You know the drill~

- Mute your cellphones or place on vibrate
- Leave the room if you must make a call
- Please use the scheduled break (rather than during the lecture) to check e-mail messages

We all thank you!
Family Planning Update 2017: What’s New in Breast and Cervical Cancer?
Topics today

- Update: ACA and its effect on direct service programs
  - We are now BCCCNP
  - FP/BCCCP Joint Project update: cervical and breast services

- Cancer prevention
  
- Breast cancer screening recommendations
  - Briefly: clinical implications of breast density

- Genetic Counseling and Testing

- Cervical cancer screening and follow-up
Update: the ACA and BCCCP

- BCCCP serves women, age 40-64, income ≤250% FPL, uninsured or underinsured
- Healthy Michigan Plan (HMP) serves up to 138% FPL (70%+ BCCCP clients)
- People with income 100-400% FPL may purchase insurance through the Marketplace.
- Insurances cover screening tests w/o co-pays (mammogram, Pap) but may not cover diagnostic services (ultrasound/biopsy/colp etc.)
- **BCCCP is available to pay for these diagnostic services.**

_How do we get the word out?_
FY13: Michigan’s BCCCP served 30K women.

April 1, 2014: HMP began enrolling

600K+ women and men have enrolled statewide, including ~75% of BCCCP clients

So: our agencies were enrolling fewer women into BCCCP (to pay for services) but were spending a lot of time helping insured women locate and connect with cancer screening services

Because of that, on July 1, 2015 – we formally became a “navigation program”

<table>
<thead>
<tr>
<th>Year</th>
<th>Clients Navigated</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY15</td>
<td>213</td>
</tr>
<tr>
<td>FY16</td>
<td>1193</td>
</tr>
<tr>
<td>FY17 (to date)</td>
<td>1980</td>
</tr>
</tbody>
</table>
- Updated brochure!
- Spanish version available
- Copies available via the MDHHS Cancer Clearinghouse
Questions?
Family Planning/BCCCNPN Joint Project

- FY00: BCCCP began providing colposcopy services for FP clients w/ abnormal Pap tests
- FY15: BCCCP began providing diagnostic testing (imaging, bx, etc.) for young women w/ abnormal CBE results
- All need to be ≤ age 39, income < 250% FPL, uninsured or underinsured (Plan First! OK)
- If cancer diagnosed, BCCCP Medicaid is available
- Plan: to continue this most successful collaboration!

- AND: women ≥ age 40 qualify for BCCCNPN, even if seen in FP clinics! (Please refer them)
Cervical Cancer FY00-16 FP/BCCCNP Joint Project
Breast Cancer <age 40
FY15-17 (to date)
Breast cancer in MI

- 2013: 7,676 Michigan women diagnosed with breast cancer
- 2014: 1,460 Michigan women died from breast cancer

- Incidence is about the same between Black and White women in Michigan, but mortality is higher for Black women.
- Deaths from breast cancer have declined in Michigan from 32.9 deaths per 100,000 Michigan women in 1995 to 22.2 deaths per 100,000 Michigan women in 2014

- Partly due to public health efforts: education to increase screening
Breast Cancer Risk Factors

- Family history of breast cancer, ovarian cancer or other hereditary breast and ovarian syndrome-associated cancer (prostate, pancreatic)
- Known deleterious gene mutation
- Prior breast biopsy with specific pathology
  - Atypical hyperplasia
  - Lobular carcinoma \textit{in situ}
- Early menarche
- Late menopause (>age 51)
- Nulliparity
- Prolonged interval between menarche and first pregnancy
Risk factors, cont.

- Menopausal hormone therapy with estrogen and progesterone (decreased risk w/ estrogen alone)
- Not breastfeeding
- Increasing age
- Certain ethnicities (Ashkenazi Jewish women)
- Higher BMI
- Alcohol consumption
- Smoking
- Dense breasts on mammogram
- Prior exposure to high-dose therapeutic chest irradiation in young women (10-30 years old)
Anticipatory guidance for all women: how to reduce breast cancer risk

- Lose (or don’t gain) excess weight
- Don’t take hormones (especially estrogen plus progestin) after menopause
- Aim for 30-60 minutes/day of moderate-to-vigorous aerobic exercise
- Drink alcoholic beverages only occasionally
- Breastfeed your babies at least 12 months
- Don’t get a CT scan unless you are sure that it’s necessary

[www.cdc.gov/nceh/radiation/ionizing.htm](http://www.cdc.gov/nceh/radiation/ionizing.htm)
Breast cancer prevention for women at higher risk

- BRCA1/2 mutation positive: bilateral mastectomy

- Recommended: Tamoxifen (and others) as pharmacologic intervention for breast cancer risk reduction

- For women at high-risk (>1.66% by Breast Cancer Risk Assessment Tool)

- Michigan Cancer Consortium: Position Paper for Health Care Providers on use of Tamoxifen to reduce risk [www.michigancancer.org](http://www.michigancancer.org)
Genetic testing!

- Important!: Before someone has genetic testing, they should have genetic counseling. For a Genetic Counselor near you: Michigan Cancer Genetics Alliance www.migrc.org

- Why a Genetic Counselor?
  - The woman herself may not be the best candidate for testing
  - Usually the best person to test is the family member with the disease (breast or ovarian cancer)
  - Doing the full panel of testing is very expensive and may not be the best choice
Genetic Counseling and Testing

- BCCCNP: focus on average-risk women and screening
- Unable to provide surveillance for high-risk women or pay for genetic counseling/testing
- Breast Cancer Awareness plates
- $ will be used to pay for indicated testing
- Genetic Counseling will be done prior to testing
Risk Assessment

- NCCN Guidelines: Breast and/or Ovarian Cancer Genetic Assessment
- Planned Parenthood uses a two-question BRSQ
  - A. Have you had breast or ovarian cancer?
  - B. Has a blood relative had breast or ovarian cancer?
  - If answer to either is “yes”, two more questions. If “yes” to either, refer to Genetic Counseling
  - (BR-SQ breast cancer risk for more information)

- Policy: GENETIC COUNSELING AND GENETIC TESTING IN MICHIGAN’S BCCCNP
For BCCCNP to pay for counseling/ testing

- Must qualify: age 25-64, female, income $\leq 250\% \text{ FPL}$, uninsured or underinsured
- Healthy Michigan Plan, Medicaid and most insurances DO pay for genetic counseling and testing
- Counseling must be provided by a certified genetic counselor, practicing in Michigan, who is participating in this project
- Refer to local BCCCNP Coordinator > contact me > will fax referral to GC
Since 2016~

- **24 women referred and enrolled in BCCNP**
- **5 GC unable to locate**
- **3 declined**
- **2 no-show**
- **3 encountered GC system barriers**

**11 proceeded to Genetic Counseling/Testing**
- **6 tested, benign results**
- **0 tested, results pending**
- **2 appointments pending**
- **2 tested, VUS**
- **1 will test her mom first**
Questions?
Cervical cancer in MI

- In 2013, 341 Michigan women were diagnosed with invasive cervical cancer
- In 2014, 107 Michigan women died from invasive disease
- 2013 Incidence: 8.8/100,000 for Black women, 6.5 for White women
- 2013/14 mortality: 3.3/100,000 for Black women, 1.8 for white women
Cervical cancer prevention

- 99+% cervical cancer is due to infection from high-risk (HR) Human Papillomavirus
- 50-60% of cervical cancer mortality is in women who’ve either never had a Pap test or haven’t had one in over 5 years.
- Public health efforts directed at information about HPV and screening and, more recently, to promote vaccination
High-risk (HR) HPV

- Worldwide, HR-HPV is responsible for 5% of all cancers
- Causes virtually all cervical cancer
- Causes most all anal cancers (85% caused by HPV 16)
- Causes some vaginal, vulvar, penile, and oropharyngeal cancers
Natural history of HPV

- **Human Papillomavirus (HPV):** group of 150+ viruses. 40+ of these are easily spread through skin-to-skin contact (vaginal, anal or oral sex)

- **HPV is most common STI:** more than half of all sexually-active people are infected w/ one or more HPV types at some time in their lives

- **Two types of sexually-transmitted HPV:**
  - Low-risk HPV strains cause skin warts (condylomata); HPV 6 and 11 causes 90% of all genital warts
  - High-risk (or oncogenic) strains of HPV cause cancer. HPV 16 and 18 causes 70% of cervical cancer in the US
HPV Natural History, cont.

- Acquisition usually occurs within first several years post sexual debut*

- Approximately 70% of new HPV infections clear within one year; up to 91% within 2 years.†

- High risk HPV types take longer to clear than low risk types

- **Persistent** infection associated with risk for neoplastic progression

---

*Winer, et al. AJE 2003
†Ho et al. NEJM 1998
Franco et al. JID 1999
High-risk (HR) HPV

- HOWEVER: most high-risk HPV infections
  - Occur w/o symptoms
  - Are clinically undetectable w/in 1-2 years
  - Do NOT become cancer

- Persistence of HPV may lead to more serious cytologic abnormalities, which, if untreated, may lead to cancer
Risk factors for HPV persistence

- Age 30 and over
- Presence of High-risk HPV types
- Smoker
- Suppressed immune system (e.g., HIV+, transplant recipient, long-term steroid use)

One theory: a generally “compromised” immune system (implicated in many other diseases)?

It’s this persistence of HR-HPV which may lead to more serious cytologic abnormalities, and which, if untreated, may lead to cancer.
HPV Natural History, in summary

Initial HPV infection

CLEARED HPV INFECTION

CIN 1

Persistent infection

CIN 2/3

CANCER

Up to 20 years

Up to 5 years

1 year

CIN = cervical intraepithelial neoplasia
Capacity to prevent HPV-related cancers is now available

- HPV4 vaccine (Gardasil™) – approved 2006
- HPV9 (Gardasil 9™) approved 2015
  - Covers 7 oncogenic HPV strains 16, 18, 31, 33, 45, 52, and 58 and 2 low-risk strains 6, 11
  - HPV9 effective against 96.7% of oncogenic strains
- Now: two doses, 0 and 6-12 months
- Target age: 11-12 (range 9-26), given along with other recommended vaccines
- Approved for both males and females
PREVALENCE OF HPV INFECTIONS TARGETED BY THE QUADRIVALENT HPV VACCINE

IN GIRLS 14 YEARS OF AGE

11.5% DECREASE

PRE-VACCINE ERA (2003-2006)
4.3%
POST-VACCINE ERA (2009-2012)

HPV9 vaccine

- HPV9 approved for anal, vulvar and vaginal cancer prevention
- HPV9 not yet approved to prevent penile or oropharyngeal cancers (but is assumed to work)
- HPV vaccine status does NOT change cervical cancer screening recommendations
How are we doing in MI?

Data source: Michigan Care Improvement Registry.
Updated: HPV Vaccine Brochure in English and Spanish

- Available via the Clearinghouse
Questions?
Breast Cancer screening recommendations

- Wouldn’t it be great if we had consensus? (as we now do with cervical cancer screening recommendations)
Important Considerations

- Screening should continue as long as a woman is in good health and is expected to live 10 more years or longer.

- All women should be familiar with the known benefits, limitations, and potential harms associated with breast cancer screening. They should also be familiar with how their breasts normally look and feel and report any changes to a health care provider right away.
The clinical encounter should encompass ongoing risk assessment, risk reduction counseling, as well as a clinical breast exam (CBE).

- Risk assessment: adequate family history of HBOC
- Reduction counseling: pharmacologic interventions

Adequate clinical breast exams include the following: upright and supine position during inspection, and palpation of all components of the breast, axilla and clavicular lymph node basins.

- Time spent on the palpable portion of the exam is associated with increased detection of palpable abnormalities.
## Recommendations for breast cancer screening (NCCN): MI Title X Guidelines

<table>
<thead>
<tr>
<th>Screening Exam</th>
<th>Interval</th>
<th>Age to Begin</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical encounter</td>
<td>Every three (3) years</td>
<td>Age 25-39</td>
<td>CBE should be part of a periodic health exam</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
<td>Age 40</td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td>Annually</td>
<td>Age 40</td>
<td>Yearly exams should continue for as long as a woman is in good health.</td>
</tr>
</tbody>
</table>
Recommendations for breast cancer screening, average-risk women *(ACS, 2015)*

<table>
<thead>
<tr>
<th>Screening Exam</th>
<th>Interval</th>
<th>Age to Begin</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>Annual, if desired</td>
<td>40-44</td>
<td>Risks/benefits should be discussed</td>
</tr>
<tr>
<td></td>
<td>Annual</td>
<td>45-54</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Every two years</td>
<td>55+</td>
<td>Annual OK if pt desires</td>
</tr>
<tr>
<td>CBE</td>
<td><strong>Not recommended</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Breast cancer disparities

- Black women now have both a higher incidence and mortality rate for breast cancer
- **Why?** Complex interplay of genetic, environmental and social factors
- Example: Being overweight/obese after menopause
- Synthetic chemical exposures (xenoestrogens) act like estrogens: PVCs, pesticides
- Long-standing problems with access to screening services, delayed diagnosis and delay in treatment
- Blacks are also less likely to participate in clinical trials;
  - Providers need to recommend them to their clients
Breast cancer in African-Americans

- Risk of breast cancer does increase with age for all women
  - Median age at diagnosis is 61 years
  - Median age at death is 68
- Racial difference: average age @ diagnosis: AA women, age 57; white women age 62.
- Male breast cancer (rare) but more likely in AA
- AA women more likely to have Triple-Negative breast cancer (TNBC)
Triple-Negative Breast Cancer (TNBC)

- Highly-aggressive breast cancer
- Cancer cells test negative for 3 receptors: estrogen (ER-), progesterone (PR-) and HER2 (HER2-).
  - This cancer doesn’t respond to hormonal therapy (tamoxifen) or therapies that target HER2 receptors, like Herceptin.

- TNBC more likely to occur before age 40-50
- 15% of BC in US, but blacks 2x likely to have as whites; Hispanics also have a higher rate than whites
- People with a BRCA1 mutation and cancer, it’s more likely to be TNBC
Breast cancer racial disparities

- IMPORTANT: Because of these racial disparities, for minority (primarily, but not solely, AA) women
  - Recommend ANNUAL mammogram
  - Beginning at age 40 (NOT 45)

- For women with a strong family history and/or BRCA1/2 mutation
  - Mammogram should begin 5 years before the youngest age at family breast cancer diagnosis
  - Example: mom had breast cancer at age 30; daughter should begin annual screening at age 25
Questions?
Challenges w/ getting mammograms

- Provider decides woman should have mammogram every 2 years.
- Clinic need for standing orders (anyone may order the mammogram if it’s due)
- Issues with referral forms
- Mammogram may be on a different day and in a different location (issues with childcare, time off of work, transportation)
- Mammogram appointments are 4-6 months out
- Difficulty making mammogram appointment during clinic
- For programs such as BCCCNP, patient doesn’t know what to say about “insurance status”
- Clinic or BCCCNP may not be getting mammogram results
Access to mammograms ("ONsite Mammography™")

- Mammograms provided “in-house” at a provider’s office
- Reduces/eliminates a number of barriers to mammogram (need for another appointment day, transportation issues, time off from work, childcare, etc.)
- This would be a great option if quality control could be assured
- Is this now an option in MI?
What is “breast density”? 

- Breast density is defined as the ratio of fat to fibroglandular tissue in the breast.

- Radiologists characterize each mammogram into one of four levels of overall density: 1) almost entirely fatty, 2) scattered areas of fibroglandular density, 3) heterogeneously dense, and 4) extremely dense.

- 80% of breasts are #2 or #3, but most of the literature involves comparing the risk of #1 vs. #4.
Mammography, cont.

- Cancer “risk” attributable to breast density: relates to the difficulty of mammogram interpretation (is probably not an independent risk factor for breast cancer)

- As a diagnostic test, there is decreased sensitivity of the mammogram in dense breasts rather than fatty breasts

- This “breast density issue” should NOT discourage women from getting mammograms!
Picture imperfect:
Mammograms often miss tumors in women with dense breast tissue, which can hide tumors from view. How the American College of Radiology classifies breast composition, with increasingly dense breasts from left to right:
Complicating issues

- However: The NCCN, USPSTF, ACS, ACOG, ACR do not recommend routine supplemental screening for women with dense breasts without other risk factors since such screening has not been shown to result in a decrease in mortality.

- If supplementary screening is desired, preliminary evidence suggests that MRI is more sensitive than ultrasound for cancer detection.
Cervical cancer screening frequency

- Review:

<table>
<thead>
<tr>
<th>Age to begin</th>
<th>Screening Exam</th>
<th>Screening Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 21-29</td>
<td>Conventional Pap test OR LBC</td>
<td>Pap test only every 3 years</td>
</tr>
<tr>
<td>Age 30-65</td>
<td>HPV and cytology “cotesting”</td>
<td>every 5 years (preferred)</td>
</tr>
<tr>
<td>Age 30-65</td>
<td>Conventional Pap test OR LBC</td>
<td>Pap test alone every 3 years (acceptable)</td>
</tr>
</tbody>
</table>

- If test(s) results are NEGATIVE, repeat only per protocol
When to stop screening

- Women aged older than 65 years with evidence of adequate negative prior screening and no history of CIN2+ within the last 20 years should not be screened for cervical cancer with any modality (adequate negative prior screening is defined as 3 consecutive negative cytology results or 2 consecutive negative cotests within the 10 years before ceasing screening, with the most recent test occurring within the past 5 years).

- Once screening is discontinued, it should not be started for any reason, even if a woman reports having a new sexual partner.
What about HPV DNA testing?

- Several different HPV tests have been approved for screening (each lab chooses the test they will use).
- Most tests detect the **DNA** of high-risk HPV, although one test detects the **RNA** of high-risk HPV.
- Some tests detect any high-risk HPV and do not identify the specific type or types that are present.
- Other tests specifically detect infection with HPV types 16 and 18, the two types that cause most HPV-associated cancers (and report it as such).
Case study #1

- C.L. is a 46 year old, Hispanic woman. On 2/16/17, she was seen in clinic. Pap was negative, HPV+. DNA testing showed HPV+ #16.
- What management would you recommend?
Management of Women ≥ Age 30, cytology negative/HPV positive

- **Normal Cytology/HPV Positive**
  - **Management of Women ≥ Age 30, who are Cytology Negative, but HPV Positive**
    - **Repeat Cotesting @ 1 year Acceptable**
    - **HPV DNA Typing Acceptable**
      - HPV 16 or 18 Positive
        - Repeat Cotesting @ 1 year
        - Manage per ASCCP Guideline
      - HPV 16 and 18 Negative
        - Colposcopy
        - Manage per ASCCP Guideline
    - **Cytology Negative and HPV Negative**
      - Repeat cotesting @ 3 years

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BCCCNP agency referred client for colposcopy. Colposcopist office declined to do colp, instead recommending co-test in 12 months.

BCCCNP agency pointed out algorithm, stressing Neg Pap/+HPV 16 required colposcopy.

Colposcopy done 5/2/17.
CL, continued

- 5/2 results:
  - Pap done with colp: Atypical Glandular Cells (AGC)
  - Colp and ECC: Adenocarcinoma in Situ

- Plan: consider hysterectomy
Questions?
What about HPV alone as a screening test?

- The U.S. Food and Drug Administration (FDA) approved a high-risk HPV test as a primary screening tool for cervical cancer, meaning it may be used without a Pap test.
  - The HPV test may be offered to women aged 25 to 65 without a Pap test.
  - If initial results are negative, women should be screened again no sooner than 3 years.

- We are waiting for USPSTF/ACS/ACOG (and others) to update their screening recommendations
- TBD: Screening begins at age 25?
- Frequency: every 3 years

**Recommended primary HPV screening algorithm**

- Primary HPV screening
  - Type 16/18+
  - 12 other hrHPV+
  - ≥ASC-US
- Cytology
  - NILM
  - Follow up in 12 months
- Colposcopy
- Routine screening

**Abbreviations:** ASC-US, atypical squamous cells of undetermined significance; NILM, negative for intraepithelial lesion or malignancy.

What might be the challenges?

- We are still struggling with implementing the screening recommendations from 2013!
- March 2017 MN study found

<table>
<thead>
<tr>
<th>Number of Paps (24 months)</th>
<th>3,920</th>
<th>Not indicated (according to guidelines)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;age 21</td>
<td>257</td>
<td>6.5% of total</td>
</tr>
<tr>
<td>&gt;age 65</td>
<td>536</td>
<td>13.67% of total</td>
</tr>
<tr>
<td>Post-hysterectomy</td>
<td>605</td>
<td>15.43% of total</td>
</tr>
</tbody>
</table>
Providers and Guidelines

- JAMA 1999 study identified a number of provider barriers
  - Lack of awareness of new guidelines
  - Lack of familiarity with guideline recommendations (recent ASCCP algorithms)
  - Lack of agreement with new guidelines
  - Lack of “outcome expectancy” (particular consequence, such as improved outcome)
  - Inertia of previous practice (habit)
  - External barriers: time limitations, lack of reminder system
  - Patient-related barriers (patient preferences)
HPV only?

- Patient resistance can be a significant issue. For example:

- Some patients are not happy with Pap q 3 years or Pap/HPV q 5 years. Doing “only” an HPV test every 3 years might be a tough sell

- Re: breast cancer screening – starting mammogram @ 45 is a tough sell, as is mammogram every 2 years.
Young women (age 21-24) w/ ASC-US or LSIL

- Your agency does LBC and has payment available to pay for reflex HPV testing.
- SR is a 23 year old women, new to Family Planning. She has an ASC-US Pap w/ + HPV. What is your management?
  - Send her for a colp now
  - Repeat Pap testing in 6 months
  - Repeat Pap testing in 1 year
  - Repeat Pap testing in 3 years
Women age 21-24 w/ ASC-US or LSIL
Your agency does LBC and has payment available to pay for reflex HPV testing. SR is a 23 year old women, new to Family Planning. She has an LSIL Pap; HPV is NOT done. What is your management?

- Send her for a colp now
- Repeat Pap testing in 6 months
- Repeat Pap testing in 1 year
- Repeat Pap testing in 3 years
Management of Women Ages 21-24 years with either Atypical Squamous Cells of Undetermined Significance (ASC-US) or Low-grade Squamous Intraepithelial Lesion (LSIL)

Women ages 21-24 years with ASC-US or LSIL

- Repeat Cytology @ 12 months Preferred
  - Negative, ASC-US or LSIL
  - Repeat Cytology @ 12 months
    - Negative x 2 ≥ ASC
    - ASC-H, AGC, HSIL
  - HPV Positive
    - Reflex HPV Testing
      - Acceptable for ASC-US only
      - HPV Negative
        - Routine Screening

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Women age 21-24, w/ ASC-H or HSIL

Management of Women Ages 21-24 yrs with Atypical Squamous Cells, Cannot Rule Out High Grade SIL (ASC-H) and High-grade Squamous Intraepithelial Lesion (HSIL)

- Colposcopy (Immediate loop electrosurgical excision is unacceptable)
  - No CIN2,3
    - Observation with colposcopy & cytology *
      - @ 6 month intervals for up to 2 years
    - High-grade colposcopic lesion or HSIL
      - Persist for 1 year
      - Biopsy
        - CIN2,3
          - Manage per ASCCP Guideline for young women with CIN2,3
        - CIN2,3
          - Manage per ASCCP Guideline
          - Diagnostic Excisional Procedure
          - Manage per ASCCP Guideline
  - Other results
    - HSIL
      - Persist for 24 months with no CIN2,3 identified
    - Routine Screening
      - "If colposcopy is adequate and endocervical sampling is negative. Otherwise a diagnostic excisional procedure is indicated.

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LSIL Pap with HPV co-test

- MS is a 35 year old woman who is new to your office. She reports a history of regular cervical cancer screening with normal Pap test results. You do a Pap test today, and the result is LSIL Pap, - HPV. Following the NEW ASCCP algorithm, what is your management?
  - Pap/HPV co-test her in one year
  - Pap/HPV co-test her in 3 years
  - Repeat the HPV in 6 months
  - Send her for a colposcopy now
CHANGED: Management of LSIL

Management of Women with Low-grade Squamous Intraepithelial Lesions (LSIL)*

LSIL with negative HPV test

Preferred

Repeat Cotesting @ 1 year

Cytology Negative and HPV Negative

Repeat Cotesting @ 3 years

LSIL with no HPV test

Acceptable

Colposcopy

≥ ASC or HPV positive

Non-pregnant and no lesion identified
Inadequate colposcopic examination
Adequate colposcopy and lesion identified

Endocervical sampling "preferred"
Endocervical sampling "preferred"
Endocervical sampling "acceptable"

No CIN2,3

Manage per ASCCP Guideline

CIN2,3

Manage per ASCCP Guideline

* Management options may vary if the woman is pregnant or ages 21-24 years.
LSIL Pap with no HPV co-test

- MS is a 35 year old woman who is new to your office. Same history as before. You do a conventional Pap test today, and the result is LSIL Pap (HPV not done). Following the NEW ASCCP algorithm, what is your management?
  - Pap/HPV co-test her in one year
  - Pap/HPV co-test her in 3 years
  - Repeat the HPV in 6 months
  - Send her for a colposcopy now
Management of LSIL

Management of Women with Low-grade Squamous Intraepithelial Lesions (LSIL)*

- **LSIL with negative HPV test**
  - Preferred
  - Repeat Cotesting @ 1 year
    - Cytology Negative and HPV Negative
      - Repeat Cotesting @ 3 years
  - Cytology Positive
    - HPV positive
      - Repeat Cotesting @ 3 years

- **LSIL with no HPV test**
  - Acceptable
  - Colposcopy
    - ≥ ASC or HPV positive
      - Non-pregnant and no lesion identified
      - Inadequate colposcopic examination
      - Adequate colposcopy and lesion identified
        - Endocervical sampling “preferred”
        - Endocervical sampling “acceptable”

- **LSIL with positive HPV test**
  - Manage per ASCCP Guideline

*Management options may vary if the woman is pregnant or ages 21-24 years.*

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SS is a 39 year old FP client, here for her first visit. Her Pap/HPV co-test result is Neg Pap/Neg HPV.

Her follow-up is
- Pap/HPV in 12 months
- Pap/HPV in 3 years
- Pap/HPV in 5 years
Pap/HPV Co-test w/ HPV DNA typing

- Angela is a 37 year old FP client, here for her first visit. Her Pap/HPV co-test result is Neg Pap/+ HPV. Your pathologist is able to do HPV DNA typing (for HPV 16/18), and her HPV is negative for those strains. Her follow-up is:
  - Pap/HPV co-test in 12 months
  - Pap/HPV co-test in 3 years
  - Send for colposcopy now
Management of Women ≥ Age 30, cytology negative/HPV positive

**Normal Cytology/HPV Positive**

Management of Women ≥ Age 30, who are Cytology Negative, but HPV Positive

- Repeat Cotesting @ 1 year Acceptable
- HPV DNA Typing Acceptable
  - HPV 16 or 18 Positive
    - HPV 16 and 18 Negative
      - Repeat Cotesting @ 1 year
  - HPV 16 and 18 Negative
    - Manage per ASCCP Guideline
- Cytology Negative and HPV Negative
  - Repeat cotesting @ 3 years
  - Manage per ASCCP Guideline

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ASCP
Pap/HPV Co-test w/ HPV DNA typing

- In 12 months, Angela returns to your clinic. Her follow-up Pap/co-test is Neg/HPV+. Her recommended follow-up is
  - Pap/HPV co-test in 12 months
  - Pap/HPV co-test in 3 years
  - Send for a colp now
Management of Women ≥ Age 30, cytology negative/HPV positive

**Normal Cytology/HPV Positive**

**Management of Women ≥ Age 30, who are Cytology Negative, but HPV Positive**

- Repeat Cotoesting @ 1 year
- HPV DNA Typing
- Repeat Cotoesting @ 1 year

**Cytology Negative and HPV Negative**

- Repeat Cotoesting @ 3 years

**HPV DNA Typing Acceptable**

- HPV 16 or 18 Positive
- HPV 16 and 18 Negative

**Colposcopy**

- Manage per ASCCP Guideline

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Follow-up of colp result of CIN1

- Jessica is a 36 year old, who, on Oct 1, had a LSIL Pap w/ + HPV.
- She was referred for a colposcopy on November 1: results CIN I. No treatment indicated or received.
- What sort of follow-up should she have?
  - Pap in 6 and 12 months
  - HPV in 12 months
  - **Pap/HPV co-test in 12 months**
  - Pap/HPV co-test in 3 years
Management of CIN1 preceded by “lesser abnormalities”

Management of Women with No Lesion or Biopsy-confirmed Cervical Intraepithelial Neoplasia — Grade 1 (CIN1) Preceded by “Lesser Abnormalities”

Follow-up without Treatment

- Cotesting at 12 months
  - HPV(-) and cytology negative
  - Age appropriate retesting 3 years later
  - Cytology negative
  - HPV(-)
  - Routine screening

≥ ASC or HPV(+) → Colposcopy

No CIN

- Manage per ASCCP Guideline

CIN 2, 3

- If persists for at least 2 years → Follow-up or Treatment

CIN 1

- If persists for at least 2 years → Follow-up or Treatment

*Lesser abnormalities* include ASC-US or LSIL Cytology, HPV 16+ or 18+, and persistent HPV

Management options may vary if the woman is pregnant or ages 21-24.

Cytology if age <30 years, cotesting if age ≥30 years

Either ablative or excisional methods. Excision preferred if colposcopy inadequate, CIN2+ on ECC, or previously treated.
Atypical Glandular Cells Case study~

- Dana is a 39 y.o. white woman here for Family Planning services.
- History: Pap 1/15/12 – Neg – no HPV done

- Pap today (8/12/15) – AGC

- What’s your plan for her?
Atypical Glandular Cells

Initial Workup of Women with Atypical Glandular Cells (AGC)

- All subcategories (except atypical endometrial cells)
  - Colposcopy (with endocervical sampling) and Endometrial sampling (if ≥ 35 yrs or at risk for endometrial neoplasia*)

  *Includes unexplained vaginal bleeding or conditions suggesting chronic anovulation.

- Atypical Endometrial Cells
  - Endometrial and Endocervical Sampling
    - No Endometrial Pathology
      - Colposcopy

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Dana, continued

- On June 28, she has a colp, bx, ECC, EMB: all Neg

- What about follow-up?
Follow-up of women with AGC Pap

Subsequent Management of Women with Atypical Glandular Cells (AGC)

- **Initial Cytology is AGC - NOS**
  - **No CIN2+, AIS or Cancer**
    - **Cotest at 12 & 24 months**
    - Both negative or Any abnormality
      - Cotest 3 years later
  - **CIN2+ but no Glandular Neoplasia**
    - **Cotest**
  - **Manage per ASCCP Guideline**

- **Initial Cytology is AGC (favor neoplasia) or AIS**
  - **No Invasive Disease**
    - **Diagnostic Excisional Procedure**
      - Should provide an intact specimen with interpretable margins. Concomitant endocervical sampling is preferred.

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Questions?
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