FAMILY PLANNING PROGRAM

# BREAST AND CERVICAL CANCER SCREENING PROTOCOLS

**Effective Date: January 1, 2021**

## CERVICAL CANCER SCREENING

The Michigan Department of Health and Human Services (MDHHS) Family Planning Medical Advisory Sub-Committee supports the use of cervical cancer screening recommendations, endorsed by the American Cancer Society (ACS) and the United States Preventive Services Task Force (USPSTF) for all Title X funded agencies.
For the follow-up of abnormal Pap test results, the Family Planning Program will follow the American Society for Colposcopy and Cervical Pathology's (ASCCP) 2019 Updated Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors. Cervical follow-up care guidelines (2019 ASCCP Cervical Risk-Based Management Guidelines) are found at: https://www.asccp.org/mobile-app

## I. PAP SCREENING RECOMMENDATIONS

A. Screening Tests
- Pap test and speculum exam should be used for routine cervical cancer screening.
- Testing for cervical cancer is performed using either Liquid-Based Cytology or Conventional (slide) Pap test (no difference in screening interval is recommended). Consideration should be given to the use of High-Risk Human Papillomavirus (HR-HPV) testing in conjunction with cervical cytology for screening clients 30 years of age and older.

B. Age to Initiate Screening:
- Screening for cervical cancer should begin at age 21
- Guidelines for clients-aged 21-24 years can be extrapolated to adolescents inadvertently screened. For example: If a transfer-in client under 21 years of age, was inadvertently Pap tested, and the Pap test was normal, follow screening interval as recommended for ages 21-24.

C. General Information
- The need for cervical cancer screening should not be the only basis for the onset of gynecological care.
- Adolescents must be able to obtain appropriate preventative health care, including, but not limited to, an assessment of health risks, counseling for pregnancy and sexually transmitted disease (STD) prevention, contraception, and treatment of STD's; even if they do not need a Pap test.
- For the purpose of these guidelines an adolescent is defined as 20 years of age or younger.
- Adolescents and young clients who have received the HPV vaccine should continue cervical cancer screening according to the current guidelines.
- Pelvic exams (speculum and bimanual) on clients 13-20 years of age are no longer required unless medically indicated.
- Pelvic exams on clients 21-39 should be performed at least at the time of routine pap testing and in-between if medically indicated.

- If a Pap test is satisfactory and negative but no endocervical cells are present, regular screening should be continued. “Regular” means according to cervical cancer screening guidelines.
- If a Pap test is satisfactory and negative but obscured/partially obscured by inflammation, repeat Pap test in 6 months.
- If the Pap test is unsatisfactory, repeat Pap test in 2-4 months. If second Pap test is unsatisfactory and/or abnormal, refer for colposcopy.
- For Chlamydia STD screening and testing (when a pelvic exam is not indicated) CDC guidelines call for use of urine testing or vaginal self-swab instead of a pelvic exam and endocervical sample may be used. (Based on availability of urine kits.)
- Clients aged $\geq$40 should have a reproductive health visit which may include an annual bimanual pelvic and speculum exam.

D. Recommendations for Cervical Cancer Screening:

| Age to Begin | Screening Exam | Screening Interval | Additional info |
|---|---|---|---|
| Age 21-29 | Conventional Pap Test OR Liquid Based Cytology (LBC) | Every 3 years (pap test alone) | HPV testing is unacceptable for screening ages 21-29 |
| Age 30-64 | Pap test alone | Every 3 years (pap test alone) | |
| Age 30-64 | HPV AND Cytology “co-testing” | Every 5 years | |
| Age 30-64 | HPV-HR test alone | Every 5 years | |

Co-testing (Pap and HPV) is recommended for cervical cancer screening in clients 30 years of age or older. If both tests are negative, testing then occurs every five years.
Cervical follow-up care provided for clients are according to the 2019 ASCCP Cervical Risk-Based Management Guidelines. https://www.asccp.org/mobile-app

**Title X funds may be used for HPV testing in accordance with the 2019 ASCCP guidelines.**

E. Relative Contraindications for Pap Testing: (Temporary Deferral)
   a. Heavy menstrual bleeding
   b. Clients less than 8 weeks post-partum (vaginal delivery) or 8 weeks post-abortion.
   c. Visible cervical mass with bleeding—refer
   d. Pandemic considerations for deferral-See Attachment “ASCCP Interim Guidance”

PLEASE NOTE: Pap testing should not be deferred if vaginal discharge or signs and symptoms of vaginal infection are present.

## II. CLIENT INFORMATION/EDUCATION

A. Regular cervical cancer screening (Pap test) is viewed as an important component of routine preventive care. Screening (via patient history) and testing for sexually transmitted infections, if indicated, should occur at the annual visit even if cervical cancer screening (Pap test) is not done.

B. Discuss the importance of Pap testing which includes:
- Frequency of Pap testing is based on recommendations from a nationally recognized professional organization**,** a client's age and Pap test history.
- Possible testing for STD.

C. Clients may be given copies of their Pap test and/or HPV test results.

## III. MANAGEMENT OF CLIENTS WITH SPECIAL CONDITIONS

A. Special Considerations:
- Clients with a histologically-confirmed HSIL (colposcopy results of ≥CIN2), whether or not they receive treatment, continue cervical cancer screening (Pap test) on a regular basis every 3 years for 25 years, screening may go beyond age 65.
- Changes in cervical screening guidelines are for the general population and do not address clients who are immunocompromised (e.g., infection with the human immunodeficiency virus).
- Clients who had in utero DES exposure continue annual cervical cancer screening (Pap test only) regardless of the testing method indefinitely.

B. Provision of Screening and Diagnostic Services for Family Planning Clients with Abnormal Pap Test Results
- Clients age 21-39 years of age seen in any Family Planning/Title X clinic that have an abnormal Pap test result requiring colposcopy can be referred to Breast and Cervical Cancer Control Navigation Program (BC3NP) for diagnostic services to confirm or rule out a cervical cancer diagnosis.
- Clients age 40-64 seen in Family Planning/Title X Clinics for cervical services may be referred to BC3NP for breast screening and diagnostic services (if needed), depending on agency caseload.

## IV. MANAGEMENT OF ABNORMAL PAP TEST RESULTS

A. Follow-up Process for Abnormal Pap test Results:
- Clinicians should develop and implement a tracking system that will notify clients of cervical screening results and follow-up diagnostic testing that is required. A method of contacting clients without violating their confidentiality must be established at the first visit.
- Documentation should be maintained in the medical record of all phone calls and letters to clients. If the pap results are HSIL, AGC, Squamous CC, or AIS and the client cannot be contacted, a certified letter should be sent to the client.
- Title X requires that all clients with an abnormal pap be notified within 6 weeks of obtaining the Pap test. Please note that the collaborative relationship with the Michigan BC3NP requires that the colposcopy be completed within 90 days of performing the pap test, therefore it is recommended that follow-up be initiated as quickly as possible.

B. Clinical Management of Pap Testing Results

- **NORMAL** cervical cytology with **ABNORMAL** appearance of the cervix
  Notify the client of the results of the pelvic examination and possible implication. This information should include the nature of the suspected disease.
  - To rule out cervical cancer, refer immediately for colposcopy with biopsy as indicated. Do not rely on cervical cytology results alone.
- **UNSATISFACTORY** cervical cytology specimen
  Repeat Pap smear in 2-4 months. If second Pap test is unsatisfactory and/or abnormal, refer for colposcopy.

- **ABNORMAL** cervical cytology report
  Notify the patient of the results of the Pap test and its implications as soon as possible but within 6 weeks of receipt of abnormal findings, including:
  - The nature of the suspected disease
  - What a precancerous lesion is
  - The need for further testing for definitive diagnosis before treatment
  - Treatment options available, benefits and risks of each

  Refer/arrange for repeat Pap test and/or diagnostic work-up and treatment based on Pap test results.

- **FOLLOW-UP OF ABNORMAL CYTOLOGY RESULTS**:
  Cervical follow-up care provided for clients are according to the 2019 ASCCP Cervical Risk-Based Management Guidelines. https://www.asccp.org/mobile-app

## V. ADDTIONAL INFORMATION

Indications for Referral

- Treatment for CIN2+
- Pregnant client with HSIL cytology
- A significant cervical lesion
- Client desiring fertility who, after excisional treatment, have recurrent or persistent cervical dysplasia
- Two “unsatisfactory for evaluation” tests 2-4 months apart
- AGC (Abnormal Glandular Cells) or AIS (Adenocarcinoma in situ) on cytology.
- Any gynecologic cancer should be referred to a Gynecologic Oncologist

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_______________________________________________Date__12/10/20______

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Reviewed/Revised 2021

## BREAST CANCER SCREENING

The Michigan Department of Health and Human Services Family Planning Medical Advisory Committee supports the use of breast screening recommendations, endorsed by the American Cancer Society (ACS), American College of Obstetricians and Gynecologists (ACOG), the National Comprehensive Cancer Network (NCCN) Breast Cancer Screening and Diagnosis Guidelines and the United States Preventive Services Task Force (USPSTF) for all Title X funded agencies.

### I. CLINICAL BREAST EXAM AND MAMMOGRAM RECOMMENDATIONS

A. Clinical breast exam (CBE) beginning at age 25 thru 39 must be offered and/or provided at least every three years even if no cervical cancer screening is performed. For clients age 21 and over, with suspicious breast masses, refer to BC3NP or to client's provider of choice for evaluation.

B. Clinical breast exam must be offered and/or provided annually starting at age 40. Refer to BC3NP or to client's provider of choice for suspicious breast masses for evaluation and management.

C. Mammogram recommendations:
- Age 40-64 at Average Risk for Breast Cancer: Annual screening mammogram (See Table 1)
- Age-25-64 at High-Risk for Breast Cancer: Screening based on client's risk factors (See Table 2)

### II. CLINICIAN GUIDELINES FOR FOLLOW-UP OF ABNORMAL BREAST CANCER SCREENING RESULTS

**A.** Breast Follow-up of abnormal CBE results (clients≥25), see NCCN Clinical Practice Guidelines in Oncology for Breast Cancer Screening and Diagnosis**.** http://www.nccn.org

B. Diagnostic services required for clients as follow-up of an abnormal breast finding or imaging result are according to the NCCN Breast Cancer Screening and Diagnosis Guidelines**.**

C. Abnormal Mammogram/Ultrasound results must be managed by BC3NP or referral to breast care provider of client's choice.

**References:**


1. American Cancer Society (ACS).
2. American College of Obstetricians and Gynecologists (ACOG)
3. United States Preventive Services Task Force (USPSTF).
4. American Society for Colposcopy and Cervical Pathology's (ASCCP)
5. NCCN Clinical Practice Guidelines in Oncology: Breast Cancer Screening and Diagnosis NCCN.org
6. The 2019 Updated Consensus Guidelines for the Management of Abnormal Cervical Screening Tests and Cancer Precursor.


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______________________________ Date __12/10/20__________

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**Table 1:**

**Breast Cancer Screening Recommendations for Average Risk Women**

| Agency Recommendation | Exam | Interval | Age to Begin | Additional Information |
|---|---|---|---|---|
| **NCCN (2018)** | Screening Mammogram (Consider tomosynthesis) | Annual | ≥ 40 | • Clinical encounter (includes risk assessment/risk reduction and Clinical Breast Exam)<br>• Breast awareness (clients should be familiar with their breasts and promptly report changes to their provider)<br>• A clinical breast exam alone is NOT considered breast cancer screening. |
| | Clinical Breast Exam (as part of the clinical encounter) | 1-3 years | 25-39 | |
| | | Annual | ≥ 40 | |
| **ACS (2015)**<br><br>S (Strong Recommendation)<br>Q (Qualified Recommendation) | Screening mammogram | Annually (S) | 45-54 | Yearly exams should continue as long as client is in good health and life expectancy ≥ 10 years |
| | | Biannual or Annual (Q) | ≥ 55 | Clients should have the opportunity to begin annual screening between the ages of 40 and 44 years |
| | CBE | Not Recommended | NA | |
| **USPSTF (2016)** | Screening Mammogram | Biennial | 50-74 | B rating: The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. |
| | | ≤ 50 | Personal decision when to start and how often | C rating: The decision to start regular biennial screening mammogram before the age of 50 should be an individual one and take client's context into account, including client values regarding benefits and harms |
| | | ≥ 75 | | Insufficient evidence – No Recommendation |
| | CBE | Not Recommended | | Insufficient evidence – No Recommendation |

**Table 2:**

**Breast Cancer Screening recommendations for Women at Increased Risk (NCCN 2018)**

| Breast Risk Factors | Exam | Interval | Age to Begin |
|---|---|---|---|
| Personal History of Breast Cancer | CBE | Annual | Post Diagnosis |
| | Mammogram | Annual | |
| Prior thoracic radiation therapy between ages of 10-30 (Current age ≥ 25) | Clinical encounter (to include CBE) | 6-12 months | Begin 10 years after radiation therapy |
| | Screening Mammogram consider tomosynthesis | Annual | Begin 10 years after radiation therapy but not prior to age 30 |
| | MRI | Annual | Begin 10 years after radiation therapy but not prior to age 25 |
| Women who have a lifetime risk >20% as defined by models largely dependent on family history (e.g. Claus, BRCAPRO, BOADICEA, Tyler-Cuzick) Consider referral to genetic counseling if not already done | Clinical encounter (to include CBE) | 6-12 months | Begin when identified as at increased risk |
| | Screening Mammogram 6 months apart from MRI (Consider tomosynthesis) | Annual | Begin 10 years prior to the youngest family member but not prior to age 30 |
| | MRI – 6 months apart from mammogram | Annual | Begin 10 years prior to youngest family member but not prior to age 25 |
| Women >/=35 with 5-year Gail Model risk of invasive breast cancer >/= 1.7% | CBE | 6-12 months | Begin when identified as at increased risk by Gail Model |
| | Screening Mammogram Consider tomosynthesis | | |
| Women who have a lifetime risk ≥ 20% based on history of LCIS or atypical ductal or lobular hyperplasia | CBE | 6-12 months | Begin post diagnosis LCIS or ADH/ALH |
| | Screening Mammogram Consider tomosynthesis | Annual | Begin post diagnosis LCIS or ADH/ALH but not prior to age 30 |
| | MRI (Consider) | Annual | Begin post diagnosis LCIS or ADH/ALH but not prior to age 25 |
| Known genetic predisposition (i.e., BRCA1/2, p53, PTEN) or other gene mutation | CBE | 6-12 months | Age 25 |
| | Mammogram Consider tomosynthesis | Annual | ≥ Age 30 |
| | MRI | Annual | ≥ Age 25 |

Additional Information

1. All recommending societies recognize the benefit of regular mammography screening for breast cancer.
2. Clients should be familiar with the known benefits, limitations, and potential harms associated with breast cancer screening.
3. Breast Awareness: Clients should be familiar with how their breast normally look and feel and report any changes to their provider right away.

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