

## 2018 UPDATE ON CERVICAL DISEASE

MARK H. EINSTEIN, MD, MS  
(MAY 2018)

### Cervical screening recommendations do not cover all circumstances

Starting cervical cancer screening at age 21 does not necessarily take into account the fact that we are seeing youngsters initiating sexual activity as young as age 9. We obviously see pregnancies early as well. Waiting to screen until age 21, therefore, may cause us to miss the development of high-grade lesions and cervical cancer. As you know, cases in the literature report instances of invasive cancer with first Pap test at age 21. Also, human papillomavirus (HPV) is spread by sexual activity, with the squamous columnar junction more susceptible to infection at a young age.

Recommendations regarding cervical cancer screening for older women also should take into account new sexual partners. Currently, both men and women are living longer and are remarrying or are sexually active with multiple partners. The fact that older women are desiring hormone replacement for vaginal lubrication and dyspareunia shows that they are sexually active even in their late 70s. I believe that the incidence of HPV infection to cervical, vaginal, and vulvar tissue will be increasing as a result.

In an age in which primary care physicians do not have time to perform Pap tests or vaginal, cervical, and vulvar exams because they are overwhelmed with keeping up with patients' major medical issues is a misunderstanding regarding current recommendations for Pap test screening.

**Elizabeth Reinoehl-McClaskey, MD**  
Onley, Virginia



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### Dr. Einstein responds

*Sexual behavior can start early, but this does not lead to cancer. When we screen, we are looking for cancer, not HPV infection, which is quite common in women and men younger than age 21. Also, one might question whether current screening techniques pick up early-onset tumors. Regarding older women, sexual activity and the rate of older women getting cervical cancer should be considered in future guidelines.*

### TACTICS FOR REDUCING THE RATE OF SURGICAL SITE INFECTION FOLLOWING CESAREAN DELIVERY

ROBERT L. BARBIERI, MD  
(EDITORIAL; APRIL 2018)

### Midwife-physician alliance benefits women

I want to thank Dr. Barbieri for the introduction to his April editorial in which he states that the “trusted nurse midwife asks you to consult on her patient.” Where I practice (in a large suburb of Kansas with a hospital where more than 5,000 babies are delivered yearly), there is a serious lack of midwives and an even greater lack of physicians to support them.

As the co-owner of an independently owned nurse-midwife practice, after losing our collaborating physician, we were unable to secure collaboration from any other group, despite our cesarean delivery rate of 5%, vaginal birth after cesarean success rate of 87%, and chorioamnionitis rate of 0%. Please continue to educate your readers on the benefit to women when all obstetric providers work together.

**Julie Gorenc, CNM**  
Lenexa, Kansas

### Dr. Barbieri responds

*I thank Ms. Gorenc for her support of OBG MANAGEMENT and share her concern about optimizing obstetric care. Given the pending shortage of clinicians, we will need all experienced clinicians to work together to ensure access to high-quality obstetric care. My observation is that many obstetricians are concerned about liability issues that can be associated with coverage of other clinicians, including nurse midwives. The quality of obstetric care and collaboration would be enhanced if our medical tort system could evolve to a “just culture,” ending the “blame and shame” associated with tort litigation.*

### 2018 UPDATE ON GYNECOLOGIC CANCER

JASON D. WRIGHT, MD  
(MARCH 2018)

### Diagnostics company asserts medical and pathology groups prefer cotesting for cervical cancer screening

We are concerned about Dr. Wright's March 2018 gynecologic cancer coverage of US Preventive Services Task Force (USPSTF) screening guidelines for cervical cancer.

CONTINUED ON PAGE 17

The article suggests that draft USPSTF cervical cancer guidelines issued in September 2017 are final when in fact that is not the case. The USPSTF issued draft guidelines in late 2017, but final publication is pending USPSTF revisions in response to submitted public comments. This means that, for now, existing USPSTF guidelines remain in place, and these guidelines clearly recommend cotesting (high-risk HPV and cytology/Pap) in women 30 to 65 years of age every 5 years as an appropriate screening modality, in alignment with the American College of Obstetricians and Gynecologists, the American Society for Colposcopy and Cervical Pathology, and the American Cancer Society, among others.

It is also notable that the proposed USPSTF guidelines have been met with sharp resistance. ACOG, as well as several organizations, including the American Society of Clinical Pathology, American Society of Cytopathology, the American Society for Cytotechnology, the College of American Pathologists, the International Academy of Cytology, and the Papanicolaou Society of Cytopathology, cite concerns with the proposed USPSTF guidelines and continue to

argue in favor of cotesting in women 30 to 65 years of age.<sup>1,2</sup>

We also fear that Dr. Wright may have provided data out of context. For instance, he notes that the USPSTF, in its draft guidelines, found that cotesting increased the number of follow-up tests but did not increase detection of CIN3+ in a decision model. Yet, the USPSTF analysis overrelied on research from European populations (not representative of the US cervical cancer experience) and excluded peer-reviewed data of women in the United States, which clearly shows that HPV-Pap together catches more cervical cancers than either Pap or HPV alone.<sup>3</sup>

**D.P. Alagia, MD, and  
Harvey W. Kaufman, MD, MBA**

Quest Diagnostics  
Madison, New Jersey

#### References

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2. Cytopathology Education and Technology Consortium. Response to new USPSTF guidelines for cervical cancer screening. October 2, 2017. <https://s3.amazonaws.com/ascpcdn/static/ONELab/pdf/2017/CETC+-USPSTF+Letter+10-2-17.PDF>. Accessed July 5, 2018.
3. Blatt AJ, Kennedy R, Luff RD, Austin RM, Rabin DS. Comparison of cervical cancer screening

results among 256,648 women in multiple clinical practices. *Cancer Cytopathol.* 2015;123:282-288.

#### Dr. Wright responds

*I thank Drs. Alagia and Kaufman for their interest in the work and their comments regarding the USPSTF cervical cancer guidelines. As stated in the article, the USPSTF recommendations are currently in draft form and subject to revision based on public comment. The guidelines are a synthesis of best available evidence and are meant to weigh the benefits and harms of various cervical cancer screening strategies. The recommendations are based in part on simulation modeling that incorporates available evidence and projects the long-term effects of multiple rounds of screening. While the decision models incorporated a large amount of data and were robust in a variety of sensitivity analyses, as with all decision analyses, they are limited by the underlying assumptions utilized in the model. Over the last 2 decades, screening practices for cervical cancer have dramatically shifted. Highlighting the USPSTF draft guidelines was meant to raise awareness among clinicians and policy makers of the evolving role of high-risk HPV testing, either alone or in combination with cytology, as a screening modality for cervical cancer.*