UPDATE
APR 2025

SULLIVAN NICOLAIDES PATHOLOGY

National Cervical Screening Program

Cervical screening
New management guidelines

Australia is now well into the eighth year of the renewed National Cervical Screening Program, based on primary HPV testing with cytology as triage. Collecting and analysing data (both nationally through the National Cancer Screening Register and within our own practice)[1,2] has enabled new information about the natural history of oncogenic high-risk HPV to be incorporated into the program, with appropriate modifications to the management guidelines.

Clinicians participating in cervical screening should be aware of a number of major changes, as outlined below, that will apply from 14 April 2025.

To access the complete document, 'Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal bleeding', visit the Cancer Council Australia website or scan the QR code.

Test of Cure (TOC) protocol

- After treatment for HSIL, individuals require **two consecutive negative HPV tests**, 12 months apart, before returning to routine 5-yearly screening.
- The HPV test can now be performed on a self-collected sample OR on a clinician-collected sample.
- A cytology test is no longer required for completion of TOC.
- Individuals with persistent HPV not 16/18 (on three consecutive annual tests) require referral to colposcopy.

Surveillance after treatment of AIS

- Annual co-testing remains the initial recommendation, with referral to colposcopy if any abnormal result is detected.
- However, after five years of negative co-testing, **the interval between testing can be extended** to three years.
- After 25 years of negative testing, individuals younger than 70 years can return to routine 5-yearly screening, while those 70 years or older can exit the screening program.

Immune-deficient people

- The precise definition of 'immune deficient' is a common enquiry received from referring clinicians over the years. The various **categories of immune deficiency** have been clarified and expanded in detail (see below).

3-yearly screening	
Recommended	**Should be highly considered**
▪ Living with HIV ▪ Solid organ transplant with immunosuppressive therapy ▪ Active haematological malignancy ▪ Haematopoietic stem cell transplant recipients ▪ Primary immunodeficiency	▪ Long-term haemodialysis (>6 m) ▪ Long-term treatment (>6 m) with highly immunosuppressive therapies: – high-dose corticosteroid treatment – selected conventional and targeted synthetic disease-modifying anti-rheumatic drugs – biologic therapies that deplete T cells – multiple immunosuppressants

Screening after total hysterectomy

- **Many people require no further screening.**
- For those who do, the protocol has been simplified to annual testing, utilising a co-test or an HPV test alone, depending on cervical pathology found at hysterectomy and on an individual's screening history. When two negative tests on two consecutive occasions are obtained, the screening may cease.

Colposcopy-relevant changes

- Colposcopists can face particular challenges with respect to patient management when colposcopy is normal, or the transformation zone cannot be visualised and/or no liquid-based cytology (LBC) result is available prior to the procedure. Based on analysis of registry data, information is now provided about the risk of underlying disease in these and other scenarios, taking into account screening history and age. **Management decisions can now be based on evidence derived through the program itself.**
- In some circumstances **endocervical curettage** can now be considered as a further diagnostic tool.
- There is now an option to **defer re-referral to colposcopy** for those testing persistently positive for HPV 16/18, if LBC and colposcopy are normal. The safety of this option, particularly in relation to older patients with negative screening histories, has been confirmed.[1,2]
- **Diagnostic excision of the transformation zone is not recommended** based solely on positivity for oncogenic HPV. Asymptomatic people with no cytological, colposcopic or histological evidence of a high-grade lesion do not routinely require such a procedure.

A final note

- **Not everyone will comply with the recommended timing of further testing.**
- Those testing positive for HPV not 16/18 on a self-collected sample, who do not return for a clinician-collected LBC within 9 months, can now be offered a follow-up self-collected HPV test. If this second HPV test is negative, they can return to routine screening.

For further information, please contact our Doctor Service Centre on 1300 767 284. To access additional resources, including select flowcharts, scan the QR code or visit snp.com.au.

References:

1 Farnsworth A, Roberts J, Garland S, et al.Detection of high-grade cervical disease among women referred directly to colposcopy after a positive HPV screening test varies with age and cytology findings. *Int J Cancer.* 2020;**147**(11):3068–3074.
2 Roberts J, Machalek D, Farnsworth A, et al. Older women testing positive for HPV16/18 on cervical screening and risk of high-grade cervical abnormality. *Int J Cancer.* 2023;**152**(8):1593–1600.

Correct at time of printing | Mar 2025

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