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# Preventing Cervical Cancer 2018

WHAT THIS WILL MEAN FOR PRIMARY CARE

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National Screening Unit

# TAKE-HOME LESSONS

- Vaccination is Primary Prevention for Cervical Cancer
- Women with Symptoms **MUST BE EXAMINED** by an experienced examiner
- Screening starting Age 25 is Secondary Prevention for Cervical Cancer
- HrHPV testing is a better test than Cytology for detecting pre-cancerous lesions
- Co-testing (HrHPV and Cervical Cytology) everyone in a public health setting leads to overtreatment and prohibitive costs.
- HrHPV testing with partial Genotyping and cytology triage cotests the population at risk.



# Cervical Cancer is a Preventable Disease

- Consider this Woman:
- 7 pregnancies and 7 living children all under the age of 12
- June 2016: Pregnant; a lump on her cervix required a c-section to have her baby as she would be unable to have a normal birth
- Diagnosed with cervical cancer at end of her last pregnancy 24 June
- Started chemo in July 2016 and died in March
- Her baby is now one
- Would have been attended by health professionals on multiple occasions over the 12 years. Probably would have been Symptomatic.
- This women was never screened.



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# Take-home Lessons

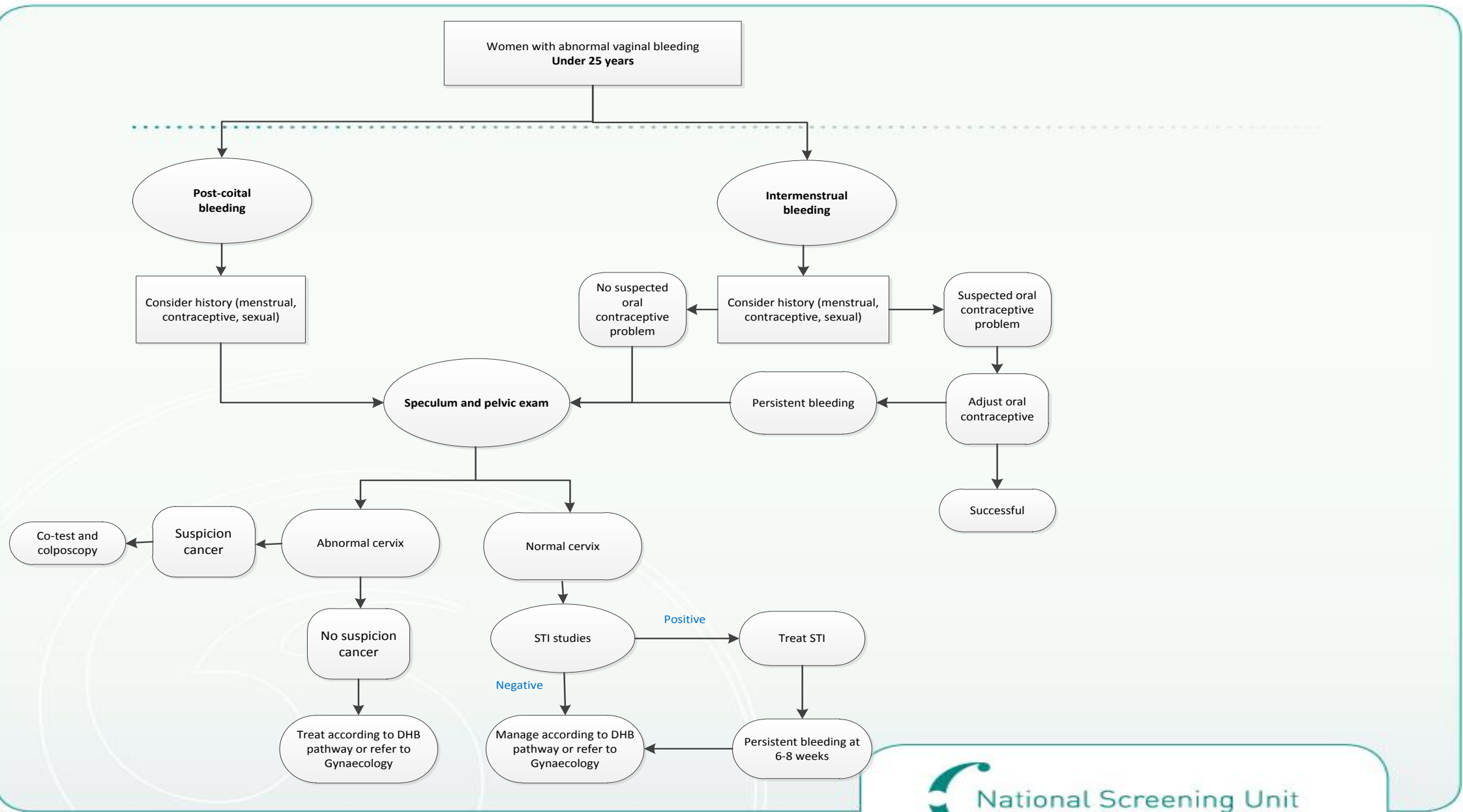
- We must find a way to engage the never screened and the under screened
- Need to utilise “Data Matching Reports”, “Support to Screening Services”
- Education by a trusted person
- Minimizing barriers to access

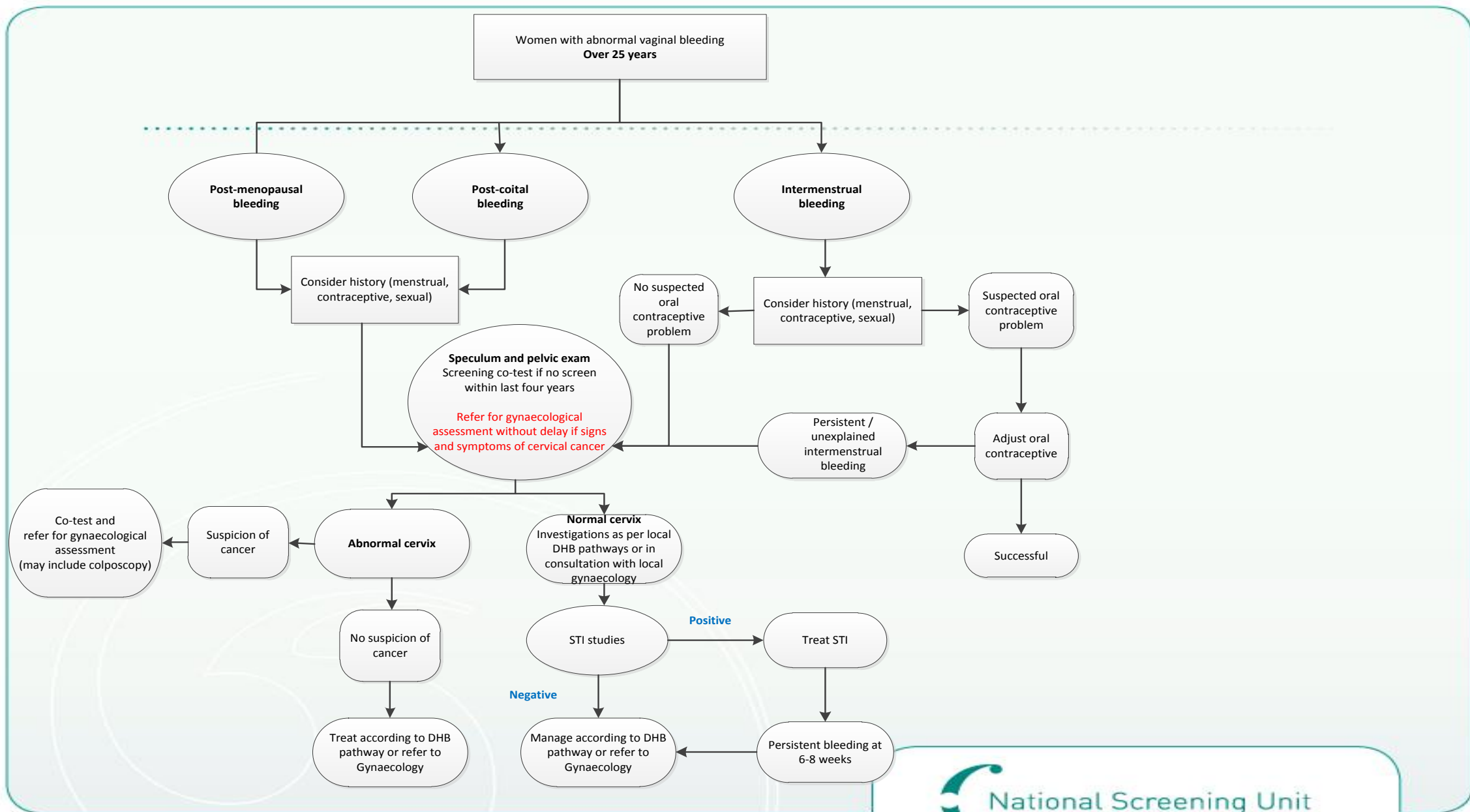


# Abnormal Bleeding

- We Must examine Symptomatic women
  - Missed cancers are not due to lack of cytology
  - Missed cancers are because of failure to examine
  - How proscriptive should we be
    - DHB Pathways
    - Local resource issues
  - Who of those examined need cytology before referral?





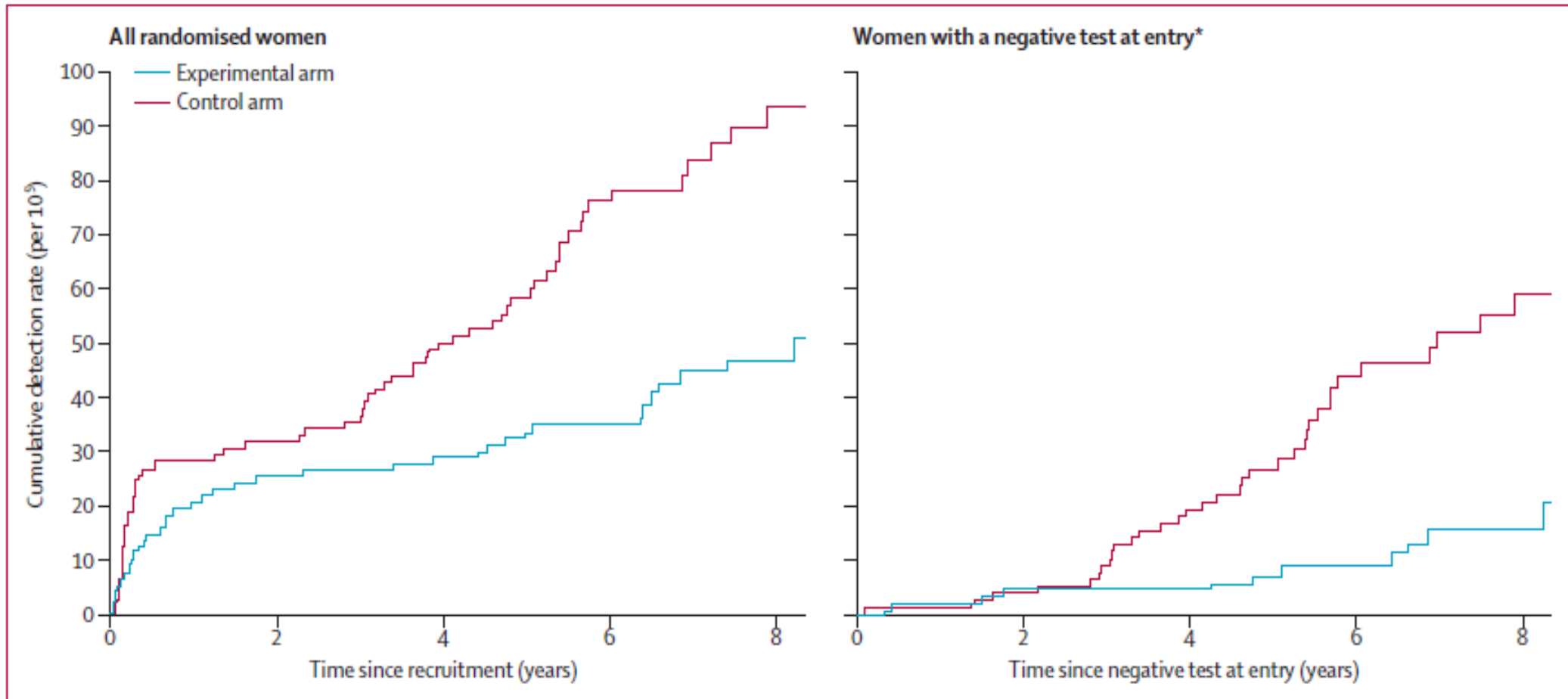


# Why is Screening Effective in Preventing Cancer of the Cervix

- Screening is effective mainly because the ability to detect treatable high-grade pre-invasive cervical lesions allows us to **prevent** invasive cervical cancer
- CIN2/3+ is a highly suitable endpoint for studies about screening effectiveness because CIN2/3 is what we are primarily trying to detect
- CIN2/3+ is not being used as a surrogate marker for invasive cancer: it is exactly the lesion we want to find







**Figure 2: Cumulative detection of invasive cervical carcinoma**

\*Observations are censored 2.5 years after CIN2 or CIN3 detection, if any.

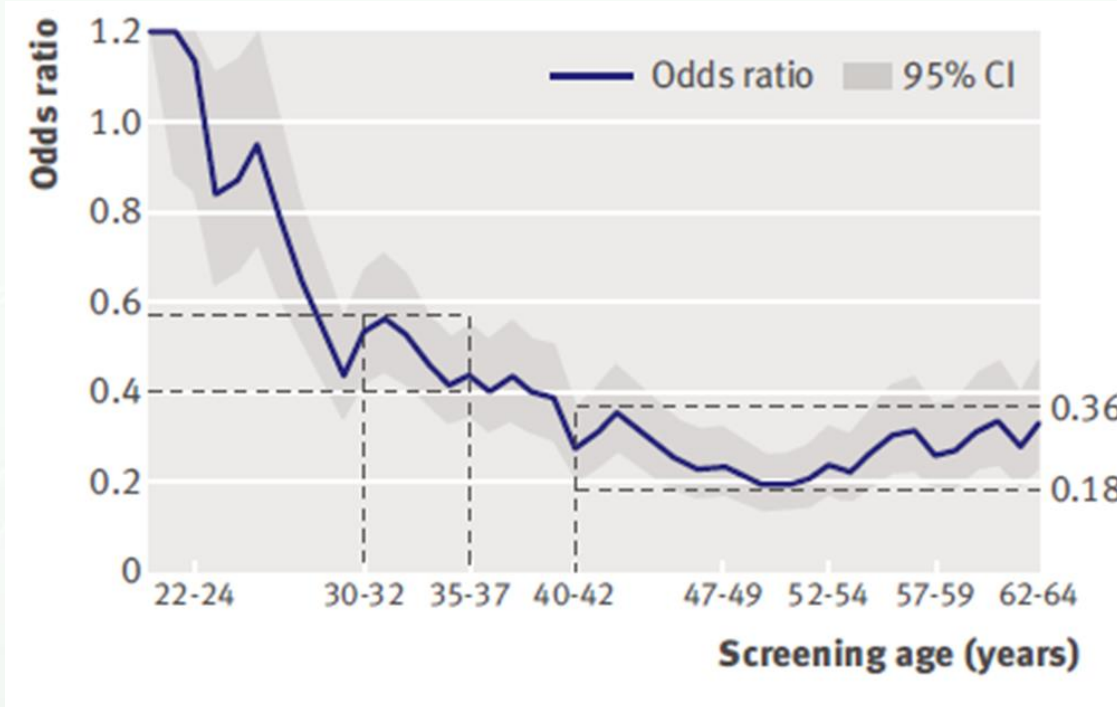
Ronco et al Lancet 2014

# Co-testing women who are at higher risk of having invasive cancer makes sense

- Selective co-testing for women who:
  - have positive hrHPV screening test
  - symptoms suspicious of invasive cancer
  - have been treated for a high-grade lesion (test of cure)
  - are at greater clinical risk (e.g. immunosuppressed)
  - this is investigation of increased individual risk, not population-based screening of asymptomatic women



# Commence screening age 25



High incidence HPV and CIN.

Low risk of cancer.

Spontaneous regression

Potential harm  
intervention

Impact of HPV vaccination

*P Sasieni BMJ 2009;339:b2968*

# Results – by age

**Incidence of cervical cancer in NZ by age and ethnicity, and ratio of the rate in 2009-2013 compared to 1985-1989 (SRR)**

	Māori women				Non-Māori women			
	1985-1989	2009-2013	SRR	95% CI	1985-1989	2009-2013	SRR	95% CI
All ages	32.5	14.8	0.45	(0.34 - 0.6)	15.6	6.5	0.42	(0.37 - 0.46)
20-69	46.3	19.9	0.43	(0.33 - 0.56)	20.6	8.6	0.42	(0.37 - 0.47)
20-24	2.5	4.7	1.89	(0.49 - 7.31)	1.1	2.9	2.75	(1.15 - 6.58)
25-49	41.5	20.6	0.50	(0.36 - 0.68)	21.3	10.3	0.48	(0.42 - 0.56)
50-69	65.6	23.2	0.35	(0.22 - 0.56)	25.3	7.9	0.31	(0.25 - 0.38)
70+	28.7	20.0	0.70	(0.21 - 2.37)	23.9	9.9	0.41	(0.32 - 0.54)

*SRR less than 1 indicates reduction compared to pre-NCSP period; SRR greater than 1 indicates an increase*

# Safety of Change

- We already have our Policy and Standards which are being updated
- Working group for Safety Monitoring Indicators

Transition

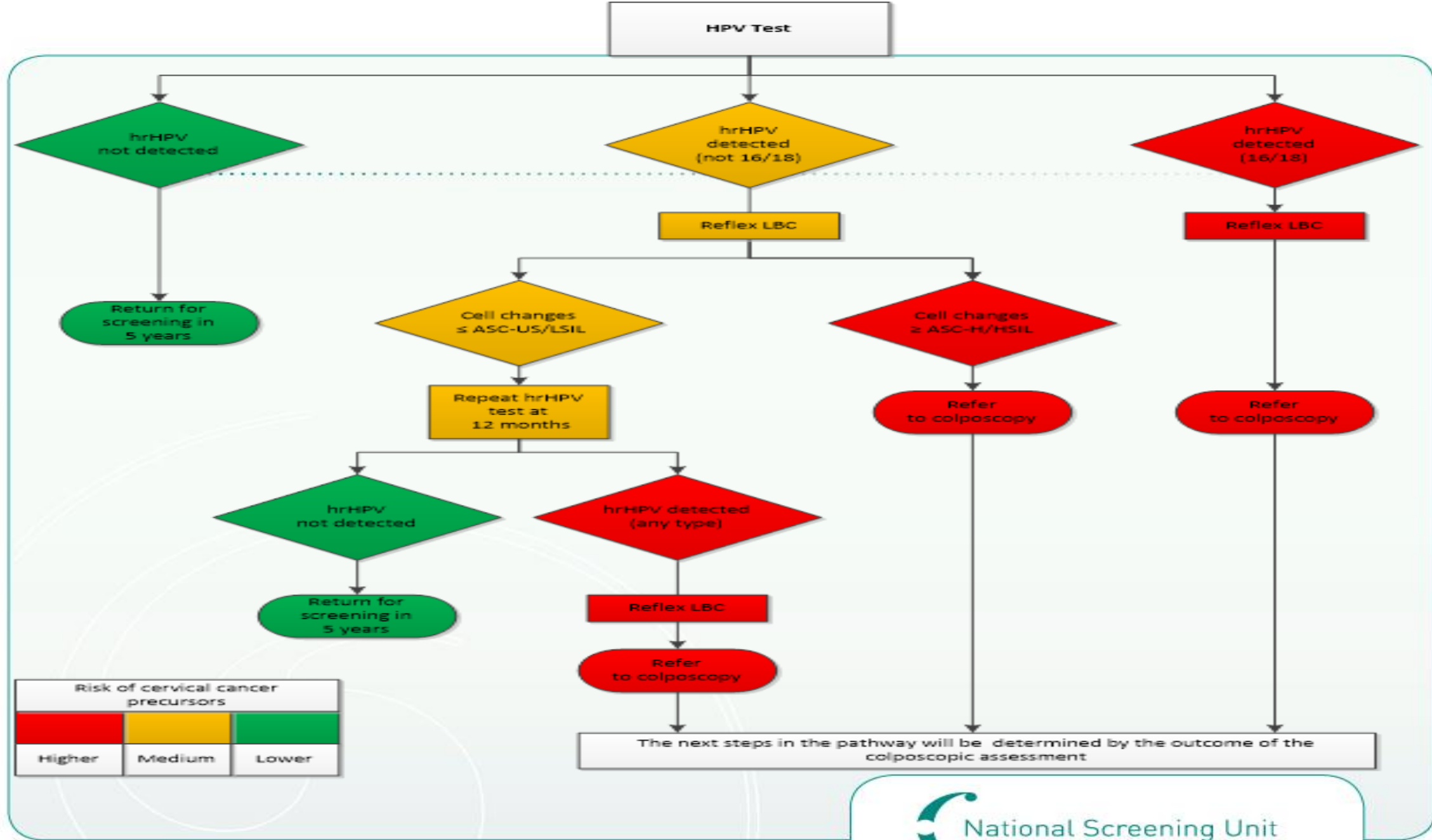
On going

Real-time Cancer audit

- Flexibility to respond to and consider research and observations from other programmes



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# Towards the End of 2018

- Screening Age 25-70
- HrHPV Primary Screening Test 5 Yearly
- Special circumstances (immune-deficient, Hysterectomy etc. covered in Guidelines)
- If currently under treatment or follow-up, continue under previous guideline until “Test of Cure” completed.
- Invitation at Age 25
- Important for primary care to use “Data Matching reports”



# Transition

- What if I am under age 25 but have not had a smear?

You will have your screening test at age 25. It will be HrHPV. If negative, next test in 5 years

- What if I am under age 25 and have had a negative smear test?

If you were ages 21 or 22 when you had your negative test, your next test will be age 25 and it will be a HrHPV test. If this is negative it will be repeated in 5 Years

If you were age 23 or above when you had your negative test you will have your next test in three years and it will be an HRHPV test. If negative it will be repeated in 5 Years





# Transition

- What if I am under age 25 and have had a positive test and not completed “test of cure”?

You will be managed in accordance with the guidelines in effect when you had your abnormal smear.

If you have had a LG smear and are due for another in 12 months then you follow through with this and are guided by the results.

High grade smears will have been referred to colposcopy and return to routine screening after “Test of Cure”









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