NWX-OS-OGC-RKVL (US)

Moderator: Sue Moskosky
April 3, 2012
1:00 pm CT

Coordinator: Welcome and thank you - one moment please. Welcome and thank you for standing by. All participants will be in a listen-only mode until the question-and-answer sessions of today's conference call. At that time, please press star 1 on your touchtone phone. Please un-mute your line and state your name clearly so that we may announce you.

Today's call is being recorded. If anyone has any objections, you may disconnect at this time.

I'd like to introduce your host for today's call, Ms. Sue Moskosky. You may begin.

Sue Moskosky: Thank you, operator. Really appreciate it and I'd like to welcome everyone and apologize that we had a little bit of a late start. But definitely want to welcome you to this Webinar, which is going to provide some very important information.

As you're aware, on March 15 the US Preventive Services Task Force issued revised guidelines for cervical cancer screening. We're honored this afternoon

to have Dr. Michael LeFevre -- Vice Chair of the Task Force -- here to explain the new guidelines and to answer your questions regarding the new guidelines.

But before I introduce Dr. LeFevre, I want to remind Title X agencies about OPA Program Instruction 09-01. If you haven't looked at it recently, I urge you to go back and look at it. It is on OPA's Web site.

And this program instruction requires that Title X providers maintain clinical protocols that are consistent with current nationally recognized standards of care.

So please don't wait for the new Title X guidelines to update your protocols regarding cervical cancer screening. If you've not already done so, we urge you to go ahead and do that now.

The new US Preventive Services Task Force guidelines are now the same as those of the American Cancer Society, American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology Screening. It's our understanding that also ACOG is currently in the process of revising its guidelines.

At the conclusion of Dr. LeFevre's presentation we'll have about 15 minutes for questions. And again, the Webinar moderator, (Diane), will come back on and provide instructions as to how you would log on to ask your questions.

So I'd like to introduce Dr. Michael LeFevre, who is the Future of Family Medicine Professor and Associate Chair of Family and Community Medicine at the University of Missouri in Columbia, Missouri.

As Medical Director for the Department of Family Medicine, he has administrative oversight of practices in six locations with more than 90,000 annual visits.

He teaches residents and medical students in the inpatient and outpatient settings and maintains an active practice across the full breadth of family medicine, including inpatient work and obstetrics.

He's also the Chief Medical Information Officer for the University of Missouri Health System and has directed the implementation of the electronic medical record across the system since 2002.

Much of his academic efforts have been in the area of evidence-based medicine and clinical policies. And he is currently a member of the US Preventive Services Task Force and the Joint National Conference on Prevention, Detection and Treatment of Hypertension.

Dr. LeFevre has many degrees, all of which from the University of Missouri, including an MD and MSPH degree. And he's been on faculty there since 1984.

So without further ado, I'd like to turn this over to Dr. LeFevre. Thank you, Dr. LeFevre.

Dr. Michael LeFevre: Thank you very much. And I'll take full blame and credit for the delay. I had trouble making my desktop show where you are viewing.

So we will get started with cervical cancer screening. And as already stated on March 15, the USPSTF and the ACS in conjunction with ASCCP and ASCP released updated cervical cancer screening recommendations. And that was

not a coincidence. So they were independently developed, but we timed the release of those so that they came out at the same time and they have remarkably similar conclusions and guidelines.

So background first of all. There are a couple of different types of cervical cancer. And squamous cell is the cancer that you all think about when you think about cervical cancer. It's present in about 70% of the cases and has historically been the primary target of cytological screening that is Pap smears. It arises at the squamocolumnar junction of the transformation zone. And there are some other types of cancers which can be present as well.

For the clinicians in the audience, a reminder of what the squamocolumnar junction is. It's the junction of where that bright red part meets the pink part and that's where we need to be sampling when we do cytology or Pap smears.

Cervical cancer mortality in two different years here. First, 1950 -- and this is unadjusted rates -- were 10.2 per 100,000 in the white population, and 18.0 in the non-white population. And then the adjusted 2007 rates you can see are dramatically lower at 2.2 and 4.3 respectively for a combined rate of 2.4.

And this dramatic decline has been attributed to the implementation and dissemination of screening. There are inevitably some other factors that have played into that, but certainly screening is one of the factors.

This graph shows both the incidence and the mortality rates at various age ranges of cervical cancer. I think a key point on this graph is that the peak age range is from about 30 to about 65. And we see the death rate climb slowly over time, but you can see that cervical cancer in the younger age group is actually quite rare and then it rises rapidly.

(Unintelligible) data would suggest that the burden of illness currently - it's been estimated that a little over 12,000 women will be diagnosed with. And in red there, 4,290 women will die of cancer of the cervix in 2011.

Just for comparison to put that in perspective, for every woman who will die of cervical cancer, five will die from colon cancer, eight will die from breast cancer, and 15 will die of lung cancer. And so you can see comparatively we have brought this down to a much lower rate than some of the other cancers.

This is an important slide from my perspective. About half of all cervical cancer deaths are in women who have not been screened or who have had inadequate follow-up to screening and treatment.

And if we could assure adequate screening of the entire population, the residual preventable burden would be small, i.e., what number of deaths would still be present if everybody was able to participate and would participate in screening.

So it raises the question of what goals we should have for any change in our prevention strategy, whether that would be immunizations -- for example, HPV immunizations -- or a change in our approach to screening.

Possible goals would include a further reduction in mortality, though I've already said that half of the deaths that we see currently are related to the absence of screening, not a failing of screening.

And there's an important caveat here, which is that the elimination of cervical cancer and/or cervical cancer mortality is not a realistic goal of screening. It's not a realistic goal of screening to eliminate any cancer or mortality from any cancer. Reduction in the burden and/or harms of screening and treatment of

screen-detected disease could in fact be one of the goals for any change in our prevention strategy related to cervical cancer.

On a slide that I quite comfortably know you cannot read the right side of this screen. I will tell you that we have - here in my department we have a series of clinical algorithms that if you're sneaky and you know how to get into them, they're not behind a firewall. And I have on this particular slide the Web addresses for those algorithms.

If you go there right now you will not see this because this is our draft, which probably within the next week or so will be up for cervical cancer screening which reflects the new guidelines. The top half of that is - top third is related to screening, the middle evaluation of an abnormal screen, and the bottom the follow-up of colposcopy.

The task force specifically addresses that top box, the screening. And so as we launch into what the recommendations are -- and I'm going to use that algorithm as a picture guide for where we are going here -- I'm going to start with the note right here before we talk about the specific guidelines.

The first note, liquid and conventional cytology -- the dry smear -- are equivalent. That's not widely accepted or appreciated. But certainly since the last time the task force looked at this the evidence has become fairly compelling.

I do acknowledge that you don't have much control over what your pathologist does. I would also note that the conventional Pap smear or cytology is quite a bit cheaper than liquid cytology. But you'll likely be using whatever your pathologist asks for.

Number two, these recommendations do not apply to women who have HIV, who are immunosuppressed in other ways, who have had (DES) exposure, or women who have been treated for CIN 2 or 3.

And for those women who have been treated for CIN 2 or 3, the next bullet point is that routine screenings should continue for at least 20 years after either spontaneous regression or appropriate management of a high grade precancerous lesion.

Next bullet. Women who have had a total hysterectomy for benign indications and have no prior history of CIN 2 or worse should not be screened.

And right now a history of HPV vaccination does not change who should be screened or how often. It would be fascinating to see over the next decade to 15 years whether HPV vaccination has any impact on screening recommendations.

So let's start with those under age 21 where we say quite directly do not screen. Do not screen for cervical cancer under age 21.

And we have to understand that. We have to look at HPV infections. And so this statement, I consider it to be an incredible statement. It is well recognized that infection with oncogenic HPV types is a necessary, although not sufficient cause of virtually all cervical cancer.

As a clinician who takes care of all ages actually -- but certainly women -- it is astounding to be able to say that about any cancer, that we know the cause and that the cause is an infectious disease.

Results from a large international collection of cervical tumor specimens reveal the presence of HPV DNA in over 99% of cases. So we have fairly well established that HPV is in fact the cause of cervical cancer.

Now there is a natural history from HPV infection to cervical cancer. It starts with transmission -- which is sexual -- leads to acute HPV infection. And then that infection has to persist, which leads to precancerous changes and then ultimately to invasive cervical cancer.

Transmission occurs primarily as a result of skin-to-skin or mucosa-to-mucosa contact. It does not require sexual intercourse, but is primarily transmitted through sexual intercourse.

A high proportion of sexually active women become infected with HPV. But only a small proportion of HPV infections go on to that next step and become persistent.

Ninety-one percent of prevalent HPV infections clear within 24 months. And that includes those infections with the high risk subtypes. So if we do a cross-section of women at any age and find those that have HPV, two years later 91% of those who had HPV will no longer have evidence of infection. So it does spontaneously clear.

And of course results in the curve that you see in front of you right now, which is the prevalence of HPV at different ages. And you can see starting down in the 14 to 19 year old age range that prevalence is up around 35%, falls somewhat in the 20s. And then when we get into the 30s we see a fairly dramatic decline which continues over the subsequent age groups.

Which brings us back to why not screen before age 21? First of all, cervical cancer is rare in the younger age group. Here I have a table and all of these things can be found on the Web under the USPSTF cervical cancer. Recommendation, the evidence report, the model data, everything is there.

This particular table shows the age-specific crude invasive cervical cancer incidence by race and age. And I'm going to focus on the upper left-hand corner of that. And if you look at the line age 15 to 19, you can see that the incidence of cervical cancer is 0.1 per 100,000 women. That is 1 in a million.

So only one in a million women age 15 to 19 will get cervical cancer, and there's certainly no assurance that any amount of screening will prevent that one woman from getting cervical cancer. So the basic premise of screening -- which is that the prevalence has to justify screening -- is not met in that younger age range.

And secondly, HPV infection is quite common and results in transient abnormalities of the cervix and detection and treatment of those abnormalities leads to harm.

And we of course say well what about sexual history? What about the young woman who had her first sexual partner at 13 and by age 18 has already had 4 sexual partners? And that does not alter the screening recommendations.

That's actually is one of the things that's been clarified, both the ACS and the USPSTF in this particular recommendation statement, which sexual history should not affect your screening.

Young women with multiple sexual partners are actually the most susceptible to the harms of screening. That is they most assuredly have HPV and that will

lead to those transient abnormalities which will lead to a lot of interventions which could in fact be harmful. Yet the possibility of benefit is vanishing close to zero.

So in simple terms, just say no to screening for cervical cancer before age 21.

Which brings us then to the next two boxes and a discussion of cytology of a Pap smear.

And from age 21 to age 64, the recommendation is to screen every three years with Pap smears. And the three years part of that will likely be the part that kind of catches everybody a little bit off guard, though nobody has really recommended annual screening for some time. We still probably have received as much feedback about that particular number as anything else. So let's kind of look at that from an evidence standpoint.

First of all, randomized control trials of screening programs at different intervals never exist. And so anybody making guidelines has to use some indirect data or indirect information.

And so, for example, no one has ever done a randomized control trial comparing colonoscopy for colon cancer screening every 5 years to every 10 years or every 20 tears. Actually that was a legitimate typo that tears part when I put it in there. And I just decided it fit well enough that I would just leave it in the slide. Every 5 years, 20 years or 20 tears. Nobody's ever done that trial.

Increasingly the task force has used modeling to gain some information about what you can expect from different screening programs.

But if we think about that, what are we going to look at as outcomes of a model? And particularly, what are the harms? Most people would suggest that a false positive result is a harm. You do things that are unnecessary to people.

Colposcopies are a harm. CIN 2/3 is a very interesting particular outcome because some would say that increased detection of those precancerous lesions would be good. But the reality is is that much of that regresses and so a great increase in detection of CIN 2/3 is actually probably a harm, of course cancer cases and cancer deaths.

So what about colposcopies? They cause pain. They cause bleeding. And we use them as a sentinel measure for downstream harms similar to using the number of colonoscopies as a sentinel measure of harm in the model of colon cancer screening.

Harms including overdiagnosis, as I've already said. CIN 2 can and does regress, so overdiagnosis and overtreatment are very real risks. CIN 3 can actually also regress as well. And the standard of care currently is to treat all CIN 2 or worse.

But common treatments -- which include, for example, LEEP and cervical conization -- has certainly a high incidence of short-term harms, such as pain and bleeding and discharge, as you can see there.

But more importantly probably and very concerning is the potential for increased risk of adverse pregnancy outcomes. Perinatal mortality, preterm delivery and low birth weight has all been linked to some treatments of CIN 2/3.

The evidence we acknowledge on specific procedures is incomplete and retrospective. But there certainly is some risk and concern about over treating these young women.

Model - I just threw this in to confuse you and to tell you that modeling is enormously complicated even if you like math, and I do like math. But if I hone in on some very specific numbers that we might glean from the model, across the top we see the interval of screening with a Pap smear or cytology starting at age 21 every year, every two years, every three years or every five years. And down the left side you can see things that we look at, such as false positives.

So you can see that screening every year results -- and this is per thousand women -- 951 false positives. And you see that rate fall as you co across that particular row to 214 if you're screening every five years. Colposcopy -- as you will recall one of our principle measures of harm -- at 1931 for annual screening, drops to 1084, 758 and 483. So a pretty dramatic decline in the number of colposcopies that are needed with less frequent screening.

We see a decline in CIN 2/3 in the next line all the way out to Q5. It's about 33% drop. And then we look at cancer cases, which do seem to increase a little bit in cancer deaths.

Now before we get too hung up on a difference, for example, between .9 and 1.5 or .3, I like to throw in a quote from one of the task force members who is an expert in modeling.

All models are wrong. Some are useful. I think to put too much credence onto the very specific numbers that you see here is probably not a good idea. But

the general patterns of both harms and benefits that you see across a pattern of screening I think we can rely on from a modeling standpoint.

And there's also an observational study which is very important -- published in July of 2011 -- it was published in Lancet Oncology. And going all the way to the bottom of that slide, they followed 313,818 women in Kaiser Permanente Northern California where they have the ability to capture data like this.

And of those women, close to 320,000 of them had a normal Pap at baseline. And then CIN 3+ -- not 2+, but 3+ -- at three years was only .17%. And in five years we do see it go up some at .36%.

And if we break the CIN 3+ down and look at invasive cancer specifically, risk of invasive cancer at five years after normal cytology -- after a normal Pap smear -- was only 7.5 per 100,000 women. That is .0075%. And so a woman who has had a normal Pap smear has much less than a 1% risk of invasive cancer over 5 years, 99.3%, if you will.

So the task force concluded the screening interval for cytology in women age 21 to 65 should be every three years. That cytology every three years demonstrates a very good balance of benefits and harms. And we feel very comfortable sending the message and the message that I will give to my patients that Pap smears every three years are safe and effective at reducing cervical cancer, while minimizing the risks of false positive results and the harms associated with treating disease that will go away without treatment.

Which brings us back to our algorithm and a conclusion then about cytology or Pap smears is every three years. But what about HPV? And what should we be doing with HPV screening?

Recall the prevalence of HPV infection and how common it is in the younger age range. And I'll jump right to the recommendation for what to do with women before age 30, which is don't.

We recommend against using HPV screening as a screen for cervical cancer in women who are under age 30. The prevalence is high, therefore the false positive rate is high. And by false positive rate I don't mean that the test is positive in someone who does not have HPV. What I mean is that the false positive means identifying someone who needs intervention for cervical cancer prevention, but they really don't because that intervention will occur for a disease that will regress spontaneously.

So again, just say no to screening for cervical cancer with HPV before age 30.

Well what about after age 30? Multiple studies of varied design demonstrate that HPV testing is actually more sensitive than cytology -- or CIN 2+ -- but less specific. So by more sensitive I mean it will pick up more cases of CIN 2, CIN 3, but it will also identify women who are not destined to have cervical cancer more often.

So the task force had the challenge of being moderately certain. Those are our works. That's what we require of ourselves that the evidence has to be moderately certain about the balance of benefits and harms.

And when we initially reviewed this and in our draft that was published, we looked at the results of six European randomized controlled trials that included HPV in some way in the experimental group, but inconsistent design, varying protocols, incomplete reporting. Perhaps most importantly,

incomplete follow-up through two rounds of testing precluded us, we thought, from making a recommendation.

And when we released our draft in the fall, we said the evidence was insufficient to determine the balance of benefits and harms of HPV screening.

But post-draft and during the public comment period, two important publications came out. The completed follow-up with the second round of the RCT in the Netherlands, as well as the Kaiser Observational Data noted earlier in the presentation.

The randomized control trial in the Netherlands randomized close to 45,000 women age 30 to 56 to either conventional cytology or co-testing with HPV and conventional cytology every five years. And Round 2, in five years both groups received co-testing.

It's a fairly complex protocol for referral for colposcopy which does not reflect the current standard of care in the United States. For example, they only immediately referred for high grade (SIL). And of course in the United States we refer for even some cases of ASCUS.

But here are the results. Recall that the denominator in each of these columns is about 20,000 women. In the left column are those who received only a Pap smear. The right column are women who had co-testing in the first round with a Pap smear and HPV. And at the end of the study we saw substantially higher rates of CIN 2, 168 versus 127. Those are numbers.

And then CIN 3, not quite as big a decline. We saw more cancer in the HPV-tested group in Round 1, but the reversal in Round 2 so that the cumulative cancer was actually somewhat lower in the co-testing group.

Does that apply to the US? We're actually more aggressive in the use of colposcopy, so we might actually find more CIN 2+.

But it's safe to conclude that co-testing every five years is as good as -- or maybe better -- than cytology every five years. And the reported harms were modest.

But we want to compare cytology every three years to co-testing every five years. The Kaiser Observational Data and further exploration in the model allowed us to fill in the gaps.

The Kaiser data -- as I said earlier -- showed an incidence of CIN 3+ of 0.17%. That was true three years after normal cytology, but also five years after a double-negative co-testing.

Other analyses confirmed increased sensitivity and decreased specificity of HPV testing relative to cytology. So the same results with co-testing every five as cytology every three. They did not report the total colposcopies.

In our model data, however, you can see that cytology every three years -- which is the first line -- and then co-testing only starting at age 30 -- the second line -- shows there's actually a reduction in colposcopy with the co-testing strategy every five years. That's 575 versus 758 in the second column.

Now there are assumptions built into the models, and I'm not going to belabor those assumptions. But one of them was that women who had normal colposcopy immediately returned to usual screening.

So what is the role for HPV testing and screening? We said a combination of Pap smear and HPV testing every five years -- or co-testing -- was comparable for women age 30 to 64 to testing with Pap smear only every three years.

And that brings us to the age to stop. Age 65 and up, discontinue screening at 65 years of age in women with three negative cytology tests in a row or two negative co-tests of Pap and HPV within the past ten years. The potential for benefit in those adequately screened in the past whose screening tests are normal is very low and the potential for harm is at least small and we think we can safely stop by age 65.

Though again, note that women who have had CIN 2+ in the past should continue to be screened for at least 20 years after that CIN 2+ goes away.

I think we should consider screening women at age 65 and beyond who do not have a history, however, of adequate screening. I will have to acknowledge that all of the data would suggest our yield in those people is still low, but we're certainly leaving the door open for them to be screened.

Two other important changes that I would like to point out. The USPSTF did not address the management of abnormal results, but the ACS and ASCCP did and to make two specific recommendations.

And the first one is somewhat groundbreaking, which is, you know, currently the recommendation is that if somebody has ASCUS on their Pap smear that we - one of the alternatives is to get an HPV test. And if the HPV is positive, send them to colposcopy. But if it is negative, they can go back and be screened routinely.

The new recommendation is that ASCUS positive HPV negative is treated as normal. In other words, in the current recommendation, closer follow-up repeating at six months and a year is required. But in the new recommendation, go back to normal screening interval. For somebody who has ASCUS and is HPV negative if, for example, their screening was cytology every three years they can come back in three years for another Pap smear.

We have a new circumstance, however, if you're going to introduce HPV screening into your protocol, which is what happens if they have a normal Pap smear or negative cytology, but they are HPV positive? That would be quite a number of women to screen with colposcopy - I should say test with colposcopy. And as you will recall from earlier in the presentation, 90+ percent of HPV goes away within two years.

So the recommendation that came out of the ASCCP and the ACS guideline is you can do one of two things. You could repeat both the co-testing in one year and only colpo if either is positive. Or you could test for HPV 16 and 18 subtypes specifically and do colposcopy of positive.

And let me just tell you that I can't do that at the University of Missouri right now. We do not offer the subtype testing for HPV 16, 18 specifically. They will be looking into it, I'm sure. But I say that to suggest that probably many of you will also have a hard time doing that second step. And so for the most part this strategy will likely be to bring these women back in a year to do HPV and cytology again, and only send them for colposcopy if either one is positive.

And that really concludes the recommendations. I'm not going to get to the bottom of the page where we talk about what happens after colposcopy. But those are the new recommendations. Fairly straightforward.

Don't screen before age 21. Screen with cytology or Pap smears every three years from age 21 to 65. And either liquid-based cytology or the conventional dry smears are equal and effective.

At age 30, for women who are interested in lengthening the interval between testing you can go to every five years by incorporating HPV testing into your screening approach and then follow-up according to the results of both tests.

At that point I think I managed to get done at almost precisely 15 minutes head of time. So I will turn it back over to our moderator, I think, and entertain any questions.

Sue Moskosky: (Diane), I'm going to turn it over to you in just a minute to tell folks how to ask questions. But we also have one question that came in in writing that I'm going to read after you give people instructions of how to tune in if they want to ask a question.

Coordinator: Thank you. If you would like to ask a question from the phone lines, please press star 1 on your touchtone phone. Please un-mute your line and state your name clearly so that we may announce you. To withdraw your question, please press star 2.

Once again, from the phone please press star 1. You are also able, I believe, to ask questions via the Web portion of the call by typing your question in.

And Ms. Moskosky, I'll turn it back over to you.

Sue Moskosky: Okay. We have one written question up here from (Karen Myers). And her question for Dr. LeFevre is as follows. "The age group of 55 to 70 year olds

are currently becoming a high risk population which is becoming infected with HIV and/or HPV. Is the recommendations to not test women ages 65 and older?"

Dr. Michael LeFevre: Yes. And, you know, the prevalence data, a couple of observations about that. And that's a fairly common question, I will say.

The prevalence data reflect current prevalence of HPV. So even with potential for increased sexual activity or with new partners in the 65 to 75 year old age range, the prevalence data that you saw about HPV are still there.

But then if you think - if we really think that the transmission rates -- persistent infection and so forth -- relate to the 65 to 75 year old age range the same as they would to the teenagers, then we would've actually faced the exact same problem, which is you're going to see cervical abnormalities that reflect a transient change related to acute infection, which is going to go away. A few of them will persist. And of those that persist, few will develop cervical cancer. And the timeframe to develop cervical cancer from that acute infection is sort of at the low end 10 years and more at the 30 to 40 year age range.

So we see our ability to prevent cervical cancer deaths in women who have been screened and had been normal at age 65 -- even if they are at risk for getting HPV at that point -- is extraordinarily low. And so we don't recommend that a sexual history in women over age 65 should change your screening.

Sue Moskosky: Thank you. We have some others who are in queue, but I'm not seeing that they've written questions up there. So I'm going to ask those folks, (Millie Jones), (Matt) somebody and (Nancy Lee) to either type in your question or go ahead and press star 1 to ask your question.

But we do have a question from (Carol). And she wants to know what does ASCUS stand for?

Dr. Michael LeFevre: My apologies. ASCUS is the least abnormal of abnormal cytology, which stands for atypical squamous cells of undetermined significance. That's when the pathologist looks at a cell and says, "I'm not sure that's normal, but I'm also not sure it's abnormal." So atypical squamous cells of undetermined significance. Again, the lowest grade of abnormal Pap smear.

Sue Moskosky: The next question is from (Nancy Lee). And her question is, "There's lots of history for including a pelvic exam as part of screening while doing a Pap test. What is the USPSTF's take on this? Should women come in for an annual pelvic exam if asymptomatic?"

Dr. Michael LeFevre: Well I'm going to wear two hats here. And I'm going to start with the USPSTF hat, which is to give you absolutely the official line, which is the USPSTF has not examined a pelvic exam as a screening test. And so we have no official policy on whether a pelvic exam should be done.

I will allude, at least, to our ovarian cancer recommendation, which is to not screen for ovarian cancer. Screening tests far more sensitive than a pelvic exam have not been demonstrated to be of benefit and have actually been demonstrated to be of significant harm, like ultrasound, for example.

And so if you're not screening for ovarian cancer and you're not screening for cervical cancer, what should you do?

Let me officially take off my USPSTF hat and put on my family physician hat and say that I actually see no reason to do a pelvic exam on an asymptomatic

woman with no complaints referable to her pelvic organs, vagina, etc., on a routine basis. And I actually think that that is a barrier many times for getting women to come into the doctor because they don't want to do that.

Having said that, there is some concern that women use their -- quote -- annual -- end quote -- as a way to access their physician about other concerns.

So we certainly want to promote other screening tests at intervals appropriate to those specific screens. And we certainly want to encourage women to come in for their general health concerns and not rely on the need to come in for a Pap smear to bring those to the attention of their providers.

Sue Moskosky: Thank you. We have another question from (Mary Lowe), who is asking whether the slides will be available on the Web site, and also the algorithm Web site.

These slides that Dr. LeFevre presented today will be available on the Office of Population Affairs' Web site within two weeks from today.

And then I believe that you provided a link to the algorithm Web site that you said would be available within a week, Dr. LeFevre, right?

Dr. Michael LeFevre: Yes, a couple weeks. You'll be able to tell by looking at the slide whether the algorithm you stumble onto is the new one. The old one doesn't look like this.

If you go to that address right now you will see the old one, not the new one.

Sue Moskosky: Okay. Then we have another question from (Karen Paris) who is asking, "Is there a difference between co-testing, combined testing and testing with reflex for HPV?"

Dr. Michael LeFevre: I think the first two things are used interchangeably, combined testing or co-testing. That means I'm going to do a Pap smear or a cytology test and I'm going to do HPV and I'm going to get the results of both of those back at the same time and I'm going to base my management on the results of both. That's co-testing.

What is currently done commonly is reflex HPV specifically when the cytology comes back with atypical squamous cells of undetermined significance, or ASCUS. And so cytology with reflex HPV is what's done currently specifically for that low-grade abnormality.

There are -- just for your information -- people who would promote doing cytology - I'm sorry doing HPV with reflex cytology. I don't want to confuse you. But that's what the Dutch decided to do after that trial. They're going to test with HPV without a Pap smear every five years, and only do the Pap smear if the HPV is positive. There's also a trial ongoing in Canada looking at a similar regiment.

But for our purposes - and I didn't do that to try to confuse you - for our purposes co-testing means do both tests, get both results back and then decide what to do. Whereas reflex means do the Pap smear, get the results back and then only do HPV in the circumstance in which we get the atypical squamous cells of undetermined significance.

Sue Moskosky: Thanks, Dr. LeFevre. There are a couple of other people whose names are on but have not actually posted a question. So I'm going to ask those - oh, here it is.

This question is from (Dustin Ryder). And it says, "What public outreach plans are being considered to get the information to our clients so they are more comfortable with these changes? Responses from women I have talked to have been mixed. So I don't know whether there's anything that you're aware of, Dr. LeFevre that the media may be picking up? Do you have any suggestions for getting the information out to the public so that they don't feel like they're not being treated adequately? Because I think that's a fear too that people are going to think it is substandard care."

Dr. Michael LeFevre: Boy, at what level shall I answer this question? Let me say first of all -- and I don't use this as a rationalization -- the task force itself is a group of 16 people with full-time day jobs that do this on the side.

And so the task force itself doesn't do much of the outreach. On the other hand, our sponsoring organization -- AHRQ, Agency for Healthcare Research and Quality -- is very interested in trying to get the message out and has an active program to try to do so.

I will tell you that the press interest in this when it was released here a couple of weeks ago was intense and there have been many articles in the press about this. I think that -- as you know very obviously -- there are an awful lot of people that aren't reading the newspaper or watching the TV. And so, you know, I think ultimately it becomes incumbent upon us as providers when women ask, "When should I come back" to say this is what we think and these are the reasons.

And yes, yes, there's pushback on is this just we're trying to save money - no. Are you a government death panel - no. We don't actually even look at costs when we make our recommendations.

And so anytime you recommend less of anything right now there's some heightened sensitivity and I suspect that we will be seeing that as clinicians taking care of patients in the clinical setting.

And I think that knowing what the recommendations are and how they were arrived at and the safety of those recommendations is important.

Sue Moskosky: (Nichols) question is what will be the screening recommendations for HIV-positive and immunecompromised patients?

Dr. Michael LeFevre: The task force has not addressed that specifically. ASCCP has something on that and there are a variety of HIV guidelines out there. In other words, how to take care of the patient with HIV that will include screening for cervical cancer and that.

But suffice it to say, more frequent screening will continue to be recommended by those who address those specific subgroups. The task force did not specifically address them.

Sue Moskosky: Okay. One of the questions is what about testing in transient populations such is often is the case with Title X clients? Is the recommendation still every three years? And what about the fact that it might be easier for a woman to remember every year rather than every three or five years? Is there a concern that women will not be tested for ten or more years?

Dr. Michael LeFevre: Let me address those two separately. Let me say that as clinicians I think that guidelines are guidelines and that we have to use some judgment.

And so, for example, if I'm seeing a woman at 2 ½ years since her last screening exam and I know her and I know that she's adverse to seeing the doctor or I know that next month she's going to be off of her Medicaid or so forth, then I may seize the day and recommend that we get as much done as we can at 2 ½ rather than wait for 3.

The second issue is are women going to have a hard time remembering. You know, screening recommendations in general have a variety of intervals. There's nothing particular annual about screening recommendations. How often should we screen for cholesterol? How often should we screen for blood pressure? How often should we do colon cancer screening?

And reaching out to folks and identifying screening opportunities for all of the things that we should be looking for is a challenge in the primary care world. I live that challenge every day. I appreciate the dilemma.

And, you know, the transient population, those are the people that -- to be perfectly frank -- fall into the category of women who don't get adequate screen and follow-up. So just getting a Pap smear done is, you know, just a part of the battle. Getting adequate follow-up for women who have abnormal Pap smears in that transient population is going to be equally difficult. And I think it's one of our public health challenges to reach that community and provide good primary care of any type, but certainly screening.

Sue Moskosky: Okay. The next question - and I think you've already covered this, but if you could just review it one more time. And that is the screening recommendations for clients that are over the age of 65.

Dr. Michael LeFevre: And so specifically if you get to age 65 and you can look back and in the last 10 years you've been screened at least twice with HPV or three times with cytology and they've all been normal, you can stop being tested indefinitely. The rest of your life you don't have to be tested again.

The exception to that, of course, would be women who had treatment for CIN 2 or worse sometime in the last 20 years. They need to continue at least 20 years beyond the point at which they were found to be clear.

So if a woman -- just making up the numbers -- had CIN 2 treated at age 52 and then every test she had after that was normal, she still wouldn't be stopping until age 72.

Sue Moskosky: Thank you. How would you manage a woman who has had a hysterectomy due to cancer but cannot provide backup documentation? I'm not clear on this question. It said, "How do you manage women who have hysterectomies because of cancer due to abnormal Paps but cannot provide backup documentation?" I think the question is more how do you manage someone who has had a hysterectomy because of a history of cancer.

Dr. Michael LeFevre: Well, you know, I read into that question two parts, which is somebody comes to you and they've had a hysterectomy but you can't get access to the pathology report. The records are not available or you try to send for records, they don't come. I live this every day also. And the woman herself says, "I had this for cancer." I think we probably all recognize that many women who say they had it for cancer probably did not. That they had CIN 2 or CIN 3 or maybe there was another reason. Or maybe they had a fibroid and they called the fibroid a tumor and therefore she thought she had cancer. Or she had

uterine cancer, not cervical cancer. And so she had a hysterectomy for uterine cancer which doesn't change the need to screen for cervical cancer.

I think we're caught between a rock and a hard spot for people for whom we have inadequate information and will likely screen and vigorously pursue those records to see if we can find out exactly what was going on.

And because some of those women might have had high grade lesions or cervical cancer or cervical cancer in (CIN 2), those women will continue to be screened.

Those are not task force guidelines. By the way, we didn't address that subpopulation either. But that is the subpopulation addressed by the ASCCP and so forth. It says, "Keep screening if you took their uterus out because they had cervical cancer or a high grade precancerous lesion." Not uterine cancer, but cervical cancer.

Sue Moskosky: Thank you. I had one additional question. And I know we're kind of running out of time. But this question is, "For the increased screening of the CIN 2 or greater patient, is this based on a cytology result or a biopsy pathology result?"

Dr. Michael LeFevre: Pathology. Not Pap smear. Pap smears are just a screening test and your recommendations for how to follow people going forward is based on tissue, biopsies and/or if they had a cone or a LEEP or something from the tissue from that procedure that tells you exactly what was going on, not an abnormal Pap smear.

Sue Moskosky: Operator, are there any other - I'm thinking that if there's any other folks on the line that would like to ask a question, we may have time for just a couple more.

Coordinator: We have, at this point, three parties that have asked a question. The first is (Barb Brecker). And your line is open.

(Barb Brecker): My question was already answered, thank you.

Coordinator: (Hope Wood), your line is open.

(Hope Wood): Hello, yes. If you have a 30-year-old who comes in with ASCUS and they do the reflex testing and it's not 16 or 18 but it is high risk, when do you bring her back?

Dr. Michael LeFevre: So that is - that is ASCUS HPV-positive. And, you know, in the US today those people go for colposcopy. If it's high risk HPV - even if it's not 16 or 18 specifically, high risk HPV-positive and ASCUS-positive, the current US guidelines are to go to colposcopy.

(Hope Wood): And when will the ASCCP updates be published?

Dr. Michael LeFevre: You know, I can't answer that question. And I have not had any personal conversations with them. We've been in conversation with some other people related to this, but not ASCCP.

I don't want to make this unduly complicated, but the critical thing out there -- from my perspective related to the ASCCP and updating guidelines -- is what to with people who are persistently HPV-positive but cytology-negative and have normal colposcopy.

You could imagine getting into a vicious screening loop with them and they end up getting colposcopy ever year or something like that, which I'm sure is not anything that anybody would recommend.

But right now the ASCCP does not have official guidelines for what to do with women who are persistently HPV-positive but Pap smear-negative who have had normal colposcopy. That's kind of a hole in the guideline right now.

(Hope Wood): Thank you.

Coordinator: The last question comes from (Mary Beth). Your line is open.

(Mary Beth): Hi, I was wondering - you said something about the Dutch are opting to test with just HPV screening and then go to cytology of the HPV is positive? So if the cytology is then negative, what is their recommendation, do you know?

Dr. Michael LeFevre: Well, they would manage that (conservatively). In the United States that falls in the category of people who you would just wait a year and screen again with HPV to see if they stay positive. And if they stay...

(Mary Beth): (You mean) in a year for HPV instead of doing a HPV and a Pap in a year?

Dr. Michael LeFevre: You know, I don't know for certain where the Dutch are going with this. They may go with both a year later.

The point about this from the Dutch perspective is that HPV testing is actually sensitive enough that adding cytology to HPV adds really very little benefit to do it routinely as opposed to reflexly.

That's not the US recommendation right now. Won't be surprised if the recommendation in the US changes in five years or something. But for right now, our recommendation is co-testing, whereas the Dutch are going to do HPV only. And if the HPV is positive, then do the cytology and manage it basically in similar ways to what we would be talking about here today.

(Mary Beth): Thank you.

Coordinator: You have no further questions at this time.

Sue Moskosky: Thank you very much. Dr. LeFevre, I'd just like to thank you once again. This has been very interesting and very informative. We really value your insight and your expertise in this area.

And just to remind participants that this Webinar will be up on the OPA Web site in two weeks from today. And I would urge you all to also make sure that your - all of the (titles and services sites) that are within your service network are aware of that so that everybody can take advantage of this important information.

So with that, I'd like to conclude the Webinar and thank everyone who participated.

Coordinator: Thank you for your participation. Your call has concluded. You may disconnect at this time.

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