Beyond the Pap

What's new and important in the Consensus Conference's soon-to-be-released new guidelines

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THE ROAD AHEAD **This new series in OBG MANAGEMENT will keep you up to date on the many changes expected to take place as a result of the 2006 Consensus Conference held in September, and the introduction of HPV vaccines.**

Our whole approach to cervical cancer prevention is likely to change within the next few years. Today, many obstetricians and gynecologists still consider the annual Papanicolaou test "the gold standard." This is going to change, however, with…

- **Adoption of HPV DNA testing** as an adjunct to cervical cytology
- **Commercially available HPV genotyping tests**, which should be available in the near future
- **Widespread vaccination** of women against HPV 16 and 18

ObGyns nationwide follow guidelines

This article summarizes the September 2006 Consensus Conference, organized by the ASCCP. The goal was to keep pace with the explosion of new data from clinical trials published in the last 5 years. The expected release date for the 2006 Guidelines is in the Spring or Summer of 2007. The 2001 Consensus Guidelines for the Management of Women With Cytologic Abnormalities have been extremely successful—they are now utilized by most clinicians and managed care organizations nationwide. In the last 5 years alone, more than 500,000 copies of the management algorithms have been downloaded from the ASCCP's Web site (http://www.asccp.org), and many more have been downloaded from the *Journal of the American Medical Association* and the national guideline clearinghouse.

In large part, this success derived from the fact that most professional societies and federal agencies that deal with cervical cancer screening partnered in their development. Although the ASCCP organized the effort, 29 professional organizations participated. This meant that when groups such as ACOG subsequently developed guidelines for their members, they closely mirrored the 2001 Consensus Guidelines.

The 2006 Consensus Conference included approximately 100 delegates, 28 national and international professional societies, and federal agencies, but the meeting itself was only the final step in a long process. For 18 months, 6 different working groups reviewed the literature and determined where changes were needed.

NEW GUIDELINES ARE EVIDENCE-BASED

"The working groups evaluated hundreds of manuscripts and studies to make certain that the new guidelines remain evidence-based"

Kathy Poole, ASCCP Executive Director

CONTINUED

NEXT MONTH

Introducing HPV vaccination

- Who to vaccinate
- Consent forms
- Tracking systems to assure all 3 visits
- Should you vaccinate "off recommendations"?

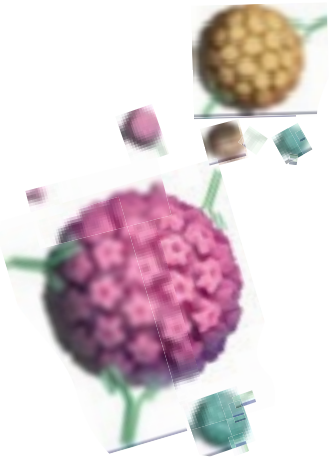
The working groups posted their findings on Internet-based bulletin boards that allowed anyone in the national or international screening community to have input.

NEW GUIDELINES ARE SIMPLER

"One of the key goals of the 2006 Guidelines is simplification"

Dr. Mark Spitzer, ASCCP President and Chairman, Department of Obstetrics and Gynecology, Brookdale University Hospital and Medical Center, Brooklyn

"Many clinicians who manage women with cytologic abnormalities are not obstetricians and gynecologists. Nurse practitioners and family practice clinicians who don't spend their entire lives dealing with abnormal Pap smears are responsible for much of the cervical cancer screening that takes place nationally," said Dr. Spitzer. "The 2001 Consensus Guidelines have sometimes been characterized as complex and difficult to follow by such clinicians."



***FAST** TRACK*

The FDA approved the HPV vaccine 18 months sooner than expected because, in Phase III trials, it proved much more effective than expected

WEB RELATED
ASCCP's website:
http://www.asccp.org

Atypical squamous cells

HPV DNA-positive ASC-US vs LSIL

No major changes were recommended for the general population with ASC-US. However, since the ALTS trial clearly demonstrated that women with ASC-US who are high-risk HPV DNA-positive are essentially identical to women with LSIL, an effort was made to ensure that recommendations for these 2 groups are identical.

IDENTICAL MANAGEMENT

"Current data clearly indicate that women with ASC-US who are HPV DNA-positive and women with LSIL have the same risk of having high-grade disease and should therefore be managed identically" **Dr. Spitzer**

Although new data resulted in a number of minor changes to ASC-US recommendations, there are more significant changes in management of ASC-US with "special circumstances." The 2001 Guidelines identified postmenopausal women and immunosuppressed women with ASC-US as "special circumstances" to be managed differently than the general population. New guidelines eliminate this distinction.

Limited colposcopy in adolescents

Previously there was no provision for managing adolescents (up to 20 years of age) with ASC-US differently than the general population. New guidelines add adolescents as a "special population," with different management. This change is based on considerable data demonstrating that the risk of cervical cancer is extremely low in adolescents, and that more than two thirds of adolescents with ASC-US are referred to colposcopy if "reflex" HPV DNA testing or repeat cervical cytology is utilized. Based on the newer data, a more conservative approach, which greatly limits use of colposcopy, will be introduced.

ASC-H

A number of studies have confirmed a high prevalence of CIN 2,3 as well as a high prevalence of high-risk HPV DNA positivity in women with ASC-H compared with women with ASC-US. Therefore, no substantive changes were made in the management recommendations for ASC-H. However, the need for a complete review of cytology, colposcopy, and histology results is downplayed for ASC-H without high-grade CIN.

LSIL and CIN 1

Basic management did not change for the general population, but did change for adolescents and postmenopausal women:

- **As with adolescents with ASC-US**, the new guidelines deemphasize colposcopy in adolescents with LSIL.
- **"Postmenopausal women with LSIL** are at lower risk for having significant cervical disease than are younger women; therefore, options were developed for these women to be managed more conservatively," explains Dr. Spitzer, Chair, LSIL, CIN 1 Working Group.

IMAGE: TODD BUCK

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***FAST** TRACK*

Treatment of CIN 1 in adolescents is particularly discouraged

Previously, management of CIN 1 depended on whether colposcopy was satisfactory. Either treatment or follow-up was acceptable for women with CIN 1 and satisfactory colposcopy, but a diagnostic excisional procedure was advised for unsatisfactory colposcopy.

This has changed. The importance of a satisfactory colposcopic examination is deemphasized, and conservative follow-up of CIN 1 (which really represents histological manifestations of a productive HPV infection rather than a cancer precursor) is now stressed. Treatment for CIN 1 is particularly discouraged among adolescents.

HSIL and CIN 2,3

Immediate "screen and treat" as a management strategy for HSIL in the general population is emphasized more. As with ASC-H, the need for a complete review of the cytology, colposcopy, and histology results for women with HSIL in whom CIN 2,3 is not identified is deemphasized.

New guidelines no longer require that women with HSIL who do not have biopsy-confirmed CIN 2,3 undergo a diagnostic excisional procedure.

Basic management of CIN 2,3 is modified in only minor ways; however, options for conservative management of adolescents with CIN 2,3 are expanded (as for other clinical scenarios such as ASC-US, LSIL, and HSIL in adolescents).

Atypical glandular cells

HPV DNA STATUS MATTERS

"Based on data obtained since the 2001 Consensus Conference, it now appears reasonable to incorporate knowledge of a woman's HPV status in management of atypical glandular cell (AGC) cytological abnormalities"

Dr. Charles Dunton, Chair, AGC Working Group, and Director, Division of Gynecological Oncology, Albert Einstein Medical Center, Wynnewood, Pa

Although the 2001 recommendation that almost all women with AGC undergo colposcopy remains, recommended follow-up will be modified to take into account HPV DNA status. Women who are high-risk HPV DNA-negative can be followed less aggressively than those who are high-risk HPV DNA-positive.

Other new guidelines

These include specific guidelines for managing **benign endometrial cells** identified during routine cytology (in both postmenopausal and cycling women) and **benign-appearing glandular cells** identified on routine cytology in women who have had a hysterectomy, as well as comprehensive management recommendations for women with **biopsy-confirmed cervical adenocarcinoma in situ.**

HPV DNA testing

"The 2001 guidelines did not address HPV DNA testing as an adjunct to cervical cytology in women aged 30 and older because HPV DNA testing was not yet FDA approved for this use," says Dr. Edward J. Wilkinson, Chair, HPV DNA Working Group, and Professor and Vice Chairman, Department of Pathology, University of Florida College of Medicine, Gainesville. Therefore, the Interim Guidance introduced by the ASCCP/NCI/ACS in 2004 was the basis for new recommendations. For the most part, the 2006 Consensus Conference formally adopted the Interim Guidance published in 2004.

Quite a bit of consideration was given to how management will change once the FDA approves **genotyping assays** that identify HPV 16 and 18 for clinical use. Once such assays become available, the new guidelines indicate that there is sufficient data to support the triage of women who are cytology-negative/HPV DNA-positive, using HPV genotyping assays that identify HPV 16 and 18. ■

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