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HPV Asked & Answered: US and Global Screening FAQs

Narrator:
Welcome to CME on ReachMD. This activity titled, HPV Asked & Answered: US and Global Screening Frequently Asked Questions, is provided by Omnia Education. This activity is supported by an independent educational grant from Roche Diagnostics.
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Here's your host, Dr. John Russell.

Dr. Russell:
As the field of women's heath accommodates change after change in cervical cancer screening recommendations, questions on the respective options, their strengths and limitations, and the societies that advocate them come up all the time. On today's program we are going to try to address the top HPV and cervical cancer FAQs, hitting our desk in conference events from around the country.
This is CME on ReachMD and I'm Dr. John Russell. Joining me to help answer pressing questions on cervical cancer screening from our audience is Dr. Warner Huh, Director and Professor in the Division of Gynecology Oncology at the University of Alabama at Birmingham.
Dr. Huh, welcome to the program.

Dr. Huh:
Thanks for having me.

Dr. Russell:
We as clinicians now being faced with new USPSTF recommendations for cervical cancer screening, what would you say are some of the key messages that you and I as clinicians should take away from these recommendations?

Dr. Huh:
That's a good question, these recommendations are draft recommendations, so they're not finalized by the United States Preventative Services Task Force, and we'll know probably in the next 6 months or so whether or not they're final, but the main takeaways from that draft recommendation is that they still continue to recommend a Pap screening or cytology screening every 3 years starting at 21 years of age, but the key change is that primary HPV testing really kind of replaces co-testing, which is really the combination of Pap smears and HPV tests together starting at 30 years of age. So, this is a pretty marked change, from their last recommendations in which they gave co-testing an A recommendation.

Dr. Russell:
So Dr. Huh, looking in what's happening in the rest of the world, how are these new recommendations differ from what's happening in other countries, or are we suddenly falling in line?

Dr. Huh:
No. This is actually pretty consistent with the rest of the world, and so, if you look at other parts of the world that have sort of well-established screening programs, including Western Europe, the UK, Australia, Canada, that there's clearly a move towards primary

HPV testing, and there's a recognition of a couple things, one of which is that Pap smears or cytology clearly serve their purpose in terms of reducing the morbidity, the mortality, and even the incidence of cervical cancer worldwide, but we have reached a point where I think that Pap smears are no longer the preferred screening test because of its limited sensitivity, and because disease rates have plummeted, in particularly countries that are well-screened, but this is really consistent with what we are seeing in the rest of the world.

Dr. Russell:
So, here in the United States, historically, we have gone through so many different recommendation updates, from cervical cancer screening with Pap cytology alone, to primary screening with HPV testing alone, to combinations with Pap cytology, aka co-testing, and now, potentially, back to screening using primary HPV testing without co-testing or Pap cytology. So, you can really see how there's a lot of questions for the clinician on the street. Clearly different societies are providing us with different recommendations, but a number of women's health practitioners are asking why we should think that the USPSTF amongst all these recommendations has it right? How would you respond to that?

Dr. Huh:
I mean that is probably the fundamentally most important question in this interview. Do they have it right? I mean, unfortunately it's unknown. I think a couple of things for the listeners to recognize is that, yes, it's extraordinarily confusing, and as someone who has been somewhat centrally involved in the screening recommendations, I even acknowledge as a practitioner that it's confusing; but the reason it's confusing is that we have collected a substantial amount of data information, not only in the US, but worldwide, about how to best screen women now, but also in the future. You know, a couple things, and one I mentioned already is that there is no question, at least in my mind, that we need to be pushing towards a screening strategy that includes HPV. It is clearly a much better screening test than cytology or Pap alone.
The thing about the task force recommendations is that, you know, some of us, including myself, you feel that perhaps the interval may be too long, and that they recommend screening every 5 years. The main primary HPV screening study and modeling study in the United States was done really after 3 years, and so it's unclear whether or not 5 years is the appropriate interval, and I know firsthand that many groups and individuals have gone back to the task force with concerns regarding that interval. The other thing is that much of the space on modeling data, and even though that modeling data has greatly informed past screening recommendations, including the recommendations from the American Cancer Society in 2012, it's modeling, and the problem with modeling is what endpoint that you use, and I don't want to get into the weeds with the listeners with this interview, but some people may not agree with the endpoint. One of the endpoints is the reduction of the rate of colposcopy. I know that some of us, including myself, don't feel that maybe that's really the most appropriate endpoint. I think the bottom line is that most of us, and many people who are experts in this area, agree that we just definitely need to be shifting towards an HPV-based screening strategy. The big question is how do we do that and how do we do that in a way that providers aren't confused, that they screen appropriately, and then we obviously educate them and their patients on the value of using an HPV based screening strategy.

Dr. Russell:
So, applying these new recommendations to our patients, we have a lot of patients who we've really helped them become educated, to come much more frequently for testing, and suddenly we are telling them they don't have to be tested so often. So, how do you address that with your patients in the office?

Dr. Huh:
That's a great question. If you ask patients, they very well might want to be screened more often even though it might put them at additional risk for unnecessary testing and procedures; that's something that the patient individually may want to consider. I mean, what I'll say is this, is that I think that that's an entirely appropriate discussion to talk about screening intervals and which test to use between the provider and the patient, and again, and I think this is an area where I think many of us recognize that as we make screening recommendations going forward, it's going to be critical for us to incorporate patient input and their opinions on how often to be screened.
So again, I personally don't have a problem, let's say if a woman wants to be screened slightly more frequently. Where I do have a problem is when we do stuff that is completely non-evidence based, it puts the patient at considerable harm, like for instance, using HPV testing every single year; that makes no sense whatsoever.
So, for the listeners again, I think that this is a reasonable discussion to be had between the patient and the provider, that if they want to screened more often they just need to be told what those risks are. The other thing that the patients need to be made aware of is that increased screening may not be covered by their insurance carrier or their payer, and so there may be some additional outpatient costs associated with that.

Dr. Russell:
So, we just discussed that there might be some patients out there who may refuse that primary HPV testing. What do you see as some

of the other barriers to adoption of primary HPV testing for cervical cancer screening, and how do you foresee us addressing this in our office-based practices?

Dr. Huh:
Well, you know, I think the greatest barriers to adoption is at the provider level, and so, our providers, depending on which generation that you trained in, they are all aware that Pap cytology has been enormously successful as a screening test for the prevention of cervical cancer, you could argue probably for all cancers; and so, the greatest challenge that I have is teaching providers about why we should be thinking about HPV? You know, why we should be thinking about it because, one, that we know that disease rates will only go down further, particularly in the area of HPV vaccinations. So, all these young girls that we have been vaccinating since 2006, well many of them are actually hitting the screening age, and it's been fully anticipated that their disease incidence will drop, and the question is how do we effectively screen them? I don't think you will find a single expert, or many experts in the world or the United States, that will argue that Pap cytology by itself will be an effective screening strategy for these women. So, it's about education for the provider.
I think other barriers are reimbursement. I know that I have heard from many providers across the United States that reimbursement for this hasn't really caught on with many of the commercial payers in the United States; and then another issue is triage. You know, so how do we address the abnormal HPV test and once they have been triaged, maybe they have disease, what's the surveillance strategy for these patients? In other words, how do we follow these patients? Do we follow them differently now that we've sort of taken cytology out of the equation? And so, really for the listeners what I'm concerned about is if the task force recommends primary HPV testing, our treatment guidelines will then no longer fully mesh with these new guidelines, and then we'll have to go back and re-modify our treatment guidelines. But, during that short period of time there's going to be a little bit of uncertainty how to best manage these patients. You know, the other thing is that in terms of showing patients and providers the value of primary HPV testing, I think we need to go to specific examples or case studies or where certain countries, like Australia, who have considerable vaccination rates in their female population, have seen enormous, amazing drops in disease incidence in their female patient population really since the advent of the vaccine. So, again, I think the bottom line is that is revolves around education and acceptance, but it is amazing to me if you will spend the time to properly educate providers, they immediately grasp at the value of why primary HPV testing, or any HPV screening strategy's worth.

Dr. Russell:
So, doctor, could I follow up on a couple of things you mentioned? So with regard to the HPV vaccination, how do you foresee the impact of us having a widely vaccinated population on the sensitivities or Pap cytology in primary HPV testing respectively?

Dr. Huh:
There is no question that HPV vaccination is going to drop disease rates in this country and worldwide, and as a consequence, given the already known limited sensitivity and positive predictive value of Pap cytology, that will only get worse and more pronounced if providers continue to screen with cytology alone; and what that means and what that translates to is that, that basically, if you do a Pap and it is read out as normal, that result may not be correct, and in reality you might be missing disease. Now, similar arguments can be made about potentially sensitivity reductions in terms of HPV testing, because again, these disease rates will drop, but I think you talk to most people and they feel that that incremental drop is a lot less, much, much less than it is for Pap cytology, and so, if there is a reason for why we need to think about now about switching our screening strategy, it's purely because of this HPV vaccination phenomenon. We know that we'll need to continue to screen women over the next many decades. I'm hoping that screening goes away entirely with HPV vaccination, but the bottom line is Pap cytology by itself eventually will not cut it; and what I anticipate in the next 5 years, potentially, is that cytology by itself will go away entirely, because we'll recognize that, yes, it served its purpose, it was a fantastic screening tool, but looking at contemporary needs, that cytology will fall well short of what we are looking for.

Dr. Russell:
And doctor, can I ask you to bring a little clarity to another topic, HPV genotype testing. So, how should the clinician who gets HPV genotype testing back, how should they triage those results? You know, who needs follow-up, who needs a procedure, and whether this testing will require us to have all kinds of different follow-up time intervals for our patients?

Dr. Huh:
That's a great question. You know, surprisingly, all of our recommendations focus on high risk HPV, which includes 13 or 14 types. They are called high risk not because of high risk behavior, they are called high risk because epidemiologically they have a much higher risk of developing cervical cancer with those types, but what we have learned is of those 13 or 14 types, all those types are not created equal; and so the next iteration of looking at high risk HPV would be looking at specific types, and over the last 5 or 6 years we have looked specifically at types 16 and 18. And so, what we know now is that there are certain "high risk types" that where patients can clearly be followed. They don't need a specific intervention, but then there are other types, like type 16 particularly, or type 18, maybe some other ones like 31 or 33, that are clearly much higher risk in terms of developing pre-cancer and cancer, and those patients might need a more immediate evaluation or even treatment down the road. And so, what we're learning is that we are actually able to risk

stratify women who are high risk HPV positive into those pools in which they carry a very high risk, they carry a relatively low risk, and they carry intermediate risk. And so, what I think you're going to see in the treatment recommendations probably in the next 3 to 5 years, is that we further risk-stratify women who are high risk HPV positive, and so that's a marked change in terms of how we manage over the last decade.
I could never have said that 10 years ago, but because of all the data that we've aggregated from multiple studies, we know that the risk profile is different depending on which HPV type you have. I think the most fundamental important message to understand is that type 16 is the most common type, but it is also the worst actor of all of them. In women who are persistently positive for 16, those women have a considerable risk of developing cervical pre-cancer and cancer during their lifetime.

Dr. Russell:
Well, with that I'd like to thank you, Dr. Warner Huh, for joining me today to cover some of our top frequently asked questions from our audiences around the country on cervical cancer screening. Dr. Huh, again, thank you for your time today.

Dr. Huh:
It was great. Thank you for having me.

Dr. Russell:
I'm Dr. John Russell from ReachMD, where you can be part of the knowledge.

Narrator:
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