



BC Cancer Agency

CARE + RESEARCH

An agency of the Provincial Health Services Authority

Screening for Cancer of the Cervix

An Office Manual for Health Care Providers



Cervical Cancer Screening Program
June 2017

www.screeningbc.ca/cervix

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Introduction

The Cervical Cancer Screening Program (CCSP) is an organized screening program that works to reduce cervical cancer incidence and mortality.

BC Cancer Agency (BCCA) and PHSA Laboratories provide medical and operational leadership for both the program and the Cervical Cancer Screening Laboratory (CCSL).

Cervical cancer screening tests have a potential for false negative and false positive results. If your patient has any clinically suspicious lesions, abnormal bleeding or other relevant symptoms, further evaluation is required even if the test result is normal.

Components of the Cervical Cancer Screening Program

Recruitment and Retention Screening Policy

In a true population-based screening program, all eligible individuals are invited to participate. At this time, recruitment to cervical cancer screening is opportunistic, in that family doctors and other health care providers initiate the sample collection from their patients. The sample is sent to the laboratory (CCSL) for processing and interpretation.

The program's centralized registry coordinates a system of recall by sending reminders to health care providers based on the appropriate screening interval recommendation for each patient.

Centralized Laboratory Services

CCSL processes and interprets approximately 550,000 tests annually. The laboratory distributes Pap test sampling supplies to health care providers at no cost.

Quality Assurance and Quality Control

CCSL demonstrates an ongoing commitment to providing quality patient care by following internationally recognized standards of excellence in lab practices. The laboratory participates in on-site accreditation inspection by the College of American Pathologists.

In addition, CCSL has submitted an application for accreditation by the College of Physicians and Surgeons of the British Columbia Diagnostic Accreditation Program. To ensure continuous quality improvement, CCSL monitors and evaluates quality indicators and obtain clinician feedback on a regular basis through a variety of methods.

Evaluation

Data is collected and analyzed on an ongoing basis to monitor the program's effectiveness and to identify areas of improvement. The program publishes an annual report every year. The report can be accessed at: www.screeningbc.ca/health-professionals

Colposcopy Service

The Provincial Colposcopy Service investigates women with abnormal results. If recommended, women should be referred promptly for colposcopy. A copy of the cytology report must accompany the referral letter. More information and the list of regional colposcopy clinics are available at: www.screeningbc.ca/cervix

Protocols for Cervical Cancer Screening

Screening 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.

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

† 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.

Screening Recommendations for 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.

	Category	Screening Recommendation	Return to Normal Screening After	Screening Stop Age
Higher than Average Risk	Immunocompromised Individuals:			
	<ul style="list-style-type: none"> Immunocompromised Individuals <i>Including those with human immunodeficiency virus (HIV/AIDS), lymphoproliferative disorders, organ transplants, and those under long-term immunosuppression therapy</i> 	Annual Screening ^t	Never	The benefits of screening beyond age 69 must be weighed in the context of the overall health of the patient
	Previous histological diagnosis of CIN 2+:			
	<ul style="list-style-type: none"> 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 3 Paps with no significant abnormality* in last 10 years – whichever occurs later
	<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> 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	

<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Invasive Cervical Cancer and 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
Previous cytological diagnosis of HSIL + (or worse):			
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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:			
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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			
<ul style="list-style-type: none"> Individuals who participate in high risk behaviors 	Follow average risk guidelines	N/A	N/A

† 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

Benefits and 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. Women should be aware of the benefits and harms of cervical cancer screening and make an informed decision to screen.

Benefits of Screening

- Screening where practiced effectively, has resulted in decreased cervical cancer incidence and mortality in women^{1,2}.
- Cervical cancer is one of the most preventable cancers. Cervical cancer begins as an infection of the uterine cervix with high risk human papillomavirus (hr-HPV) that needs to persist for many years. The transition from initial HPV infection to invasive cancer seems to take decades in most cases, with a minimal latency period of approximately 7 years^{3,4}.
- Cervical cancer screening saves lives. Most cervical cancer cases occur among women who have not undergone screening or who have had a long interval between Pap tests. In BC, about 58% of the 178 patients diagnosed with invasive cervical cancer in 2014 were five years or more overdue for screening⁵. The majority of cases are diagnosed in the 30-39 and 40-49 age groups⁵.
- Women between the ages of 25-69 stand to benefit the most from screening.

Harms of Screening

- Most HPV infections and pre-cancerous lesions resolve spontaneously, particularly among younger women who are of childbearing age^{6,7}.
- Over-diagnosis and treatment of these transient cervical intraepithelial neoplasia (CIN) is associated with substantial harms, including heightened psychosocial consequences in the women treated⁸, increased risk of pre-term and low-birth weight babies (especially for women treated with excisional approaches)^{9,10} 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 outcomes¹¹.
- Initiating screening in women under 25 can produce more harm than benefit, as cervical cancer is not common in women under age 25.

¹ Arbyn M, Raifu AO, Bray F, Weiderpass E, Anttila A. Trends of cervical cancer mortality in the member states of the European Union. *European Journal of Cancer* 2009;45:2640-8.

² Quinn M, Babb P, Jones J, Allen E. Effect of screening on incidence of and mortality from cancer of cervix in England: evaluation based on routinely collected statistics. *BMJ* 1999;318(7188):904-8.

³ Hildesheim A, Hadjimichael O, Schwartz P, et al.: Risk factors for rapid onset cervical cancer. *Am J Obstet Gynecol* 1999;180:571-577.

⁴ Liebrich C, Brummer O, Von WR, et al.: Primary cervical cancer truly negative for high-risk human papillomavirus is a rare but distinct entity that can affect virgins and young adolescents. *Eur J Gynaecol Oncol* 2009;30:45-48.

⁵ 2016 Cervical Cancer Screening Program Annual Report, BC Cancer Agency, www.screeningbc.ca

⁶ Woodman CB, Collins SI and Young LS. The natural history of cervical HPV infection: unresolved issues. *Nature Reviews: Cancer*. 2007; 7(1): 11-22.

⁷ Kulasingam S, Havrilesky L, Ghebrey R et al. Screening for Cervical Cancer: A Decision Analysis for the U.S. Preventive Services Task Force. 2011. Available at <http://www.uspreventiveservicestaskforce.org/uspstf11/cervcancer/cervcanceres.pdf>. Accessed January 2012.

⁸ Fylan F. Screening for cervical cancer: a review of women's attitudes, knowledge, and behaviour. *The British Journal of General Practice*. 1998; 48(433): 1509-14.

⁹ Martin-Hirsch PP, Paraskevaidis E, Bryant A, Dickinson HO, Keep SL. Surgery for cervical intraepithelial neoplasia. *Cochrane Database Syst Rev*. 2010(6):CD001318.

¹⁰ Kristensen J, Langhoff-Roos J and Kristensen FB. Increased risk of preterm birth in women with cervical conization. *Obstetrics and Gynecology*. 1993; 81(6): 1005-8.

¹¹ Arbyn M, Kyrgiou M, Simoons C, Raifu AO, Koliopoulos G, Martin-Hirsch P, Prendiville W, Paraskevaidis E. Perinatal mortality and other severe adverse pregnancy outcomes associated with treatment of cervical intraepithelial neoplasia: meta-analysis. *BMJ*. 2008 Sep 18;337:a1284

Role of the Health Care Provider

All Pap tests submitted for cervical cancer screening must be accompanied by a gynecological cytology requisition that identifies the name of a licensed health care provider in British Columbia to whom the Pap test report and follow-up reminder letters can be sent.

A “licensed health care provider” is a member in good standing of the BC College of Physicians and Surgeons, the College of Registered Nurses of BC or the Association of Naturopathic Physicians of BC. Registered midwives and certain nursing stations in rural areas are also acceptable.

RNs who meet the additional competency criteria for pelvic exams and cervical screening are encouraged to apply for an individual provider number. The application form is available at: www.screeningbc.ca/health-professionals

Health care providers play a key role in:

- Identifying individuals eligible for cervical cancer screening.
- Educating patients about the benefits and limitations of screening.
- Educating patients about the importance of regular cervical cancer screening.
- Informing patients of the signs and symptoms of cervical cancer.
- Forwarding copies of Pap test results to a patient’s primary health care provider (with her consent).

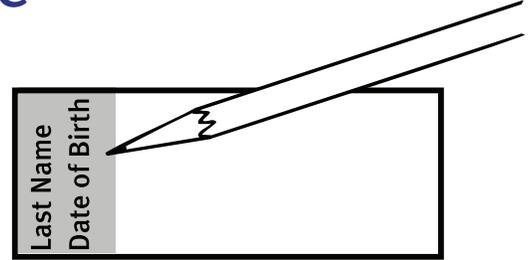
The health care provider is responsible for:

- A mechanism to ensure a report is received for each Pap test submitted.
- A mechanism to inform the woman of the Pap test result, including normal results.
- Protocols to ensure women are referred for specialist assessment and investigation when required, and ongoing care is coordinated.
- Protocols to support recall of women for regular Pap tests as recommended.

Pap Sampling Technique

Slide Labeling is Mandatory

Use a pencil to print the woman's date of birth and surname on the frosted end of the slide. Include at least the first seven letters if the surname has more than 7 letters. The name and DOB must be easy to read, written correctly and match the name and DOB on the requisition. DOB (dd/mm/yyyy) must match DOB registered with the Medical Service Plan. Pap sample will be rejected when surname and DOB are not written on the slide, or when there is a discrepancy in the DOB.



Single Slide Method

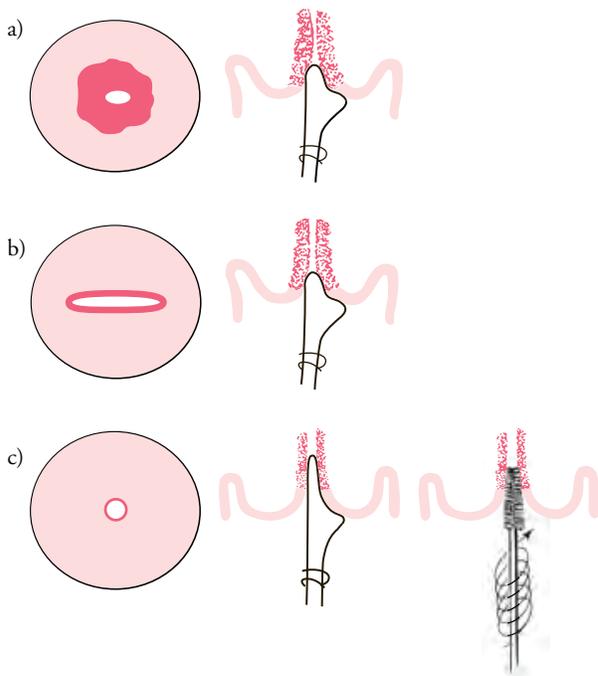
Please use the single slide method. Multiple slides from one woman are not necessary or cost effective. Women with a double cervix are the obvious exception. If two sites are sampled (i.e. cervix and endocervix), they can be applied side-by-side on the same side of a single slide.

Variations in Cervical Transformation Zone

A major cause of a false negative test is failure to sample the transformation zone (squamocolumnar junction).

The transformation zone is the region lying between the columnar epithelium of the endocervix and the mature squamous epithelium of the ectocervix. It is here that carcinogens act upon the squamous metaplastic cells of the transformation zone to cause squamous dysplasia and squamous carcinoma.

Generally, during the reproductive years, the transformation zone lies on the ectocervix. Post-menopausally, it recedes within the endocervix.



The location of the squamocolumnar junction is dependent on the woman's age, parity, hormonal status and any previous surgery.

If squamocolumnar junction is visible, sample with a spatula. If not visible (i.e. in the canal), sample with the elongated end of spatula or cytobrush.

- a) Reproductive age group, nulligravida; squamocolumnar junction often visible on ectocervix lateral to os. Os (small, round or oval). Sample with spatula.
- b) Reproductive age group, parous; squamocolumnar junction often at or near external os. Sample with spatula.
- c) Post menopause. Squamocolumnar junction often in canal. Cervical os often smaller. Sample with elongated end of spatula and cytobrush.

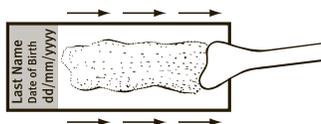
Obtaining the Sample

1. Gently insert a sterile, pre-warmed speculum to visualize cervix. A small (tiny) amount of lubricant may be used on the lower bill of the speculum for post menopausal women.
2. Gently cleanse the cervix with cotton pledget if obscured with discharge or secretions.
3. Identify extent of transformation zone and probable squamocolumnar junction.

If Squamocolumnar Junction is Visible

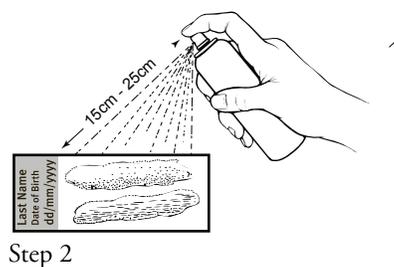
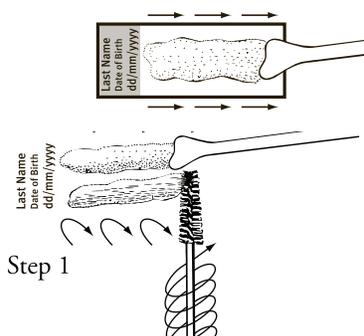
- Rotate a spatula 360° once to obtain a single sample.
- Smear the sample onto the labeled slide.
- Fix the sample immediately (before it is air-dried) using a cytology spray fixative.

Hold the fixative 15-20 cm (6 to 8 inches) away from the slide and evenly spray the slide by depressing the plunger 2 or 3 times. (See Step 2 below).



If Squamocolumnar Junction is Not Visible

- First use a spatula for the exocervical specimen.
- Then use a cytobrush or the elongated end of the spatula for the endocervical sample. Rotate cytobrush 180° only.
- Place both specimens side-by-side lengthwise on a single slide and fix immediately.



Cautions

- Use of the cytobrush is not recommended in pregnant women.
- If a clinically suspicious lesion is seen, biopsy immediately.
- If the patient is menstruating or infection is present reschedule exam.
- Irregular bleeding may be a symptom of gynecological malignancy. Pelvic examination with lower genital tract and appropriate investigation is indicated.

The use of cotton swabs for sampling is associated with cellular trapping and distortion and is not recommended.

Equipment and Supplies

Equipment and supplies	Order from:
Examination table	Medical supplier
Good illumination	
Bi-valve speculum (various sizes)	
Endocervical brush	
Cytology spray fixative (e.g. cytospray)	
Extended-tip spatula	Cervical Cancer Screening Laboratory (supplied free of charge)
Glass microscope slide with frosted end	
Container for transporting slide to the lab	
Requisition form	
Lead pencil for labeling slide	Stationery supplier

Completing the Gynecologic Requisition Form

To ensure the woman's demographics are up-to-date, the laboratory requires:

- Current and all previous surnames. Ensure correct spelling and enter first and middle names, if applicable. The name on the Requisition Form and the name on the slide must match exactly.
- CareCard or Personal Health Number (PHN).
- Date of birth (day/month/year) on the Requisition Form and on the slide must match exactly.

To ensure accurate report delivery, the laboratory requires:

- Practitioner's full address, including postal code and telephone number.
- Practitioner's MSC or Provider Number.
- Practitioner or clinic responsible for follow up, if different from above.

To ensure optimum evaluation of specimens, the laboratory requires:

- Date of the patient's last menstrual period (LMP).
- Relevant clinical history e.g., discharge, bleeding, suspicious lesions, medications.
- Relevant past history, such as the reason for the hysterectomy procedures, previous abnormal Pap tests, previous cervical malignancies, previous cervical investigations and/or treatments. This information helps determine appropriate follow-up recommendations.
- Please print clinical comments clearly on requisitions to ensure they are legible.

Transporting the Pap sample

To ensure that the slides arrive at the Cervical Cancer Screening Laboratory:

- The labeled slides, which must have a minimum of the first 7 letters of the surnames and the dates of birth written in pencil on the frosted end of each slide, should be placed in the mailing containers provided.
- The completed gyne requisition should be folded, wrapped around each slide-mailing container and secured with an elastic band. There is no need to apply a patient identification label to the mailing container.
- Pap samples requiring expedited processing due to clinical concerns should be marked URGENT on the sample's outer packaging using a red marker in addition to writing URGENT on the requisition.
- The slide and requisition should be sent by courier or Canada Post addressed to the laboratory (Slides may be collected and sent in weekly batches):

Cervical Cancer Screening Laboratory
c/o Central Processing and Receiving
655 West 12th Avenue
Vancouver, BC V5Z 4R4

Phone: 1-877-747-2522 (1-877-PHSA LAB)

Specimen Rejection Policy

Inadequately labeled, mislabeled or unlabeled specimens have been identified as a significant source of sample error worldwide. For this reason, the Cervical Cancer Screening Laboratory must accurately identify all slides that are processed in the laboratory. The Laboratory will not process unlabeled, insufficiently labeled or mislabeled slides. Health care providers are advised when a new sample needs to be collected.

A Pap sample may be rejected for these technical reasons:

- Slide was received broken or was broken during handling in the laboratory and is considered beyond repair
- Slide was not labeled with woman's surname and date of birth
- Mismatch between the name and date of birth on the slide and the name and date of birth on the requisition
- Improperly or unclearly labeled slide

Optimal and Unsatisfactory Tests

What is an optimal cervical cancer screening test?

The presence of endocervical cells, metaplastic cells, and squamous cells suggest a high probability that the transformation zone has been sampled, which is necessary for a cervical smear to be considered optimal.

Cytologists continue to debate the criteria necessary to ensure that the transformation zone has been sampled.

The presence of squamous metaplastic cells and endocervical cells and/or atypical cells is generally regarded as evidence of adequate sampling of the transformation zone.

Pap samples can be considered unsatisfactory for these interpretative reasons:

- 75% or more of the test is obscured by inflammatory exudate or blood
- Too few cells are present on the test (generally less than 8,000 well-preserved, well-visualized squamous cells)
- Sample is too thick (cells are on top of each other so cytotechnologist is unable to examine individual cells)
- Sample consists mainly of endocervical glandular cells (sample mainly from the endocervical canal and not representative of the transformation zone)
- Cells are too poorly preserved for adequate interpretation, due to poor fixation or micro-organism presence.

Human Papillomavirus 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.

Of note is that the HPV types associated with visible genital warts do not predispose to invasive cancer. At present, the role of HPV testing for cervical cancer

screening is being evaluated in British Columbia in a large randomized trial, the HPV FOCAL Study, which began in 2007. For further details about the HPV FOCAL Study, visit: www.bccancer.bc.ca/hpvfocal

An HPV vaccine that protects against the most common HPV types associated with cervical cancer has been available in Canada since 2006. This allows us to move in the direction of preventing this common infection in the hopes of further reducing the incidence of cervical cancer. In 2008, the HPV vaccine was introduced into BC's school-based vaccination program for girls in Grades 6 and 9. The grade 9 program will end after 2010/2011.

Emerging Technologies

Recent advances in gynecological cytology have focused on improving specimen preparation and processing and on the interpretation of cytological findings. They will lead to an increase in screening accuracy and subsequently improve the detection rate of pre-invasive and invasive cervical malignancies.

Liquid-Based Cytology (Thin-Layer Cytology)

The sample is collected with a spatula and/or brush in the same way as for the conventional Pap test. Instead of testing the sample on the slide, the specimen is washed directly into a vial containing liquid fixative.

Slide preparations are made from the liquid sample in the laboratory. The cells are fixed more uniformly, mucus is dissolved, large cell clusters are dispersed and debris and excessive blood are removed in the slide preparation.

Random cell disbursement allows for easier interpretation. Evidence on whether liquid based cytology increases the detection of significant cervical cancer precursor lesions is inconclusive. It is not currently available in British Columbia.

HPV Testing

Infection with high risk strains of Human Papillomavirus (HPV) are a necessary step in the development of cervical cancer. Large randomized controlled trials have shown that HPV testing is more sensitive but less specific than Pap testing. BC Cancer Agency and BC Centre for Disease Control are conducting a three-arm randomized controlled trial to evaluate HPV Testing as primary screening for cervical cancer within an organized cervical cancer screening program, The HPV FOCAL Study is funded by the Canadian Institute of Health Research (CIHR).

For more information visit the HPV FOCAL website: www.bccancer.bc.ca/hpvfocal

Machine-Assisted Screening

Computerized screening devices are algorithm-based decision making instruments. Some automated screening devices require specially prepared and/or stained slides, while others can use routinely stained tests. These machines can be used for primary screening or as re-screening devices. In the United States, where 10% of all negative slides must be re-screened, an automated device was shown to detect 2 – 3 times more false-negatives than manual interpretation. In a primary screening mode, up to 25% of all slides from women with a low probability of having cervical precancerous lesions can be scanned by machine only without further intervention by a cytotechnologist.

Education Materials

Education materials for health care providers and women are available at no charge from the Cervical Cancer Screening Program. Health care providers can obtain education materials by using the order form on the Cervical Cancer Screening Program website: www.screeningbc.ca/health-professionals

Materials for health care providers

- Educational video (online or DVD) – A Women-Centered Approach to Cervical Cancer Screening
- Cervical Cancer Screening Policy Change - 2016 Reference Guide Supporting Health Professionals
- Cervical Cancer Screening Protocol Fact Sheet
- Website: www.screeningbc.ca/health-professionals

Materials for patients

- Brochures about cervical cancer screening and abnormal results
- Posters
- “Next Steps” tear-off pad
- Website: www.screeningbc.ca/cervix

Feedback

It is important that we receive your feedback to ensure that this Manual meets your needs and the needs of the Cervical Cancer Screening Program.

Please forward any comments/suggestions you may have after using the Eleventh Edition of the Office Manual to:

Cervical Cancer Screening Program
Administration Office
8th Floor, 686 West Broadway
Vancouver, BC V5Z 1G1
Fax: 604-660-3645
e-mail: screening@bccancer.bc.ca

Ordering Supplies

To order supplies from the Cervical Cancer Screening Laboratory please fax requests to 604-707-2606.

For general inquiries related to the Cervical Cancer Screening Laboratory please call 1-877-747-2522.