

ACP Releases Best Practice Advice on Screening for Cervical Cancer

Key Points for Practice

- Cytology without HPV testing should be performed every three years starting at 21 years of age to screen for cervical cancer.
- Cytology with HPV testing may be performed starting at 30 years of age to increase screening intervals to every five years.
- Screening should stop after 65 years of age in the setting of three consecutive negative cytology results or two consecutive negative cytology plus HPV cotesting results, with the most recent test performed within the previous five years.

From the AFP Editors

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This series is coordinated by Sumi Sexton, MD, Associate Deputy Editor.

A collection of Practice Guidelines published in AFP is available at <http://www.aafp.org/aafp/practguide>.

Screening for cervical cancer has likely contributed to decreased incidence and mortality rates of the disease over the past several decades. However, the medical cost of screening is substantial. New evidence-based guidelines aim to minimize the harms of overscreening while maximizing benefit. Based on the best available evidence, the American College of Physicians (ACP) has released best practice advice on cervical cancer screening in average-risk, asymptomatic women 21 years or older. This advice is targeted to all clinicians, and refers to screening for cervical precancerous and cancerous lesions detected on cytology and other tests for high-risk types of human papillomavirus (HPV). This advice is supported by the American Congress of Obstetricians and Gynecologists and endorsed by the American Society for Clinical Pathology.

Best Practice Advice

ACP's best practice advice focuses on increasing the age at which to begin screening, increasing the screening interval, and discontinuing screening in low-risk women.

(1) *Clinicians should not screen average-risk women younger than 21 years.* This applies regardless of sexual history. Cytologic abnormalities are common in this age group, but clinically important cervical lesions are rare.

If screened, many women younger than 21 years will have colposcopy and biopsy, with some treated for lesions with a high likelihood of regression.

(2) *Clinicians should begin screening average-risk women at 21 years of age once every three years with cytology (cytologic testing without HPV tests).* HPV testing is not recommended in this age group because of the high prevalence of HPV infection.

(3) *Clinicians should not screen average-risk women with cytology more often than once every three years.* Annual screening is no longer recommended because of increased rates of false-positive results with minimal effect on subsequent cancer. The average time for a high-grade precancerous lesion to progress to cancer is 10 years. The three-year interval allows sufficient time for identification and treatment.

(4) *Clinicians may screen using a combination of cytologic and HPV testing once every five years in average-risk women 30 years or older who prefer longer screening intervals.* This strategy, known as cotesting, is an alternative to cytology alone. The rationale for this approach is that women with normal cytologic results and no evidence of high-risk HPV are at low risk of cervical cancer; therefore, the screening interval may be safely extended to five years.

(5) *Clinicians should not test for HPV in average-risk women younger than 30 years.* HPV testing alone or in combination with cytology is not recommended for primary screening in this population. The U.S. Preventive Services Task Force qualifies this as a grade D recommendation, because there are likely no net benefits or the harms outweigh them.

(6) *Clinicians should discontinue screening average-risk women older than 65 years after three consecutive negative cytology results, or ►*

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two consecutive negative cytology plus HPV test results within 10 years, if the last one was performed within the previous five years. Cervical cancer is uncommon in older women who have had normal previous screening results, although the chance of false-positive results with consequent invasive interventions continues.

(7) *Clinicians should not screen average-risk women of any age after hysterectomy with removal of the cervix.* After surgical removal of the cervix, the risk of cervical cancer is zero, making screening in these patients extremely low-value.

Talking Points with Patients

When discussing cervical cancer screening with patients, clinicians should explain that beginning screening too early can lead to testing and treating lesions that may resolve on their own. Screening more often than

every three years increases the chance of false-positive test results and invasive procedures while offering little benefit. In low-risk women older than 65 years, continuing cervical cancer screening provides little to no benefit with the potential for invasive procedures. After hysterectomy with removal of the cervix, patients can be reassured that there is no risk of cervical cancer.

Guideline source: American College of Physicians

Evidence rating system used? No

Literature search described? No

Guideline developed by participants without relevant financial ties to industry? Yes

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MARA LAMBERT, *AFP* Senior Associate Editor ■

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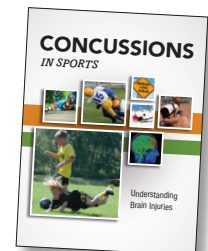


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