from test characteristics and existing consensus thresholds
- Reduces the need for interim guidance and frequent consensus conferences

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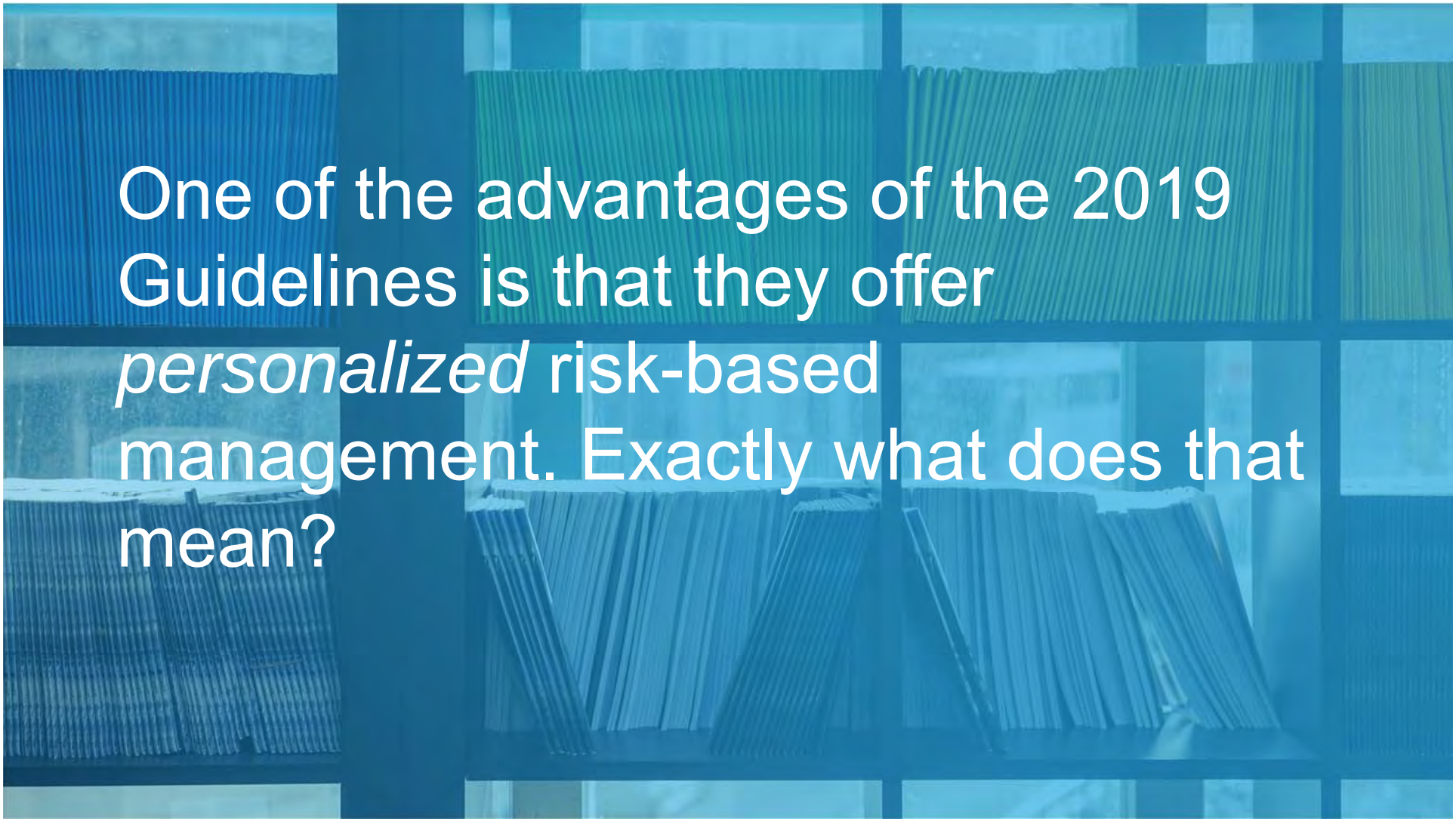

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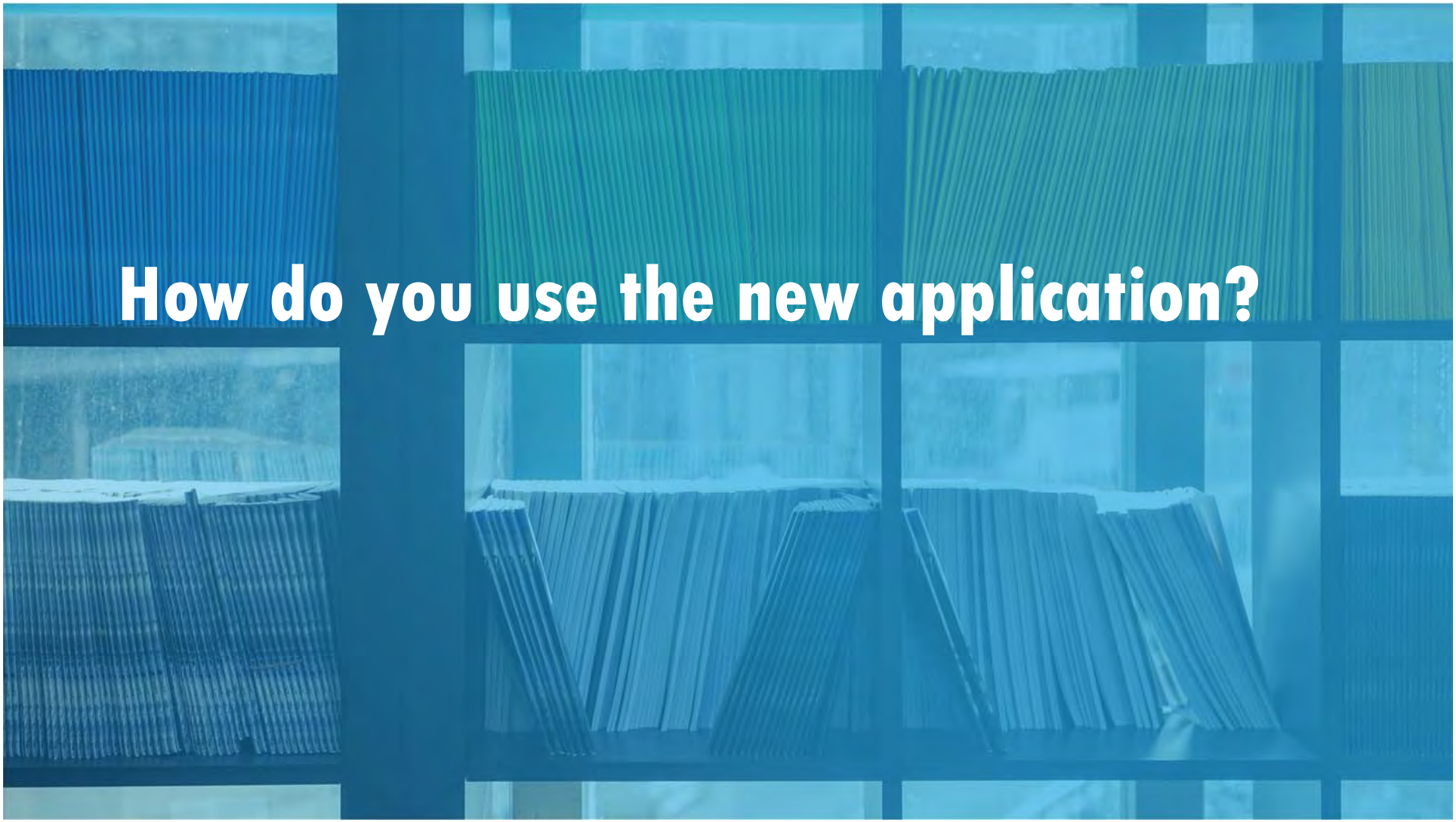
Personalized Risk-Based Management

- Most important risk for CIN 2/3+ is a persistent Hr HPV infection
- When successive rounds of cervical screening are done with HPV-based testing (HPV alone or cotesting), it is possible to determine whether persistent HPV infection is present
- Integrated into CIN 3+ risk estimations that determine management decisions
- Tailored to the individual, rather than relying on the “generic” algorithms that were used in the earlier consensus guidelines



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Mobile App

https://www.asccp.org/mobile-app

The ASCCP Management Guidelines App is Now Available

Streamline navigation of the ASCCP Risk Based Management Consensus Guidelines with the **NEW** ASCCP Management Guidelines App

- Evidence-based management guidelines
- Simple navigation
- Uncomplicated guidance

Available on the App Store

GET IT ON Google Play

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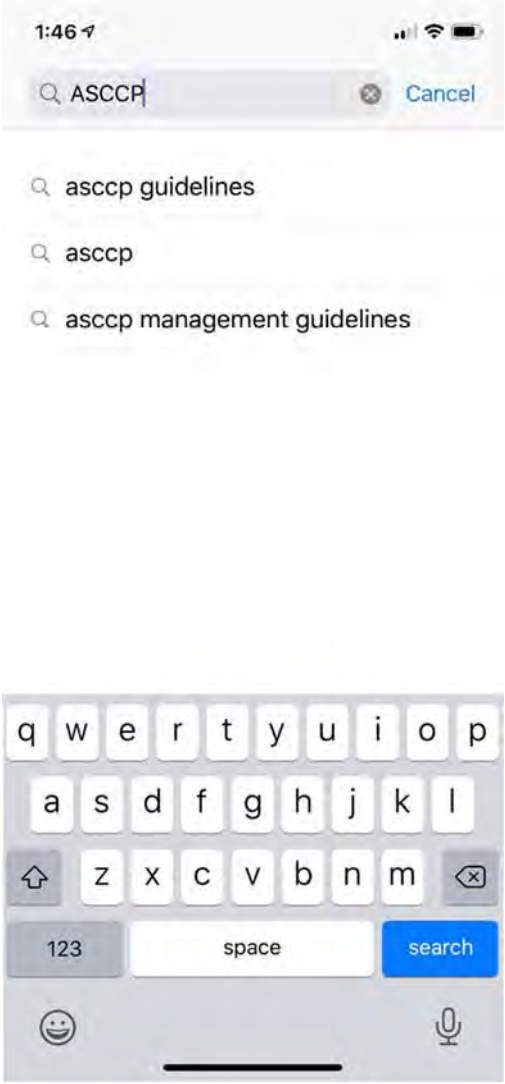

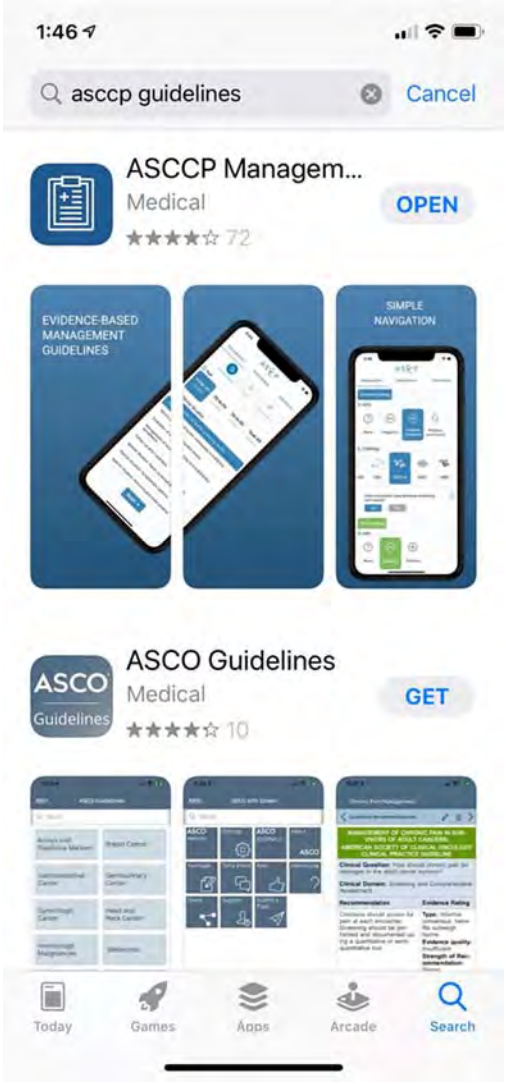

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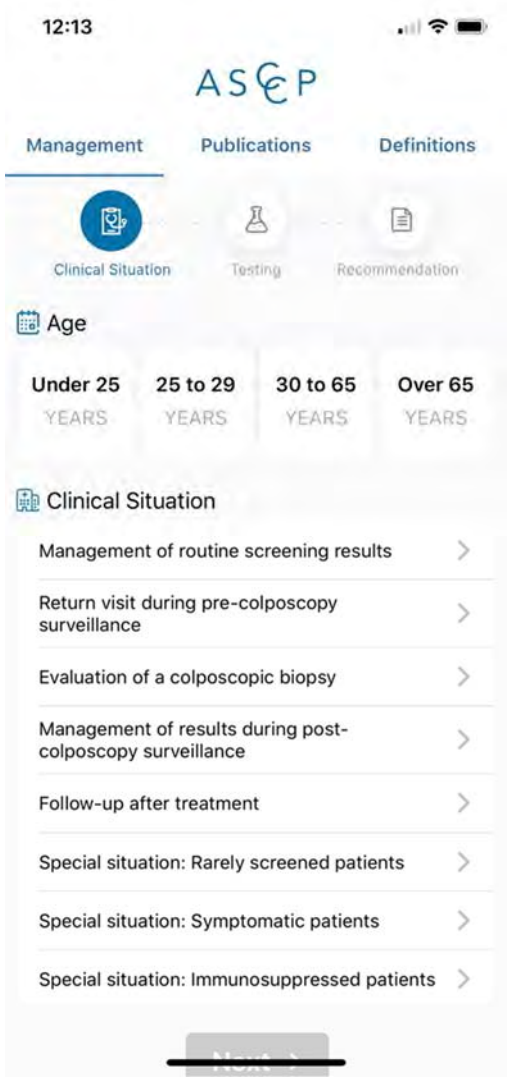

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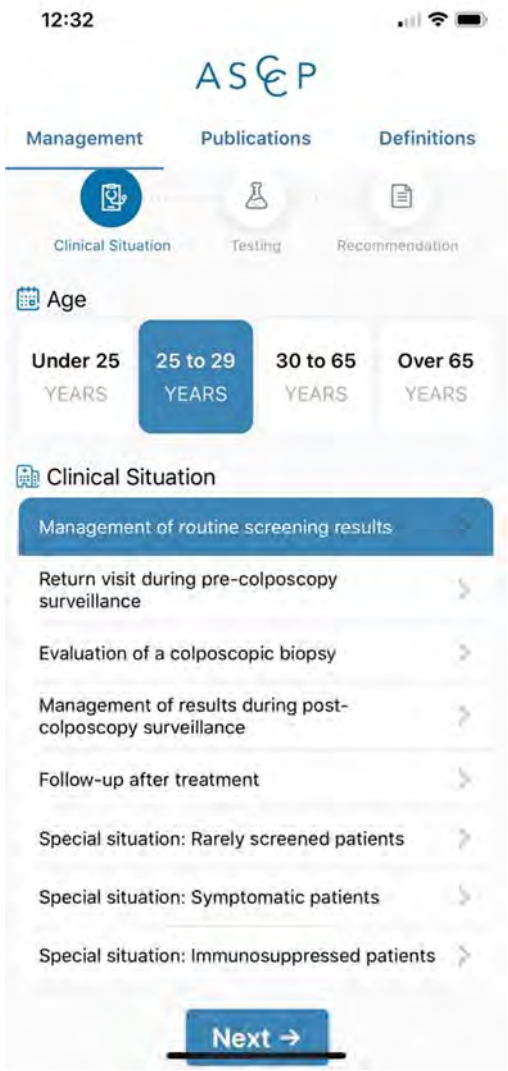

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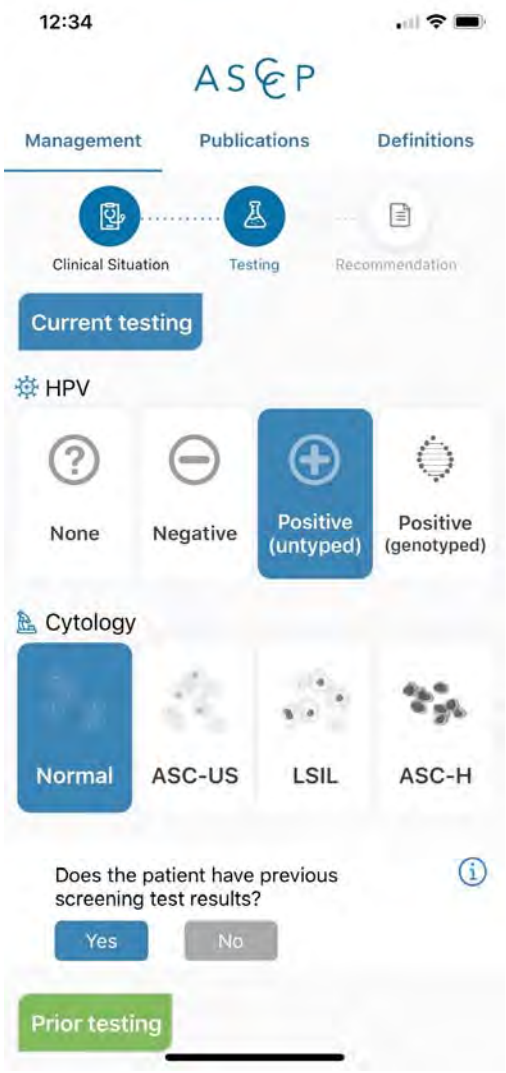

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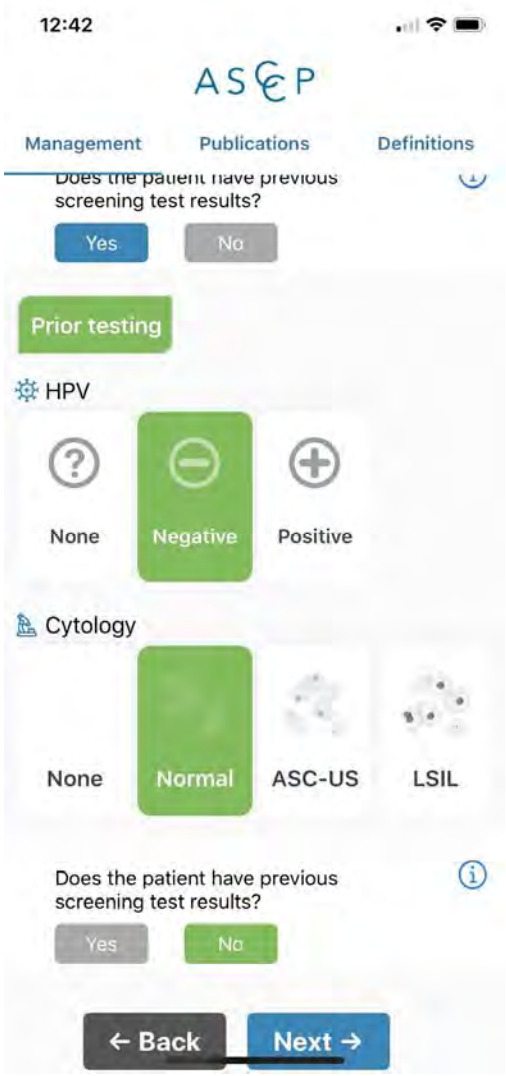

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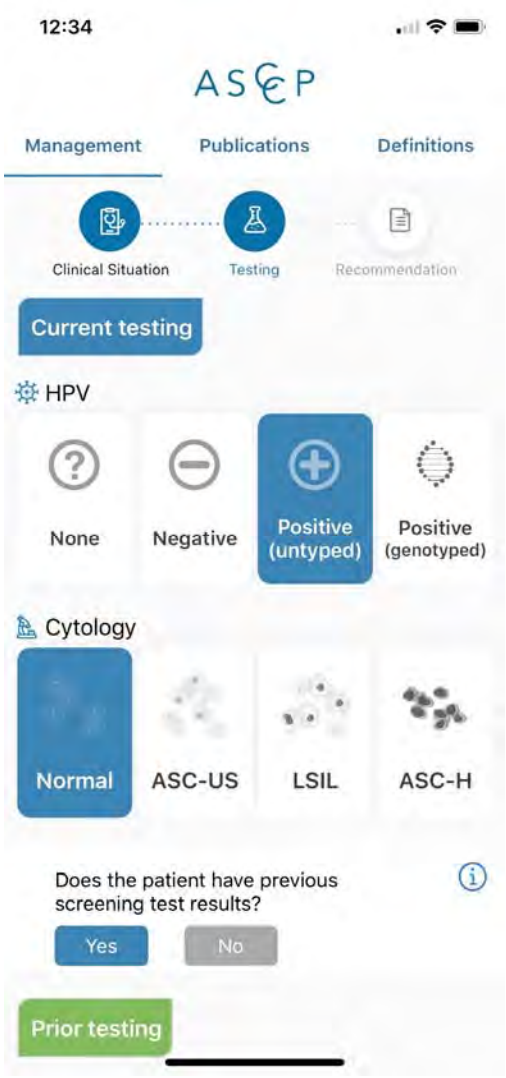

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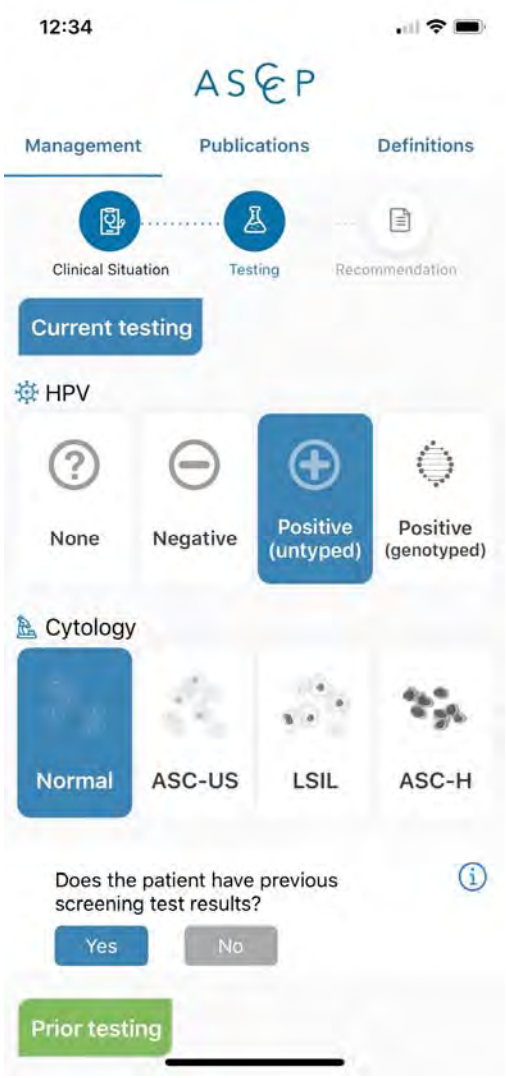
If, at any time, you want to start over from the beginning click on *Management.*



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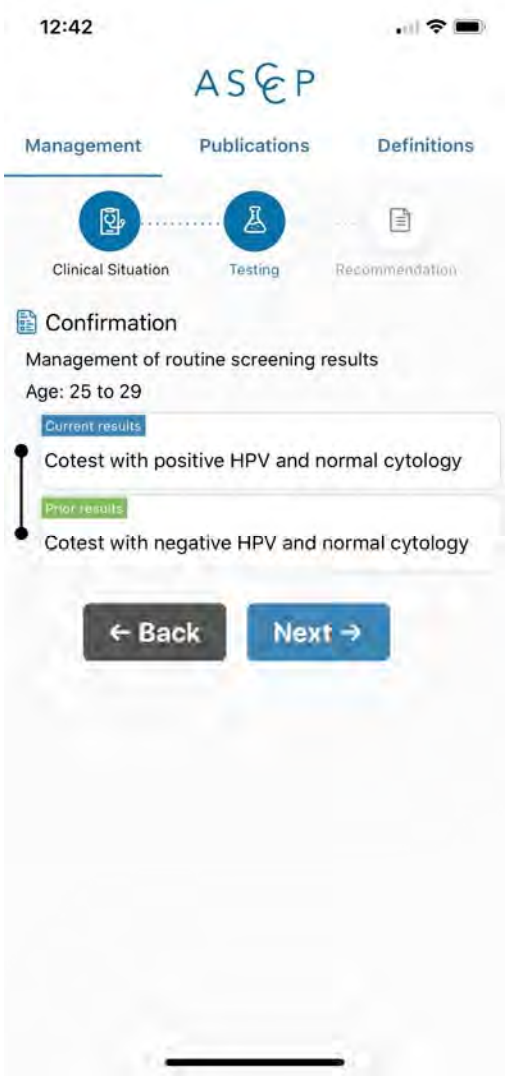

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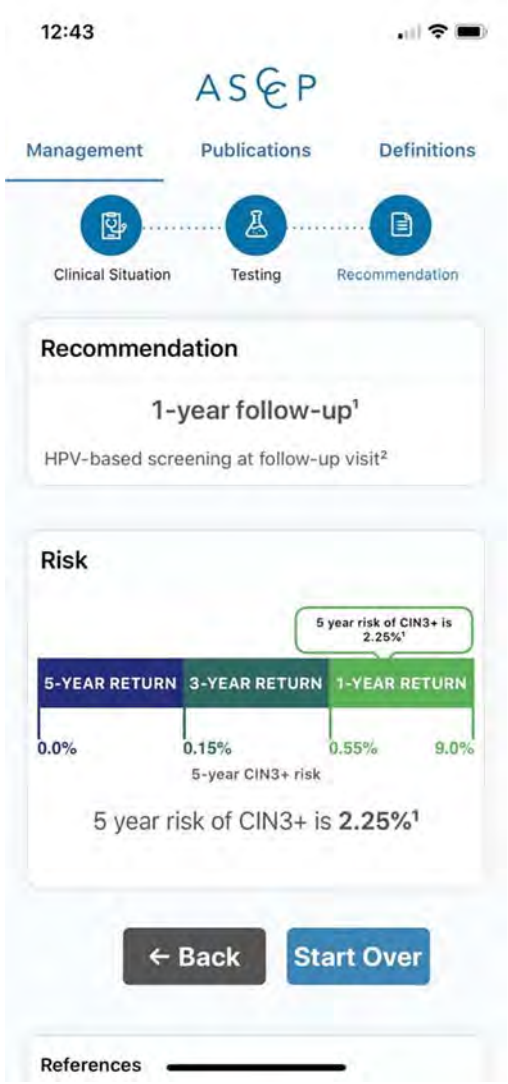
It provides a percent risk and recommendation



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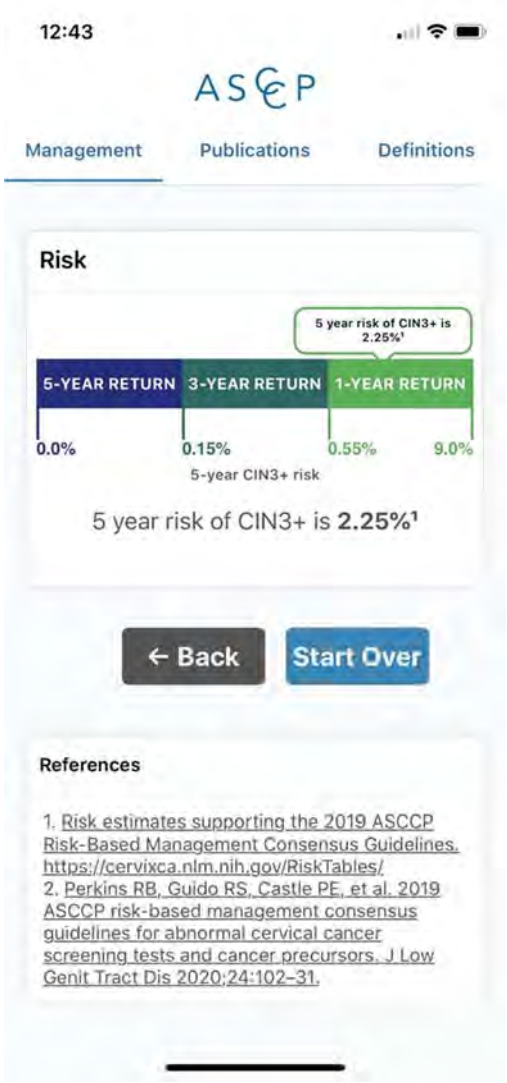
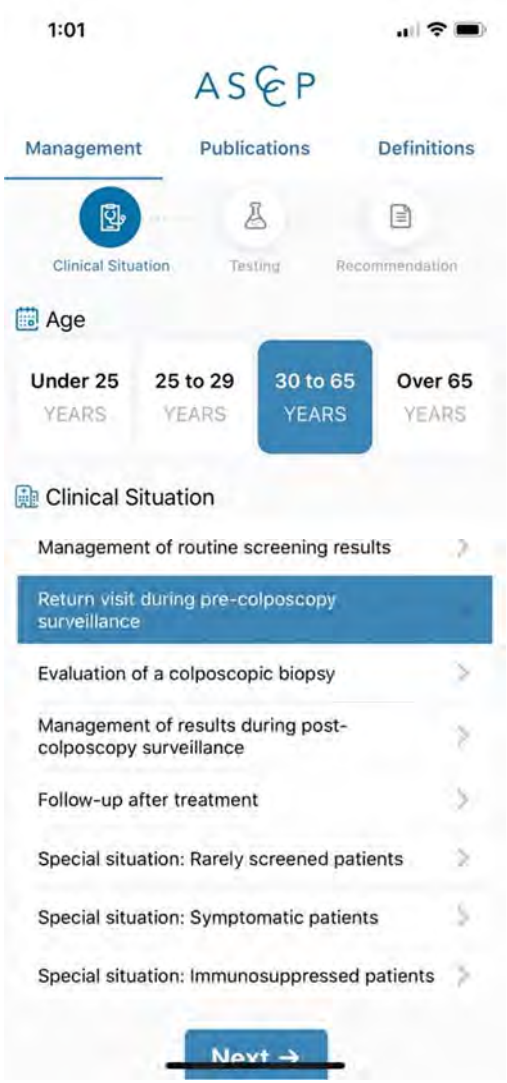
Hyperlink to the article that contains the data upon which the guideline is based



Use this when the person is being followed-up after an abnormal cytology and / or HPV result that did not (yet…) warrant colposcopy



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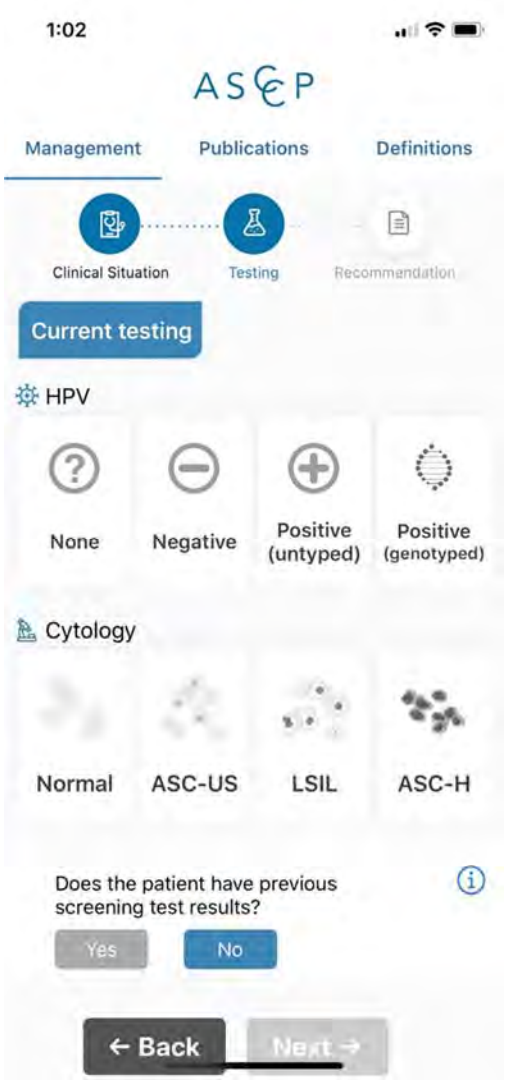

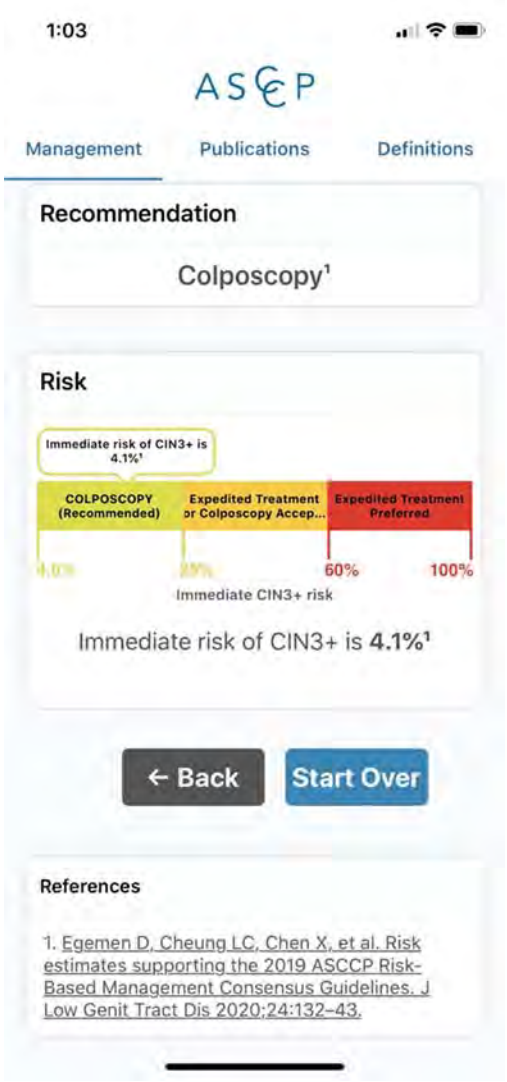

It provides a percent risk and recommendation

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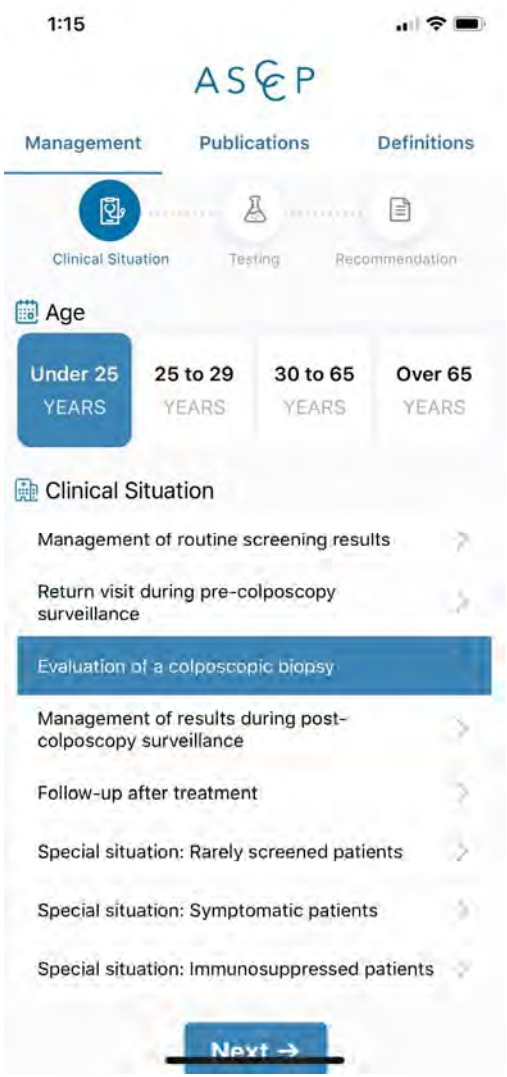
Use to get recommendation when pathology results from the colposcopy are known



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ASCCP

Management | Publications | Definitions

Clinical Situation — Testing — Recommendation

Colposcopy

NO CIN | Histologic LSIL (CIN 1) | Histologic HSIL (CIN 2) | Histologic HSIL (CIN 3) | Histologic HSIL (unspecified) | AIS

← Back | Next →

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1:22

ASCCP

Management | Publications | Definitions

Recommendation

Refer to Algorithm[1]

Consider colposcopy and HPV-based testing at 6 and 12 months, UNLESS lesion is unspecified HSIL, specified CIN3, is not fully visualized or is in the endocervical canal.[1]

Figure

Special populations

Pregnancy

← Back | Start Over

1:20

ASCCP

Management | Publications | Definitions

Clinical Situation | Testing | Recommendation

Recommendation

Treatment[1]

Diagnostic excisional procedure is preferred and ablation is acceptable when the SCJ and the upper limit of lesion(s) are visible during colposcopy.[1]

Figure

Special populations

Pregnancy

1:22

ASCCP

Management | Publications | Definitions

Recommendation

Refer to Algorithm[1]

Observation, Treatment or Review[1]

Figure

Special populations

Pregnancy

← Back | Start Over

References

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With Tremendous Thanks To:

- ASCCP
- Consensus voting participants
- KPNC team
- NCI statistical team
- Steering committee members
- Working group participants

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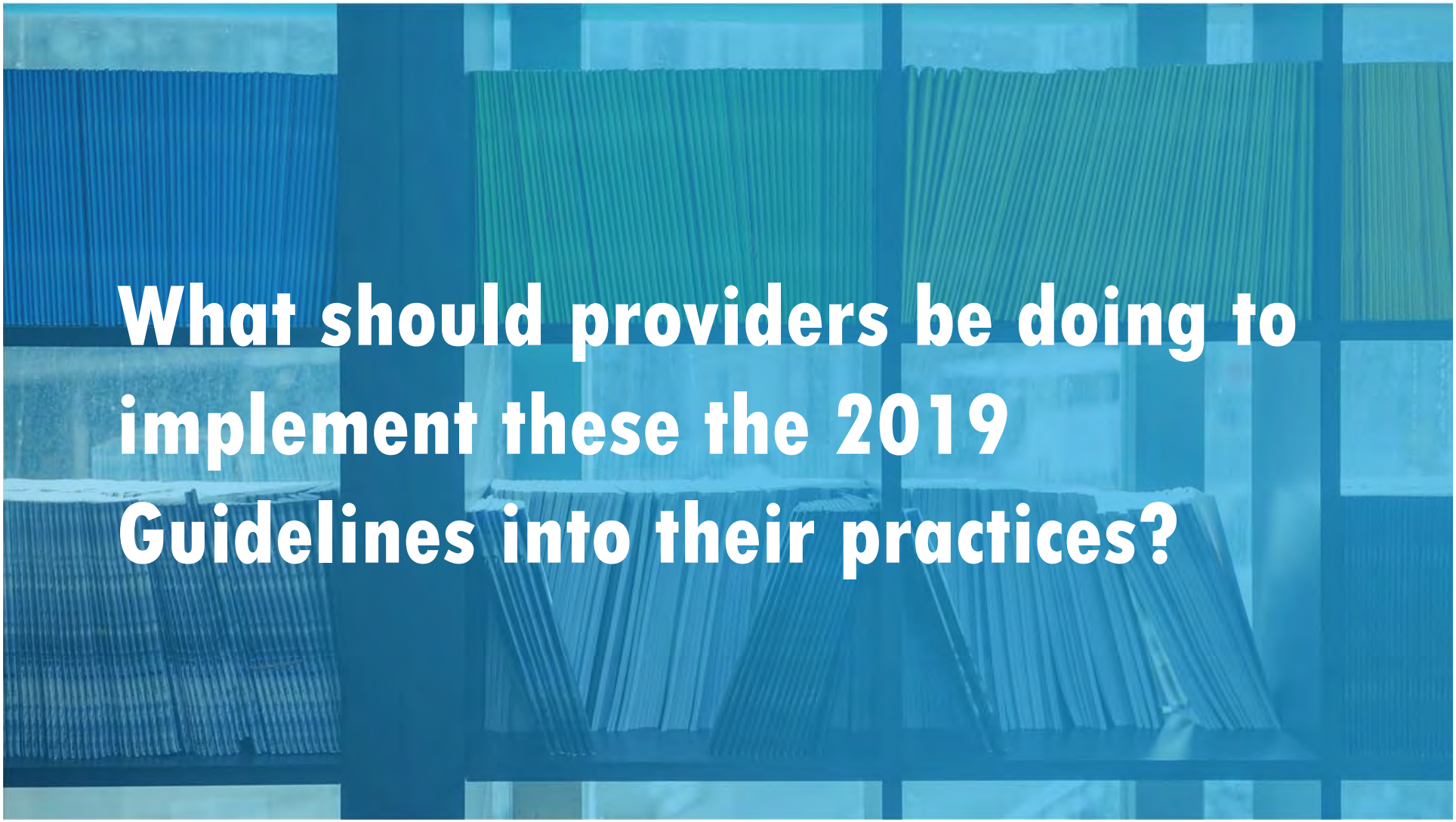

What should providers be doing to implement these the 2019 Guidelines into their practices?

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Implementing the 2019 Guidelines

- Clinicians and staff doing patient follow-up: obtain App
- Update clinic protocols for screening and colposcopy
- Train / in-service staff on the 2019 Guidelines
- Inform patients who are under surveillance that they will be managed based on updated guidelines
- Watch for updated coding and billing state family planning programs, Title X, and commercial health plans

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Resources for Download

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Sawaya G, et al.
JAMA October 2020;
324:1157-8

JAMA Insights | WOMEN'S HEALTH

Managing Minimally Abnormal Cervical Cancer Screening Test Results

George F. Sawaya, MD; Robyn Lamar, MD, MPH; Rebecca B. Perkins, MD, MSc

The approach to cervical cancer screening has changed substantially over the past decade. Current screening strategies for individuals older than 30 years include cytology (Papanicolaou tests), testing for high-risk (oncogenic) types of human papillomavirus (hrHPV), or both (co-testing).[1] However, various possible combinations of test results have led to complex management algorithms, especially for test results considered to be minimally abnormal, defined as results for which it is unclear whether the next step should be colposcopy (a magnified view of the cervix, often with biopsies) or close follow-up. This article provides an update for the approach to the initial management of minimally abnormal cervical cancer screening test results.

Supplemental content

In April 2020, 19 organizations released consensus guidelines that formalized a strategy for management of cervical cancer screening test results using a framework based on estimates of underlying high-grade precancerous lesions or cancer (known collectively as cervical intraepithelial neoplasia grade 3 or worse [CIN3+]).[2] Estimates were derived from screening outcomes observed in more than 1.5 million individuals aged 25 to 65 years enrolled in a prepaid health plan.[3] In this population, about 90% of test results were normal and about 0.75% were severely abnormal. The remainder were minimally abnormal, a category that includes an hrHPV-positive test result with a concurrent normal cytologic interpretation (negative for intraepithelial lesion or malignancy), atypical squamous cells of undetermined significance (ASC-US), and low-grade squamous intraepithelial lesion (LSIL).

Figure. Initial Management for Minimally Abnormal Cervical Cancer Screening Test Results in Average-Risk Individuals[a]

Cytologic test result	hrHPV test result	hrHPV genotyping result	Recommended clinical action
NILM	hrHPV+	HPV-16+ or HPV-18+	Colposcopy
		HPV-16/18 unknown or HPV-16− and HPV-18−	hrHPV testing with or without cytology in 1 y[b]
ASC-US	hrHPV+	HPV-16+ or HPV-18+	Colposcopy
		HPV-16/18 unknown or HPV-16− and HPV-18−	Colposcopy or If hrHPV− within previous 5 y, hrHPV testing with or without cytology in 1 y[b]
	hrHPV unknown		hrHPV testing with or without cytology in 1 y[b]
	hrHPV−		hrHPV testing with or without cytology in 3 y[b]
LSIL	hrHPV+	HPV-16+ or HPV-18+	Colposcopy
		HPV-16/18 unknown or HPV-16− and HPV-18−	Colposcopy or If hrHPV− within previous 5 y, hrHPV testing with or without cytology in 1 y[b]
	hrHPV unknown		Colposcopy
	hrHPV−		hrHPV testing with or without cytology in 1 y[b]
Unknown[c]	hrHPV+	HPV-16+ or HPV-18+ or HPV-16/18 unknown or HPV-16− and HPV-18−	Colposcopy

National
Family Planning
& Reproductive Health Association

Highlights of 2019 ASCCP Risk-Based Management Guidelines

Implications for Family Planning Service Providers

Written by: Michael Policar, MD and Patty Cason, RN, MS, FNP-BC.

Reviewed by: Rebecca Perkins, MD. Associate Professor of Obstetrics and Gynecology, Boston University School of Medicine.

Introduction

In April 2020, the *2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors were published*[1]. This is the 4th edition of management Guidelines, updating the 2001, 2006 and 2012 versions. While they are evolutionary, rather than revolutionary, the new guidelines were developed based on a greater amount of longitudinal data derived from a larger database than was previously available [2,3] and validated against several other databases. This resulted in significant changes in the content of the recommendations which are now consistently based on estimated risk for combinations of current and past results. Methods of accessing management recommendations have shifted in comparison to the earlier versions to facilitate access.

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SF General Dysplasia Clinic

Zuckerberg San Francisco General Hospital Cervical Dysplasia Clinic Guidelines, 2021

Disclaimer: *These guidelines are based on USPSTF (2018), ACOG (2016, 2020), ASCCP (2019) and SGO (2020) recommendations. They are provided as an abbreviated version of the more detailed guidelines in an effort to increase efficiency and ease of use. They are not an absolute substitution for the more detailed guidance offered in the original source documents or for clinical judgment in the care of individual patients.*

Table 1: Cervical cancer screening as recommended by the USPSTF (2018) and ACOG (2016) for average-risk individuals[a]

Age to begin	**21** regardless of sexual history[b]
Method and interval, by age	**Ages 21-65:** Cytology every 3 years or **Ages 21-29:** Cytology every 3 years **Ages 30-65:** HPV testing with or without cytology every 5 years *Note: Must use an FDA-approved HPV test for primary screening (cobas, Onclarity)*
Age to end	**65** if 3 consecutive normal cytology results or 2 consecutive normal cytology plus HPV test results within the prior 10 years, with the most recent normal test within the prior 5 years.[c]

[a]Average-risk defined as no prior diagnosis of cervical intraepithelial neoplasia grade 2 or a more severe lesion, those who are not immunocompromised (e.g., HIV infected) and those with no *in utero* exposure to diethylstilbestrol (for whom annual cytology is recommended by ACOG).
[b]American Cancer Society (ACS, 2020) recommends beginning at age 25.
[c]ACS 2020 specifies no abnormal test results within the prior 10 years and adds the ending criterion of 2 consecutive negative HPV test results alone. Note that screening continuation is advised for at least 25 years after treatment of CIN2 or 3, even if screening extends past age 65.

Special populations	
Pregnant	Screening as above.
After total hysterectomy, no prior CIN2+	Screening should not be performed.
After total hysterectomy, CIN2+ within the prior 25 years	HPV testing with or without cytology every 3 years for at least 25 years or Cytology annually for at least 25 years
Individuals with immunocompromise (ACOG 2016: HIV infection, after solid-organ transplantation; ASCCP 2019: above plus after stem cell transplantation; systemic lupus erythematosus; rheumatoid arthritis on medications; inflammatory bowel disease on medications)	**Age to begin:** Within 1 year of onset of sexual activity or, if already sexually active, within the first year after HIV diagnosis but no later than 21 (regardless of sexual history) **Age to end:** None **Method and interval, by age:** **Ages 21-65:** Cytology annually; after 3 consecutive normal cytology tests, may screen every 3 years or **Ages 21-29:** Cytology annually; after 3 consecutive normal cytology tests, may screen every 3 years **Ages 30-65:** Cytology plus HPV testing every 3 years
Prior invasive cervical cancer	Surveillance as per gynecologic oncology protocols

Abbreviations: USPSTF, US Preventive Services Task Force; ACOG, American College of Obstetricians and Gynecologists, HPV, human papillomavirus; CIN2+ cervical intraepithelial neoplasia grade 2, 2/3, 3, AIS or cancer.

Sawaya GF; Smith-McCune K; Lamar R. Perron-Burdick M. Finalized 17 Oct 2020. Do not use after 31 Dec 2021

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Questions?

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At the end of the eval, you will get a link that you will place into your browser to get to the CE site and pay the $20 fee.

Questions? Contact us at learningexchange@essentialaccess.org

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Upcoming Events

Cervical Cancer Screening and Prevention Webinar Series

Webinar 3: Patient-centered Conversations About HPV and Abnormal Test Results: Evidence-Based, and Efficient
December 4, 2020 - 12:00 PM - 1:30 PM

Webinar 4: Challenging Case Studies in the Implementation of the Risk Based Management Guidelines
December 11, 2020 - 12:00 PM- 1:30 PM

Family Planning Health Worker Virtual Certification Training

Blends online modules and 4 instructor-led Zooms over a 4-week period
Thursdays in January and February 2021

Women's Health Update 2021 Virtual Conference
March 2, 2021 – Mark your calendar!!

Register at essentialaccesstraining.org for these and other Online Courses and On-Demand Webinars via our Learning Portal

Questions? Contact us at learningexchange@essentialaccess.org

References

- Perkins RB, et al. 2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors. Journal of Lower Genital Tract Disease, 2020; 24(2):102-131.
- Egemen D, et al. Risk Estimates Supporting the 2019 ASCCP Risk-Based Management Consensus Guidelines. Journal of Lower Genital Tract Disease.2020; 24(2):132-143.
- Cheung LC, et al. 2019 ASCCP Risk-Based Management Consensus Guidelines: Methods for Risk Estimation, Recommended Management, and Validation Journal of Lower Genital Tract Disease. 2020;24(2):90-101.
- Massad LS, et al. 2012 ASCCP Consensus Guidelines Conference. Obstet Gynecol. 2013 Apr;121(4):829-46.

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References

- Wentzensen N, et al. ASCCP Colposcopy Standards: risk-based colposcopy practice. J Low Genit Tract Dis 2017; 21:230-4.
- Wentzensen N, et al. Evidence-based consensus recommendations for colposcopy practice for cervical cancer prevention in the United States. J Low Genit Tract Dis 2017; 21:216-22.
- Perkins RB, Fuzzell LN, et al. Incorporating Stakeholder Feedback in Guidelines Development for the Management of Abnormal Cervical Cancer Screening Tests. J Low Genit Tract Dis. 2020;24(2):167-177.