**Cervical Cancer Screening**

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

**Note:** It is critical that females who do not need annual cervical cancer screening continue with annual appointments to obtain other appropriate preventive healthcare. Women with significant comorbidities or life-threatening illnesses may forego cervical cancer screening. This algorithm is not intended for women with a personal history of cervical cancer.

**AGE TO BEGIN**

- **Under 21 years of age**: Screening not recommended
- **21 - 29 years of age**: Liquid-based Pap test every 3 years
- **30 - 65 years of age**: Co-testing (Pap test and Human Papillomavirus (HPV) testing) every 5 years (preferred) or Primary HPV testing with reflex cytology every 5 years (preferred) or Pap test with reflex HPV testing every 3 years or Pap test alone every 3 years
- **> 65 years of age**: Routine screening is usually not recommended with adequate prior screening. If prior screening is inadequate, provider should discuss guidelines with patient.

**SCREENING**

- **Previous hysterectomy with removal of the cervix in individuals without a history of high-grade cervical precancerous lesions or cervical cancer**

**RECOMMENDATION**

- Abnormal Pap test and/or positive HPV test

**Note:** Patients who have received the Human Papillomavirus (HPV) vaccine should continue to be screened according to the above guideline.

1. See the Cervical Cancer treatment or Survivorship algorithms for the management of women with a personal history of cervical cancer
2. Because of the relatively high HPV prevalence before age 30 years, HPV co-testing is recommended only for women with human immunodeficiency virus (HIV) in this age group
3. Patients with certain risk factors [diethylstilbestrol (DES) exposure in utero, immunosuppression such as HIV or organ transplant on immunosuppressive therapy] should continue to be screened annually. Patients with HIV should have Pap testing alone or Pap testing and HPV co-testing twice in the first year after diagnosis and then annually. Screening in patients with HIV should continue throughout a patient’s lifetime (and not, as in the general population, end at 65 years of age).
4. An alternative option would be to wait until age 25 and screen with primary HPV testing every 5 years
5. Prior screening:
   - 2 consecutive negative co-tests (Pap tests with HPV testing) within the past 10 years with the most recent test within the last 5 years or
   - 3 consecutive negative Pap tests within the past 10 years with the most recent test within the last 3 years or
   - 2 consecutive negative primary HPV tests within the past 10 years with the most recent test within the last 5 years
6. Patients with supracervical hysterectomies should follow the guidelines as for patients without a hysterectomy
Cervical Cancer Screening

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

SUGGESTED READINGS


Cervical Cancer Screening

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

DEVELOPMENT CREDITS

This screening algorithm is based on majority expert opinion of the Cervical Cancer Screening workgroup at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

Core Development Team Leads
Therese Bevers, MD (Cancer Prevention)
Joyce Dains, DrPH, JD, RN, FNP-BC, FNAP, FAANP (Nursing)
Andrea Milbourne, MD (Gynecologic Oncology & Reproductive Medicine)
Lois Ramondetta, MD (Gynecologic Oncology & Reproductive Medicine)
Kathleen Schmeler, MD (Gynecologic Oncology & Reproductive Medicine)

Workgroup Members
Heather Alexander, PgDip, BA (Community Alliances)
Mona Armaos, MSN, RN (Gynecologic Oncology & Reproductive Medicine)
Powel Brown, MD, PhD (Cancer Prevention)
Wendy Garcia, BS*
Ernest Hawk, MD (Cancer Prevention)
Denise Nebgen, MD, PhD (Gynecologic Oncology & Reproductive Medicine)
Ana Nelson, MSN, RN, DNP, FNP (Cancer Prevention)
Karen Rabel, APRN, MSN, ANP-BC (Gynecologic Oncology & Reproductive Medicine)
Priya Thomas, MD (Cancer Prevention)
Hannah Warr, MSN, RN, CPHON*

*Clinical Effectiveness Development Team