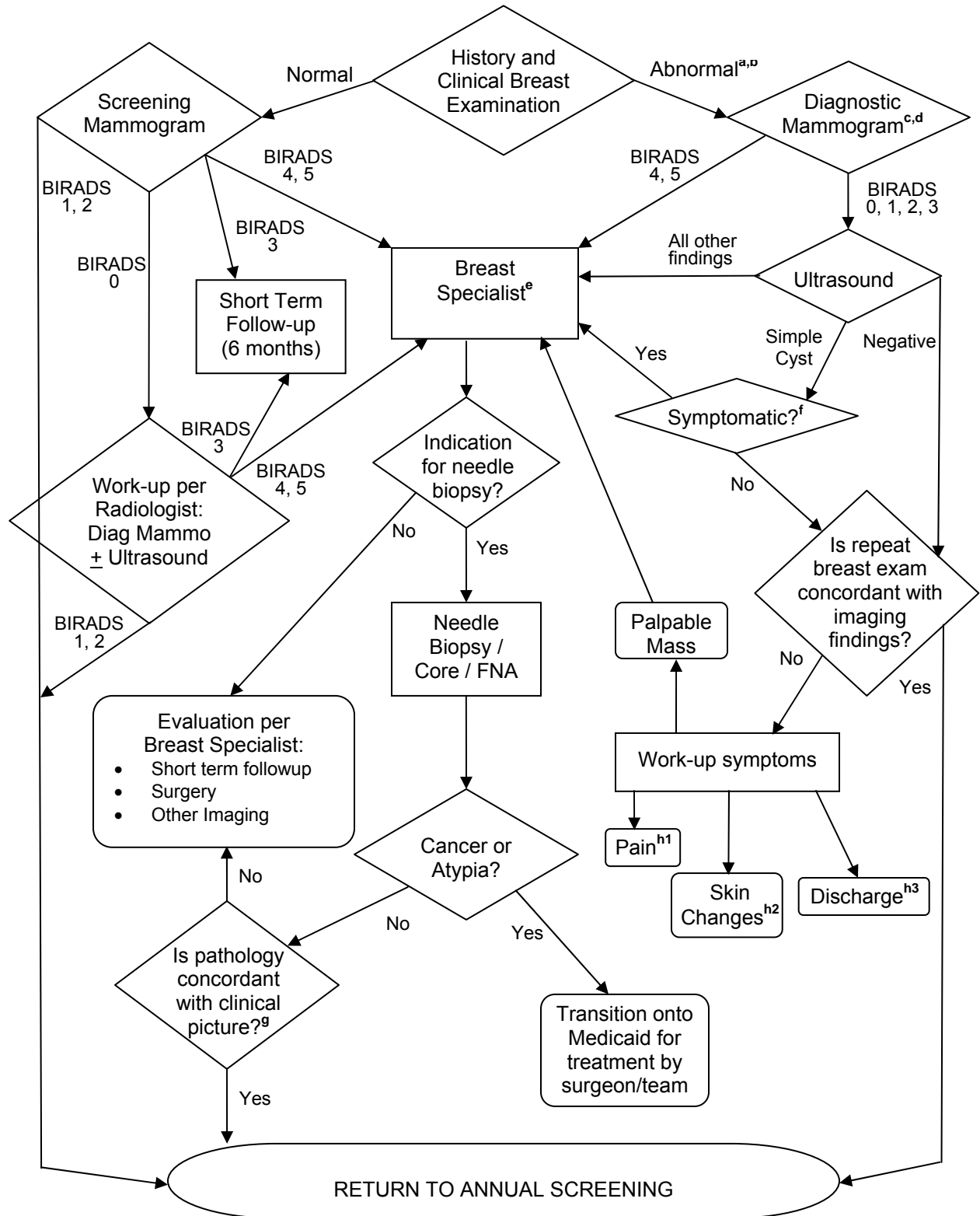


WBCHP BREAST CARE ALGORITHM



WBCHP Breast Care Algorithm Notes

- a) If mass appears to be a simple cyst, one may perform an aspiration initially to obviate lengthy workup and expedite treatment. However, imaging is more accurate in undisturbed breast tissue. Delay the mammogram for about two weeks for needle tracks to resolve.
- b) Abnormal may include mass, discharge, pain, and skin or nipple changes. (See “h” below.)
- c) Diagnostic mammogram within two months does not need to be repeated. One may use a two month old mammogram for a current evaluation.
- d) Ultrasound may be the initial imaging method for women under 30 years old.
- e) Here, breast specialist means an experienced clinician able to dependably obtain a valid tissue diagnosis. This includes radiologists, surgeons, and adequately trained primary care providers.
- f) Non-painful simple cysts confirmed by ultrasound and mammography need not be aspirated. (See “h” - breast pain below.)
- g) Concordant means lesion found by imaging satisfactorily explains clinical symptoms or signs and pathology.
- h) Workup of varied breast symptoms:
 - h1. Breast Pain:
 - All women with symptomatic breast pain should be initially evaluated using the breast algorithm. Ultrasound may identify a simple cyst.
 - Women with cyclic pain should be evaluated for hormone irregularities or medications influencing hormonal balance. **WBCHP does not cover laboratory testing or treatment in this case.**
 - Women with non-cyclic pain may be referred to a breast specialist if no hormonal cause can be found.
 - h2. Discharge:
 - All women with symptomatic discharge should be initially evaluated using the breast algorithm.
 - If bloody or heme-occult positive, refer to breast specialist.
 - Persistent spontaneous unilateral nipple discharge can be worked up by the addition of a ductogram in addition to the usual imaging workup.
 - If non-bloody discharge is spontaneous and persists over two months, refer to breast specialist.
 - If bilateral discharge consider hormonal, medication, non-prescription supplement, or physiologic causes.
 - h3. Skin Changes involving nipple or other sites on the breast:
 - All women with symptomatic skin changes should be initially evaluated using the breast algorithm.
 - Unilateral skin changes may be treated with either a short course of antibiotics or topical steroid creams. **WBCHP does not cover this type of therapy.** If signs or symptoms do not resolve, refer to a breast specialist.

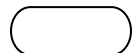
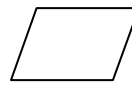
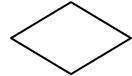
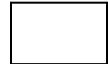
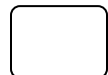
Thank you to Cary Kaufman, MD for developing and preparing this algorithm.

WBCHP Breast Care Algorithm Key

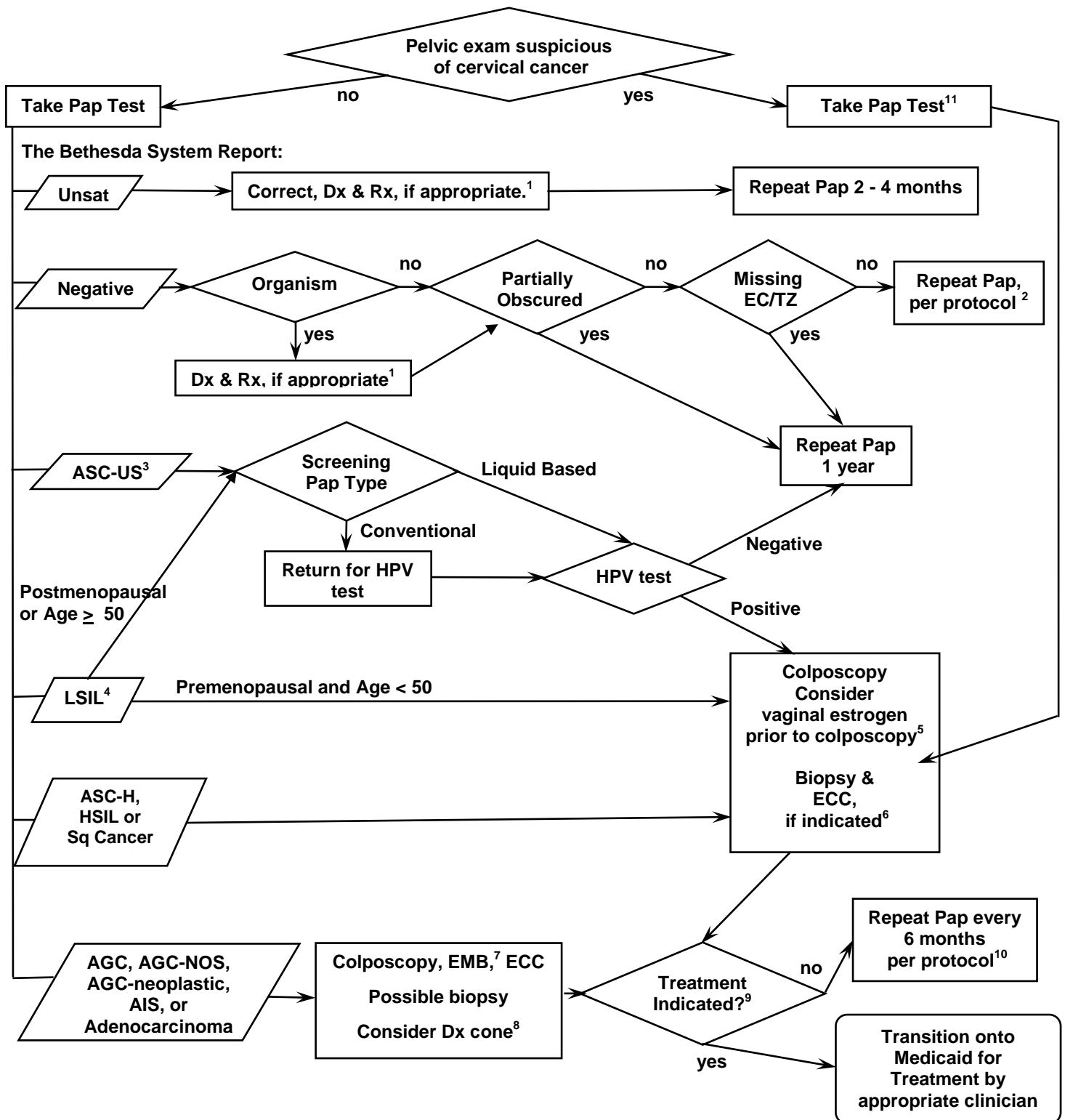
BIRADS Categories:

- BIRADS 0 = assessment incomplete
- BIRADS 1 = negative
- BIRADS 2 = benign
- BIRADS 3 = probably benign (less than 2% risk of cancer)
- BIRADS 4 = suspicious abnormality (2-94% risk of cancer)
 - 4A = low suspicion (2-32% risk)
 - 4B = intermediate suspicion (33-66% risk)
 - 4C = moderate suspicion (67-94% risk)
- BIRADS 5 = highly suggestive of malignancy (95% and greater risk of cancer)
- BIRADS 6 = biopsy proven cancer (100%), take appropriate action

Shapes:

-  = Beginning and End of Process
-  = Data or Information Gathered
-  = Decision Point
-  = Process
-  = Alternate Process

HSPW CERVICAL CARE ALGORITHM



HSPW Cervical Care Algorithm Notes

1. **Not covered by HSPW.**
2. If the Pap is liquid-based repeat the Pap every 2 years until the woman has 3 consecutive, negative (normal) results, then repeat Paps every 3 years. If the Pap is conventional repeat Paps yearly until the woman has 3 consecutive, negative (normal) results, then repeat Paps every 3 years. Here is a table showing the schedule of Paps based on the type of Pap a woman might have at each screening visit.

Year	Possible Screening Schedules							
	A	B	C	D	E	F	G	H
1	CP	LB	CP	CP	LB	LB	CP	LB
2	CP		LB	CP			LB	
3	CP	LB		LB	CP	LB		CP
4			LB		CP		CP	LB
5		LB				CP		
6	CP or LB			CP or LB				
7			CP or LB		CP or LB		CP or LB	CP or LB
8		CP or LB				CP or LB		
9	CP or LB			CP or LB				
10			CP or LB		CP or LB		CP or LB	CP or LB

CP = Conventional Pap Smear
LB = Liquid Based Pap Smear

Assumes All Screens are Negative (normal)


3. If initial Pap is liquid-based and the result is ASC-US, high risk HPV testing should be performed immediately from the initial specimen. If the Pap is conventional and the result is ASC-US or the HPV test cannot be done due to insufficient fluid, collect the HPV test in a return visit. Alternatively a repeat Pap with high risk HPV testing may be done in 6 months after a conventional Pap.
4. All women 50 years old and older (regardless of menopausal status) and postmenopausal women under 50 with an LSIL Pap should be managed in a similar fashion to an ASC-US result. HSPW covers and pays for HPV testing with an FDA approved and clinically validated test for high risk HPV types only.
5. Most postmenopausal women not on hormone replacement therapy need vaginal estrogen before colposcopy. Consult with the colposcopist on dose. Prescribe estrogen cream in the vagina each night at bedtime for 3 weeks. Stop vaginal estrogen 5 to 7 days before the colposcopy appointment. **HSPW covers this vaginal estrogen therapy.**


6. If the Pap was HSIL, but the biopsies and/or ECC are negative or only show CIN 1, a diagnostic LEEP may be indicated. Before performing a LEEP have a pathologist review the cytology and correlate with the tissue samples (possibly making more slides). WBCHP provides limited coverage for diagnostic LEEP in these cases. **This needs approval from the Prime Contractor before the procedure is done.**
7. Endometrial biopsy (EMB) is indicated in all women over age 35 with atypical glandular changes on the Pap. EMB is covered by WBCHP for women with AGC.
8. Management of glandular abnormalities is complex. If Pap was read as AGC-neoplastic or worse and no AIS or cancer was found, either in the cervix or endometrium, review all the findings. Since the Pap and biopsy are not diagnostic, a full review of all studies (Paps, colposcopy, biopsies, ECC, EMB) prior to cone biopsy is essential and should be reviewed by at least two consultants. If the AGC-neoplastic or worse is confirmed, a diagnostic cone is needed. WBCHP provides limited coverage for diagnostic cold-knife cone in these cases (not LEEP or laser cone). This needs approval from the WBCHP Prime Contractor before the procedure is done.
9. Treatment for histological diagnoses of CIN 2 (moderate dysplasia), CIN 3 (severe dysplasia), carcinoma in situ (CIS), adenocarcinoma in situ (AIS) of cervix, or cervical cancer are covered by the Medicaid Breast and Cervical Cancer Treatment Program (BCCTP). Management of endometrial cancer, vaginal cancer, and other non-cervical disease is NOT covered by the Medicaid BCCTP; however, the woman may be eligible for services through some other mechanism. CIN 1 is not ordinarily treated and is not covered under the Medicaid BCCTP.
10. Follow-up depends upon the original Pap and the colposcopic findings.
 - a. If the Pap was read as AGC-NOS and no cervical or endometrial neoplasia is found, the woman needs repeat Pap smears every 4 to 6 months until she has 4 consecutive, negative (normal) Paps containing endocervical cells. If any Pap is AGC-NOS or ASC-US/LSIL, or worse, she needs colposcopy by an expert in management of complex cytologic situations. Review the cytology and correlate with the clinical picture and tissue samples.
 - b. If the Pap was read as ASC-US or LSIL and the colposcopy/biopsy are CIN 1, atypia, or normal, **preferably**, do an HPV test in 1 year. HSPW **will** pay for HPV testing in this situation. Alternatively, repeat Paps every 6 months until 2 consecutive negative (normal) results, and then resume regular screening. In either case, if abnormal, repeat colposcopy.
11. When a pelvic exam is clinically suspicious for cancer, ask the laboratory to expedite the reading of the Pap smear. Wait for the Pap result then refer even if the Pap is normal. (See Cervical Cancer Screening chapter in the 2008 HSPW Administrative and Performance Manual for details about clinical signs of cervical cancer.)

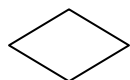
*This algorithm will be updated as necessary when the ASCCP guidelines are published.
Thank you to Vivien Hanson, MD for developing and preparing this algorithm.*

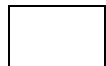
WBCHP Cervical Care Algorithm Key


Shapes:

 = Beginning and End of Process

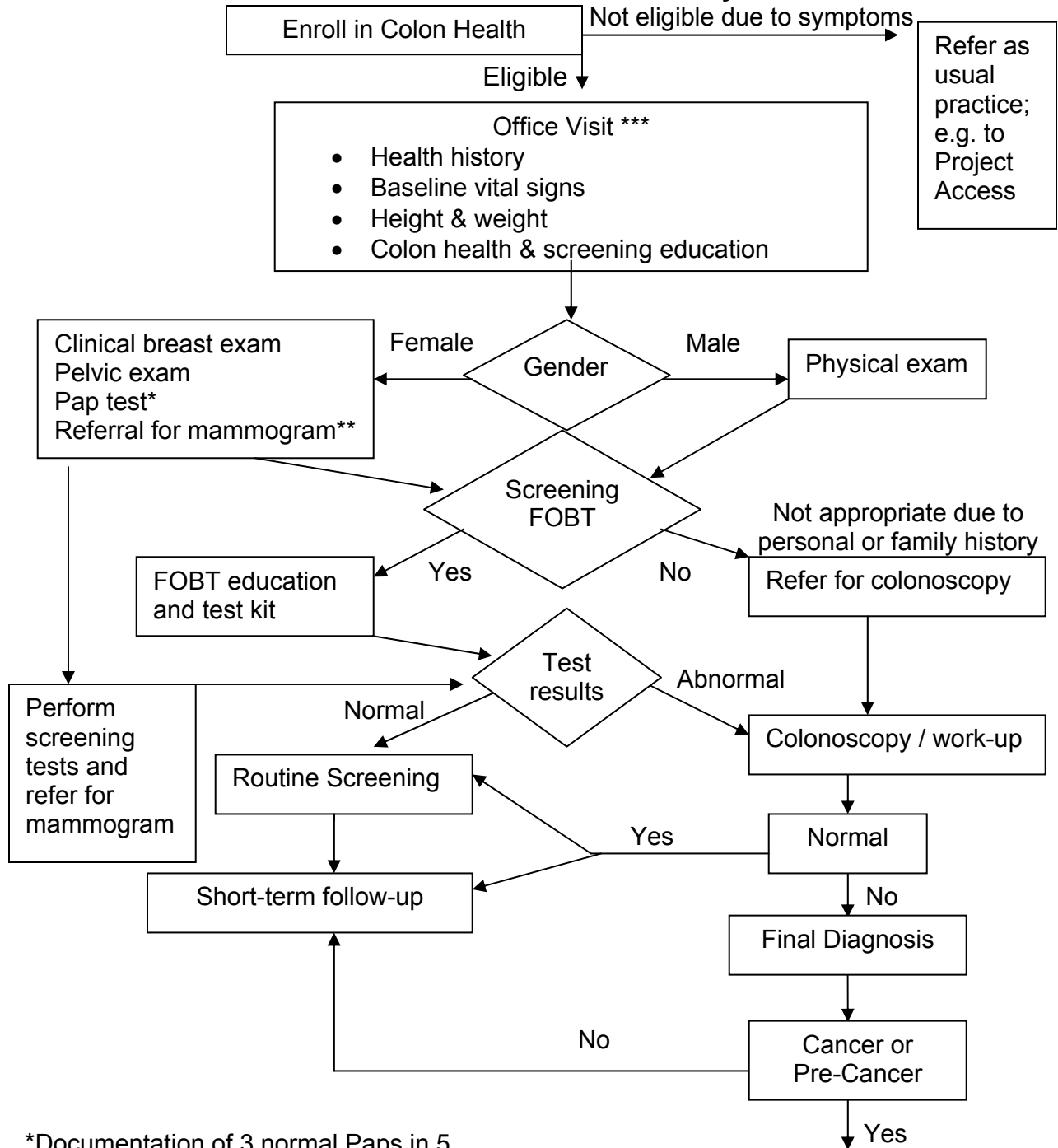
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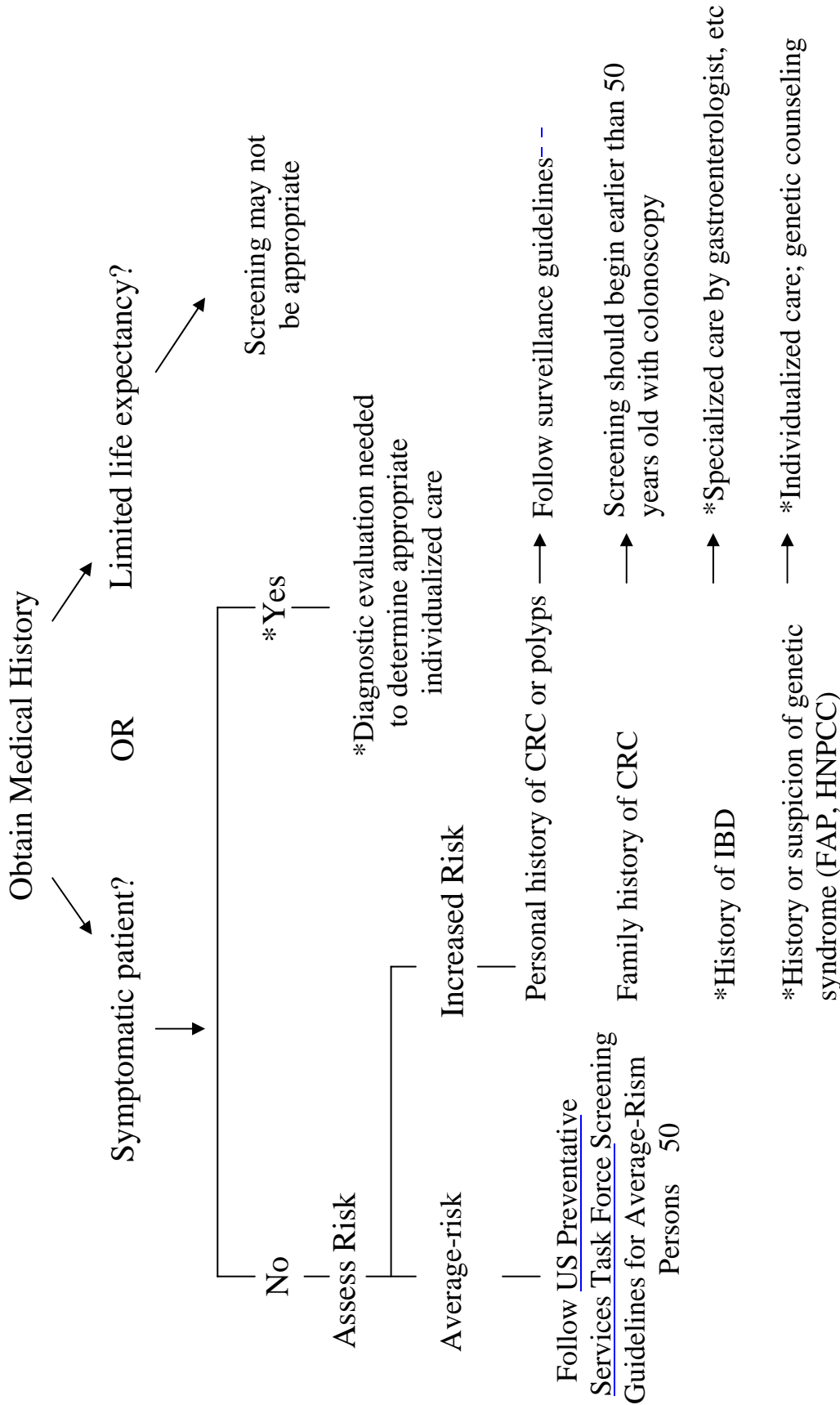
BCCHP Client Services Pathway



*Documentation of 3 normal Paps in 5 years precludes need for Pap except every 3 years.
 **Mammogram every 18-36 months depending on age
 ***Men – health history, vital signs, height, weight & FOBT education and test kit

Treatment through WBCHP- Medicaid or alternate sources for CRC diagnosis (Emergency Medicaid or Charity Care)

Colorectal Cancer Screening Algorithm for Adults Aged 50 Years and Older



IBD = Inflammatory Bowel Disease
 HNPCC = Hereditary Nonpolyposis CRC
 FAP = Familial Adenomatous Polyposis

*Washington Breast, Cervical and Colon Health Program will not pay for this service

3.5. Screening for Colorectal Cancer: Clinical Summary of US Preventative Services Task Force Recommendation

Population	Adults age 50 to 75 years	Adults Ages 76 to 85 years	Adults Older Than 85 years
Recommendation	Screen with high-sensitivity FOBT, sigmoidoscopy, or colonoscopy Grade: A	Do not screen routinely (case by case) Grade: C	Do not screen Grade: D
	For all populations, evidence is insufficient to assess the benefits and harms of screening with computed tomographic colonography and fecal DNA testing. Grade: I (insufficient evidence)		
Screening Tests	High-sensitivity FOBT, sigmoidoscopy with FOBT, and colonoscopy are effective in decreasing colorectal cancer mortality. The risks and benefits of these screening methods vary. Colonoscopy and flexible sigmoidoscopy (to a lesser degree) entail possible serious complications.		
Screening Test Intervals	Intervals for recommended screening strategies: <ul style="list-style-type: none"> • Annual screening with high-sensitivity FOBT • Sigmoidoscopy every 5 years with high-sensitivity FOBT every 3 years • Screening colonoscopy every 10 years 		
Balance of Harms and Benefits	The benefits of screening outweigh the potential harms for 50- to 75-year-olds.	The likelihood that detection and early intervention will yield a mortality benefit declines age 75 because of the long average time between adenoma development and cancer diagnosis.	
Implementation	Focus on strategies that maximize the number of individuals who get screened. Practice shared decision making: discussion with patients should incorporate information on test quality and availability. Individuals with a personal history of cancer or adenomatous polyps are followed by a surveillance regimen, and screening guidelines are not applicable.		
Relevant USPSTF Recommendations	The USPSTF recommends against the use of aspirin or nonsteroidal anti-inflammatory drugs for the primary prevention of colorectal cancer.		

For a summary of the evidence go to www.preventiveservices.ahrq.gov.

These recommendations do not apply to individuals with specific inherited syndromes or those with inflammatory bowel disease.

Additional guidelines for BCCHP: If an individual has a first degree relative diagnosed with colorectal cancer before age 60, the individual should be screened 10 years younger than the relative's age at diagnosis. The individual should be screened by colonoscopy. **In-office samples from Digital Rectal Exams (DRE) are not acceptable tests for fecal occult blood. The three sample take-home FOBT test or the take home FIT test is recommended.**

