Cervical Cancer Screening
Clinician Guide

Introduction
These recommendations were adopted from the USPSTF 2012 Screening for Cervical Cancer guideline. This guideline is intended to assist primary care physicians and other health care professionals in the screening for cervical cancer in adult women.

Population
These recommendations apply to women who have a cervix, regardless of sexual history. These recommendations do not apply to women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (such as those who are HIV positive).

Recommendations

Younger than 21 years
- In women younger than age 21 years, do not screen for cervical cancer.

Ages 21–29 Years
- In women ages 21 to 29 years, screen for cervical cancer with cytology (Pap smear) every 3 years.
- In women younger than age 30 years, do not screen for cervical cancer with HPV testing (alone or with cytology).

Ages 30–65 Years
- In women ages 30 to 65 years, screen for cervical cancer with cytology every 3 years or co-testing (cytology/HPV testing) every 5 years.

Older than 65 years
- In women older than age 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer, do not screen for cervical cancer. ¹

Women with Hysterectomy
- In women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (cervical intraepithelial neoplasia [CIN] grade 2 or 3), do not screen for cervical cancer.

¹ In women with no history of cervical dysplasia or adenocarcinoma, adequate prior screening is defined as 3 consecutive negative cytology results or 2 consecutive negative HPV results within 10 years before cessation of screening, with the most recent test occurring within 5 years. Due to the low risk of progression to cancer in women older than 65 years, screening should not resume after cessation, even if a woman reports having a new sexual partner. Women with a history of CIN 2, CIN 3, or adenocarcinoma in situ should continue screening for a total of 20 years after spontaneous regression or appropriate management of CIN 2, CIN 3, or adenocarcinoma in situ, even if it extends the screening past age 65 years.
<table>
<thead>
<tr>
<th>Recommendation Language</th>
<th>Strength*</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start, initiate, prescribe, treat, etc.</td>
<td>Strong affirmative</td>
<td>Provide the intervention. Most individuals should receive the intervention; only a small proportion will not want the intervention.</td>
</tr>
<tr>
<td>Consider starting, etc.</td>
<td>Weak affirmative</td>
<td>Assist each patient in making a management decision consistent with personal values and preferences. The majority of individuals in this situation will want the intervention, but many will not. Different choices will be appropriate for different patients.</td>
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<tr>
<td>Consider stopping, etc.</td>
<td>Weak negative</td>
<td>Assist each patient in making a management decision consistent with personal values and preferences. The majority of individuals in this situation will not want the intervention, but many will. Different choices will be appropriate for different patients.</td>
</tr>
<tr>
<td>Stop, do not start, etc.</td>
<td>Strong negative</td>
<td>Do not provide the intervention. Most individuals should not receive the intervention; only a small proportion will want the intervention.</td>
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</tbody>
</table>

*Refers to the extent to which one can be confident that the desirable effects of an intervention outweigh its undesirable effects.

**DISCLAIMER**

This guideline is informational only. It is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners, considering each patient’s needs on an individual basis. Guideline recommendations apply to populations of patients. Clinical judgment is necessary to design treatment plans for individual patients.