DENVER HEALTH MEDICAL PLAN INC. | DENVER HEALTH MEDICAID CHOICE

CLINICAL PRACTICE GUIDELINE

Guideline Number: DHMP_DHMC_PG1015 **Effective Date: 9/2018**

Guideline Subject: Routine Cervical Cancer Screening **Revision Date: 9/2019**

Pages: 1 of 2

Greg Kamar 9-12-18

Quality Management Committee Chair **Date**

I. PURPOSE:

To define the standard of care for routine cervical cancer screening as required by Denver Health Medical Plan (DHMP) and Denver Health Medicaid Choice (DHMC).

DHMP/DHMC recognizes the importance of screening for cervical cancer. Screening allows cancer to be found and identified at an early stage, when successful treatment is most likely. Finding and treating cervical dysplasia early can help prevent most cervical cancers (American Cancer Society, 2014).

II. POPULATION:

Routine screening will be completed for women with a cervix, regardless of sexual history, 21-65 years of age. Members who have had a total hysterectomy, with removal of the cervix, are exempt from screening if they have had no history of high-grade cervical dysplasia.

These routine screening guidelines do not apply to the following high-risk populations of women:

- Have a history of high grade cervical dysplasia or cervical;
- In-utero exposure to diethylstilbestrol;
- Women who are immunocompromised (such as those who are human immunodeficiency virus (HIV) positive).

III. GUIDELINE:

A. Screening Tests and Interval:

1. Cytology (Pap smear): ages 21-65 per table below
2. HPV combined with cytology (co-test): every 5 years in women ages 30-65
3. Documentation of total hysterectomy or absence of cervix is necessary to be excluded from screening

POPULATION	SCREENING RECOMMENDATION
Women 21-65 years	Screen with cytology (Pap smear) every 3 years
Women ages 30-65 years	Screen via cytology every 3 years, or co-testing (cytology/HPV testing) every 5 years
Women <21 years of age	Do not screen
Women older than 65 years, or women without a cervix (total hysterectomy)	Do not screen Continued screening recommended for high-risk women with previous high grade cervical dysplasia or cervical cancer and at provider discretion

B. Timing of Screening:

1. Screening earlier than 21 years, regardless of sexual history, is not recommended
2. Clinicians and patients should base the decision to end screening on whether the patient meets the criteria for adequate prior testing and appropriate follow-up

NOTE:

This guideline is designed to assist providers by providing an analytical framework for the evaluation and treatment of patients, and is not intended either to replace a clinicians judgment or to establish a protocol for all patients with a particular condition.

DENVER HEALTH MEDICAL PLAN INC. | DENVER HEALTH MEDICAID CHOICE

CLINICAL PRACTICE GUIDELINE

Guideline Number: DHMP_DHMC_PG1015	**Effective Date: 9/2018**
Guideline Subject: Routine Cervical Cancer Screening	**Revision Date: 9/2019**
Pages: 2 of 2	

_____

Quality Management Committee Chair **Date**

C. Risk Assessment:

1. Human Papillomavirus (HPV) infection is associated with cervical cancer
2. Other factors associated with increased risk of cervical cancer include: HIV infection; compromised immune system; in-utero exposure to diethylstilbestrol; smoking of tobacco; and previous treatment of a high-grade cervical dysplasia or cervical cancer

D. Grading of Cervical Dysplasia:

LSIL: Low-grade squamous intraepithelial lesion, previously CIN 1, Cervical Intraepithelial Neoplasia	Mildly atypical changes in the lower 1/3 layer of the cervical epithelium AND or negative for p16 immunostaining	Low risk for progression to carcinoma; often resolves without treatment
HSIL: High-Grade Squamous intraepithelial lesion, previously CIN 2 and CIN 3	Moderately or severely atypical changes in the lower 2/3 or greater layers of the cervical epithelium AND positive for p16 immunostaining	Higher-risk, requires additional screenings and/or treatment

E. Further Care:

1. It is expected that patients with detected cervical dysplasia, cervical cancer, and other needs receive follow-up and are managed according to currently recommended standards of care.
2. Close follow-up with colposcopy and cytology under certain circumstances is acceptable for women 21-24 years of age, to avoid invasive procedures for individuals with CIN II-III/HSIL.
3. Please refer to the Denver Health Pap Smear Algorithm v. 1015a for additional information.

IV. ATTACHMENTS:

A. U.S. Preventive Services Task Force: Clinical Summary of Screening For Cervical Cancer Recommendation
B. General_PAP_Algorithm_ v 1015a

V. REFERENCES:

Agency for Healthcare Research and Quality. (n.d.). *Clinical Summary: Cervical Cancer Screening -US Preventive Services Task Force Recommendations.* https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/cervical-cancer-screening

American Academy of Family Physicians. (2012, September 15). *American Family Physician.* www.aafp.org/afp

American Cancer Society. (2014, December 11). *Cervical Cancer Prevention and Early Detection .* http://www.cancer.org/acs/groups/cid/documents/webcontent/003167-pdf.pdf

Clinical Summary of U.S. Preventive Services Task Force Recommendation

Release Date: March 2012

Population	Women ages 21 to 65	Women ages 30 to 65	Women younger than age 21	Women older than age 65 who have had adequate prior screening and are not high risk	Women after hysterectomy with removal of the cervix and with no history of high-grade precancer or cervical cancer	Women younger than age 30
Recommendation	Screen with cytology (Pap smear) every 3 years. Grade: A	Screen with cytology every 3 years or co-testing (cytology/HPV testing) every 5 years. Grade: A	Do not screen. Grade: D	Do not screen. Grade: D	Do not screen. Grade: D	Do not screen with HPV testing (alone or with cytology). Grade: D
Risk Assessment	Human papillomavirus (HPV) infection is associated with nearly all cases of cervical cancer. Other factors that put a woman at increased risk of cervical cancer include HIV infection, a compromised immune system, in utero exposure to diethylstilbestrol, and previous treatment of a high-grade precancerous lesion or cervical cancer.					
Screening Tests	Screening women ages 21 to 65 years every 3 years with cytology provides a reasonable balance between benefits and harms. Screening with cytology more often than every 3 years confers little additional benefit, with large increases in harms. HPV testing combined with cytology (co-testing) every 5 years in women ages 30 to 65 years offers a comparable balance of benefits and harms, and is therefore a reasonable alternative for women in this age group who would prefer to extend the screening interval.					
Timing of Screening	Screening earlier than age 21 years, regardless of sexual history, leads to more harms than benefits. Clinicians and patients should base the decision to end screening on whether the patient meets the criteria for adequate prior testing and appropriate follow-up, per established guidelines.					
Interventions	Screening aims to identify high-grade precancerous cervical lesions to prevent development of cervical cancer and early-stage asymptomatic invasive cervical cancer. High-grade lesions may be treated with ablative and excisional therapies, including cryotherapy, laser ablation, loop excision, and cold knife conization. Early-stage cervical cancer may be treated with surgery (hysterectomy) or chemoradiation.					
Balance of Harms and Benefits	The benefits of screening with cytology every 3 years substantially outweigh the harms.	The benefits of screening with co-testing (cytology/HPV testing) every 5 years outweigh the harms.	The harms of screening earlier than age 21 years outweigh the benefits.	The benefits of screening after age 65 years do not outweigh the potential harms.	The harms of screening after hysterectomy outweigh the benefits.	The potential harms of screening with HPV testing (alone or with cytology) outweigh the potential benefits.
Other Relevant USPSTF Recommendations	The USPSTF has made recommendations on screening for breast cancer and ovarian cancer, as well as genetic risk assessment and *BRCA* mutation testing for breast and ovarian cancer susceptibility. These recommendations are available at http://www.uspreventiveservicestaskforce.org/.					

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to http://www.uspreventiveservicestaskforce.org/.

Pap Smear Algorithm

v.1015a

SPECIMEN ADEQUACY

Satisfactory

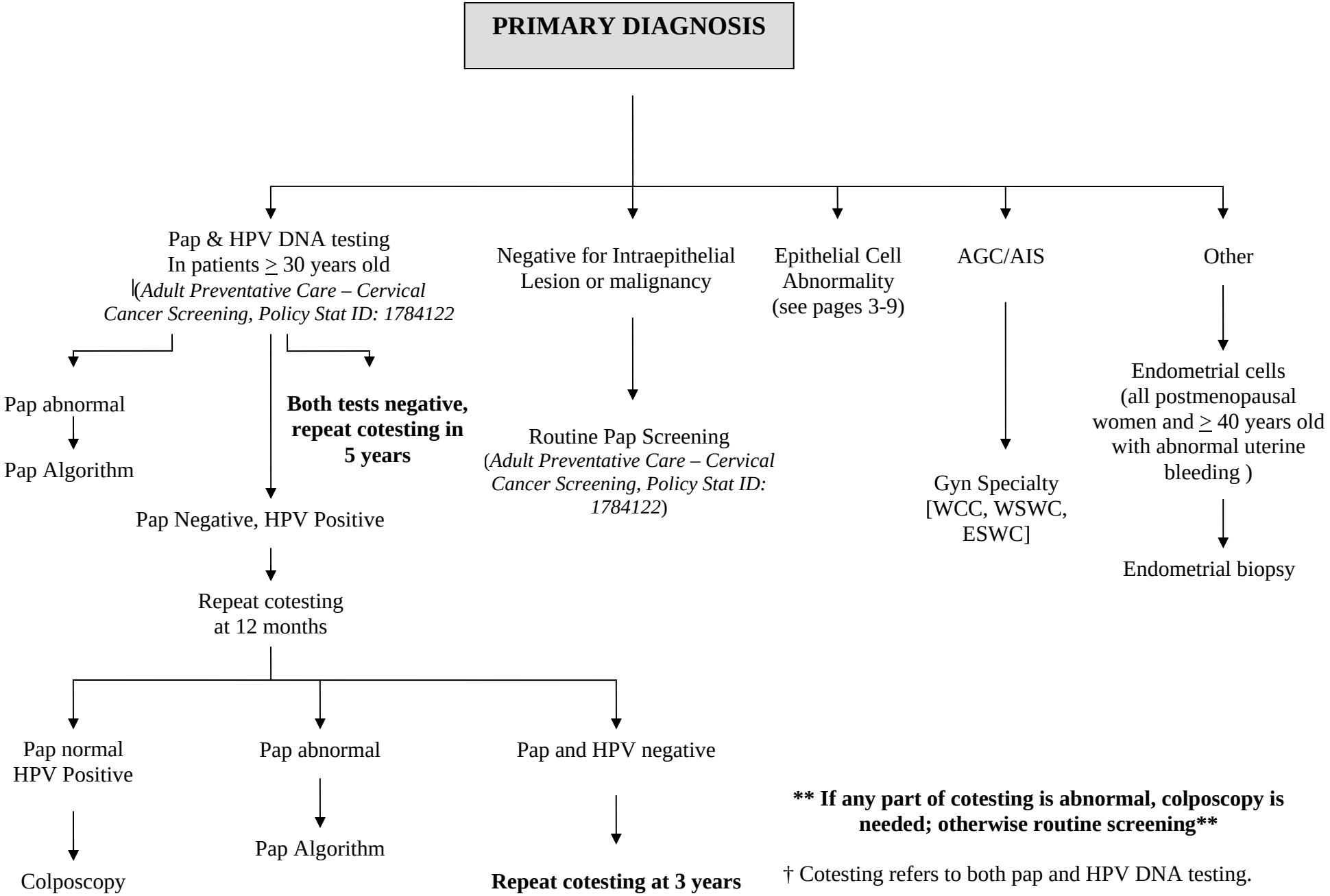
Next Pap per *Adult Preventative Care – Cervical Cancer Screening, Policy Stat ID: 1784122*

Unsatisfactory

Repeat Pap 2-4 months

If two (2) unsatisfactory Paps

Gyn Specialty
[WCC, WSWC, ESWC]



**** If any part of cotesting is abnormal, colposcopy is needed; otherwise routine screening****

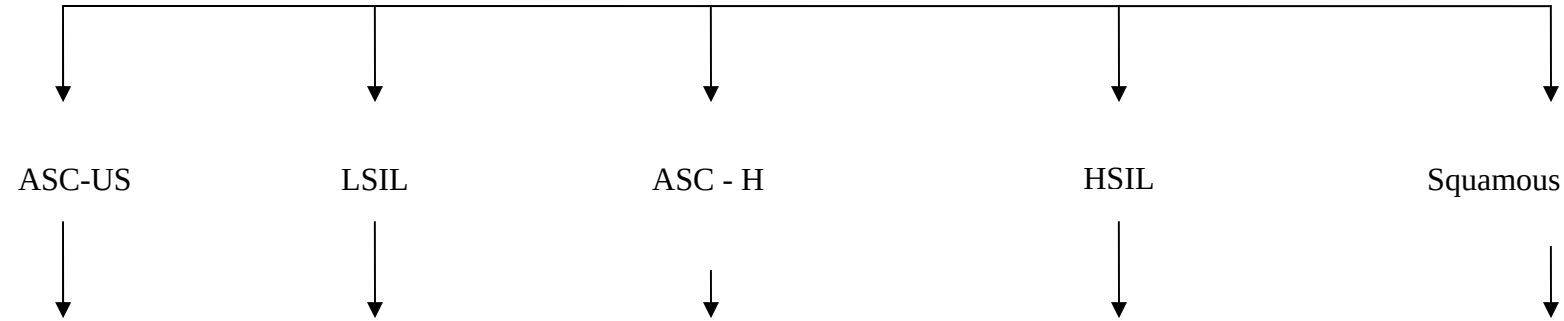
† Cotesting refers to both pap and HPV DNA testing.

Pap Smear Algorithm

EPITHELIAL CELL ABNORMALITY

Squamous Cell

- **Age 21-24:** See page 6
- **Pregnancy:** See page 7
- **HIV +:** See page 8



ASC-US	LSIL	ASC - H	HSIL	Squamous Cell CA
See page 4	See page 5	Gyn Specialty [WCC, WSWC, ESWC] *(all patients ,regardless of HPV status)*	Gyn Specialty [WCC, WSWC, ESWC] *(all patients ,regardless of HPV status)*	Gyn Specialty [WCC] (*all patients, regardless of HPV status)*

*For all women ages 21 -24 please refer to Page 6
*For pregnant women please refer to Page 7
*For all HIV + women please refer to Page 8

EPITHELIAL CELL ABNORMALITY

Squamous Cell

ASC-US

HPV DNA Testing
(reflex)

HPV Positive

Colposcopy*

no CIN
CIN1/LSIL
CIN2/LSIL

Cotesting at 12 months

≥ ASC or HPV Positive

Colposcopy

Pap and HPV Negative

Cotesting at 3 years

CIN2/HSIL
CIN3/HSIL

Gyn specialty
[WCC, WSWC, ESWC]

HPV Negative‡

Cotesting at 3 years †

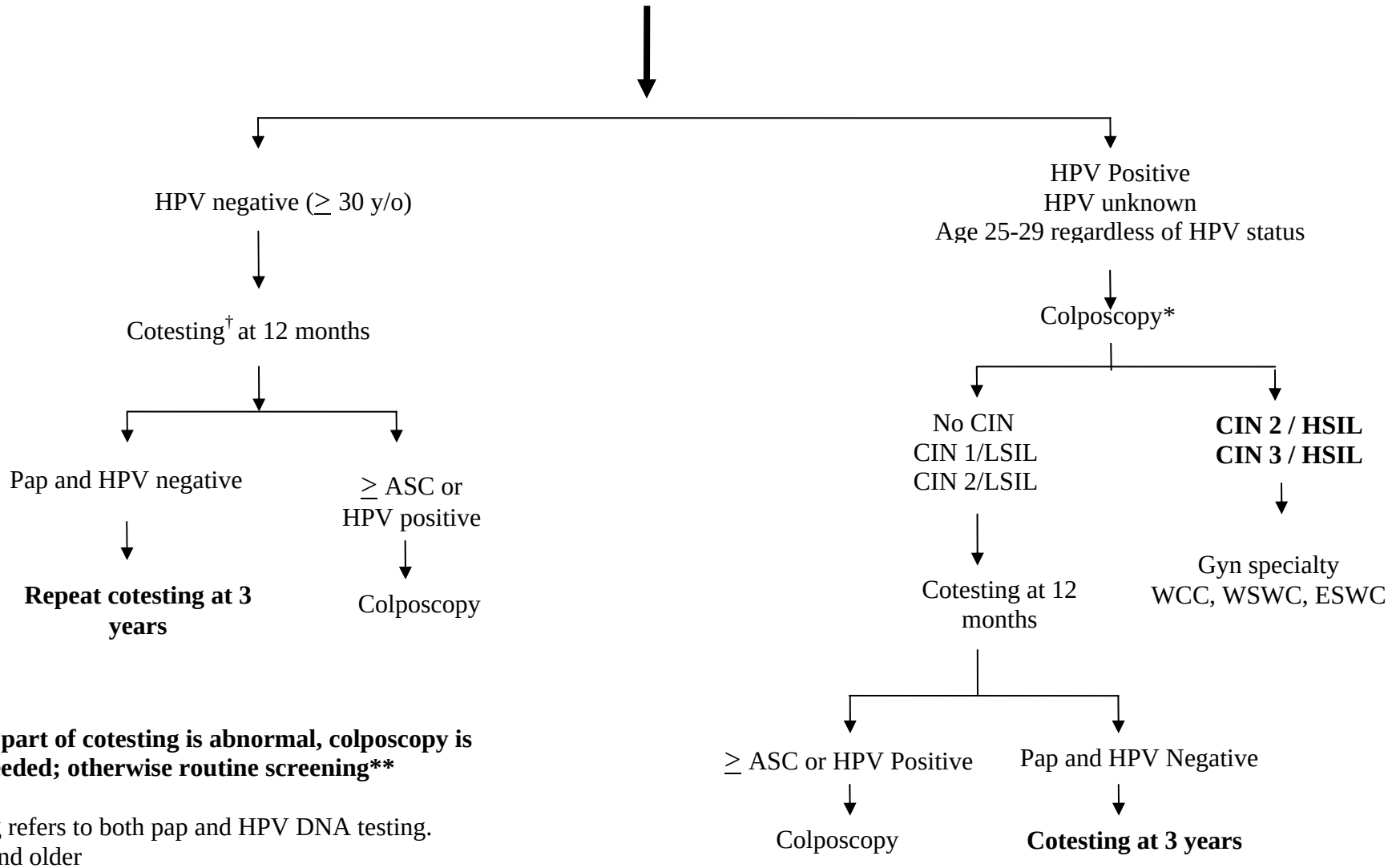
**** If any part of cotesting is abnormal, colposcopy is needed; otherwise routine screening****

† Cotesting refers to both pap and HPV DNA testing.
‡ Age 25 and older
* If pregnant, defer colposcopy to 6 weeks postpartum.

EPITHELIAL CELL ABNORMALITY

Squamous Cell

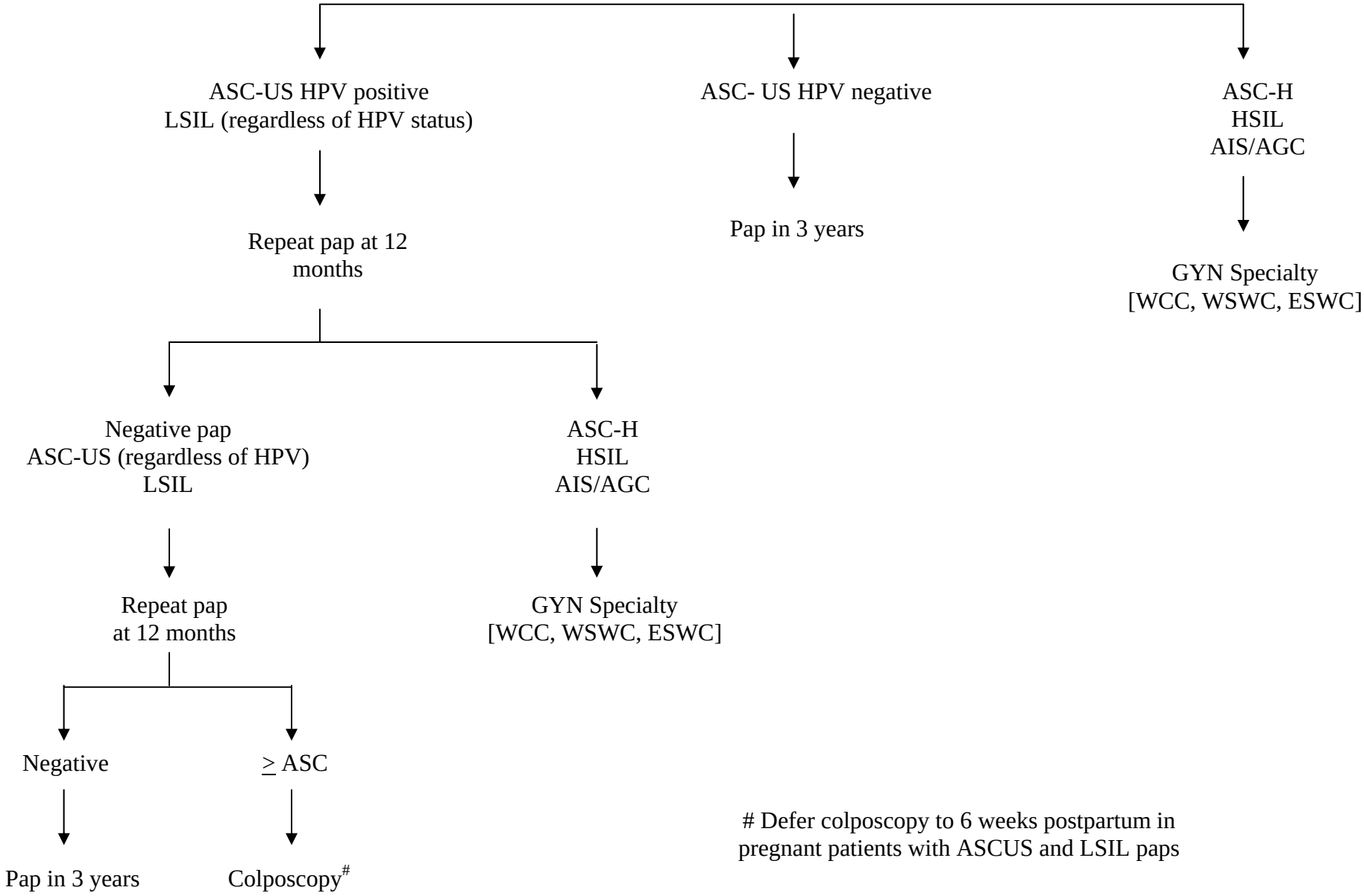
LSIL



**** If any part of cotesting is abnormal, colposcopy is needed; otherwise routine screening****

† Cotesting refers to both pap and HPV DNA testing.
‡ Age 25 and older
* **If pregnant, defer colposcopy to 6 weeks postpartum**

Women Ages 21-24



Defer colposcopy to 6 weeks postpartum in pregnant patients with ASCUS and LSIL paps

EPITHELIAL CELL ABNORMALITY

PREGNANCY‡

ASC-US

- Age 21- 24 — See page 6
- Age 25 and older — See page 4

LSIL

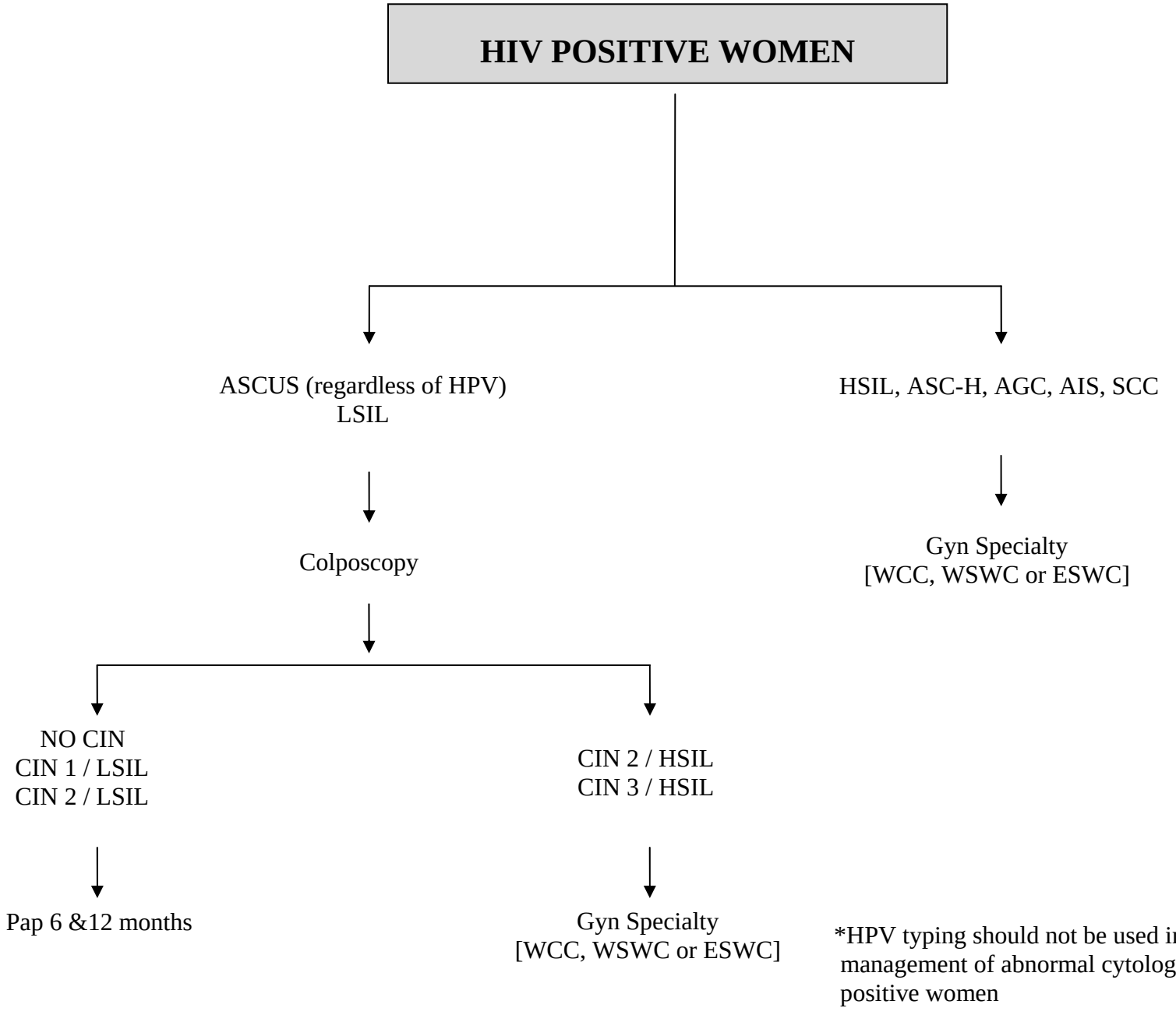
- Age 21- 24 — See page 6
- Age 25 and older — See page 5

HSIL

ASC-H
AIS
AGC

Immediate referral to
Gyn Specialty
[WCC, WSWC, ESWC]
(any adult, regardless of HPV status)

Colposcopy
at any gestational age



*HPV typing should not be used in screening or management of abnormal cytology/histology in HIV positive women