ASCO® Guidelines

Secondary Prevention of Cervical Cancer: ASCO Resource-Stratified Guideline Update				
Clinical Question	**Recommendation**	**Type**	**Evidence Quality**	**Strength**
Maximal Setting				
What are the best method(s) for primary screening?	***1.1.** In maximal resource settings, cervical cancer screening with HPV DNA testing should be offered every 5 years from ages 25 to 65 years (either self- or clinician-collected). On an individual basis, women may elect to receive screening until 70 years of age.	EB test, interval, and age (25-65) FC until age 70	H	S
	1.2. 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.	EB	I	M
What is the best triage/ management strategy for women with positive results or other abnormal (e.g., discordant HPV/cytology) results?	**1.3.** 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.	EB	H	S
	1.4. 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.	EB	I	S
	1.5. 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.	EB	H	S

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	1.6. 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.	FC	I	S
What are the best management strategies for women with precursors of cervical cancer?	**1.7.** 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]) or, where LEEP is contraindicated, ablative treatments may be offered.	EB	H	S
What are the best strategies for follow-up after treatment of women with these precursors?	**1.8.** 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.	FC	I	M
Enhanced Setting				
What are the best method(s) for primary screening?	***2.1.** 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) (either self- or clinician-collected).	EB	H	S
	2.2. If there are two consecutive negative screening test results, subsequent screening should be extended to every 10 years.	FC	I – L	M
	2.3. 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.	FC	L	W
What is the best triage/ management strategy for women with positive results or other abnormal (e.g., discordant HPV/cytology) results?	**2.4.** 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.	EB	H	S
	2.5. 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.	EB	I	S

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	2.6. 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.	EB	H	S
What are the best management strategies for women with precursors of cervical cancer? What are the best strategies for follow-up after treatment of women with these precursors?	**2.7.** 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.	EB	H	S
	2.8. 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.	FC	I	M
Limited Setting				
What are the best method(s) for primary screening?	***3.1.** In limited settings, cervical cancer screening with HPV DNA testing should be offered to women 30 to 49 years of age every 10 years, corresponding to 2 to 3 times per lifetime (either self- or clinician-collected).	EB age range FC interval	I	M
What is the best triage/ management strategy for women with positive results or other abnormal (e.g., discordant HPV/cytology) results?	***3.2.** 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 VIA. If institutions are currently using reflex cytology, they should transition from cytology to HPV genotyping.	EB for cytology & genotyping FC for VIA	H for cytology & genotyping L for VIA	S for cytology & genotyping W for VIA
	Qualifying Statement: In limited settings the preference is to do direct treatment, with triage using partial genotyping.			
What are the best management strategies for women with precursors of cervical cancer? What are the best strategies for follow-up after treatment of women with these precursors?	***3.3.** If cytology triage results are abnormal (i.e. ≥ atypical squamous cells of undetermined significance [ASC-US]), women should be referred to quality assured colposcopy (the first choice, if available and accessible for women who are ineligible for thermal ablation), 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.	EB	I	M
	***3.4.** If HPV genotyping or VIA or VAT triage results are positive, then women should be treated. If the results from these forms of triage are negative, then repeat HPV testing at the 12-month follow-up.	EB	H	S

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	3.5. If test results are positive at the repeat 12-month follow-up, then women should be treated.	FC	I	M
	3.6. For treatment, clinicians should offer ablation if the criteria are satisfied; if not and resources available, then offer LEEP.	EB	H	S
	3.7. After women receive treatment for precursor lesions, follow-up should consist of the same testing at 12 months.	FC	I	M
Basic Setting				
What are the best method(s) for primary screening?	***4.1.** Health systems in basic settings should move to population-based screening with HPV testing at the earliest opportunity (either self- or clinician-collected). If HPV DNA testing for cervical cancer screening is not available, then VIA should be offered with the goal of developing health systems. Screening should be offered to women 30 to 49 years of age, at least every 10 years (increasing the frequency to every 5 years, resources permitting).	EB	I	S
What is the best triage/ management strategy for women with positive results or other abnormal (e.g., discordant HPV/cytology) results?	***4.2.** If the results of available HPV testing are positive, clinicians should then perform VAT followed by treatment with thermal ablation and/or LEEP, depending on the size and location of the lesion.	FC	L	M
What are the best management strategies for women with precursors of cervical cancer?	***4.3.** If primary screening is VIA and results are positive, then treatment should be offered with thermal ablation and/or LEEP, depending on the size and location of the lesion.	EB	I	M
What are the best strategies for follow-up after treatment of women with these precursors?	**4.4.** 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.	FC	I	M

Abbreviations. ASC-US, atypical squamous cells of undetermined significance; DNA, deoxyribonucleic acid; EB, evidence based; FC, formal consensus; H, high; HPV, human papillomavirus; L, low; LEEP, loop electrosurgical excision procedure; M, moderate; QA, quality assurance; S, strong; VAT, visual assessment for treatment; VIA, visual inspection with acetic acid; W, weak

Notes. * Updated recommendation

