Summary of Recommendations and Conclusions

The following recommendations are based on good and consistent scientific evidence (Level A):

- Cervical cancer screening should begin at age 21 years. Women younger than age 21 years should not be screened regardless of the age of sexual initiation or the presence of other behavior-related risk factors.
- Women aged 21–29 years should be tested with cervical cytology alone, and screening should be performed every 3 years. Co-testing should not be performed in women younger than 30 years.
- For women aged 30–65 years, co-testing with cytology and HPV testing every 5 years is preferred.
- In women aged 30–65 years, screening with cytology alone every 3 years is acceptable. Annual screening should not be performed.
- Women who have a history of cervical cancer, have HIV infection, are immunocompromised, or were exposed to diethylstilbestrol in utero should not follow routine screening guidelines.
- Both liquid-based and conventional methods of cervical cytology collection are acceptable for screening.
- In women who have had a hysterectomy with removal of the cervix (total hysterectomy) and have never had CIN 2 or higher, routine cytology screening and HPV testing should be discontinued and not restarted for any reason.
- Screening by any modality should be discontinued after age 65 years in women with evidence of adequate negative prior screening results and no history of CIN 2 or higher. Adequate negative prior screening results are defined as three consecutive negative cytology results or two consecutive negative co-test results within the previous 10 years, with the most recent test performed within the past 5 years.

The following recommendations are based on limited and inconsistent scientific evidence (Level B):

- Women with ASC-US cytology and negative HPV co-testing results have a very low risk of CIN 3 and should continue with routine screening as indicated for their age.
- Women with a history of CIN 2, CIN 3, or adenocarcinoma in situ should continue to undergo routine age-based screening for 20 years after the initial posttreatment surveillance period, even if it requires that screening continue past age 65 years.
- Women should continue to be screened if they have had a total hysterectomy and have a history of CIN 2 or higher in the past 20 years or cervical cancer ever. Continued screening for 20 years is recommended in women who stil have a cervix and a history of CIN 2 or higher. Therefore, screening with cytology alone every 3 years for 20 years after the initial posttreatment surveillance period seems reasonable for women with a hysterectomy.
- Women with negative cytology and positive HPV co-testing results who are aged 30 years and older should be managed in one of two ways:
  1. Repeat co-testing in 12 months. If the repeat cervical cytology test result is LSIL or higher or the HPV test result is still positive, the patient should be referred for colposcopy. Otherwise, the patient should return to routine screening (Fig 1).
  2. Immediate HPV genotype-specific testing for HPV-16 alone or HPV-16/18 should be performed. Women with positive results from tests for HPV-16 alone or HPV-16/18 should be referred directly for colposcopy. Women with negative results from tests for HPV-16 or HPV-16/18 should be co-tested in 12 months, with management of results as described (Fig. 2).

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Women who have received the HPV vaccine should be screened according to the same guidelines as women who have not been vaccinated.

Proposed Performance Measure

Percentage of women aged 21–65 years who were tested at intervals shorter than recommended for their age

References

1. Howlader N, Noone AM, Krapcho M, Neyman N, Aminou R, Altekruse SF, et al, editors. SEER cancer statistics review, 1975-2009 (vintage 2009 populations). Bethesda (MD): National Cancer Institute; 2012. Available at: http://seer.cancer.gov/csr/1975_2009_pops09. Retrieved July 27, 2012. (Level II-3) ⇦
2. Siegel R, Naishadham D, Jemal A. Cancer statistics, 2012. CA Cancer J Clin 2012;62:10–29. (Level II-3) [PubMed] [Full Text] ⇦
3. Ferlay J, Shin HR, Bray F, Forman D, Mathers C, Parkin DM. GLOBOCAN 2008 v1.2, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10. Lyon (France): International Agency for Research on Cancer; 2010. Available at: http://globocan.iarc.fr. Retrieved August 3, 2012. (Level II-3) ⇦
4. Arbyn M, Castellsague X, de Sanjose S, Bruni L, Saraiya M, Bray F, et al. Worldwide burden of cervical cancer in 2008. Ann Oncol 2011;22:2675–86. (Level III) [PubMed] ⇦
5. Gustafsson L, Ponten J, Bergstrom R, Adami HO. International incidence rates of invasive cervical cancer before