Overview Table: Cervix Screening Recommendations and Results

For the complete Program Overview, go to www.bccancer.bc.ca/screening/Documents/Cervix-Program-Overview.pdf

Summary Screening Recommendations	
Age to Start Screening	• Initiate screening at age 25. Cervical screening is not recommended for those over age 25 who have never been sexually active.
Cessation of Cervical Screening	• **Average Risk:** Stop screening at age 69, provided that there has been a negative HPV screening test between the ages of 65 and 69 and under no active surveillance of pre-cursor abnormalities. • **Immunocompromised:** Stop screening at age 74 provided there has been a negative HPV screening test between the ages of 65 and 69 and under no active surveillance of pre-cursor abnormalities. • Those who have been discharged from colposcopy, but have not yet completed the post discharge 12 month cotest (HPV and cytology testing) before age 69 (average risk) or 74 (immunocompromised), should continue with screening until they have had a negative cotest. After this, screening can be discontinued.
Management of Those over age 69 with HPV Positive Results	• Refer to colposcopy directly. • If colposcopic evaluation is negative, discharge to primary care for a repeat HPV test in 12 months. If patients continue to be HPV positive, refer back to and follow in colposcopy until HPV negative or aged 79. • At age 79 and the colposcopic examination is negative, HPV positive patients can be discharged with no further need for screening.

Screening of Immunosuppressed	• Immunosuppressed patients to initiate cervix screening with an HPV test starting at age 25 if they are or have ever been sexually active. • Immunosuppressed patients who are HPV negative to screen every 3 years with an HPV test. • Immunosuppressed patients can stop screening at age 74, provided that there has been a negative HPV screening test between the ages of 69 and 74 and they are under no active surveillance of pre-cursor abnormalities. • Immunosuppressed patients who are positive for high risk HPV, regardless of genotype or cytology results, refer directly to colposcopy.
Screening of Transgender, Gender-Diverse and Non-Binary People	Cervix Present • Follow the recommendations for average risk screening for cervix screening. Cervix Removed • No prior CIN 2, CIN 3 or AIS, cervix screening not recommended. People who have had a total hysterectomy with history of CIN 2, CIN 3 or AIS should have a cotest (HPV and cytology testing) on a sample from the vaginal vault at 12 months post hysterectomy. Any positive HPV test or a high grade or glandular cytology result should be referred directly to colposcopy. After a negative cotest, screening can be discontinued. Neovagina, No Cervix • Individuals who had a vaginoplasty or surgically created vagina, screening is not recommended.
Screening of DES-Exposed Patients	• Annual colposcopic examination of both the cervix and vagina with cotest (HPV and cytology testing) is recommended until age 69.

Screening in Pregnancy	• Screening is not necessary as a routine part of pre-natal screening for those who are up to date with screening. Screening can be delayed in patients who are expected to continue to engage with the health system until they are postpartum. • Provider-collected cervix screening can be offered during pregnancy if screening is due or overdue. • Use prenatal care as an opportunity to engage under or never screened patients in the screening program.
Screening after Hysterectomy	• People who had a total hysterectomy (i.e. cervix removed and with no past or present high-grade cervical abnormality (i.e. CIN 2, CIN 3, AIS or cervical carcinoma) can discontinue screening. • People who had a subtotal hysterectomy with conservation of the cervix and with no past or present high-grade cervical abnormality (i.e. CIN 2, CIN 3, AIS or cervical carcinoma) should continue to follow average risk guidelines. • People who have had a total hysterectomy with current or past high-grade cervical abnormality (i.e. CIN 2, CIN 3 or AIS) should have a cotest (HPV and cytology testing) on a sample from the vaginal vault at 12 months post hysterectomy. Any positive HPV test or if cytology shows ASC-H, HSIL or AGC, refer to colposcopy. If HPV is negative and cytology is NILM, ASCUS or LSIL, screening can be discontinued.
Screening after Excisional Treatment for High Grade Cervical Intraepithelial Neoplasia (CIN)	• After discharge from colposcopy, cotest (HPV and cytology testing) at 12 months through their primary care provider. • If HPV is negative and cytology is NILM, ASCUS or LSIL they can transition back to routine HPV-based screening at 3 year intervals (average risk) or 1 year interval (immunocompromised). • If at the 12 months cotest (HPV and cytology testing), high risk HPV is positive or if cytology shows ASC-H, HSIL or AGC, re-refer to colposcopy. • Screening can be discontinued at age 69 (average risk) or 74 (immunocompromised) provided the patient has had a negative cotest (HPV and cytology testing) and they are under no active surveillance of pre-cursor abnormalities.

Screening after Excisional Treatment for Endocervical Adenocarcinoma in Situ (AIS)	• After discharge from colposcopy, cotest (HPV and cytology testing) at 12 months through their primary care provider. • If HPV is negative and cytology is NILM, ASCUS or LSIL they can transition back to a cotest (HPV and cytology testing) at 3 year intervals (average risk) or 1 year interval (immunocompromised). • If High risk HPV is positive or if cytology shows ASC-H, HSIL or AGC, re-refer to colposcopy. • Screening for HPV negative patients can be discontinued at age 69 (average risk) or 74 (immunocompromised) provided that there has been a negative cotest (HPV and cytology testing) at last screen and they are under no active surveillance of pre-cursor abnormalities.
Screening after Cervical Cancer Treated with Surgery or Radiation	• The patient's colposcopist or oncologist is responsible for outlining the post-treatment follow-up of a patient diagnosed with cervical cancer for the first 5 years. • Once discharged from the care of the colposcopist/oncologist, screening is no longer recommended. Ongoing surveillance for recurrence by someone experienced in cervical disease is recommended.
Cervical Evaluation in Those Exhibiting Signs and Symptoms of Cervical Cancer	• Cervix screening is only appropriate for those who are age eligible and asymptomatic. • People with symptoms eg. post coital bleeding, abnormal bleeding and/or a persistent vaginal discharge should have a speculum examination by someone with experience in gynecologic exams. • Providers can perform a cotest (HPV and cytology testing) and referral to a colposcopist is appropriate and may be expedited if the clinical suspicion is high. • A cotest (HPV and cytology testing) is not required for referral and referral should not be delayed pending results of the cotest.

Cervix Screening Results	
HPV Invalid	• Repeat HPV testing. Unless a cotest (HPV and cytology testing) was recommended, a self-screening test will be sent to the patient at the time of the invalid result notification. • If repeat test is invalid, refer to colposcopy. • Patients who continue to have an invalid result with 3 separate tests, regardless of collection method, will be referred to colposcopy.
Rejected Samples	• CCSL will reject and will not process specimens if specimen identification cannot be confirmed. • Unless a cotest (HPV and cytology testing) was recommended, a self-screening test will be sent to the patient at the time of the invalid result notification.
Unsatisfactory Samples	• Samples which are inadequate for interpretation due to poor preservation or obscuring elements. • Unless a cotest (HPV and cytology testing) was recommended, a self-screening test will be sent to the patient at the time of the invalid result notification.
High Risk HPV Negative	• Repeat cervical screening in 5 years. • Shorter screening interval recommendation for immunocompromised patients and after treatment for CIN 2, CIN 3 or AIS.
High Risk HPV 16/18 Positive	• Refer to colposcopy. • If screening is performed with a provider-collected sample, the CCSL will perform a cytological evaluation to aid in the colposcopist's decision. • If screening is performed by self-sampling, colposcopist will collect a cytology sample to aid with management decisions.
High Risk HPV Other Positive with ASC-H, HSIL or AGC Cytology	• Refer to colposcopy.
High Risk HPV Other Positive with Unknown or Unsatisfactory Cytology Result	• Follow-up cervical screening with primary care provider. • If cytology samples are reported as unsatisfactory on two different occasions, colposcopy referral is recommended.

High Risk HPV Other Positive with Cytology Negative (NILM), ASCUS or LSIL	• Repeat HPV in 12 months.
	• If repeat HPV test is negative, return to routine screening (e.g. every 5 years for average risk patients).
	• If repeat HPV test is positive for any HPV type; refer to colposcopy.
	  ○ If screening is performed with a provider-collected sample, the CCSL will perform a cytological evaluation to aid with colposcopist's decision.
	  ○ If screening is performed by self-screening, colposcopist will collect a cytology sample at the time of colposcopy to aid with management decisions.

ASCUS and LSIL	• Pap test will be triaged by reflex HPV testing.
	  ○ If HPV test is positive for HPV other than 16 or 18; HPV testing is recommended in 12 months.
	  ○ If HPV test is positive for HPV 16 or 18; colposcopy referral is recommended.
	  ○ If HPV test is negative; return to routine screening (e.g. every 5 years for average risk patients).

ASC-H, HSIL, Moderate Dysplasia and Severe Dysplasia	• Refer to colposcopy.
Atypical Glandular Cells	• Refer to colposcopy.
Benign Endometrial Cells in Cervical Sample	• Cervical cytology examination has poor sensitivity for endometrial carcinoma and should not be used as a screening test to either rule in or rule out an endometrial abnormality.
Atypical Endometrial Cells or Endometrial Carcinoma	• Refer to colposcopy or a general gynecologist for further evaluation which should include an endometrial biopsy.
Possible Extrauterine Carcinoma or Rare Malignancies	• Features of possible extrauterine carcinoma or rare malignancies may be identified in cytology samples collected from participants who are HPV positive. • These should be dealt with on a case-by-case basis and may need a multidisciplinary team approach for management. Contact the CCSL for clarification of the results if needed.