Dr Alice Dobinson, Gynaecologist

Cervical Cancer Prevention in 2022

In December 2017 – 5 years ago, The National Cervical Screening Program changed from a 2 yearly screening regime utilising cytology to a 5 yearly HPV screening with recourse to liquid based cytology for women with oncogenic HPV. There was a shift in age group also as the new program included women aged 25-69 years and existing testing up to 74 years. HPV testing every 5 years is more effective with equivalent safety and was expected to show a reduction between 24-36% in incidence and mortality from cervical cancer in Australian women compared to the 2 yearly screening which it usurped. Intuitively, a two yearly screening test would at first blush seem more likely to have a higher sensitivity, however the combination of pap smears utilising cytology, which actually has a significant false-negative rate and the well-established extremely low chance of developing cervical cancer in the absence of "high risk" oncogenic types of HPV, sits behind the success of the new screening program. This guideline has been updated in January most recently and comes into effect on the first of July this year. The following are the points from this voluminous document which I believe have changed recently and warrant mention.

The guidelines are easily accessible through: https://www.cancer.org.au/clinical-guidelines/cervical-cancer-screening/?title=Guidelines:Cervical_cancer/Screening

The graphical depictions of how to manage each of the screening detected abnormalities are a wonderfully efficient resource that can quickly help direct appropriate management. Though it is a hefty document to read through, specific situations – for example pregnancy, are quite easily accessible.

At the time of the guideline shift, the national registry of pap smears also shifted and helpfully, when accessed through PRODA, a convenient snapshot of a woman's cervical screening background can be accessed. For those times where a woman isn't sure if she is due for another smear or what the result of her last screening test was, this is an efficient and valuable resource for clinicians. Understanding the context in which the abnormal CST sits is important.

There was a slight change in the recommendations in February 2021, which relates to the management of HPV other. It is now the case, that unless the woman is over 50, Indigenous or was overdue for more than 2 years, referral for colposcopy is not indicated now until there is a 3rd finding of HPV, where CST's are taken at 12 month intervals. If at any point during this follow-up the LBC returns with a finding LSIL or HSIL, the woman will require referral.

Until the most recent update, there has been an option for self-collection of a HPV sample for women who were over 30, under-screened (more than 2 years overdue), or never screened women. This has changed in the newest version to now include all women where screening is indicated. Currently, only around 63% of eligible women are up-to-date with the screening recommended by the NCSP. The expansion of self-collection aims to increase participation and equitably accelerate Australia's progress towards the elimination of cervical cancer.

Abnormal bleeding is a common presentation. It is important to keep in mind that for women experiencing postcoital, intermenstrual or post-menopausal bleeding, though a cervical screening test may be undertaken, this is something different to "screening". These guidelines now offer a guide around outlining the management of these presentations. My summary of these recommendations is:

- **Postcoital bleeding:** cervical cancer needs to be excluded. All women with this symptom should have a co-test and a chlamydia test. If the bleeding is a "one off" event, and the above tests are normal, than a referral to a gynaecologist is not warranted. If the bleeding is persistent or recurrent, even if the above tests are normal, she should still be referred.
- **Persistent unexplained abnormal bleeding patterns**: should have STI check, co-test and transvaginal ultrasound, and a referral for gynaecological assessment should be undertaken.
- **Postmenopausal bleeding:** is abnormal and always requires investigation. Because bleeding can affect sensitivity of tests, the co-test should be performed in this situation, a transvaginal ultrasound and referral to a gynaecologist.

There are two other important groups of women to have on your radar – these are women who are immunocompromised secondary to HIV or treatment with immunosuppressant drugs to prevent transplant rejection. These women have a higher risk of HPV progression to cervical cancer, the guidelines recommend for these specific groups to have HPV testing every 3 years. Finally, if you have done a speculum examination and you hold a clinical suspicion of cervical abnormality, even if the CST returns with no abnormality detected, trust your clinical acumen, and refer for colposcopy as a biopsy may be indicated.

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About Dr Alice Dobinson

Dr Alice Dobinsonis an experienced Obstetrician Gynaecologist. Dr Dobinson enjoys all aspects of general gynaecology including postmenopausal and perimenopausal bleeding issues, contraceptive advice, menopausal symptom management, ovarian cysts and cervical screening follow-up issues. She has a special interest in persistent pelvic pain. Alice is passionate about women's health and is known for empathetic, evidence-based care.

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