New Cervical Cancer Screening Recommendations from the U.S. Preventive Services Task Force and the American Cancer Society/American Society for Colposcopy and Cervical Pathology/American Society for Clinical Pathology

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Today, new recommendations for cervical cancer screening are being released by two separate groups: the U.S. Preventive Services Task Force (USPSTF) and a multidisciplinary partnership among the American Cancer Society/American Society for Colposcopy and Cervical Pathology/American Society for Clinical Pathology (ACS/ASCCP/ASCP). The USPSTF recommendations will be published in the March 15, 2012, issue of *Annals of Internal Medicine* and are available at the USPSTF website (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). The ACS/ASCCP/ASCP recommendations will be presented March 15, 2012, at the ASCCP 2012 Biennial Meeting and will be published in *CA: A Cancer Journal for Clinicians,* the *Journal of Lower Genital Tract Disease,* and the *American Journal of Clinical Pathology*. As published by ACS, the guidelines are available here: http://onlinelibrary.wiley.com/journal/10.3322/(ISSN)1542-4863.

What do the two groups recommend?

Key recommendations in the guidelines are shown in the below Table. Although the two sets of guidelines were developed independently, they are generally consistent.

Table: USPSTF and ACS/ASCCP/ASCP Guidelines at a Glance*

Population†	USPSTF ‡	ACS/ASCCP/ASCP§
Younger than 21 years	Recommends against screening. Grade: D recommendation.	Women should not be screened regardless of the age of sexual initiation or other risk factors. ?
21–29 years	Recommends screening with cytology every 3 years. Grade: A recommendation.	Screening with cytology alone every 3 years is recommended.
30–65 years	Recommends screening with cytology every 3 years or for women who want to lengthen the screening interval, screening with a combination of cytology and HPV testing every 5 years. Grade: A recommendation.	Screening with cytology and HPV testing ("co-testing") every 5 years (preferred) or cytology alone every 3 years (acceptable) is recommended.

Older than 65 years	Recommends against screening women who have had adequate prior screening¶ and are not otherwise at high risk for cervical cancer. Grade: D recommendation.	Women with evidence of adequate negative prior screening¶ and no history of CIN2+ within the last 20 years should not be screened. Screening should not be resumed for any reason, even if a woman reports having a new sexual partner.
After hysterectomy	Recommends against screening in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (ie, CIN 2 or 3) or cervical cancer. Grade: D recommendation	Women of any age following a hysterectomy with removal of the cervix who have no history of CIN2+ should not be screened for vaginal cancer. Evidence of adequate negative prior screening is not required. Screening should not be resumed for any reason, including if a woman reports having a new sexual partner.
HPV vaccinated	Women who have been vaccinated should continue to be screened.	Recommended screening practices should not change on the basis of HPV vaccination status.

* USPSTF, U.S. Preventive Services Task Force; ACS/ASCCP/ASCP, American Cancer Society/American Society for Colposcopy and Cervical Pathology; ASCP, American Society for Clinical Pathology; HPV, human papillomavirus; CIN, cervical intraepithelial neoplasia.

†These guidelines were developed to address cervical cancer screening in the general population. These guidelines do not address special, high-risk populations who may need more intensive or alternative screening. These special populations include women 1) with a history of cervical cancer, 2) who were exposed in utero to diethylstilbestrol (DES), and 3) who are immune-compromised (eg, infection with human immunodeficiency virus).

‡The USPSTF recommendations are based on its assessment of *net benefit*—identified benefits minus identified harms. Interventions that are deemed to have substantial net benefit receive an A grade; interventions with moderate to substantial net benefit receive a B grade; interventions with small net benefit receive a C grade; interventions that have no or negative net benefit (have harms that exceed the benefits) receive a D grade. If the available evidence does not meet USPSTF standards, an "I statement" is issued. Each letter grade is accompanied by a suggestion for practice. For A and B recommendations, the suggestion is to "offer/provide this service." For D recommendations, the suggestion is to "recommend against" the use of this service.

§The majority of recommendations are ''strong,'' meaning that the group is confident that further research would be unlikely to change the recommendation, based on the overall quality of the available evidence, the prospect of obtaining better evidence, and the balance between benefits and harms. The strength of each recommendation is noted in the individual Working Group reports in an online supplement..

?When to begin screening was addressed at the 2009 Practice Improvement in Cervical Screening and Management (PICSM) Symposium on Management of Cervical Abnormalities in Adolescents and Young Women. This question was not part of the review for the new guidelines.

¶Adequate negative prior screening is three consecutive negative cytology results or two consecutive negative co-tests within the 10 years before cessation of screening, with the most recent test occurring within the past 5 years.

What is new about these guidelines?

This is the first time that USPSTF has recommended the combined use of cervical cytology and high-risk human papillomavirus (HPV) DNA testing ("co-testing"). The previous USPSTF guidelines had indicated that evidence was insufficient to make a recommendation regarding the use of co-testing. USPSTF now recommends that women age 30-65 years should be screened by either cytology every 3 years or co-testing every 5 years.

In contrast, ACS/ASCCP/ASCP finds that co-testing every 5 years is *preferred* to cytology alone but that cytology alone every 3 years is an *acceptable* strategy. In choosing to make co-testing the preferred strategy, ACS/ASCCP/ASCP focused on evidence from multiple randomized trials showing that co-testing has improved performance compared with cytology alone. Specifically, co-testing has increased sensitivity for detecting cervical intraepithelial neoplasia grade 3 or greater (CIN3+), and women who have undergone co-testing have a lower risk of CIN3+ and invasive cancer after the first screening round. Because of this improved performance, co-testing can be used for screening at less frequent intervals than cytology alone. In addition, co-testing offers greater risk reduction than cytology alone for adenocarcinoma of the cervix and its precursors.

What is the College's position on these new guidelines?

The College participated in the development of both sets of recommendations. The College serves as a partner organization of the USPSTF and sent official representatives to the symposium at which the ACS/ASCCP/ASCP guidelines were determined. Through these official channels, the College had opportunities to review the preliminary work that led to the recommendations and made comments with the goal of improving women's health. In addition, Fellows of the College served on both the USPSTF and the ACS/ASCCP/ASCP work groups leading to these recommendations, although not as official representatives of the College.

The College applauds the work of these organizations in integrating the significant new evidence that has become available into the revised guidelines. Each set of recommendations was developed under a separate work plan, with its own policies and procedures for evidence collection and analysis. The very similar recommendations are reassuring because although they were developed independently and by different methodology, they drew on a common evidence base, which was interpreted the same way by different groups of experts. The College encouraged and facilitated collaboration among the groups, urging that consistency of message would benefit American women and the clinicians who care for them. This message was clearly heard.

The College now moves to its final phase of evaluating the recommendations. They will be evaluated by committees that make the College's recommendations on screening for cervical cancer. Any new guidelines from the College will be published in *Obstetrics & Gynecology.*

Why do all these organizations—including the College—discourage annual cervical cancer screening?

Cervical cancer is typically slow growing, and most cancers are found in women who have never been screened or who have not been screened in the past 5 years. *Recommending less frequent screening for cervical cancer is not new.* The ACS has recommended less frequent screening for some women since 1980. The College has made similar recommendations since 1989. Note that the new guidelines from USPSTF and ACS/ASCCP/ASCP are for women at *average risk*. More frequent testing may be appropriate for women with conditions that place them at an increased risk of cervical cancer, such as immunocompromise or human immunodeficiency virus (HIV) infection.

These recommendations reflect a balance between benefits and harms. Both cervical cytology and testing for high-risk types of HPV DNA can detect cervical cancer and its precursors, but each will detect many abnormalities that will not go on to become cancer. Annual screening with cytology alone has been shown to lead to a very small increase in cancers prevented but greatly increases the number of unnecessary procedures and treatments. The prevalence of transient HPV infections and associated low-grade lesions is high, but most of these will regress within 1 to 2 years. The small fraction of lesions that do not regress will, on average, require many years to progress to cancer. Identifying and treating lesions that will likely regress on their own does not provide a benefit large enough to outweigh the harms. These harms may include anxiety associated with a "positive" cancer screening test, potential stigmatization from the diagnosis of a sexually transmitted infection, discomfort from additional diagnostic and treatment procedures, bleeding from treatment, and, longer term, an increased risk of pregnancy complications such as preterm delivery in women previously treated with excisional procedures for precancerous lesions. While cost was explicitly *not* considered in the guideline development, increased testing and treatment clearly has associated cost and may be an additional potential harm for some women. Extending the interval for screening strikes the most appropriate balance between benefits and harms.

As noted in the ACS/ASCCP/ASCP guidelines, no screening test has perfect sensitivity, and preventing all cervical cancer is unrealistic. Even with annual cervical cancer screening, a small risk of cancer would remain after screening.

Do these new recommendations mean the end of the annual visit for women?

The revised recommendations do not at all mean the end of the annual visit. The decreased requirement for cervical screening frees up valuable time at the visit, which will facilitate clinicians' ability to address the many other important components of health care screening and evaluation.

Screening for cervical cancer is an important part of ongoing ambulatory care for women, but it is far from the only service provided by obstetrician-gynecologists and other clinicians during a well-woman exam. When screening for cervical cancer is not indicated due to interval since last screen, hysterectomy status, or age, clinicians can instead focus on other health care concerns that will be more valuable to women—instead of spending clinician and patient time on a health care service with limited benefit. For example:

- Adolescents and young women can benefit from counseling on healthy diet, risky behaviors, family planning, and —if they are sexually active—testing for sexually transmitted diseases. The focus for cervical cancer for this age group should be on primary prevention through HPV vaccination.
- Women of reproductive age will benefit from counseling and shared decision making on family planning, including support for consistent, effective use of their chosen method.
- Women in the later reproductive years and perimenopausal women will benefit from counseling on the menopausal transition, osteoporosis prevention, and referral for mammography and colorectal cancer screening.
- Both women of reproductive age and postmenopausal women benefit from ongoing evaluation of continence and pelvic floor function, which can be essential to their health and social functioning.

The well-woman visit has always been more than just a "Pap smear," and the decreased need for cervical screening actually constitutes a minor change to an important aspect of a woman's health care.

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