DENVER HEALTH MEDICAL PLAN INC.™ DENVER HEALTH MEDICAID CHOICE

CLINICAL PRACTICE GUIDELINE

Guideline Number: DHMP_DHMC_PG1015	**Effective Date: 11/1/2021**
Guideline Subject: Routine Cervical Cancer Screening	**Revision Date: 11/1/2022**
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Gregg Kamas 10/1/2021

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 for the identification of pre-cancer or cancer 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 21-29 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 and no history of high grade cervical dysplasia (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. Do not screen if woman has had regular negative testing in the past.

B. Timing of Screening:

1. Screening earlier than 21 years, regardless of sexual history, is not recommended

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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

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 as well as AIS, atypical glandular cells needs further testing and/or treatment	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 testing 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 Policy Stat documents "Cervical Cancer Screening" and "Centralized Management of Abnormal Pap Results by Denver Health Registered Nurses" **ATTACHMENTS:**

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

V. REFERENCES:

U.S. Preventive Services Task Force. *Final Recommendation Statement: Cervical Cancer: Screening.* July 2019. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening2

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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.

Table 1. USPSTF Recommendations for Routine Cervical Cancer Screening

Population*	Recommendation	USPSTF Recommendation Grade†
Aged less than 21 years	No screening	D
Aged 21–29 years	Cytology alone every 3 years‡	A
Aged 30–65 years	Any one of the following: • Cytology alone every 3 years • FDA-approved primary hrHPV testing alone every 5 years • Cotesting (hrHPV testing and cytology) every 5 years	A
Aged greater than 65 years	No screening after adequate negative prior screening results§	D
Hysterectomy with removal of the cervix	No screening in individuals who do not have a history of high-grade cervical precancerous lesions or cervical cancer	D

Abbreviations: FDA, U.S. Food and Drug Administration; hrHPV, high-risk human papillomavirus testing.

*These recommendations apply to individuals with a cervix who do not have any signs or symptoms of cervical cancer, regardless of their sexual history or HPV vaccination status. These recommendations **do not apply** to individuals who are at high risk of the disease, such as those who have previously received a diagnosis of a high-grade precancerous cervical lesion. These recommendations also do not apply to individuals with in utero exposure to diethylstilbestrol or those who have a compromised immune system (eg, individuals with human immunodeficiency virus).

†Grade A denotes that "The USPSTF recommends the service. There is high certainty that the net benefit is substantial." A Grade D definition means that, "The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits." For more information on the USPSTF grades, see https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions

‡Primary hrHPV testing is FDA approved for use starting at age 25 years, and ACOG, ASCCP, and SGO advise that primary hrHPV testing every 5 years can be considered as an alternative to cytology-only screening in average-risk patients aged 25–29 years.

§Adequate *negative prior screening test results* are defined as three consecutive negative cytology results, two consecutive negative cotesting results, or two consecutive negative hrHPV test results within 10 years before stopping screening, with the most recent test occurring within the recommended screening interval for the test used (1, 5).

Data from Curry SJ, Krist AH, Owens DK, Barry MJ, Caughey AB, Davidson KW, et al. Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. JAMA 2018;320:674–86. Available at: https://jamanetwork.com/journals/jama/fullarticle/2697704. Retrieved April 12, 2021.

Clinical Summary: Screening for Cervical Cancer

Population	Women aged 21 to 29 years	Women aged 30 to 65 years	Women younger than 21 years, women older than 65 years with adequate prior screening, and women who have had a hysterectomy
Recommendation	Screen for cervical cancer every 3 years with cytology alone. Grade: A	Screen for cervical cancer every 3 years with cytology alone, every 5 years with hrHPV testing alone, or every 5 years with cotesting. Grade: A	Do not screen for cervical cancer. Grade: D

Risk Assessment	All women aged 21 to 65 years are at risk for cervical cancer because of potential exposure to high-risk HPV types (hrHPV) through sexual intercourse and should be screened. Certain risk factors further increase risk for cervical cancer, including HIV infection, a compromised immune system, in utero exposure to diethylstilbestrol, and previous treatment of a high-grade precancerous lesion or cervical cancer. Women with these risk factors should receive individualized follow-up.
Screening Tests	Screening with cervical cytology alone, primary testing for hrHPV alone, or both at the same time (cotesting) can detect high-grade precancerous cervical lesions and cervical cancer. Clinicians should focus on ensuring that women receive adequate screening, appropriate evaluation of abnormal results, and indicated treatment, regardless of which screening strategy is used.
Treatments and Interventions	High-grade cervical lesions may be treated with excisional and ablative therapies. Early-stage cervical cancer may be treated with surgery (hysterectomy) or chemotherapy.

Abbreviation: HPV=human papillomavirus.

These recommendations apply to individuals who have a cervix, regardless of their sexual history or HPV vaccination status. These recommendations do not apply to individuals who have been diagnosed with a high-grade precancerous cervical lesion or cervical cancer, those with in utero exposure to diethylstilbestrol, or those who have a compromised immune system (eg, individuals living with HIV).

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