Washington State Department of Health
DOH 342-043 March 2014

BCCHP CERVICAL CARE ALGORITHM

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

This algorithm does not replace clinical judgment in particular cases. There may be exceptions which should be discussed with BCCHP staff.

Cervical Cancer Screening Results Follow-up Table[1]

RESULT		FOLLOW-UP	Notes and Management of Follow-up
PAP	**HPV**		
Unsat.[2]	Unknown[3]	Repeat Pap 2-4 months	First treat infection, if present.[4] If repeat Pap negative, return to routine screening, otherwise manage for new results.
	Negative		
	Positive	Repeat Pap 2-4 months	First treat infection, if present.[4] If repeat Pap negative, cotest in 1 year, otherwise manage for new results.
Negative & no EC/TZ or Quality Indicators[5]	Unknown[3]	HPV triage or Rescreen 3 years	
	Negative	Rescreen 5 years	
	Positive	Cotest 1 year[6]	If Pap and HPV both negative, rescreen in 3 years If Pap ASC-US or worse, or HPV positive, needs colposcopy,[7,8] with ECC and EMB,[9] if indicated.
Negative	Unknown[3]	Rescreen 3 years	
	Negative	Rescreen 5 years	
	Positive	Cotest 1 year[6]	If Pap and HPV both negative, rescreen in 3 years If Pap ASC-US or worse, or HPV positive, needs colposcopy,[7,8] with ECC and EMB,[9] if indicated.
ASC-US	Unknown[3]	HPV triage[10]	If HPV triage negative, repeat cotest in 3 years, if positive, needs colposcopy.[7] If woman declines HPV triage see note 11.
	Negative	Cotest 3 years	
	Positive	Colposcopy[7]	
LSIL	Unknown[3]	Colposcopy[7] or HPV triage[10]	In postmenopausal woman, use HPV triage. If HPV triage negative, repeat cotest in 1 year, otherwise do colposcopy.[7] In premenopausal woman use colposcopy.
	Negative	Cotest 1 year	If Pap and HPV are negative, cotest in 3 years. If Pap is ASC-US or worse, or HPV positive, do colposcopy,[7,8] with ECC and EMB,[9] if indicated.
	Positive	Colposcopy[7]	See ASCCP Guidelines for colposcopy management, and summary in the notes.[8,12] See the Breast and Cervical Cancer Treatment Program (BCCTP) Policy & Procedure.[14,15]
ASC-H, HSIL	n/a	Colposcopy[7]	
AGC,[13] AIS	n/a	Colposcopy,[7] ECC, EMB[9]	

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NOTES

1. Based on the 2012 national guidelines published by the American Society for Colposcopy and Cervical Pathology (ASCCP).
2. Unsatisfactory specimens are:
   - Blood, inflammation, etc. obscures most of the cells, 75% or greater.
   - Specimen is very scanty or inadequately fixed.
3. Unknown means the test was either not done or was unsatisfactory.
4. **Treatment not covered by BCCHP.** Defer repeat Pap until after the infection has resolved.
5. Quality Indicators are when specimens are somewhat limited:
   - EC/TZ means lack of endocervical cells/transformation zone component.
   - Blood, inflammation, etc. obscures some of the cells, 50-75%.
   - Specimen may be scanty or poorly fixed.
6. HPV (16,18) genotyping is not covered by BCCHP, per CDC requirements.
7. Most postmenopausal women not on hormone replacement therapy need vaginal estrogen before colposcopy. **BCCHP covers this vaginal estrogen therapy.** 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.
8. If the Pap was ASC-H or HSIL, but the biopsies and/or ECC are negative or only show LSIL (CIN 1), a diagnostic LEEP may be indicated. First, have a pathologist review the cytology and correlate with the tissue samples (possibly making more slides) and ensure colposcopist has taken adequate biopsies, evaluated the vagina, and reviewed pictures (if available). If the diagnosis is revised, manage results as indicated, otherwise:
   - In reproductive age women, repeat Pap and HPV cotest at 1 and 2 years.
     - If both HPV tests and Paps are negative, repeat cotesting in 3 years.
     - If either Pap is abnormal or either HPV test is positive, repeat colposcopy. If HSIL (CIN 3) is found, treatment is indicated (see note 15). For continuing unexplained HSIL Pap, a diagnostic LEEP is indicated.
   - Postmenopausal women may be followed similarly with cotesting. However, diagnostic LEEP is probably preferred, since the risk of cancer is higher and they no longer have reproductive concerns. (also see note 7)
   - BCCHP provides limited coverage for diagnostic LEEP in these cases. **A diagnostic LEEP always needs approval from the Prime Contractor before the procedure is done.**
9. ECC and endometrial biopsy (EMB) are indicated, in addition to colposcopy, in all women over age 35 with AGC or AIS on the Pap. EMB is covered by BCCHP for women with AGC or AIS. (see note 13)
10. HPV triage is preferred for postmenopausal women, since ASC-US or LSIL in postmenopausal women is frequently due to atrophic changes.
11. In case of ASC-US Pap and HPV unknown results and a woman declines HPV triage then repeat Pap in 1 year. If Pap negative, rescreen in 3 years; if ASC-US or worse, do colposcopy,[7,8] with ECC and EMB,[9] if indicated.

Reviewed by BCCHP Medical Advisory Committee March 2014

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NOTES

12. Management of colposcopy results (also see ASCCP Guidelines):
    - Histological diagnosis of LSIL (CIN 1) is not ordinarily treated. Follow-up for presumed "persistent" LSIL (CIN 1) is covered by BCCHP. However, treatment is never covered under the Breast and Cervical Cancer Treatment Program (BCCTP).
    - Histological diagnosis of HSIL (CIN 2, CIN 2-3 or CIN 3) is ordinarily treated and is covered by BCCTP (see notes 14 & 15):
        - Consider offering to review all cytological, histological and colposcopic findings; this should **always** be done for reproductive age women who might want children. Review includes:
            - Consult with pathologist for review and correlation of cytology and histology findings
            - Have colposcopist review picture and notes, confirm adequacy
        - Inform reproductive age women who might want future pregnancies about increased risk of premature delivery after treatment (especially if excisional), that progression takes a long time, and options:
            - Observation with Pap and adequate colposcopy every 6 months for up to 2 years
            - Treatment options, contrasting excision (LEEP, cone, etc.) versus cryocautery
        - Postmenopausal women, discuss treatment options: excision (LEEP, cone, etc.), cryocautery
13. Management of glandular abnormalities is complex. If Pap was read as atypical glandular changes (AGC)-neoplastic or worse and no adenocarcinoma *in situ* (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 (Pap results, 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 not explained, a diagnostic cone is needed. BCCHP provides limited coverage for diagnostic cold-knife cone in these cases (not LEEP or laser cone). **Cone needs approval from the BCCHP Prime Contractor before the procedure is done.**
14. Treatment for histological diagnosis of HSIL (CIN 2) is covered by the BCCTP only for U.S. citizens and lawful Permanent Residents (LPRs) in the U.S. for 5 years or more. For other clients, contact the BCCHP Prime Contractor to discuss coverage. Ablation and cryocautery are not covered by BCCHP.
15. HSIL (CIN 2-3) or worse are eligible for BCCTP. Treatment for HSIL (CIN 2-3), HSIL (CIN 3), adenocarcinoma *in situ* (AIS), invasive squamous carcinoma of the cervix and endocervical adenocarcinoma is covered by BCCTP. Management of endometrial cancer, vaginal cancer, and other non-cervical disease is **NOT covered** by the BCCTP; however, the woman may be eligible for services through some other mechanism. In addition, women with AIS histology may need extensive workup, which involves scans and laparoscopy, as cells could be from ovarian or more remote cancers.