

CERVICAL SCREENING



a pocket guide

NHS
Cancer Screening Programmes

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This booklet is a simple guide to cervical screening.

We hope you find it useful – whether you work for or take a professional interest in the NHS Cervical Screening Programme.

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Cancer Screening Programmes

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The NHS Cervical Screening Programme

What is cervical screening?

- Cervical screening is *not* a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix (the neck of the womb).
- Early detection and treatment can prevent around 75 per cent of cancers developing but like other screening tests, it is not perfect. It may not always detect early cell changes that could lead to cancer.
- The first stage in cervical screening is either a smear test or a liquid based cytology (LBC) test.
- Most women consider these procedures to be only mildly uncomfortable.

What is a smear test?

- A sample of cells is taken from the cervix for analysis. A doctor or nurse inserts an instrument (a speculum) to open the woman's vagina and uses a spatula to sweep around the cervix.
- The sample of cells is 'smear'd' on to a slide which is sent to a laboratory for examination under a microscope.

What is LBC?

- LBC is a new way of preparing cervical samples for examination in the laboratory.
- A sample of cells is taken using a spatula which brushes cells from the cervix.
- Rather than smearing the sample onto a microscope slide as happens with the conventional smear, the head of the spatula, where the cells are lodged, is broken off into a small glass vial containing preservative fluid or rinsed directly into the preservative fluid.

- The sample is sent to the laboratory where it is spun and treated to remove obscuring material, for example mucus or pus, and a random sample of the remaining cells is taken. A thin layer of the cells is deposited onto a slide. The slide is examined in the usual way under a microscope by a cytologist.
- LBC is currently being introduced. Due to retraining of laboratory staff and sample takers, roll-out is expected to take place over the next five years.

LBC will:

- Reduce the number of inadequate cervical tests (for example, the introduction of LBC at the pilot sites reduced the reported rate of inadequate tests from 9 per cent to 1-2 per cent).
- Reduce the pressure on a skilled workforce (fewer inadequate tests and clearer to read samples). Nationally, the workload would be reduced from 4.2 million slides per annum to 3.9 million slides.
- Reduce levels of anxiety in women who accept their invitation for cervical screening due to quicker reporting time and a reduction in the number of women recalled.

What does the NHS Cervical Screening Programme do?

- The programme aims to reduce the number of women who develop invasive cervical cancer (incidence) and the number of women who die from it (mortality).
- It does this by regularly screening all women at risk so that conditions which might otherwise develop into invasive cancer can be identified and treated.

Who is eligible for screening?

- Cancer Research UK (CRUK) evaluated the interval for cervical screening. The findings indicate that a more effective and targeted programme can be provided by changing the frequency of screening according to a woman's age.¹
- The Advisory Committee on Cervical Screening has accepted recommendations made by CRUK scientists. National recommendations have been changed as follows:

Age Group (Years)	Frequency of Screening
25	First invitation
25-49	3 yearly
50-64	5 yearly

The change is recommended to take place after a woman's next cervical test.

- The NHS call and recall system invites women who are registered with a GP. This also keeps track of any follow-up investigation and, if all is well, recalls the woman for screening in three or five years time. It is therefore important that all women ensure their GP has their correct name and address.
- Women who have not had a recent cervical test may be offered one when they attend their GP or family planning clinic on another matter.

Why are women under 25 and women over 65 not invited?

- Invasive cancer is rare in women under 25 but changes in the cervix are common. This means that younger women may get an abnormal result when there is nothing wrong.

¹ P Sasieni, J Adams and J Cuzick, *Benefits of cervical screening at different ages: evidence from the UK audit of screening histories*, *British Journal of Cancer*, July 2003

- Cervical cancer is very rare in women under 25. Evidence suggests that screening women under the age of 25 may do more harm than good by resulting in unnecessary investigations after false positive results suggest that they appear to have cervical abnormalities when in fact they do not. Screening women from the age of 25 will help reduce anxiety as well as the number of unnecessary investigations and treatments in younger women.
- Any woman under 25 who is concerned about her risk of developing cervical cancer, or her sexual health generally, should contact her GP or Genito-Urinary Medicine (GUM) clinic.
- Women aged 65 and over who have had three consecutive negative cervical tests in the preceding ten years are taken out of the recall system. The natural history and progression of cervical cancer means it is highly unlikely that such women will go on to develop the disease.
- Women aged 65 and over who have never had a cervical test are entitled to one.

What about women who are not sexually active?

- The NHS Cervical Screening Programme invites all women between the ages of 25 and 64 for cervical screening. If a woman has never been sexually active with a man, research evidence shows that her chance of developing cervical cancer is very low. In these circumstances, a woman might choose to decline the invitation for cervical screening on this occasion.

When was the NHS Cervical Screening Programme set up?

- Cervical screening began in Britain in the mid-1960s. Although many women were having regular smear tests by the mid-1980s, there was concern that those at greatest risk were not being tested and that those who had positive results were not being followed up and treated effectively.
- The NHS Cervical Screening Programme was set up in 1988 when the Department of Health instructed all health authorities to introduce computerised call-recall systems and to meet certain quality standards.

How many women are screened?

- The programme screens almost four million women in England each year. Of the 3.6 million women in the target age group screened in 2002-03, 2.7 million were tested following an invitation and about 0.9 million were screened opportunistically at the suggestion of the sample taker or of the woman herself.²
- For clinical reasons some women have more than one cervical test during the course of a year and an estimated 4.1 million tests were examined by pathology laboratories during 2002-03.²
- Of the 13.8 million women aged 25-64 eligible for cervical screening in 2002-03, 81.2 per cent had been screened within the previous five years.²

How is the programme organised?

- More than 100,000 people are involved in cervical screening. They include the doctors and nurses who take the tests in GP surgeries and community clinics, the laboratory staff who review the slides and the people who run the computer systems.

2 Department of Health Statistical Bulletin, Cervical Screening Programme, England 2002-2003

- The National Coordination Office, based in Sheffield, is responsible for improving the overall performance of the programme. Set up in 1994, its priorities are to:

Develop systems and guidelines which will assure a high quality of cervical screening throughout the country.

Improve communications within the programme and to women.

Identify important policy issues and help resolve them.

- Every Primary Care Trust has a nominated person responsible for its cervical screening programme.
- Regional Directors of Public Health are responsible for the quality assurance network in their region.

How much does the programme cost and how is it funded?

- Cervical screening, including the cost of treating pre-cancerous lesions, has been estimated to cost around £150 million a year in England. The cost per woman screened equates to £37.50.
- Primary Care Trusts commission cervical screening from the overall allocation they receive from the Department of Health.
- The new General Medical Services (GMS) Contract for GPs came into effect on 1st April 2004. Under the new contract, target payments no longer exist. Instead, GPs are being funded to provide a cervical screening service to national guidelines. Cervical screening is funded through the global sum paid to each GP practice monthly in advance. In addition, further funding is available for delivering a quality service. For example, half of the available extra funding is rewarded on a sliding scale for screening between 25 per cent and 80 per cent of eligible women who have had an adequate cervical screening test performed in the last three to five years.





Cervical cancer – incidence, mortality and risk factors

What is the incidence of cervical cancer?

- There were an estimated 2,400 new cases of invasive cervical cancer in England in 2000.³
- Cervical cancer incidence fell by 42 per cent between 1988 and 1997 (England and Wales). This fall is directly related to the cervical screening programme.⁴
- There was a 25 per cent decrease in the incidence rate of cervical cancer for women under the age of 70 from 1990 to 1992. This has been attributed to the rapid increase in coverage of the cervical screening programme which occurred from 1989 onwards.⁵
- In 1995 there were 10.4 newly diagnosed cases of cervical cancer per 100,000 women.⁶ By 1999 this had fallen to 9.3 per 100,000 women.⁷
- Cervical screening now saves approximately 1,300 lives per year.⁸
- In 1999 21,617 women in England were found to have the most severe type of Cervical Intraepithelial Neoplasia 3 (CIN3).⁷ This can only be detected by screening and is treated to prevent invasive cancer developing.
- UK incidence rates are slightly below the European Union average while the mortality rates are slightly above.⁹
- An estimated 471,000 new cases of cervical cancer are diagnosed each year in the world with 80 per cent of these occurring in the less developed world.⁹

3 National Statistics, *Cancer Registrations, England 2000*

4 National Statistics, *Health Statistics Quarterly 07, Autumn 2000*

5 *Cancer Incidence and Mortality in England and Wales: trends and risk factors.* Swerdlow, Silva and Doll OUP 2001

6 National Statistics MB1 No 28 *Cancer statistics. Registrations 1995-1997*

7 National Statistics MB1 No 30 *Registrations of cancer diagnosed in 1999*

8 Sasieni P, Adams J, *BMJ* 1999; 318:1244-1245

9 *Cancer Stats, Cervical Cancer – UK, January 2003, Cancer Research UK, London*

How many women die from cervical cancer?

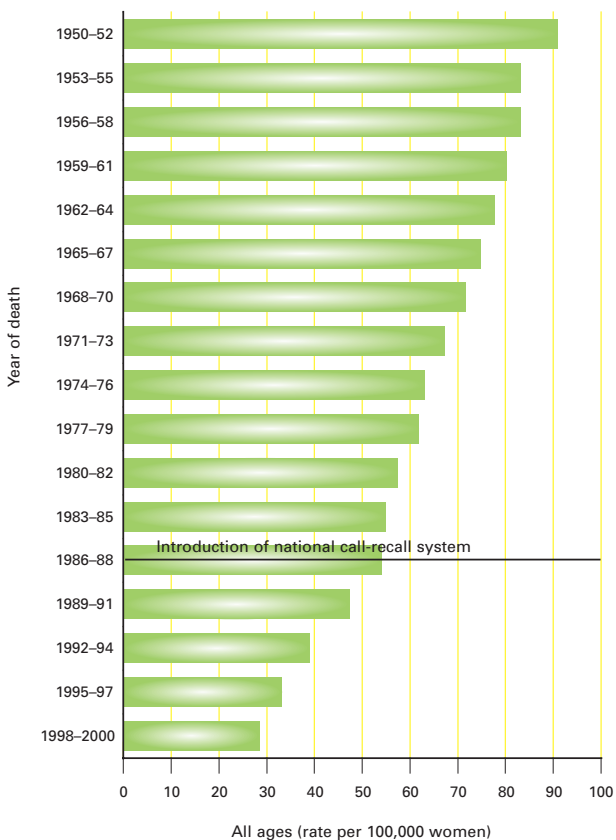
- For the first time ever death rates from cervical cancer have fallen below 1,000 in England. In 2002, 927 deaths from cervical cancer were registered.¹⁰
- Mortality rates generally increase with age. Less than 5 per cent of cervical cancer deaths occur in women under 35.¹¹
- Mortality rates in 2000 were 60 per cent lower (3.3 per 100,000 women) than they were 30 years earlier (8.3 per 100,000 in 1971).¹¹
- Cervical cancer is the eleventh most common cause of cancer deaths in women in the UK, compared with third world countries where it is one of the most common killers. It accounts for around 2 per cent of all female cancers in the UK.¹¹
- The latest relative survival figures for England show that an average of 84 per cent of women diagnosed with cervical cancer between 1993 and 1995 were alive one year later and 66 per cent were alive five years later.¹¹



¹⁰ Health Statistics Quarterly, Summer 2003, National Statistics

¹¹ Cancer Stats, Cervical Cancer – UK, January 2003, Cancer Research UK, London

Death from cancer of the cervix in England and Wales, 1950-2000



What are the risk factors for cervical cancer?

- The exact cause of cervical cancer is not known. However, it is known that certain types of human papilloma virus (HPV) are linked with around 95 per cent of all cases of cervical cancer.
- Women with many sexual partners, or whose partners have had many partners, are more at risk.
- Using a condom gives some protection while long term use of oral contraceptives increases the risk.
- The benefits of taking oral contraceptives far outweigh the risks for the majority of women.
- Women who smoke are about twice as likely to develop cervical cancer as non-smokers.
- Women with a late first pregnancy have a lower risk than those with an early pregnancy; the risk rises with the number of pregnancies.
- Women in manual social classes are at higher risk than those in non-manual social classes.
- Women who have had a total hysterectomy for other non-malignant reasons cannot get cervical cancer and no longer need cervical screening.
- Women who take immunosuppressant drugs (for example, after an organ transplant) are at increased risk of developing cervical cancer.

Despite the risk factors, cervical screening can prevent around 75 per cent of cancer cases in women who attend regularly. Screening is one of the best defences against cervical cancer. Many of those who develop it have never been screened. The biggest risk factor therefore is non-attendance.





Cervical screening – results and treatment

- Under national quality assurance guidelines, 80 per cent of women should receive the result of their cervical test in writing within four weeks and all women should be informed within six weeks.¹²
- Cytology, the study of cells, enables cervical tests to be grouped into different grades. This helps the doctors decide what action needs to be taken.

GRADE	EXPLANATION	ACTION
NEGATIVE	No abnormalities detected	Routine recall after three to five years
ABNORMAL	Cellular appearances which cannot be described as normal	Refer for colposcopy after one borderline change or three abnormal tests at any grade in a ten year period
Borderline changes	Endocervical cell changes	Refer for colposcopy after one test is reported as borderline
	Squamous cell changes	Refer for colposcopy after three tests in a series are reported as borderline
Mild dyskaryosis	Cellular appearances consistent with CIN* 1	Ideally refer for colposcopy but it remains acceptable to recommend a repeat test after one test reported as mild dyskaryosis. If two tests are reported as mild dyskaryosis refer for colposcopy
Moderate dyskaryosis	Cellular appearances consistent with CIN 2	Refer for colposcopy
Severe dyskaryosis	Cellular appearances consistent with CIN 3	Refer for colposcopy
Suspected invasive cancer	Possibility of invasive cancer	Refer for colposcopy. Women should be seen urgently within two weeks of referral
INADEQUATE	The test cannot be interpreted. It may be too thick or too thin, obscured by inflammatory cells, blood, incorrectly labelled or does not contain the right type of cells	Repeat the test. Refer for colposcopy after three consecutive inadequate samples

NHSCSP Publication No.20: *Colposcopy and Programme Management Guidelines for the NHS Cervical Screening Programmes*

*The abnormal changes, or lesions, on the skin of the cervix are known as cervical intraepithelial neoplasia (CIN). The appearance that is noted when cells are scraped from the surface of CIN lesions onto a slide in a cervical test is called dyskaryosis.

12 *Quality assurance guidelines for the cervical screening programme, NHSCSP publication no. 3, January 1996*

What is colposcopy?

- Colposcopy is performed by specially trained clinicians at an outpatient appointment. A colposcope, a low-powered microscope, is used to examine the woman's cervix to assess the extent and severity of any problem and to determine appropriate treatment. Colposcopy further examines non-invasive conditions (CIN 1-3) so that a sample of tissue can be taken from the cervix for diagnosis and/or treatment as required.

When should the cervix be treated?

- Not all grades of abnormality are referred for immediate treatment. Some abnormalities may disappear on their own without treatment.
- The Colposcopy and Programme Management Guidelines for the NHS Cervical Screening Programme¹³ set out a clear protocol which aims to ensure that women at a very low risk of developing cervical cancer are not referred unnecessarily. Following referral to colposcopy a rapid return to community based cytology is also recommended for women at low risk, whereas those at high risk will be maintained on follow-up for up to ten years following treatment.
- At colposcopy samples can be taken from the cervix. If histological diagnosis indicates CIN 2 or 3 the affected part of the cervix can be removed or destroyed. Women with CIN 1 may be treated or kept under surveillance with repeat cervical tests. CIN 1 often disappears without treatment.

13 NHSCSP Publication No.20: Colposcopy and Programme Management Guidelines for the NHS Cervical Screening Programmes

What kind of treatment is available?

- There are two main methods of treatment. The abnormal cells in the cervix may be destroyed using laser ablation or cold coagulation treatments or the abnormality may be cut away using loop diathermy or laser excision. Loop diathermy, where a thin wire loop cuts through and removes the abnormal area, is the most common treatment, used by 71 per cent of clinics.
- Hysterectomy is not usually necessary for CIN. Treatment aims to preserve a woman's fertility and ability to have children wherever possible.
- Surgery is the main form of treatment for localised cases for the few women who have cancer, while radiotherapy and chemotherapy may be used for more extensive disease.



Future developments in cervical screening

Human Papilloma Virus (HPV)

- Human papilloma viruses are a group of more than 80 viruses, some of which are associated with an increased risk of cervical cancer. Most women are infected with the virus at some point, but it is not yet possible to tell which of these will go on to develop CIN, abnormalities of the cervix, nor which of them will naturally expel the virus by the normal functioning of their immune system. Most HPV infections disappear without treatment and even those women who contract high risk HPVs rarely go on to develop cervical cancer.
- Carrying out an HPV test at the same time as a woman has a cervical test may help to decide how to manage the woman if her test shows minor abnormalities, and could avoid referral to colposcopy with its associated anxiety. The LBC pilot also looked at using HPV testing as triage. The evaluation results from the HPV pilot should be available by the end of 2004 as the women need to be followed up.

ARTISTIC trial

- Professor Henry Kitchener is leading a trial investigating HPV as a primary screening test. The trial, entitled ARTISTIC (A Randomised Trial of HPV Testing in Primary Cervical Screening), is taking place in Manchester, Stockport, Wigan & Leigh and Salford & Trafford, and began in June 2001. It will last for six years.

The trial should:

- Provide clear evidence on the costs, medical effects and psychosocial impact of adding HPV testing to cervical cytology.

- Provide an estimate of the effectiveness and costs of HPV as a stand-alone test.
- Determine the contribution of HPV detection to the cervical screening programme, particularly to sensitivity, specificity and inadequate smears.
- Address methodological issues in HPV testing.

The study population comprises 25,000 women aged 20-64 who are attending general practices for routine cervical screening and who consent to having a HPV test.

TOMBOLA study

- The Trial of Management of Borderline and other Low grade Abnormal smears (TOMBOLA) was established to understand the most appropriate way to deal with HPV positive results and associated psychological issues. Funded by the Medical Research Council, the study started recruiting women in December 1999. It is a seven year multi-centre trial and is being run from Dundee, Aberdeen and Nottingham.

Our answers to questions asked about HPV infection

Questions from women

Is there any treatment?

There is no reliable treatment to get rid of the virus, but since it disappears spontaneously over time in most women, a 'wait and see policy' is the usual management.



Should women and/or their partner practise safe sex or use barrier methods of contraception?

Correct and consistent use of male or female condoms would appear to be a sensible precaution. The virus might, however, have been present for some time before its detection and thereby passed on before condoms were used and so it is difficult to give specific advice on this. Some people come across the virus and never show its presence, developing a kind of immunity. Others harbour it for short or long periods of time without its presence being detected. There are no clinical trials to prove the efficacy or otherwise of barrier methods in this respect.

The presence of HPV is not a contraindication to attempting to become pregnant.

How long might she have had the infection?

This is an impossible question to answer since the virus can remain in your body without harm for considerable periods of time or be quickly dealt with by the immune system.

Questions from men

Should they see a doctor or attend a GUM clinic?

If men are worried about their partners having HPV found in screening, they might wish to visit their GP or GUM clinic for a further explanation and/or examination.

Can he be tested to see if he has HPV?

At present there is no reliable test to demonstrate the presence of the virus in men.

Can he be treated?

This is unnecessary (just as it is in women) unless the virus develops into clinical warts (growths), which project above the surrounding skin.



How long might he have had the infection?

This is an impossible question to answer since the virus can remain in your body without harm for considerable periods of time or be quickly dealt with by the immune system.

New ways of working

- Since December 2001 the NHS Cervical Screening Programme has been instrumental in the development of new ways of working with professional scientists in the programme.
- A new grade of Advanced Biomedical Scientist Practitioner has been introduced which brings additional reporting skills to the service.
- These practitioners undergo substantial extra training and study culminating in a qualification by examination run jointly by the Royal College of Pathologists and the Institute of Biomedical Science.



Informed choice

- Every woman registered with a GP will receive her first invitation for a cervical test at 25 years old. Every effort is made to minimise women's anxiety at all stages of screening. Invitations and recall letters are carefully worded and include a contact number for those who have questions.
- To help them make an informed choice about whether or not to come for cervical screening, all eligible women receive a leaflet 'Cervical Screening – THE FACTS' with their invitation. The leaflet explains the benefits and limitations of cervical screening.
- This initiative is part of the NHS Cancer Plan and follows efforts to make the limitations of screening better understood in the wake of the Bristol Inquiry and Alder Hey. The leaflet also addresses the need to inform patients about the use of personal information for audit, as advised in General Medical Council guidance as well as tying in with the Data Protection Act, the Human Rights Act and Disability Discrimination Act.
- The leaflet has been produced in Braille and on tape in English and has been translated into 17 languages: Arabic, Bengali, Cantonese, Farsi, French, Greek, Gujarati, Hindi, Italian, Polish, Punjabi, Somali, Spanish, Turkish, Ukrainian, Urdu and Vietnamese.



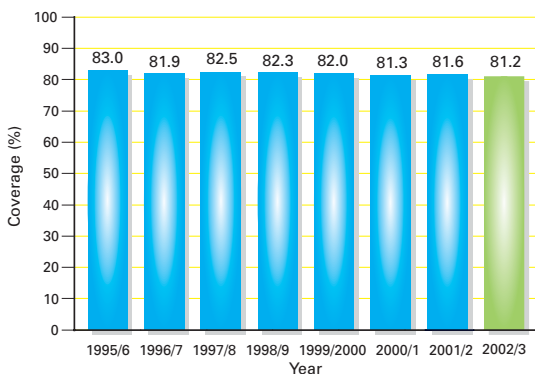
What happens to samples once they have been looked at?

- Samples are kept for 10 years by the laboratory so that they can compare a patient's most recent cervical test with their screening history. The laboratory may review all screening records as part of the programme's aim to offer a quality service and help increase the expertise of staff. When a review shows that a woman should have been cared for differently, she will be contacted and offered information about the reviewed case.

Coverage of the target population

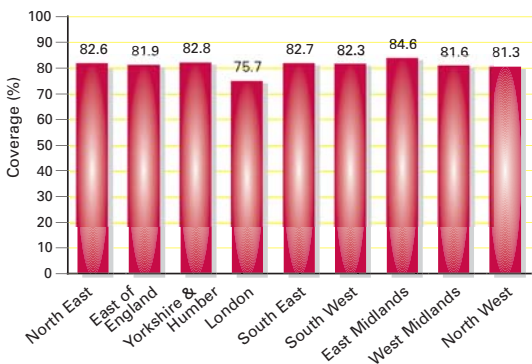
- The effectiveness of the programme can also be judged by coverage. This is the percentage of women in the target age group (25 to 64) who have been screened in the last five years. If overall coverage of 80 per cent can be achieved, the evidence suggests that a reduction in death rates of 65 to 70 per cent is possible in the long term. In 2002/03 the coverage of eligible women was 81.2 per cent.¹⁴
- Coverage of the target age group by the NHS Cervical Screening Programme has almost doubled from 45 per cent in 1988/89 to around 81 per cent in 2002/03.

Coverage (less than five years since last adequate test) of the target age group (25 - 64)



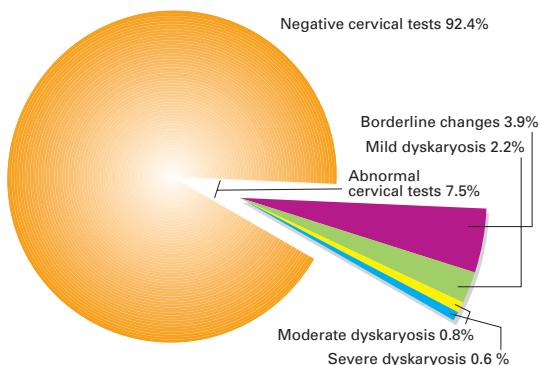
¹⁴ Department of Health Statistical Bulletin, Cervical Screening Programme, England, 2002 / 2003

Coverage by NHS region: Percentage of women who had a smear test in the last five years – on 31 March 2003



Results of screening in 2002/2003

- In 2002/03, 3.6 million women were screened in England. About one in 10 cervical tests examined were inadequate specimens where no result could be determined. Of the adequate tests 92.4 per cent were negative. The test results for adequate cervical tests are shown below.¹⁵



¹⁵ Department of Health Statistical Bulletin, Cervical Screening Programme, England, 2002 / 2003



What happens in the NHS Cervical Screening programme?

The NHS Call and Recall system:

- Holds a list of all patients registered with a GP in the area it covers.
- Sends the list of women due for screening to each GP to check the records (for correct name and address and in case it is not appropriate for them to be invited).
- Sends the invitation letters and reminder letters.
- Sends the results letters.

The sample takers:

A woman can choose to be screened at her GP surgery, by the GP practice nurse or at a community clinic, such as a family planning or well-woman clinic. Sample takers:

- Take the samples in line with quality standards and using the most up-to-date methods.
- Check that the results are returned to the GP surgery and to the woman.
- Arrange for repeat screening if necessary.

The laboratory:

- Interprets the tests. All slides are screened by a bio-medical scientist or a cytology screener. Tests which are thought to be abnormal are screened again by senior laboratory staff and are given a result code which depends on the degree of abnormality seen.
- Follows strict quality assurance procedures, including rapid review by a senior member of staff of all tests originally classed as negative.
- Sends the results to the Primary Care Trust, the GP and the sample taker (if not the GP).

- Runs a failsafe system for checking that all abnormal tests are followed up.
- Reports on biopsies (samples of tissue taken at colposcopy) and provides a histological diagnosis.

Tests are screened in the hospital's pathology department. A consultant pathologist has overall responsibility.

The colposcopy service:

- Accepts referrals from GPs.
- Takes samples from the cervix (a biopsy) to obtain a histological diagnosis.
- Diagnoses conditions from colposcopic examination.
- Treats the condition.
- Follows up treatment with further investigation if necessary.
- Discharges the patient back to the call-recall system.
- Runs a failsafe system for checking the follow-up of all patients treated.

This service is provided in the gynaecology and genitourinary medicine departments of the general hospital.

The primary care team:

This includes the woman's GP and all practice staff.

- Encourages women to be screened when they are due and keeps women informed about the different stages of the screening programme.
- Answers questions and concerns that women may have regarding test results, follow-up and treatment.
- The GP refers women for further treatment if necessary, regardless of whether he or she was the sample taker.
- Incidental findings of infections are not part of the NHS Cervical Screening Programme but may be reported and acted upon according to local protocols.



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