

# Updated Cervical Cancer Screening Guidelines

Practice Advisory  | April 2021

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The American College of Obstetricians and Gynecologists (ACOG) joins ASCCP and the Society of Gynecologic Oncology (SGO) in endorsing the U.S. Preventive Services Task Force (USPSTF) cervical cancer screening recommendations [1](#), which replace ACOG Practice Bulletin No. 168, *Cervical Cancer Screening and Prevention*, as well as the 2012 ASCCP cervical cancer screening guidelines [2](#).

The adoption of the USPSTF guidelines expands the recommended options for cervical cancer screening in average-risk individuals aged 30 years and older to include screening every 5 years with primary high-risk human papillomavirus (hrHPV) testing. Primary hrHPV testing uses high-risk HPV testing alone (no cytology) with a test that is approved by the U.S. Food and Drug Administration (FDA) for stand-alone screening. Consistent with prior guidance, screening should begin at age 21 years, and screening recommendations remain unchanged for average-risk individuals aged 21–29 years and those who are older than 65 years [Table 1](#). Management of abnormal cervical cancer screening results should follow current ASCCP guidelines [3](#) [4](#).

**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: <ul style="list-style-type: none"><li>• Cytology alone every 3 years</li><li>• FDA-approved primary hrHPV testing alone every 5 years</li><li>• Cotesting (hrHPV testing and cytology) every 5 years</li></ul>	A
Aged greater than 65 years	No screening after adequate negative prior screening results§	D

Hysterectomy  
with respect to the cervix.

Abbreviations:  
testing.

\*These recommendations apply to women of average risk for cervical cancer who have not had a hysterectomy and do not have preexisting conditions that would contraindicate testing (e.g., immunodeficiencies, human papillomavirus).

†Grade of benefit.

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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.

There are now three recommended options for cervical cancer screening in individuals aged 30–65 years: primary hrHPV testing every 5 years, cervical cytology alone every 3 years, or co-testing with a combination of cytology and hrHPV testing every 5 years **Table 1**. All three screening strategies are effective, and each provides a reasonable balance of benefits (disease detection) and potential harms (more frequent follow-up testing, invasive diagnostic procedures, and unnecessary treatment in patients with false-positive results) **1**. Data from clinical trial, cohort, and modeling studies demonstrate that among average-risk patients aged 25–65 years, primary hrHPV testing and co-testing detect more cases of high-grade cervical intraepithelial neoplasia than cytology alone, but hrHPV-based tests are associated with an increased risk of coloscopies and false-positive results

**1 6 7.**

Currently, there are two hrHPV tests approved by the FDA for primary screening in individuals aged 25 years and older. Although cytology alone is the recommended screening method for individuals aged 21–29 years, ACOG, ASCCP, and SGO advise that primary hrHPV testing every 5 years can be considered for average-risk patients aged 25–29 years based on its FDA-approved age for use and primary hrHPV testing's demonstrated efficacy in individuals aged 25 years and older.

## Future

### *Primary*

In 2020, the ACS recommended primary hrHPV testing for women aged 25–65 years as the sole screening test for cervical cancer.

of this shift is the significant increase in access to screening services

and among communities of color, which have disproportionately high rates of cervical cancer

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incidence, morbidity, and mortality **8 9 10**. Although cytology-based screening options are still included in the ACS guidelines in acknowledgement of these barriers to widespread access and implementation, ACS strongly advocates phasing out cytology-based screening options in the near future **5**. Until primary hrHPV testing is widely available and accessible, cytology-based screening methods should remain options in cervical cancer screening guidelines. Although HPV self-sampling has the potential to greatly improve access to cervical cancer screening, and there is an increasing body of evidence to support its efficacy and utility, it is still investigational in the United States **5 11**.

*Age to Initiate Screening*

The introduction of vaccines targeting the most common cancer-causing HPV genotypes has advanced the primary prevention of cervical cancer. As vaccination coverage increases and more vaccinated individuals reach the age to initiate cervical cancer screening, HPV prevalence is expected to continue to decline [12](#) [13](#). This could prompt future changes to screening guidelines, such as raising the screening initiation age to 25 years, as is recommended in the recently updated ACS guidelines [5](#). Although HPV vaccination rates continue to improve, nationwide HPV vaccination coverage remains below target levels, and there are racial, ethnic, socioeconomic, and geographic disparities in vaccination rates [13](#) [14](#) [15](#) [16](#). Cervical cancer screening rates also are below expectations, with the lowest levels reported among individuals younger than 30 years [17](#) [18](#). Raising the screening start age to 25 years could increase the already high rate of underscreening among individuals aged 25–29 years and exacerbate existing health inequities in cervical cancer screening, incidence, morbidity, and mortality [10](#) [17](#) [18](#) [19](#). Given these significant health equity concerns and the current suboptimal rates of cervical cancer screening and HPV vaccination, ACOG, ASCCP, and SGO continue to recommend initiation of cervical cancer screening at age 21 years.

## Conclusion

Although and co-testing strategy is inadequate and persistent, these components at age 21 years are important for cervical cancer prevention. To strengthen the impact of the HPV vaccine, we must provide comprehensive reproductive health care.

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