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What Fewer OB/GYN Visits Mean for Cervical Cancer Screening in Primary Care Settings

Dr. Allen:
Do your patients see their OB/GYN annually? Well, unless you are that OB/GYN, you may be surprised to hear that most patients do not, and the percentages are somewhat staggering. So, how can primary care physicians, or PCPs, ensure that these women still receive appropriate preventative care, such as cervical cancer screenings?

Welcome to Women's Health Update on ReachMD. I am your moderator, Dr. Renee Allen, and here to highlight how PCPs can actually screen for cervical cancer in their practice setting is Dr. Amy Clouse, Associate Director of the Family Medicine Residency Program at Abington-Jefferson Health.

Dr. Clouse, welcome to you.

Dr. Clouse:
Thanks so much for having me today, Dr. Allen.

Dr. Allen:
So, Dr. Clouse, let's begin with a review of the current guidelines for cervical cancer screening, which, as I understand, there is a fair amount of confusion over best practices. What can you tell us about these guidelines and how they interact or how they overlap?

Dr. Clouse:
The 3 main organizations that publish cervical cancer screening guidelines are the American College of Obstetricians and Gynecologists, the American Society for Colposcopy and Cervical Pathology, and the United States Preventive Service Task Force. They all agree that cervical cancer screening should start at age 21, unless the woman is immunocompromised. This is due to the very low risk of cervical cancer in this age group, which is less than about 0.1%, which turns out to be about 1 to 2 cases of cervical cancer per one million women in the 15 to 19 age group.

In the age group 21 to 29, women should be tested with a PAP test alone every 3 years. Co-testing, or doing a pap test along with a test for high-risk HPV is not recommended in this age group. One, because of the high prevalence of the high-risk HPV in this age group, and also because of the low incidence of cervical cancer.

In the 30 to 65 age group, the 2012 guidelines recommended two options for cervical cancer screening: either with cervical cytology alone every 3 years, or with co-testing every 5 years. However, recently we've seen a change in these guidelines. In August of 2018, the United States Preventive Service Task Force published guidelines that for women in this age group 30 to 65, they now recommend a third option that we can do high-risk HPV testing alone every 5 years as an alternative for screening with a pap test every 3 years alone, or screening with the combination of the cytology or high-risk HPV testing every 5 years. This was based on data from both clinical trials and cohort studies showing that there's now strong evidence for the effectiveness of high-risk HPV testing used alone as a cervical cancer screening test. The American College of Obstetricians and Gynecologists, and the American Society for Colposcopy and Cervical Pathology, have both endorsed this guideline from the United States Preventive Service Task Force.

So now we have three options in this age group: cervical cytology alone every 3 years, high-risk HPV testing alone every 5 years, or co-testing every 5 years. We can stop screening for cervical cancer at age 65 in women who have evidence of adequate negative screening tests and who have no history of CIN2 or higher. Adequate negative screening is defined as three negative cytology results consecutively or two negative co-test results within the previous ten years.

Dr. Allen:
All right, Dr. Clouse, let's consider these recommendations from the primary care standpoint specifically. In your experience, what role do PCPs have in cervical cancer screening, especially in those situations where patients may not be seeing their OB/GYN on a regular basis?

Dr. Clouse:

Well, as I mentioned above, those intervals between Pap smears have really increased. We used to think that you'd go to see your OB/GYN every year, but now that interval may be 3 or 5 years, so I think that PCPs have a huge role in cervical cancer screening, first in knowing the guidelines, and to also recommend the Pap smear when it's appropriate, and often to even perform that Pap smear for patients who may not be going to their OB/GYN.

Dr. Allen:
And in your personal practice, what kind of screening do you find most useful and why?

Dr. Clouse:
So, in my practice I do perform Pap smears, and I use the Pap test in conjunction with high-risk HPV testing, either as triage in the under age 30 age group or as co-testing for the 30 to 65 age group, and I do this because I am following the guidelines, and I've seen through that following the guidelines makes the most sense for cervical cancer screening and to catch all cervical cancers early in the precancerous stage.

Dr. Allen:
Well, for those just joining us, this is Women's Health Update on ReachMD. I am your ReachMD host, Dr. Renee Allen, and joining me to explore how primary care clinicians can get more involved in cervical cancer screening is Dr. Amy Clouse.

Dr. Clouse, we've gotten a better sense of the role of screening in primary care settings from the first half of this interview. But I want to cover some of the barriers that are out there as well. First off, we know that some PCPs are hesitant to add cervical cancer screening for various reasons, one being not to step on the toes of their OB/GYN colleagues. Do you encounter any reluctance among your peers, and if so, how do you address it?

Dr. Clouse:
Well, I don't know that it's necessarily reluctance among my peers. I think it's more that we sometimes forget to address the issue of cervical cancer screening thinking that it's in our OB/GYN colleague's realm, so I think that the issue is more about reviewing a patient's history and knowing when to recommend that Pap smear. The idea of cervical cancer screening can sometimes get lost amid a primary care provider's busy agenda of also talking about colon cancer screening or breast cancer screening, so I think it's just important that when the intervals are 3 and 5 years, that we keep track of that and not forget when to recommend that again.

Dr. Allen:
Another obstacle I think that's facing PCPs is that they might not know how or when to bring the subject

up with their patients. Can you share any tips you've learned for adding these conversations into your patient visits?

Dr. Clouse:
I think that, one, at a health maintenance visit, reviewing all of the health maintenance topics that we would go over with patients, so like when I might talk about it's time to order your mammogram, let me also review when was the last time that you had a Pap smear. That's easy. But also, if a patient's not regularly coming in for a health maintenance visit, it also should be a primary care doctor's responsibility to look at all of their health maintenance, so periodically to look at Pap smears, mammograms, or colon cancer screening, for example. To just go back and to have some sort of a trigger in your chart to look back on cervical cancer screening I think is probably the most important thing. For me, I keep a little tab at the bottom of my electronic medical record that reminds me to ask about all of the health maintenance issues, even if it's not a health maintenance visit.

Dr. Allen:
Dr. Clouse, before we wrap up, do you have any other thoughts or recommendations you'd like our listeners to take with them into their practice?

Dr. Clouse:
Well, now that we know that the human papilloma virus is the cause of cervical cancer, I think that it's important to remember that because HPV is so incredibly common and easily transmitted, but also so transient, it's important that we know the guidelines for cervical cancer screening and also to use the high-risk HPV testing in our practices if we are performing cervical cancer screening in our offices.

Dr. Allen:
This has been, I think, a great look into how women's healthcare and preventative screening is becoming a joint responsibility for OB/GYNs and primary care clinicians alike. Many thanks to Dr. Amy Clouse for joining me today. Dr. Clouse, it was so great having you on the program.

Dr. Clouse:
Thank you, Dr. Allen. I really appreciate the opportunity.