Cervical Cancer Screening Policy Change

Frequently Asked Questions

2016 Reference Guide Supporting Healthcare Professionals in Communicating Screening Information to Patients

www.screeningbc.ca/cervix
Forward

Changes to BC’s Cervical Cancer Screening Policy

Decreases in cervical cancer incidence and mortality have been highly correlated with the availability of organized screening programs. Since the introduction of BC’s Cervical Cancer Screening Program (CCSP) in the early 1960s, the province has successfully reduced cervical cancer rates by 70 per cent.

Building on this success, British Columbia and other jurisdictions with organized screening programs have been gathering valuable outcome data, contributing to a better understanding of cervical cancer control.

In British Columbia, an expert committee was convened in 2012 by the BC Cancer Agency to review the evidence pertaining to cervical cancer screening. The committee recommended that BC’s cervical cancer screening guidelines be changed to reflect the latest evidence, and ensure that women continue to benefit from screening, but avoid unnecessary tests and follow-up treatment.

Cervical cancer screening, as one of the clinical prevention services included in the Government of British Columbia’s Lifetime Prevention Schedule (LPS) was reassessed with the latest evidence in 2014. The LPS evidence supported changes to the screening guidelines.

As part of the preparation to implement the new policy, BC Cancer Agency reconvened the expert panel in 2015 to ensure the evidence is up to date. The following changes will be in effect Summer 2016:

- **Start Age**: Increase BC’s cervical cancer screening start age to 25
- **Screening Interval**: Increase the routine screening interval to 3 years
- **Repeat Cytology**: Decrease the length of conservative management of low grade abnormalities to 12 months

The next page summarizes the recommendations, and subsequent pages of this booklet delve into topic areas that have been flagged by BC primary care providers. Each topic area includes cited clinical evidence and key messages that can be shared with your patient. The key messages have been tested with a diverse sample of screen eligible individuals to maximize comprehension and understanding of this new policy.

British Columbia is also exploring technology changes to reflect advances in the detection of cervical precursor lesions and the presence of Human Papillomavirus (HPV) infection. We will keep you informed of any future changes for BC as they unfold.

We hope you find this resource helpful and look forward to our continued partnership in further reducing British Columbia’s cervical cancer incidence and mortality.

Sincerely,

Dr. Dirk Van Niekerk, MD, FRCP
Medical Director, Cervical Cancer Screening Program
BC Cancer Agency
**Clinical Summary of BC’s New Cervical Cancer Screening Policy**

Screening in an asymptomatic population aims to identify high-grade pre-cancerous lesions which can be treated to prevent the development of cervical cancer.

High grade lesions may be treated with ablative and excisional therapies, including laser ablation, loop electrosurgical excision procedure (LEEP) and cold knife conization.

Cervical cancer may be treated with surgery (hysterectomy) and/or radiation +/- chemotherapy.

<table>
<thead>
<tr>
<th>Average Risk</th>
<th>Recommendation</th>
<th>Screening Test</th>
<th>Screening Interval</th>
<th>Balance of Screening Harms and Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 25-69</td>
<td>Screen</td>
<td>Cytology</td>
<td>3 years</td>
<td>Benefits outweigh harms</td>
</tr>
<tr>
<td>Never had sexual contact*</td>
<td>Do not screen</td>
<td>No test</td>
<td>N/A</td>
<td>Harms outweigh benefits</td>
</tr>
<tr>
<td>Have received the HPV vaccine</td>
<td>Screen</td>
<td>Cytology</td>
<td>3 years</td>
<td>Benefits outweigh harms</td>
</tr>
<tr>
<td>In same sex relationship</td>
<td>Screen</td>
<td>Cytology</td>
<td>3 years</td>
<td>Benefits outweigh harms</td>
</tr>
<tr>
<td>Transgender with a cervix</td>
<td>Screen</td>
<td>Cytology</td>
<td>3 years</td>
<td>Benefits outweigh harms</td>
</tr>
<tr>
<td>After total hysterectomy†</td>
<td>Do not screen</td>
<td>No test</td>
<td>N/A</td>
<td>Harms outweigh benefits</td>
</tr>
<tr>
<td>Age &lt; 25</td>
<td>Do not screen</td>
<td>No test</td>
<td>N/A</td>
<td>Harms outweigh benefits</td>
</tr>
<tr>
<td>Age &gt; 69‡</td>
<td>Do not screen</td>
<td>No test</td>
<td>N/A</td>
<td>Harms outweigh benefits</td>
</tr>
<tr>
<td>Immunocompromised women§</td>
<td>Screen</td>
<td>Cytology</td>
<td>Annual</td>
<td>Benefits outweigh harms</td>
</tr>
<tr>
<td>History of pre-cancerous lesions or cervical cancer</td>
<td>Screen</td>
<td>Cytology</td>
<td>Annual</td>
<td>Please see section on Screening Recommendation for Individuals at High Risk of Developing Cervical Cancer</td>
</tr>
</tbody>
</table>

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

† Including removal of cervix, with no history of pre-cancerous lesions or cervical cancer.

‡ Provided there are 3 negative tests in preceding 10 years and no high risk criteria.

§ Immunocompromised includes those diagnosed with human immunodeficiency virus (HIV/AIDS), lymphoproliferative disorders, an organ transplant, and those under long-term immunosuppression therapy.
Cervical Cancer

How long does it take for cervical cancer to develop?

Once cervical cells begin to change, it typically takes 10-15 years for invasive cervical cancer to develop. As the cells change, they first become cervical intraepithelial neoplasia (CIN) grade 2 or 3. Given the threshold for treatment in BC is CIN 2 (moderate dysplasia), the incidence of invasive cervical cancer in BC is rare.

Clinical Evidence

- Cervical cancers usually develop very slowly, starting with cellular atypia due to infection with oncogenic (high-risk) types of the human papillomavirus (hr-HPV), then cervical dysplasia, and finally invasive cervical cancer. The pre-cancerous lesions are usually detectable through screening and are treatable in the majority of cases. In most cases, it takes years for these lesions to turn into cervical cancer.
- In a widely publicized study from New Zealand, progression to invasive carcinoma was 30% at 30 years in women who were left untreated after a histological diagnosis of CIN 3.
- Cancers of the cervix mainly include carcinomas of the mucosal epithelium, especially squamous cell carcinoma (up to 80% of cases) and adenocarcinoma (which occur in glandular cells).
- Long-term decreases in incidence rates for squamous cell carcinoma have been highly correlated with the availability of organized screening programs. In Canada, for example, the age-adjusted incidence for squamous cell carcinoma of the cervix declined from 11.1 per 100,000 women to 5.3 between 1970 and 1996.
- On the other hand, many countries, even those with organized screening programs, have seen an increase in adenocarcinoma of the cervix. In the United States, the age-adjusted incidence rate of adenocarcinoma increased by 29.1% between 1973 and 1996. In Canada, the age-adjusted incidence rate of adenocarcinoma increased from 1.1 per 100,000 women to 1.5 between 1970 and 1996. A key reason for this difference in trend between squamous cell carcinoma and adenocarcinoma is that Pap screening has had limited effectiveness in detecting precursors of adenocarcinoma.

References

Cervical Cancer

What Your Patient Should Know

• Long term infection with a high risk type of HPV can cause cervical cancer.
• There are many types of HPV infections, and most of them clear up by themselves without causing any problems. But sometimes HPV does not clear from the body. Over time it can cause changes in the cells on the cervix that cannot be seen or felt. These cells can change to cervical cancer if not found and treated early enough.

Did You Know?

Cervical cancer affects women in all countries – developed or not. Cervical cancer is more common in less developed countries because they often don’t have access to organized cervical cancer screening. Since the introduction of BC’s Cervical Cancer Screening Program in the early 60’s – the first in the world – the province has successfully reduced cervical cancer rates by 70%.
Human Papillomavirus

What is the link between HPV and cervical cancer?

Human papillomavirus (HPV) is a group of more than 100 different types of related viruses – 15 of which may cause anogenital cancer. HPV infection is very common, and will affect almost all individuals at some point in their lives. Although most HPV infections will clear on their own, long-term infection with high-risk HPV (hr-HPV) can cause precancerous changes to cells of the cervix, which can lead to cervical cancer if left undetected or untreated.

Clinical Evidence

- Evidence has now confirmed that long term persistent hr-HPV infection is necessary for the development of cervical cancer.  
- HPV is transmitted sexually, primarily through intercourse (vaginal or anal). Transmission requires skin to skin contact and intercourse is not a pre-requisite.  
- HPV infection is highly prevalent and most individuals will be infected with HPV at some point in their lives, with a 75% lifetime risk of infection.  
- Of the more than 100 known types of HPV, 15 can be defined as high-risk (hr-HPV) types and can cause cervical cancer. The two most prevalent hr-HPV types (associated with ~70% of cervical cancers) are HPV-16 and 18.  
- Low-risk HPV (lr-HPV) types cause anogenital warts (AGW) and are not associated with cervical cancer or its precursors. The two most common lr-HPV types are HPV-6 and 11.  
- The majority of HPV infections are cleared by the body's immune system within about 2 years. This is particularly the case in adolescents and women under the age of 30.  
- Research has found that long-term infection with hr-HPV types may lead to cervical dysplasia which can progress to cervical cancer if left undetected or untreated.  
- It typically takes 10 to 15 years from the time of an initial hr-HPV infection until a cancer forms.  
- It is not possible to predict which pre-cancerous lesions will become a cancer and which will regress. As a result, the threshold for treatment in BC is CIN 2.

References

13 Stanley, M. Pathology and epidemiology of HPV infection in females. Gyne Onc. 2010; 117: 55-510
Human Papillomavirus

What Your Patient Should Know

- HPV is a common virus. There are many types of HPV, and most of them clear up by themselves without causing any problems.
- There are two groups of HPV that may infect the cervix – low risk and high risk. Low risk types are **not** associated with cervical cancer but may cause genital warts and abnormal screening results. Long term infection with a high risk type of HPV may lead to cervical cancer or its precursors.
- HPV is transmitted through sexual activity, including intimate touching, oral, vaginal and anal sex.
- HPV infections are very common in women and men. Most people will get it at some point in their lives – often without knowing it.
- Sometimes HPV does not clear from the body. Over time it can cause changes in the cells on the cervix that cannot be seen or felt. These cells can change to cervical cancer if not found and treated early enough.
- HPV can take more than a decade to progress to pre-cancerous cells or cervical cancer. Screening can identify early abnormalities caused by HPV, which could develop into cervical cancer over time.
- By identifying abnormalities early, they can be treated and cancer can be stopped from developing. If cervical cancer is caught at its earliest stage, the chance of survival is more than 85 per cent.

Did You Know?

HPV is very common - most people have been exposed to HPV at some point in their lives without even knowing they had it.
HPV Vaccine

Do individuals who have received the HPV vaccine still need to be screened?

Individuals who have received the HPV vaccine still require cervical cancer screening because the vaccine does not protect against all types of HPV that can cause cervical cancer.

Clinical Evidence

- Three prophylactic HPV vaccines have been developed and approved for use in Canada, all of which are recommended by the National Advisory Committee on Immunization (NACI): Gardasil®9 (HPV9), Gardasil® (HPV4) and Cervarix® (HPV2).
- All three HPV vaccines protect against infection from HPV types 16 and 18 which cause about 70% of cervical cancers, 80% of anal cancers, and a significant proportion of other cancers such as oropharyngeal, penile, vaginal and vulvar. The quadrivalent and nonavalent vaccines also protects against infection from HPV types 6 and 11, which cause about 90% of anogenital warts.
- In 2015 Health Canada approved Gardasil®9, a second-generation HPV vaccine. Gardasil®9 is designed to prevent cervical, vulvar, vaginal and anal cancers caused by nine HPV strains, five more than the original Gardasil vaccine which has been in use since 2006. The earlier version (HPV4) covered HPV types 6, 11, 16, and 18. Gardasil®9 covers five more high risk types – type 31, 33, 45, 52, and 58, which researchers say are responsible for roughly another one in five cases of cervical cancer. This means that Gardasil®9 covers HPV types which cause 90% of cervical cancers. Gardasil®9 is not currently used in the BC school-based HPV vaccination program, but is available for private purchase.
- The same screening process must be applied to both vaccinated and unvaccinated individuals because HPV types that are not prevented by the vaccines cause a proportion of cervical lesions. Health professionals must educate patients about this to prevent complacency and false reassurance.
- Use of the HPV vaccine will reduce the number of women who have cervical dysplasia, thereby reducing the number of women with abnormal cervical cancer screening results and the associated follow up and treatments.

Did You Know?

Those not eligible for a free HPV vaccine can purchase it at most pharmacies, travel clinics and at some sexual health clinics. The HPV9 vaccine costs about $500 for the three doses over 6 months. The HPV4 vaccine costs about $450 for the three doses over 6 months. The HPV2 vaccine costs about $300 for the three doses over 6 months. Some health insurance plans cover the cost of the vaccine.
What Your Patient Should Know

- The HPV vaccine protects against the main types of HPV that can cause changes in the cells of the cervix, but not all.
- Women who have received the HPV vaccine still need to be screened regularly.
- The HPV vaccine is recommended for females age 9 to 45.
- The HPV vaccine is provided free to girls in Grade 6 in BC. Girls and young women born in 1994 or later who missed getting the HPV vaccine may contact their health care provider to get immunized at no cost.
Harms of Cervical Cancer Screening

What are the harms of cervical cancer screening?

While cervical cancer screening has proven very effective in decreasing the incidence of pre-cancer and cervical cancer, like any screening test, it isn’t perfect. It is possible that screening may result in false positive, or false negative results. False positive screens lead to unnecessary follow up and treatments, many of which may have long-term consequences for pregnancy or cause undue anxiety and distress.

Clinical Evidence

- Screening where practiced effectively, has resulted in decreased cervical cancer incidence and mortality in women\textsuperscript{20,21}.
- It is now well established that persistent infection with an oncogenic type of Human Papillomavirus (HPV) is necessary for the development of pre-cancer and cervical cancer\textsuperscript{22,23}.
- Most HPV infections and pre-cancerous lesions resolve spontaneously, particularly among younger women who are of childbearing age\textsuperscript{24}. Therefore, programs are calling for more conservative management of younger women\textsuperscript{25,26}.
- Commencing screening at a younger age is associated with an increase in the number of false-positive test results and unnecessary colposcopies regardless of the screening interval\textsuperscript{27}.
- Over-diagnosis and treatment of transient CIN is associated with substantial harms, including adverse psychosocial consequences in the women treated\textsuperscript{28,29}, increased risk of pre-term and low-birth weight babies (especially for women treated with excisional approaches)\textsuperscript{30}, and unnecessary utilization of health care resources.
- A 2008 study concluded that in the treatment of CIN, all excisional procedures seem to be associated with adverse obstetric morbidity, but among these, only cold knife conisation is associated with a significantly increased rate of severe outcomes\textsuperscript{31}.

References

Harms of Cervical Cancer Screening

What Your Patient Should Know

- Although most screening interpretations are accurate, there are some cases where women are identified as possibly having a cervical abnormality when they do not (false-positive) or, some cases of pre-cancer or cervical cancer may not be identified (false-negative).

- Cervical cancer screening is not as effective in younger women. Women under 25 have a higher prevalence of lesions that often clear without treatment.

- Cervical cancer screening identifies women who are at increased risk of developing cervical cancer. In young women, most of the abnormalities identified are transient and will resolve on their own within about 2 years. Treatment can lead to unnecessary anxiety and distress, or long-term consequences for pregnancy.

- Abnormal cells in the cervix are a result of persistent infection with high risk HPV. Infection with HPV is extremely common in women under age 25, however, most of these infections clear on their own within about 2 years.

- Starting cervical cancer screening at age 25 will reduce the number of unnecessary follow-up and treatments.

Did You Know?

While younger women are more likely to have abnormal cervical cancer screening results, the proportion of abnormal results that represent serious abnormalities is significantly lower among younger women.
Start Age

Why is BC changing the recommended start age for cervical cancer screening to 25?

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

1) Invasive cervical cancers in women younger than age 25 are rare;
2) Screening is relatively ineffective in younger women;
3) Women under 25 have a higher prevalence of lesions that often clear without treatment;
4) 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.

Clinical Evidence

Invasive cervical cancers in women younger than age 25 are rare.

- Analysis of 24 years of BC data\cite{34} collected from 1986 to 2009 indicates an incidence rate for cervical cancer of 0.50 cases per 100,000 women at age 20, 1.35 per 100,000 for women age 20 to 24 and 7.24 per 100,000 for women age 25 to 29. An incidence rate of 1.35 per 100,000 equates to less than two cases per year in women age 20 to 24.
- In Canada between 2005 and 2007, a total of 39 women age 20 to 24 (an average of 13 per year) were diagnosed with invasive cervical cancer, for an incidence rate of 1.20 per 100,000\cite{35}. Such a low incidence rate may not satisfy a key criterion for screening, which requires that a screening program facilitate prevention of an important public health problem at a population level\cite{36}.

Screening is relatively ineffective in younger women.

- Starting screening at a younger age is associated with an increase in the number of false-positive test results and colposcopies regardless of the screening interval\cite{37}.
- In countries where screening starts earlier than age 25, rates of cervical cancer are not significantly different than in countries that start screening at age 25 or older\cite{38}.

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

- As explained by Jayasinghe et al. in a 2011 review paper, “young women ≤25 years have the highest rate of infection because they have an immature cervical epithelium that is prone to HPV infection, lack acquired immunity and engage in high-risk sexual behaviour.”\cite{39}
- The majority of HPV infections are cleared by the body’s immune system. This is particularly the case in adolescents and younger women\cite{40,41,42}.
- HPV infections generally regress in about 2 years. HPV was found to persist to at least 30 months in just 9 per cent of women under age 30, compared to 21% of women age 30 and over\cite{43}.
- There is potential for over-diagnosis (and subsequent unnecessary treatment) of high grade cervical intraepithelial neoplasia (CIN) in women under age 25 because of the transient nature of HPV infection, and CIN lesions usually regress in this age group\cite{44,45}.

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.

- Over-diagnosis and treatment of transient CIN is associated with substantial harms, most importantly an increased risk of pre-term and low-birth weight babies (especially for women treated with excisional approaches), but also adverse psychosocial consequences\cite{46}.
Did You Know?
Both Finland and the Netherlands start cervical cancer screening at age 30 and both countries have some of the lowest cervical cancer mortality rates in the world.

What Your Patient Should Know

- Women should start cervical cancer screening at age 25, even if they became sexually active before this age.
- Screening women younger than age 25 has not changed the number of cervical cancer cases or cervical cancer deaths in this age group.
- Cervical cancer is rare in younger women regardless of whether they have received the HPV vaccine or not. In BC, for example, the peak incidence occurs between the ages of 35 to 44, with very few cases under the age of 25.
- Cervical cancer screening is not effective in women under age 25, and this age group is more likely to get lesions that clear without treatment.
- There are risks associated with unnecessary treatment, including undue anxiety and stress, as well as long-term consequences for pregnancy.
- Regardless of age, talk to your doctor if you experience any of the following symptoms:
  - Abnormal vaginal bleeding (such as bleeding in between periods, bleeding during/after sex or after menopause).
  - Abnormal or persistent vaginal discharge.
  - Pelvic pain, or pain during sexual intercourse.

References

34 Krueger et al. What is the most appropriate age to start screening women for cervical cancer? BCMJ, Vol. 55, No. 6, July, August 2013, page(s) 282-286
Screening Interval for Average Risk Woman

Why is BC changing the recommended interval for cervical cancer screening to 3 years?

Evidence, including BC data, demonstrates that cytology testing every three years is just as effective and safe as annually or biannually.

Clinical Evidence

- The relative effectiveness of differential cervical cancer screening intervals was first investigated in a 1986 analysis by the International Agency for Research on Cancer (IARC). Using data from eight countries (1,381 women with squamous cell carcinoma of the cervix and 2,259 age-matched controls), investigators compared the effect of different screening intervals on cervical cancer rates in women aged 20-64 (see table below). Based on this modeling exercise, annual screening from ages 20-64 produced the greatest reduction in cervical cancer incidence (93%), while five-yearly screening produced the lowest reduction (70%). On the other hand, screening every 5 years was the most efficacious approach, with just 549 tests required to prevent 1 cervical cancer. This IARC evidence is the basis for guidelines that recommend 3-5 year screening intervals, including the World Health Organization (WHO) guidelines which recommend 3-yearly screening from age 30.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Interval (Years)</th>
<th>Lifetime Tests</th>
<th>% Reduction in Incidence of Cervical Cancer</th>
<th>Tests per Cervical Cancer Prevented</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-64</td>
<td>1</td>
<td>45</td>
<td>93%</td>
<td>3,030</td>
</tr>
<tr>
<td>20-64</td>
<td>3</td>
<td>15</td>
<td>91%</td>
<td>1,042</td>
</tr>
<tr>
<td>25-64</td>
<td>3</td>
<td>13</td>
<td>90%</td>
<td>917</td>
</tr>
</tbody>
</table>


- Since the IARC study, numerous other studies have found that cervical cancer screening with cytology every three years is optimal.

- A large study that included data from the National Breast and Cervical Cancer Early Detection Program found insignificant further mortality reduction from cervical cancer for screening every year as compared with screening every three years.
Did You Know?

A study comparing Australia’s two year interval to the United Kingdom’s three year interval found similar effectiveness in screening every two years and screening every three years. Other provinces in Canada that already conduct cervical cancer screening every three years include Alberta, Manitoba, Ontario and Nova Scotia.

What Your Patient Should Know

- Average risk women between the ages of 25 to 69 should have a cytology screening (Pap test) every three years.
- Evidence shows that cytology screening (Pap test) every three years is just as effective and safe as every two years.
- Cervical cancer screening every three years after age 25 is sufficient. Screening earlier and more often increases the likelihood of causing harm, including unnecessary follow-up and treatments, many of which may have long-term consequences for pregnancy or cause undue anxiety and distress.
- Cervical cancer is caused almost exclusively by certain strains of human papillomavirus (HPV). HPV can take more than a decade to progress to pre-cancerous cells or cervical cancer.

References

**Individuals at High Risk of Developing Cervical Cancer**

Immunocompromised individuals and those previously treated for dysplasia are considered at high risk of developing cervical cancer and should be screened annually. Individuals currently being assessed by a colposcopy clinic or being followed by a cancer clinic should not undergo additional cervical cancer screening unless directed by the treating physician.

The table below outlines screening recommendations based on expert opinion, as there is currently insufficient data to support evidence-based cervical cancer screening recommendations for individuals at higher than average risk of developing cervical cancer.

<table>
<thead>
<tr>
<th>Category</th>
<th>Screening Recommendation</th>
<th>Return to Normal Screening After</th>
<th>Screening Stop Age</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunocompromised Individuals:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Immunocompromised Individuals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including those with human immunodeficiency virus (HIV/AIDS), lymphoproliferative disorders, organ transplants, and those under long-term immunosuppression therapy</td>
<td>Annual Screening†</td>
<td>Never</td>
<td>The benefits of screening beyond age 69 must be weighed in the context of the overall health of the patient</td>
</tr>
<tr>
<td><strong>Previous histological diagnosis of CIN ≥2+:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CIN ≥2+ (not including AIS): treated (cone, LEEP, ablative therapy), HPV negative, discharged from colposcopy</td>
<td>Follow average risk guidelines</td>
<td>N/A</td>
<td>Age 69 or 25 years since most recent diagnosis with 3 Paps with no significant abnormality* in last 10 years – whichever occurs later</td>
</tr>
<tr>
<td>• CIN ≥2+ (not including AIS): treated (cone, LEEP, ablative therapy), HPV positive, discharged from colposcopy</td>
<td>Annual screening</td>
<td>At least 3 negative Paps in last 5 years</td>
<td>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</td>
</tr>
<tr>
<td>• CIN ≥2+ (not including AIS): untreated (regressed and discharged)</td>
<td>Annual screening</td>
<td>At least 3 negative Paps in last 5 years</td>
<td>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</td>
</tr>
<tr>
<td>• CIN ≥2+ (includes AIS): untreated and lost to follow-up</td>
<td>Refer to colposcopy for assessment</td>
<td>N/A</td>
<td>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</td>
</tr>
</tbody>
</table>
### Individuals at High Risk of Developing Cervical Cancer

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommended Screening Frequency</th>
<th>Screening Duration or Age</th>
<th>Additional Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenocarcinoma in situ (AIS) treated with LEEP or cone biopsy and discharged from colposcopy</td>
<td>Annual screening</td>
<td>25 years after the most recent histological evidence of AIS</td>
<td>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</td>
</tr>
<tr>
<td>Invasive Cervical Cancer and discharged from colposcopy or the BC Cancer Agency</td>
<td>Annual screening</td>
<td>At least 3 negative Paps in last 5 years</td>
<td>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</td>
</tr>
</tbody>
</table>

Previous cytological diagnosis of HSIL + (or worse):

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommended Screening Frequency</th>
<th>Screening Duration or Age</th>
<th>Additional Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSIL: CIN 1 or negative at initial colposcopy, no subsequent biopsy or follow-up</td>
<td>Refer to colposcopy for assessment</td>
<td>N/A</td>
<td>Age 69 with at least 3 Paps with no significant abnormality* in last 10 years</td>
</tr>
<tr>
<td>HSIL: CIN 1 or negative at colposcopy, discharged from colposcopy</td>
<td>Annual screening</td>
<td>At least 3 negative Paps in last 5 years</td>
<td>Age 69 with at least 3 Paps with no significant abnormality* in last 10 years</td>
</tr>
<tr>
<td>Adenocarcinoma in situ (AIS) cytological diagnosis. CIN 1 or negative at colposcopy, discharged from colposcopy.</td>
<td>Annual screening</td>
<td>25 years after the most recent cytological evidence of AIS</td>
<td>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</td>
</tr>
</tbody>
</table>

Total hysterectomy (with the cervix removed) and a history of:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommended Screening Frequency</th>
<th>Screening Duration or Age</th>
<th>Additional Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive cervical cancer</td>
<td>Vaginal vault smear annually</td>
<td>At least 3 negative Paps in last 5 years</td>
<td>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</td>
</tr>
<tr>
<td>Histologically proven CIN 2+ (including AIS) at colposcopy or hysterectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histologically proven VAIN 2+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cytological diagnosis of HSIL + (includes AIS): CIN 1 or negative at hysterectomy</td>
<td>Vaginal vault smear annually</td>
<td>N/A</td>
<td>At least 3 negative Paps in last 5 years</td>
</tr>
</tbody>
</table>

High risk behaviors

<table>
<thead>
<tr>
<th>Condition</th>
<th>Recommended Screening Frequency</th>
<th>Screening Duration or Age</th>
<th>Additional Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals who participate in high risk behaviors</td>
<td>Follow average risk guidelines</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

† Immunocompromised individuals should start screening at age 25; however as there is not sufficient data at this time to support this start age, providers may wish to initiate screening for these patients at age 21.

* Significant abnormality is anything more severe than ASCUS/LSIL
Contact us:
Cervical Cancer Screening Program
801–686 West Broadway
Vancouver, BC V5Z1G1
screening@bccancer.bc.ca