Understanding the National Cervical Screening Program Management Pathway:
A Guide for Healthcare Providers
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CST</td>
<td>Cervical Screening Test performed on either a clinician-collected or self-collected screening sample</td>
</tr>
<tr>
<td>DES</td>
<td>Diethyl-stilboestrol</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
</tr>
<tr>
<td>NCSP</td>
<td>National Cervical Screening Program</td>
</tr>
<tr>
<td>Oncogenic</td>
<td>Potential to cause cancer</td>
</tr>
<tr>
<td>LBC</td>
<td>Liquid-based cytology. This cytology test is prepared by placing the cervical sample in liquid suspension, rather than directly applying the sample on a microscope slide like a conventional Pap test</td>
</tr>
<tr>
<td>LSIL</td>
<td>Low-grade squamous intraepithelial lesion</td>
</tr>
<tr>
<td>pLSIL</td>
<td>Possible low-grade squamous intraepithelial lesion</td>
</tr>
<tr>
<td>HPI-I</td>
<td>Healthcare Provider Identifier – Individual</td>
</tr>
<tr>
<td>HSIL</td>
<td>High-grade squamous intraepithelial lesion</td>
</tr>
<tr>
<td>pHSIL</td>
<td>Possible high-grade squamous intraepithelial lesion</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>An operation to remove the uterus. Depending on the type of hysterectomy performed, accompanying organs such as the fallopian tubes, ovaries and cervix may be removed at the same time</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule is the schedule of fees for medical services set by the Australian Government covering a wide range of consultations, procedures and tests, and the Schedule fee for each of these items. There are different pathology MBS item numbers depending on the purpose of the test.</td>
</tr>
<tr>
<td>NCSR</td>
<td>National Cancer Screening Register</td>
</tr>
<tr>
<td>NPV</td>
<td>Negative predictive value. The post-test probability of a negative test: i.e. if a person tests negative, what is the probability they do not have the condition?</td>
</tr>
<tr>
<td>PPV</td>
<td>Positive predictive value. The post-test probability of a positive test: i.e. if a person tests positive, what is the probability they have the condition?</td>
</tr>
<tr>
<td>Test of Cure</td>
<td>It is recommended that patients who have received treatment for a high-grade abnormality should complete Test of Cure surveillance to confirm their treatment has been successful. Test of Cure surveillance is a co-test (HPV and LBC test) performed 12 months after treatment, and annually thereafter, until the patient receives a negative co-test on two consecutive occasions. They should then return to five-yearly screening.</td>
</tr>
<tr>
<td>Co-testing</td>
<td>Co-testing involves the pathology laboratory performing both the HPV test and LBC test concurrently on the same specimen. This means that the LBC test is performed irrespective of the HPV test result, without requiring an additional request. There are different pathology MBS item numbers depending on the purpose of the test.</td>
</tr>
<tr>
<td>Self-collection</td>
<td>Some patients may be eligible to collect their own vaginal sample for cervical screening; also known as self-collection. This may help patients that are overdue for a cervical screening or have never been screened. Check the Self-collect section of this booklet to see if your patient is eligible.</td>
</tr>
</tbody>
</table>
Introduction

Why are the changes taking place?

Between 2012 and 2014, the Medical Services Advisory Committee (MSAC) assessed an extensive range of clinical evidence and modelling of potential screening pathways. MSAC made a recommendation for the new Cervical Screening Test and pathway.

From 1 December 2017:

- a five-yearly Cervical Screening Test will replace the two-yearly Pap test
- patients who are already having Pap tests should have their first Cervical Screening Test when they are next due for a Pap test (this is usually two years after their most recent Pap test for those patients with a normal screening history)
- patients who have ever been sexually active should commence screening at 25 years of age and have a Cervical Screening Test every five years until they reach 74 years
- patients who have been vaccinated against human papillomavirus (HPV) need to have regular cervical screening as the vaccine protects against some oncogenic types of HPV, but does not protect against all oncogenic types
- healthcare providers will still perform a vaginal speculum examination and take a cervical sample, but the sample medium is liquid-based and will be tested for the presence of HPV
- the new Cervical Screening Test will be supported by a new National Cancer Screening Register (NCSR)
- the NCSR will send invitations and reminder letters on behalf of the National Cervical Screening Program (NCSP) to patients when they are next due, and follow-up letters when patients have not attended further investigations or tests
- cytology will no longer be for primary screening but liquid-based cytology (LBC) will be used to triage patients who have HPV detected from the Cervical Screening Test; the pathology laboratory will automatically perform this reflex test on the same sample to determine which clinical pathway to recommend
- if you currently write on your pathology form ‘Not for Register’ to remove patients from the cervical screening register, this is no longer accepted. If a patient chooses to ‘opt out’ of the National Cancer Screening Register then the patient themselves, or with their consent; their healthcare provider, or their personal representative can arrange this by calling 1800 627 701.

Ensure you order the correct test for your patient. To avoid ordering a test that your patient is not eligible for and having your patient charged the cost of this test by the pathology laboratory, check the table at the back of this booklet or your National Cervical Screening Program (NCSP) Quick Reference Guide.

Pathology MBS items have changed – What do I write on a pathology request form as of 1 December 2017?

From 1 December 2017, Pap tests will no longer be eligible for Medicare rebates. The MBS items for cervical and vaginal pathology testing for cervical pre-cancer and cancer have been updated to operationalise the new clinical pathway and National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) recommendations. Further information is available throughout this booklet to assist you in ordering the correct test.
Clinical information on pathology request forms assists pathology laboratories in performing the right tests, matching the right clinical recommendations and selecting the right MBS item/s. Practitioners will need to specify on the pathology request form:

1. whether the collection is part of routine screening or is for clinical management or for screening symptomatic women; and

2. the tests required; and

3. other relevant clinical information e.g. screening history, DES exposed.

This information will assist the laboratory to identify which pathology MBS item number to use and will minimise queries back to you.

**What is HPV?**

HPV is easily transmitted via skin contact during sexual activity. It is extremely common in men and women who have ever been sexually active, with most people being infected with at least one type of HPV at some point in their life without ever knowing it.

**What is the link between HPV and cervical cancer?**

Nearly all cervical cancers are caused by an HPV infection. While HPV infections are normally cleared naturally by the immune system, sometimes they cause cervical cells to become abnormal. The body is usually able to rid itself of HPV and the abnormal cells, but in some cases this doesn’t happen and the abnormal cells develop into cervical cancer. The time from HPV infection to cervical cancer is usually 10–15 years.

**Cause of cervical cancer**

Cervical cancer is a rare outcome of persistent infection with oncogenic HPV types. Infection with an oncogenic HPV type is necessary, although not sufficient, for the development of cervical cancer. HPV types 16, 18 and 45 are most predominantly associated with cervical cancer, with types 16 and 18 detected in 70–80% of cases in Australia.  

**What to say to patients who ask about cervical cancer not caused by HPV**

More than 99% of cervical cancers are caused by HPV, which includes squamous cell carcinoma and adenocarcinoma. There are other, very rare types of cervical cancer, including neuroendocrine or small cell cancer, that account for less than 1% of all cervical cancer. Neither the Pap test nor the new Cervical Screening Test effectively detects neuroendocrine cancers.

**Explaining to HPV-vaccinated patients why they still need to participate in cervical screening**

HPV types 16 and 18 cause more than 70% of cervical cancers in Australia. The HPV vaccine protects against both these types; however, it does not protect against other types of HPV known to cause cervical cancer. Therefore, vaccinated patients are still at risk of significant cervical abnormalities from these other oncogenic HPV types and need to participate in regular cervical screening.
The new Cervical Screening Test and Pathway - A risk-based approach

The new Cervical Screening Test every five years is more effective than, and just as safe as, a Pap test every two years.

The new Cervical Screening Test detects infection with HPV.

HPV testing for cervical screening is more sensitive than cytology (i.e. Pap tests) and detects the potential for progression to high-grade lesions earlier, thus preventing more cervical cancers. Screening using HPV testing also has the potential to improve detection of adenocarcinoma and its precursors.

The new Cervical Screening Test and pathway is a risk-based approach to the management of patients participating in the NCSP. Patients are managed according to their risk of developing significant cervical abnormalities which is determined by their Cervical Screening Test result.

Partial genotyping is used to classify the type of HPV into one of two groups: oncogenic HPV 16/18 or oncogenic HPV types not 16/18 as a pooled result.

If HPV is detected, the pathology laboratory will automatically conduct a reflex LBC test on the same sample, to determine if any cervical cell abnormalities are present. This assists in determining the patient’s risk rating and triaging for colposcopy.

Patients are managed according to their risk of developing significant cervical abnormalities, which is determined by their HPV test result and reflex LBC result, if indicated.

If both tests are performed, the pathology report will include the combined result as a risk category and the recommended clinical management. If any glandular abnormalities are detected on a screening test, follow up in accordance with the 2016 Guidelines.

There are three risk categories: low risk, intermediate risk and higher risk.

Understanding the clinical pathway and risk ratings

Understanding low risk

What does a low risk result mean?

A low risk result means HPV was not detected. HPV is required for the development of most cases of cervical cancer. Patients at low risk of developing cervical cancer can safely return for a Cervical Screening Test in five years.

We cannot assure patients that they are at ‘no risk’ because they may subsequently acquire an HPV infection or have a latent infection that becomes active and may develop into cervical cancer over time, usually 10–15 years.

Patients with a low risk result will be invited to screen again in five years.

Is rescreening at five years safe?

It is safe for a patient with a low risk result to wait for five years before their next Cervical Screening Test. Evidence about the natural history of cervical cancer has shown that the average time taken for a persistent HPV infection to cause cervical abnormalities and then progress to cervical cancer is usually 10–15 years. No screening test is 100 per cent effective, however because the HPV test has a high negative predictive value, patients who have not had HPV detected are at low risk of developing significant cervical abnormalities or cervical cancer within five years. Because of this, patients will only need to have a Cervical Screening Test every five years. The five-year period between screening tests will be the same for patients regardless of their HPV vaccination status.
Understanding intermediate risk

What does an intermediate risk result mean?

An intermediate risk result means an HPV not 16/18 was detected and a reflex LBC conducted on the same sample showed that the patient has negative, possible LSIL, or LSIL abnormal cervical cells. An intermediate risk result is not associated with high-grade cell changes that require treatment. Patients with an intermediate risk result will be invited by the NCSP to return for a repeat HPV test in 12 months. This is to check if their body has cleared the HPV infection.

What happens 12 months after an intermediate risk result?
The patient should have a repeat HPV test, and will receive one of two possible results:

- HPV not detected: The immune system has cleared the HPV infection. The patient can now safely return to five-yearly screening.
- HPV detected (any type): This result means that there is a persistent HPV infection (any type). Since HPV is detected, reflex LBC will be performed and the patient will be referred for colposcopic assessment (regardless of LBC result). Further investigation with colposcopy will assist in the identification of abnormal cells that require treatment, to prevent the progression to cervical cancer.

Understanding higher risk

What does a higher risk result mean?

A higher risk result means the patient has received one of two possible results:

- HPV not 16/18 detected: If HPV not 16/18 is detected, a reflex LBC will be conducted on the same sample. If possible HSIL or HSIL abnormal cervical cells are detected the patient should be recommended a colposcopic assessment because they are at a higher risk of cervical cancer. A colposcopy will determine if a biopsy is needed and this will determine if treatment is required.
- HPV 16/18 detected: HPV types 16 and 18 are associated with approximately 70% of cervical cancers. These HPV types are also more likely to progress to cervical cancer than other oncogenic HPV types. Regardless of the reflex LBC test result, the patient should be recommended to have a colposcopic assessment because they are at a higher risk of cervical cancer. The LBC will inform the colposcopic assessment.

If a glandular abnormality is detected on a screening test, follow up in accordance with the 2016 Guidelines.

If you would like some Tips and resources for communicating results to patients go to page 19 of this booklet. For more information on Further testing and treatment go to page 20 of this booklet.

Screening pathway for clinician-collected cervical sample

For clinician-collected cervical samples, refer to the screening pathway (Figure 1, opposite) and the results matrix (Table 1, see page 8) to see how the risk categories and management strategies are determined based on the combined HPV and LBC (if performed) results.
Figure 1: Cervical screening pathway for clinician-collected sample

Sample collected for CST and sent to pathology laboratory

HPV test with partial genotyping

- HPV not detected
- HPV not 16/18 detected
- HPV 16/18 detected
- Unsatisfactory HPV test

Reflex LBC

- Unsatisfactory LBC
- Negative
- pLSIL/LSIL
- pHSIL/HSIL

Repeat HPV test in 12 months

- HPV not detected
- HPV detected (any type)

Reflex LBC

- No HPV found (normal)
- No HPV found (normal)
- No HPV found (normal)
- HPV infection still present
- Cellular changes present that may need treatment
- HPV infection present
- Unatisfactory test, sample could not be read

Collect new sample for LBC only in 6–12 weeks

Return to screening in 5 years

Refer to specialist (colposcopy)

Collect new sample for HPV only in 6–12 weeks

Definitions: CST = Cervical Screening Test HPV = Human papillomavirus; LSIL = low-grade squamous intraepithelial lesion; HSIL = high-grade squamous intraepithelial lesion; LBC = liquid-based cytology.

Diagram adapted from Cervical Screening Guidelines 2016.

Legend

Low
Intermediate
Higher

Risk of cervical cancer precursors in the next five years.
### Understanding the National Cervical Screening Program Management Pathway

<table>
<thead>
<tr>
<th>Risk of significant cervical abnormalities</th>
<th>HPV test result</th>
<th>Reflex LBC result</th>
<th>Recommended management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk result</td>
<td>HPV not detected</td>
<td>–</td>
<td>Return to screening in 5 years</td>
</tr>
<tr>
<td>Intermediate risk result</td>
<td>HPV not 16/18 detected</td>
<td>Negative, possible LSIL or LSIL</td>
<td>Repeat HPV test in 12 months</td>
</tr>
<tr>
<td>Higher risk result</td>
<td>HPV not 16/18 detected</td>
<td>Possible HSIL or HSIL</td>
<td>Refer to specialist (colposcopy)</td>
</tr>
<tr>
<td></td>
<td>HPV 16/18 detected</td>
<td>Any LBC result</td>
<td>Refer to specialist (colposcopy)</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>Unsatisfactory HPV test</td>
<td>Collect new sample for HPV test in 6–12 weeks</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>HPV not 16/18 detected</td>
<td>Collect new sample for LBC only in 6–12 weeks</td>
</tr>
</tbody>
</table>

Table 1: Cervical Screening Test results for clinician-collected sample

### Collecting a Cervical Screening Test sample

This section provides information on collecting the sample for a Cervical Screening Test for:
- asymptomatic patients
- symptomatic patients
- pregnant women

#### Cervical Screening Test – Step-by-step instructions

A vaginal speculum examination is still required to obtain a cervical sample, and the procedure for this remains unchanged.

1. **After the patient is prepared and comfortable, begin the speculum examination by examining the external genitalia for any abnormalities, then:**
   - warm the speculum, and apply a small amount of water-based lubricant
   - hold the speculum in your hand with the handle facing down, and the blades closed
   - gently part the labia and encourage the patient to breathe out while you slowly insert the closed speculum into the vagina using slight downward pressure, keeping the lower blade against the posterior wall of the vagina
   - ask the patient if they are in any discomfort and encourage feedback throughout the procedure,
   - open the blades just slightly, then tilt the speculum forward a little to allow maximum visualisation of the external orifice of the cervix uteri (external os).

2. **Once the cervix is visualised, inspect for the following features:**
   - colour, size, shape
   - position
   - abnormal areas (lesions)
   - surface characteristics
   - the transformation zone (squamocolumnar junction; where the endocervical canal lining meets the squamous epithelium) which may or may not be visible
   - discharge
3. The objective of cervical screening is to sample cells from the transformation zone of the cervix, where HPV is present and cell abnormalities that precede the development of squamous cell carcinoma are usually found.

Additional factors that should be considered when choosing a device(s) include: prior treatment and prior cytology results. Collect a sample of cells from the cervix using a spatula, brush or broom sampling device, following the manufacturer’s instructions. The choice of device depends on the location of the transformation zone, which is influenced by the patient’s age and menopausal status.

It is optimal for the cervical sample to contain both ectocervical and endocervical cells, however, the sample will not be deemed as unsatisfactory if there is no endocervical component.

4. After, or before, the sample has been collected, record the patient name, DOB and ID number on the specimen vial and any other patient identifiers required by the laboratory, and note the following on the pathology request form:

- patient information
- cervical screening history and other relevant medical history (including gynaecological history)
- if any cervical abnormalities were visualised during the cervical examination

Next, place the vial and pathology request form in a specimen bag for transport to the laboratory.

Ask the patient how they would like to be advised of the results and document their preference, to ensure they are adequately notified of their results.

5. After sample collection, ensure the details of the consultation and procedure are accurately documented in the patient’s clinical record.

The NPS MedicineWise Online Education Modules provide information on how to take a sample for a Cervical Screening Test. See Module 4 (Screening in Practice) of Changes to the National Cervical Screening Program at www.learn.nps.org.au/

### Asymptomatic patients

Most patients presenting for their Cervical Screening Test will be asymptomatic and be within the eligible age range of 25 to 74 years of age. When completing the pathology request form for asymptomatic patients who require a clinician-collected Cervical Screening Test (CST) use the information in the last column below:

<table>
<thead>
<tr>
<th>Patient presents as</th>
<th>Context*</th>
<th>Age</th>
<th>Sample type</th>
<th>Test type</th>
<th>What to write on the pathology request form</th>
</tr>
</thead>
</table>
| Asymptomatic        | NCSP routine five-yearly screening  
• Only 1 of this MBS item is claimable in a 57-month period | ≥ 24yrs & 9mths | Cervical HPV test | Cervical Screening Test (CST) |
| Asymptomatic        | Screening in specific populations  
• Immune-deficient | Any age | Cervical HPV test |  
• HPV test, Immune-deficient |

Symptomatic patients
Patients who have signs or symptoms suggestive of cervical cancer are tested and managed on a different clinical pathway from those who are asymptomatic.

The following signs or symptoms can be suggestive of cervical cancer:
- unusual or abnormal vaginal bleeding (post-coital, inter-menstrual or post-menopausal)
- pain during intercourse, or
- unusual vaginal discharge.

Note that abnormal vaginal bleeding can also be associated with genital tract malignancy or premalignant conditions, as well as other conditions such as polyps, adenomyosis, leiomyomas, coagulopathies, ovulatory disorders, endometrial disorders, sexually transmitted infection and iatrogenic causes.

Cervical cancer is an uncommon cause of abnormal vaginal bleeding at any age; however, it should be considered and excluded in all patients who present with abnormal vaginal bleeding.

Any relevant presenting symptoms should be documented in the patient’s clinical notes and the pathology request form for her co-test.

Patients at any age who have signs or symptoms suggestive of cervical cancer should have a co-test (HPV and LBC). Consider referral for the appropriate investigations to exclude genital tract malignancy.

Co-test
What is a co-test?
Co-testing involves the pathology laboratory performing both the HPV test and LBC test concurrently on the same specimen. This means that LBC is performed irrespective of the HPV test result, without requiring an additional request.

When is a co-test required?
Co-testing is recommended for symptomatic patients (usually abnormal vaginal bleeding) requiring investigation, patients exposed to diethyl-stilboestrol (DES), and if requested by their daughters, patients undergoing Test of Cure (TOC) surveillance and for patients who have been treated for glandular abnormalities. If required, ‘co-test’ must be specifically noted on the pathology request form as well as the reason for the co-test.

When completing the pathology request form for symptomatic patients who require a Co-test use the information in the last column below:

<table>
<thead>
<tr>
<th>Patient presents as</th>
<th>Context*</th>
<th>Age</th>
<th>Sample type</th>
<th>Test type</th>
<th>What to write on the pathology request form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic</td>
<td>For investigation of symptoms – e.g. abnormal bleeding</td>
<td>Any age</td>
<td>Cervical</td>
<td>Co-test (HPV &amp; LBC)</td>
<td>“Co-test” or “HPV &amp; LBC”, Symptomatic</td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>Follow-up or post-treatment for clinical management</td>
<td>Any age</td>
<td>Cervical</td>
<td>Co-test (HPV &amp; LBC)</td>
<td>“Co-test” or “HPV &amp; LBC”, Test of Cure “Co-test” or “HPV &amp; LBC” Post-treatment “Co-test” or “HPV &amp; LBC”, DES</td>
</tr>
</tbody>
</table>


Testing during pregnancy
If a patient is due for screening, screening can be carried out safely at any time provided that the correct equipment is used. A cytobrush or combi-brush should not be inserted into the cervical canal because of the risk of bleeding. The sample collection device will vary depending on the type provided by the pathology laboratory.
Self-collection for HPV should not be offered during pregnancy. If a patient receives a positive HPV or LBC result during pregnancy, the following recommendations apply:

<table>
<thead>
<tr>
<th>Result</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV detected (16/18)</td>
<td>Early* referral for colposcopy regardless of LBC result</td>
</tr>
<tr>
<td>HPV detected (not 16/18) and LBC showing possible HSIL, HSIL or glandular abnormality</td>
<td>Early* referral for colposcopy</td>
</tr>
<tr>
<td>HPV detected (not 16/18) and negative LBC, possible LSIL or LSIL</td>
<td>Repeat HPV test in 12 months</td>
</tr>
</tbody>
</table>

*When practical and not deferred until postpartum period.


### Previous hysterectomy

For patients who have had a total hysterectomy for documented benign reasons (e.g. menorrhagia, fibroids) no further tests are required if they had a normal screening history prior to their hysterectomy.

Patients who have had a total hysterectomy with past history of HSIL should have co-testing (HPV and LBC) 12 months after treatment and annually until both tests are negative on two consecutive occasions at which time they can discontinue screening. Self-collection for HPV testing is not appropriate for patients who have had a total hysterectomy with past history of HSIL. If a woman has already completed Test of Cure prior to the hysterectomy, and there was no cervical pathology, she does not require any follow-up.

In situations of unknown screening history, the management depends on the cervical pathology at the time of hysterectomy. Depending on this the woman either undergoes test of cure management or HPV testing.

Patients who have had a subtotal hysterectomy (i.e. cervix is not removed) should have routine five-yearly Cervical Screening Tests, or as recommended if they have experienced a recent cervical abnormality.

<table>
<thead>
<tr>
<th>Patient presents as</th>
<th>Context*</th>
<th>Age</th>
<th>Sample type</th>
<th>Test type</th>
<th>What to write on the pathology request form</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV test after total hysterectomy</td>
<td>• No evidence of cervical pathology on hysterectomy specimen and patient screening history not available</td>
<td>Any age</td>
<td>Vaginal vault</td>
<td>HPV test</td>
<td>Vaginal vault HPV</td>
</tr>
<tr>
<td></td>
<td>• Unexpected LSIL or HSIL identified in hysterectomy specimen;</td>
<td></td>
<td></td>
<td>Co-test (HPV &amp; LBC)</td>
<td>Vaginal vault “Co-test” or “HPV &amp; LBC”</td>
</tr>
<tr>
<td></td>
<td>• Hysterectomy for treatment of HSIL in the presence of benign gynaecological disease; or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Following histologically confirmed HSIL without previous Test of Cure and no cervical pathology in hysterectomy specimen.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When test results are unsatisfactory

Occasionally the primary test results may be unsatisfactory, possibly not containing enough of the ectocervical and endocervical cells and the pathology laboratory will request that another test be performed.

Where the primary test result is unsatisfactory, the following information should be used when requesting another test:

<table>
<thead>
<tr>
<th>Patient presents as</th>
<th>Context*</th>
<th>Age</th>
<th>Sample type</th>
<th>Test type</th>
<th>What to write on the pathology request form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat test following an unsatisfactory test</td>
<td>Following an unsatisfactory test • Only claimable when preceded by another cervical or vaginal MBS Item</td>
<td>Any age</td>
<td>Cervical</td>
<td>HPV test</td>
<td>HPV test, previous result unsatisfactory</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vaginal</td>
<td>HPV test</td>
<td>HPV test, previous result unsatisfactory</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cervical</td>
<td>LBC</td>
<td>LBC, previous result unsatisfactory</td>
</tr>
</tbody>
</table>


Test of Cure: Management after treatment for high-grade abnormalities

It is recommended that patients who have received treatment for a high-grade abnormality should complete Test of Cure surveillance to confirm their treatment has been successful. Test of Cure surveillance is a co-test (HPV and LBC test) performed 12 months after treatment, and annually thereafter, until the patient receives a negative co-test on two consecutive occasions. They should then return to five-yearly screening.

Use the following information on your pathology request for patients who require screening following treatment for high-grade cervical abnormalities:

<table>
<thead>
<tr>
<th>Patient presents as</th>
<th>Context*</th>
<th>Age</th>
<th>Sample type</th>
<th>Test type</th>
<th>What to write on the pathology request form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic Follow-up or post-treatment for clinical management • Following treatment of HSIL (also called “test of cure”)</td>
<td>Any age</td>
<td>Cervical</td>
<td>Co-test (HPV &amp; LBC)</td>
<td>“Co-test” or “HPV &amp; LBC”, Test of Cure</td>
<td></td>
</tr>
</tbody>
</table>


Managing patients aged 70–74 years

**Low risk** – Patients aged 70 to 74 years where HPV is not detected are eligible to exit the program.

**Intermediate or higher risk** – Patients aged 70 to 74 years where HPV is detected (any type) should be followed up in accordance with the 2016 Guidelines. Patients aged 70 to 74 years with a HPV detected (any type) are recommended to be referred directly for colposcopy assessment.

If you would like some Tips and resources for communicating results to patients go to page 19 of this booklet. For more information on Further testing and treatment go to page 20 of this booklet.
Self-collected vaginal sample for HPV test

Eligibility criteria

Self-collection of a vaginal sample for screening is available for patients aged 30 years or over, who have declined to have a cervical sample collected by a clinician, and are either:

- overdue for cervical screening by two years or longer (ie. Four years or more since their last Pap test, or seven years or more since their last Cervical Screening Test), or
- have never screened.

Self-collection is not suitable if your patient is; under 30, pregnant, or thinks they might be pregnant, symptomatic or experiencing unusual bleeding, pain or discharge, or has had a total hysterectomy with a past history of high-grade squamous intraepithelial lesion (HSIL) or has been exposed to diethyl-stilbestrol (DES) in utero.

Supporting patients in clinical management

Before offering the option to self-collect, ensure the patient is eligible for self-collection.

During consultation with an eligible patient explain the following:

- how to collect a vaginal sample.
- a self-collected sample is from the vagina (not the cervix), and can only be tested for HPV. Any cell changes cannot be seen in this sample.
- results will be sent directly to the healthcare provider.

When sending the sample to the pathology lab, include relevant details on the pathology request form, and arrange for the sample to be taken to the pathology laboratory. It is suggested that the discussion should include the pros and cons of each option to ensure the woman is able to make an informed decision. It is also suggested that HPV is explained if needed.

Use the following information on your pathology request form for asymptomatic patients who require a self-collected Cervical Screening Test (CST):

<table>
<thead>
<tr>
<th>Patient presents as</th>
<th>Context*</th>
<th>Age</th>
<th>Sample type</th>
<th>Test type</th>
<th>What to write on the pathology request form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic</td>
<td>Screening under- and never-screened patients • ≥30 years of age and • At least 2 years overdue or never-screened and • Declines cervical sampling • Only 1 of this MBS item is claimable in a 7 year (84 mth) period</td>
<td>≥30yrs</td>
<td>Vaginal</td>
<td>HPV test</td>
<td>HPV test, self-collected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>LBC</td>
<td>Cervical Standalone LBC</td>
</tr>
<tr>
<td>Follow-up self-collect HPV test (clinical management)</td>
<td>Only claimable within 21 months following the detection of oncogenic HPV (any type) on a self-collected screening test</td>
<td>≥30yrs</td>
<td>Vaginal</td>
<td>HPV test</td>
<td>self-collect HPV follow-up test</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>LBC</td>
<td>Cervical Standalone LBC</td>
</tr>
</tbody>
</table>

To check when your patient last had a Cervical Screening Test or Pap test call the NCSR on 1800 627 701.

How to collect a self-collected sample
Self-collection must be requested and facilitated by a Cervical Screening Test provider who also offers routine cervical screening services.

The following instructions are available as a printed resource for patients who are eligible to self-collect a vaginal sample. It is suggested that you talk your patient through these instructions and make them familiar with the particular self-collect swab your health care facility uses before giving them a copy to use while taking their sample. These instruction sheets can be ordered in pads at www.cancerscreening.gov.au/cervical/resources
Understanding the self-collect clinical pathway

The vaginal sample taken by the patient through the self-collection process is tested for HPV only.

If HPV (not 16/18) is detected, at the follow-up appointment with the healthcare provider the patient is encouraged to obtain a clinician-collected cervical sample for LBC testing.

If the patient refuses to have a clinician-collected sample, to avoid losing her to follow-up you should encourage her to return in 12 months for a repeat HPV test preferably by a healthcare provider. However you should advise the patient that this action may delay the management of a possible cervical abnormality.

If HPV (16/18) is detected the patient is referred directly for colposcopy and a cervical sample for LBC will be collected at that visit.

If you would like some Tips and resources for communicating results to patients go to page 19 of this booklet. For more information on Further testing and treatment go to page 20 of this booklet.

For self-collected vaginal samples, refer to the screening pathway (Figure 2, opposite) and the results matrix (Table 2, below) to see how the risk categories and management strategies are determined based on HPV (and LBC if subsequently performed) results. If glandular abnormalities are detected on a screening test follow up in accordance with the 2016 Guidelines.

<table>
<thead>
<tr>
<th>HPV test result</th>
<th>LBC</th>
<th>LBC result</th>
<th>Risk of significant cervical abnormalities within next 5 years</th>
<th>Recommended management</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV not detected</td>
<td>Not required</td>
<td>Not applicable</td>
<td>Low</td>
<td>Return to screening in 5 years</td>
</tr>
<tr>
<td>HPV not 16/18 detected</td>
<td>Recommend woman returns for clinician-collected LBC</td>
<td>Negative, possible LSIL or LSIL</td>
<td>Intermediate</td>
<td>Repeat HPV test in 12 months</td>
</tr>
<tr>
<td>HPV not 16/18 detected</td>
<td>Recommend woman returns for clinician-collected LBC</td>
<td>Possible HSIL, HSIL or any glandular</td>
<td>Higher</td>
<td>Refer to specialist (colposcopy)</td>
</tr>
<tr>
<td>HPV 16/18 detected</td>
<td>LBC collected at time of colposcopy, not required prior to referral</td>
<td>Any result</td>
<td>Higher</td>
<td>Refer to specialist (colposcopy)</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Collect new sample for HPV only in 6 to 12 weeks</td>
</tr>
</tbody>
</table>

Table 2: Cervical Screening Test results and LBC guidance for self-collected sample

Further information is available at www.cancerscreening.gov.au

**Figure 2:** Cervical screening pathway for self-collected vaginal sample

**HPV test with partial genotyping**

- **HPV not detected**

- **HPV not 16/18 detected**
  - HPV 16/18 detected
  - Un satisfactory HPV test

**Cervical sample required for LBC**

- **Un satisfactory LBC**
- **Negative**
- **pLSIL/LSIL**
- **pHSIL/HSIL**

- **Repeat HPV test in 12 months**

- **HPV not detected**
- **HPV detected (any type)**

- **No HPV found (normal)**
- **Un satisfactory test, sample could not be read**
- **No HPV found (normal)**
- **HPV infection still present**
- **Cellular changes present that may need treatment**
- **HPV infection present**
- **Un satisfactory test, sample could not be read**

- **Return to screening in 5 years**
- **Collect new sample for LBC only in 6–12 weeks**
- **Return to screening in 5 years**
- **Refer to specialist (colposcopy)**
  - LBC can be collected at this visit
- **Collect new sample for HPV only in 6–12 weeks**

**Definitions:**
- HPV = Human papillomavirus
- LSIL = low-grade squamous intraepithelial lesion
- HSIL = high-grade squamous intraepithelial lesion
- LBC = liquid-based cytology

Diagram adapted from Cervical Screening Guidelines 2016.
Talking with patients about cervical screening

The long cervical abnormalities stage prior to cervical cancer provides an opportunity for early detection of abnormalities through cervical screening to enable treatment before cancer develops.

Uptake and acceptance of the importance of cervical screening and follow-up can be impacted by patient knowledge, experience and comfort. To assist patients in making an informed choice about cervical screening, a good level of relevant knowledge about the Cervical Screening Test is required.

Key information to mention may include:

- the link between persistent HPV infection and cervical cancer, noting
  - HPV infections are usually cleared by the immune system in 1–2 years
  - if infection persists, in rare cases it can lead to development of cervical cancer after about 10–15 years
- cervical screening is based on HPV testing, and that cells in the sample will only be studied for changes if HPV is detected
- the sample collection procedure is similar to the previous Pap test
- patients are invited to start cervical screening from the age of 25 and continue screening until they are 74 years old
- screening is only required once every five years for patients who do not have HPV detected

Additional information to support conversation with patients is available on the Department of Health’s website at www.cancerscreening.gov.au/cervical/resources.

Medicine Update: The National Cervical Screening Program is changing – a publication by NPS MedicineWise, summarising the changes for patients can be found at www.nps.org.au/medical-info/clinical-topics/news/the-national-cervical-screening-program-is-changing

Addressing cervical screening in under-screened and never-screened patients

Eighty per cent of Australian patients who develop cervical cancer are under-screened or have never-screened.

With the renewal of the NCSP there is an increased focus on engaging specific sub-groups in Australia who are less likely to engage in cervical screening. These include, but are not limited to patients from culturally and linguistically diverse backgrounds, those with disabilities, patients who have experienced sexual trauma and/or domestic violence, those who identify as Aboriginal and Torres Strait Islander, and those who identify as lesbian, gay, bisexual, transgender, queer or questioning and intersex (LGBTQI).

It is important to remember that these sub-groups are not homogeneous, and each person’s individual circumstances will influence their participation in cervical screening.

When discussing cervical screening with your patients, particularly those who may be under-screened or never-screened, it’s important to be mindful of these considerations:

- building trust and rapport is vital. Creating a sense of safety and security will go a long way towards allaying concerns or fears
- demonstrate respect and inclusivity through the language you use and by creating an inclusive atmosphere of your health service, e.g. waiting room displays and consumer resources in various languages
- ensure patients understand that their Cervical Screening Test results will remain confidential
- reassure patients that the procedure will be undertaken carefully and respectfully, and that they will be able to undress in private and given a sheet to cover their lower body
• use visual aids where appropriate, particularly with patients with low literacy levels or those who may be embarrassed discussing sexual activity or their genitalia
• give patients time to feel comfortable with new information, to ask questions and make informed decisions
• don’t make assumptions about cultural background, sexual history, sexual preferences, literacy levels or knowledge of their bodies
• use face-to-face or a telephone interpreter if language is a barrier

Further education and resources are available for providers who would like to learn more about engaging under-screened and never-screened patients in cervical screening. These can be found at [www.cancerscreening.gov.au/cervical/resources](http://www.cancerscreening.gov.au/cervical/resources).

**Tips and resources for communicating results to patients**

Explain Cervical Screening Test results to patients in a compassionate, open, non-judgemental manner and using plain language.

When abnormal Cervical Screening Test results occur, it is important to explain to patients that this does not necessarily mean they have cancer.

Patients may feel anxious or worried if they are told they have HPV and need further investigation following their Cervical Screening Test.

It can be helpful to explain that HPV is a very common infection that is spread by genital skin-to-genital skin contact. Most people have HPV at some point in their lives but never know they have it as there are usually no symptoms. HPV is so common it could be considered a normal part of being sexually active.

In most cases, the HPV infection will be cleared by the immune system in 12 months.

When describing LBC results, avoid using terminology such as ‘pre-cancerous’ as it causes anxiety and may be inaccurate. Reassure patients that cervical cancer is a rare outcome, and that low-grade changes are common, usually transient and can safely be monitored for 12 months.

Please direct patients to [www.cancerscreening.gov.au/cervical/resources](http://www.cancerscreening.gov.au/cervical/resources) for further information about the NCSP. You can also order resources for patients which you can use in conversations with them, or to display in your practice. Resources written by healthcare providers, for healthcare providers can also be found on this website. The NPS MedicineWise Online Education Modules will provide you with clinical advice on how to apply cervical screening within the 2016 Guidelines (CPD accredited), as well as practical advice and videos to help you engage patients of culturally and linguistically diverse communities and patients with an intellectual disability. See the online course Changes to the National Cervical Screening Program at [www.learn.nps.org.au/](http://www.learn.nps.org.au/)

Further testing and treatment
Patients with a higher risk test result require further testing and will be referred to a specialist for assessment and possibly treatment. Primary healthcare providers may need to be prepared to answer some general questions.

What is a colposcopic assessment?
If a higher risk result is given, a colposcopic assessment will be needed. During this procedure, the healthcare provider inserts a speculum into the vagina (like during a Cervical Screening Test) and uses an instrument called a colposcope, which looks like a pair of binoculars on a stand. The colposcope allows the doctor to have a magnified view of the cervix to check the extent and nature of any problem. The colposcope stays outside of the body.

During the colposcopy, a small sample of tissue (a biopsy) may be taken from any abnormal looking areas of the cervix. The sample will be sent to a laboratory for testing. It will take up to two weeks for the result to come back to the doctor. Arrangements should be made for the patient to discuss the results when they are available and to find out if treatment is required.

If a biopsy is taken, the patient may have some discomfort for a short time. They should be advised to avoid vigorous physical exercise for 24 hours and avoid sexual intercourse for one to two days. They may shower, but should avoid swimming, bathing and spas for one to two days. These precautions are to reduce the risk of bleeding and/or infection. There may be some brown discharge and ‘spotting’ for a few hours afterwards, so it is a good idea to take a thin sanitary pad or panty liner to the appointment.

Treatment for abnormalities
Most patients with HPV will not develop high-grade cervical abnormalities.

However, some high-risk types of HPV may be more difficult for the body to clear naturally. Long-term infection with oncogenic HPV can increase risk of high-grade cervical abnormalities, which may lead to cervical cancer. Treatment for abnormalities caused by HPV infection may be required.

Wire loop excision
This procedure uses a wire loop to remove abnormal cells from the cervix, and takes 15–30 minutes. Most patients are able to have treatment using a local anaesthetic, which is usually more convenient but some may require a general anaesthetic and a short hospital stay. Most are able to return to normal activities within two to three days.

Laser
This method uses heat from a laser beam to remove abnormal cells from the cervix, and takes 15–30 minutes. Most patients are able to have treatment using a local anaesthetic, which is usually more convenient, but some may require a general anaesthetic and a short hospital stay. Most are able to return to normal activities within two or three days.

Cone biopsy
In this minor operation, a cone-shaped section of the cervix containing the abnormal cells is removed. This usually requires a general anaesthetic and a day or, rarely, an overnight hospital stay.

Only a small number of patients will need a cone biopsy. It is the recommended treatment when the abnormal cells are higher in the cervical canal and/or affect the glandular cells. It may also be recommended to remove potentially cancerous cells.

Care after treatment
After any form of treatment the patient should not swim, use tampons or have vaginal intercourse for three to four weeks until the cervix has healed. Strenuous exercise should be avoided for seven to ten days following treatment as this increases the risk of bleeding and infection.
National Cancer Screening Register

The National Cancer Screening Register (Register) supports the NCSP by providing a safety net to patients and healthcare providers to support usual care.

The Register will support you to manage your patient’s personal information and participation in the Register for cervical screening.

Privacy in the Register

Your patient’s personal details and screening history is securely stored in the Register. The Register is protected by the latest state-of-the-art-data security measures, in accordance with strict Australian Government information security requirements and legislation. All information in the Register is stored on shore in Australia.

As the data custodian, the Commonwealth Department of Health will have control over the information in the Register, especially with respect to use and disclosure of this protected information.

Program correspondence

The Register provides an invitation and reminder service to women who are due for cervical screening or other follow-up tests, encouraging them to make an appointment with their healthcare provider.

The Register may also send you notifications to indicate that your patient has not attended important clinical follow-up tests or examinations.

You may find the following NCSP Correspondence Quick Reference Guide helpful to understand the communications process:

<table>
<thead>
<tr>
<th>NCSP Correspondence</th>
<th>Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk category</strong></td>
<td><strong>Timing/Details</strong></td>
</tr>
<tr>
<td>Low risk</td>
<td>Screening invitation sent 3 months prior to their due date.</td>
</tr>
</tbody>
</table>
| | Screening reminders sent at:  
  • 3 months after their due date.  
  • 2 years post their due date. | ✓ | ✗ |
| Intermediate risk | Invitation sent 3 months prior to their due date. | ✓ | ✗ |
| | If no further test results are received by the NCSR, reminders will be sent to the healthcare provider and the individual after the due date. Generally reminders will be sent in the following order:  
  1. To the patient  
  2. To the healthcare provider  
  3. To the patient | ✓ | ✓ |
| Higher risk | If no follow up is received by the NCSR – reminders will be sent to the individual, if contact from the NCSR with the healthcare provider has not resolved the individual’s clinical management status. Generally reminders will be sent in the following order:  
  1. To the healthcare provider  
  2. To the patient | ✓ | ✓ |

If no response at 4 years and 9 month after the due date, a new screening round will commence with an invitation to screen.
Supporting your patients through the Register

Eligible individuals, or personal representatives on their behalf, can manage their personal information including contact information and make the following requests to the Register. With consent, you can also perform these functions on behalf of your patients.

<table>
<thead>
<tr>
<th>Request to the Register</th>
<th>Effect on patient</th>
<th>Effect on healthcare provider</th>
</tr>
</thead>
</table>
| Cease contact and correspondence | • Your patient will no longer receive correspondence or contact from the Register.  
• Clinical information, including test results, will continue to be stored on the Register. | • You can continue to access your patient’s clinical information or screening history through the Register. |
| Defer Screening | • Your patient can temporarily defer correspondence from the Register for any period of time.  
• Clinical information, including test results, will continue to be stored on the Register during this time. | • You can continue to access your patient’s clinical information or screening history through the Register. |
| Opt out | • Your patient can opt out of the Register and will no longer receive contact or correspondence from the Register.  
• Any clinical information, including test results, will not be stored on the Register from the time of opting out. | • You can still provide cervical screening services for your patient without the safety net of the Register.  
• You will not be able to request screening histories for this patient. |
| Pseudonym | • Protects your patient’s identity.  
• All contact or correspondence sent by the Register on behalf of the NCSP will be directed to the pseudonym rather than the legal name. | • Search for the patient in the Register using their pseudonym.  
• Your patient’s legal name should be written on the pathology request form for Medicare payments. |
| Nominate a Healthcare Provider | • Patients can nominate a healthcare provider for the NCSP. | • Both the nominated and treating healthcare providers will receive correspondence from the NCSP. |

With consent, you can also withdraw the above Register requests at any time.

Contacting the Register

When contacting the Register you will need to provide your:

• First Name
• Last Name
• Medicare Provider Number  
• HPI-I (if not known, another identifier will be required)

Find out your patient’s screening history by calling **1800 627 701**

Pathology laboratories can no longer act on NFR (not for Register) instructions on the pathology request form. If a patient chooses to ‘opt out’ of the National Cancer Screening Register then the patient themselves, or with their consent; their healthcare provider, or their personal representative can arrange this by calling **1800 627 701**.

Opting a patient out of the NCSR for cervical screening will not opt this patient out of other screening programs (i.e. bowel screening), and they can rejoin the Register any time.
# More information

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
</table>
| State and Territory Cervical Screening Programs | For information on cervical program initiatives in your state or territory go to their website. | ACT  [www.act.gov.au/cervicalscreening](http://www.act.gov.au/cervicalscreening)  
| National Cancer Screening Register    | If you need to check if a patient has previously had a Cervical Screening Test and when they last had this test | Phone: 1800 627 701 |
| National HPV Vaccination Register     | If you need to check if a patient has already had the HPV vaccine, and how many doses they have received | [www.hpvregister.org.au](http://www.hpvregister.org.au)  Phone: 1800 478 734 |
| Cancer Council (State and Territory)  | For information on cervical cancer prevention, treatment and support | [www.cancer.org.au](http://www.cancer.org.au)  Phone: 13 11 20 |
| Translating and Interpreting Service | If your patient has difficulty communicating in English | Phone: 13 14 50  (same cost as a local call) |
| TTY (teletypewriter)                  | If your patient is hearing or speech impaired | [www.relayservice.gov.au](http://www.relayservice.gov.au)  Phone: 1800 555 630 (free call) |
Pathology Tests for Cervical and Vaginal Testing

Why have the MBS items for pathology tests changed?
From 1 December 2017, Pap tests will no longer be eligible for Medicare rebates. The MBS items for cervical and vaginal pathology testing for cervical pre-cancer and cancer have been updated to operationalise the new clinical pathway and National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) recommendations.

What do I write on the pathology request form?
Clinical information on pathology request forms assists pathology laboratories in performing the right tests, matching the right clinical recommendations and selecting the right MBS item/s. Practitioners will need to specify on the pathology request form:
1. whether the collection is part of routine screening or is for clinical management or for screening symptomatic women; and
2. the tests required (refer to the tables opposite); and
3. other relevant clinical information e.g. screening history, DES exposed.
The information will assist the laboratory to identify which pathology MBS item number to use and will minimise queries back to you.

How will the pathology laboratory manage my request?
Upon receipt of a liquid sample the pathology laboratory will:
• perform tests as requested;
• access the patient’s screening histories from the National Cancer Screening Register to confirm appropriate testing protocol and contact the requestor if there is discrepancy from requested tests as well as inform the clinical recommendation; and
• issue a combined report containing the results of the Human Papillomavirus (HPV) and/or Liquid Based Cytology (LBC) test if performed and management recommendation.

Are the MBS items for pathology tests gender specific?
The pathology MBS items for cervical screening are not gender specific. Any patient with a cervix is eligible for an MBS rebate if the eligibility criteria prescribed in the requested item is met. In addition to women this includes transgender men and may include intersex or gender fluid people.

When should I request a self-collect HPV test for my patient?
Patients are only eligible to self-collect a vaginal sample for HPV testing if they meet all the following:
• asymptomatic and not pregnant; and
• aged 30 years and over; and
• two or more years overdue for a screening test or have never screened.

How is a self-collect HPV test request handled differently at the laboratory?
A self-collected sample can only be tested for HPV.
• If oncogenic HPV 16/18 is detected, patient should progress to colposcopy.
• If oncogenic HPV not 16/18 is detected, the patient should return to have a follow up LBC as soon as possible.

What if my patient asks for a Pap test after 1 December 2017?
From 1 December 2017, Pap tests by traditional smear testing will no longer be eligible for Medicare rebates and any samples submitted will attract an out-of-pocket expense.
# Pathology Test Guide for Cervical and Vaginal Testing

<table>
<thead>
<tr>
<th>Context</th>
<th>Age</th>
<th>Sample type</th>
<th>Test type</th>
<th>What to write on the pathology request form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asymptomatic:</strong>   NCSP routine five-yearly screening           Only 1 of this MBS item is claimable in a 57-month period</td>
<td>≥ 24yrs &amp; 9mths</td>
<td>Cervical</td>
<td>HPV test</td>
<td>Cervical Screening Test (CST)</td>
</tr>
<tr>
<td>        Screening under- and never-screened patients             ≥ 30 years of age and         At least 2 years overdue or never-screened and</td>
<td>≥ 30yrs</td>
<td>Vaginal</td>
<td>HPV test</td>
<td>HPV test, self-collected</td>
</tr>
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Online Training - CPD points

To assist you to understand the changes to the NCSP, the department and NPS MedicineWise have developed online training modules which are accredited for CPD points with RACGP, ACRRM, ACN, ACM and APNA.

These online training modules cover the information about the changes to cervical screening and the new clinical management recommendations that support the new Cervical Screening Test from the 2016 Guidelines, including:

- understanding the difference between the new Cervical Screening Test and the Pap test
- collecting a Cervical Screening Test sample
- understanding the new risk categories and pathways
- managing women transitioning with abnormalities to the new clinical pathway
- practical advice and videos to help you engage patients of culturally and linguistically diverse communities and patients with an intellectual disability.

The training is available now at NPS MedicineWise see the online course Changes to the National Cervical Screening Program at https://learn.nps.org.au/.

Resources to support you with under-screened and never-screened women

Further education and resources are available for providers who would like to learn more about engaging under-screened and never-screened patients in cervical screening. These can be found at www.cancerscreening.gov.au/cervical.


References

4. RCT data shows HPV testing has a 98% NPV. Pathak N et al. Accuracy of urinary human papillomavirus testing for presence of cervical HPV: systematic review and meta-analysis. BMJ 2014;349:g5264.