Guideline

Health New Zealand
Te Whatu Ora

Addendum to Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand

This update should be read in conjunction with the Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand, June 2023.

Background

Clinical practice guidelines require regular review. The Clinical Practice Guidelines (CPG) for Cervical Screening in Aotearoa New Zealand were finalised in June 2023 and implemented in September 2023, coinciding with the introduction of HPV Primary Screening.

Updated guidelines have been developed to replace the June 2023 version. These updates have significant implications for digital infrastructure, Register services, communications, and provider training, and will require substantial resources for full implementation.

Importantly, some changes—particularly those affecting the Cervical Screening Register—must be in place before the guidelines can be fully enacted. However, certain components of the updated guidelines that enhance clarity and enable colposcopy clinics to allocate resources more effectively can be implemented immediately, as they do not require changes to the Register. These components are introduced here.

Definitions, translations and acronyms

Please refer to the current Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand for terminology, abbreviations and definitions.

Associated documents

Associated policies, procedures and resources
Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand
Standards of practice for providers of National Cervical Screening Programme services

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Purpose of the update

This addendum describes clinical scenarios from the updated Clinical Practice Guidelines where colposcopy clinics can safely direct their resources more effectively, and addresses some gaps in the current guidelines. This update can be implemented immediately and supersedes the current guidelines.

- Section 6. Section R6.05: Type 3 TZ at colposcopy and ASC-US/LSIL cytology – cytological review prior to observation.
- Section 8. Section R8.03: Active surveillance of CIN2 in participants aged under 30.
- Section 8. Section R8.06: Management of positive margins after treatment of HSIL in participants aged under 50 years.
- Section 9. Section R9.14: Follow-up after excision treatment for AIS.
- Screening after gynaecological cancer.
- Section 12: Immune deficiency.

Guideline updates

Section 6. Section R6.05: Type 3 TZ at colposcopy and ASC-US/LSIL cytology – cytological review prior to observation.

The current guidelines advise those with Type 3 TZ at colposcopy and ASC-US/LSIL cytology require cytological review at MDM.

UPDATED RECOMMENDATION	
R6.05 Type 3 TZ at colposcopy and ASC-US/LSIL cytology – cytological review prior to observation.	For those with a Type 3 TZ who are HPV positive, LG cytology and normal colposcopy, MDM cytological review is not required.

Section 8. Section R8.03: Active surveillance of CIN2 in participants aged under 30.

The current guidelines state that it may be acceptable to offer a period of colposcopic observation to some participants who have a histological diagnosis of CIN2.

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The updated guidelines are more explicit regarding recommendations around this. The criteria for active surveillance of CIN2 are detailed here and shown in Figure 1:

RECOMMENDATION	
R8.03 **Active surveillance of CIN2 in participants aged under 30.**	Participants aged under 30 at time of diagnosis can be offered active surveillance of CIN2 if: • there is a Type 1 or 2 TZ **and** a CIN3 or invasive lesion is excluded • CIN2 has been diagnosed on histology and reviewed at MDM • The participant agrees to regular 6 monthly follow-up colposcopy examinations including repeat cervical cytology, and biopsy of any lesions present • the participant understands that the time period for colposcopic observation of CIN2 could be up to 24 months • Treatment must be offered if the CIN2 has not resolved within 24 months. If CIN3 is diagnosed during follow-up, then treatment is recommended.
	Practice Point It is important to discuss the benefits and risks of active surveillance of CIN2 with participants to guide shared decision making when opting for surveillance or treatment. Participants should be informed that they can change the plan from active surveillance to treatment at any time during the follow-up if CIN2 is still present. When CIN2 has regressed, participants can be discharged from colposcopy clinic and should complete a Test of Cure prior to returning to the regular screening interval.

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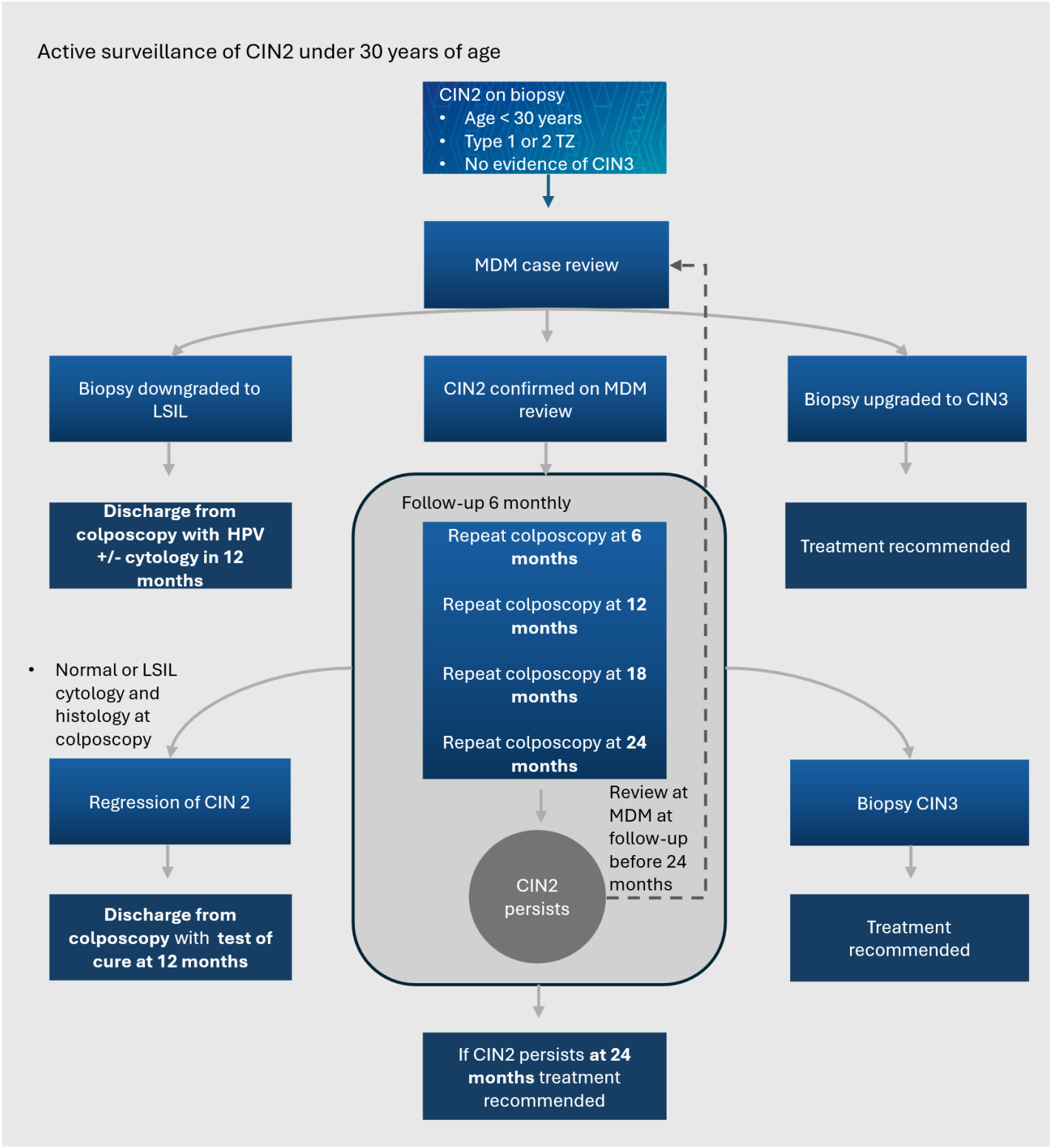
Figure 1: Active surveillance of CIN2 under 30 years of age



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Section 8. Section R8.06: Management of positive margins after excision treatment of HSIL in participants aged under 50 years.

The current guidelines state that the first Test of Cure surveillance following treatment for HSIL should be in colposcopy clinic if the histology does not show complete excision. Follow-up is in primary care if the histology shows complete excision.

The updated guidelines remove the requirement for colposcopy follow-up in those aged under 50 who have positive excision margins at time of treatment. This is because HPV testing is more sensitive than either colposcopy or excision margin status.

UPDATED RECOMMENDATION	
R8.06 Management of positive margins after excision treatment of HSIL in participants aged under 50 years.	For those aged under 50 with positive excision margins at the time of their HSIL treatment, Test of Cure follow-up can be done in primary/community care.

Section 9. Section R9.14: Follow-up after excision treatment for AIS.

The current guidelines recommend colposcopy follow-up for those with completely excised HPV positive AIS.

The updated guidelines recommend that when participants are treated for histologically confirmed HPV detected AIS and the histology confirms clear margins, follow-up can occur in primary/community care. This is because a positive HPV test has shown to be the most significant predictor of residual disease. The follow-up should be a co-test at 6 and 18 months for a Test of Cure.

UPDATED RECOMMENDATION	
R9.14 Follow-up after excision treatment for AIS.	Following treatment for HPV detected AIS with clear excision margins, follow-up can be in primary/community care (not colposcopy) with a co-test at 6 and 18 months.

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Screening after gynaecological cancer.

This is not explicit in the current guidelines.

HPV and cytology testing following treatment for cervical and vaginal cancer is not screening. Because of this, anyone with cervical or vaginal cancer is unenrolled from the Cervical Screening Register and communications (notifications) from the National Cervical Screening Programme (NCSP) should not be sent. NCSP does not provide recommendations on tests received for this group, except for those with a stage 1a1 Cervical Cancer.

UPDATED RECOMMENDATION

For people who have had stage 1a1 cervical cancers (squamous cell cancer (SCC) or adenocarcinoma):

- Treated by local excision (i.e. LLETZ or cone): these participants will return to regular cervical screening after successful treatment and completion of a Test of Cure.
    - If HPV is detected (any type) or cytology is abnormal during the Test of Cure period participants should be referred to colposcopy.
    - If there is an HPV detected test after the completion of a Test of Cure, further management should follow the HPV primary screening guidelines.
- Treated by total hysterectomy: these participants can cease cervical screening after completing a Test of Cure.

For people who are unenrolled because of previous cancer, there are no restrictions on continuing to have HPV or cervical cytology tests. This should be determined by the clinician and the participant. NCSP will not be making recommendations on tests and management for this group.

For people who have had a HSIL *without a Test of Cure* prior to a hysterectomy for a non-cervical gynaecological cancer, a Test of Cure should be undertaken. If the Test of Cure results are HPV not detected and negative cytology on two consecutive occasions 12 months apart, the participant can cease screening.

People with gynaecological cancers who have had a sub-total hysterectomy should continue screening and will continue to receive notifications from the Cervical Screening Register.

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Section 12: Immune deficiency.

The updated guidelines are more explicit as to what constitutes immune deficiency for the purposes of cervical screening and can be applied now.

SCREENING INTERVAL	CONDITIONS AND MEDICATIONS
3-yearly screening recommended [a]	Living with human immunodeficiency virus (HIV), regardless of viral load
	Solid organ transplant with immunosuppressive therapy
	Active haematological malignancy (e.g. Leukaemia, lymphoma, other lymphoproliferative disorder, plasma cell dyscrasia)
	Haematopoietic stem cell transplant (HSCT) recipients or chimeric antigen receptor T-cell (CAR-T) therapy within 2 years of transplantation. Has chronic graft versus host disease.
	Primary immunodeficiency including combined immunodeficiency syndromes (e.g. systemic lupus erythematosus, complement deficiencies)
	Major antibody deficiency (e.g. common variable immune deficiency [CVID] or agammaglobulinemia).
	Defects of innate immunity, including phagocytic cells (e.g. NF-kappa-B essential modulator (NEMO) deficiency syndrome, natural killer (NK) cell deficiency)
	Defects of immune regulation (e.g. autoimmune enteropathy or ulcerative colitis)
	Phenocopies of primary immunodeficiencies
3-yearly screening should be highly considered [b]	Long term haemodialysis or peritoneal dialysis (>6 months)
	When participants are taking multiple immunosuppressants where the cumulative effect is considered to be severely immunosuppressive Participants taking long-term treatment (>6 months) with highly immunosuppressive therapies.

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SCREENING INTERVAL	CONDITIONS AND MEDICATIONS
	Including the following immunosuppressive medications:
	High-dose corticosteroid treatment equivalent to >20 mg/day of prednisone for ≥14 days in a month, or pulse corticosteroid therapy
	Selected conventional and targeted synthetic disease-modifying anti-rheumatic drugs (sDMARDS), taken for long-term treatment for > 6 months: leflunomide
	Mycophenolate
	Methotrexate (≥10 mg/week)
	Azathioprine (≥1mg/kg day)
	6-mercaptopurine (≥0.5 mg/kg/day)
	Alkylating agents: cyclophosphamide, chlorambucil
	Systemic calcineurin inhibitors: cyclosporin, tacrolimus
	JAK inhibitors: tofacitinib, baricitinib, ruxolitinib, upadacitinib
	Multiple sclerosis medications: dimethyl fumarate, fingolimod, teriflunomide
	TNF inhibitors: etanercept, infliximab
	Anti-interleukin monoclonal antibody therapy: secukinumab, dupilumab, tocilizumab
	Anti-integrins: natalizumab
	Anti-complement antibodies: eculizumab
	Anti-CD52 antibodies: alemtuzumab
	Sphingosine 1-phosphate receptor modulators: fingolimod
	Potent B-cell or T-cell depleting therapy within the last 12 months: muromonab, teplizumab, rituximab, ocrelizumab

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Some conditions and medications are NOT considered immune suppressant in the context of cervical screening:

	CONDITIONS AND MEDICATIONS
Conditions not considered immune deficient in the context of cervical screening	Diabetes
	Thyroid disease (Graves' disease)
	Previous splenectomy
	Coeliac disease
Medications not considered immunosuppressive in context of cervical screening	Hydroxychloroquine, sulfasalazine or mesalazine when used as monotherapy
	Low-dose or brief corticosteroid therapy
	Replacement corticosteroid treatment for adrenal insufficiency
	Most standard chemotherapy regimens for solid tumours are not considered to be highly immunosuppressive, as well as other antineoplastic treatments, such as hormone therapy, immunotherapy and targeted therapy
	People with history of cancer and those being treated with chemotherapy short-term (< 6 months) for solid tumours. **However,** particular cases, especially with prolonged treatments or multiple prior lines of cytotoxic therapy, may be discussed with the oncologist.

Further information

For further information about this update, contact your clinical lead or email NCSP@tewhatuora.govt.nz.

Review history*

Version	Updated by	Date	Description of changes