Updated Guidelines for Management of Cervical Cancer Screening Abnormalities

Practice Advisory | October 2020

ASCCP recently released its *Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors* [1]. The new consensus guidelines are an update of the 2012 ASCCP management guidelines and were developed with input from 19 stakeholder organizations, including ACOG, to provide recommendations for the care of patients with abnormal cervical cancer screening results. ACOG officially endorses the new management guidelines, which update and replace Practice Bulletin No. 140, *Management of Abnormal Cervical Cancer Screening Test Results and Cervical Cancer Precursors*.

Key Updates

Although many of the management recommendations remain unchanged from the 2012 guidelines, there are several important updates (Box 1). Unlike the 2012 ASCCP guidelines that relied on test results-based algorithms, the new consensus guidelines follow a risk-based approach to determine the need for surveillance, colposcopy, or treatment. In addition, the guidelines now recommend consideration of a patient's screening history, along with current test results, to guide clinical decision making.

Box 1. Essential Changes From Prior Management Guidelines

1. **Recommendations are based on risk, not results.**

    - Recommendations of colposcopy, treatment, or surveillance will be based on a patient's risk of CIN 3+ determined by a combination of current results and past history (including unknown history). The same current test results may yield different

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    - Expedited treatment was an option for patients with high-grade squamous intraepithelial lesion (HSIL) cytology in the 2012 guidelines; this guidance is now better defined.

    - For nonpregnant patients 25 years or older, expedited treatment, defined as treatment without preceding colposcopic biopsy demonstrating CIN 2+, is preferred when the immediate risk of CIN 3+ is ≥ 60%, and is acceptable for those with risks between 25% and 60%. Expedited treatment is preferred for nonpregnant patients 25 years or older with HSIL cytology and concurrent positive testing for HPV genotype 16 (HPV 16) (ie, HPV 16-positive HSIL cytology) and never or rarely screened patients with HPV-positive HSIL cytology regardless of HPV genotype.

    - Shared decision making should be used when considering expedited treatment, especially for patients with concerns about the potential impact of treatment on

pregnancy outcomes.

4. **Excisional treatment is preferred to ablative treatment for histologic HSIL (CIN 2 or CIN 3) in the United States. Excision is recommended for adenocarcinoma in situ (AIS).**

5. **Observation is preferred to treatment for CIN 1.**

6. **Histopathology reports based on Lower Anogenital Squamous Terminology (LAST)/World Health Organization (WHO) recommendations for reporting histologic HSIL should include CIN 2 or CIN 3 qualifiers, ie, HSIL (CIN 2) and HSIL (CIN 3).**

7. **All positive primary HPV screening tests, regardless of genotype, should have additional reflex triage testing performed from the same laboratory specimen (eg, reflex cytology).**

    - Additional testing from the same laboratory specimen is recommended because the findings may inform colposcopy practice. For example, those HPV-16 positive HSIL
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histologic HSIL, CIN 2, CIN 3, or AIS. Continued surveillance at 3-year intervals beyond 25 years is acceptable for as long as the patient's life expectancy and ability to be screened are not significantly compromised by serious health issues.

    - The 2012 guidelines recommended return to 5-year screening intervals and did not specify when screening should cease. New evidence indicates that risk remains elevated for at least 25 years, with no evidence that treated patients ever return to risk levels compatible with 5-year intervals.

9. **Surveillance with cytology alone is acceptable only if testing with HPV or cotesting is not feasible. Cytology is less sensitive than HPV testing for detection of precancer and is therefore recommended more often. Cytology is recommended at 6-month intervals when HPV testing or cotesting is recommended annually. Cytology is recommended annually when 3-year intervals are recommended for HPV or cotesting.**

10. **Human papilloma virus assays that are Food and Drug Administration (FDA)-approved for screening should be used for management according to their regulatory approval in the United States. (Note: all HPV testing in [the guidelines] refers to testing for high-risk HPV types only).**

    - For all management indications, HPV mRNA and HPV DNA tests without FDA approval for primary screening alone should only be used as a cotest with cytology, unless sufficient, rigorous data are available to support use of these particular tests in management.

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Table 1. CIN 3+ Risk Thresholds for Management

Expedited treatment preferred*	≥ 60%†
Expedited treatment or colposcopy acceptable*	25% to < 60%†
Colposcopy recommended	4% to < 25%†
Repeat test in 1 year	0.55% to < 4%‡

	Repeat test in 3 years 0.15% to < 0.55%‡
	Return to routine screening at 5-year intervals < 0.15%‡

*For nonpregnant patients 25 years or older.

†Refers to immediate CIN 3+ risk.

‡Refers to 5-year CIN 3+ risk.

Data from Perkins RB, Guido RS, Castle PE, Chelmow D, Einstein MH, Garcia F, et al. 2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors. J Low Genit Tract Dis. 2020;24(2):102–131.

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In additional to enabling the provision of more individualized clinical care, the new risk-based management paradigm will facilitate the incorporation of new screening and management technologies into clinical decision making and accommodate changes in disease prevalence over time. The risk database will continue to be updated as new testing methods and follow-up data emerge, and the new framework will allow management to be adjusted accordingly and consistently. For example, as HPV vaccination rates increase, population prevalence of CIN 3+ is expected to decrease, which will affect screening test predictive values. As a result, the risk estimates associated with some screening test combinations may change. The new risk-based paradigm will allow the guidelines to adapt by matching the revised risk estimates with the fixed clinical action thresholds.

Implementation

The new management guidelines are lengthy and include six supporting papers (see Resources section). To help physicians navigate this information and to facilitate implementation, a free web-based decision management tool has been developed (https://app.asccp.org/). In addition, a smartphone app is available at nominal cost for both Android and iOS platforms (https://www.asccp.org/mobile-app). Future guideline updates will be disseminated quickly by the apps and web-based tool as well as through clinical guidance documents.

Please contact clinical@acog.org with any questions.

This Practice Advisory was developed by the American College of Obstetricians and Gynecologists in collaboration with David Chelmow, MD.

Reference

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