Transcript Details
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Evolving Cervical Cancer Screening Options in Clinical Practice

Narrator:

You are listening to ReachMD. Welcome to this medical industry feature entitled: **Evolving Cervical Cancer Screening Options in Clinical Practice,** sponsored by Roche Diagnostics. This program is intended for physicians.

Dr. Allen:

In January 2016, the American College of Obstetricians and Gynecologists (ACOG) released a practice bulletin and issued guidance supporting the use of FDA-approved human papilloma virus test for first-line cervical cancer screening. ACOG'S guidance accumulated more than 50 years of continuing progress led by the introduction of the Pap test and the steady decline in the incidence of cervical cancer. More recently, increased understanding of the role of HPV in cervical cancer development has shed new light on how HPV testing can be integrated into cervical cancer screening with the goal of identifying patients at risk earlier while reducing over testing and unnecessary interventions.

I am your host, Dr. Renee Allen, and I would like to welcome Dr. Lawrence Glad to the program. Dr. Glad is a Clinical Assistant Professor at the University of Pittsburgh School of Medicine.

Dr. Glad, thank you for being here today.

Dr. Glad:

It's my pleasure, Renee.

Dr. Allen:

Okay, Dr. Glad, let's set the stage a bit for our audience. Can you explain to us the current state of affairs regarding cervical cancer screening guidelines?

Dr. Glad:

Certainly, doctor. In 2014, the FDA approved the first HPV test with an indication for the primary screening of cervical cancer, and in 2015, that was followed by both the Society for Gynecologic Oncology and the American Society for Colposcopy and Cervical Pathology publishing joint interim clinical guidance. That was meant to provide a roadmap, a guide, for physicians wanting to perform HPV primary screening. They determined several things. First of all, primary HPV screening is an acceptable alternative to our current cervical cancer screening methods, both due to equivalence or superior effectiveness. Only FDA-approved assays with specific primary HPV screening indications should be used. And in 2016, the American Congress of OB/GYN released a practice bulletin, and that basically said that in women 25 years and older, the FDA-approved primary HPV screening test could be considered as an alternative to current cytology-based cervical cancer screening methods. If screening with primary HPV testing is to be used, it should be performed as per the ASCCP and the SGO interim guidance. And that was released in January earlier this year.

Dr. Allen:

Okay, thank you for that overview. Do you differentiate between the words “societal guidelines,” such as the 2012 cervical cancer screening guidelines, and “societal guidance” or “practice bulletins,” such as the ASCCP/SGO interim guidance, or even the 2016 ACOG practice bulletin?

Dr. Glad:

Guidance and practice bulletins are ways our professional societies keep the clinician informed of new patient care strategies. It's a way to go ahead and give us information as they're forming their thoughts, so those occur before official updated guidelines are released. What really occurs, what really is highlighted in the guidance or practice bulletin is typically included in the next round of guidelines which then follow from there on.

Dr. Allen:

So, then how important do you think it is to choose an HPV test that is supported by interim guidance documents and guideline updates then, Dr. Glad?

Dr. Glad:

It's really beneficial to choose a test that gives you access to every screening option, from taking those patients who have Pap smear cytology results with atypical squamous cells of uncertain significance and being able to triage those patients, to co-testing or screening patients from the ages of 30 to 65 with both cytology, Pap smears and HPV testing, and then to screen them primarily for cervical cancer with an HPV test. That gives us the flexibility we need as healthcare providers to alter our screening methodology as we need to for our patients.

Dr. Allen:

Okay, Dr. Glad, now I want to explore the medical value of HPV primary screening. So, are there any advantages to choosing a screening strategy that includes HPV testing as the first-line of defense?

Dr. Glad:

Certainly, Dr. Allen. A negative result on the approved HPV primary screening test provides twice the assurance of a negative Pap test in predicting those patients who will progress on to carcinoma in situ or severe dysplasia. Primary HPV screening can include women age 25 to 29. And in the ATHENA study, about one-third of all cases of severe dysplasia carcinoma in situ were found in women in that age group. That means that more than half of the cases in those women age 25 to 29 were actually found by the HPV test but had negative Pap smears, so a negative Pap smear doesn't mean the absence of cancer. HPV testing offers far superior sensitivity, typically greater than 90% compared to the pap smear.

Dr. Allen:

If you are just tuning in, you are listening to ReachMD, and I am your host, Dr. Renee Allen, and I have the pleasure of speaking with OB/GYN Dr. Lawrence Glad on the topic of recent updates with cervical cancer screening guidelines and the impact on clinician practice.

Dr. Glad, in the first half you spoke a bit about the advantages of choosing a screening strategy that includes HPV testing as the first line of defense. Has your protocol for cervical cancer screening and follow-up testing changed in the last 5 years?

Dr. Glad:

It certainly has, Dr. Allen. Until 2014, I was performing cytology, Pap smear screening alone, in patients age 21 to 29, and using HPV testing in the reflex fashion for those patients who had either atypical squamous cells of uncertain significance or other abnormalities. And then for patients age 30 to 65, I was co-testing with both cytology, Pap smear, and HPV testing and then basing my decisions for treatment on those results.

In 2014, when the FDA approved the first primary screening of cervical cancer indication for an HPV test, I began to look more closely at the results, especially the results of the ATHENA trial that discussed what was actually happening and what they found with primary HPV screening. Then in 2015, when both the SGO and ASCCP published joint interim guidance, that made me start to really think about this for my patients and begin to offer it for some of those patients I felt were high risk. Finally, in this year, in January 2016, when ACOG published a practice bulletin, it began the opportunity for me to offer all of my patients a chance to have HPV primary screening for cervical cancer once they turned the age of 25.

Dr. Allen:

Okay, Dr. Glad, so you have incorporated it into your clinical practice; then can you please explain how a clinician can successfully incorporate primary screening into their own practice?

Dr. Glad:

To incorporate primary HPV screening into your practice, you must understand the algorithm. It's truly essential. The algorithm

reconciles primary HPV cervical cancer screening with other established screening and management protocols by placing the most sensitive test, HPV first, followed by the most specific test, the Pap. So, if the HPV is negative, your patient returns to a routine 3-year screening interval. If the patient has an HPV test that's positive for either HPV genotype 16 or HPV genotype 18, they are directly referred to colposcopy for further evaluation. If your patient is positive for one of the other 12 high-risk HPV genotypes, they are then reflexed to cytology. And based on the results of the Pap smear, whether it shows ASCUS or greater, they're then referred to colposcopy.

The idea is to limit the direct referral to colposcopy to only those patients who are positive for the highest risk genotypes, those patients who are at the highest risk for developing cervical precancer and cancerous lesions. That algorithm helps to prevent both unnecessary referrals and the overtreatment of patients.

So, the introduction that we have with HPV testing has really created the need for us, as healthcare providers, and for our staff to counsel our patients. We need to explain why the test is being ordered, what the results will mean to the patients, and that minimizes the stigma associated with the fact that HPV, human papilloma virus, is a sexually transmitted infection. Physicians need to explain to our patients that HPV infections are common, and most of them do resolve over time, that HPV infections are largely asymptomatic until they are at an advanced stage, so this testing helps to find it earlier.

Dr. Allen:

Dr. Glad, do you have any final remarks for our listening audience to be mindful of?

Dr. Glad:

Definitely. As healthcare providers, change in clinical practice tends to come slowly, but change will come, especially as cervical cancer screening guidelines are updated to address this new data. We, as physicians, really begin to adopt effective screening protocols for cervical cancer, and as we begin to go ahead and introduce HPV testing for our patients once they turn 25, we have an opportunity, and that opportunity is to more clearly identify the risk of cervical disease, to stratify and to modify our patient management accordingly, and to contribute significantly to reducing the overall incidence of cervical cancer in our patients.

Dr. Allen:

Dr. Glad, thank you so much for sharing your insight with our ReachMD audience.

Dr. Glad:

It's been a pleasure speaking with you, Dr. Allen.

Narrator:

You have been listening to ReachMD. The preceding program was sponsored by Roche Diagnostics.