COMPENDIUM

Answers to Participant Questions
HPV Triage: Enhancing Cervical Cancer Screening in Manitoba Webinar
October 22, 2021

CancerCare Manitoba
ActionCancerManitoba
BreastCheck CervixCheck ColonCheck

CANCERCARE MANITOBA WEBINAR COMPENDIUM

HPV Triage: Enhancing Cervical Cancer Screening in Manitoba

FRIDAY, OCTOBER 22, 2021, 12-1PM CST

Responses to Questions Asked by Webinar Participants
https://www.cancercare.mb.ca/screening/hcp/education

IMPLEMENTATION OF HPV TRIAGE

1. **When will we start HPV triage in Manitoba?**
    - In approximately 2 -3 months from the webinar (November 2021 – January 2022).

2. **Does HPV triage provide a tool to improve Cervical cancer screening rates in remote northern communities?**
    - Not specifically no. Triage in and of itself will not improve screening rates in Northern communities. Triage does help to pave the way for primary HPV testing (e.g. self-sampling). Activities we currently engage in to promote screening across Manitoba:
        - Invitation and recall letters
        - Social media
        - Advertising campaigns (radio, print, digital)

    If you would like support to brainstorm specific activities for your community, contact the Health Education Team at Screening@cancercare.mb.ca

RESULT MANAGEMENT

3. **45 y F ... 6 m ago ASCUS (No HPV test then) ... Now again ASCUS (HPV tests all negative) ===> go back to routine screening??? (Doesn't sound right)**
    - The algorithms for HPV testing do not become valid until implementation which will occur this winter. Once HPV triage is implemented, a patient who is age 45 and has an ASCUS cytology interpretation will have her sample tested for high-risk HPV. If the hrHPV test result is negative, then yes, she can return to routine screening. The HPV test is a DNA genotyping process that is very sensitive and overrides the cytology *interpretation*.

4. **Would absence of TZCs affect the HPV detection or you either have or not?**
    - Absence of TZ should not impact HPV detection. Insufficient cellularity is likely the only thing that would decrease HPV detection.

5. **What immunocompromised patient should do a pap yearly, says do in guidelines. What if never abnormal pap x 20 yes then on drug?**

Our Cervical Cancer Screening Learning Module states in chapter 3 on page 11:

Patient Characteristics	Management
Immunosuppressed or HIV positive. Immunosuppression is: o CD4 count of less than 400 in HIV-positive women, or o Transplantation with immunosuppressive therapy for more than 3 years	Screen every year **All** cytological abnormalities (including low-grade lesions) should be referred to colposcopy

6. **Just to clarify, under 30 yrs with LSIL or ASCUS, follow current guidelines with repeat Pap in 6 months?**
   - Correct.

7. **Why does someone who has had normal regular Pap tests and then will get a Pap come back with cancer? Can it progress that quickly?**
   - Cervical cancer is typically a very slow growing cancer. The Pap test is best at detecting squamous cell carcinomas/dysplasia, but not very good at detecting adenocarcinomas until they are quite advanced. If a patient has consistent negative results over a long period of time and suddenly presents with an invasive cervical cancer, it is more likely she has an adenocarcinoma. This is one of the benefits to HPV vaccination; it can help prevent adenocarcinomas.

8. **Why does someone get an abnormal Pap when in strictly monogamous relationship 15-20 years?**
   - If either partner has been infected prior to initiation of a monogamous relationship, HPV transmission can occur. It's also important to keep in mind that HPV transmission can occur without penetration, so if either person had **any** sexual contact (skin-to-skin contact between the oral, anal or genital areas), transmission may have occurred and remained in the body over decades. We may not be seeing Pap changes until many years after initial HPV infection

9. **If patient previous CIN2 has normal Pap x20 years, in monogamous relationship, do they need Q1 yr till 69?**
   - There is no evidence to state how long a person with a history of high-grade histopathology should continue with annual screening. After 15-20 years and an earnest conversation with the patient about the benefits and harms, a patient/provider may jointly determine to increase the interval to every 2 or 3 years. Remember the relationship is not the determining factor. Annual Paps are surveillance for RECURRENCE of HPV-mediated disease she had previously, not new disease.

10. **If patient had a hysterectomy and CIN3 is there a role for Pap test subsequent?**
    - Yes. A patient with a total hysterectomy and a history of CIN3 cervical histopathology should continue screening with annual vaginal vaults.

11. **I would like to clarify. If an individual was infected with HPV (type unknown) at age 20... they proceed with routine screening starting at age 21 with normal results and at age 35 have an abnormal pap (LSIL) it is possibly caused from the HPV exposure at age 20?**
    - Correct. There is no way to know from which partner a patient acquired their HPV infection.

12. **How often would you do cervical cancer screening for someone with oropharyngeal cancer (HPV related) (every one or three years) and would they be getting HPV reflex testing?**
    - A person with oropharyngeal cancer would not be screened more frequently for cervical cancer than a person at average risk for cervical cancer. The decision to triage a cytology result for HPV testing would follow the same pathway as explained in the webinar (patients 30 and over with an ASCUS result, patients 50 and over with an LSIL result). See the Screening Guidelines for average risk recommendations. HPV is spread by skin to skin contact primarily, so they may be at increased risk for anogenital HPV, but not necessarily, depending on their activities.

13. **I may have missed this, but if you have HPV 16 or 18 and "other hpv" positive --> do you follow as hr HPV +ve or is there other follow up?**
    - If HPV 16, HPV 18, or HPV Other are detected on an HPV test, the patient requires a referral to colposcopy by the specimen collector. There is no additional follow-up beyond the colopscopy referral. Once the patient is discharged from colposcopy, the patient would return to screening according the Screening Guidelines.

14. **If patient normal paps for 20 yrs, comes q 3 yr, then started methotrexate, do you need to do yearly, what is chance abnormal?**
    - Use of methotrexate is not sufficiently immunosuppressive to require annual cervical cancer screening.
      Reference: J Obstet Gynaecol Can 2019;41(8):1177−1180
      https://doi.org/10.1016/j.jogc.2019.03.005

15. **So just to clarify, with the second case study, she had a LSIL 8 months prior then ASCUS on her repeat, but because she was hrHPV negative she does not require colposcopy as would previously been done?**
    - Correct. The HPV test result is more sensitive than the Pap test and therefore overrides the cytology result.

16. What are recommendations for endometrial cells in 46 year old with monthly menses?

- See our Screening Guidelines; snapshot taken from applicable section:

Benign endometrial cells	If there is abnormal bleeding: Refer for endometrial biopsy. Less than 45 years of age: In the absence of abnormal bleeding, continue routine screening Equal to or greater than 45 years of age: Refer for endometrial biopsy, regardless of menstrual history.

17. Will this change RNs independently completing and managing cervical screening?

- No.

18. Does the referral go directly to Colposcopy? or would it still come from the Primary Care provider?

- The specimen collector will receive the patient result from the lab and be required to make the colposcopy referral. The process is unchanged.

19. Will primary care nurses and providers still be responsible for the referrals to colposcopy?

- The specimen collector, as prior to HPV testing, is responsible to make the colposcopy referral.

20. Is the info on 1yr vs. 3 yr routine screening in the pap testing info on the web site?

- Please see the Screening Guidelines and for more detail see the Cervical Cancer Screening Learning Module for Healthcare Providers (excerpt from chapter 3, page 10 below).

CLIENTS WHO REQUIRE INCREASED SURVEILLANCE

The following outlines patient characteristics that warrant increased surveillance and provides management recommendations for each of these characteristics.

Patient Characteristics	Management
Recent abnormal Pap test result	Follow up as per the CervixCheck Screening Guidelines "Management of Results"
***Previous high-grade cervical pathology result (≥HSIL/CIN2/moderate dysplasia)**	Screen every year *once discharged from colposcopy*. Screen annually until client meets the criteria to discontinue as per the CervixCheck Screening Guidelines.
Immunosuppressed or HIV positive. Immunosuppression is: ○ CD4 count of < 400 in HIV-positive women, or ○ Transplantation with immunosuppressive therapy > 3 years	Screen every year **All** cytological abnormalities (including low-grade lesions) should be referred to colposcopy
Exposure to diethylstilboestrol (DES) in utero	Screen every year with cytology and colposcopy of cervix and vagina
Previous endometrial cancer	Screening can be discontinued following a complete hysterectomy if patient has no history of high-grade cervical histopathology prior to cancer
Previous ovarian cancer	Screening can be discontinued following a complete hysterectomy if patient has no history of high-grade cervical histopathology prior to cancer
Previous cervical or vaginal cancer	Continue screening annually for as long as the client is biologically healthy

HPV VACCINATION

21. Can a 38 year old man with an HPV-associated squamous cell cancer of the oropharynx receive a provincially funded Gardasil vaccination? If not, should he pay for one?

- Criteria for eligibility criteria determined by Manitoba Health can be found on their website at: https://www.gov.mb.ca/health/publichealth/cdc/vaccineeligibility.html
- The last bullet under the HPV vaccine section talks about CancerCare Manitoba patients who are eligible to have their HPV vaccine costs covered by Manitoba Health, if felt to be appropriate by their oncologist.

22. **For individuals with hrHPV who have male partners who are outside of the vaccine eligibility criteria, is there any role for additional screening for their male partners given the prevalence of HPV associated oropharyngeal cancer in males?**
    - Unfortunately, there are no organized screening programs for male HPV-related cancers. Males should consider getting vaccinated against HPV. Some healthcare plans do provide some vaccination coverage.

LABORATORIES

23. **Do you think that ASCUS will be "called" more by cytotechnologist and pathologist more due to the reflex HPV testing that will be added to the testing?**
    - The diagnosis of ASCUS requires some cytomorphologic abnormality in the squamous cells. Having significant increase in the rate of ASCUS is unlikely, but we will monitor or diagnostic criteria after implementation and compare them to the pre-implementation numbers.

24. **Will the testing now take longer to provide us with results?**
    - Lab results may take slightly longer than previous cytology processing alone, however, the benefit to the provider and patient is that there will be ONE report complete with the cytology interpretation and HPV test result. Note: HPV testing will impact approximately 3,000 women annually.

25. **What lab will be performing HPV testing? Cytology or Microbiology Lab?**
    - HPV testing will be performed by trained personnel in an accredited lab.

26. **What is the anticipated affect on turn-around time of results due to batching of samples for HPV testing?**
    - As discussed above, the expected slight increase in turnaround times will only impact a fraction of cases. As the processes will be established and polished after implementation, the turnaround time increase can be minimized.