

Instructions for Completing and Submitting Webinar-related Forms

After the completion of this webinar, **all** participants must complete the following forms:

- PARTICIPANT DEMOGRAPHIC FORM
- PROGRAM EVALUATION FORM

If you would like to receive a **CME** or **Nursing** certificate, please complete the above aforementioned forms along with:

- ATTENDANCE VERIFICATION FORM

All forms must be submitted by **Friday, April 30, 2010**.

Please submit all forms by either **US mail**, attention **Alma Krcic** at Cicatelli Associates 505 Eighth Avenue, 16th Floor, NY, NY 10018 or **fax** to **Alma Krcic** at 212-629-3321. Please include a fax cover sheet. Respondents' information will be held confidential. If you have any questions, please contact **Alma Krcic** at 212-594-7741x249. Thank you.

Note: All forms must be received together in order to receive a certificate.



505 Eighth Avenue
 New York, NY 10018
 Ph: 212.594.7741
 Fax: 212.629.3321

PLEASE DO NOT USE A FAX COVER PAGE

DATE: _____ NUMBER OF PAGES: _____

ATTENDANCE VERIFICATION
Implementing Evidenced Based Practices Pap Smears
April 14, 2010

Instructions: To receive a CME or Nursing certificate complete this form, the demographic form and the evaluation form. **Submit them together by fax to Alma Krcic at 212-629-3321 by Friday, April 30, 2010.** All forms must be received together in order to receive a certificate. Respondent's information will be held confidential.

TITLE/DEGREE: MD DO RN NP PA LPN

OTHER _____

Please choose only one:

I WOULD LIKE A CME or NURSING CERTIFICATE

THE ADDRESS PROVIDED BELOW IS MY WORK HOME ADDRESS:

 First Name Last Name

 Agency Name (if Applicable)

 Street

 City, State, Zip Code

 Email Address () Telephone Number

Program ID: 13966



PROGRAM EVALUATION

Program Title: Implementing Evidenced-Based Practices Pap Smears

Date: April 14, 2010

Program ID: 13966

Circle your answers

1. To what extent did the presentation meets its stated objectives:	Poor	Fair	Good	Very Good	Excellent
a. Compare current recommendations of major medical organizations with their past guidelines	1	2	3	4	5
b. Review evidence that informs current management guidelines	1	2	3	4	5
c. Apply current recommendations to management of abnormal pap smears	1	2	3	4	5
d. Counsel patients in a manner that will increase likelihood that they will comply with guidelines but at the same time reduce patient anxiety	1	2	3	4	5
2. To what extent did the objectives relate to the overall purpose?	1	2	3	4	5
3. Your satisfaction with your level of participation during the presentation.	1	2	3	4	5
4. Usefulness of the instructional materials.	1	2	3	4	5
5. Degree to which this was a good learning experience.	1	2	3	4	5
6. Overall satisfaction with the presentation.	1	2	3	4	5

PLEASE RESPOND TO THE FOLLOWING (print your answers):

7. The most useful part of the presentation was:

8. The least useful part of the presentation was:

9. As a result of attending this presentation, I plan to:

10. The mix of theory and skill practice at this presentation was:

too much theory

too much practice

a good mix of both

PLEASE RATE THE FACILITATOR(S) ON A SCALE OF 1 (LOWEST) TO 5 (HIGHEST):

Circle your answer for each facilitator on the line indicated.

11. I felt the facilitator(s):	Name	Disagree					Agree
a. Knew the subject matter thoroughly.	<u>Elizabeth Lorde-Rollins, MD</u>	1	2	3	4	5	
b. Presented the information clearly.	<u>Elizabeth Lorde-Rollins, MD</u>	1	2	3	4	5	
c. Provided opportunities for participation.	<u>Elizabeth Lorde-Rollins, MD</u>	1	2	3	4	5	
d. Provided opportunities for questions.	<u>Elizabeth Lorde-Rollins, MD</u>	1	2	3	4	5	
e. Was able to hold my attention.	<u>Elizabeth Lorde-Rollins, MD</u>	1	2	3	4	5	
f. Extent to which the teaching methods were effective.	<u>Elizabeth Lorde-Rollins, MD</u>	1	2	3	4	5	

12. What changes would you recommend for improving this presentation?

13. What additional presentations would you like to attend in the future?

14. Please rate your experience using this web-based training forum by visiting www.cicatelli.org/evals. Thank you.

15. Additional comments:

IF YOU ARE REQUESTING A NURSING OR CME CERTIFICATE, PLEASE RESPOND TO THE FOLLOWING:

1. What is your medical profession?

- MD DO APN/NP PA
 RN PhD Other (please specify) _____

2. Continuing Education presentations "must be free of commercial bias for or against any product." In your opinion, was this program fair, balanced and free of commercial bias? Yes No

3. What percentage of the material presented is new to you?

- 0% 20% 40% 60% 80% 100%

4. After attending this presentation, will you make any changes to your practice? Yes No

5. If yes, explain how:

6. If no, list the barriers that affect change in your practice:

Thank you for completing the Program Evaluation.

Cicatelli Associates Inc.

Anonymous Participant Demographic Form



To target our services better, we are asking all of our participants to complete the following information.

Gender Female Transgender
 Male Intersex

Age

Are you of Hispanic, Latino, or Spanish origin?
 Yes No

Race (select all that apply)
 American Indian/Alaskan Native
 Asian
 Black or African American
 Native Hawaiian/Other Pacific Islander
 White
 Other: _____

Highest level of formal education
 Less than High School Diploma Bachelor's Degree
 High School Diploma/GED Master's Degree
 Some College Doctoral Degree
 Associate's Degree

Advanced degrees and certifications (select all that apply)
 MD/DO CNA RD MPH
 PA LPN/LVN CHES MSc
 DDS RN CASAC MA
 OD NP LCSW MS
 PhD CNM LPC Other (fill in below)
 JD CNS LMHC
 CPA ACRN MSW

Primary functional role(s) (select all that apply)

<input type="radio"/> Accounting	<input type="radio"/> Medical Director
<input type="radio"/> Administrator/Supervisor	<input type="radio"/> Nutritionist
<input type="radio"/> Board Member	<input type="radio"/> Outreach Worker
<input type="radio"/> Care Provider/Clinician	<input type="radio"/> Patient Advocate/Navigator
<input type="radio"/> Case Mgmt. Technician	<input type="radio"/> Peer Educator/Advocate
<input type="radio"/> Case Manager	<input type="radio"/> Program Director
<input type="radio"/> Childcare Worker	<input type="radio"/> Program Manager/Coord.
<input type="radio"/> Clergy/Spiritual Leader	<input type="radio"/> Psychiatrist
<input type="radio"/> Community Follow-Up Worker	<input type="radio"/> Psychologist
<input type="radio"/> Counselor/Therapist	<input type="radio"/> Social Worker
<input type="radio"/> Data Manager	<input type="radio"/> Student/Graduate Student
<input type="radio"/> Epidemiologist	<input type="radio"/> Trainer/Teacher/Faculty
<input type="radio"/> Financial Manager	<input type="radio"/> Volunteer
<input type="radio"/> Health Educator	<input type="radio"/> Not Working/Not Employed
<input type="radio"/> Medical Assistant	<input type="radio"/> Other

How long have you been in your primary functional role? years

Area(s) of specialization (select all that apply)

<input type="radio"/> Adolescent Health	<input type="radio"/> Pediatrics
<input type="radio"/> CAM	<input type="radio"/> Prenatal Care/OB/Gyn
<input type="radio"/> Criminal Justice	<input type="radio"/> Primary Care
<input type="radio"/> Early Childhood	<input type="radio"/> Reproductive Health
<input type="radio"/> Education	<input type="radio"/> Research
<input type="radio"/> HIV/AIDS	<input type="radio"/> STIs/STDs
<input type="radio"/> Information Systems	<input type="radio"/> Substance Abuse
<input type="radio"/> International Health	<input type="radio"/> Tobacco Control
<input type="radio"/> Mental Health	<input type="radio"/> Violence Prevention
<input type="radio"/> Nutrition/Obesity	<input type="radio"/> Other
<input type="radio"/> Oncology/Cancer	

How long have you been in your primary area of specialization? years

Principal employment setting (select all that apply)

<input type="radio"/> Adolescent Health Center	<input type="radio"/> EMS/Police/Fire	<input type="radio"/> Homeless Shelter	<input type="radio"/> School/Educational Institution
<input type="radio"/> CBO/Community Agency	<input type="radio"/> Faith-Based Org.	<input type="radio"/> Hospice/Palliative Care	<input type="radio"/> State/Local Health Dept.
<input type="radio"/> Child Welfare Services/Foster Care	<input type="radio"/> Family Planning Agency	<input type="radio"/> Hospital or Hospital-Based Clinic	<input type="radio"/> STD Clinic
<input type="radio"/> Community/Migrant Health Ctr.	<input type="radio"/> HIV/AIDS Service Org.	<input type="radio"/> Long-Term Care Facility	<input type="radio"/> Substance Abuse Treatment Prg
<input type="radio"/> Correctional Facility	<input type="radio"/> HMO/Managed Care Org.	<input type="radio"/> Mental Health Facility	<input type="radio"/> Tribal/Indian Health Center
<input type="radio"/> Domestic Violence/Rape Crisis Ctr.	<input type="radio"/> Home Care	<input type="radio"/> Private Practice	<input type="radio"/> Other
<input type="radio"/> Early Childhood Facility			

Zip-code of your principal employment setting

Location of your principal employment setting
 Urban Suburban Rural Indian Reservation

Thank you for completing this questionnaire!



Conference call-in information

- Call-in number for Audio: 1-866-551-3680
- Access Code: 3371133#

Implementing Evidence-Based Practices: Pap Smears

Elizabeth Lorde-Rollins, M.D., M.Sc.
 Assistant Professor of Obstetrics and Gynecology
 Assistant Professor of Pediatrics
 Mount Sinai Adolescent Health Center
 Consultant, Cicatelli Associates Inc.

April 14, 2010

Course Objectives

Following this training, participants will be able to:

- Compare current recommendations of major medical organizations with their past guidelines
- Review evidence that informs current management guidelines
- Apply current recommendations to management of abnormal pap smears
- Counsel patients in a manner that will increase likelihood that they will comply with guidelines but at the same time reduce patient anxiety

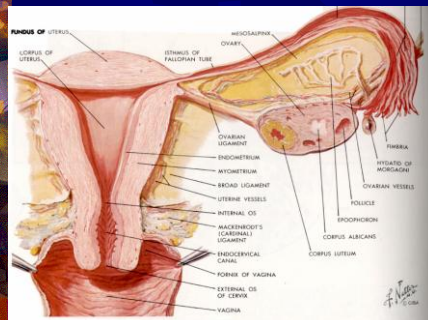
Faculty Disclosure

- No conflicts
 - Current research support: NIH
- No stocks
- No interest in pharmaceutical firms
- Medical Education Speakers Network

What is a Pap Smear?

- A screening test for cervical cells
- More accurately termed cervical cytology
- Ideally a sample of squamous cells on the cervical portio and endocervical cells within the canal
- Not always representative of all cells that are present
- Possible to traumatize cells that are collected such that they appear deranged in the lab but were fine in vivo

Cervical Anatomy

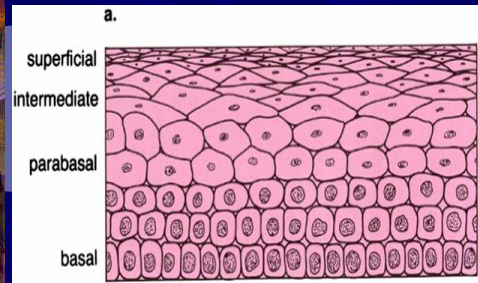


A Brief History of Cervical Cytology

- early 19th century : Compound microscope invented
- 1845: Donne's *Atlas* describes vaginal cells
- 1908, 1910: Shauenstein and Rubin describe precancerous lesions of the cervix
- 1925: Hinselmann develops colposcope
- 1928: Schiller uses term "carcinoma in situ" extensively in his work on early stages of cervical carcinoma
- 1928: Papanicolaou and Babes independently report presence of cancer cells in cervical smears
- 1943: Papanicolaou publishes "Diagnosis of Uterine Cancer by the Vaginal Smear"
- 1947: Ayre introduces concept of direct sampling of the cervix using a cervical scraper
- Mid-1990s: development of liquid-based cervical cytology

Chang AR. The cervical smear test in the next millennium. *HKMJ* 1999; 5(3): 294-302

Cervical Squamous Epithelium



Benign Squamous Epithelium

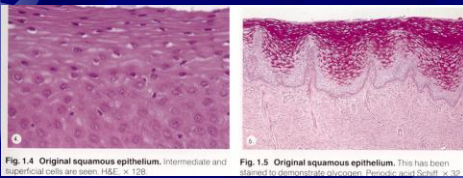
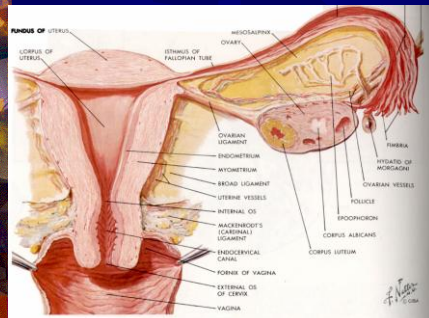
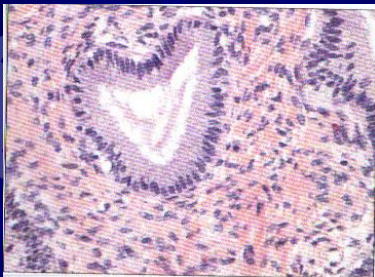


Fig. 1.4 Original squamous epithelium. Intermediate and superficial cells are seen. H&E. $\times 320$.
 Fig. 1.5 Original squamous epithelium. This has been stained with hematoxylin and eosin. (Reprinted from *Textbook of Histology*, 2nd ed.)

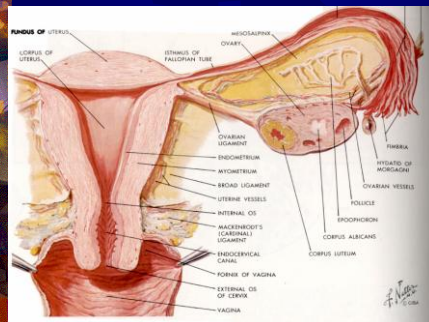
Cervical Anatomy



Benign Endocervical Epithelium



Cervical Anatomy



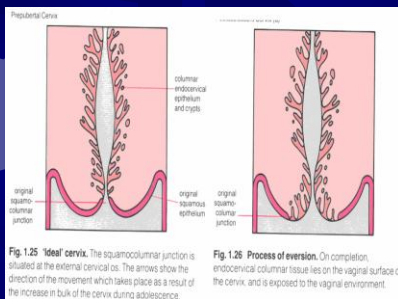
The Transformation Zone

- Ideally, the squamocolumnar junction (SCJ) would be situated at the external os, with squamous tissue on the portio and columnar epithelium lining the endocervical canal
- During puberty, "eversion" of the EC canal occurs secondary to increases in the size and shape changes of the cervix
- This change occurs in response to sex steroid hormones, and also occurs in pregnancy and in the neonatal period

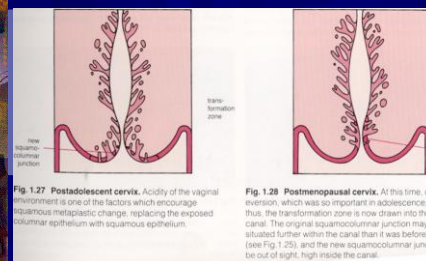
The Transformation Zone, continued

- Defined as the area of the cervix bounded caudally by the original squamocolumnar junction and cephalically by the highest point that squamous metaplasia reaches
- Squamous metaplasia results from the acidity of the vaginal environment
- An area initially covered by columnar epithelium becomes covered by squamous epithelium
- Squamous metaplasia is a physiological event

The Transformation Zone



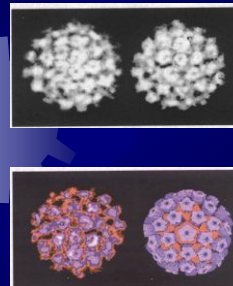
The Transformation Zone continued



Human Papillomavirus

- 60-80% prevalence in sexually active populations worldwide
- Over 140 subtypes isolated
- Approximately 40 are sexually transmitted
- Approximately 15 subtypes are capable of inducing dysplasia

HPV's Structure



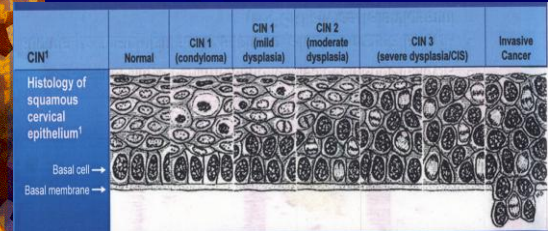
- HPV encodes seven early proteins and two late proteins
- E5, E6 and E7 functions involve cellular transformation
- Elimination of the G1 and G2 checkpoints is a key event in dysplasia progression

HPV's Natural History

- Non-enveloped, closed-circular, double-stranded DNA virus of about 7900 base pairs
- Enters basal epithelial cell and enters latent phase
- Typical patent phase lasts 1-8 months, but may persist for years
- Once viral expression begins, typical growth phase lasts 3-6 months
- Immune response lasts 3-6 months and eradicates virus in 80% of cases

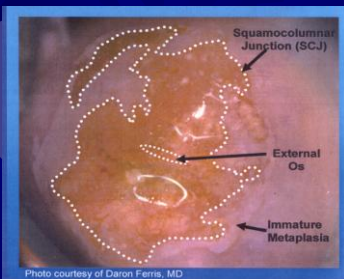
Hakim AA et al. *Curr Tx Options Onc*
2007; 8: 393-401

How HPV Induces Dysplastic Change



Braaten KP, Laufer MR. *Rev Obstet & Gynecol* 2008; 1(1): 2-10

Biologic Susceptibility of the Immature Cervix



Risk Factors for HPV Infection

Women:

- Young Age
- Lifetime number of sexual partners
- Early coitarche
- Male partner sexual behavior
- Smoking
- Oral contraceptive use
- Uncircumcised partner

Men:

- Young Age
- Lifetime number of sexual partners
- Being uncircumcised

Insinga 2003; Ho 1996

How Common is HPV Infection in the U.S.?

- By 50 years of age, at least 80% of women will have acquired genital HPV infection
- Estimated incidence: 6.2 million per year
- Estimated prevalence: 20 million

CDC, 2004; Cates, 1999

HPV Disease Burden in U.S.: Cervical Cancer

- Cervical cancer accounts for 15% of female cancers in developing countries, 3.5% of new female cancers in US
- 11,150 estimated new cases in 2007
- 3,670 estimated cervical cancer deaths in 2007
- In the United States, more than 50% of those diagnosed with cervical cancer have not been screened in over 5 years; over 25% have never been screened
- In the U.S.: 8.2/100,000 for white women, 10.9/100,000 for African Americans, 13.6 for Latinas

Braaten KP, Laufer MR. *Rev Obstet & Gynecol* 2008; 1(1): 2-10
Jemal A et al. *Cancer statistics, 2009*
CA Cancer Jnl Clin 2009; 59: 225-249

International HPV Disease Burden: Cervical Cancer

- Cervical cancer affects approximately 500,000 women each year
 - 493,000 new cases in 2002
 - 274,000 deaths in 2002
 - WHO estimates 510,000 diagnoses in 2007 and 288,000 deaths
- 83% of those affected live in developing countries
- Incidence ranges 20-fold around the world

Parkin D, Bray F. *Vaccine* 2006; 24(S1): S3111-S3125

If Cervical Screening is So Effective, Why Perform It Less Often?

- Patient anxiety
- Expense to health care system
- Excessive Screening leads to excessive treatment
- Treatment for cervical dysplasia may have adverse consequences
 - Sexual function
 - Higher risk of preterm birth and low birth-weight infants
- Screening teens does not reduce their cervical cancer mortality

ACOG Practice Bulletin #109. Cervical cytology screening. *Obstet Gynecol* 2009; 114(6): 1409-1420
Cox JT. Update on cervical disease. *OBG Mgt* 2010; 22(3): 22-34

2009 ACOG Guidelines for Cervical Cytology Screening

- No cervical screening prior to age 21
- Screen women 21-29 yrs old every 2 years
- Women 30 years and older may be screened every 3 years if they've had 3 consecutive negative screens, and are not at high risk
 - HIV negative
 - not immunocompromised
 - have no history predisposing to cervical dysplasia
 - CIN 2, CIN 3, or invasive cervical cancer
 - in utero DES-exposure

ACOG Practice Bulletin #109. Cervical cytology screening. *Obstet Gynecol* 2009; 114(6): 1409-1420

Comparison of Screening Guidelines

Organization	1995	2003	2009
American College of Obstetricians and Gynecologists (ACOG)	Begin cervical screening with coltarche	Begin cervical screening 3 yrs after coltarche, no later than age 21	No cervical screening prior to age 21
	Screen annually thereafter	Annual screening thereafter regardless of smear type (conventional or LBC)	Screen women 21-29 yrs old every 2 years
(Adapted from ACS 1987 guidelines)	Post-hysterectomy, no screening	Screen women older than 29 yo q 3 yrs if they've had 3 consecutive negative screens. HIV +, DES-exposed, and immunocompromised women may need more frequent screens. Women with hx of CIN 2, CIN 3, or cervical cancer require annual screen.	Women older than 29 may be screened q 3 yrs if they've had 3 consecutive negative screens, are HIV -, not immunocompromised, and have no hx of CIN 2, CIN 3, or in utero DES-exposure
		Women with hx of CIN 2 or CIN 3 at time of hysterectomy require annual screening until 3 consecutive negative cytology results	
		No upper age limit for screening	

ACOG Practice Bulletin #45. Cervical cytology screening. *Obstet Gynecol* 2003; 102(2): 417-427
ACOG Practice Bulletin #109. Cervical cytology screening. *Obstet Gynecol* 2009; 114(6): 1409-1420

Comparison of Screening Guidelines

Organization	1995	2002	2009
United States Preventive Services Task Force (USPSTF)	Followed ACS's 1987 guidelines	Begin cervical screening 3 yrs after coltarche, no later than age 21	No change
		As above, and discontinue cervical screening in women who have undergone hysterectomy for benign reasons	
		Discontinue screening at age 65 if prior screens have been negative and are otherwise at low risk for cervical cancer	

Cox JT. The development of cervical cancer and its precursors: what is the role of human papillomavirus infection? *Curr Opin Obstet Gynecol* 2006; 18(suppl 1) S5-S13

Comparison of Screening Guidelines

Organization	1987	2002	2009
American Cancer Society (ACS)	All women who are or have been sexually active OR have reached age 18 should be screened annually.	Begin cervical screening 3 yrs after coltarche, no later than age 21.	No change
	After 3 or more consecutive negative cytology screens, women may be screened less frequently at discretion of her physician.	Annual screen with conventional smear, q 2 year screen with LBC for women under 30 yrs old.	No change
		Beginning at age 30, women with 3 consecutive negative screens may be screened q 2-3 yrs with either conventional or LBC.	As per prior recommendations; in addition, HPV DNA testing and cytology q 3 years is a reasonable option.
		HIV +, DES-exposed, immunocompromised, and women with hx of CIN 2, CIN 3, or cervical cancer require annual screening.	No change
		Discontinue screening in women aged 70 and older after 3 consecutive negative screens and no positive cytology in prior 10 years.	No change

www.cancer.org/docroot/CRI/content accessed 4/12/2010

Saslow D et al. ACS guideline for the early detection of cervical neoplasia and cancer. *CA: Cancer Jnl Clin* 2002; 52: 342-352

Comparison of Screening Guidelines

Organization	1995	2002	2009
World Health Organization (WHO)	Begin cervical screening at age 35	Cervical cytology at least q 3-5 years where attainable Visualization with acetic acid and direct biopsy of suspicious areas may be a viable alternative; no recommendation for frequency HPV DNA testing may be a viable alternative to cytology Any screening program would ideally take place within an organized infrastructure so that follow-up and treatment of abnormal results could be assured	No change

duToit GC. WHO cervical cancer screening guidelines — how relevant to us? *So Afr Med J* 1995; 85(1): 52

Cox JT. The development of cervical cancer and its precursors: what is the role of human papillomavirus infection? *Curr Opin Obstet Gynecol* 2006; 18(suppl 1) S5-S13

World Health Organization. Cervical cancer screening in developing countries: report of a WHO consultation. WHO Publications, Geneva; 2002.

Case One: VT

- VT is a 17 yo G2P0, coitarche age 13, whose mother brings her to your office for the first time. VT has had a recent termination of pregnancy and her mother is interested in VT beginning a contraceptive method.
- You take a medical history, which is unremarkable.
- At this initial exam, do you perform a screening test for cervical cytology?

VT's visit continues

- You don't perform cytology at this visit, but in addition to discussing and performing a full physical including a pelvic exam, you perform screening tests for sexually transmitted infections.
- VT's screens for chlamydia and HIV are both positive; her HIV test is confirmed by Western blot.
- Do you perform cervical cytology now for VT?

VT's Cervical Cytology

- If without epithelial lesions or malignancy
- If ASCUS, negative for high risk HPV DNA
- If ASCUS, positive for high risk HPV DNA
- If LSIL or greater

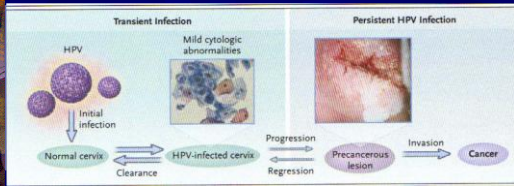
Case Two: AL

- AL is sent to you by another clinician for evaluation of her abnormal cervical cytology. She is a 19 yo G0, coitarche age 17, who's had 2 lifetime partners, both male.
- Her cytology was reported as ASCUS, positive for high risk HPV.
- What do you do with this patient?
- What would you have done with this patient this time last year?

AL's Second Visit

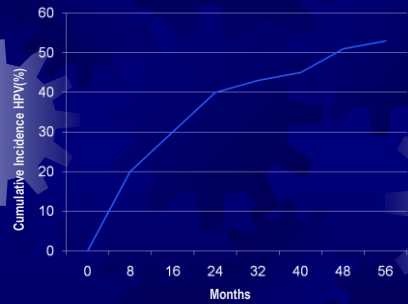
- At her next visit, AL admits to you that she wasn't entirely forthcoming with her previous clinician, but she was afraid to tell you at the first visit.
- In fact, she has been sexually active for 4 years, not 2, and her lifetime number of partners is 10, not 2.
- Does this change your management?
- Would it have changed your management last year?

Natural History of HPV Infections



Wright TC, Schiffman M. Adding a test for HPV DNA to cervical cancer screening. *NEJM* Feb 6, 2003; 348(6): 489-490

Incidence of HPV After Initiating Sex



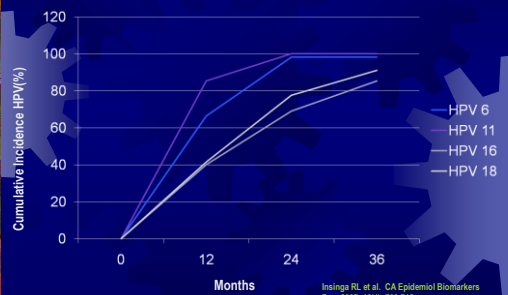
Winer RL, et al. Genital HPV infection: incidence and risk factors in a cohort of female university students. *Am J Epidemiol* 2003; 157(3): 218-226

Cervical HPV and Early Coitarche

- Biologic factors increase susceptibility of female adolescents to cervical HPV
 - Low production of cervical mucous
 - Immature columnar cells at cervical portio
 - Incomplete local immunity
- Sexual exposure may accelerate squamous metaplasia
- Mechanical trauma of sexual activity may induce squamous metaplasia (unclear)

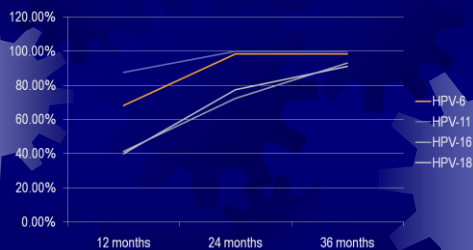
Kahn JA *Curr Opin Ped* 2001; 13: 309-309. Rager KM *Curr Wom Health Rep* 2002; 2: 468-475.

Acquisition of HPV (16-23 year olds)



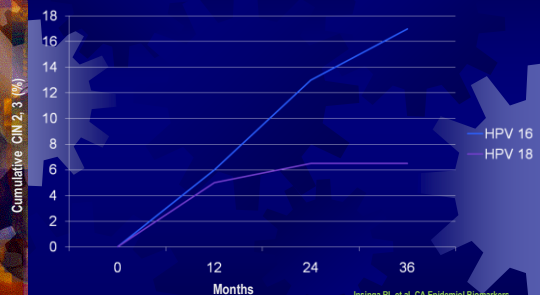
Insinga RL, et al. *CA Epidemiol Biomarkers Prev* 2007; 16(4): 709-715

Clearance of HPV (16-23 year olds)

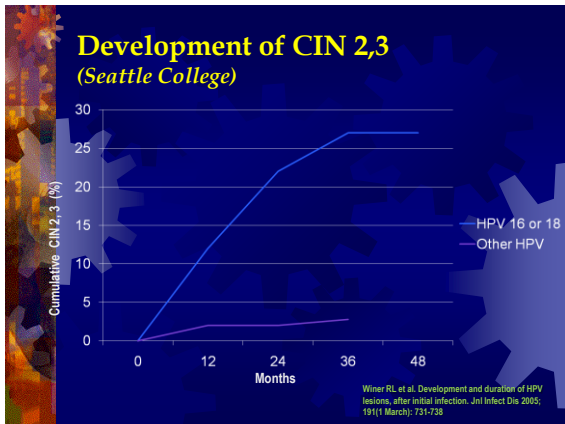


Insinga RL, et al. *CA Epidemiol Biomarkers Prev* 2007; 16(4): 709-715

Development of CIN 2,3 (16-23 year olds)



Insinga RL, et al. *CA Epidemiol Biomarkers Prev* 2007; 16(4): 709-715



- ### Risk Factors for HPV Persistence
- Smoking
 - Immunocompromise
 - HIV
 - s/p organ transplant
 - Chronic steroid therapy
 - Infection with HPV types 16 and/or 18
 - Infection with multiple subtypes
 - Ethnicity?

- ### HPV in Adolescents
- An estimated 6.2 million sexually active men and women contract HPV annually
 - Of these, 74% are estimated to occur in individuals aged 15-24
 - Prevalence in adolescent females has ranged from 30-50% in previous studies; cumulative prevalence greater
- Ho GY. *NEJM* 199; 338: 423-8
 Moscicki AB, *Ped Clin NA* 1999; 46: 783-807
 Brown DR, *J Infect Dis* 2005; 191: 182-193

- ### Natural History of HPV
- Key Messages
- HPV is quite prevalent in young women
 - However, HPV 16 and 18 are less prevalent than many think
 - Most infections “clear” within 36 months
 - CIN 2, 3 develops more quickly and at a higher rate than previously thought

- ### Case Three: KC
- KC is a 21 yo G0 who comes to the office during her spring break. She has heard she can get free refills of Nuvaring at your office; that is her only reason for coming, as she is without complaint.
 - Her past hx is unremarkable.
 - Her initial cytology is negative, and you tell her that although you recommend sti screening frequently, she doesn't need cytology repeated for another 2 years.
 - Four months later, KC requests sleeping pills for insomnia. Closer questioning reveals that KC is beginning to remember being sexually assaulted at the age of 5 or 6. Do your recommendations change?

Are There Any Problems with the New Recommendations?

OPINION COMMENTARY

8 FEBRUARY 2010 • SEATTLE, WASH.

Pap Smear Guidelines May Backfire for Some

The new guidelines on cervical cancer screening from the American College of Obstetricians and Gynecologists are welcome. They advise that women should not have their Pap smears before age 21, and that women aged 21-29 every 3 years. Women aged 30 and older who have had three consecutive negative cervical cytology test results may be screened every 2 years with either a Pap smear or liquid-based cytology.

But the majority of the population, these are good guidelines. That's because most women do not have access to the health care system—let alone an appropriate level of cervical cancer. That's most women over 40 who have been exposed to the human papillomavirus (HPV) virus. In addition, there is a lack of cervical cancer screening in many women who are immunocompromised by HIV, organ transplant, or chronic steroid use.

Another group that these recommendations may not be appropriate for is young women who are at high risk for dysplasia and cancer. For Pap smears, it is not clear that these advanced data can be used to reach this population. It is because late negative with this test may mean that a patient may have false negative at 21 and following the new guidelines after the next false Pap smear could show advanced disease or even cancer. So young women who are at high risk of cervical cancer, such as those who become sexually active at 11 or 12, should not have their Pap smears either than the rest of the population.

In addition to the issue of young women, there are other groups of women that will require greater attention. These are women who are at high risk of dysplasia, such as those who are immunocompromised by HIV, organ transplant, or chronic steroid use.

So, there is a natural progression of knowledge regarding the detection of cervical cancer. In the country of Maryland, Baltimore, Dr. Tinsley had a high rate of cervical cancer. It is important to be aware of these guidelines.

Interpret With Caution

Existing Guidelines Caution Re:

- HIV + patients
- Immunocompromised patients
- Patients exposed to DES in utero
- Patients with a history of CIN 2, CIN 3, or invasive cervical cancer
- "Women at high risk for developing cervical cancer"

Caution May Also Be Prudent:

- Patients at high demographic risk for cervical cancer
- Patients with history or in whom we suspect early childhood sexual abuse
- Patients with limited access to screening once older than age 21

In Conclusion...

- The new guidelines will likely decrease cervical cytology screening rates in teens, who have been over-treated for cervical dysplasia historically
- Patients require anticipatory guidance regarding cytology screening, especially in the absence of actual testing
- Clinicians should consider individual patient risk for cervical cancer when implementing the new guidelines
- Cotesting (utilizing HPV DNA testing and cytology) at less frequent intervals in women age 30 and over may represent our best hope for early detection and cost effectiveness

Thank You!

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