NORTH CAROLINA
Advisory Committee
on Cancer Coordination and Control

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Cervical Cancer Screening Position Statement

Cervical cancer is the third most common gynecologic malignancy and tenth most common type of cancer of women in the United States (WHO/ICO Summary Report 2010). Globally, more than 500,000 new cervical cancer diagnoses are made annually, with approximately 275,000 deaths, for a mortality rate of 52%. This disparity in cervical cancer incidence and death is attributed in large part to inadequate access to cervical cancer screening and prevention programs in developing countries.

Numerous screening methods have been proposed internationally by various professional societies, including: Pap cytology alone, Pap cytology with HPV testing as triage (HPV testing for atypical squamous cells of unknown significance [ASC-US] on cytology), cytology with HPV co-testing (cytology and HPV testing obtained together), HPV testing alone, or HPV testing followed by Pap cytology triage (cytology in patients who are positive for high risk oncogenic subtypes of HPV). Recommendations for use of cervical cytology and HPV testing continue to vary among professional societies, with variable adoption of these guidelines by providers as well.

In 2012, updated cervical cancer screening recommendations were published by three of the most prominent professional societies in the United States: American Society for Colposcopy and Cervical Pathology (ASCCP), U.S. Preventive Services Task Force (USPSTF), and the American College of Obstetricians and Gynecologists (ACOG). These most recent guidelines show a greater degree of harmony across these governing bodies than prior guidelines. All three professional societies recommend initiating screening at age 21 and ceasing screening at age 65 with an adequate screening history. All groups recommend against HPV co-testing in women under 30 years of age; however, after age 30, ASCCP and ACOG recommend HPV co-testing every five (5) years as the preferred method of cervical cancer screening, while USPSTF suggests this as only an “option.” Primary HPV testing without concurrent cytology for cervical cancer screening is not currently recommended by ASCCP and USPSTF and is not addressed by ACOG.

Current guidelines do not comment specifically on testing for specific HPV subtypes, but most providers do not advocate performing this test, particularly as part of screening. There is ongoing investigation about the various HPV subtypes, their distribution among different populations of women, and whether there may be any clinical benefit in subtyping.

Table: Summary of Screening Recommendations

	ACS / ASCCP	USPSTF	ACOG
Age to begin screening	Age 21. Women aged <21 years should not be screened regardless of the age of sexual initiation or other risk factors. (Strong recommendation)	Age 21. (A recommendation) Recommend against screening women aged <21 years. (D recommendation)	Age 21 regardless of the age of onset of sexual activity. Women aged <21 years should not be screened regardless of age at sexual initiation and other behavior-related risk factors. (Level A evidence)
Annual screening	Women of any age should not be screened annually by any screening method. (Strong recommendation)	Individuals and clinicians can use the annual Pap test screening visit as an opportunity to discuss other health problems and preventive measures. Individuals, clinicians, and health systems should seek effective ways to facilitate the receipt of recommended preventive services at intervals that are beneficial to the patient. Efforts also should be made to ensure that individuals are able to seek care for additional health concerns as they present.	In women aged 30–65 years, annual cervical cancer screening should not be performed. (Level A evidence) Patients should be counseled that annual well-woman visits are recommended even if cervical cancer screening is not performed at each visit.
Screening interval			
Cytology			
21-29 years	Every three (3) years. (Strong recommendation)	Every three (3) years. (A recommendation)	Every three (3) years. (Level A evidence)
30-65 years	Every three (3) years. (Strong recommendation)	Every three (3) years. (A recommendation)	Every three (3) years. (Level A evidence)
HPV co-test			
21-29 years	HPV co-testing should not be used for women aged <30 years.	Recommend against HPV co-testing women aged <30 years. (D recommendation)	HPV co-testing should not be performed in women aged < 30 years. (Level A evidence)
30-65 years	Every five (5} years (Strong recommendation) This is the preferred method (Weak recommendation)	For women who want to extend their screening interval, HPV co- testing every 5 years is an option. (A recommendation)	Every five (5) years; this is the preferred method. (Level A evidence)
Primary HPV testing	For women aged 30-65 years, screening by HPV testing alone is not recommended in most clinical settings. (Weak recommendation)	Recommend against screening for cervical cancer with HPV testing (alone or in combination with cytology) in women aged <30 years. (D recommendation)	Not addressed.
Age to stop screening	Aged >65 years with adequate screening history.	Aged >65 years with adequate screening history. (D recommendation)	Aged >65 years with adequate screening history (Level A evidence)

	ACS / ASCCP	USPSTF	ACOG
Screening after hysterectomy	Women who have had a total hysterectomy (removal of the uterus and cervix) should stop screening. Women who have had a supra-cervical hysterectomy (cervix intact) should continue screening according to guidelines. (Strong recommendation)	Recommend against screening in women who have had a hysterectomy (removal of the cervix). (D recommendation)	Women who have had a hysterectomy (removal of the cervix) should stop screening and not restart for any reason. (Level A evidence)
Need for bimanual pelvic exam	Not addressed in 2012 guidelines but was addressed in 2002 ACS guidelines.	Addressed in USPSTF ovarian cancer screening recommendations (draft).	Addressed in 2012 well-woman visit recommendations. Aged <21 years, no evidence supports the routine internal examination of the healthy, asymptomatic patient. An "external-only" genital examination is acceptable. Aged ≥21 years, no evidence supports or refutes the annual pelvic examination or speculum and bimanual examination. The decision whether or not to perform a complete pelvic examination should be a shared decision after a discussion between the patient and her health care provider. Annual examination of the external genitalia should continue.
Screening among those immunized against HPV 16/18	Women at any age with a history of HPV vaccination should be screened according to the age specific recommendations for the general population.	The possibility that vaccination might reduce the need for screening with cytology alone or in combination with HPV testing is not established. Given the uncertainties, women who have been vaccinated should continue to be screened.	Women who have received the HPV vaccine should be screened according to the same guidelines as women who have not been vaccinated. (Level C evidence)

The NC ACCCC concurs with the American Cancer Society (ACS), ASCCP, ACOG and USPSTF as follows:

1. Screening should be initiated at age 21 and stopped at age 65 as long as the individual in question has had an adequate screening history and negative previous tests

2. There is general consensus against HPV co-testing in women less than 30 years of age; however, after age 30, it is generally recommended that HPV co-testing be continued every 5 years as the preferred method of cervical cancer screening.

3. Primary HPV testing without concurrent cytology for cervical cancer screening is not currently recommended.

This does not apply to women who have been diagnosed with a high-grade precancerous cervical lesion or cervical cancer, women within utero exposure to diethylstilbestrol, or women who have a compromised immune system (e.g., women living with HIV).

Currently, given that the available HPV vaccines do not protect women from all oncogenic HPV types, the ASCCP, USPSTF, and ACOG all recommend screening vaccinated women in an identical fashion to unvaccinated women.

The NC ACCCC recommends that scientific evidence related to cervical cancer screening be re-examined in five years (2024). If, however, compelling evidence regarding screening becomes available before the scheduled review, the NC ACCCC recommends immediate review of the current position statement.

Approved by NC ACCCC. Date: May 17, 2019