The Royal College of Pathologists of Australasia
ABN 52 000 173 231

Durham Hall 207 Albion Street Surry Hills NSW 2010 Australia
Telephone 61 2 8356 5858 Facsimile 61 2 8356 5828

RCPA
The Royal College of Pathologists of Australasia

Policy

Subject: **Cervical Screening**
Approval Date: November 2009, November 2013
Review Date: November 2016
Review By: Cytopathology AC
Number: 2/2009

RCPA Policy Proposal

The RCPA strongly supports the National Cervical Screening Program. However coordination of screening and HPV immunisation within a single framework, working together, is essential if the gains of the past fifteen years are not to evaporate. It must be recognised that even with universal immunisation of twelve year olds, substantial immunisation of young women, possible vaccination of boys, and the development of second generation vaccines with broader coverage, it will take at least five to ten years for meaningful data, monitoring changes in the prevalence of disease in the community, to become available.

Any review of the Program with respect to age of screening, screening interval, and screening technology must be underpinned by data relating vaccination history, screening uptake, disease incidence, disease management and disease outcome. This would require transfer of (or amalgamation of) data of State Pap test registers to establish a National Register that is either linked to, or at least capable of data interchange with, the National Vaccination Register.

The current commercially promoted proposal to introduce primary screening by HPV testing associated with triage with Pap testing, should be viewed with the understanding of the financial implications not only of the actual cost of testing, but also the associated potential impact of downstream investigation of women who have tested “positive”. It must be recognised that the “stigma” of a positive “high risk” HPV test, (recognised to be highly sensitive but with low specificity), even if Pap triage yields a negative outcome, will cause ongoing anxiety that will inevitably result in an increase in subsequent colposcopic and histological evaluation.

Specific Issues relating to “change”

“Program” issues:
Screening age, Screening frequency, Screening technology
Although the most desirable approach is considered to be “no change” in the basic structure of the Program in the short term, it is evident that the cost of vaccination has added materially to the cost of the Program. Savings in downstream costs of disease treatment and health outcomes are difficult to achieve in the short term, so cost “offsets” will be sought. These should be considered together, in a coordinated manner, by representation from all “stakeholders” in light of evidence of current disease trends, and benefit and cost of change. Piecemeal “trimming at the edges” should be discouraged.

Research should be directed as follows:

1: Identification of barriers to uptake of vaccination and identification of characteristics of women who do not accept vaccination. It is important to identify whether these are also the women who do not accept screening.
In particular focus should be on those groups, such as Aboriginal and Torres State Islanders, who are known to have a high rate of cervical cancer mortality.
Promotion of "self testing" using a tampon as a "sampling instrument" needs to be approached with caution. The adequacy is known to be "patchy" with almost 100% failure to access the endocervix, and although as a method of sampling for HPV testing it presents an attractive option for women who do not accept current screening approaches, the potential to spread to women who are currently receiving the benefits of a traditional screening methodology threatens the efficacy of the current program.

2: Long term monitoring of the cohort of twelve year old girls that have been vaccinated. It should be recognised that Australia has a unique position to acquire data by virtue of the "early" introduction of a vaccination program, combined with the relatively early age of commencement of screening. Although minor modification of the "timing", such as a modest increase in screening interval would not compromise this opportunity, significant changes to the methodology of screening threatens to invalidate the outcome of such monitoring.

3: Monitoring of the vaccination history of women who develop cervical disease.
For this to be meaningful the major initiative of communication between a National Vaccination Register and National Pap test Registers with good treatment/histological data is an early imperative.

4: Vaccination history and HPV subtyping of all new cases of high grade cervical lesions presenting to Dysplasia Clinics/Private Practices, should be captured.
Research that documents the relationship of vaccination/absence of vaccination, viral sub-type, and development of disease, including the temporal relationship should be encouraged/funded .

Workforce Issues

The Program, for the foreseeable future, will rely on the availability of a skilled workforce to maintain the "screening function" that currently is based on the assessment of cellular samples from the cervix, be they in "conventional" or "liquid based" form.
Although the "long term future" of gynaecological cytology is clearly identified to be shrinking, the term of its life is as yet indeterminate.

The training of cytologists and cytopathologists requires support. Many of the training opportunities in institutes of higher education have been terminated. This should be reviewed/remedied as competent laboratory personnel who have both gynaecological and non-gynaecological cytology skills are highly sought, and the broad range of techniques learned within the curricula of tertiary training institutions allow diversity of ability that is transferable over time to new technologies that are evolving rapidly in cyto/histo/immuno/molecular laboratory settings. It is the policy of the RCPA to support the continuation of cytology training within the curriculum of tertiary institutions and to maintain a requirement for competence in cytopathology in its trainees for Fellowship.

New technologies

1: Liquid based cytology and associated "imaging" technology
2: HPV DNA testing

The influence of these entities on the National Cervical Screening Program will undoubtedly be determined on the basis of evolution of the cost structure.
Currently they are expensive. Liquid based methodology, as currently practiced, costs approximately double the cost of conventional cytology. The uptake of imaging technology and the workforce and cost implications, whilst scientific merit has been demonstrated, is difficult to anticipate at this time.
HPV DNA testing, currently with very limited "rebate opportunity", and with currently only one "FDA Approved" test, costs three to four times the current Pap test rebate. Undoubtedly this will change with the expiry of existing patents and the advent of more accredited test methods, opening up the opportunity of wider "triage" testing. However the use of HPV DNA testing as a primary screening test retains significant disadvantage relating to its high sensitivity and low specificity, that currently hinders its replacement of a "cytology based" established screening program.

CONCLUSION
It should be recognised that the RCPA, far from pursuing its "vested interests", has, through relationships with NPAAC, the RANZCOG, NH&MRC and AIHW, been central in driving "change" in processes to measure and monitor quality parameters integral to the success of the Program. It is recommended that a collaborative approach to Program change should replace the independent actions of the various involved entities, and the somewhat confrontational attitude that has been evident over recent years.

The role of the RCPA in training and certification of pathologists, and providing both the policy for, and the implementation of, Quality Assurance in cytological, histological, microbiological and molecular technologies, is central to the continuing success of the Program.