

## **An Update on Cervical Cancer Screening and Prevention in Alabama**

**Satellite Conference and Live Webcast  
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## **Faculty**

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## **Cervical Cancer: Scope of the Problem and Missed Opportunities**

- **There are no conflicts of interest for this presentation**

## **Objectives**

- **Understand the scope of the problem of cervical cancer in the US and Alabama**
- **Understand ways of decreasing missed opportunities of screening women for cervical cancer**
- **Understand the importance of offering or referring young women for the HPV vaccine**

**The use of the pap smear  
for cervical cancer  
screening has decreased  
the rate of cervical cancer  
greater than 75%**

**Devesa SS, et al., 1987**

### **Incidence Trends**

- From 2002 to 2011 in the United States, the incidence rate of cervical cancer:
  - Decreased significantly by 1.8% per year among women
  - Decreased significantly by 1.2% per year among white women
  - Decreased significantly by 2.7% per year among black women

### **Incidence Trends**

- Decreased significantly by 3.9% per year among Hispanic women
- Remained level among American Indian/Alaska Native women
- Decreased significantly by 3.2% per year among Asian/Pacific Islander women

### **Mortality Trends**

- From 2002 to 2011 in the United States, the death rate from cervical cancer:
  - Decreased significantly by 1.1% per year among women
  - Decreased significantly by 0.8% per year among white women
  - Decreased significantly by 2.3% per year among black women

### **Mortality Trends**

- Decreased significantly by 2.2% per year among Hispanic women
- Remained level among American Indian/Alaska Native women
- Decreased significantly by 3.0% per year among Asian/Pacific Islander women

### **Cervical Cancer Rates**

- Cervical cancer incidence rate in Alabama ranks third highest in the United States
- Cervical cancer mortality rate in Alabama ranks seventh highest

### **Behavioral Risk Factors Surveillance System 2012**

- 7 out of 10 women, who have not been screened in the last 5 years, have had a regular doctor and health insurance
- More than half of all new cervical cancers occur in women, who have never been screened or have not been screened, in the 5 years prior to diagnosis

**The mean number of opportunities to be screened in the 5 years before diagnosis was 17.8**

Decker K, et al., 2009

### **Cervical Cancer Statistics**

- In 2014, only 36.8% of adolescent females in Alabama have had greater than or equal to three HPV vaccine doses
- Cervical cancer screening is provided more consistently in urban areas than in rural areas

– Harlan LC et al., 1991

### **Cervical Cancer Statistics**

- In the United States, only 23.2% of women 18-26 years of age had at least one HPV vaccine dose

– Williams WW et al., 2013

### **Women Who Had Insurance, Who Did Not Have Pap Smears, in a 3 Year Period:**

- 87% had at least one doctor's visit
- Had an average of 25 health insurance claims
- 44% of claims were with primary care providers

Chattopadyay SK et al., 2005

**Many women with late-stage cancer had pap smears with abnormal results and were lost to follow up**

### **Opportunities**

- Screen or refer all women in your practice according to published guidelines
- Know the screening guidelines
  - Be careful not to waste limited resources by screening more frequently, but by all means, screen when appropriate!

### **Opportunities**

- Educate women regarding the importance of screening
  - Address barriers and fears
- Design a system that ensures proper follow up and limits the “lost to follow up patients”

### **Opportunities**

- Strongly recommend and educate preteens and teens regarding the importance of the HPV vaccines
  - Administer or refer them for the vaccine

### **Management of Abnormal Pap Smears**

### **Objectives**

- Know how to manage abnormal pap smears in women 21-24 years of age
- Know the initial work up and subsequent management in women with Atypical Glandular Cells pap smears
- Know when it is appropriate to perform a pap smear after a woman has a hysterectomy
- Know how to manage abnormal pap smears after hysterectomy

- There are no conflicts of interest for this presentation

- 2012 Updated Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Tests and Cancer Precursors
- American Society for Colposcopy and Cervical Pathology

– Massad LS et al., 2013

### **Unsatisfactory Cytology**

- **Unsatisfactory results are usually from insufficient squamous cells**
- **HPV testing can not be relied upon in this situation**

- **Women with insufficient, or absence of, endocervical cells or transformation zone, are not at increased risk of CIN3+**

- **An ASC-US, HPV negative pap is considered abnormal and cannot be used as an exit for screening**

- **If LSIL, HPV negative then repeat co-testing in one year is preferred**
- **In postmenopausal women with LSIL and no HPV test, options include HPV testing, repeat cytology in 6-12 months, or colposcopy**

- **In women 21-24 years of age and HSIL, see and treat is unacceptable**

- **AGC (favor neoplasm) or AIS with initial colposcopy showing no invasive disease, then diagnostic excisional procedure is recommended and ECC is preferred**

- **ECC that shows CIN1 should not be treated as a traditional “positive ECC”**

- **If CIN1 or no lesion preceded by “lesser abnormality” and either:**
  - 1. Colposcopy is inadequate**
  - 2. ECC contains CIN2+ or is ungraded CIN or**
  - 3. Has previously been treated**
- **Then diagnostic excisional procedure is recommended**

- **If HSIL persists for 24 months without identification of CIN2+, then a diagnostic excisional procedure is recommended**

- **Regardless of antecedent cytology, treatment of CIN1 in women aged 21-24 is not recommended**

- **Women with unambiguous CIN3 have the immediate precursor to invasive cancer and should not be observed, regardless of age or concern about future fertility**

- **Hysterectomy is unacceptable as primary therapy for CIN2, CIN3, or CIN2,3**
- **For CIN2, CIN3, or CIN2,3 routine screening is recommended for at least 20 years, even if this extends screening beyond 65 years of age**

- If CIN2, CIN3, or CIN2,3 is identified at the margins of a diagnostic excisional procedure, or in an endocervical sample obtained immediately after the procedure, then hysterectomy is acceptable if a repeat diagnostic procedure is not feasible

- A repeat diagnostic excisional procedure or hysterectomy is acceptable for women with a histologic diagnosis of recurrent or persistent CIN2, CIN3, or CIN2,3

- Colposcopic changes associated with AIS can be minimal
- AIS frequently extends into the endocervical
- AIS can be multifocal and discontinuous

- CKC or LEEP may be used, but care must be taken to keep the specimen intact and the margins interpretable, avoiding fragmentation of the specimen, including “top hat” serial endocervical excisions

- Asymptomatic women with a history of hysterectomy for benign disease, and no history of CIN2+, require no further screening

• Khan MJ et al., 2015

- I. In women without a history of CIN2+ who are inappropriately screened after hysterectomy, or women with a history of CIN2+ after completing 20 years of surveillance following CIN2+ who have either:

- A. ASCUS, hrHPV positive
- B. LSIL
- C. Normal cytology, hrHPV positive

Then:

- 1. Repeat co-testing in 1 year or**
- 2. Repeat cytology every year for 2 years is recommended**

- I.D. Then:  
If co-testing for 1 year or cytology for 2 years is negative, then cessation of screening is recommended**
- I.E. Alternatively, if ASC-US or LSIL and HPV 16/18 positive, then vaginal colposcopy**

- I.F. If persistent VaIN1/LSIL, for 2 years in women inappropriately screened, then may extend screening to every 2-3 years**

- II. For any woman with a history of hysterectomy and an AGC, ASCH, or HSIL pap smear, vaginal colposcopy is recommended**

- III. Follow up after treatment for CIN2+ (including if hysterectomy)**
  - A. Co-testing at 12 and 24 months**
  - B. If both are negative, then retest in 3 years**
  - C. Then if all tests are negative, routine screening for at least 20 years**

- III.D. If VaIN1/LSIL or p16 negative VaIN2, defer colposcopy and repeat co-testing in 12 months**



**III.E. If VaIN1/LSIL is persistent in women post treatment for CIN2+, HSIL/VaIN3, or p16 positive VaIN 2, repeat co-testing in 1 year**

**F. Then if cytology is greater than or equal to LSIL or hrHPV positive, vaginal colposcopy**

**• Treatment is recommended for histology of HSIL/VaIN3/p16 positive VaIN2**

### **References**

- Charts for Management of Abnormal Pap Smears Section – American Society of Colposcopy and Cervical Pathology**