



**DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420**

IL 10-2005-014

In Reply Refer To: 13

August 8, 2005

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

**CERVICAL CANCER SCREENING FOR WOMEN
ENROLLED IN THE VA HEALTH CARE SYSTEM**

1. Cervical cancer is the tenth leading cause of cancer death in women. Studies have shown that early detection of cervical cancer is lifesaving. Although 92 percent of women survive 5 years when cervical cancer is localized, only 13 percent survive the disseminated disease. Cervical cancer mortality is 40 percent higher in black women under age 65 than in white women the same age. Each year approximately 50 million women undergo Papanicolaou (Pap) testing in the United States. Of these, approximately 3.5 million, or 7 percent, are diagnosed with cytological abnormalities requiring additional follow up or evaluation. Determining which women with cytological abnormalities are at risk for significant cervical disease, performing appropriate diagnostic workups, and providing treatment are a significant public health challenge. Approximately 10,370 new cases of cervical cancer will be identified in 2005 with about 3,710 women dying from the disease. A reduction in cervical cancer mortality to 2.0 deaths per 100,000 women is a goal of Healthy People 2010. Virtually all cervical cancers are thought to be a result of human papilloma virus (HPV) infection. About 95 percent of women with invasive cervical cancer have evidence of HPV.
2. Women currently comprise 7 percent of the total veteran population. The women veteran population is increasing and women presently make up approximately 20 percent of active duty personnel. It is anticipated by 2010, 10 percent of all veterans will be women. The women veteran population is younger than their male counterpart with 62 percent of women under age 45. The majority of women veterans fall within the age range where cervical cancer screening is recommended as part of a regular cancer screening program. Guidance for cervical cancer screening has been recently updated by the National Cancer Institute (NCI), American College of Gynecologists (ACOG), American Cancer Society (ACS) and the United States Preventive Services Task Force (USPSTF).
3. The main risk factors for the development of cervical cancer are: having first sexual intercourse at a young age, having many sexual partners, smoking cigarettes, having a diet low in vitamin A and C, using oral contraceptive pills, having a weakened immune system, having high parity, having a previous history of vulvar or vaginal squamous dysplasia, and having a history of sexually transmitted diseases (STDs).

4. Study of cervical cytology by either conventional Pap smear methodology or liquid-based cytology, approved by the Federal Drug Administration (FDA) in 1996, is essential for cervical cancer screening. The American Society of Clinical Pathology (ASCP) and the College of American Pathology (CAP) state that the two FDA-approved liquid-based preparations (LBP) are considered to be at least equivalent to the conventional Pap smear in their ability to detect preneoplastic and neoplastic lesions of the cervix. Some studies have suggested improved sensitivity for LBP Pap tests. Specificity is either comparable to, or moderately decreased, with conventional Pap tests. HPV testing is not recommended as a screening tool and should only be employed when atypical squamous cells (ASC) are identified by cytology. ASC is subdivided into atypical squamous cells-undetermined significance (ASC-US) and atypical squamous cells-high grade (ASC-H); the latter category is more likely to be associated with a precancerous cervical lesion. Either conventional Pap smear or liquid-based cytology is acceptable for cervical cancer screening; however, testing for HPV may be performed immediately when LBP is utilized.

5. Clinical Considerations

a. It is universally recommended that annual screening for cervical cancer begin within 3 years of first intercourse or at age 21 whichever occurs first. These screenings need to be every 2 years if using a Pap smear with liquid-based cytology.

b. ACOG, ACS, and NCI recommend screening every 3 years after age 30 following three successive cytologically negative smears if in a monogamous relationship. Women with new sexual partners need to be tested annually until three successive negative smears. **NOTE:** *USPSTF does not recommend the three-successive negative smears.* Women of any age who are immunocompromised, are infected with Human Immunodeficiency Virus (HIV), were exposed to diethylstilbesterol (DES) in utero, or have a previous diagnosis of cervical intraepithelial neoplasia (CIN) II/III or cancer need to be screened annually.

c. ACS guidelines suggest waiting until age 30 before lengthening the screening interval. ACOG identifies additional risk factors that might justify annual screening, including a history of cervical neoplasia, infection with HPV or other sexually transmitted diseases (STDs), or high-risk sexual behavior, but data are limited to determine the benefits of these strategies.

d. All women need to have an annual pelvic exam and clinical breast exam even if they have had a hysterectomy.

6. Summary of Recommendations for Screening Cervical Cancer

a. Initiation of testing between the ages of 18 to 30:

(1) Annual cervical cancer screening with conventional Pap smear, or every 2 years when used in conjunction with liquid-based cytology.

(2) Reflex HPV testing for positive ASC-US or ASC-H results.

b. After age 30:

(1) Screening per paragraph 5.

(2) ACS recommends annual pelvic exam after age 40 for other forms of gynecological cancer.

(3) Most cervical cancer is of squamous cell etiology; however, the rate of adenocarcinoma appears to be rising. Women who have been exposed to DES in utero are at higher risk for clear cell adenocarcinoma (CCA). Cytologic testing is not a reliable way to screen for these types of cancers. Rather, clinical signs and symptoms often herald the appearance of these entities.

c. Cervical cancer screening may be discontinued:

(1) At age 65 with no evidence of abnormal or positive cytology testing over the previous 10 years.

(2) If an hysterectomy was performed for benign pathology and no cervix is present. Surgical records must confirm benign reasons for the hysterectomy and that the patient did in fact have her entire cervix removed (surgical report, pathology reports, etc). If this is not available, the provider must assume that some portion of the cervix remains.

NOTE: It is recommended that patients in high risk groups for HPV, and who may not be good historians, i.e. patients with a diagnosis of mental illness, receive a pelvic examination and a Pap smear to confirm negative status prior to cessation of testing.

d. A history of sexual trauma in an individual patient may contribute to the patient foregoing pelvic exam and cervical cancer screening (the exam or test could trigger memories and unpleasant reactions), which leads to inadequate screening. It would be of benefit to identify these women and help them undergo the needed screening.

7. References

- a. National Cancer Institute www.nci.nih.gov
- b. United States Preventive Services Task Force www.ahrq.gov
- c. American Cancer Society Cancer Facts 2005.
- d. UpToDate online 13.1 <http://uptodateonline.com>
- e. Public Law 102-585, Veterans Health Care Act of 1992.
- f. American College of Gynecologists www.acog.org
- g. VHA Handbook 1330.1.

IL 10-2005-014
August 8, 2005

h. American Society for Colposcopy and Cervical Pathology 2001 Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities found at www.asccp.org/

i. Title 38 United States Code 1701.

j. Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996.

k. Title 38 Code of Federal Regulations 17.30.

l. Federal Register, Vol. 64, No. 193, October 6, 1999, Rules & Regulations.

8. Questions concerning implementation of cervical cancer screening should be directed to the Director, Women Veterans Health Program, at 202-273-8577.

Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 8/10/05
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 8/10/05