

Position Statement

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GYNAECOLOGICAL CYTOLOGY / Screening and diagnostic cytology for prevention of cervical cancer / Cervical Screening Program

Fundamental principle: There needs to be (as there once was) a specific body (or at least a small group of appropriately skilled staff) at Commonwealth level that has the specific responsibility of managing the cervical cancer prevention program including screening and vaccination. This body should review the Screening Program AS A WHOLE to determine what is optimal, how can it be afforded, how can it be monitored for safety, and its role into the future to establish that the program outcome does not deteriorate. There must be a continuing reduction in the incidence and mortality of cervical cancer in the cohort of women who will not benefit from vaccination as well as primary prevention of the disease in vaccinated women.

1. Monitoring a program of cervical cancer prevention

- **Monitoring Pap tests, investigation, biopsy reports and treatment**
- **Monitoring HPV tests**
- **Monitoring vaccine uptake**

The necessity of a centralised **National Register** to replace the current diverse Registers in all States has been apparent for many years. Advances in Information Technology provide the tools to develop a single population Register that can incorporate all three of these divisions of an integrated cervical cancer prevention program, with the opportunity of financial rationalisation and provision of much more reliable National data than the current arrangement.

2. Quality Assurance for the Pap test

The current programs and accreditation methods provide a rigorous framework but the financial impost that is born by laboratories conforming to these *requirements* must be reflected in the remuneration structure. Remuneration must relate to intellectual and workforce input and it is unacceptable that this Test continues to be considered a loss leader.

3. Pathologist workforce shortage

Although a threat to all of pathology, this is a particular problem for gynaecological cytopathology because there is reluctance to make a commitment to what is perceived as a dying specialty. The role of clinicopathological input in establishing a standard of care for women participating in the Program should not be underestimated.

4. Role of New Technologies

- (a) **Liquid based cytology** combined with automated pre-screening of samples offers the opportunity for optimising a progressively depleting screening workforce. Additionally it is able to provide a sample that can be used for molecular testing for viral and other microbial pathogenic agents. Studies have indicated that the reduction in

unsatisfactory samples (a problem in Australia really mainly in rural and indigenous communities), and some improvement in sensitivity, may be added benefits.

(b) Testing for High Risk HPV subtypes, because of its very high negative predictive value for serious HPV induced disease, may be useful in several ways:

- In combination with Pap test as a primary screening tool
- As a triage for women with Low Grade and Possible Low Grade Pap tests
- As a triage for women with Possible High Grade Pap tests
- As an opportunity for a self-collected screening test in poorly screened sectors of the population who may have cultural or geographic barriers to conventional sample taking.

(c) HPV Vaccines

Modelling to ascertain the outcome of a variety of vaccination strategies and their impact on disease incidence / protection from cervical cancer will require information that is currently not available with respect to duration of protection. Short term estimates of disease prevention in the population of women who have already been exposed to HPV, as a guide to screening strategy, are currently ill-founded and dangerous.

The importance of population vaccination (that is, both females and males) is fundamental to eventual eradication of pathogenic HPV from the population. (Lessons learned from the early mistakes in the Rubella vaccination program in this regard need to be remembered.)

5. Variation in the Screening Program to offset the increased costs of new strategies

Change in the screening interval may be contemplated as part of a reorganised program. A recent paper (Canfell et al) suggests that the 3 yearly program in the United Kingdom (UK) has achieved a similar reduction in mortality to the 2 yearly interval in Australia. However both the incidence (8.3 per 100,000) and mortality (3.1 per 100,000) of cervical cancer are significantly higher in the UK than in Australia (6.9 per 100,000 and 1.7 per 100,000 in 2002). The IARC Working Group on Cervical Cancer Screening (IARC Scientific Publications No 76, 1986) stated that there was little outcome difference between 2 yearly and 3 yearly screening. However this has been questioned in the intervening years.

The introduction of a package of strategies listed above has the potential of creating a new scenario and the increased period of protection offered by a negative screening episode incorporating high risk HPV testing of a liquid based sample that has had automated pre-screening is likely to allow an increase in the screening interval to be an option for change. Clarification of the pattern of development of cervical neoplasia also indicates that the **age of commencement of screening** could be increased to at least 22 with further savings. Clearly if uncertainty in cytological assessment can be resolved by **High Risk HPV triage** whereby a negative result may return women to a routine screening protocol perhaps preventing expensive gynaecologic investigation and surgical treatment, further savings are possible. Similarly the more widespread uptake of this test as a **test of cure** following treatment of a cervical lesion will prevent unnecessary annual screening that some women may have been subjected to for thirty or forty years.

Recruitment strategies both to cervical screening and to vaccination must be improved to counter the reported reduction, over the past few years, in the percentage of women availing themselves of the Cervical Cancer Prevention Program.