



## CERVICAL CYTOLOGY MANAGEMENT

<b>DEFINITION</b>	<p>Cervical precancerous abnormalities and occult small carcinomas that may lead to invasive cancer can be detected by the Pap. Screening guidelines for cervical cancer were updated in 2012. A structured evidence evaluation process, known as the Grading Recommendations Assessment, Development, and Evaluation (GRADE) system, was utilized to form the new guidelines. The current ACOG Guidelines recommend women younger than 21 years should not be screened regardless of the age of sexual initiation or other risk factors, as this may lead to unnecessary treatment of lesions with a high probability of regressing spontaneously. Women from ages 21 to 29 screened every three years using either the standard Pap or liquid-based cytology. Because of the high prevalence of HPV infections in women younger than 30, HPV testing should not be used either as a stand-alone or a cotest. Women age 30 to 65, the recommendation is screening with cytology and HPV testing (cotesting) every five years (preferred) or cytology alone every three years. Women with certain risk factors may need more frequent screening, including those who have HIV, are immunosuppressed, were exposed to diethylstilbestrol (DES) in utero, and have been treated for cervical intraepithelial neoplasia (CIN) 2, CIN 3, or cervical cancer. Routine cervical cytology should be discontinued in women (regardless of age) who have had a total hysterectomy for noncancerous reasons, as long as they have no history of CIN2 or higher. It is reasonable to stop cervical cancer screening at age 65 if there is adequate negative prior screening (three consecutive negative cytology results or two consecutive negative cotests with the previous 10 years) and no history of high-grade intraepithelial lesion or carcinoma within the last 20 years, screening may be discontinued. Once discontinued, screening should not resume. ACOG also recommends that women who have been vaccinated against HPV should follow the same screening guidelines.</p>
<b>SUBJECTIVE</b>	<p>May include:</p> <ol style="list-style-type: none"><li>1. Recent or past history of abnormal pap smear.</li><li>2. History of HPV infection and/or other sexually transmitted infections.</li><li>3. Multiple sexual partners.</li><li>4. History of diethylstilbestrol (DES) exposure in utero.</li><li>5. Immunosuppressive disease or therapy.</li><li>6. Drug, alcohol, and/or tobacco use.</li><li>7. Sex with high risk males, multiple partners, history of HPV.</li><li>8. Symptoms may include: vaginal discharge, odor, intermenstrual or postcoital bleeding (sometimes seen with cervical malignancy).</li><li>9. Weight loss, fatigue (late signs of cervical carcinoma).</li><li>10. Difficulty with compliance of follow up measures/recommendations</li></ol>
<b>OBJECTIVE</b>	<p>May include:</p> <ol style="list-style-type: none"><li>1. No symptoms or clinical signs.</li><li>2. Wet mount may indicate fungal, bacterial, or trichomonal infections.</li><li>3. Cervical cultures may indicate chlamydia, gonorrhea, herpes, or other infections.</li><li>4. Classic DES changes may be noted (cervical sulcus, collar).</li><li>5. External genitalia may exhibit erythema, discharge, or gross lesions (including warts, leukoplakia).</li><li>6. Speculum exam may reveal discharge, erythema of cervix and/or vagina, and gross lesions (including warts, leukoplakia). Cervical carcinoma may present as an ulceration, a raised friable lesion, necrosis, or it may appear as normal tissue.</li><li>7. Bimanual exam may reveal a hard, enlarged, and fixed cervix (in late cervical carcinoma).</li></ol>

<b>LABORATORY</b>	Recent pap smear.
<b>ASSESSMENT</b>	Abnormal cervical cytology report. The Grade System and 2013 ASCCP Pap Smear Management Guidelines (See Attachment 1).
<b>PLAN</b>	<p>Must include:</p> <ol style="list-style-type: none"> <li>1. All pap smear reports reviewed by an advanced practice nurse, physician assistant or physician.</li> </ol> <p>May include:</p> <ol style="list-style-type: none"> <li>1. Repeat pap smear or referral for colposcopy as indicated.</li> <li>2. Wet mount as indicate</li> <li>3. Appropriate STD testing.</li> <li>4. Treatment/management (Following is a Link to Attachment 2: <a href="http://www.asccp.org/pdfs/consensus/algorithms">http://www.asccp.org/pdfs/consensus/algorithms</a> Management may vary depending upon client history, clinical signs and/or compliance. Note essential change from prior management guidelines include: *Cytology reported as negative but lacking endocervical cells can be managed without early repeat.</li> </ol>
<b>CLIENT EDUCATION:</b>	<p>May include:</p> <ol style="list-style-type: none"> <li>1. Explain purpose, results, and plan for follow-up of abnormal pap smear.</li> <li>2. Discuss the possible premalignant nature of results and need for close and continuous follow-up.</li> <li>3. Discuss the concept that cervical cancer and its precursors are related to infection by a sexually transmitted agent (i.e., HPV, usually 99%, <u>but not 100%</u>).</li> <li>4. Discuss the emotional aspects of findings on client's self-esteem, body image, and sexuality.</li> <li>5. Reassure and educate that behaviors which promote optimal wellness may enhance the immune system and aid with resolution (i.e., don't smoke, antioxidant diet, folic acid, vitamins).</li> <li>6. Review safe sex practices.</li> <li>7. RTC as appropriate per plan.</li> </ol>
<b>CONSULT / REFER TO PHYSICIAN</b>	<ol style="list-style-type: none"> <li>1. As indicated by cytology and clinical findings.</li> <li>2. MD referral mandatory for cytology or clinical findings which indicate malignancy.</li> <li>3. For counseling as appropriate.</li> </ol>

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References:

1. American Society for Colposcopy and Cervical Pathology (ASCCP) 2013 Guidelines on Management of Women with Cytological Abnormalities.  
<http://www.asccp.org/pdfs/consensus/algorithms>
2. The American Congress of Obstetricians and Gynecologists, ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician- Gynecologists: Screening for Cervical Cancer. November, 2012.