BC CANCER CERVIX SCREENING

Provincial Health Services Authority

CERVICAL CANCER
SCREENING, DIAGNOSIS AND MANAGEMENT

DATE: APRIL 2022

PRESENTER: DR. LILY PROCTOR

Disclosures

- None

Objectives

- To review the principles of screening for cervical cancer
- To review the HPV virus and its role in cervical cancer
- To review the diagnosis and management of cervical dysplasia
- To review the diagnosis and management of cervical cancer

Programmatic Screening

Screening for disease is the examination of asymptomatic individuals in order to classify them as likely or unlikely to have the disease that is the object of screening.

People who appear likely to have the disease are investigated further to arrive at a final diagnosis. Those people who are found to have the disease are then treated.

- Morrison AS. Screening in chronic disease. Oxford: University Press. 1992

Principles of Programmatic Screening

- Evidence from well-conducted studies that early detection improves health outcomes;
- There is accepted treatment for patients with recognised disease;
- There is an effective test available;
- Facilities exist for diagnosis and treatment;
- The benefits of screening outweigh any potential harms;
- Prevalence of the disease is high enough to justify the effort and costs of screening.

- World Health Organization

What Causes Cervical Cancer?

Human Papilloma Virus

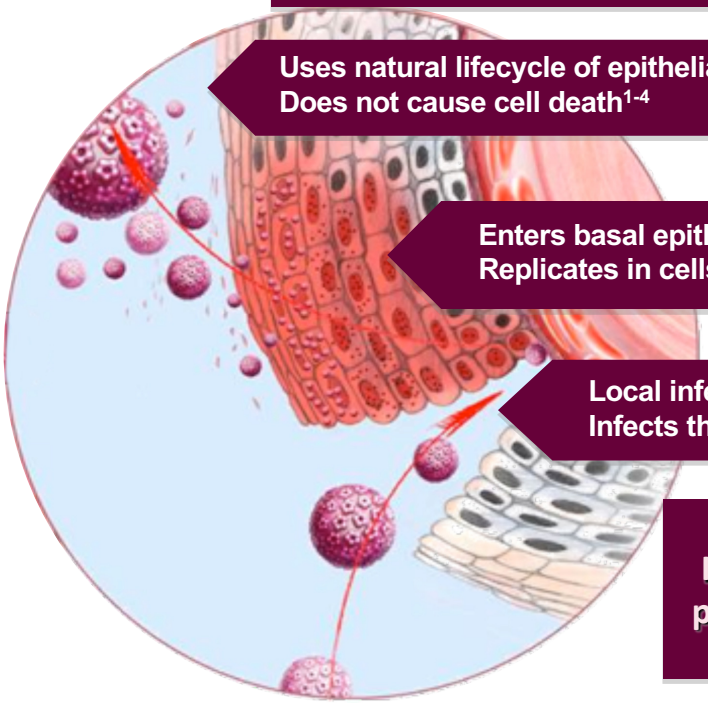
- 99.7% of cervical cancer is caused by the persistence of HR-HPV
- HPV 16 and 18 – 71% of cases
- HPV 31, 33, 45, 52, 58 – 19% of cases
- Previous exposure does not protect against future exposure.

Normal immunology

- Pathogen enters host, usually has contact with blood
- Innate immune system (phagocytes, cytokines, complement) detects pathogen and attempts to neutralize
- Innate immune system activates the adaptive immune response (antibodies, cytotoxic effector cells) <- memory is created

The HPV life cycle: A sophisticated immune evasion mechanism

Poor exposure to antigen presenting cells



Uses natural lifecycle of epithelial cells to release new viruses[1-4]
Does not cause cell death[1-4]

Enters basal epithelial cell, integrates DNA in host cell[1-4]
Replicates in cells; remains intraepithelial[1-4]

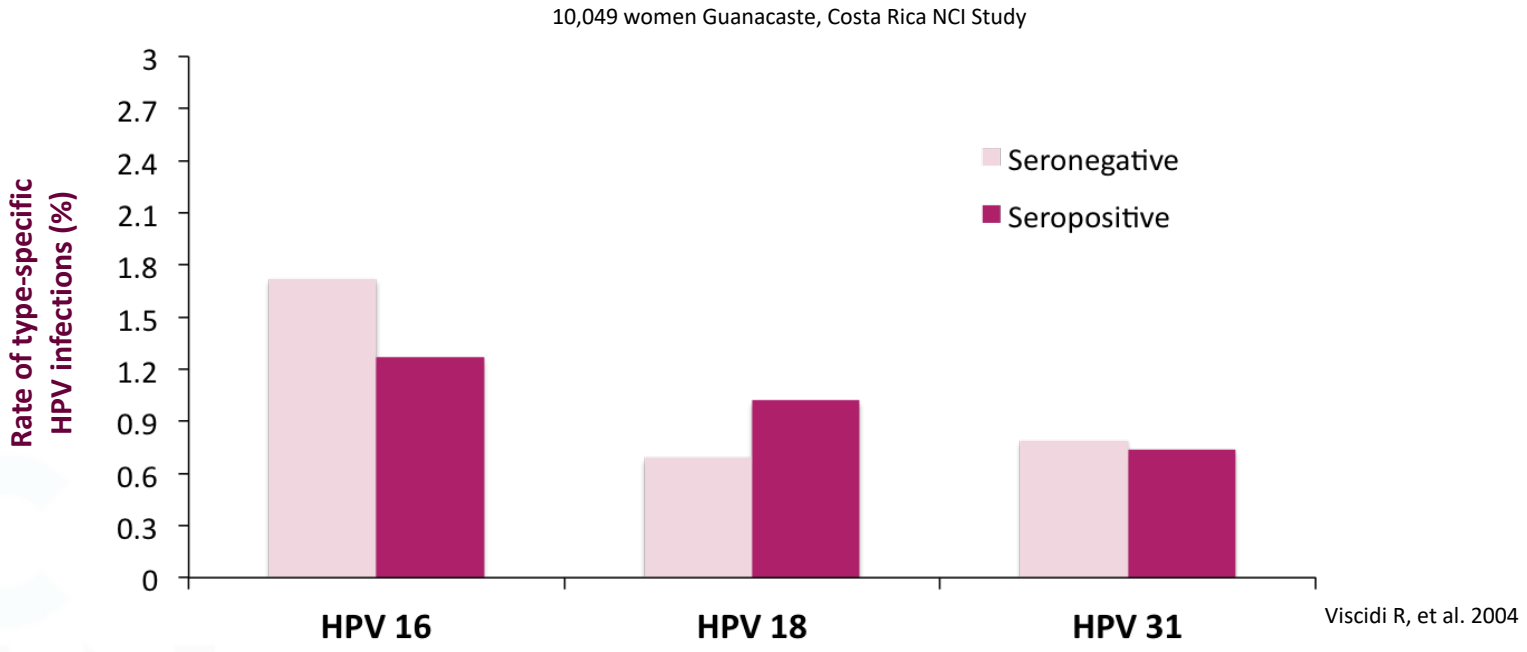
Local infection[1-4]
Infects the epithelium through micro abrasions[1-4]

Infection with HPV is not reliably protective against future infection

1. Stanley M et al . 2006..

Landmark observational measurement: Previous exposure does not protect against future exposure

HPV-seropositive women have similar rates of HPV infections as HPV-seronegative women[1]



Viscidi R, et al. 2004

Summary: HPV immunology

- Immune response to HPV is complex and incompletely understood
- Natural infection -> low antibody levels; does not reliably protect against future infection
- High levels of antibodies produced in response to HPV vaccination neutralize virus and prevent entry into cells

Cervical Cancer Screening Program

PROGRAM OBJECTIVE	To reduce cervical cancer incidence and mortality by finding pre-cancers and cancer at an early stage through routine screening
TARGET POPULATION	Women age 25-69 years
SCREENING TEST	Cytology *Pap test is provided by health care providers across BC; specimens sent to central lab in Vancouver for processing and reporting*
RESULTS	Lab sends results to health care provider, lab results are available to patients through myehealth Program mails notice to patients recommended for colposcopy, cytology in 6 months or unsatisfactory results needing repeat
REMINDER	Mailed notice to patient 8 weeks before being due, then at due date if no result received Notice sent to provider when patient is 12 weeks overdue

Poll question

- What age do we start cervical cancer screening in BC?

1. At the onset of sexual activity irrespective of age
2. Age 21
3. Age 25
4. Age 30

Screening Policy Comparison

CERVICAL CANCER SCREENING	POLICY SINCE JUNE 2016
START AGE	Age 25
CERVICAL CANCER SCREENING INTERVAL	3 years
CERVICAL CANCER SCREENING STOP AGE	Age 69
TRIAGE OF POSITIVE RESULTS	Refer to colposcopy if ASC-H, AGC or HSIL+
	Repeat every 6 months for 1 year if ASCUS or LSIL

Screening Policy

- Why is it important to for patients to repeating their pap test every 3 years?

Poll question

- What is the sensitivity of a pap test (ie. What percentage of patients with cervical dysplasia will have an abnormal pap test)
- 1. 95%
  2. 75%
- 3. 55%
- 4. 35%

Screening Policy

- Why is it important to for patients to repeating their pap test every 3 years

Sensitivity of a pap test – 55%

Specificity of a pap test – 95%

BC's Cervical Cancer Screening Policy

		RECOMMENDATION	SCREENING INTERVAL	BALANCE OF HARMS & BENEFITS
AVERAGE RISK	Age 25-69	Screen	3 years	**Benefits outweigh harms**
	Never had sexual contact*	Do not screen	N/A	Harms outweigh benefits
	Received the HPV Vaccine	Screen	3 years	**Benefits outweigh harms**
	In same sex relationships	Screen	3 years	**Benefits outweigh harms**
	Transgender with a cervix	Screen	3 years	**Benefits outweigh harms**
	After TOTAL hysterectomy	Do not screen	N/A	Harms outweigh benefits
	Age <25	Do not screen	N/A	Harms outweigh benefits
	Age >69	Do not screen	N/A	Harms outweigh benefits
HIGHER THAN AVERAGE RISK	Immunocompromised women	Screen	Annual	**Benefits outweigh harms**
	History of pre-cancerous lesions or cervical cancer	Screen	Annual Until 25 years after diagnosis with at least 5 negative cytology in last 10 years	**Benefits outweigh harms**

** Sexual contact includes intercourse as well as digital or oral sexual contact involving the genital area of a partner of either gender*

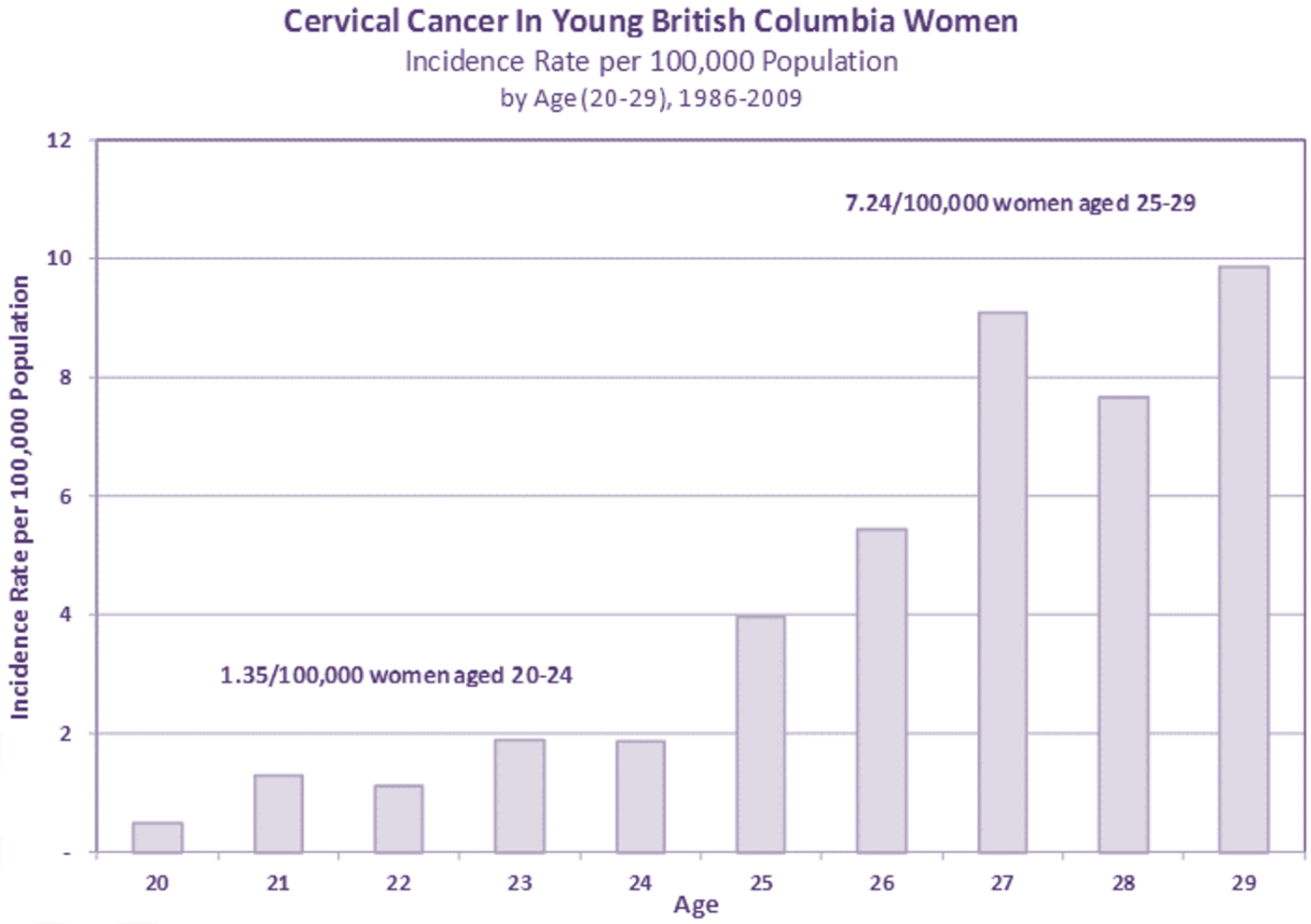
Age to Start Screening

Evidence suggests four well founded reasons for initiating screening at age 25:

- Invasive cervical cancers in women younger than age 25 are rare;
- Screening is relatively ineffective in younger women;
- Women under 25 have a higher prevalence of lesions that often clear without treatment;
- There are risks associated with unnecessary follow-up and treatments, many of which may have long-term consequences for pregnancy or cause undue anxiety and distress.

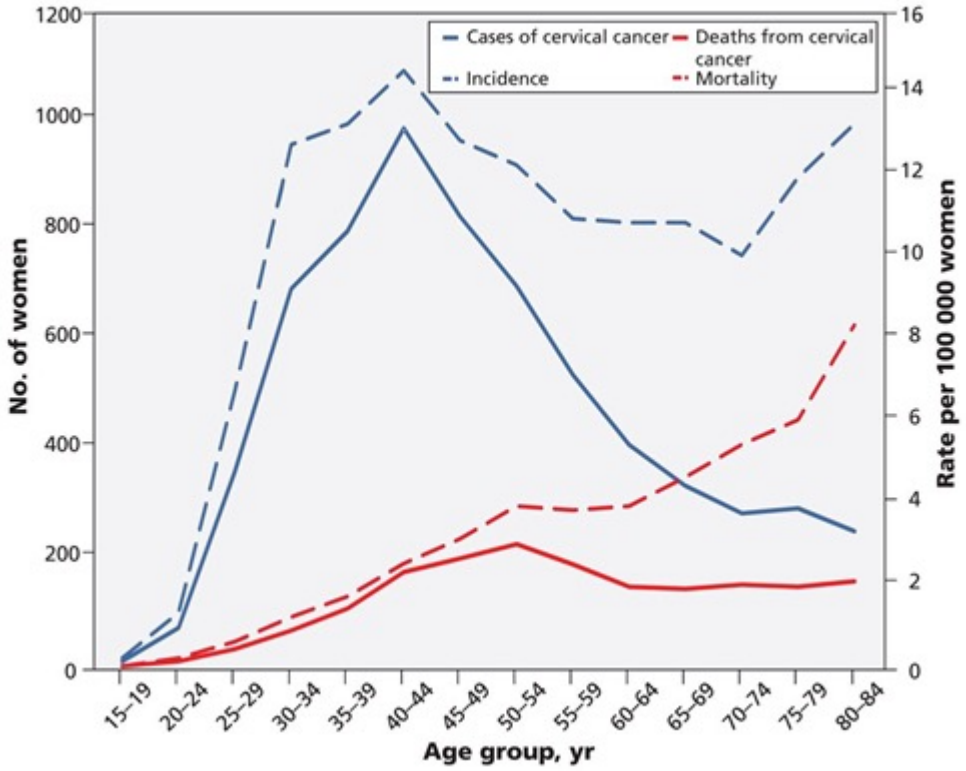
Age to Start Screening

Cancers in women younger than age 25 are rare



Age to Start Screening

Invasive cervical cancers in women younger than age 25 are rare



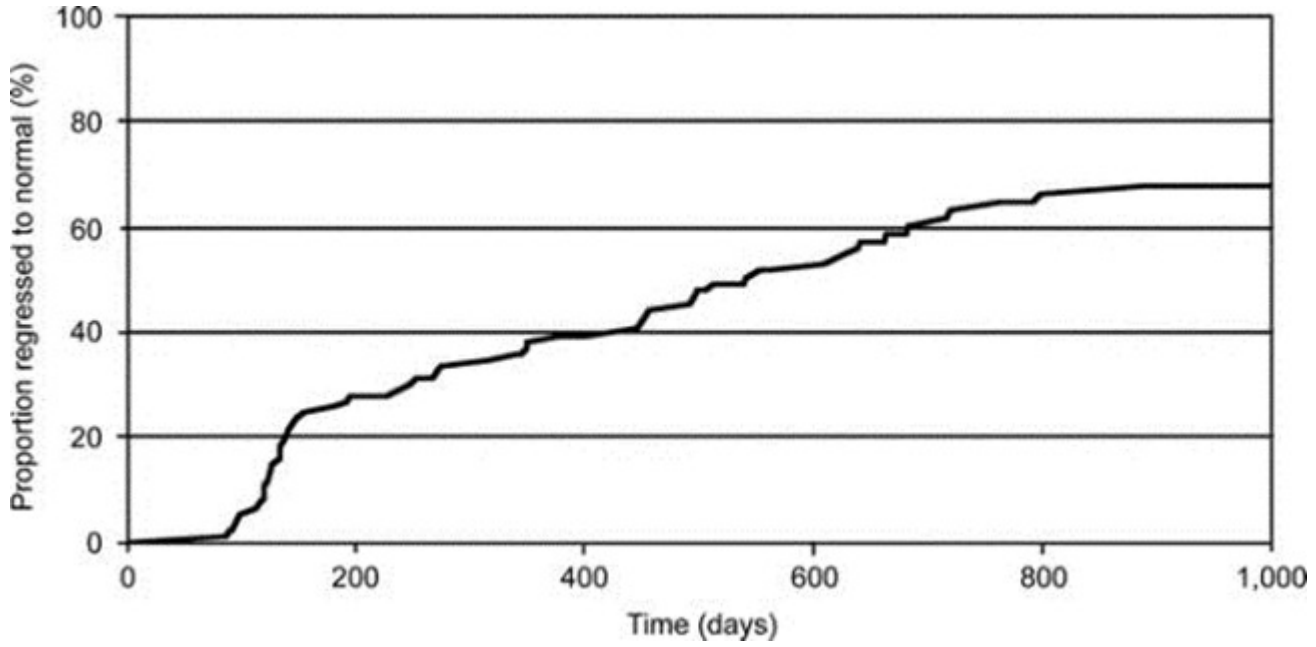
Canadian Task Force on Preventive Health Care CMAJ 2013;185:35-45

Cases of and deaths from cervical cancer, with associated incidence and mortality (rates per 100 000 women), among Canadian women (2002–2006) by age group

Age to Start Screening

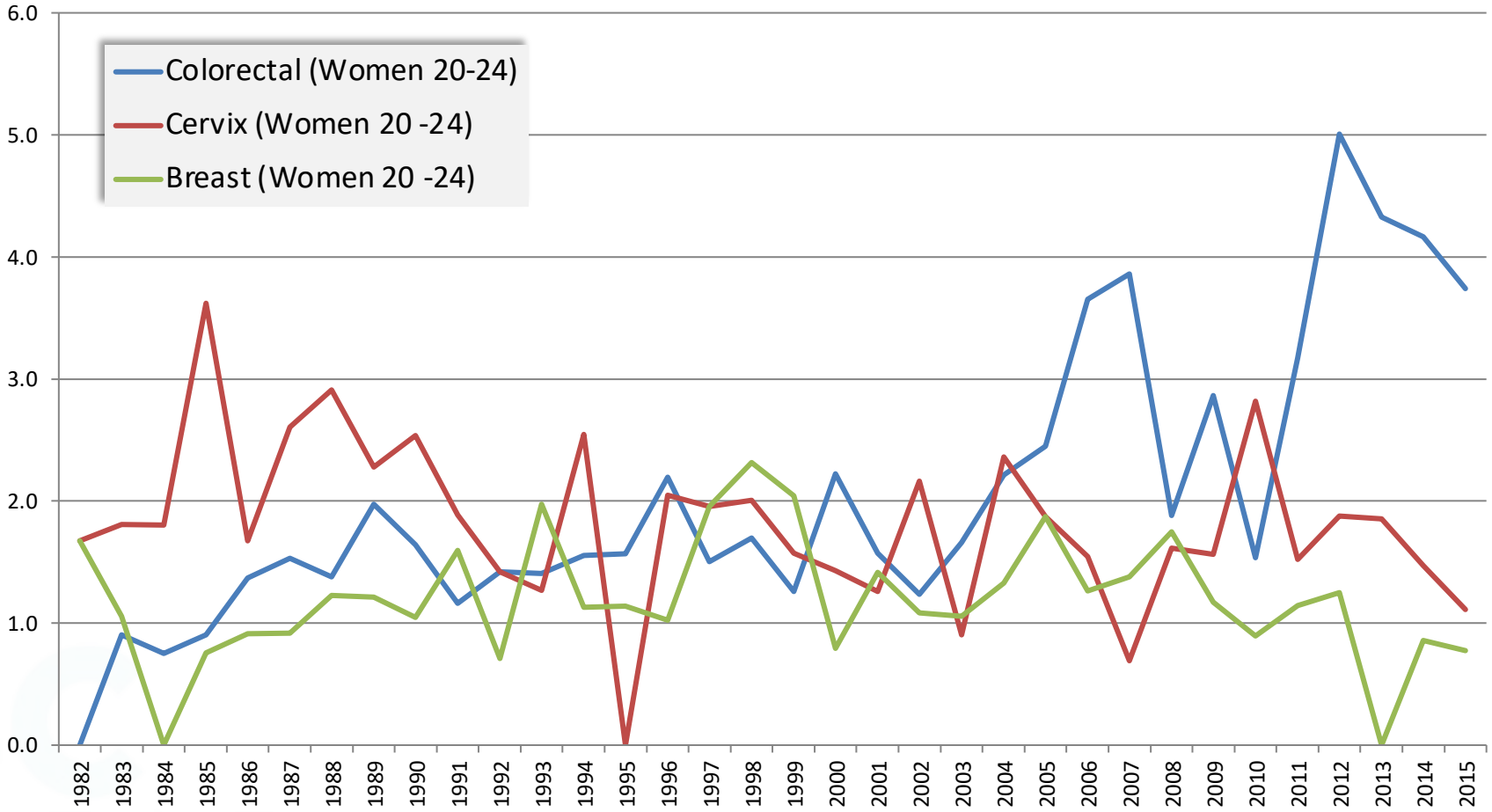
Women under 25 have a higher prevalence of lesions that clear without treatment

Regression of Cervical Intraepithelial Neoplasia 2 in Young Women



Obstetrics & Gynecology. 116(6):1373-1380, December 2010.

Cancer incidence (Australia)
Women 20 to 24



https://www.aihw.gov.au/reports/cancer/cancer-data-in-australia/acim-books

Age to Start Screening

There are risks associated with unnecessary follow-up and treatments

Outcome (# studies)		Cases	Controls	Pooled relative risk (95% CI)
2nd trimester loss (4)		1.6%	0.4%	2.60 (1.45-4.67)
Preterm birth < 34/40 (5)		2.9%	2.3%	2.21 (1.33-3.67)
PPROM (6)		5.1%	2.5%	2.37 (1.64-3.44)
Preterm birth <37/40	vs. no dysplasia (15)	8.6%	4.6%	1.86 (1.58-2.21)
	vs. dysplasia untreated (4)	10.0%	7.2%	1.08 (0.88-1.33)

Kyrgiou *et al*, Cochrane Database Syst Rev 2015 Sep 29:9
Conner *et al*, Obstet Gynecol 2014;123(4):752-61

Age to Start Screening

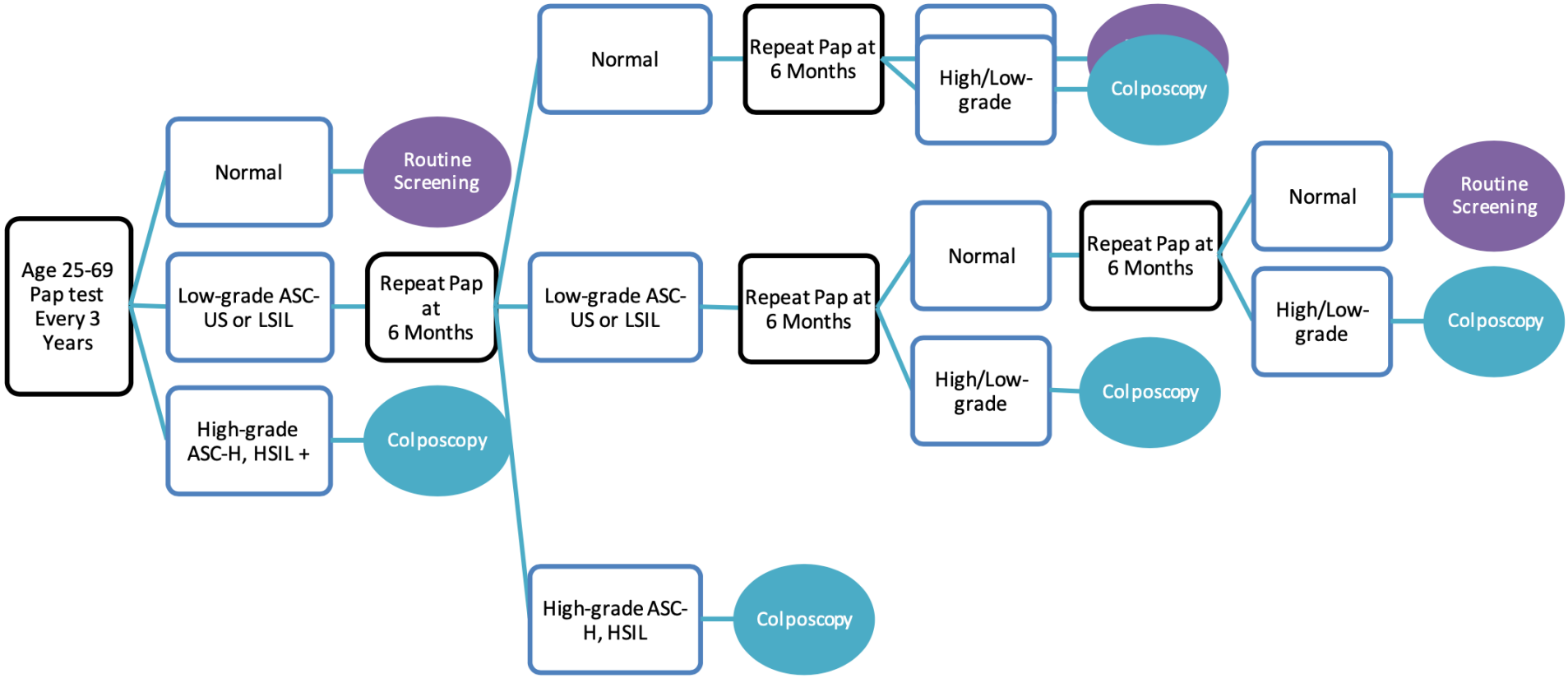
There are risks associated with unnecessary follow-up and treatments

LEEP and preterm births

		% preterm births	Odds ratio for preterm birth (95% CI)
Depth of LEEP	<12 mm	5.3%	1.00
	13-15	4.4%	0.82 (0.55-1.23)
	16-19	7.2%	1.44 (0.96-2.16)
	>20	9.0%	1.76 (1.21-2.55)
	<10 vs. >10 mm		2.61 (1.28-5.34)
Number of LEEPs	2 vs. none	11.4%	3.78 (2.58-5.53)
	2 vs. 1		1.88 (1.27-2.78)

Noehr *et al*, Obstet Gynecol 2009;114(6):1232-8
Kyrgiou *et al,* Lancet 2006;367(9509):489-498

Algorithm for abnormal pap results



What happens after an abnormal Pap Test?

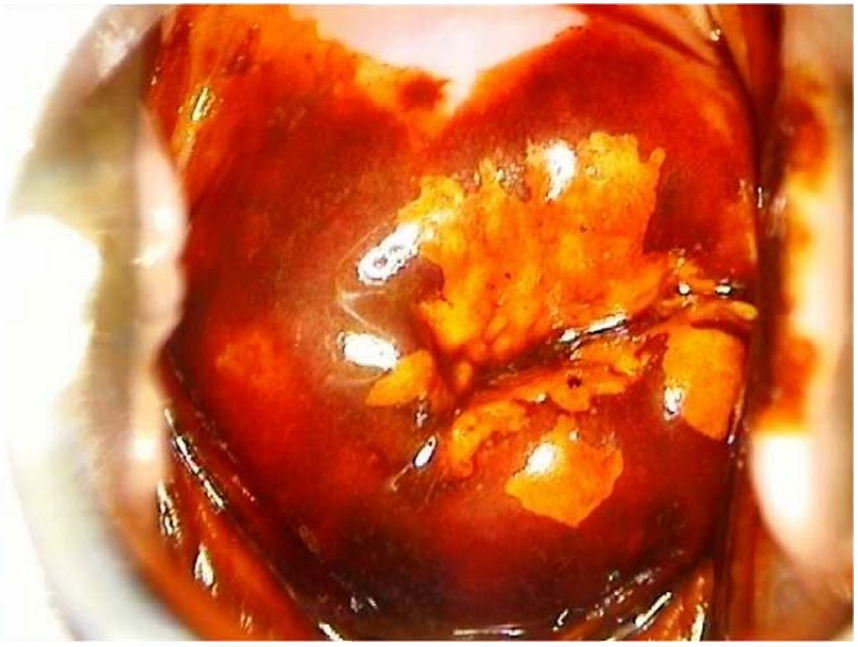
Table 4: Positive Predictive Value of Cytology Result

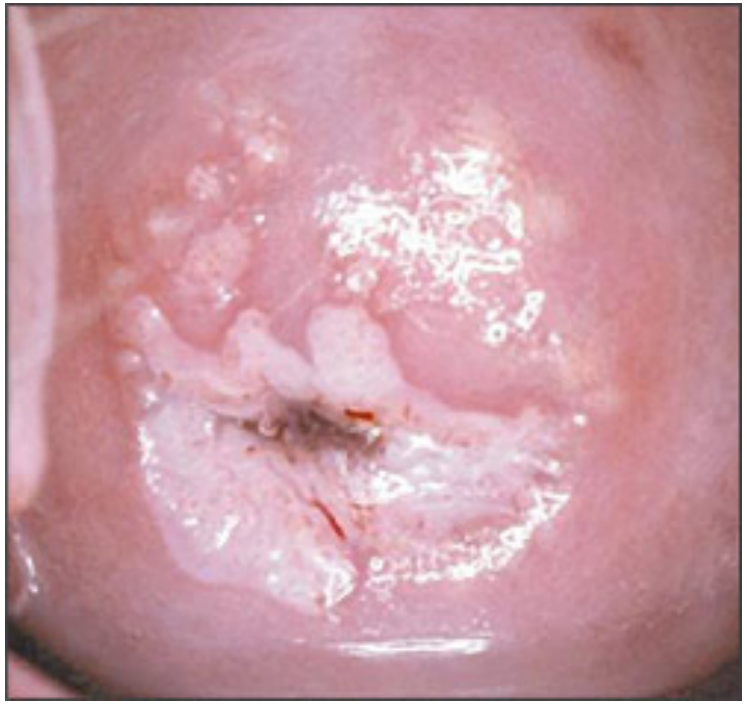
Cytology Result	PPV for CIN 2, CIN3 or Cancer	PPV for CIN 3 or Cancer	PPV for Cancer
ASCUS	20.20%	9.02%	0.08%
LSIL	27.25%	11.99%	0.05%
ASC-H	53.99%	35.19%	0.90%
HSIL (moderate dysplasia)	67.00%	39.16%	0.42%
HSIL (severe dysplasia)	88.36%	75.35%	4.18%
AGC-NOS	18.60%	14.14%	2.42%
AGC-FN	70.13%	66.23%	23.12%
AIS	81.82%	81.82%	36.36%
Squamous cell carcinoma	90.79%	90.79%	34.21%
Adenocarcinoma	67.86%	67.86%	42.86%

What happens after an abnormal Pap Test?

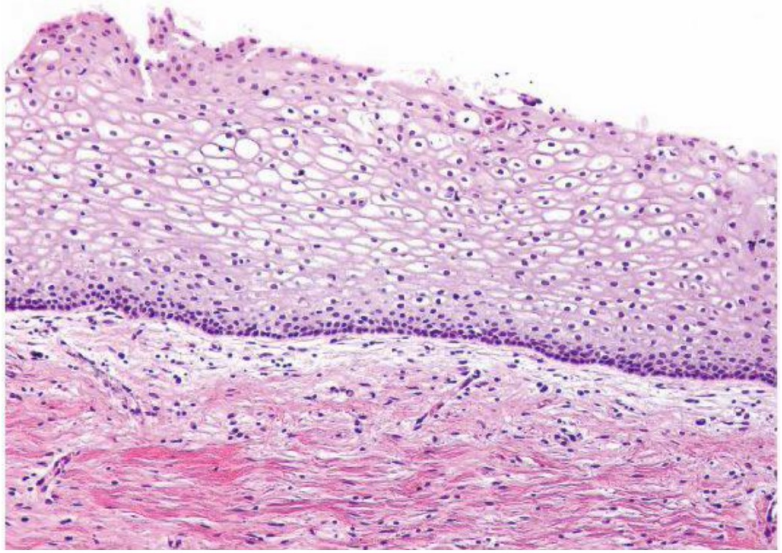
COLPOSCOPY:

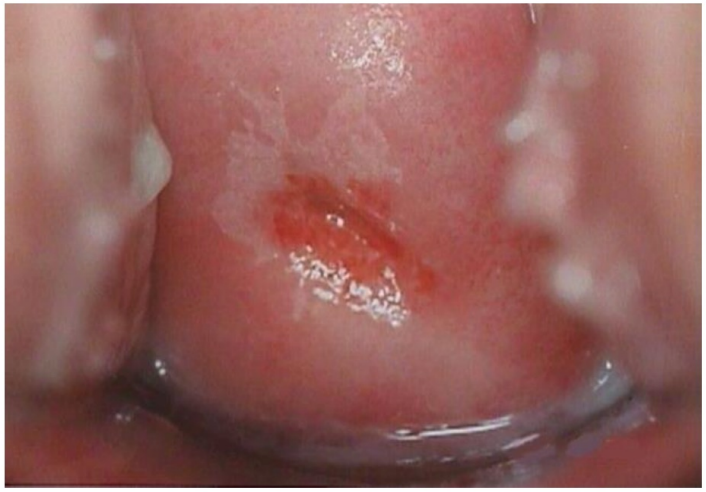
- Microscopic Visualization and Directed Biopsies



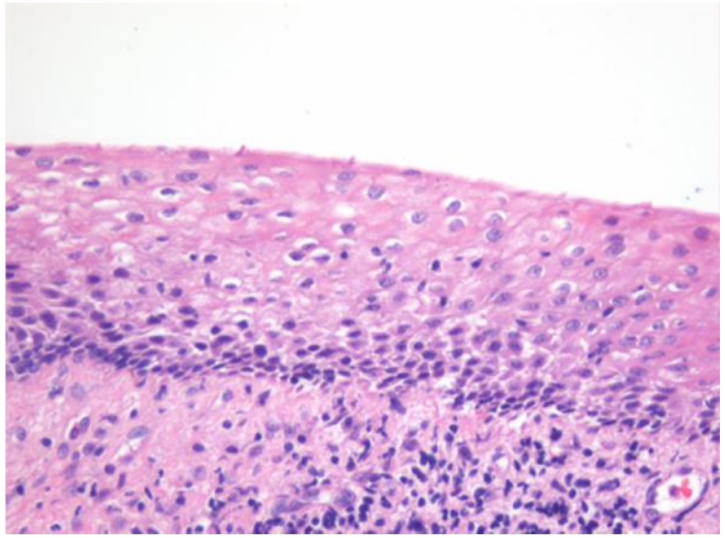


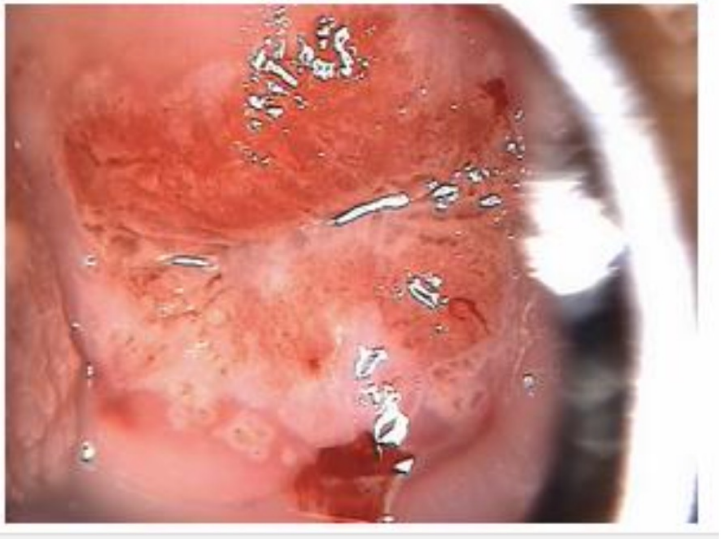
CIN1



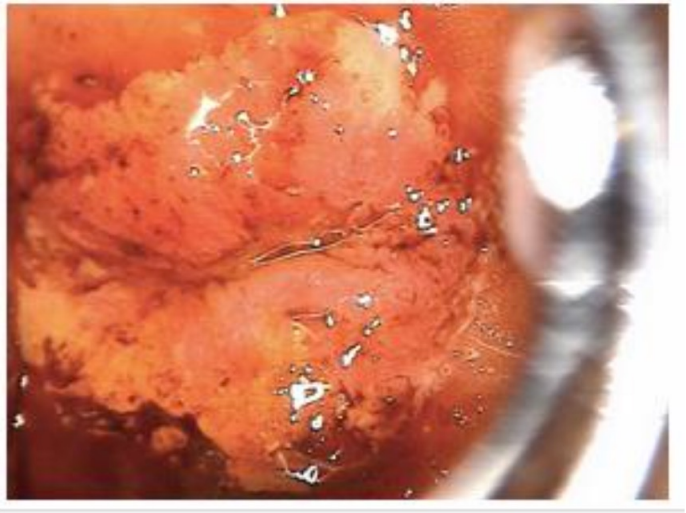


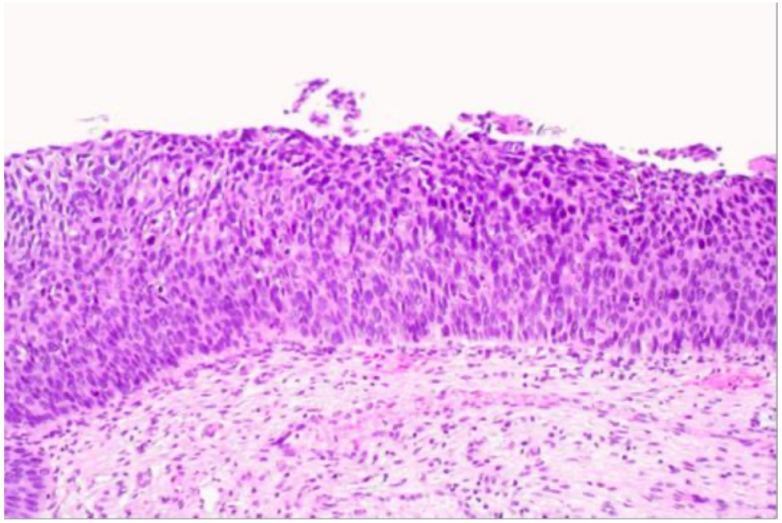
CIN2





CIN3





Management of CIN2+

- LEEP Excision

http://www.bccancer.bc.ca/screening/cervix/results/leep

Pap Smear, Colpo and LEEP = Secondary Prevention

What if we miss this opportunity and

Exam or Colposcopy Shows Cancer

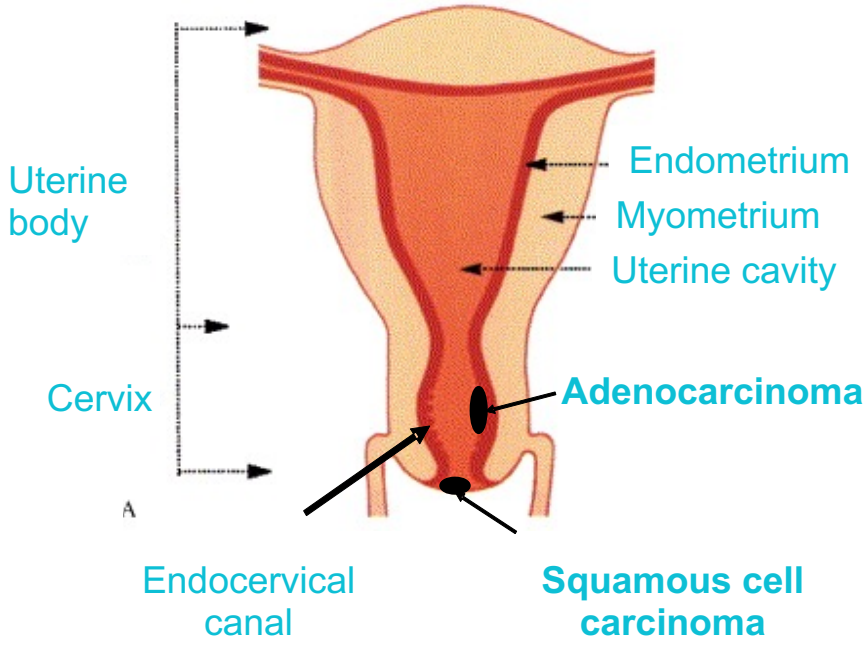
CERVICAL CANCER

- Cancer of the uterine cervix is the 13th most common cancer in Canadian women, with an estimated 1500 new diagnoses per year
- 99.7% of cervical cancer is caused by the persistence of HR-HPV

Types of cervical cancer

- There are two main types of cervical cancer
  - squamous cell carcinomas (70%)
  - adenocarcinomas (25%)

Histological location of adenocarcinoma and squamous cell carcinoma of the cervix

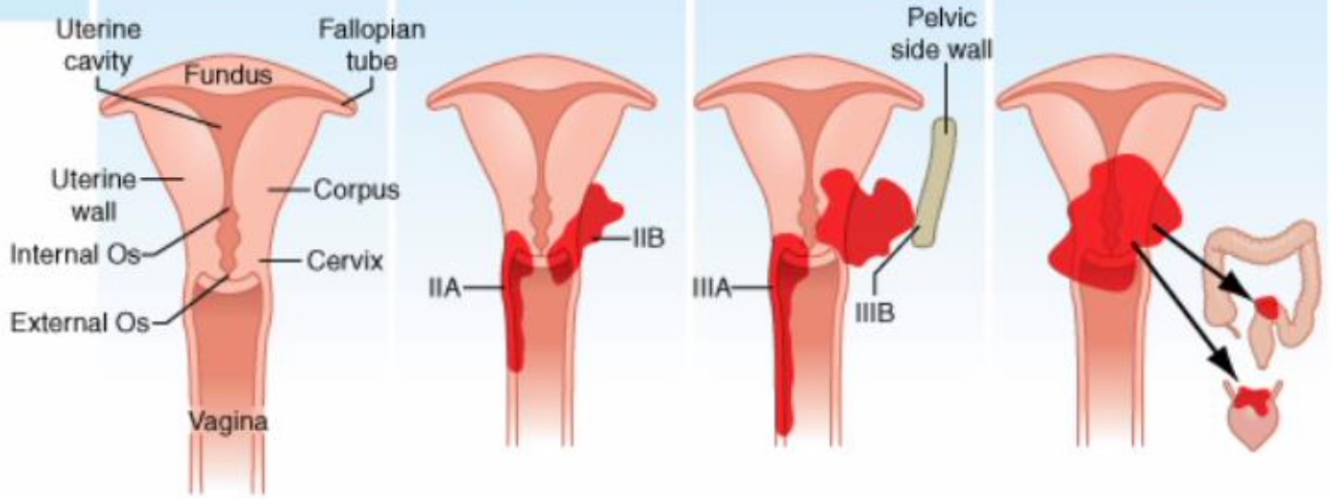


1. Burd EM. Clin Microbiol Rev 2003; 16:1–17;
2. Kjaer SK, et al. Epidemiol Rev 1993; 15:486–498.

Staging

Staging of cervix cancer

Stage	0	I	II	III	IV
Extent of tumor	Carcinoma in-situ	Confined to cervix	Disease beyond cervix but not to pelvic wall or lower 1/3 of vagina	Disease to pelvic wall or lower 1/3 vagina	Invades bladder rectum or metastasis
5-year survival	100%	85%	65%	35%	7%
Stage at presentation		47%	28%	21%	4%



Source: Fauci AS, Kasper DL, Braunwald E, Hauser SL, Longo DL, Jameson JL, Loscalzo J: *Harrison's Principles of Internal Medicine*, 17th Edition: http://www.accessmedicine.com

Management of Cervical Cancer

Primary Radical Surgery
+/- adjuvant ct/RT

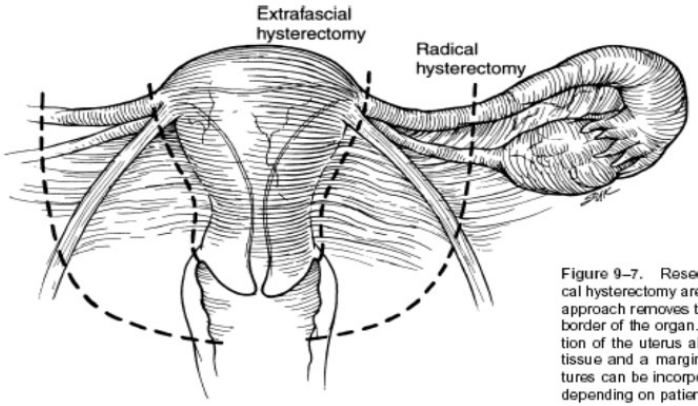
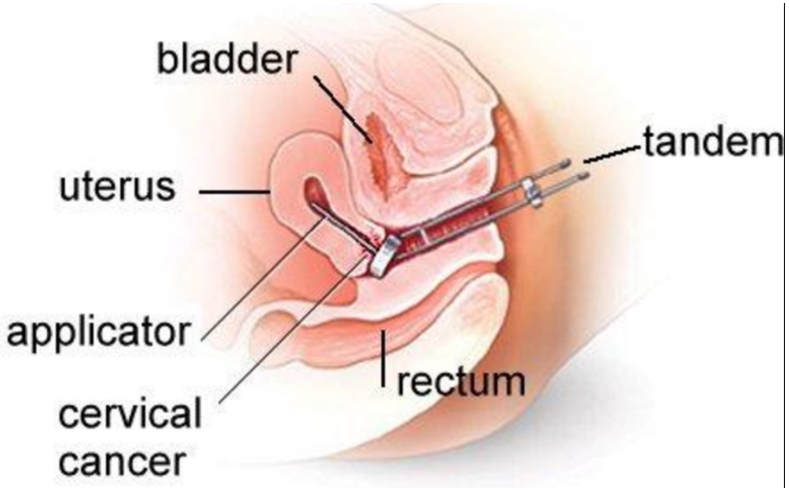


Figure 9–7. Resection margins for extrafascial and radical hysterectomy are significantly different. The extrafascial approach removes the cervix and uterus just at the lateral border of the organ. Radical hysterectomy includes resection of the uterus along with its attached parametrial soft tissue and a margin of upper vagina. The adnexal structures can be incorporated into the resection or preserved, depending on patient age and desire.

Primary Radical Ct/Radiation



Poll Question

- Patient X has stage 1B2 SCC cervix (2cm, no extension beyond the cervix). Which treatment is associated with a higher chance of cure
- 1. Surgery
- 2. Radiation

Clinical Trial > Lancet. 1997 Aug 23;350(9077):535-40.
doi: 10.1016/S0140-6736(97)02250-2.

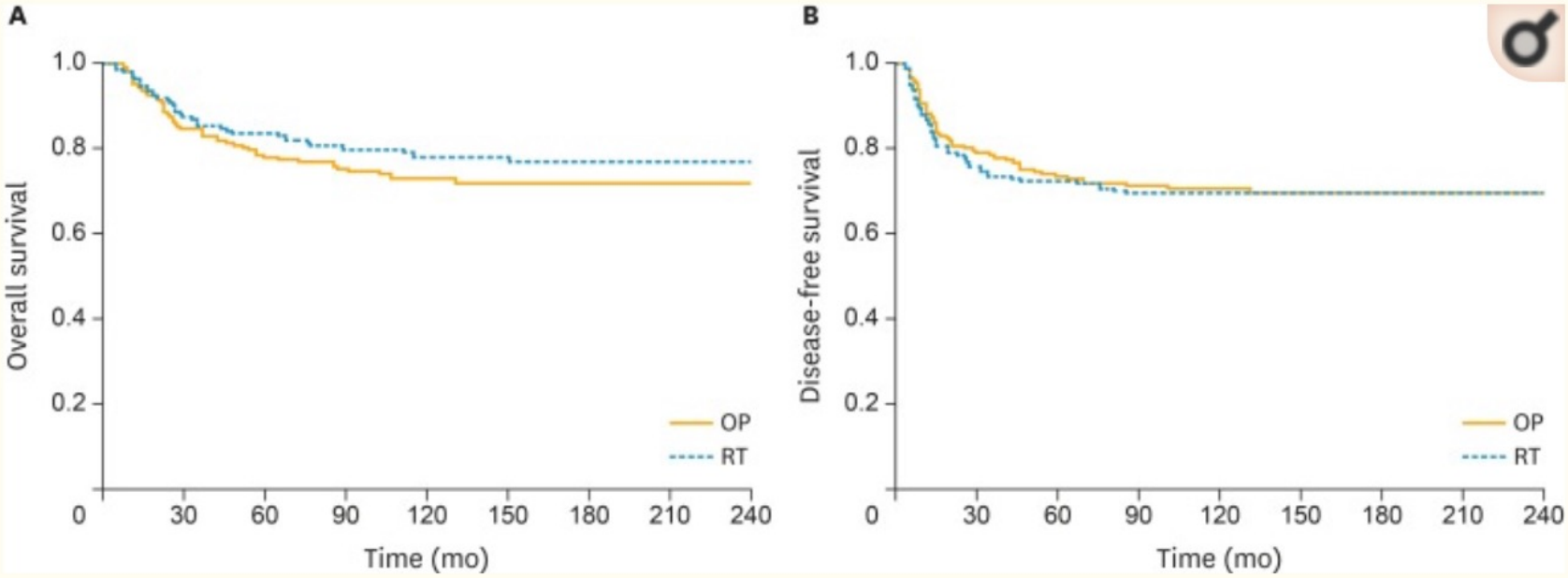
Randomised study of radical surgery versus radiotherapy for stage Ib–IIa cervical cancer

F Landoni [1], A Maneo, A Colombo, F Placa, R Milani, P Perego, G Favini, L Ferri, C Mangioni

Affiliations + expand

PMID: 9284774 DOI: 10.1016/S0140-6736(97)02250-2

Stromal invasion >=3mm and tumor less than 4cm in size



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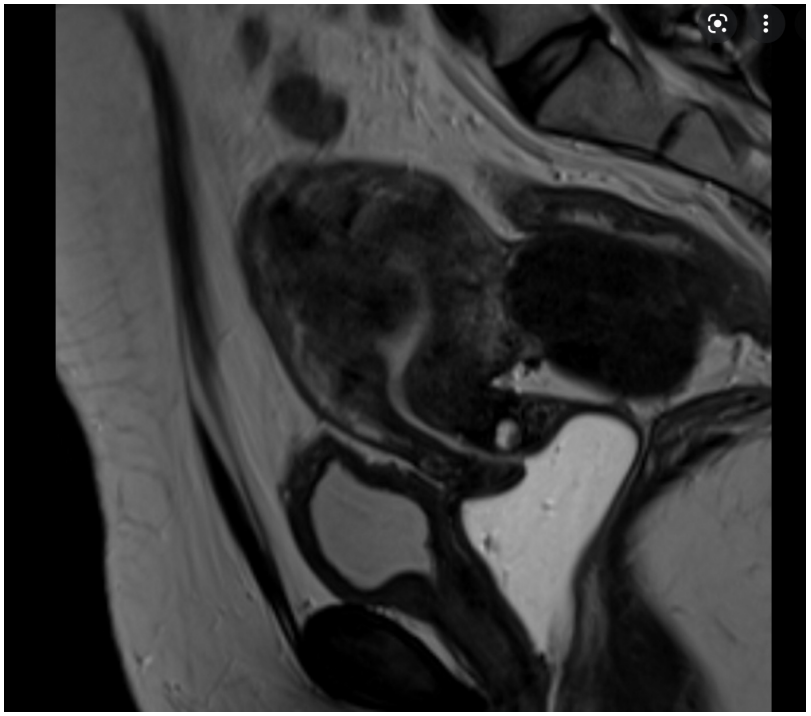
	Surgery						Radiotherapy group	
	Surgery only		Surgery plus radiotherapy		Total			
	≤4 cm	>4 cm	≤4 cm	>4 cm	≤4 cm	>4 cm	≤4 cm	>4 cm
Number of patients	53 (52)	9 (9)	62 (62)	46 (46)	115 (114)	55 (55)	113 (105)	54 (53)
Relapses	7 (13%)	2 (22%)	15 (26%)	17 (37%)	23 (20%)	19 (34%)	21 (18%)	23 (42%)
Pelvic	4	2	7	9	11	11	12	16
Distant	3	. .	9	8	12	8	9	7
Morbidity								
Grade 2–3†	16 (31%)	3 (33%)	18 (29%)	11 (24%)	34 (30%)	14 (25%)	13 (12%)	6 (11%)
Short-term	10 (16%)		22 (20%)		32 (19%)		11 (7%)	
Long-term	15 (24%)		31 (29%)		46 (27%)		25 (16%)	

*Parentheses show number of patients who actually received this treatment instead of intention to treat. †% calculated for number of patients who actually received treatment.

Table 3: **Relapses and morbidity**

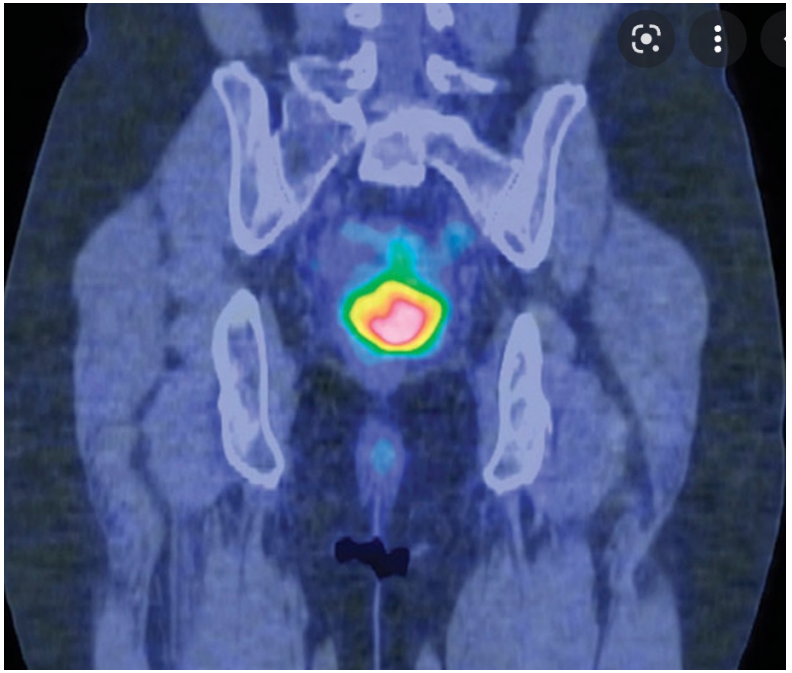
Investigations

- MRI looks for:
  - Depth of stromal invasion
  - Tumor diameter
  - Parametrial extension
  - Vaginal extension
  - Nodal involvement

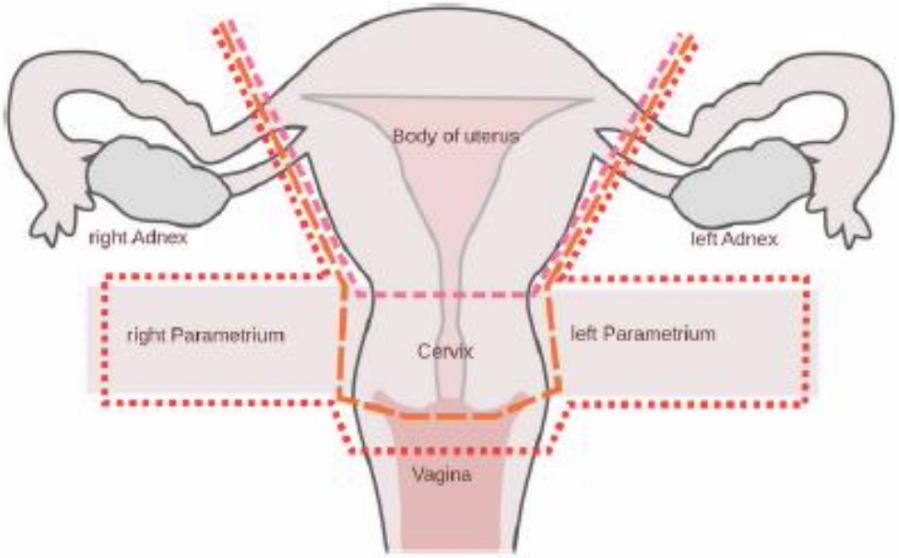


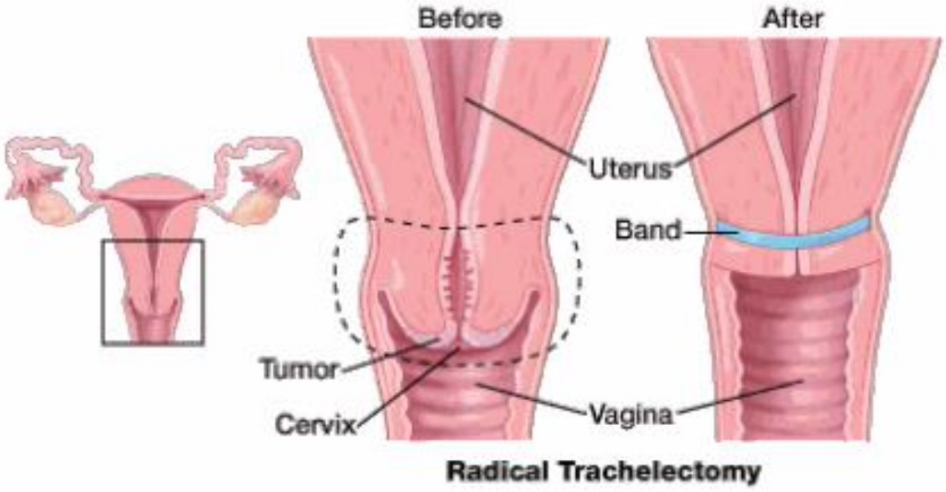
Investigations

- PET looks for:
  - Distant metastasis
  - Nodal involvement

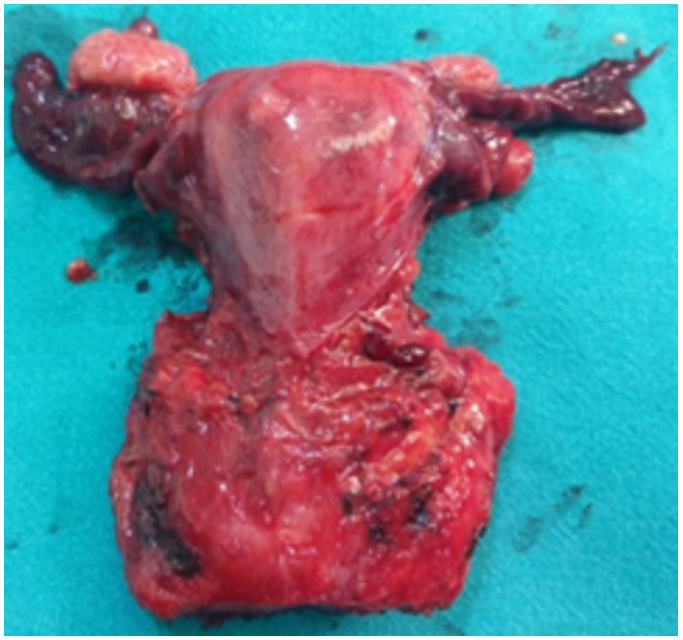


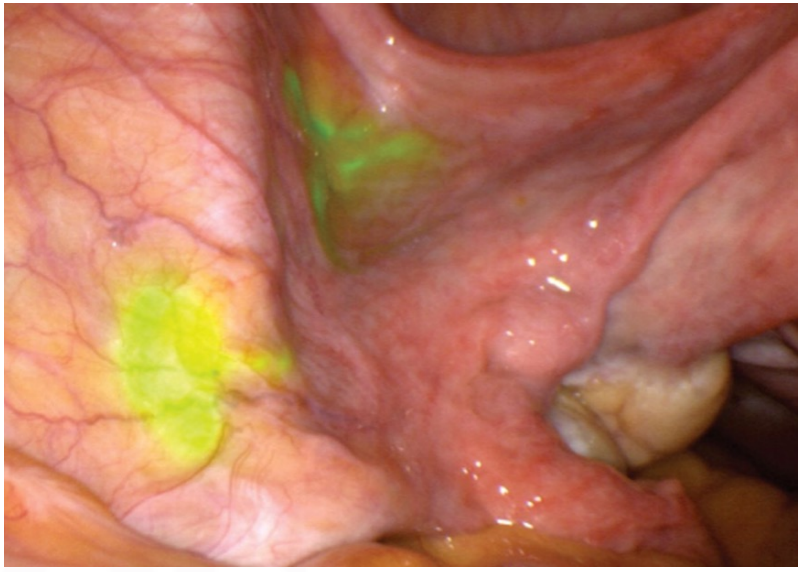
Surgery for Stage 1 Cervical Cancer

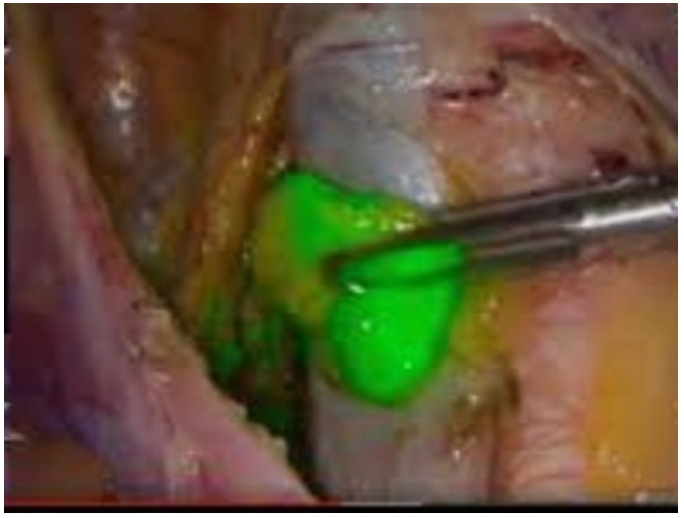




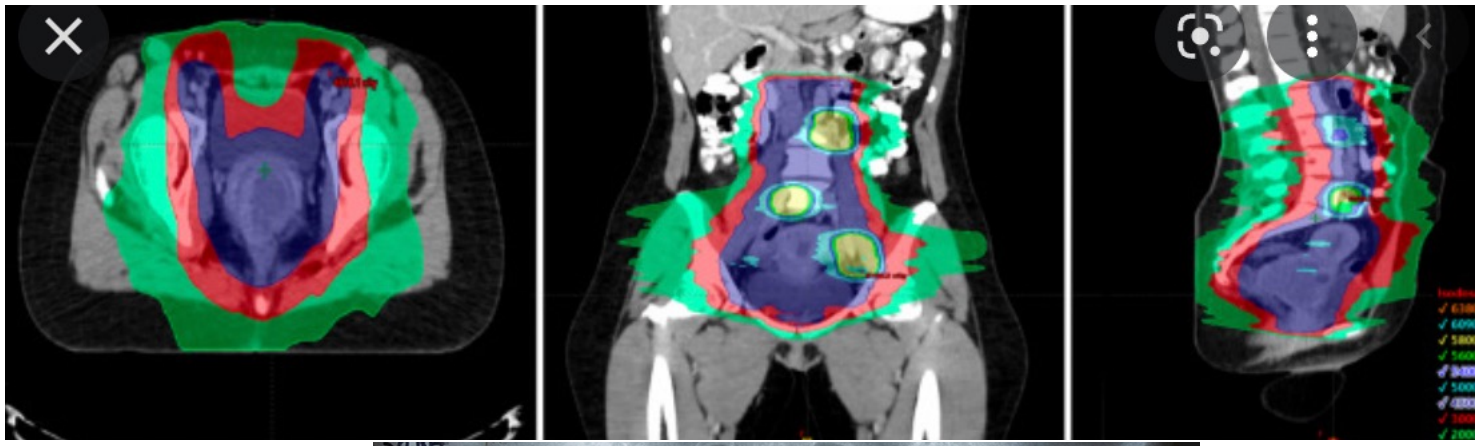
Radical Hysterectomy and Sentinel Node Biopsy

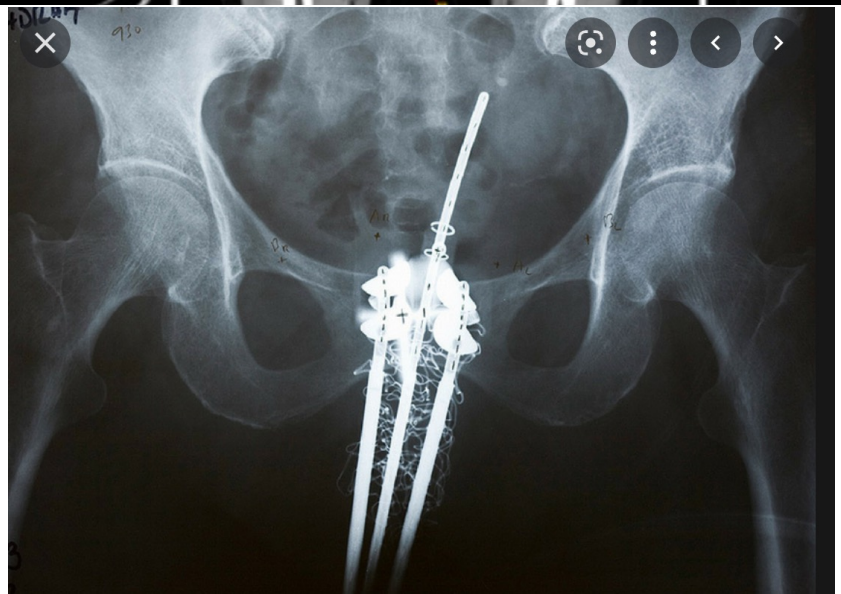






Radiation for Stage 1b2 + Cervical Cancer

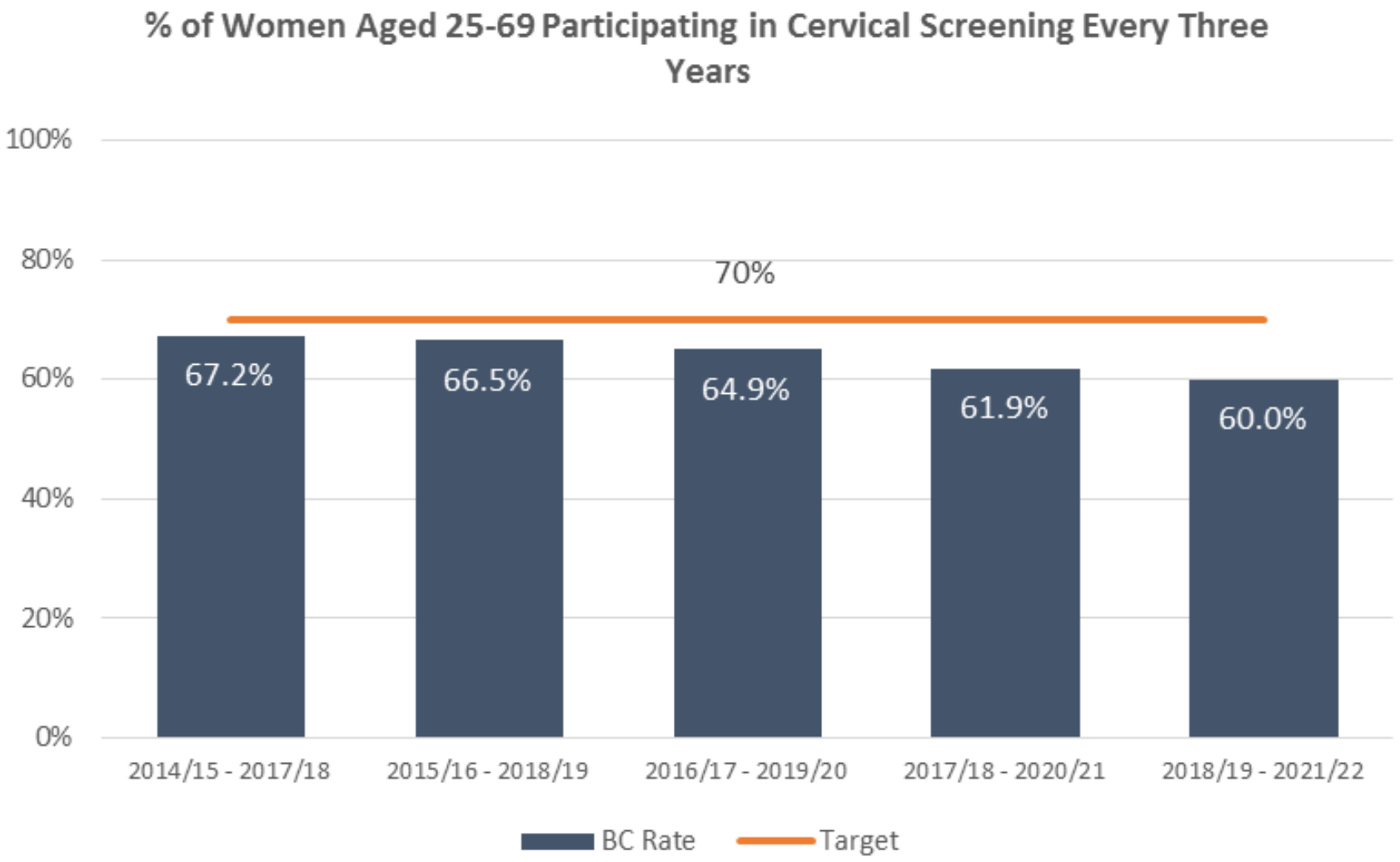




How Can You Prevent Cervical Cancer

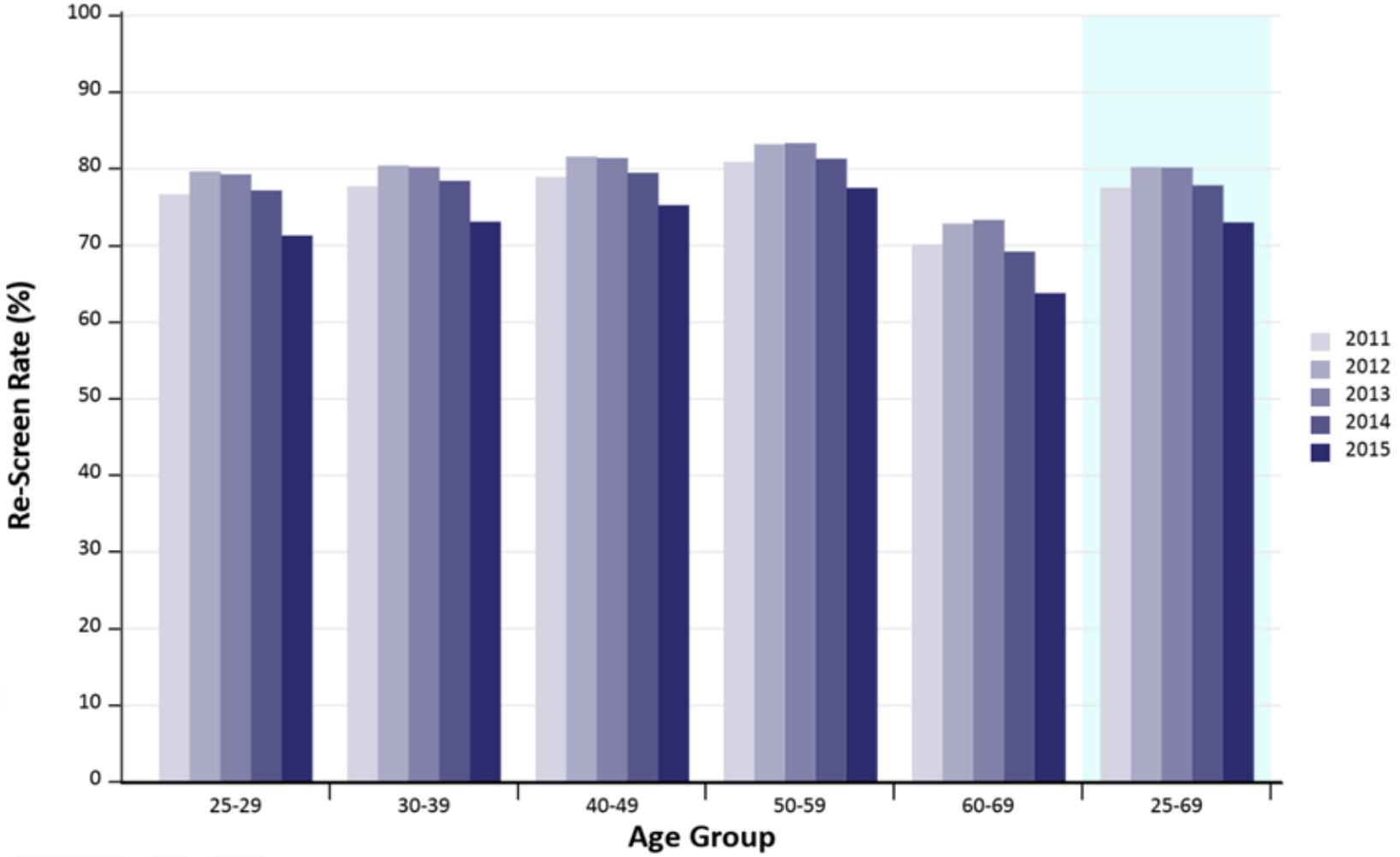
- Screening effectiveness depends on:
  - ***Women's participation***
  - ***Sample quality***
  - ***Adequate management and treatment of abnormal results***
  - Laboratory performance

Screening Rates



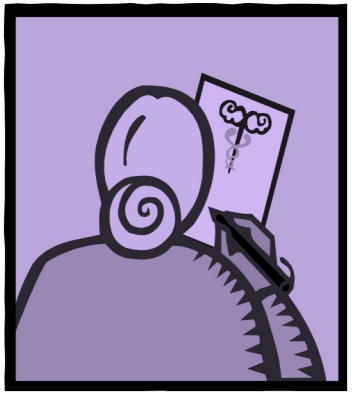
42-Month Retention Rate

by Age Group Over Time, 2011 – 2015



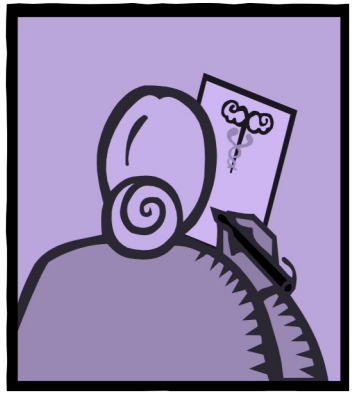
How can I fight cervical cancer?

- **Identify eligible women** for screening
- **Look for people** in your practice **less likely** to participate in screening
  - New immigrants
  - South East Asian and Chinese populations
  - First Nation, Inuit and Metis people
  - Trans, gender diverse and non-binary people
  - People with a low income
  - People who do not speak the language that the service is being provided in

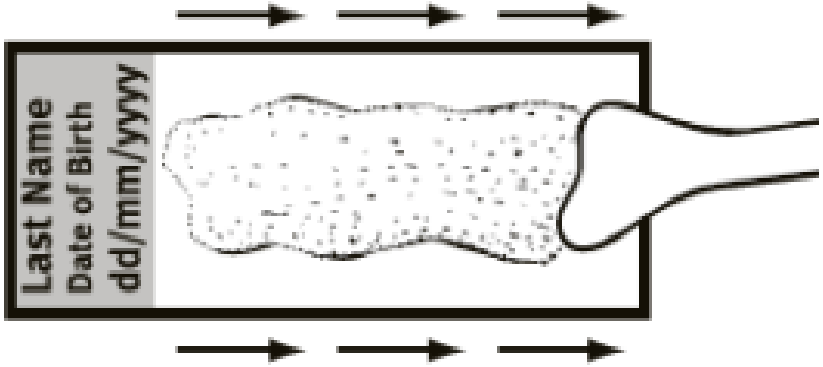


How can I fight cervical cancer?

- Obtain high **quality smears**



- SINGLE slide
- Cytobrush! – think glandular cells (Adenoca)
- LABEL the slide in PENCIL
  - NAME and DOB
  - 2,000 smears per day!!!
- Use cytospray IMMEDIATELY
  - 10 seconds makes a difference
  - By 1 minute – largely air dried



How can I fight cervical cancer?

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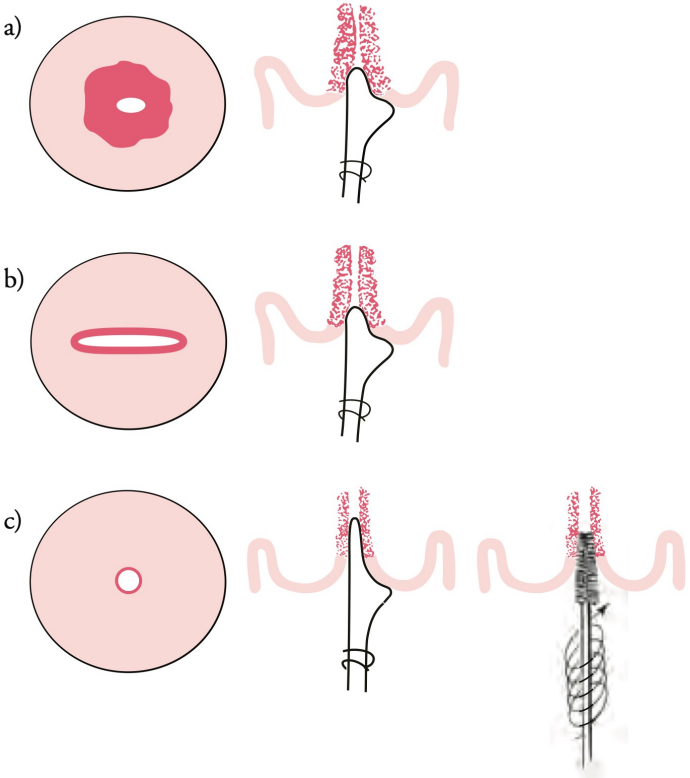
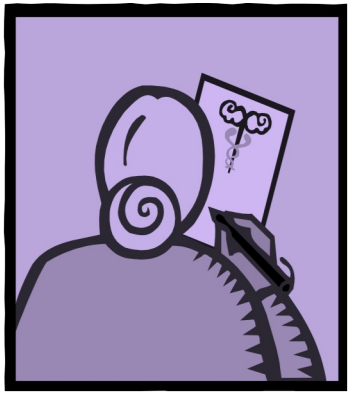
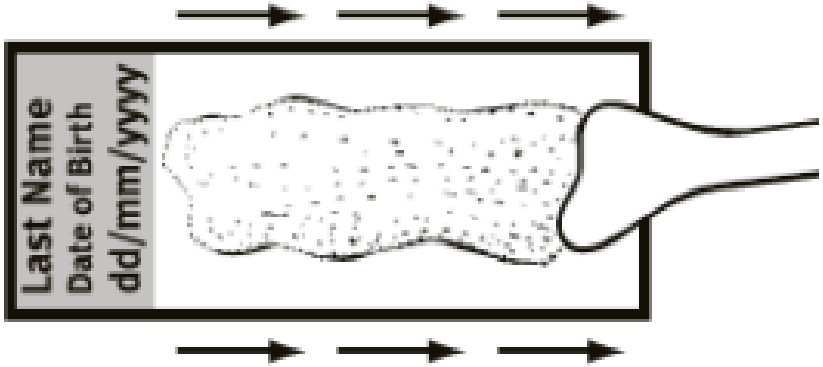
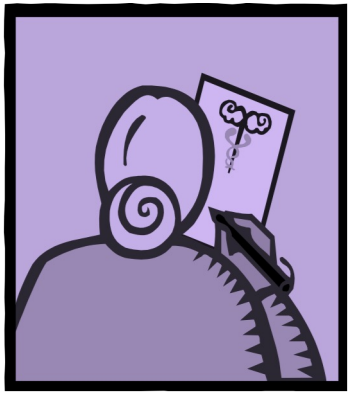






How can I fight cervical cancer?

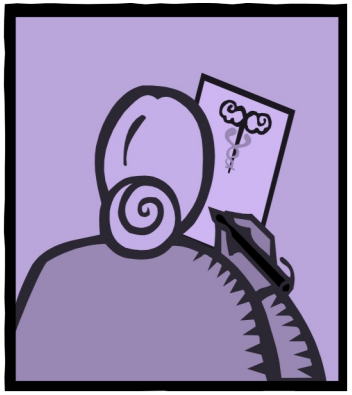
- Support people to access a female provider when needed
- Let people know that if follow-up is needed they will be contacted for an appointment and will receive a notice in the mail
- Ensure referrals have gone on for those recommended for colposcopy (notice of referral from BC Cancer)



How can I fight cervical cancer?

Encourage Retention:

- Culturally safe care
- Trauma informed care
- Non binary approach to gender identity and health
  - Transgender men 37% less likely to be UTD with pap screening compared to cisgender women

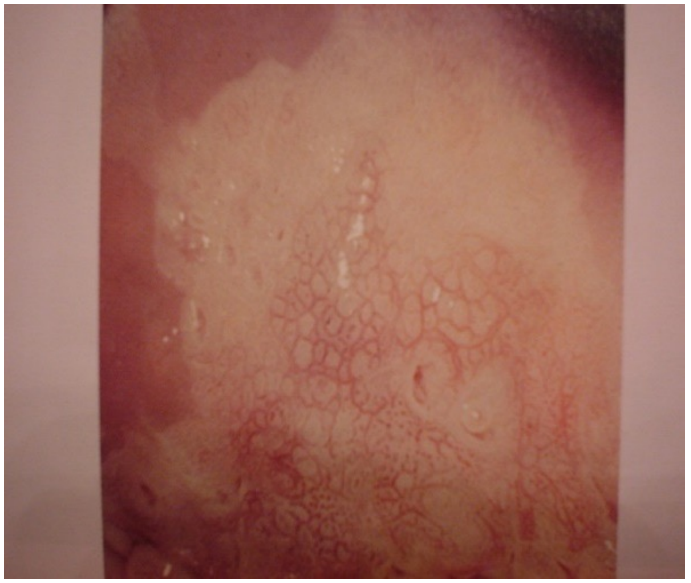


Address Risk Factors:

- Encourage **smoking cessation**
- Encourage and provide **HPV vaccination**

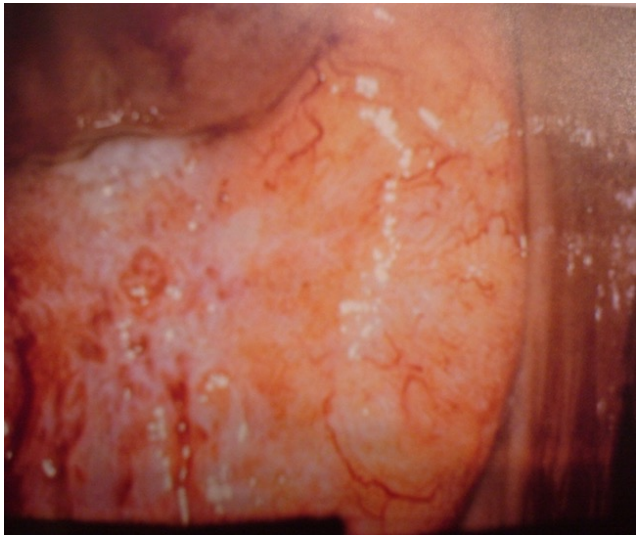
Screening Challenges in B.C.

- 10% of eligible women have NEVER had a Pap smear
- >20% of women have had inadequate screening
- >50% of women with cancer had inadequate screening



Screening Challenges in B.C.

- Poorly screened women
  - More advanced disease
  - Higher mortality
- Rate of cervical cancer is up to 4-6 times higher in First Nations women



Prevention

Cervical cancer is almost *entirely* preventable through:

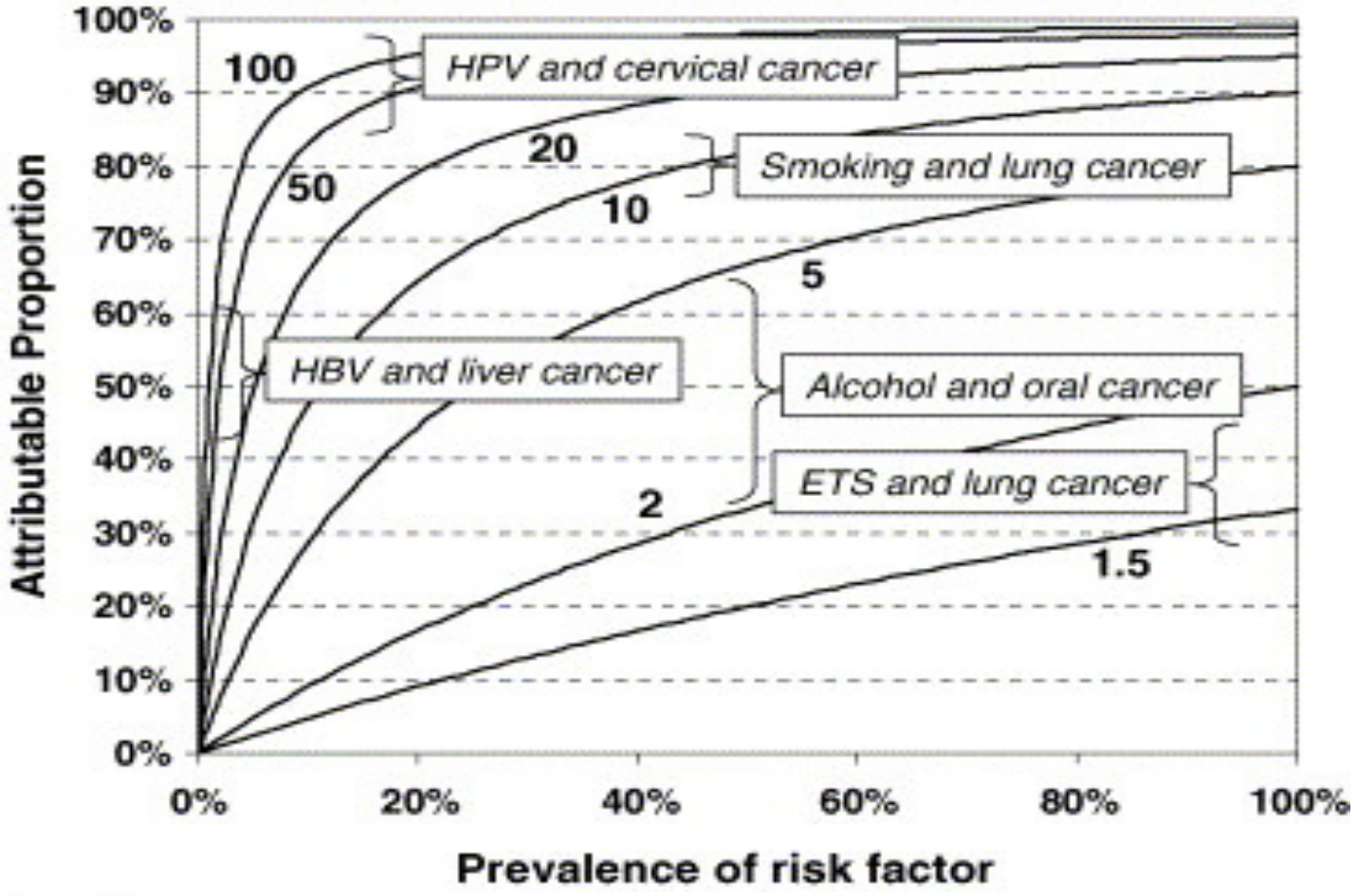
1) Primary Prevention (Vaccination):

- HPV vaccination is ideally given to people *before* they become sexually active and are exposed to HPV
- HPVV offers the best immune response when given to those under the age of 15, but still effective if given later
- Recommended post treatment for cervical dysplasia to prevent recurrence
- It's never to late to receive the vaccine

2) Secondary Prevention (Screening):

- Detecting and treating pre-cancer *before* it becomes invasive

The strongest statistical relationship ever identified in cancer epidemiology



Is not just cervical cancer.

CDC: Top HPV-Associated Cancer Is Now Oropharyngeal

Cancer Type	Average Annual Change (%)
Cervical	-1.6
Vaginal	-0.6
Oropharyngeal in men	2.7
Oropharyngeal in women	0.8
Anal in men	2.1
Anal in women	2.9
Vulvar	1.3

MMWR Morb Mortal Wkly Rep. 2018;67:918-924

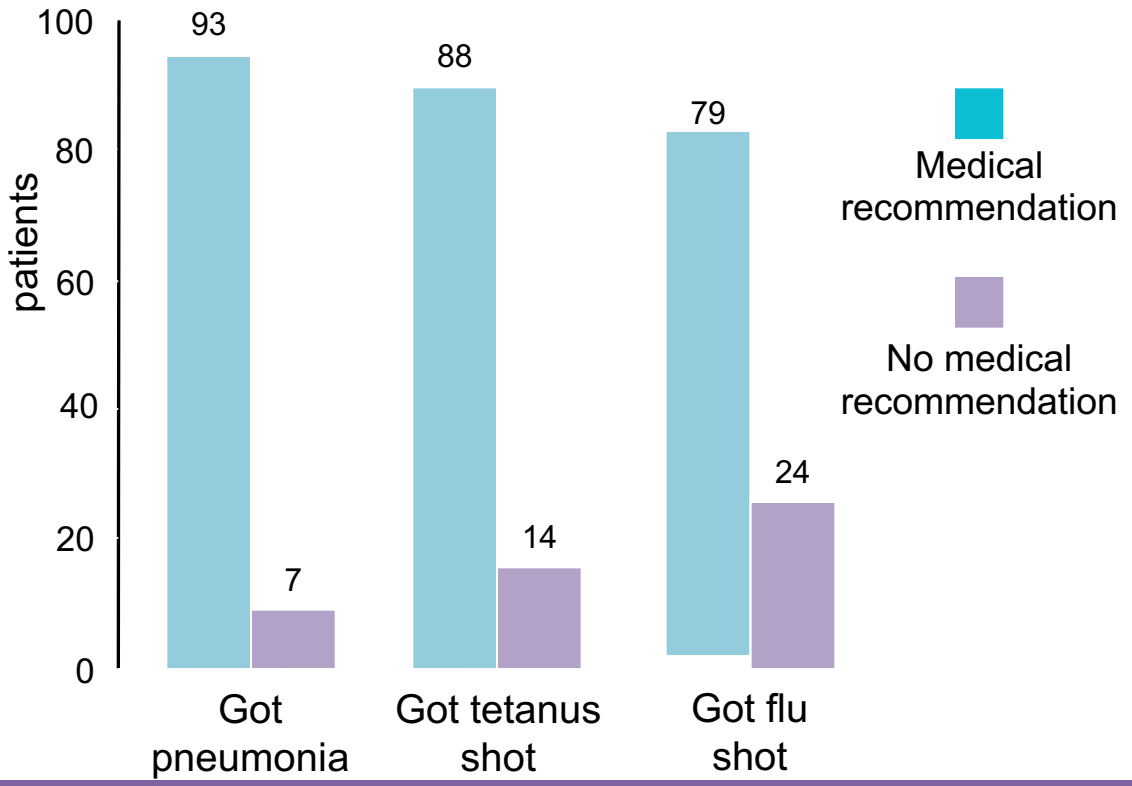
Healthcare Professional's Recommendation

Communication

Explaining the need for immunization

- Clearly conveying the risks[1]
- Strong physician/ provider recommendation[1]

Recommendation is critical[2]

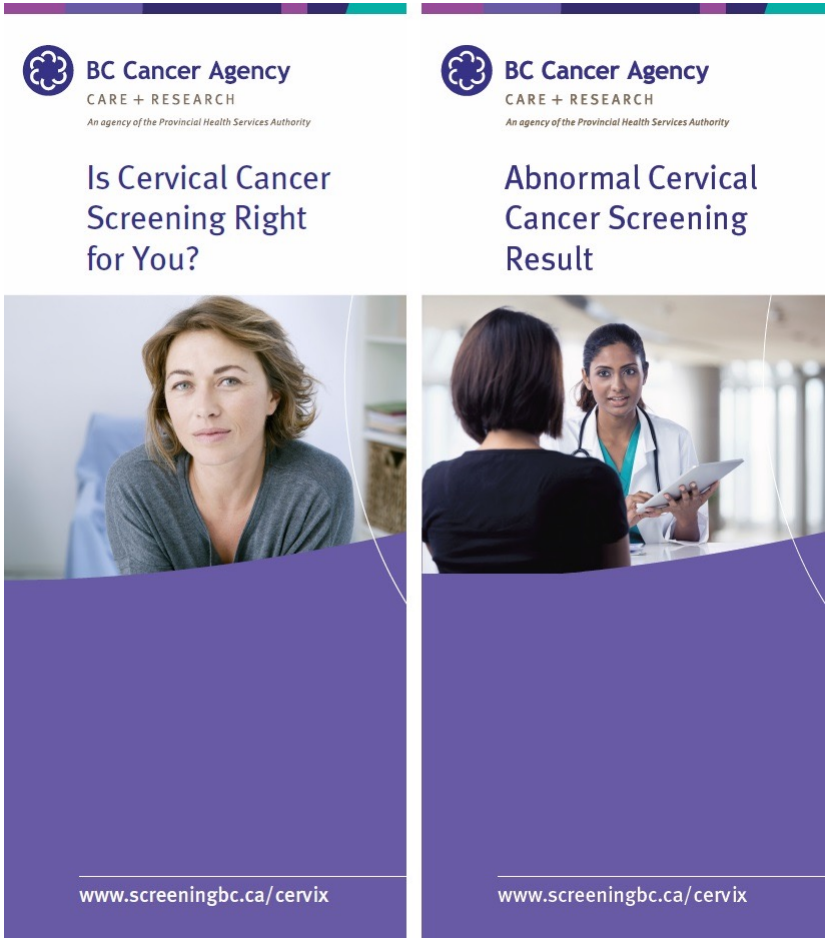


- Reinforce key points about each vaccine
- Discuss vaccine safety
- Address the risks encountered by unvaccinated people

1. Burns IT, et al. 2005; 54:S58-S62.
2. PHAC 2006 Canadian Adult Immunization Coverage Survey.

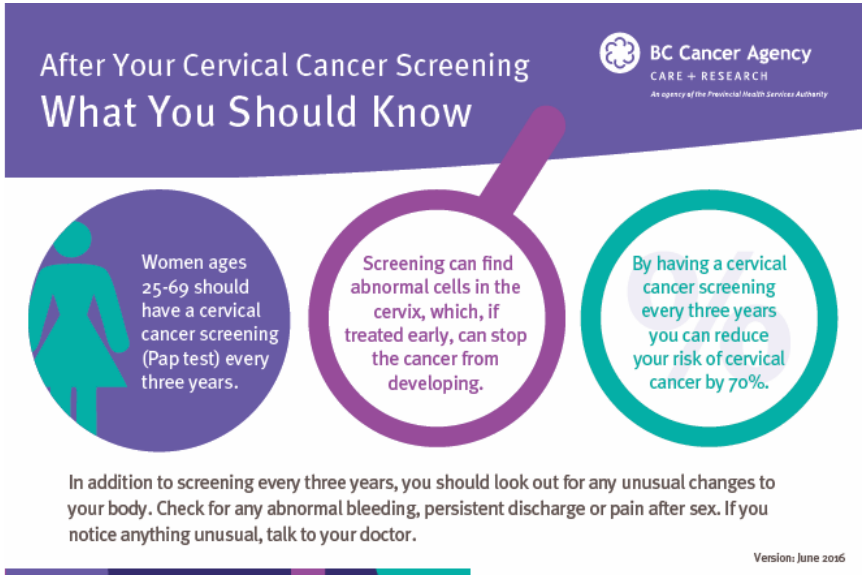
Resources

- Patient brochures in multiple languages (English, Punjabi, Chinese)
  - Is Cervical Cancer Screening Right for You?
  - Abnormal Cervical Cancer Screening Result



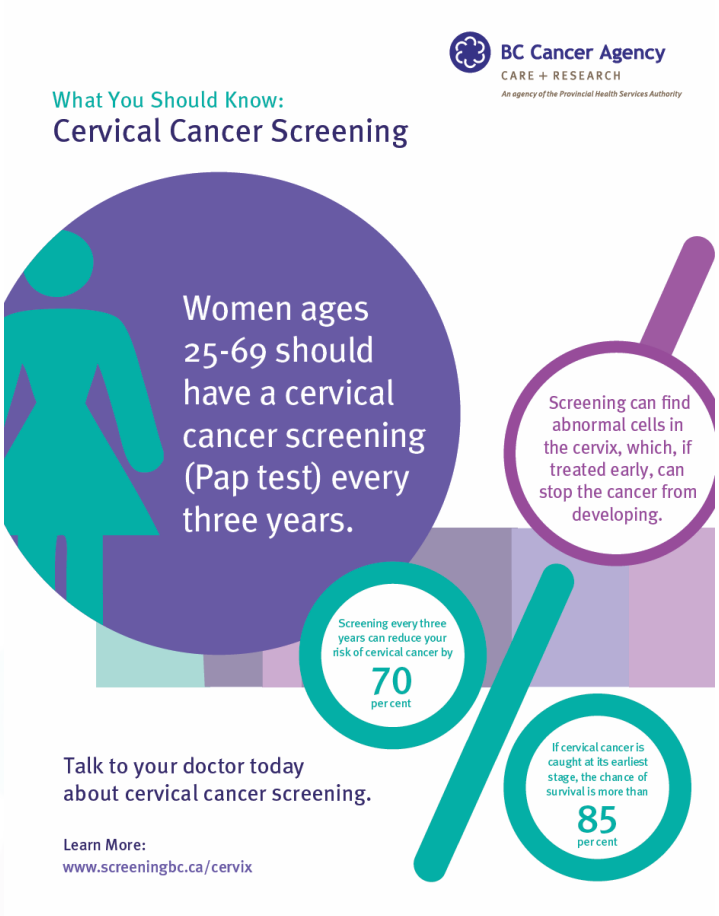
Resources

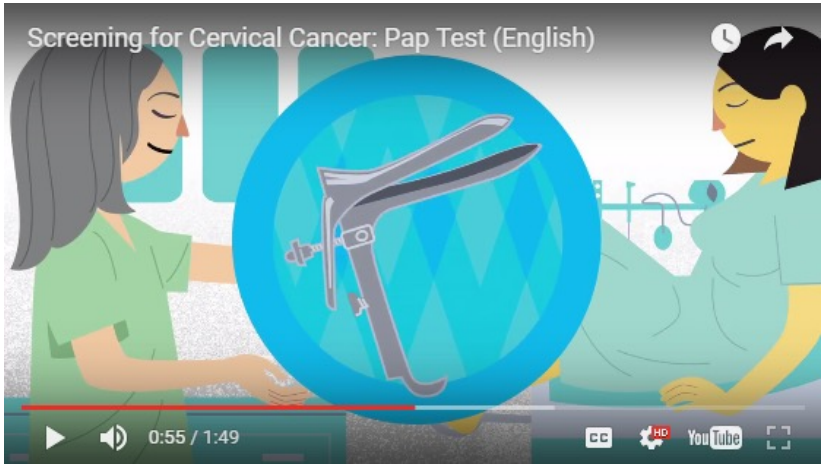
- “After Your Cervical Cancer Screening” tear-off pad



Resources

- "What You Should Know" clinic poster





- "Screening for Cervical Cancer: Pap Test" animated video
  - Available in multiple languages (English, Cantonese, Mandarin and Punjabi)

BC CANCER CERVIX SCREENING

Provincial Health Services Authority

Colposcopy

Answering your questions about your colposcopy procedure

screeningbc.ca/cervix

If you have recently had an abnormal Pap test result, your health care provider may recommend a follow up colposcopy appointment.

What does an abnormal Pap test result mean?

An abnormal cervical cancer screening (Pap test) result means that cells have been found on your cervix that do not look normal. Abnormal results are common and do not mean that you have cancer or precancerous cells.

Abnormal results are common and do not mean that you have cancer or precancerous cells. Abnormal cervical cancer screening (Pap test) results means that some cells on your cervix do not appear normal and require more testing.

What is colposcopy?

Colposcopy is a procedure used to examine your cervix and vagina. The doctor will use a special instrument called a colposcope to look for abnormalities. During the colposcopy, the doctor may take a biopsy of any areas that appear abnormal.

Colposcopy is a procedure used to examine your cervix and vagina for any abnormalities using a special instrument called a colposcope. During the colposcopy, the doctor may take a biopsy of any areas that appear abnormal.

Common Questions

What are the risks of having a colposcopy?

The risk of complications from a colposcopy is small, however a biopsy can cause an infection or bleeding in rare instances.

Is the colposcopy procedure painful?

The colposcopy itself should not be painful, but it may be uncomfortable. If a biopsy is taken during the procedure, you may experience slight pinching or cramping sensations.

What happens after the colposcopy?

There may be some spotting if a biopsy was taken which should stop within the first 24-48 hours. A tampon can be used to protect from spotting but ensure it is removed 3 hours after insertion.

What happens during my colposcopy?

1. The colposcopy exam will take less than 10 minutes to complete and will begin much like a Pap test.
2. The exam starts off much like a Pap test: a doctor (usually a gynecologist or specially-trained general practitioner) will use a "speculum" to gently spread the vaginal walls to get a better look at the cervix.
3. The doctor will use vinegar or iodine on your cervix to make any abnormalities more visible. The doctor will then perform a biopsy (taking a small tissue sample) for testing.
4. A gynecologist or specially-trained general practitioner will insert a speculum to gently spread the vaginal walls so as to get a better look at your cervix.
5. To make any abnormalities more visible, the doctor will place a small amount of vinegar or iodine on your cervix.
6. The doctor will then take a tissue sample, also known as a biopsy, from your cervix for additional testing.

Understanding the results of your colposcopy

My colposcopy results were normal and showed only low-grade cervical dysplasia (CIN1). What should I do now?

It is common to not require further treatment for mild or low-grade cervical dysplasia. Your doctor will explain your colposcopy results and will advise you on any next steps.

My colposcopy results were abnormal, showing high-grade dysplasia (CIN2, CIN3). What should I do next?

High-grade dysplasia can become cancerous if left untreated. Your doctor will discuss the option for a Loop Electrosurgical Excision Procedure (LEEP), which can be performed in the colposcopy clinic.

If not treated, over time, high-grade dysplasia may become cancerous. The most common treatment is the Loop Electrosurgical Excision Procedure (LEEP). The LEEP can be done in the colposcopy clinic.

BC Cancer Screening

Search...

Breast | Cervix | Colon | Health Professionals | Contact

Menu

Cervix / Further Testing / Colposcopy

Colposcopy

If you have recently had an abnormal Pap test result, your health care provider may recommend a follow up colposcopy appointment.

Colposcopy is a procedure used to examine your cervix and vagina.

In this section

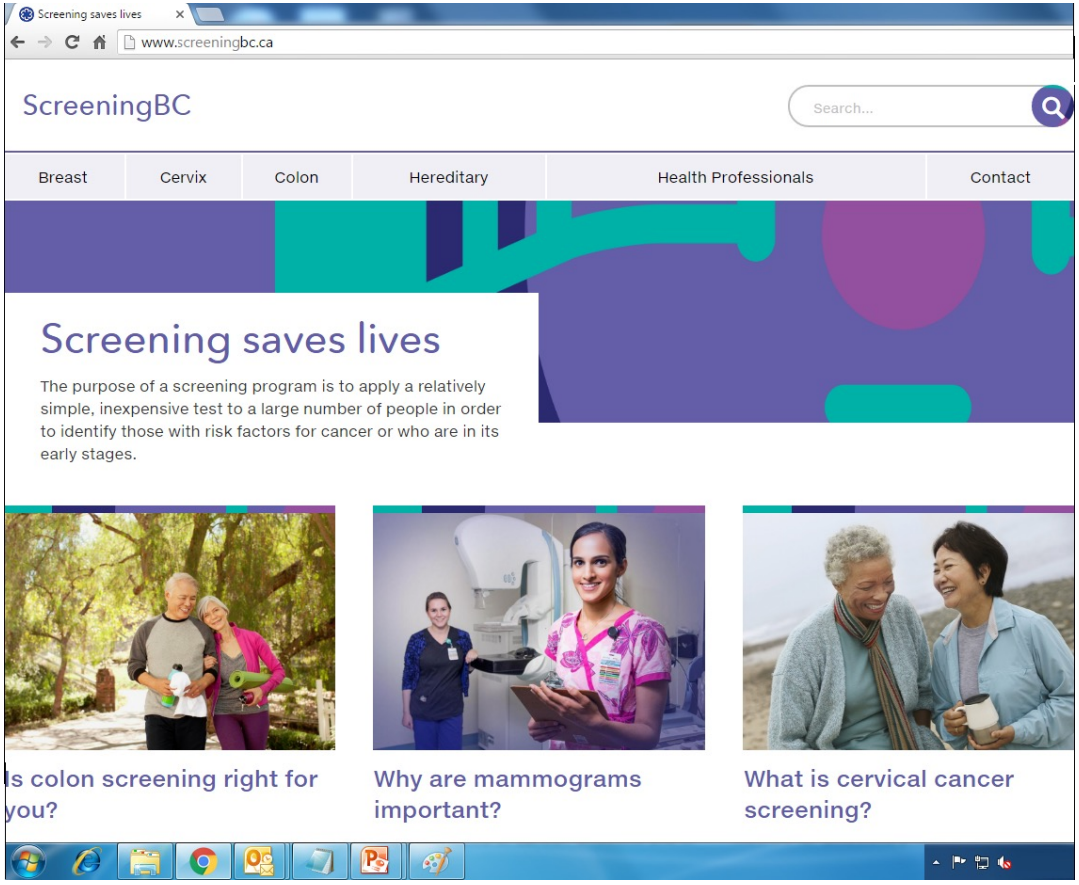
- Results
- Further Testing
- Your Next Cervical Screening

A cervical cancer screening (Pap test) can save your life. To book a test, call your

Information for patients to be integrated into Screening BC Cervix Screening section.

For more information…

Visit www.screeningbc.ca



Resources – Provider and Patient

- http://www.bccancer.bc.ca/screening/health-professionals/cervix
- http://www.bccancer.bc.ca/screening/health-professionals/cervix/colposcopy#Resources
- HPV FOCAL FAQ
  - http://www.bccancer.bc.ca/our-research/participate/cervical-screening
- www.sexualityandu.ca
- www.hpvinfo.ca
- http://immunizebc.ca/diseases-vaccinations/hpv
- NACI Guidelines:
  - http://www.phac-aspc.gc.ca/naci-ccni/index-eng.php

THANK YOU!!

Questions?

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BC's Cervical Cancer Screening Policy

Higher than Average Risk - NEW *Implemented June 2016*

http://www.bccancer.bc.ca/screening/Documents/CCSP_GuidelinesManual-ScreeningRecommendationsHighRisk.pdf

	CATEGORIES	SCREENING RECOMMENDATION	RETURN TO NORMAL SCREENING AFTER	SCREENING STOP AGE
HIGHER THAN AVERAGE RISK	**Immunocompromised individuals:**			
	• Including those with human immunodeficiency virus (HIV/AIDS), lymphoproliferative disorders, organ transplants, and those under long-term immunosuppression therapy	Annual screening	Never	The benefits of screening beyond age 69 must be weighed in the context of the overall health of the patient
	Previous cytological diagnosis of HSIL+ (or worse) or histological diagnosis of CIN 2+:			
	• CIN 2+ (not including AIS): treated (cone, LEEP, ablative therapy), HPV negative, discharged from colposcopy	Follow average risk guidelines	N/A	Age 69 or 25 years since most recent diagnosis with at least 3 Paps with no significant abnormality* in last 10 years – whichever occurs later
	• CIN 2+ (not including AIS): treated (cone, LEEP, ablative therapy), HPV positive, discharged from colposcopy	Annual screening	At least 3 negative Paps in last 5 years	Age 69 or 25 years since most recent diagnosis with at least 3 Paps with no significant abnormality* in last 10 years – whichever occurs later
	• CIN 2+ (not including AIS): untreated (regressed and discharged)	Annual screening	At least 3 negative Paps in last 5 years	Age 69 or 25 years since most recent diagnosis with at least 3 Paps with no significant abnormality* in last 10 years – whichever occurs later
	• CIN 2+ (includes AIS): untreated and lost to follow-up	Refer to colposcopy for assessment	N/A	Age 69 or 25 years since most recent diagnosis with at least 3 Paps with no significant abnormality* in last 10 years – whichever occurs later
	• Adenocarcinoma in situ (AIS) treated with LEEP or cone biopsy and discharged from colposcopy	Annual screening	25 years after the most recent histological evidence of AIS	Age 69 or 25 years since most recent diagnosis with at least 3 Paps with no significant abnormality* in last 10 years – whichever occurs later
	• Invasive Cervical Cancer and Annual screening discharged from colposcopy or the BC Cancer Agency	Annual screening	At least 3 negative Paps in last 5 years	Age 69 or 25 years since most recent diagnosis with at least 3 Paps with no significant abnormality* in last 10 years – whichever occurs later

** significant abnormality is anything more severe than ASCUS/LSIL*

BC's Cervical Cancer Screening Policy

Higher than Average Risk - NEW *Implemented June 2016*

http://www.bccancer.bc.ca/screening/Documents/CCSP_GuidelinesManual-ScreeningRecommendationsHighRisk.pdf

	CATEGORIES	SCREENING RECOMMENDATION	RETURN TO NORMAL SCREENING AFTER	SCREENING STOP AGE
HIGHER THAN AVERAGE RISK	**Previous cytological diagnosis of HSIL + (or worse):**			
	• HSIL: CIN 1 or negative at initial colposcopy, no subsequent biopsy or follow-up	Refer to colposcopy for assessment	N/A	Age 69 with at least 3 Paps with no significant abnormality* in last 10 years
	• HSIL: CIN 1 or negative at colposcopy, discharged from colposcopy	Annual screening	At least 3 negative Paps in last 5 years	Age 69 with at least 3 Paps with no significant abnormality* in last 10 years
	• Adenocarcinoma in situ (AIS) cytological diagnosis. CIN 1 or negative at colposcopy, discharged from colposcopy.	Annual screening	25 years after the most recent cytological evidence of AIS	Age 69 or 25 years since most recent diagnosis with at least 3 Paps with no significant abnormality* in last 10 years – whichever occurs later
	Total hysterectomy (with the cervix removed) and a history of:			
	• Invasive cervical cancer • Histologically proven CIN 2+ (including AIS) at colposcopy or hysterectomy • Histologically proven VAIN 2+	Vaginal vault smear annually	At least 3 negative Paps in last 5 years	Age 69 or 25 years since most recent diagnosis with at least 3 Paps with no significant abnormality* in last 10 years – whichever occurs later
	• Cytological diagnosis of HSIL + (includes AIS): CIN 1 or negative at hysterectomy	Vaginal vault smear annually	N/A	At least 3 negative Paps in last 5 years
	High risk behaviors			
	• Individuals who participate in high risk behaviors	Follow average risk guidelines	N/A	N/A

** significant abnormality is anything more severe than ASCUS/LSIL*