Nuevas guias de tamizaje de OMS y ASCO

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A catalyst for global health

Objetivos del tamizaje

- Evitar la morbilidad y mortalidad por el cáncer de cuello uterino
- Detectar lesiones que podrían transformarse en cáncer invasor
- Evitar la detección de lesiones benignas y transitorias

Una prueba de detección identifica a las mujeres en situación de riesgo en la población

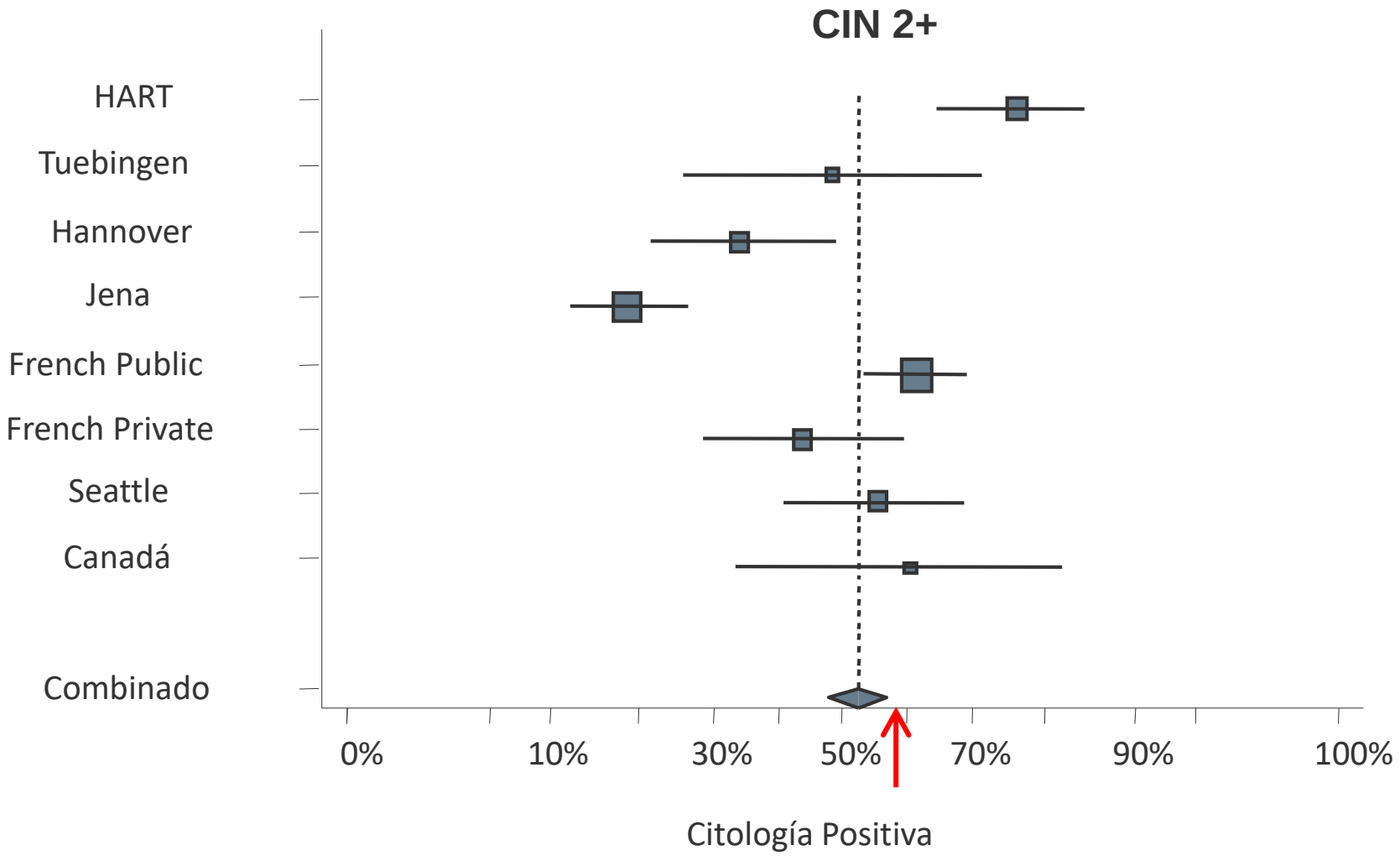
- La prueba ideal tiene alta sensibilidad
  - Cuando la sensibilidad aumenta, la especificidad baja y los falsos positivos aumentan
  - Por lo tanto, se necesita hacer el seguimiento de las pruebas con una prueba más específica

- El tamizaje con la prueba de Papanicolaou hace esto al revés
  - El examen de Pap tiene alta especificidad, pero la sensibilidad es de 50 – 70%

Sensibilidad de la Citología: CIN2+

Cuzick *et al*., IJC, 2006

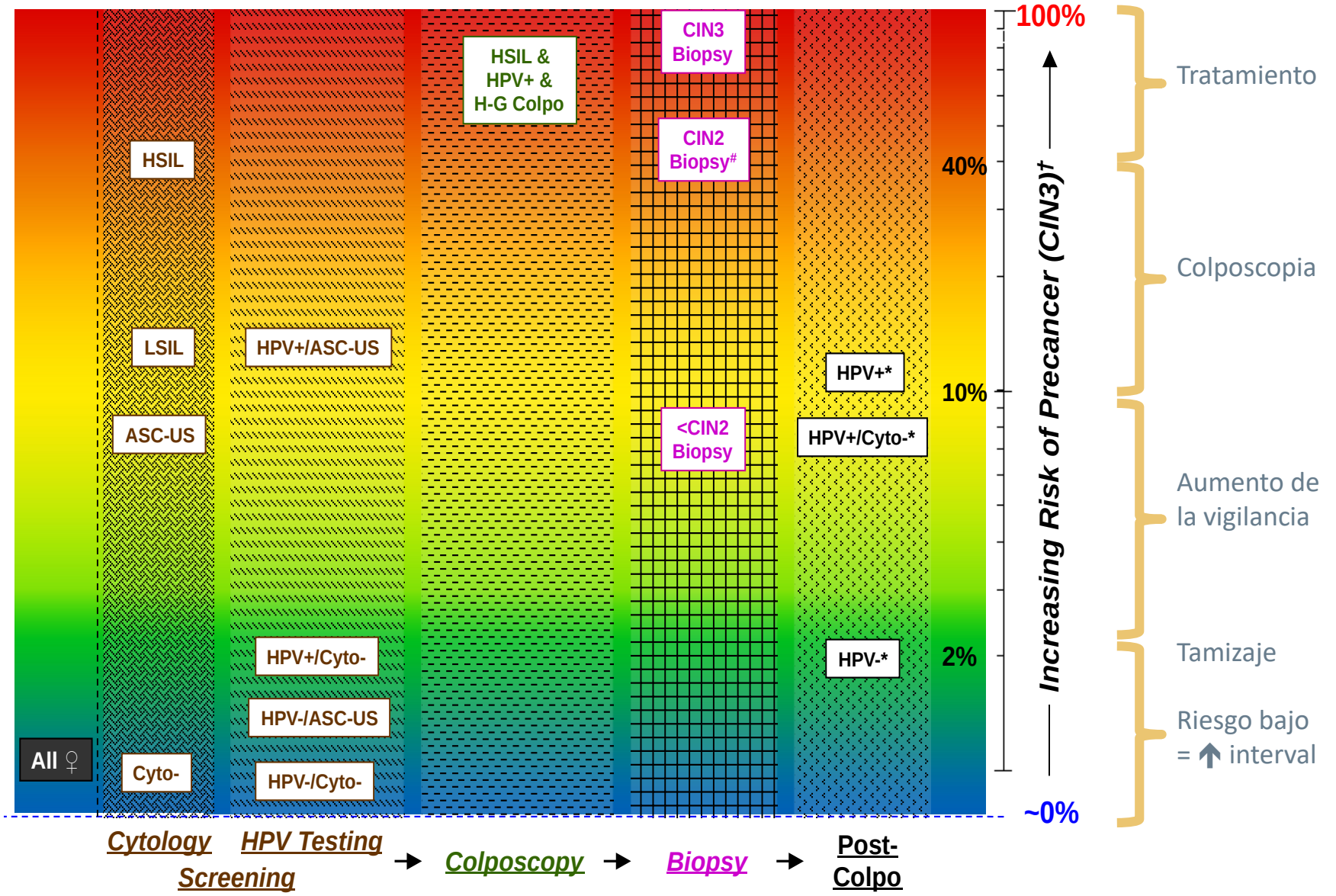
Mayrand *et al*., NEJM, 2007



“Evolución” de indicaciones sobra la detección de CxCa

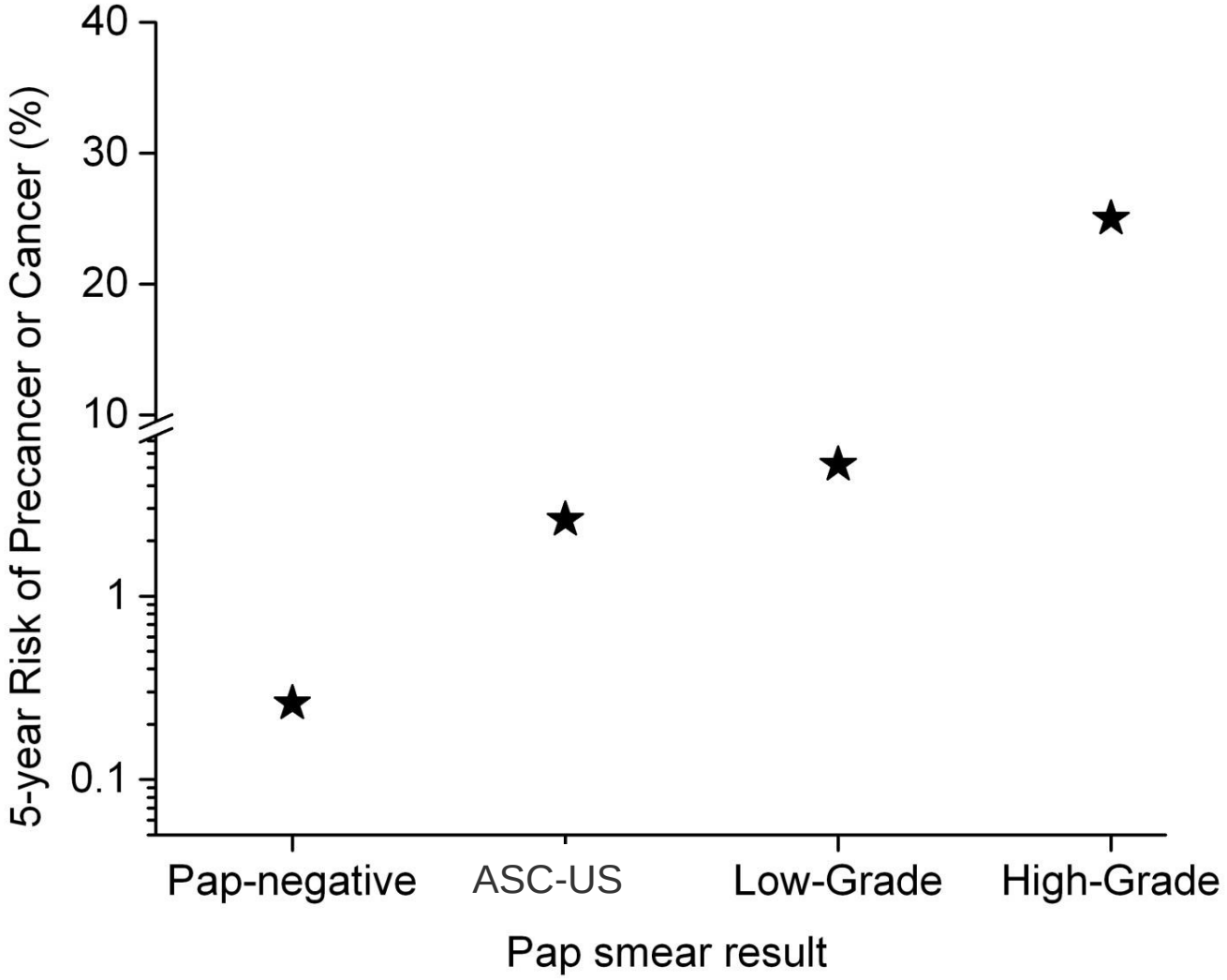
Organización (year)	ACS (2002) (52)	USPSTF (2003)	ACOG (2003) (53)	ASCCP (2004)* (45)	ACS-ASCCP-ASCP (2012) (46)	USPSTF (2012) (47)	ASCCP-ASCP-SGO (2015)* (50)
Edad para empezar la detección	3 años después del inicio de las relaciones sexuales o a 21 años	3 años después del inicio de las relaciones sexuales o por 21 años	3 años después del inicio de las relaciones sexuales pero no mayor de 21 años		21 años	21 años	
Menores de 30	Pap cada año o LBC cada 2 años; La prueba del VPH para la clasificación de la citología ASC-US	Pap cada ≤3 años	Pap o LBC cada año		Pap o LBC cada 3 años ; La prueba del VPH para la clasificación de la citología ASC-US	Pap or LBC cada 3 años ; La prueba del VPH para la clasificación de la citología ASC-US	25-29 años : HPV testing cada 3 años
30 o mas	Pap/LBC cada 2-3 años; VPH y Pap/LBC cotesting cada ≥3 años	Pap cada ≤3 años	Pap/LBC cada año; Cada 2-3 parra mujeres ≥30 con 3 citologias negativas*	HPV y Pap/LBC cotesting cada ≥3 años	HPV y Pap/LBC cotesting cada 5 años (preferido); Pap o LBC cada 3 años (aceptable)	HPV y Pap/LBC cotesting cada 5 años (preferido); Pap o LBC cada 3 años (aceptable)	HPV testing cada 3 años
Edad para detener tamizaje	70 años despues de 3 resultados negativos en los ultimos 10 años	Mujeres >65 resultados negativos que no estan a alto riesgo cervical ≥CIN3	pruebas concluyentes para establecer superior limite de edad		65 años	65 años	

Manejo: estratificación de riesgo



Castle, Jeronimo, Sideri, *JLGTD*, 2008

Riesgo de ≥CIN3 para cada resultado Pap



Katki *et al*., J Low Genit Tract Dis, 2013

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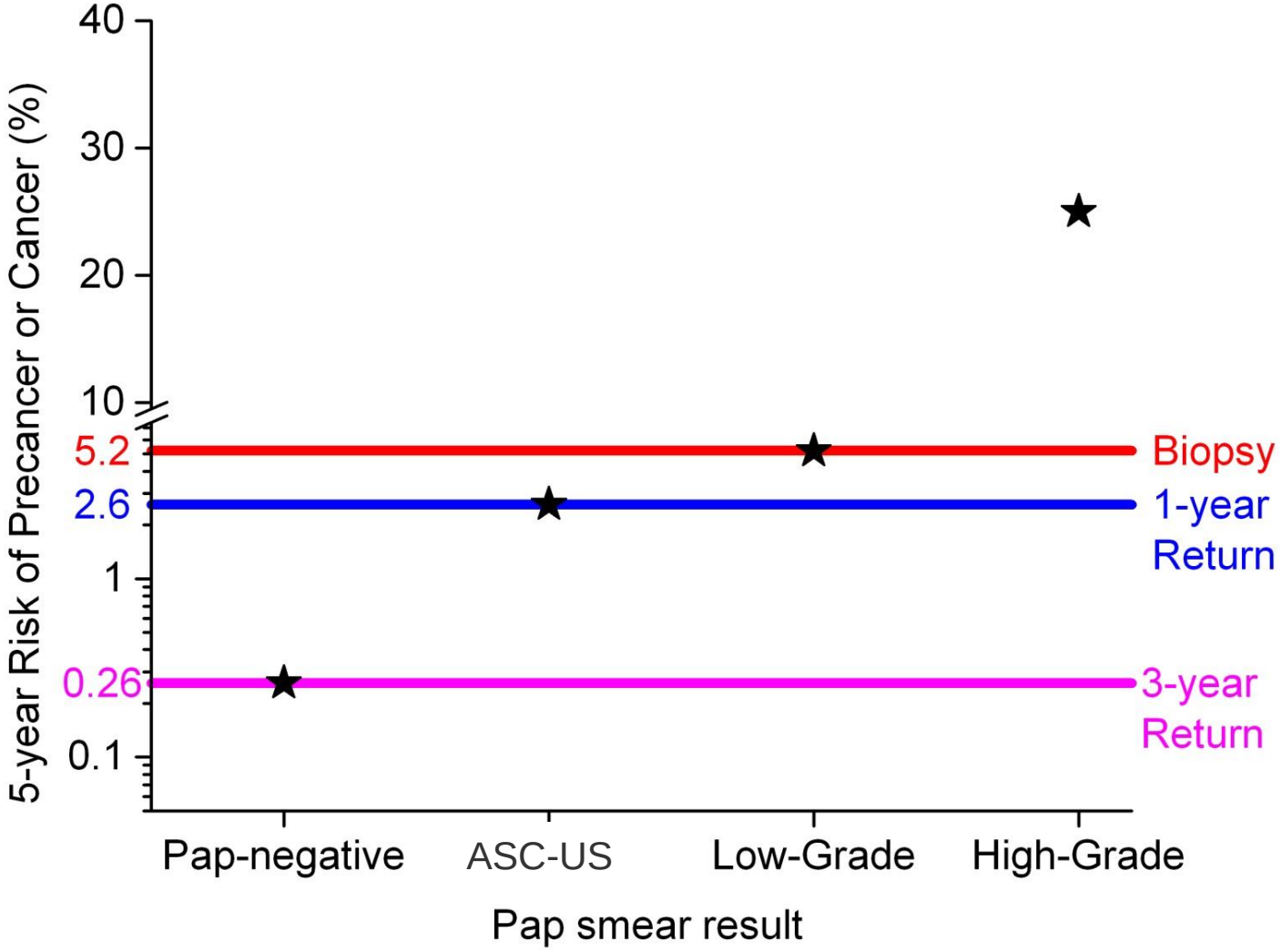
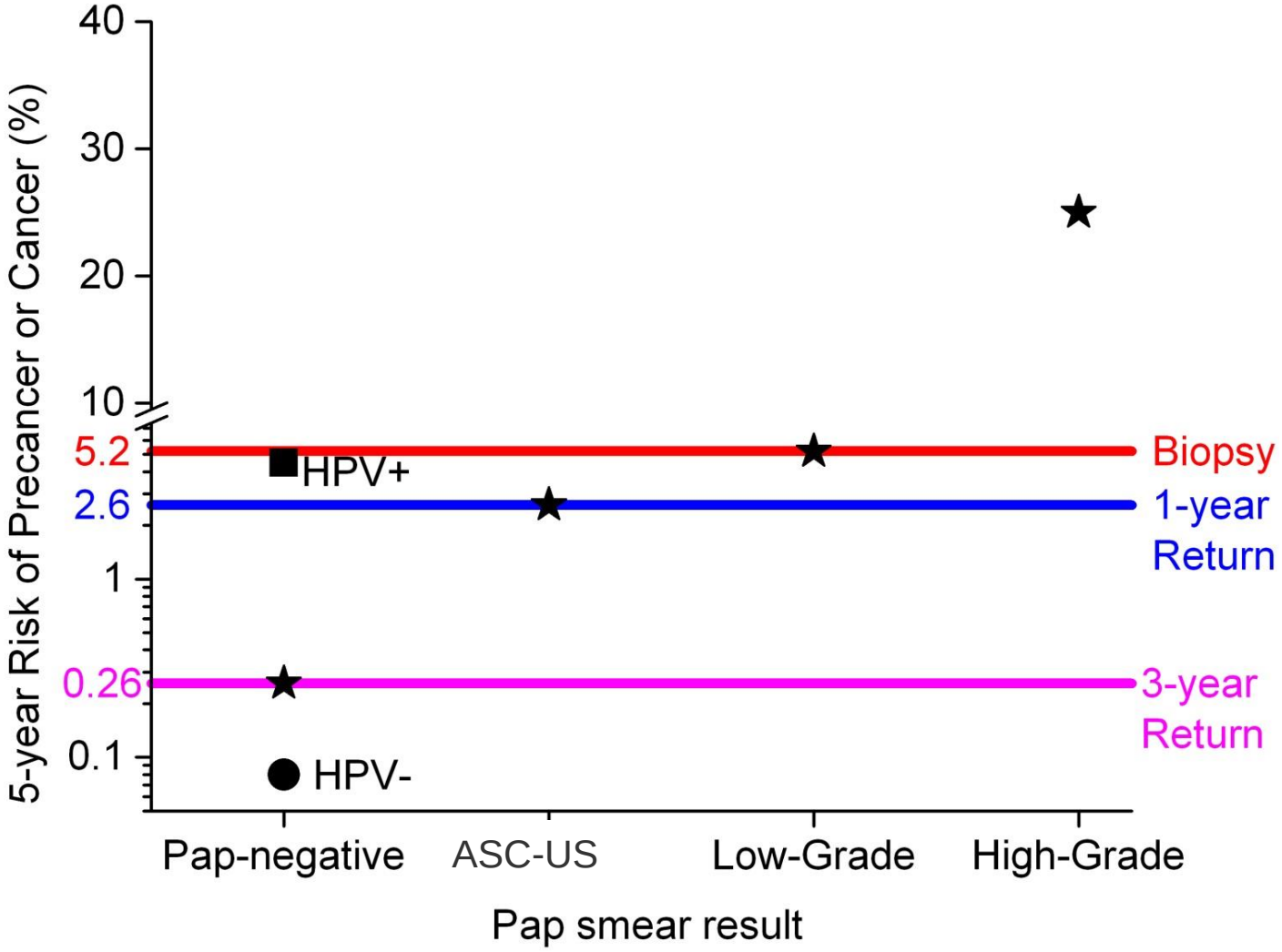
Límites de riesgo implícitos usados en la actual prueba de Papanicolaou (solo)



Manejo de HPV+ y HPV-
Resultados Pap negativos



Katki *et al*., J Low Genit Tract Dis, 2013

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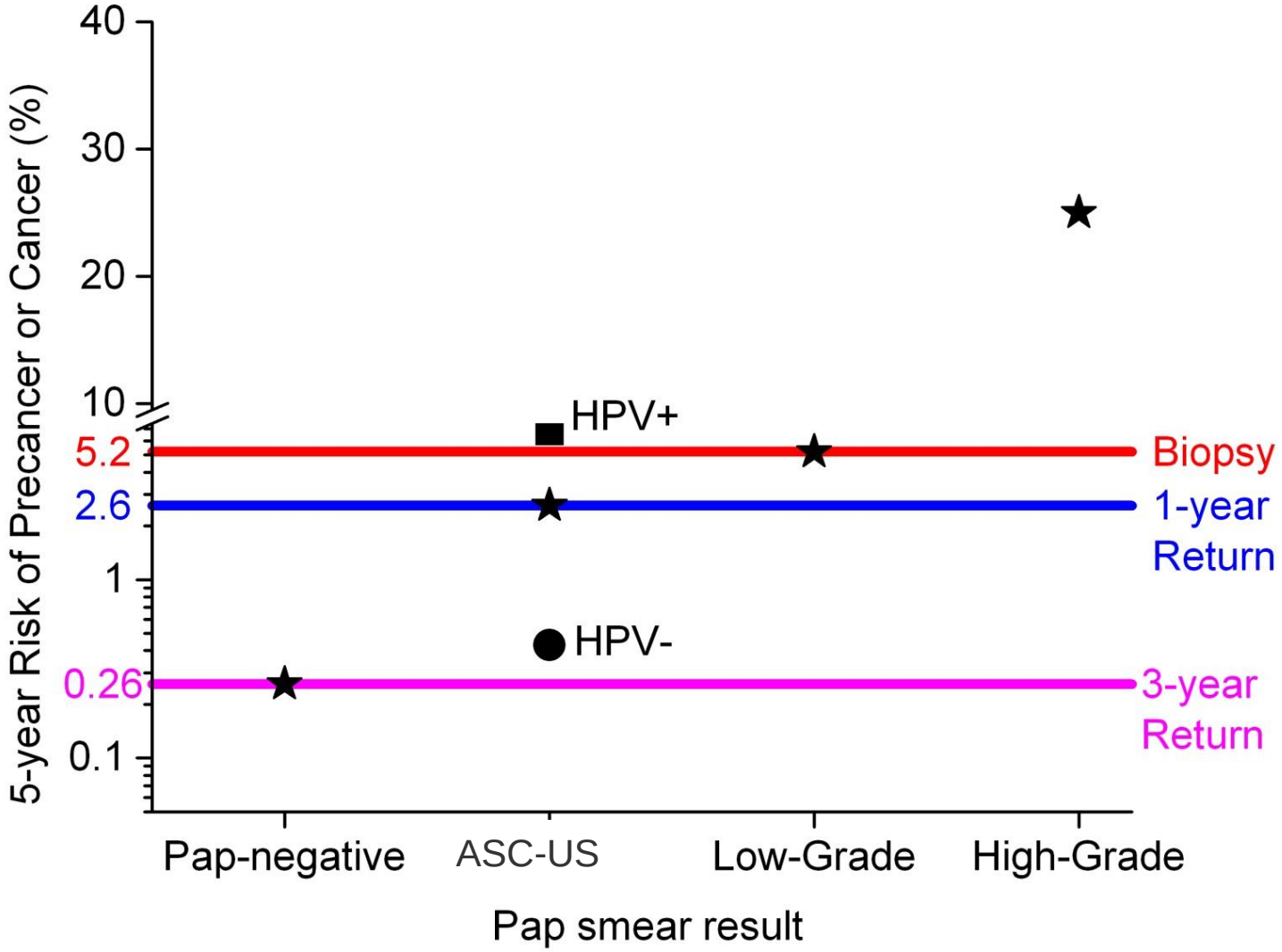
Manejo de HPV+ y HPV-
Resultados Pap Confusos



Katki *et al*., J Low Genit Tract Dis, 2013

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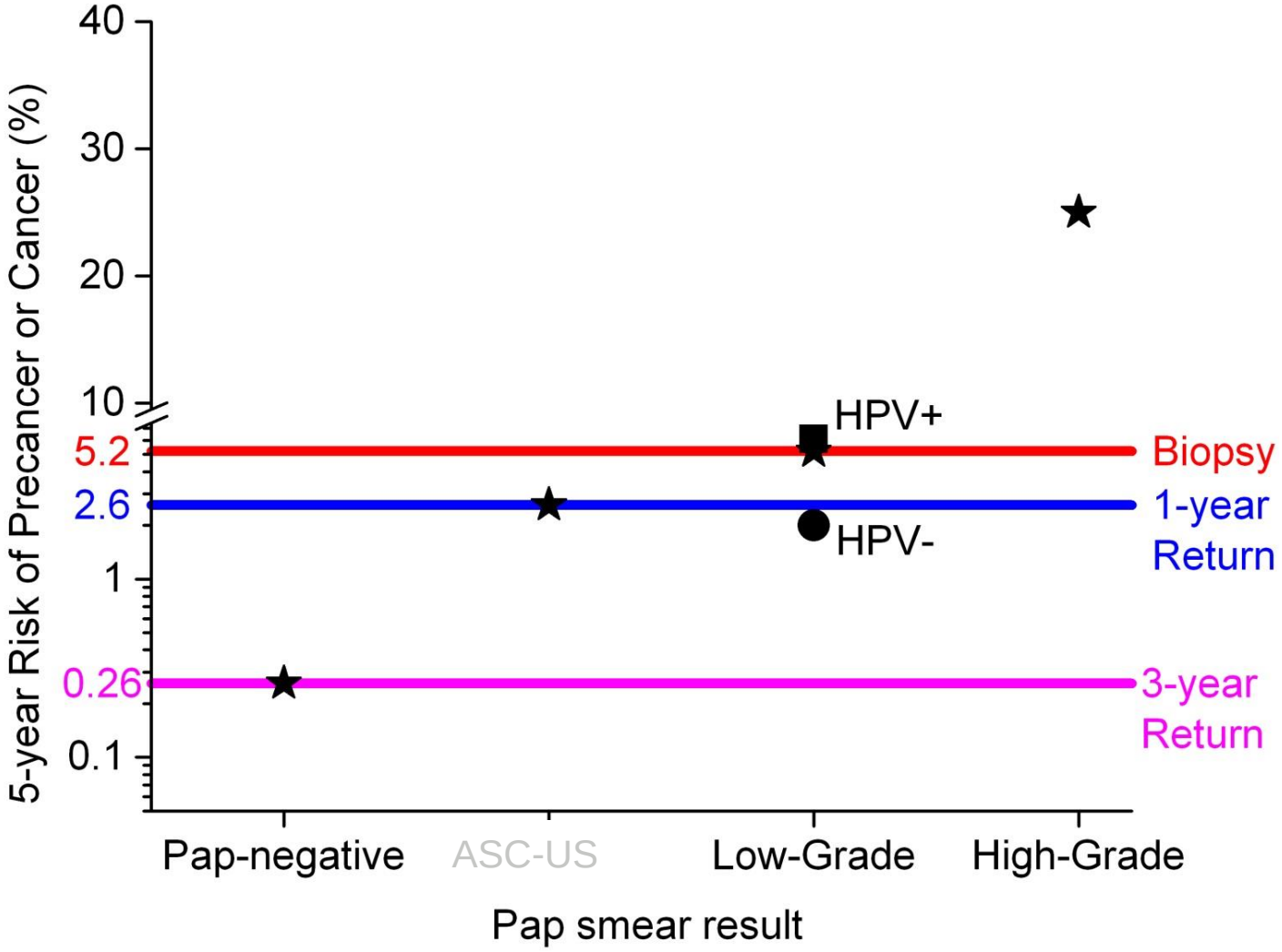
Manejo de HPV+ y HPV-
Resultados Pap Bajo-Grado



Katki *et al*., J Low Genit Tract Dis, 2013

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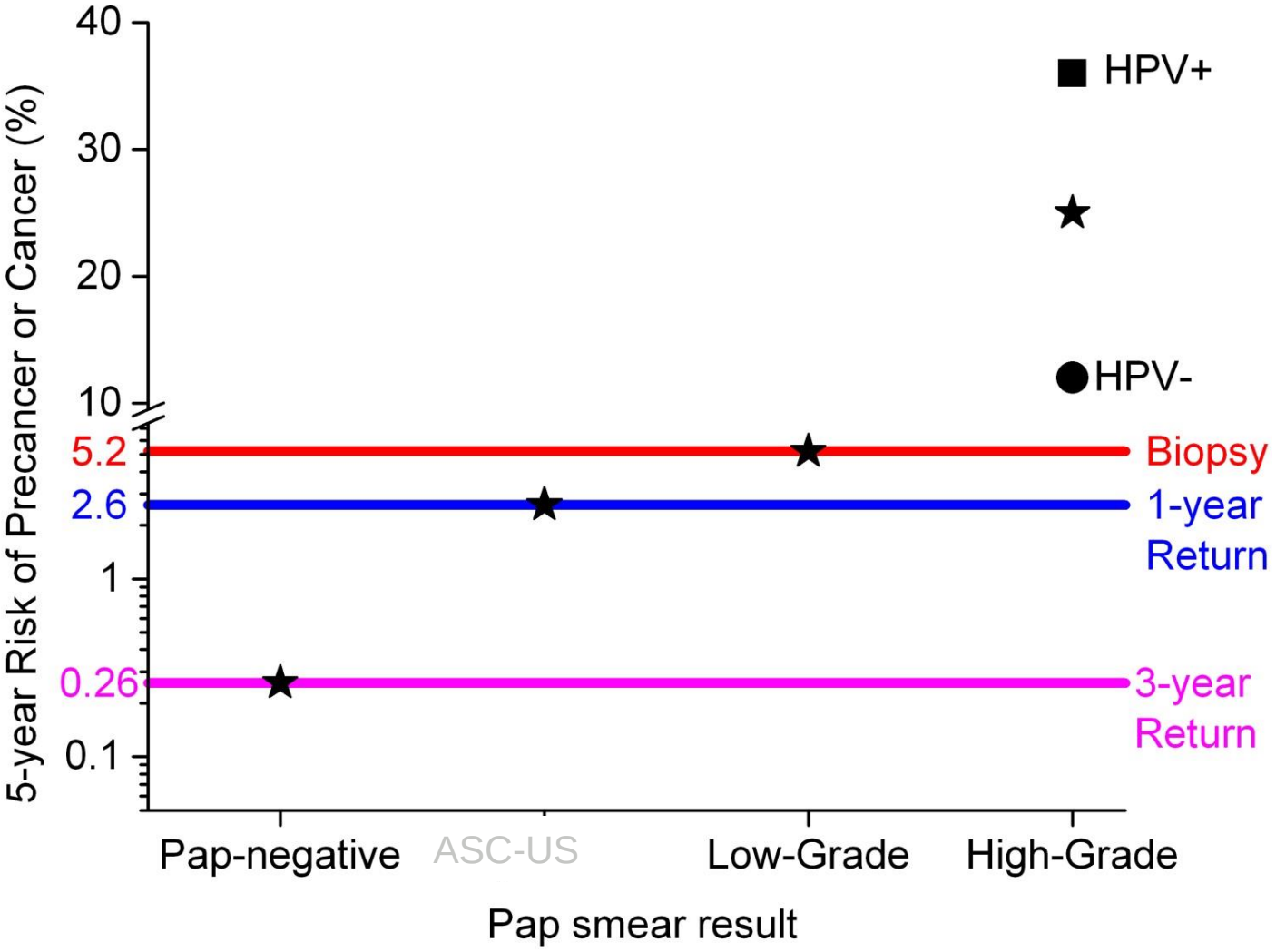
Manejo de HPV+ y HPV-
Resultados Pap Alto-Grado



Katki *et al*., J Low Genit Tract Dis, 2013

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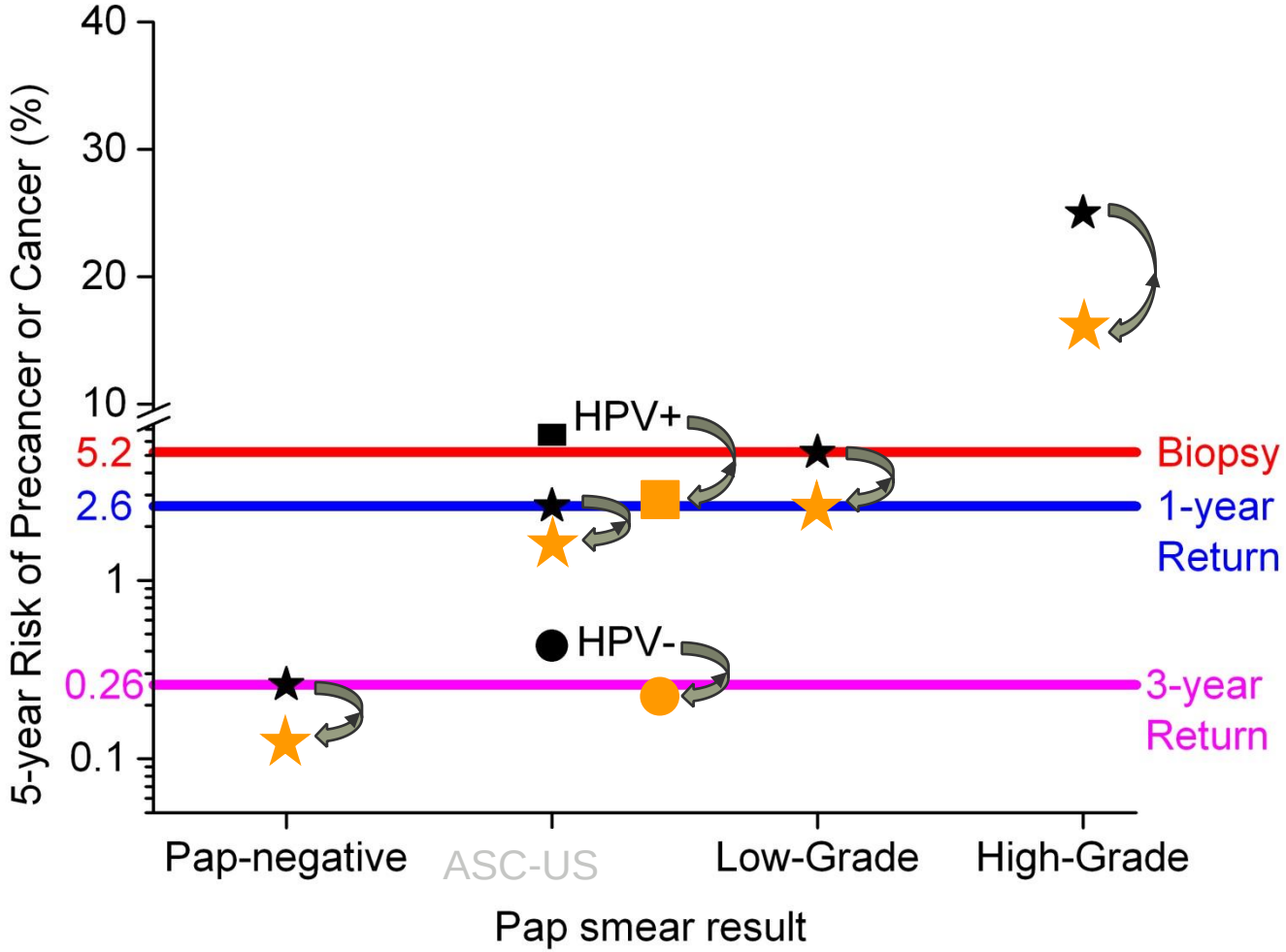
¿Qué sucederá en una Población Vacunada HPV16/18?



Katki *et al*., J Low Genit Tract Dis, 2013

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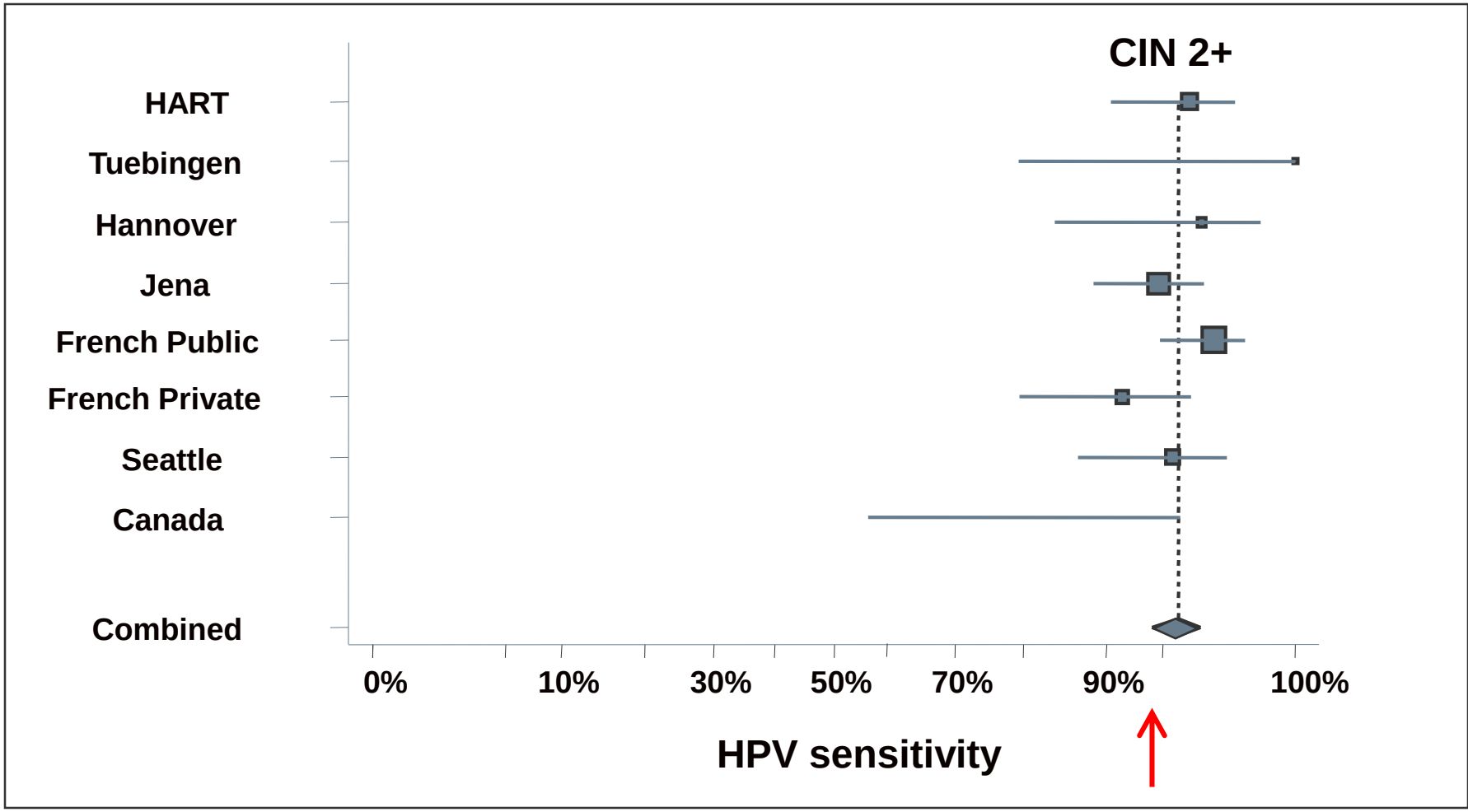
Test para detección de VPH



Cuzick *et al*., IJC, 2006
Mayrand *et al*., NEJM, 2007

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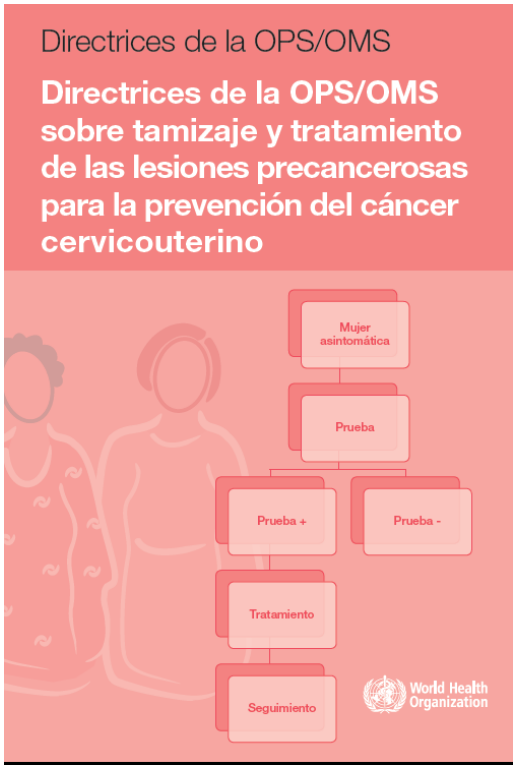

NUEVA GUÍA DE LA OPS/OMS

Tamizaje y tratamiento de las lesiones precancerosas para la prevención del cáncer cervicouterino

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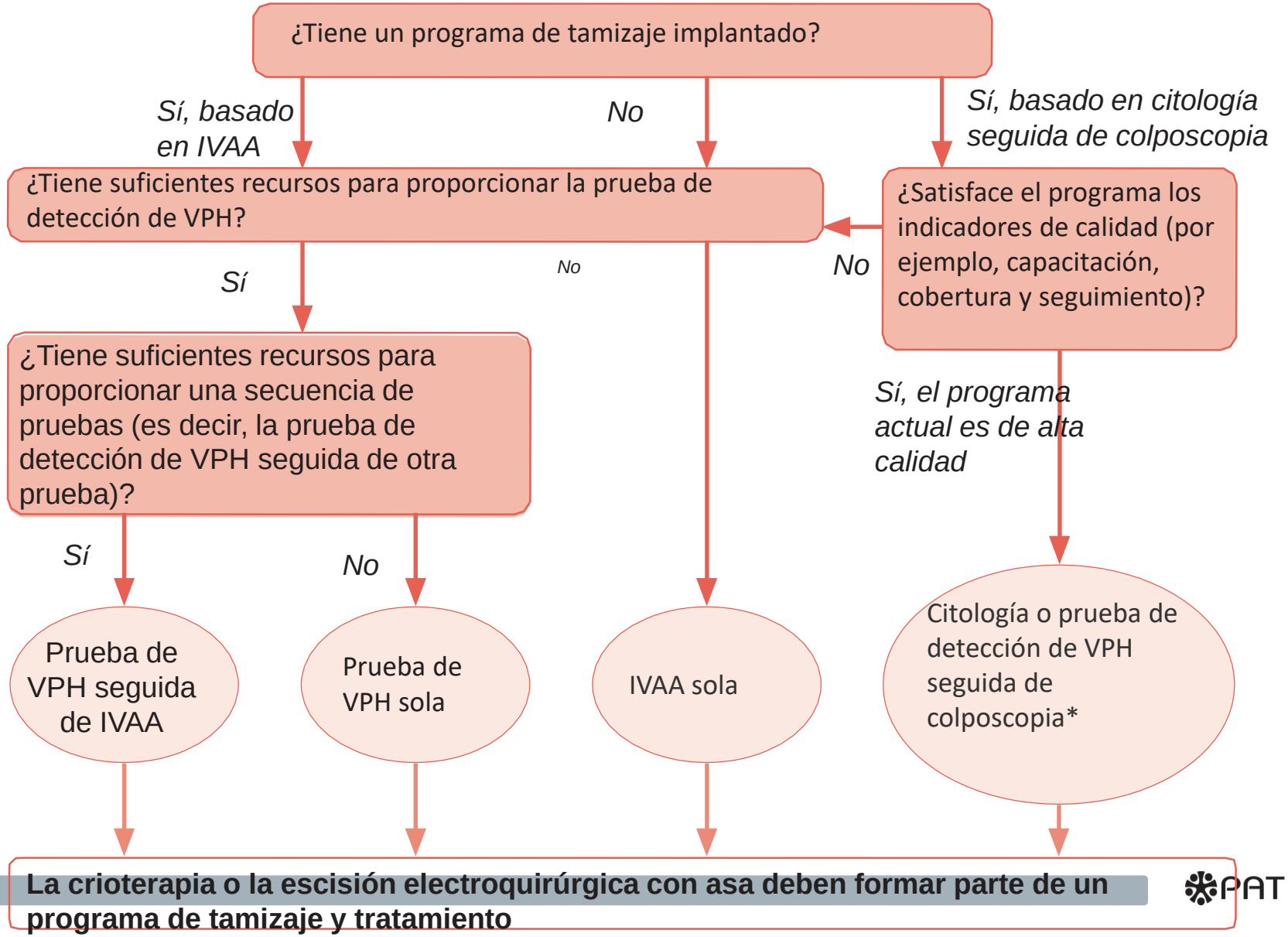
LA TOMA DE DECISIONES SOBRE ESTRATEGIAS DE TAMIZAJE Y TRATAMIENTO DEL CÁNCER CERVICOUTERINO



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EL GRUPO DE EXPERTOS SUGIERE

- Una prueba de **VPH y tratamiento**, con preferencia sobre otras opciones. Esta estrategia se puede utilizar con, o sin, la prueba de **triaje con IVAA**.

- En los países en los que ya exista una estrategia de tamizaje apropiada y de alta calidad basada en citología seguida de colposcopia, podría utilizarse tanto una prueba de **VPH seguida de colposcopia** como la **citología seguida de colposcopia**.

- En los entornos con recursos limitados donde la prueba de detección de VPH no sea factible, el grupo de expertos sugiere una estrategia de tamizaje con **IVAA y tratamiento.**

- El grupo de expertos sugiere una estrategia de tamizaje con IVAA y tratamiento sobre una estrategia de tamizaje con citología seguida de colposcopia, que requieren más recursos para el control de la calidad y capacitación, y un período de espera, así como una segunda visita.

- Una prueba de detección de **VPH seguida de citología**, y en las mujeres con resultados anormales para ambas pruebas, referir para la colposcopia, biopsia y tratamiento según el resultado de la biopsia.

ASCO GUIDELINES™

Secondary Prevention of Cervical Cancer: American Society of Clinical Oncology Resource-Stratified Clinical Practice Guideline

www.asco.org/rs-cervical-cancer-secondary-prev-guideline

special article

Secondary Prevention of Cervical Cancer: ASCO Resource-Stratified Clinical Practice Guideline

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This guideline has been endorsed by the International Gynecologic Cancer Society and the American Society for Colposcopy and Cervical Pathology (Data Supplement).
Clinical Practice Guideline Committee Approved: July 5, 2016

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Authors' disclosures of potential conflicts of interest and contributions are found at the end of this article.
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executive summary

Purpose To provide resource-stratified, evidence-based recommendations on the secondary prevention of cervical cancer globally.

Methods ASCO convened a multidisciplinary, multinational panel of oncology, primary care, epidemiology, health economic, cancer control, public health, and patient advocacy experts to produce recommendations reflecting four resource-tiered settings. A review of existing guidelines, a formal consensus-based process, and a modified ADAPTE process to adapt existing guidelines were conducted. Other experts participated in formal consensus.

Results Seven existing guidelines were identified and reviewed, and adapted recommendations form the evidence base. Four systematic reviews plus cost-effectiveness analyses provided indirect evidence to inform consensus, which resulted in ≥ 75% agreement.

Recommendations Human papillomavirus (HPV) DNA testing is recommended in all resource settings; visual inspection with acetic acid may be used in basic settings. Recommended age ranges and frequencies by setting are as follows: maximal: ages 25 to 65, every 5 years; enhanced: ages 30 to 65, if two consecutive negative tests at 5-year intervals, then every 10 years; limited: ages 30 to 49, every 10 years; and basic: ages 30 to 49, one to three times per lifetime. For basic settings, visual assessment is recommended as triage; in other settings, genotyping and/or cytology are recommended. For basic settings, treatment is recommended if abnormal triage results are present; in other settings, colposcopy is recommended for abnormal triage results. For basic settings, treatment options are cryotherapy or loop electrosurgical excision procedure; for other settings, loop electrosurgical excision procedure (or ablation) is recommended. Twelve-month post-treatment follow-up is recommended in all settings. Women who are HIV positive should be screened with HPV testing after diagnosis and screened twice as many times per lifetime as the general population. Screening is recommended at 6 weeks postpartum in basic settings; in other settings, screening is recommended at 6 months. In basic settings without mass screening, infrastructure for HPV testing, diagnosis, and treatment should be developed.
Additional information can be found at www.asco.org/rs-cervical-cancer-secondary-prev-guideline and www.asco.org/guidelineswiki.

It is the view of of ASCO that health care providers and health care system decision makers should be guided by the recommendations for the highest stratum of resources available. The guideline is intended to complement, but not replace, local guidelines.

INTRODUCTION

The purpose of this guideline is to provide expert guidance on secondary prevention with screening for cervical cancer to clinicians, public health authorities, policymakers, and laypersons in all resource settings. The target population is women in the general population at risk for developing cervical cancer (specific target ages depend on the resource level).

There are large disparities regionally and globally in incidence of and mortality resulting from cervical cancer, in part because of disparities in the provision of mass screening and primary prevention. Different regions of the world, both among and within countries, differ with respect to access to prevention and treatment.

Approximately 85% of incident cervical cancers occur in less developed regions (also known as low- and middle-income countries [LMICs]) around the world, representing 12% of women's cancers in those regions. Eighty-seven percent of deaths resulting from cervical cancer occur in these less-developed regions.[1] Some of the regions in the world with the highest mortality rates include the WHO Southeast Asia and Western Pacific regions, followed by India and Africa.[1] As a result of these disparities, the ASCO Resource-Stratified Guidelines Advisory Group

ASCO Guideline Panel Members

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Clinical Questions

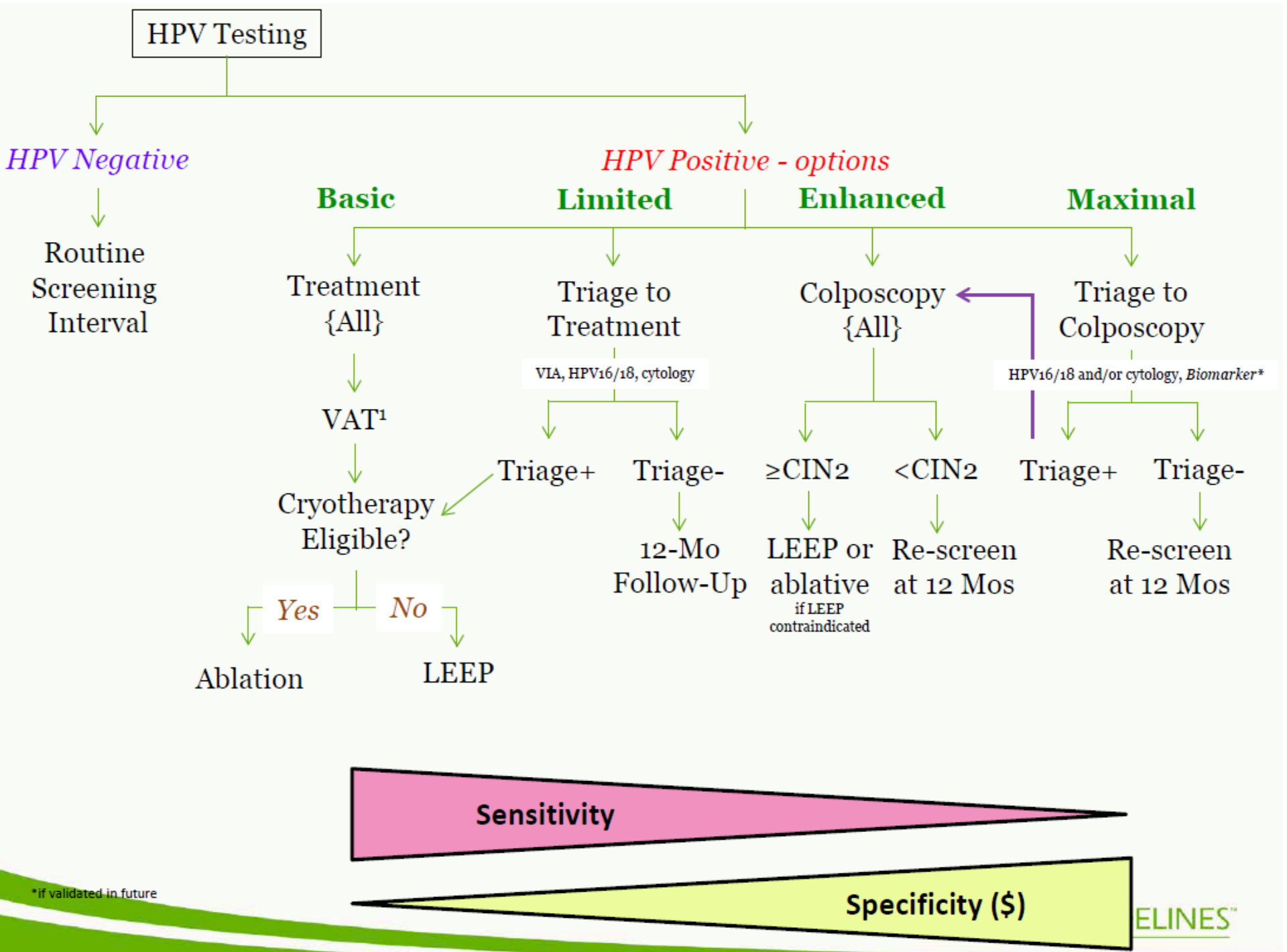
This clinical practice guideline addresses four overarching clinical questions:

(1) What is the best method(s) for screening for each resource stratum?

(2) What is the best triage strategy for women with positive screening results or other abnormal (e.g., discordant HPV/cytology) results?

(3) What are the best management strategies for women with precursors of cervical cancer?

(4) What screening strategy should be recommended for women who have received HPV vaccination?


HPV Testing
HPV Negative
Routine Screening Interval
HPV Positive - options
Basic
Limited
Enhanced
Maximal
Treatment {All}
VAT¹
Cryotherapy Eligible?
Yes
No
Ablation
LEEP
Triage to Treatment
VIA, HPV16/18, cytology
Triage+
Triage-
12-Mo Follow-Up
Colposcopy {All}
≥CIN2
<CIN2
LEEP or ablative
if LEEP contraindicated
Re-screen at 12 Mos
Triage to Colposcopy
HPV16/18 and/or cytology, Biomarker*
Triage+
Triage-
Re-screen at 12 Mos
Sensitivity
Specificity ($)
*if validated in future

Summary of Recommendations

Maximal resource setting

- In maximal resource settings, cervical cancer screening with HPV DNA testing should be offered every 5 years from ages 25 to 65 years. On an individual basis, women may elect to receive screening until 70 years of age (Type: evidence-based for test, interval and age [25-65]; Type: formal consensus-based [until age 70]; Evidence quality: high; Strength of recommendation: strong).

- Women who are ≥ 65 years of age who have had consistently negative screening results during past ≥ 15 years may cease screening. Women who are 65 years of age and have a positive result after age 60 should be reinvited to undergo screening 2, 5, and 10 years after the last positive result. If women have received no or irregular screening, they should undergo screening once at 65 years of age, and if the result is negative, exit screening (Type: evidence-based; Evidence quality: intermediate; Strength of recommendation: moderate).

Summary of Recommendations

- If the results of the HPV DNA test are positive, clinicians should then perform triage with reflex genotyping for HPV 16/18 (with or without HPV 45) and/or cytology as soon as HPV test results are known (Type: evidence-based; Evidence quality: high; Strength of recommendation: strong).

- If triage results are abnormal (ie, ≥ ASC-US or positive for HPV 16/18 [with or without HPV 45]), women should be referred to colposcopy, during which biopsies of any acetowhite (or suggestive of cancer) areas should be taken, even if the acetowhite lesion might appear insignificant. If triage results are negative (eg, primary HPV positive and cytology triage negative), then repeat HPV testing at the 12-month follow-up (Type: evidence-based; Evidence quality: intermediate; Strength of recommendation: strong).

- If HPV test results are positive at the repeat 12 month follow-up, refer women to colposcopy. If HPV test results are negative at the 12- and 24-month follow-up or negative at any consecutive HPV test 12 months apart, then women should return to routine screening (Type: evidence-based; Evidence quality: high; Strength of recommendation: strong).

Summary of Recommendations

- Women who have received HPV and cytology co-testing triage and have HPV-positive results and abnormal cytology should be referred for colposcopy and biopsy. If results are HPV positive and cytology normal, repeat co-testing at 12 months. If at repeat testing HPV is still positive, patients should be referred for colposcopy and biopsy, regardless of cytology results (Type: formal consensus-based; Evidence quality: intermediate; Strength of recommendation: strong).

- If the results of the biopsy indicate that women have precursor lesions (≥CIN2), then clinicians should offer loop electrosurgical excision procedure (LEEP; if there is a high level of quality assurance [QA][1]) or, where LEEP is contraindicated, ablative treatments may be offered. (Type: evidence-based; Evidence quality: high; Strength of recommendation: strong). [Note: See Table 2 in guideline re: QA]

- After women receive treatment for precursor lesions, follow-up should consist of HPV DNA testing at 12 months. If 12-month results are positive, continue annual screening; if not, return to routine screening (Type: formal consensus-based; Evidence quality: intermediate; Strength of recommendation: moderate).

Summary of Recommendations

Enhanced Resource Setting

- In enhanced resource settings, cervical cancer screening with HPV DNA testing should be offered to women 30 to 65 years of age, every 5 years (i.e. second screen five years from the first) (Type: evidence-based; Evidence quality: high; Strength of recommendation: strong).

- If there are two consecutive negative screening test results, subsequent screening should be extended to every 10 years (Type: formal consensus-based; Evidence quality: intermediate-low; Strength of recommendation: moderate).

- Women who are ≥ 65 years of age who have had consistently negative screening results during past ≥ 15 years may cease screening. Women who are 65 years of age and have a positive result after age 60 should be reinvited to undergo screening 2, 5, and 10 years after the last positive result. If women have received no or irregular screening, they should undergo screening once at 65 years of age, and if the result is negative, exit screening (Type: formal consensus-based; Evidence quality: low; Strength of recommendation: weak).

Summary of Recommendations

- If the results of the HPV DNA test are positive, clinicians should then perform triage with HPV genotyping for HPV 16/18 (with or without HPV 45) and/or reflex cytology (Type: evidence-based; Evidence quality: high; Strength of recommendation: strong).

- If triage results are abnormal (ie, ≥ASC-US or positive for HPV 16/18 [with or without HPV 45]), women should be referred to colposcopy, during which biopsies of any acetowhite (or suggestive of cancer) areas should be taken, even if the acetowhite lesion might appear insignificant. If triage results are negative (eg, primary HPV positive and cytology triage negative), then repeat HPV testing at the 12 month follow-up (Type: evidence-based; Evidence quality: intermediate; Strength of recommendation: strong).

- If HPV test results are positive at the repeat 12 month follow-up, refer women to colposcopy. If HPV test results are negative at the 12- and 24-month follow-up or negative at any consecutive HPV test 12 months apart, then women should return to routine screening (Type: evidence-based; Evidence quality: high; Strength of recommendation: strong).

Summary of Recommendations

- If the results of colposcopy and biopsy indicate that women have precursor lesions (≥CIN2), then clinicians should offer LEEP (if there is a high level of QA) or, where LEEP is contradicted, ablative treatments may be offered (Type: evidence-based; Evidence quality: high; Strength of recommendation: strong).

- After women receive treatment for precursor lesions, follow-up should consist of HPV DNA testing at 12 months. If 12-month results are positive, continue annual screening; if not, return to routine screening (Type: formal consensus-based; Evidence quality: intermediate; Strength of recommendation: moderate).

Summary of Recommendations

Limited Resource Setting

- Cervical cancer screening with HPV DNA testing should be offered to women 30 to 49 years of age every 10 years, corresponding to two to three times per lifetime (Type: evidence-based [age range], Type: formal consensus-based [interval]; Evidence quality: intermediate; Strength of recommendation: moderate).

- If the results of the HPV DNA test are positive, clinicians should then perform triage with reflex cytology (quality assured) and/or HPV genotyping for HPV 16/18 (with or without HPV 45) or with visual assessment for treatment (VAT) (For cytology and genotyping - Type: evidence-based; Evidence quality: high; Strength of recommendation: strong) (For VAT – Type: formal consensus-based; Evidence quality: low; Strength of recommendation: weak).

- If cytology triage results are abnormal (i.e. ≥ASC-US), women should be referred to quality assured colposcopy (the first choice, if available and accessible), during which biopsies of any acetowhite (or suggestive of cancer) areas should be taken, even if the acetowhite lesion might appear insignificant. If colposcopy is not available, then perform VAT (Type: evidence-based; Evidence quality: intermediate; Strength of recommendation: moderate).

Summary of Recommendations

- If HPV genotyping or VAT triage results are positive, then women should be treated. If the results from both of these forms of triage are negative, then repeat HPV testing at the 12-month follow-up (Type: evidence-based; Evidence quality: high; Strength of recommendation: strong).

- If test results are positive at the repeat 12 month follow-up, then women should be treated (Type: formal consensus-based; Evidence quality: intermediate; Strength of recommendation: moderate).

- For treatment, clinicians should offer ablation if the criteria are satisfied; if not and resources available, then offer LEEP (if there is a high level of QA) (Type: evidence-based; Evidence quality: high; Strength of recommendation: strong).

- After women receive treatment for precursor lesions, follow-up should consist of the same testing at 12 months (Type: formal consensus-based; Evidence quality: intermediate; Strength of recommendation: moderate).

Summary of Recommendations

Basic Resource Setting

- If HPV DNA testing for cervical cancer screening is not available, then VIA should be offered with the goal of developing health systems and moving to population-based screening with HPV testing at the earliest opportunity. Screening should be offered to women 30 to 49 years of age, at least once per lifetime, but not more than three times per lifetime (Type: evidence-based; Evidence quality: intermediate; Strength of recommendation: strong).

- If the results of available HPV testing are positive, clinicians should then perform VAT followed by treatment with cryotherapy and/or LEEP, depending on the size and location of the lesion (Type: formal consensus-based; Evidence quality: low; Strength of recommendation: moderate).

Summary of Recommendations

- If primary screening is VIA and results are positive, then treatment should be offered with cryotherapy and/or LEEP, depending on the size and location of the lesion (Type: evidence-based; Evidence quality: intermediate;[2] Strength of recommendation: moderate).

- After women receive treatment for precursor lesions, then follow up with the available test at 12 months. If the result is negative, then women return to routine screening (Type: formal consensus-based; Evidence quality: intermediate; Strength of recommendation: moderate).

Gracias

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