VCS Pathology

Leaders in HPV & cervical screening

Australian Centre for the Prevention of Cervical Cancer

The National Cervical Screening Program:

Key information for Health Professionals

Contents

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Overview: The National Cervical Screening Program

The National Cervical Screening Program (NCSP) is for screening of HPV vaccinated and unvaccinated ASYMPTOMATIC women and people with a cervix who have ever had any form of sexual activity. It also provides advice about the investigation of symptomatic patients.

Key Messages

- Start screening at age 25.
- Finish screening with a negative exit test from age 70-74.
- 5 yearly primary Human Papillomavirus (HPV) testing with partial genotyping and Liquid-Based Cytology (LBC) triage.
- Routine screening participants have the option to screen using a self-collected vaginal sample or a clinician-collected cervical sample for HPV testing, accessed through a healthcare provider in both cases.
- Patients at any age with symptoms of post-coital, post-menopausal, or persistent unexplained inter-menstrual bleeding are eligible for diagnostic co-testing (both HPV and LBC), regardless of when their last cervical screening test was performed.

Test procedures:

All Cervical Screening Tests (CSTs), either clinician-collected or self-collected involve:

- A primary test for 14 oncogenic HPV types known to be associated with the development of invasive cervical cancer.
- Partial genotyping to separately identify oncogenic HPV types 16 and 18 which cause ~70-80% of cervical cancer and 12 other oncogenic HPV types known as oncogenic HPV (not 16/18).
- Triaging with LBC for any cellular changes caused by infection with oncogenic types of HPV (not 16/18) to determine follow-up and management.

Clinician-collected Cervical Screening Tests

A clinician-collected CST is an HPV test. If HPV is detected, reflex LBC is undertaken on cervical cells in the liquid-based sample. This is known as reflex Liquid Based Cytology (LBC). The laboratory will carry out LBC without requiring a specific request from you.

To take a cervical sample: insert a speculum, visualise the cervix and sample from the transformation zone, using appropriate sampling devices. Transfer the cellular material into an LBC medium, such as ThinPrep.

HPV self-collection

A self-collected sample is taken from the vagina (not the cervix) and is tested for the presence of HPV. Recent evidence shows a CST using a self-collected vaginal sample is as accurate in detecting HPV and biopsy confirmed cervical intra-epithelial neoplasia (CIN) 2+ as a clinician-collected sample taken from the cervix during a speculum examination.

Self-collected samples cannot be used for LBC. To ensure patients can make an informed choice about their method of screening, they should be advised that, occasionally, they may need to return for another appointment for a clinician-collected cervical sample for LBC triage if some types of HPV are detected in their sample. For more information, refer to the *Health Professional's Guide: self-collection of HPV samples* on page 12.

Self-collection removes a significant barrier to participation in screening and may be a more acceptable option for those who have never screened or are overdue or those who are anxious about the procedure.

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Key result recommendations

- Participants in whom HPV is not detected, from either a clinician-collected or self-collected sample, should re-screen in 5 years.
- Participants with oncogenic HPV types 16 /18 detected should be referred directly for colposcopy. This should occur without the need to return for LBC prior to colposcopy if the original sample was self-collected and irrespective of reflex LBC results if the specimen was clinician-collected.
- Participants in whom other oncogenic HPV types (not 16/18) are detected in their clinician-collected sample will be triaged according to the reflex LBC result and screening history.
- Participants in whom other oncogenic HPV types (not 16/18) are detected in their self-collected sample will be recommended to return for a clinician-collected cervical sample for LBC. Triage will be based on the LBC results and screening history.
- Participants with an unsatisfactory CST result (HPV or LBC) should return for a repeat HPV or LBC, as relevant.

Clinical enquiries

- VCS Pathology provides a free Clinical Advisory Service for healthcare practitioners.
- For any clinical enquiries, please contact VCS Pathology:
    - Ph: (03) 9250 0300 or 1800 611 635 (toll free)
    - Email: liaisonteam@acpcc.org.au

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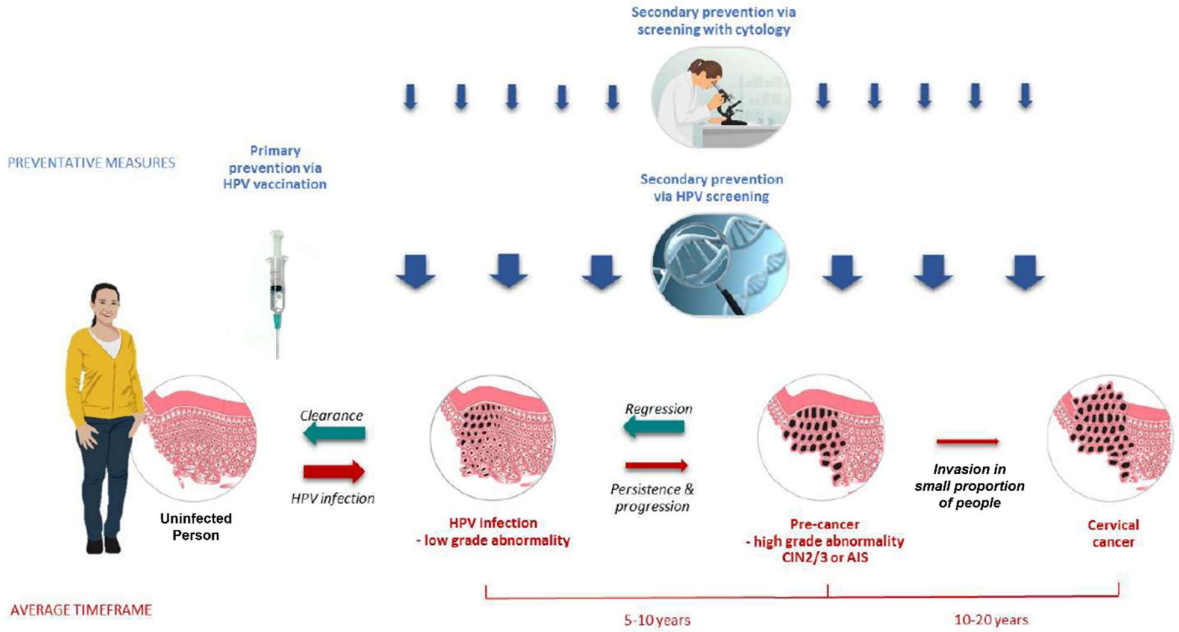
Background: HPV and cervical cancer

- HPV is critical in the pathogenesis of cervical cancer and the risk of developing cancer increases significantly with persistent HPV infection.
- Genital HPV infection is usually transient and most often asymptomatic. Genital HPV infections are transmitted mainly by skin-to-skin or mucosa-to-mucosa contact during intimate sexual contact. It is highly contagious, and most people acquire infection within a few years of becoming sexually active.
- There are about 40 genital HPV types, 14 are classified as oncogenic as they are associated with anogenital cancer, including squamous and adenocarcinoma of the cervix. HPV types 16 and 18 cause 70- 80% of cervical cancers.
- However, while HPV is an extremely common genital infection, anogenital cancer is a rare outcome because most infections are cleared and progression from any persistent infection to invasive cervical cancer is generally slow.
- The immune system clears the virus within one to two years in the ~90% of those with genital HPV infection.
- Persistent infection with oncogenic HPV (especially type 16) is associated with a significantly elevated risk of developing high grade cellular abnormalities of the cervix.
- It is estimated that persistent HPV infections and pre-cancer are established within 5-10 years from less than 10% of new infections. Invasive cancer occurs rarely in a small portion of patients with pre-cancer over decades.
- Cervical HPV infection is common in young sexually active women and people with a cervix, however HPV vaccination has resulted in a reduction in the prevalence of vaccine preventable HPV (16/18) infections which are associated with ~70% of cervical cancers.
- After the introduction of vaccination, Australia experienced rapid falls in rates of cervical infections with vaccine targeted oncogenic HPV types 16 & 18, in anogenital warts associated with HPV 6 & 11 infections, and in histologically confirmed high grade intraepithelial lesion (HSIL).
- Vaccination to include a further 5 oncogenic HPV types began in 2018. The impact is yet to be felt as these people have not yet reached screening age.



This illustration has been adapted from Schiffman M 2005

Figure 1: HPV to cervical cancer

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HPV testing is safe and effective

Starting to screen at age 25 is safe

- Cervical cancer is extremely rare in people under 25. Screening people aged under 25 years regularly since 1991 has had no impact on the incidence and mortality of cervical cancer in this age group. Notably the main impact of the program has been on the rate of squamous cancer in women aged 25 years and older.
- The changing cervical screening environment was prompted by the impact of HPV vaccination. HPV vaccine coverage in Australia was reported as 80.5% of females and 78% of males by the age of 15, having received the full course of HPV vaccine in 2020. The benefit of the HPV vaccine includes documented reductions in the prevalence of cervical pre-cancerous lesions now extending to people in their late 20s.
- The International Agency for Cancer Research (IARC) recommends that cervical screening commence at age 25 at the earliest, because *'there is minimal benefit and substantial harm in screening below age 25*'.
- This approach will reduce the harms associated with screening younger participants, in particular, by reducing the side-effects of over-investigation and treatment including pain, bleeding and infection. Evidence links treatment of the cervix with a small, but important increased risk of preterm delivery. Therefore, the later age to commence screening protects women from long term complications associated with future pregnancies because of over diagnosis and treatment.
- **Patients at <u>any age</u> with symptoms suggestive of cervical cancer (post-coital, post-menopausal, or persistent unexplained intermenstrual bleeding) should have a co-test (diagnostic cytology and HPV testing) and appropriate referral.**
- Young women and people with a cervix who commence sexual activity prior to 14 years of age and who did not receive the HPV vaccine before sexual debut, could be considered for a single HPV test on an individual basis between the ages of 20-24 years, if requested.

Screening every 5 years is safe and effective

- Several studies have demonstrated the significant increased sensitivity of the HPV test, as compared to cytology, and have shown that the likelihood of developing a significant cervical abnormality, cervical intraepithelial neoplasia grade 3 (CIN 3) or cervical cancer within 5-6 years of a negative HPV test is low and less than the likelihood of developing cervical intraepithelial neoplasia grade 3 (CIN 3) or cancer within two years of a negative Pap test.
- There is a large body of evidence demonstrating that HPV-based screening provides greater protection against the development of invasive cervical cancers (including both squamous cell carcinoma and adenocarcinoma) than cytology-based screening, even when HPV testing is performed at longer screening intervals.
- Eligible screening participants should be assured that a five-yearly CST is safer and more effective than a two-yearly Pap test.
- Participants with a negative CST result should be told that they are extremely unlikely to develop a significant abnormality of the cervix or cancer in the next five years, at which time they will receive a reminder to return for repeat screening.
- Participants should be advised to see their healthcare practitioner if they experience any unexplained symptoms during the screening interval such as unusual vaginal bleeding, pain or discharge, even if the last screening test was normal.

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Patient education: Explaining HPV to patients

Tips

- Normalise the infection: HPV has been referred to as the 'common cold of sexual activity'.
- Avoid using terminology such as 'pre-cancerous' and 'oncogenic' as it causes anxiety and is usually inaccurate.
- If you have any queries, please call VCS Pathology on 03 9250 0300

Key messages

- Most patients with genital HPV will not develop high-grade cervical abnormalities, as the virus usually clears by itself. However, when cervical cancer occurs, HPV is found in the majority (>90%) of cases.
- Some types of HPV may be more difficult for the body to clear naturally.
- Long-term infection with these HPV types can increase the risk of high-grade cervical abnormalities, which may lead to the development of cervical cancer, if untreated.
- Screening is necessary for all woman and people with a cervix who have ever had any form of sexual contact, even if they are not currently sexually active.

What is genital HPV?

- HPV is a virus that is passed on by genital skin-to-skin contact during sex.
- **It is extremely common in people who have had intimate sexual contact.**
- Some types of (non-oncogenic) HPV cause genital warts, but most HPV infections do not cause any symptoms at all.
- HPV is usually cleared by the body's immune system in less than two years.
- Occasionally HPV remains inactive in cells and can be re-activated in later life. **HPV infections identified in testing may not have been recently acquired.**

HPV transmission

- The virus enters the body through tiny breaks in genital skin; it is not spread via blood.

Treatment of HPV

- Treatment of the virus itself is not needed nor available. The body's immune system usually clears the infection.
- Antibiotics do not treat HPV infection.

HPV and sexual history

- People can have HPV for a long time without ever knowing. It may have been acquired many years ago.

Condoms and HPV

- Condoms offer limited protection against HPV as they do not cover all the genital skin. However, they do provide excellent protection against infections such as chlamydia, gonorrhoea, and HIV, and are recommended in new sexual relationships.

Young sexually active women and people with a cervix should see their Health Professional for:

- A chlamydia test each year
- Contraceptive advice for heterosexual and bisexual patients.

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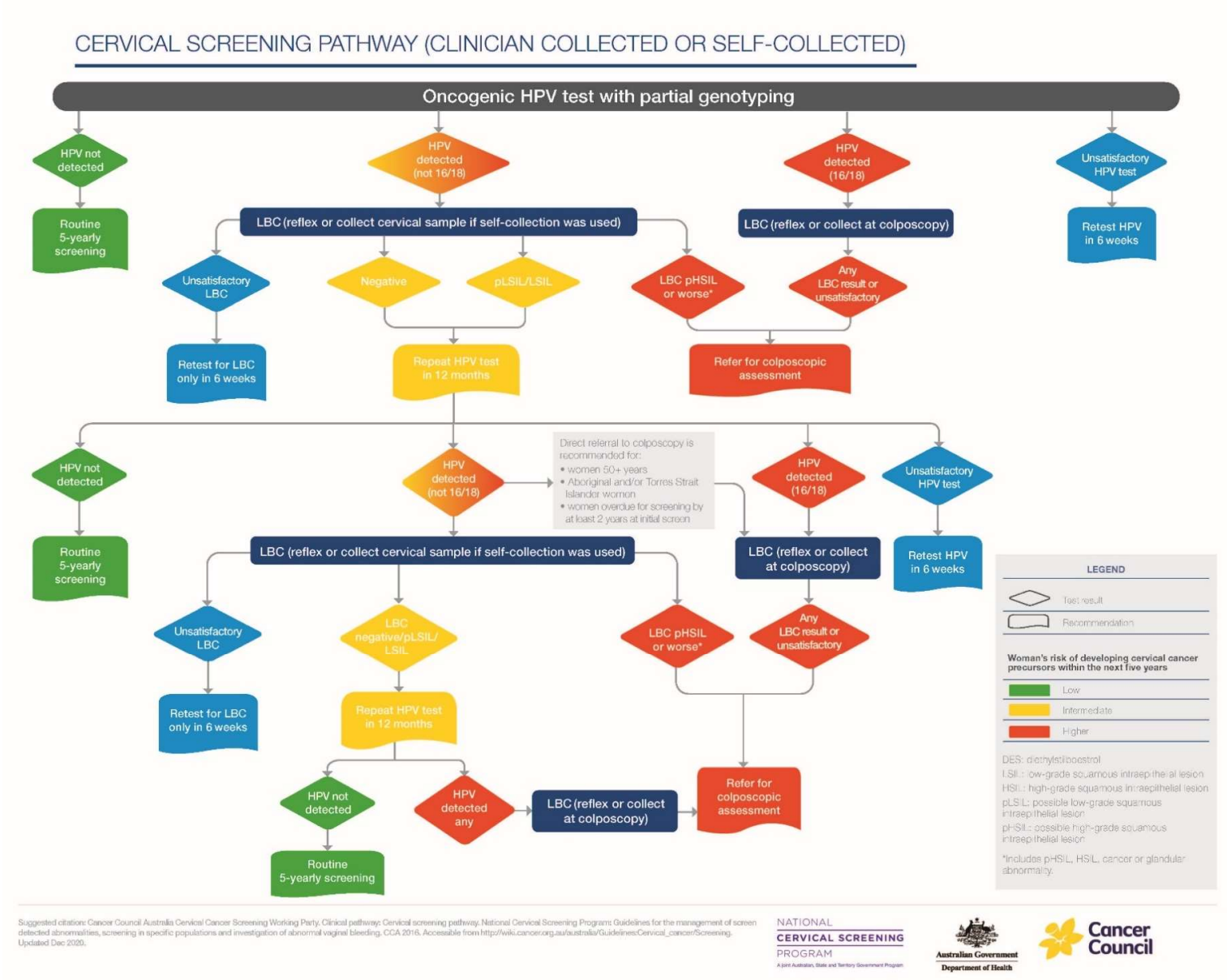
Desktop aid: A risk-based approach to managing asymptomatic screening participants

Risk of significant cervical abnormality	Cervical Screening Test (CST) result	Recommended management
Low	Oncogenic HPV not detected	Routine 5-yearly CST
Risk not yet assigned	Oncogenic HPV detected (not 16/18) on self-collected sample	Recall for clinician-collected cervical sample for LBC
Intermediate risk	Oncogenic HPV detected (not 16/18) with negative, possible LSIL or LSIL LBC	Repeat CST in 12 months
	Oncogenic HPV again detected (not 16/18) at 12-month follow-up test, with negative, possible LSIL or LSIL on LBC	Repeat CST in another 12 months (24 months after initial test)* *Exclusions to this recommendation: - Aboriginal and/or Torres Strait Islander - >50 years of age - Overdue by > 2 years at the time of the initial test
Higher	Oncogenic HPV (16/18) detected with any/no LBC result	Refer for colposcopic assessment regardless of cytological result
	Oncogenic HPV (16/18) detected with unsatisfactory LBC	Refer for colposcopic assessment regardless of cytological result (if self-collected sample, no need to recall for cervical sample for LBC)
	Oncogenic HPV detected (not 16/18) detected with possible HSIL or HSIL on LBC	Refer for colposcopic assessment at the earliest opportunity, ideally within 8 weeks
	Oncogenic HPV detected (any type) with glandular abnormalities including adenocarcinoma-in-situ on LBC	Refer to a gynaecologist with expertise in suspected malignancies or a specialised gynaecological oncologist
	Invasive squamous cell carcinoma (SCC) or adenocarcinoma	Refer to a gynaecological oncologist or gynaecological cancer centre for urgent evaluation, ideally within 2 weeks
	HPV detected (any type) in a patient with immune deficiency	Refer for colposcopic assessment regardless of cytological result (if self-collected sample, no need to recall for cervical sample for LBC)
	Oncogenic HPV (any type) persisting at 12-month follow-up following initial oncogenic HPV (not 16/18) if patient is: - Aboriginal and /or Torres Strait Islander - >50 years of age - Overdue by > 2 years at the time of the initial test.	Refer for colposcopic assessment regardless of cytological result
	Oncogenic HPV (any type) persisting at 24-month follow-up test after previous HPV detected (not 16/18)	Refer for colposcopic assessment regardless of cytological result (no need to recall for cervical sample for LBC if self-collected specimen)
Unsatisfactory	Unsatisfactory (invalid) HPV	On a clinician-collected sample - repeat sample in 6 weeks On self-collected sample - repeat sample at earliest convenience
	Oncogenic HPV detected (not 16/18) with unsatisfactory LBC	Repeat only LBC in 6 weeks after dealing with any remediable problem



https://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening

Instructions: Taking an effective cervical sample

Sampling instruments


Cervical sampler broom


Cervex-Brush Combi


Endocervical brush


Plastic Spatula

Sampling technique

For pre-menopausal patients

Choose between:

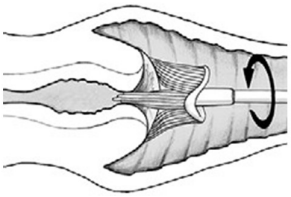
- **Cervical sampler broom**: rotate 3–5 times plus (optional) **Endocervical brush**: insert ensuring that you can see the lower row of the bristles and make a quarter rotation.
- **Cervex-Brush Combi**: insert central part of the brush into the os and rotate clockwise twice.
- **Spatula**: rotate 1 or 2 times, taking care to keep contact with the ecto-cervix plus **Endocervical brush**: insert ensuring that you can see the lower row of the bristles and make a quarter rotation.

For peri and post-menopausal patients

Choose between:

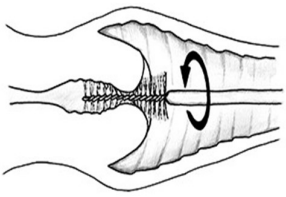
- **Cervical sampler broom**: rotate 3–5 times plus **Endocervical brush**: insert ensuring that you can see the lower row of the bristles and make a quarter rotation.
- **Cervex-Brush Combi**: insert central part of the brush into the os and rotate clockwise twice.
- **Spatula**: rotate 1 or 2 times, taking care to keep contact with the ecto-cervix plus **Endocervical brush**: insert ensuring that you can see the lower row of the bristles and make a quarter rotation.
- Use endocervical brush after using broom or spatula due to the possibility of bleeding caused by the brush compromising the quality of the ectocervical sample.

Cervical sample broom



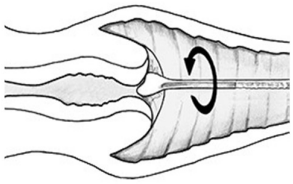
- Clockwise
- 3-5 times ensuring lateral bristles fan out

Endocervical brush



- Clockwise
- ¼ turn is sufficient

Plastic Spatula



- Clockwise
- 1-2 times well applied to ectocervix

Lubricants

- Have the potential to interfere with the quality of screening tests.
- Should be water soluble and carbomer-free.
- Acceptable lubricants may change due to product availability or manufacturing issues. Check with your laboratory if you are unsure whether you are using a suitable lubricant.
- Apply a small amount (the size of a five-cent piece or smaller) to the outer portion of the speculum taking care to avoid the tip of the speculum.
- Luke-warm water to warm and lubricate the speculum presents the least risk to the quality of the sample.

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Transferring cellular material into a ThinPrep vial

Cervical sampler broom or Cervex-Brush Combi

- Rinse the broom/brush as quickly as possible into the vial by pushing the broom into the bottom of the vial 10 times, forcing the bristles apart.
- As a final step, swirl the broom vigorously to further release material.
- Do not leave any part of the sampling device in the fluid for ThinPrep.

Spatula (Plastic)

- Rinse the spatula as quickly as possible into the vial by swirling the spatula vigorously in the vial 10 times.
- Do not leave any part of the sampling device in the fluid for ThinPrep.

Endocervical Brush

- Rinse the brush as quickly as possible in the solution by rotating the device in the solution 10 times while pushing against the vial wall.
- Swirl the brush vigorously to further release material.
- Do not leave any part of the sampling device in the fluid for ThinPrep.

Don't forget!

- Tighten the cap so that the black line on the cap passes the black line on the vial.
- Record the patient's surname, first name and date of birth on the vial.
- Or apply ID label.
- Record the patient's information and relevant medical history on the request form.

* Images supplied by Hologic (Australia) Pty Ltd

Note:

SurePath samples:

Instruments should be broken off and left in the vial.

Pregnancy

Do not use the endocervical brush or Cervex-Brush Combi.

Video:

For a detailed demonstration of instruments and correct sampling technique, please watch our: 'Taking a Cervical Screening Test - Instructional Video'

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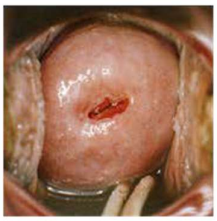
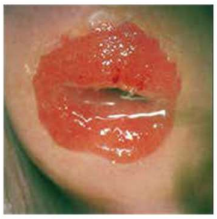
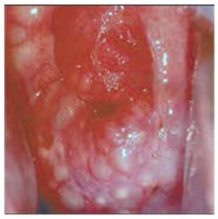
Visual Reference: Cervix Reference Card

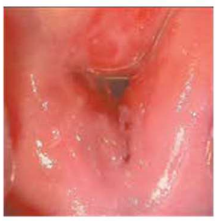
This aid will assist you to identify a range of cervical appearances when undertaking a clinician-collected Cervical Screening Test. If you are uncertain about the appearance of the cervix, we recommend you seek a second opinion.

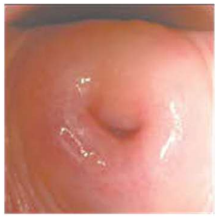
Further investigation not required in asymptomatic women


Nulliparous[1]

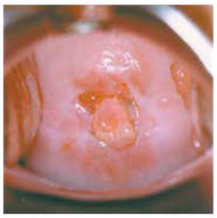

Eversion / ectropion[2]

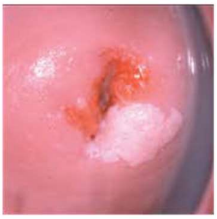

Nabothian follicies


Multiparous

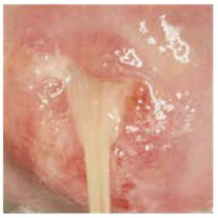

Atrophy

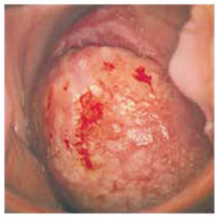
Consider further investigation


Polyp

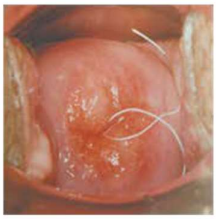

Cervical wart

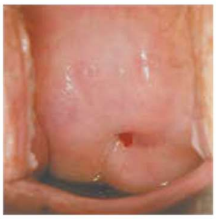
Should be investigated

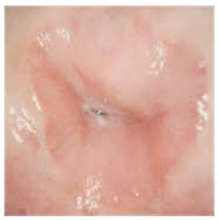

Mucopurulent discharge[3]


Cancer[2]

Post-intervention - further investigation not required in asymptomatic women


Intra Uterine Device (IUD)


Stenosis


Post treatment[2]

Reproduced with permission from:
1 Wolfendale, Margaret, 1995. Taking Cervical Smears. British Society for Clinical Cytology: page 12.
2 Burghardt, Erich, 1984. Colposcopy Cervical Pathology Textbook and Atlas. Georg Thiem Verlag. Germany: pages 162 & 174.
3 Cartier, René, 1984. Practical Colposcopy. Laboratoire Cartier. Switzerland: page 168.

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Health Professional's guide: self-collection of HPV samples

Key points

- Self-collection is a vaginal swab taken for HPV testing, containing vaginal, not cervical cells.
- LBC cannot be performed on this sample.
- **Self-collection can be offered as an option for all routine cervical screening participants**, and at other points in the cervical screening pathway where only an HPV test is required.
- **A self-collected vaginal sample is as accurate as a clinician-collected sample taken from the cervix during a speculum examination for the detection of HPV** and biopsy confirmed cervical intra-epithelial neoplasia (CIN) 2. Self-collected samples also yield partial genotyping information, separately identifying HPV (16/18) and other types of HPV (not 16/18).
- Healthcare practitioners still need to offer a consultation for cervical screening, whether it be a self-collected or clinician-collected sample.
- It is the responsibility of the requesting healthcare practitioner to facilitate patient access to, and return of, self-collected samples, requesting tests from laboratories (including identifying the sample as self-collected on the pathology request form) and communicating results and any follow-up requirements to patients.
- The patient does not need to be observed while taking a self-collected test. However, a healthcare practitioner can assist the patient to take a vaginal sample with the patient's permission - this is still considered self-collection.
- Self-collection should be offered in a clinic setting wherever possible as sample collection is considered more likely in this context. However, self-collection may occur in other settings at the discretion of the requesting healthcare practitioner and with the recommended self-collection device.
- If HPV is detected on a self-collected vaginal sample, depending on the type of HPV detected, the patient will need to return for a clinician-collected cervical sample for LBC testing, or referral to a specialist.
- The laboratory report will be sent to the practitioner, not the participant.
- Self-collection allows all eligible participants to have the option to take their own vaginal sample for HPV testing, removing a significant barrier to participation in screening. It is an effective tool to engage participants, who are lapsed or never screened, into the screening program.
- There are some groups that are less likely to screen, including Aboriginal and/or Torres Strait Islander people, culturally and linguistically diverse communities, people who identify as LGBTQ+ or are intersex, people with disability, people who have experienced sexual violence, post-menopausal women and people who have had previous negative cervical screening experiences. Self-collection may be more acceptable to individuals in these groups.
- **Self-collection is suitable for use in pregnancy** – check with your pathology provider to make sure they can process samples taken during pregnancy.

To be eligible for self-collection a participant must:

- Be aged between 25-74 and due or overdue for cervical screening.
- Not need a co-test for any reason.

Self-collection is not appropriate for some people, such as those who:

- Have symptoms suggestive of cervical cancer (post-coital, post-menopausal or persistent unexplained inter-menstrual vaginal bleeding, or persistent unexplained unusual vaginal discharge).
- Are undergoing Test of Cure surveillance or have been treated for adenocarcinoma-in-situ (AIS).
- Have had a total hysterectomy with history of high-grade squamous intraepithelial lesion (HSIL) and require Test of Cure.
- Have been exposed to diethylstilbesterol (DES) in utero.

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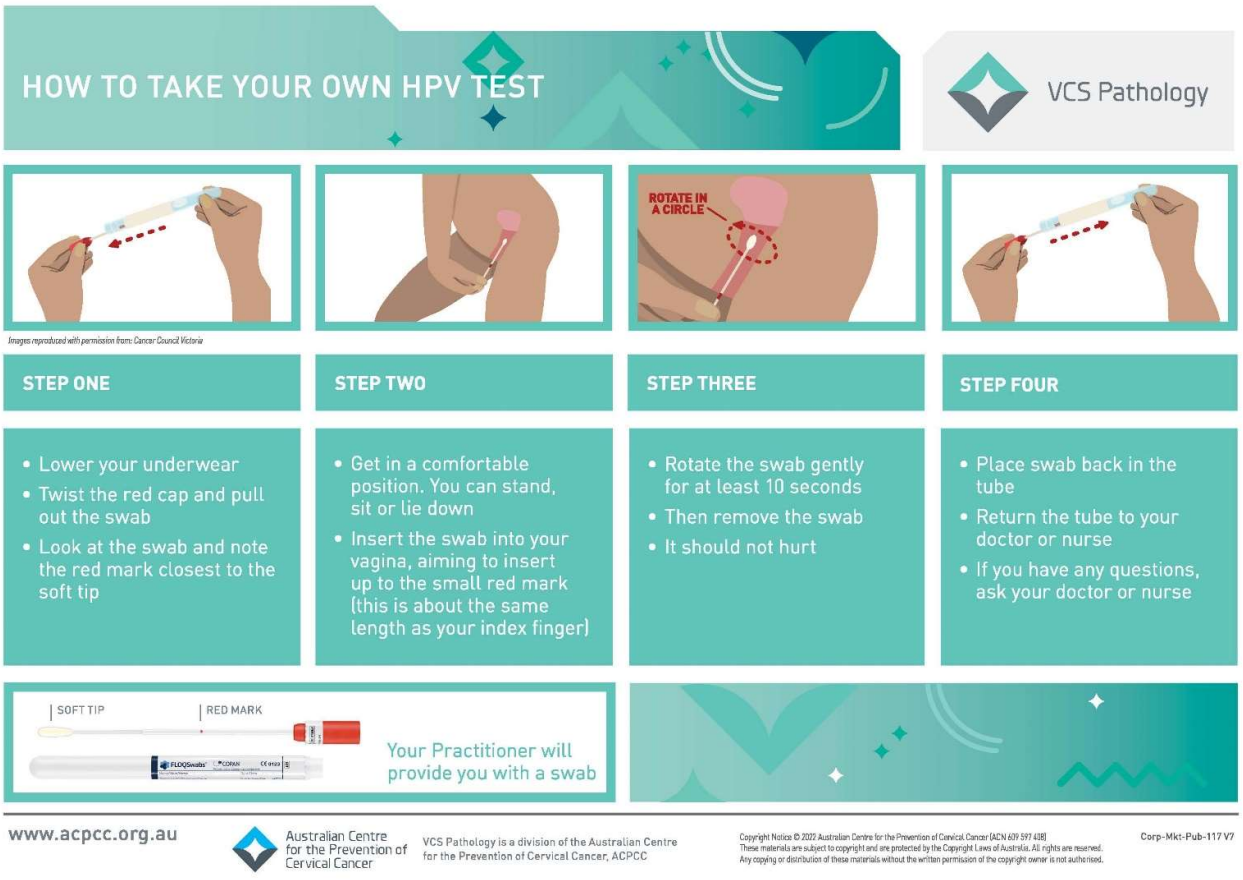
Tips for supporting patients to take a self-collected HPV test

- **Healthcare practitioners are best placed to talk with their patients about cervical screening to determine the best option of testing for their patients.**
- Patients who have never screened or are lapsed screeners and those who are anxious about cervical screening may find self-collection a more acceptable option.
- Reassure participants in a sensitive and culturally appropriate manner about the test, use a visual guide (enclosed) to explain how the test is done.
- Use in language instructions where possible – VCS Pathology has self-collection instructions available in 20 languages on the ACPCC website
- Reassure the patient that the test is easy to do. Show them the sampling device, describing the soft-tip and red mark, indicating they should insert the swab up to the red mark and rotate for 10 seconds.
- Tell the patient that taking the sample should not hurt.
- Provide clear information on the pros and cons of both screening options (including possible follow-up requirements if HPV is detected using self-collection) to support informed decision-making by the patient.
- Discuss and document the patient's preferred method for receiving test results and how they will be followed up if HPV is detected.



VCS Pathology self-collection instructions, available at www.acpcc.org.au/practitioners/resources/

Management of self-collection results

Oncogenic HPV not detected on self-collected sample:

- Patients who do not have oncogenic HPV detected should be told their risk of developing cervical cancer is low.
- These people will be invited to re-screen in 5 years. Add a recall for a CST in 5 years.

Oncogenic HPV detected on self-collected sample:

- A small number of patients will have oncogenic HPV detected. These patients should be contacted by the practice to tell them that further investigation is required and to arrange a follow-up visit at their earliest convenience.

HPV (16/18) detected

- For patients with oncogenic HPV (16/18) detected, refer for colposcopy. This should not be delayed. There is no need for the patient to return for a clinician-collected sample for LBC. The cervical sample for LBC will be obtained by the colposcopist at the time of colposcopy.

HPV (not 16/18) detected

- For patients with oncogenic HPV (not 16/18) detected, recall the patient to collect a sample from the cervix for LBC. Explain to the patient that the LBC result will guide further management.
- If the LBC result is negative, possible LSIL or LSIL, the patient should be recalled in 12 months for a repeat HPV test.
- If the LBC result is possible HSIL, HSIL or any glandular abnormality, refer to colposcopy, preferably within 8 weeks.

Self-collection pathology providers

There is a range of collection devices and methods available for use under the National Cervical Screening Program for self-collected samples. As a result, different pathology laboratories may have varying collection and handling instructions and requirements.

Check with your pathology provider to:

- confirm that they can process self-collected samples, or
- confirm that they can refer self-collected samples to an accredited laboratory, if necessary, and
- order the correct collection device and other consumables for offering self-collection, and
- confirm any collection, handling and transport requirements.

The most commonly used self-collection swab is the Copan 552C.80 dry flocked swab (red topped). Depending on the pathology provider these swabs will be either:

- delivered dry to the laboratory for processing, or
- re-suspended into a ThinPrep vial at the time of collection, with the vial then delivered to the laboratory for processing.

Check with your pathology provider to find out about collection and handling requirements for self-collected samples.

Copan 552C.80 dry flocked swab, red-topped

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VCS Pathology

Leaders in HPV & cervical screening

Cervical screening options: Supporting your patient to make the choice

VCS Pathology has produced this handy guide for healthcare practitioners bringing together the information needed to support your patients to make an informed choice about their screening method. This is available to download from the ACPCC website.

<table>
<tr><th></th><th>Clinician-collected cervical sample</th><th>Self-collected vaginal sample</th></tr>
<tr><td>Is it accurate?</td><td colspan="2">Both methods have equivalent sensitivity for the detection of HPV and CIN2+/AIS[1,2]</td></tr>
<tr><td>Identifies HPV infection?</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Is liquid-based cytology (LBC) and co-testing possible?</td><td>Yes</td><td>No</td></tr>
<tr><td>Indicated for
• Those who are eligible and due or overdue for cervical screening, including during pregnancy
• Other points in the pathway where only an HPV test is required.</td><td>Yes</td><td>Yes</td></tr>
<tr><td>• Patients who have postcoital or intermenstrual bleeding, post-menopausal bleeding, or unexplained persistent unusual vaginal discharge[3]
• Those undergoing Test of Cure surveillance or have been treated for adenocarcinoma-in-situ
• Patients who have had a total hysterectomy with history of high-grade squamous intraepithelial lesion
• Patients who were exposed to diethylstilbesterol in utero.</td><td>Yes</td><td>No</td></tr>
<tr><td>Management of participants in whom HPV is not detected >90%</td><td>Return in 5 years</td><td>Return in 5 years</td></tr>
<tr><td>Management of participants in whom HPV (not 16/18) is detected ~6%</td><td rowspan="2">Reflex LBC performed on original sample, no need to return for a further sample to be taken</td><td>Return for clinician-collected cervical sample for LBC.
The incidence of HPV (not 16/18) is highly age dependent.
NCSR data[4]
<table>
<tr><td>25-29 years</td><td>17%</td><td>50-54 years</td><td>4%</td></tr>
<tr><td>30-34 years</td><td>10%</td><td>55-59 years</td><td>3%</td></tr>
<tr><td>35-39 years</td><td>6%</td><td>60-64 years</td><td>3%</td></tr>
<tr><td>40-44 years</td><td>5%</td><td>65-69 years</td><td>3%</td></tr>
<tr><td>45-49 years</td><td>4%</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td></td><td>Patients aged 70 to 74 with HPV (not 16/18) detected are referred to colposcopy.</td></tr>
<tr><td>Management of participants in whom HPV (16/18) is detected ~2%</td><td>Refer for colposcopy</td><td>Refer for colposcopy</td></tr>
<tr><td>Management of Unsatisfactory HPV test</td><td>Repeat in 6 weeks</td><td>Repeat at earliest convenience</td></tr>
</table>

1 Arbyn et al, Detecting cervical precancer and reaching underscreened women by using HPV testing on self samples: updated meta-analyses BMJ 2018; 363 :k4823
2 Saville et al, Analytical performance of HPV assays on vaginal self-collected vs practitioner-collected cervical samples: the SCoPE study, Journal of Clinical Virology (2020), doi: https://doi.org/10.1016/j.jcv.2020.104375
3 Co-testing is not required for breakthrough or irregular bleeding due to hormonal contraception or a sexually transmitted infection, heavy menstrual bleeding, or contact bleeding at time of obtaining a routine cervical screening test sample
4 Smith et al, BMJ 2022;376:e068582 Available at: https://www.bmj.com/content/376/bmj-2021-068582

Summary: Chlamydia testing in the context of the NCSP

1. All people who have ever had sex should be tested for Chlamydia (*Chlamydia trachomatis*) every twelve months until the age of 30. After age 30 test selectively according to risk or request.
2. Testing for Chlamydia can be done on specimens taken for the NCSP (note that testing for Gonorrhoea (*Neisseria gonorrhoeae*) can also be undertaken in this way if clinically indicated.)
3. When undertaking cervical screening in women and people with a cervix who are also eligible for a Chlamydia test you can either:
    - take a cervical sample and transfer it to the liquid based medium and request a CST and Chlamydia
    - organise for a self-collected vaginal swab to be taken and request a CST self-collected and Chlamydia (if referring to VCS Pathology).

      For other pathology providers make sure you check whether they are able to test for chlamydia using the same swab. Some laboratories may not be able to perform Chlamydia testing on the same self-collected vaginal swab taken for the NCSP, and a separate swab may be required.
4. FPU (first pass urine) is an alternative test for Chlamydia (although vaginal or cervical samples are preferred). FPU does not need to be the first of the day and it does not matter when they last passed urine. Get the sample when your patient is there.
5. For further details on diagnosis, management and follow-up check the current Australian guidelines:
    - https://sti.guidelines.org.au/sexually-transmissible-infections/chlamydia
6. For details on contact tracing requirements, refer to the Australasian Contact Tracing Guideline – Chlamydia:
    - https://contacttracing.ashm.org.au/chlamydia

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