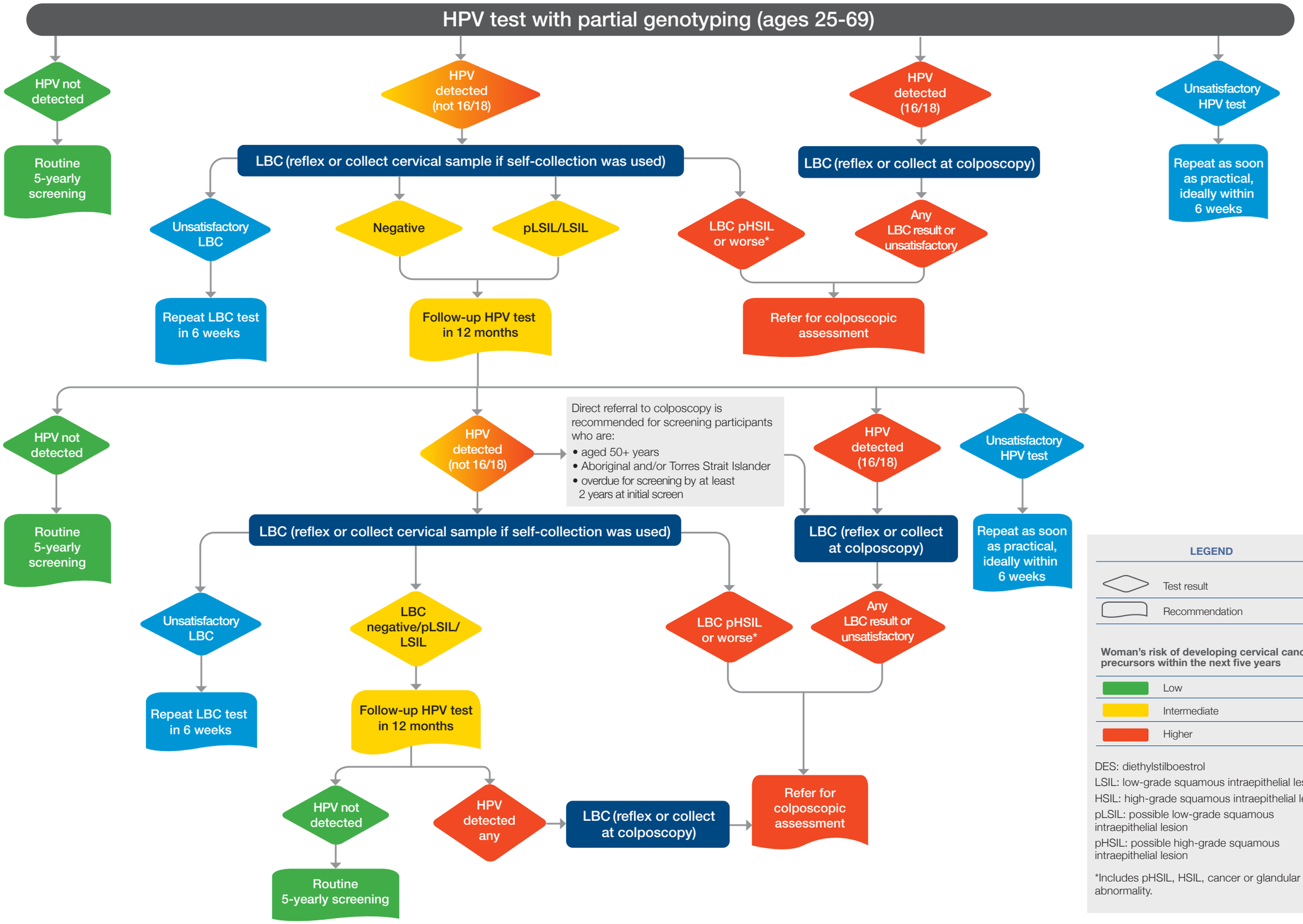
6.1: ROUTINE CERVICAL SCREENING (AGES 25-69 YEARS)



Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. CCA 2016. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening. Updated Dec 2020.

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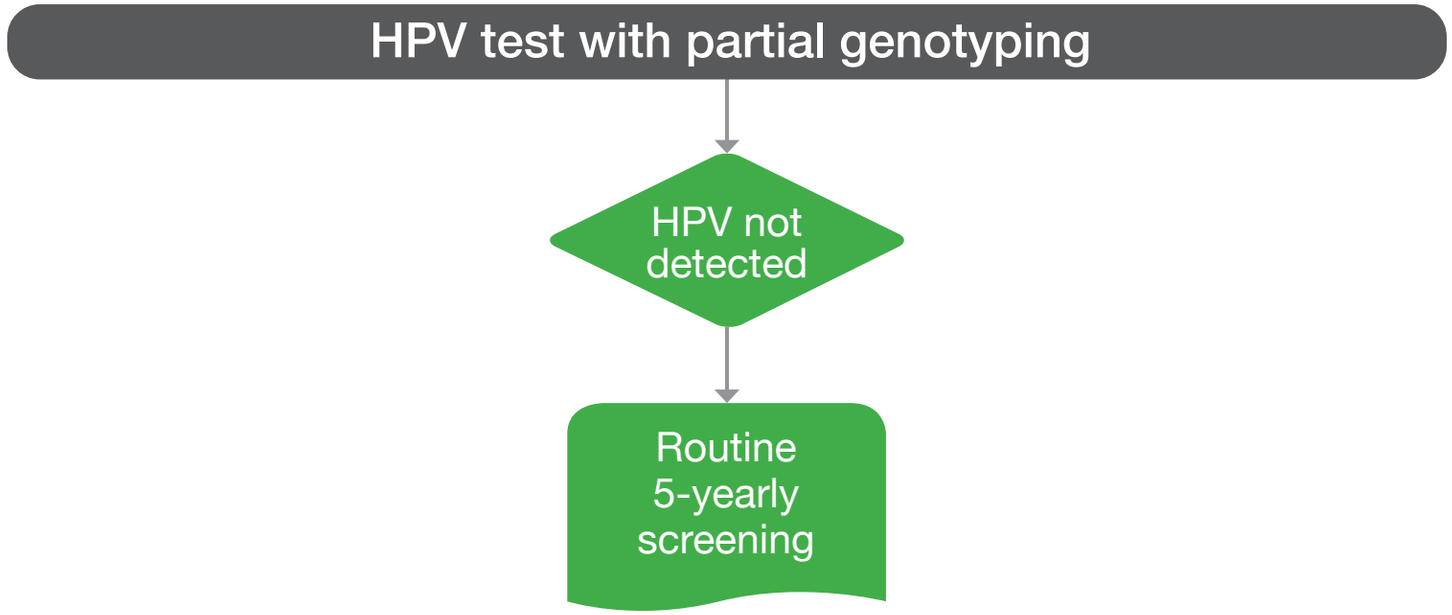
6.2: CERVICAL SCREENING PATHWAY (CLINICIAN COLLECTED OR SELF-COLLECTED)



LEGEND

- Test result
- Recommendation

Woman's risk of developing cervical cancer precursors within the next five years

- Low
- Intermediate
- Higher

DES: diethylstilboestrol

LSIL: low-grade squamous intraepithelial lesion

HSIL: high-grade squamous intraepithelial lesion

pLSIL: possible low-grade squamous intraepithelial lesion

pHSIL: possible high-grade squamous intraepithelial lesion

*Includes pHSIL, HSIL, cancer or glandular abnormality

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening. Updated Dec 2020.

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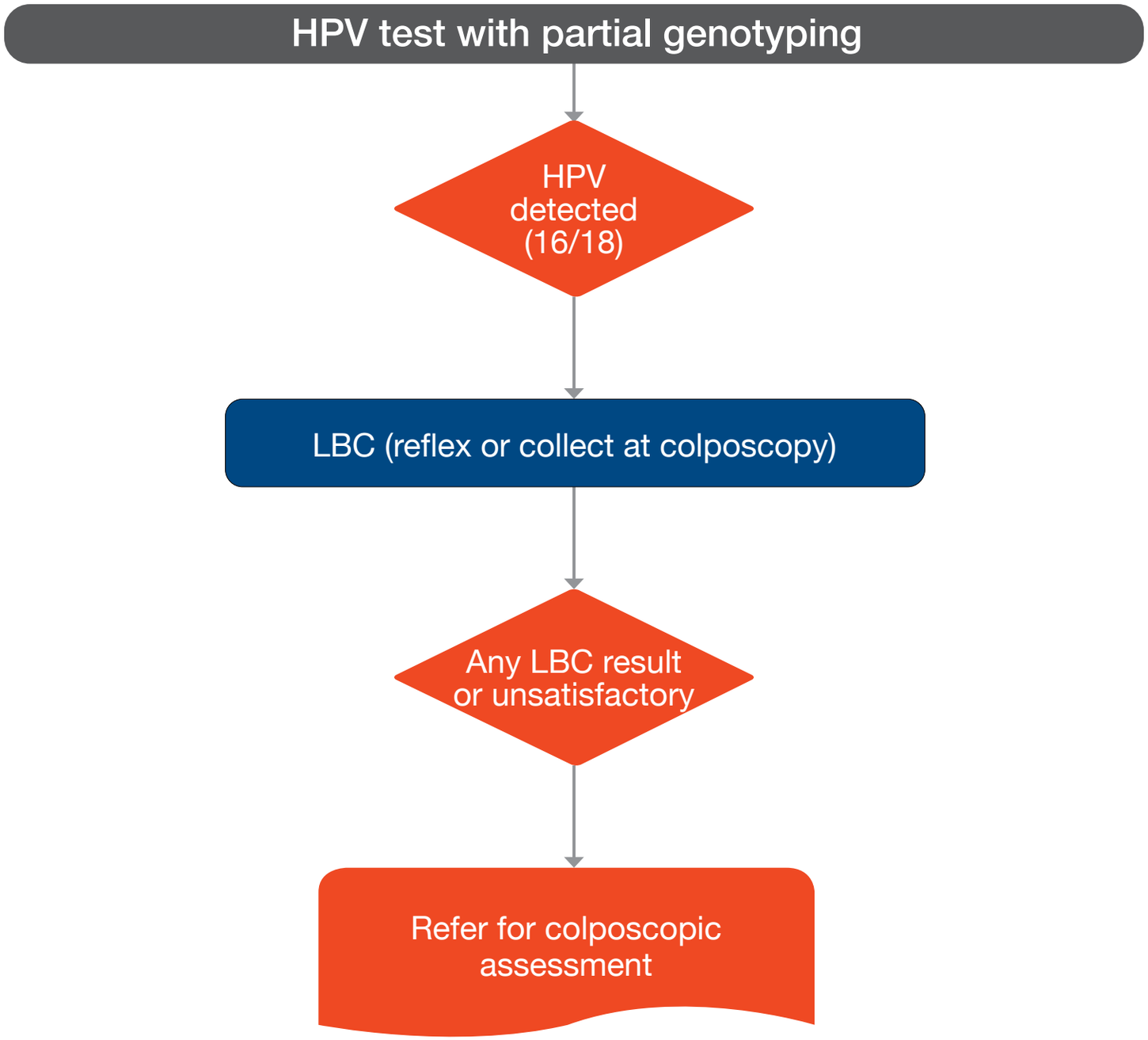
6.3: CERVICAL SCREENING PATHWAY (CLINICIAN COLLECTED OR SELF-COLLECTED)



LEGEND

- Test result
- Recommendation

Woman's risk of developing cervical cancer precursors within the next five years

- Low
- Intermediate
- Higher

DES: diethylstilboestrol

LSIL: low-grade squamous intraepithelial lesion

HSIL: high-grade squamous intraepithelial lesion

pLSIL: possible low-grade squamous intraepithelial lesion

pHSIL: possible high-grade squamous intraepithelial lesion

*Includes pHSIL, HSIL, cancer or glandular abnormality

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening. Updated Dec 2020.

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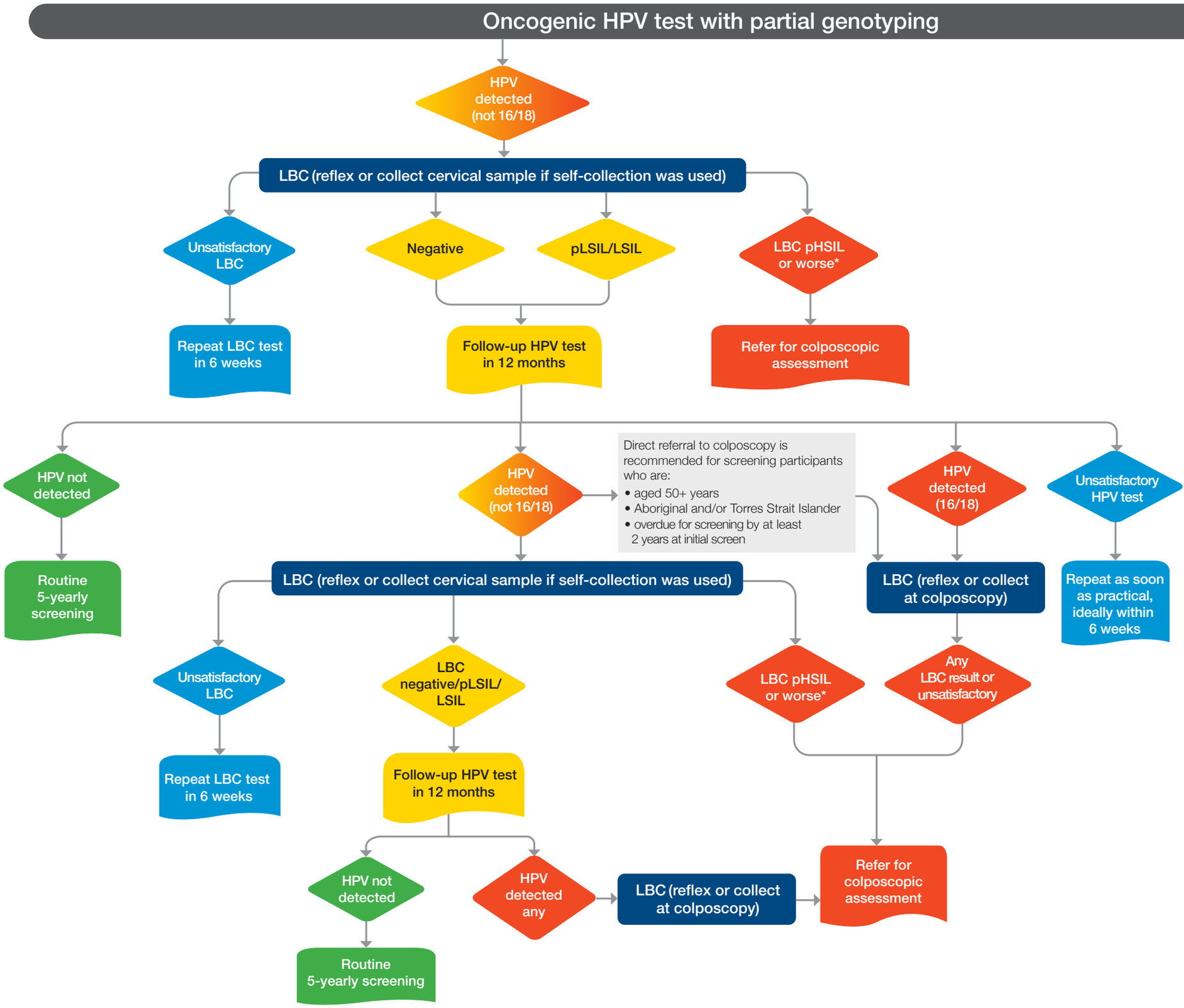
6.4: CERVICAL SCREENING PATHWAY (CLINICIAN COLLECTED OR SELF-COLLECTED)



Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. CCA 2016. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening. Updated Dec 2020.

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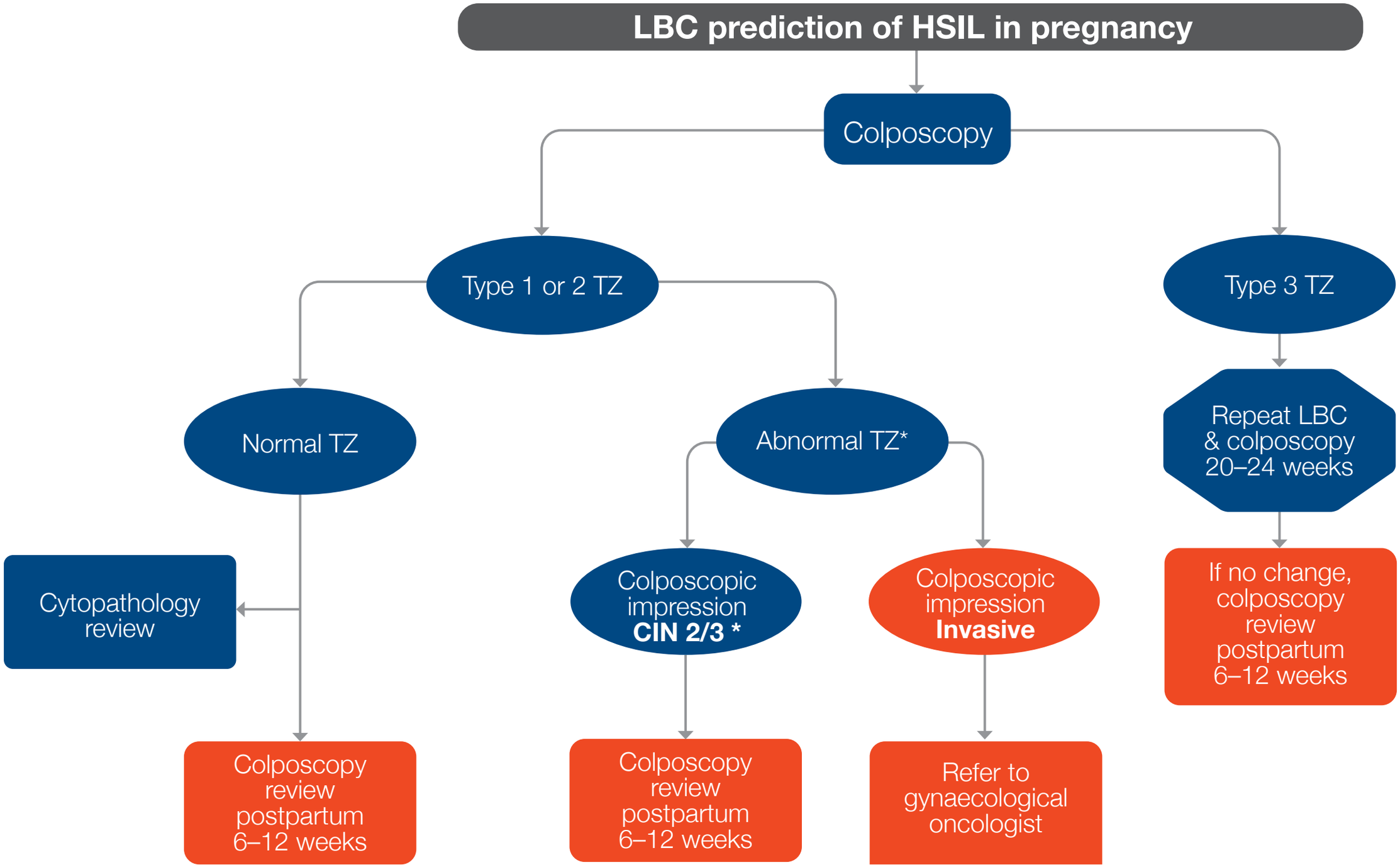
7.1: MANAGEMENT OF A LBC PREDICTION OF HSIL IN PREGNANCY



*Biopsy not usually necessary in pregnancy

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Management of a LBC prediction of HSIL in pregnancy. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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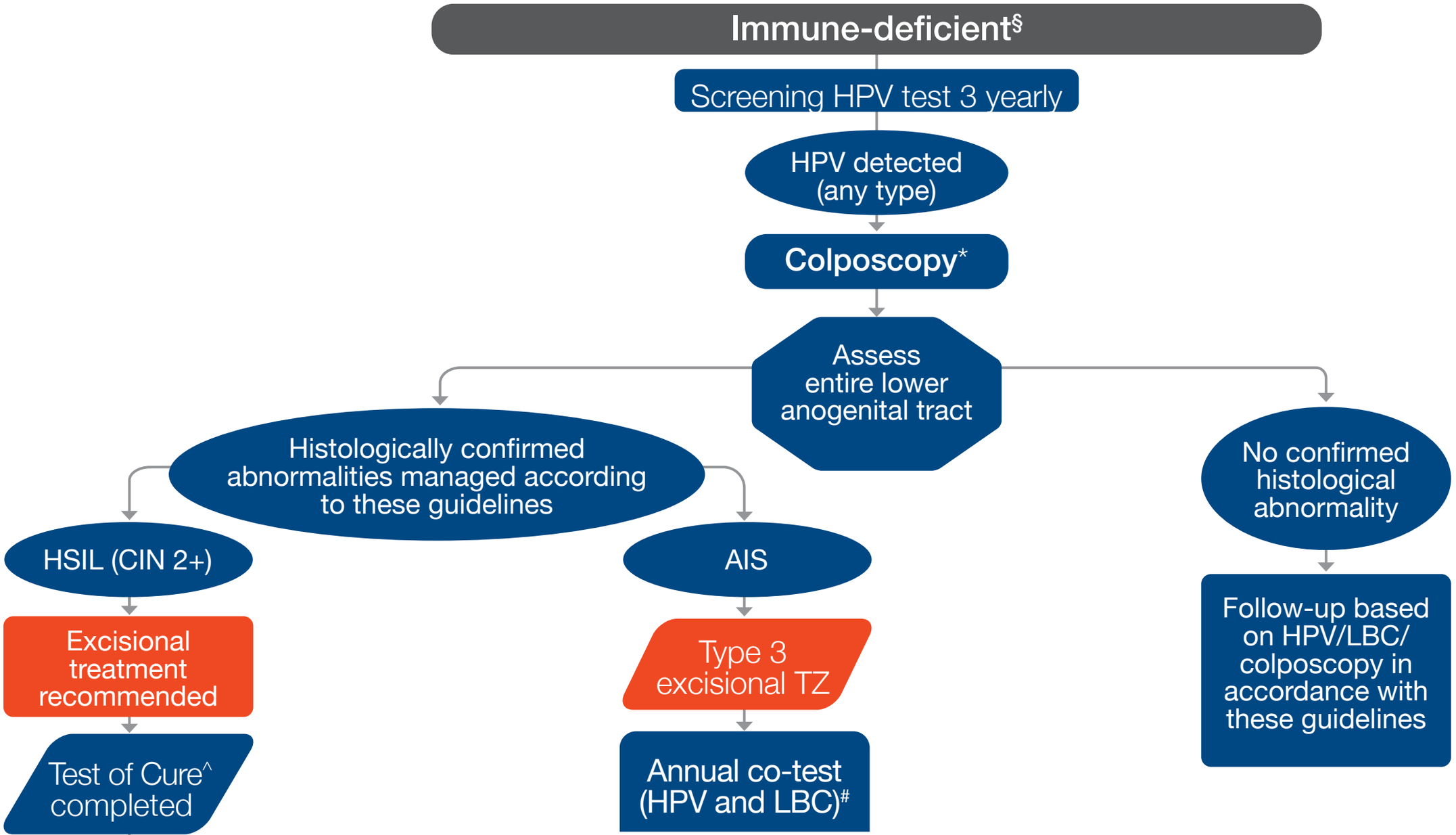
7.2: MANAGEMENT OF SCREEN DETECTED ABNORMALITIES IN IMMUNE DEFICIENT SCREENING PARTICIPANTS§



§ Refers to groups with severe immune deficiency who are at substantially higher risk of cervical precancer and cancer. See Table 1 for guidance on immune-deficient groups where 3-yearly screening is recommended or should be considered

* Reflex LBC or collect cervical sample for LBC at colposcopy if self-collection was used

^ HPV test 12 months after treatment & annually thereafter, until they have two consecutive negative HPV tests, when they can return to routine 3 yearly screening

If surveillance tests have been done for 25 years or more since the time of treatment and all tests are negative, people can be returned to routine screening. If they have already had a negative co-test when aged 70 years or older they can exit screening.

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Management of screen detected abnormalities in immune-deficient women. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.*CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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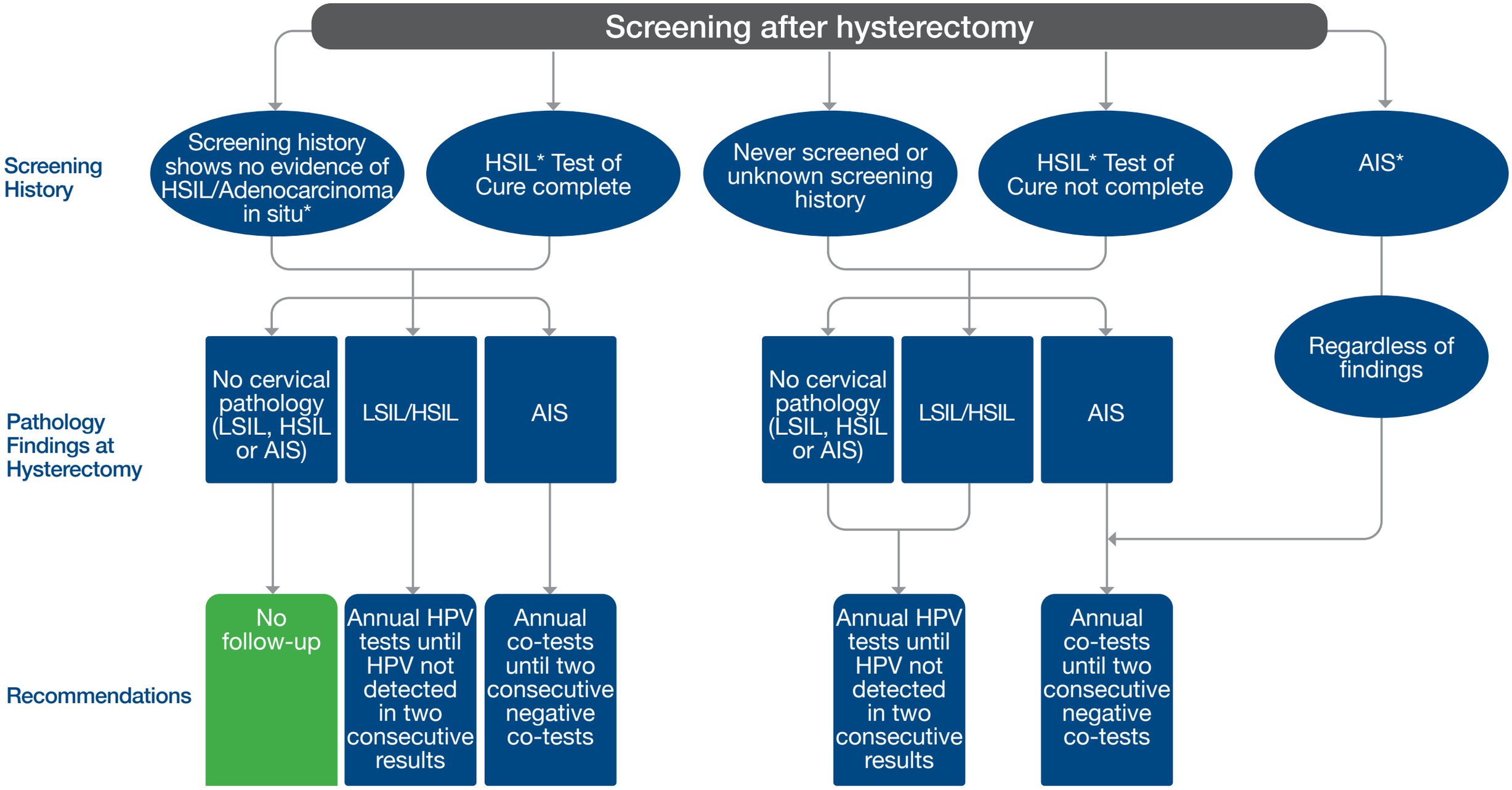
7.3: SCREENING AFTER HYSTERECTOMY



* Histologically confirmed
LSIL = Low-grade squamous intraepithelial lesion
HSIL = High-grade squamous intraepithelial lesion
AIS = Adenocarcinoma in situ

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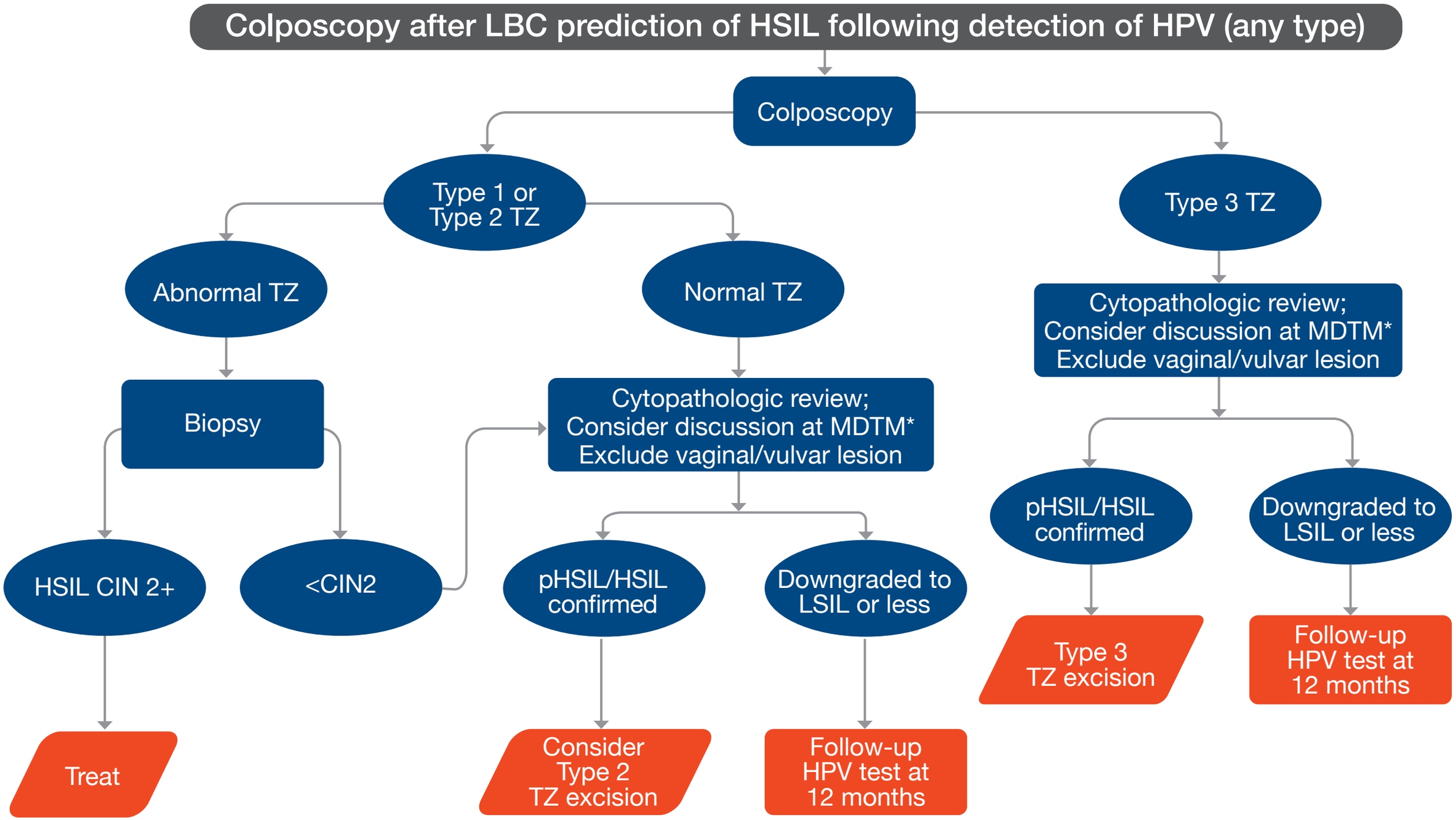
8.1: COLPOSCOPY MANAGEMENT AFTER LBC PREDICTION OF HSIL

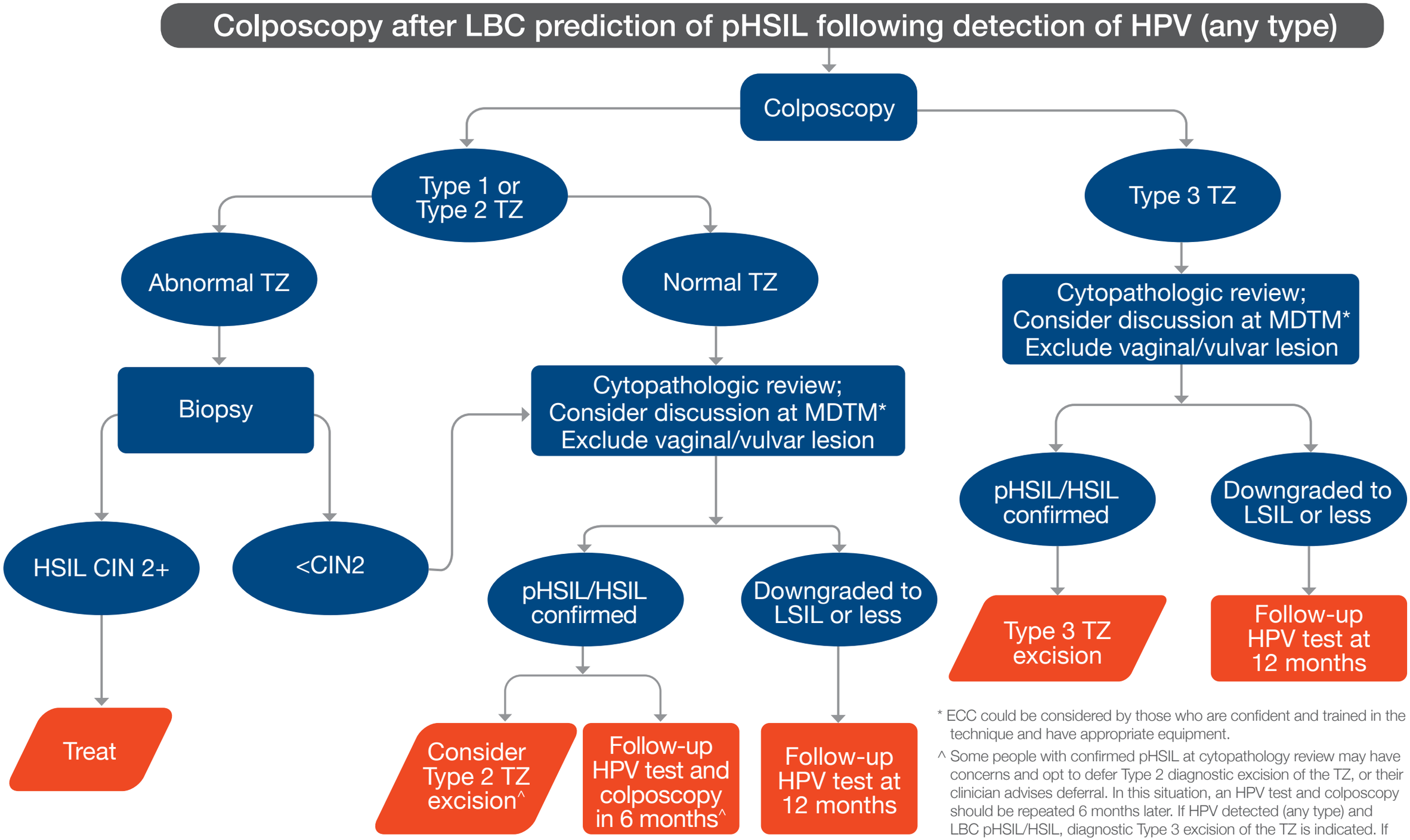


* MDTM: Multidisciplinary team meeting

* ECC could be considered by those who are confident and trained in the technique and have appropriate equipment.

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Normal colposcopy after LBC prediction of possible HSIL. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

8.2: COLPOSCOPY MANAGEMENT AFTER LBC PREDICTION OF POSSIBLE HSIL



* ECC could be considered by those who are confident and trained in the technique and have appropriate equipment.

^ Some people with confirmed pHSIL at cytopathology review may have concerns and opt to defer Type 2 diagnostic excision of the TZ, or their clinician advises deferral. In this situation, an HPV test and colposcopy should be repeated 6 months later. If HPV detected (any type) and LBC pHSIL/HSIL, diagnostic Type 3 excision of the TZ is indicated. If HPV detected (any type) and LBC negative, pLSIL or LSIL or HPV not detected, repeat HPV test in 12 months.

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Normal colposcopy after LBC prediction of possible HSIL. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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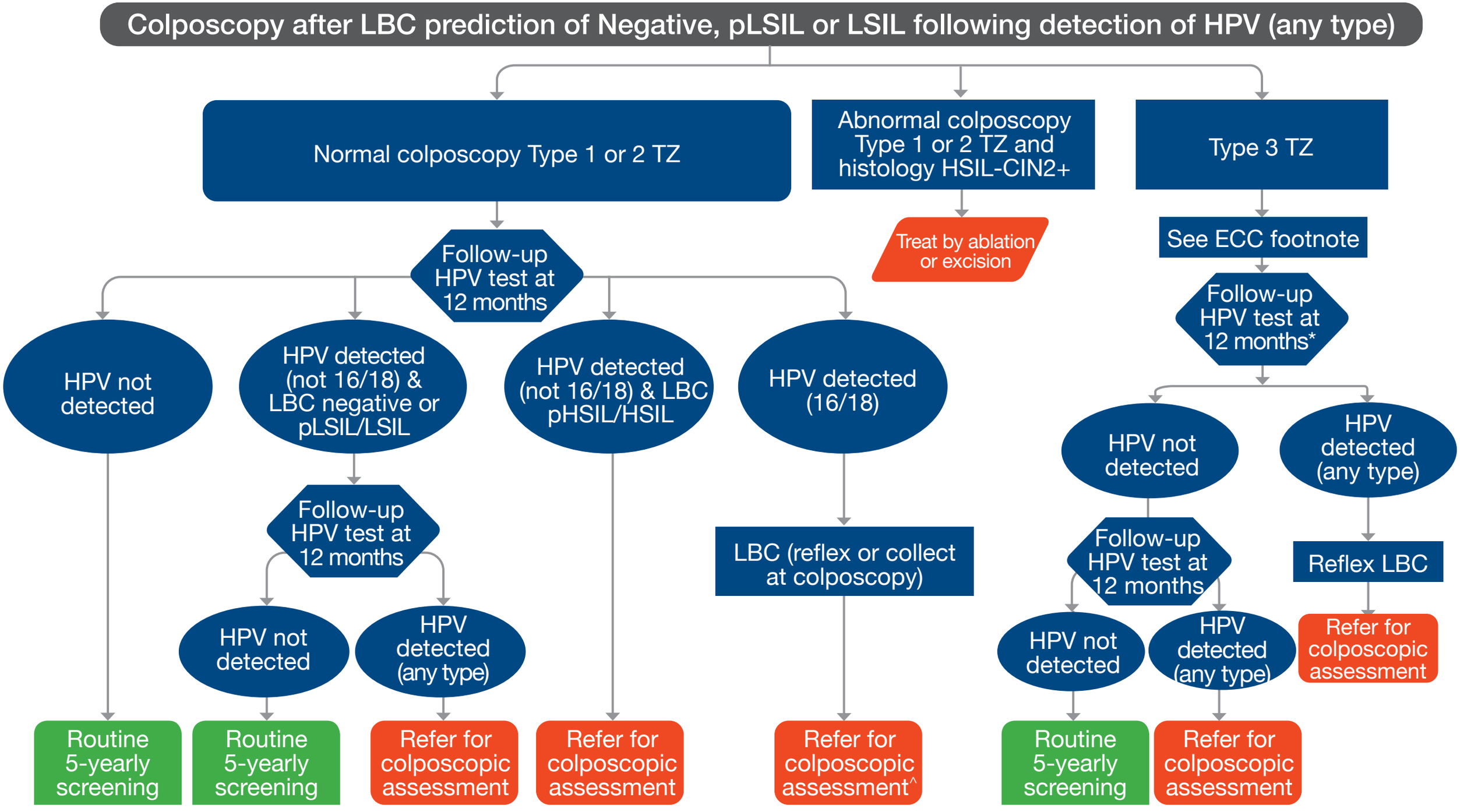
8.3: COLPOSCOPY MANAGEMENT AFTER LBC PREDICTION OF NEGATIVE, pLSIL OR LSIL



* ECC could be considered by those who confident and trained in the technique and have appropriate equipment for screening participants with HPV (16/18) detected who have never been screened before (and are aged 26+)

^ If LBC is performed prior to colposcopy, and is negative, then the HPV test could be re-peated in another 12 months before re-referral to colposcopy.

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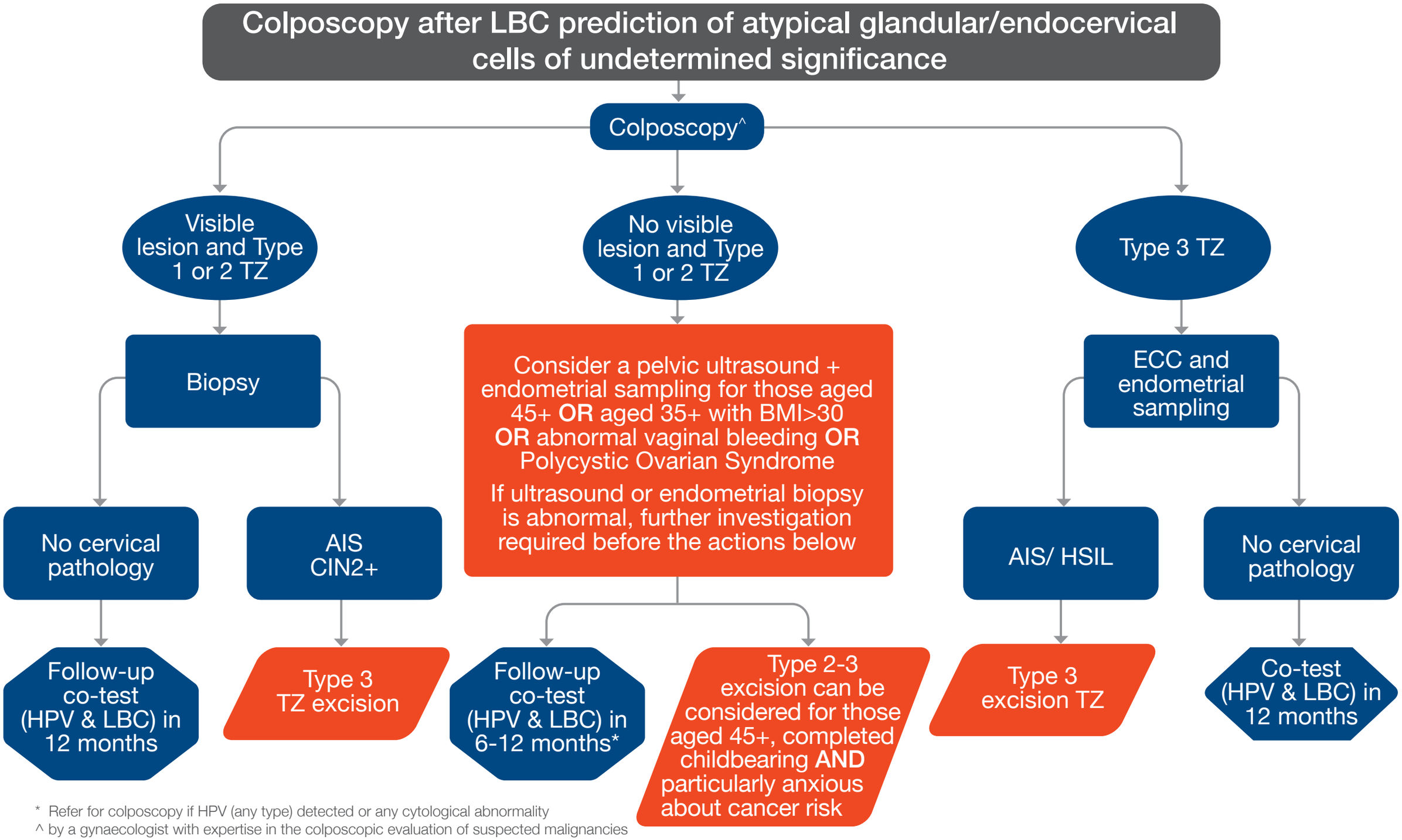
8.4: COLPOSCOPY MANAGEMENT AFTER LBC PREDICTION OF ATYPICAL GLANDULAR/ENDOCERVICAL CELLS OF UNDETERMINED SIGNIFICANCE



* Refer for colposcopy if HPV (any type) detected or any cytological abnormality
^ by a gynaecologist with expertise in the colposcopic evaluation of suspected malignancies or a gynaecological oncologist

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Management of LBC predicting atypical glandular/endocervical cells of undetermined significance. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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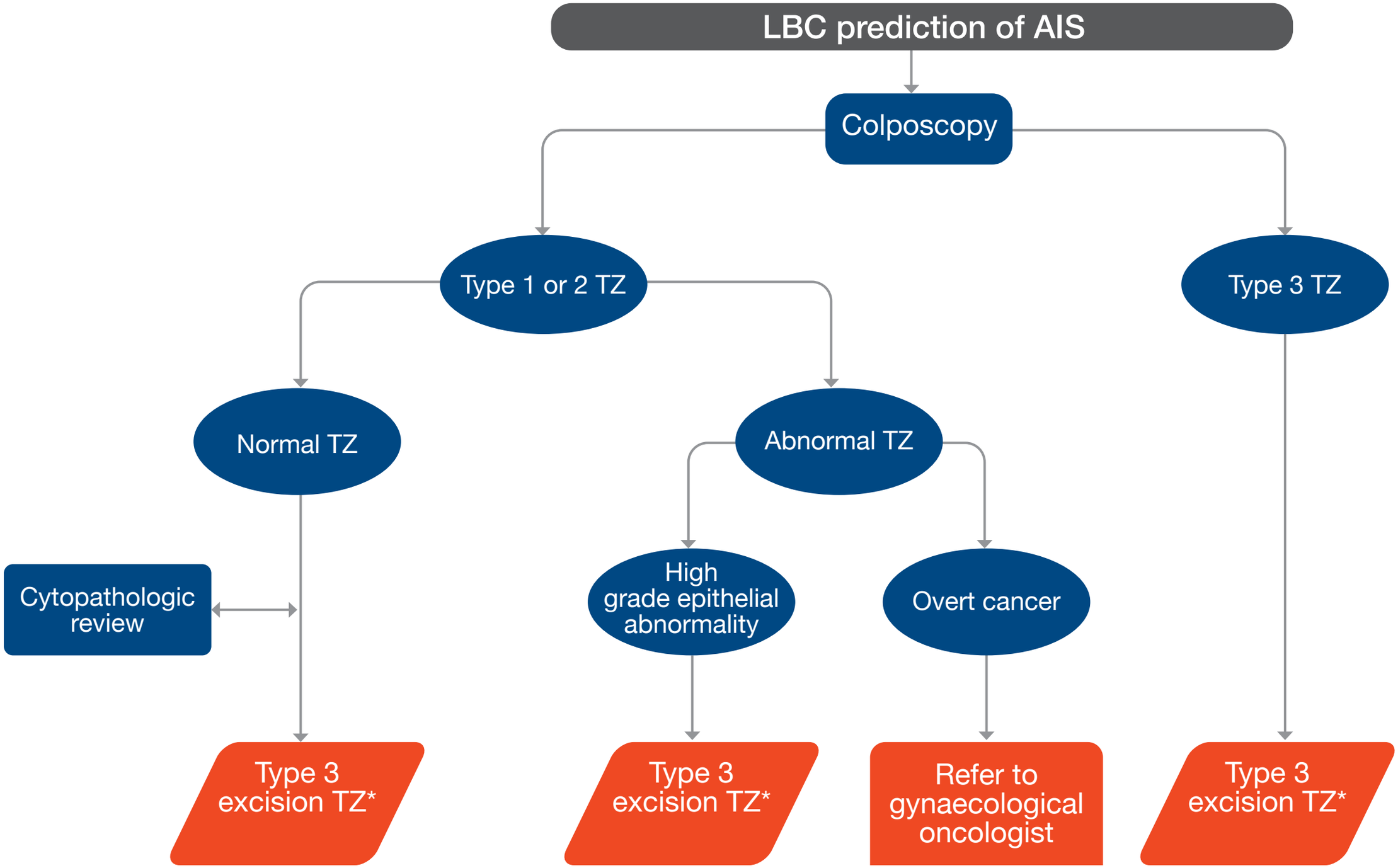
8.5: MANAGEMENT OF LBC PREDICTION OF A HIGH GRADE GLANDULAR LESION (AIS)



* Usually a cold-knife cone biopsy

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Management of LBC prediction of a high grade glandular lesion (AIS). *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2016.
Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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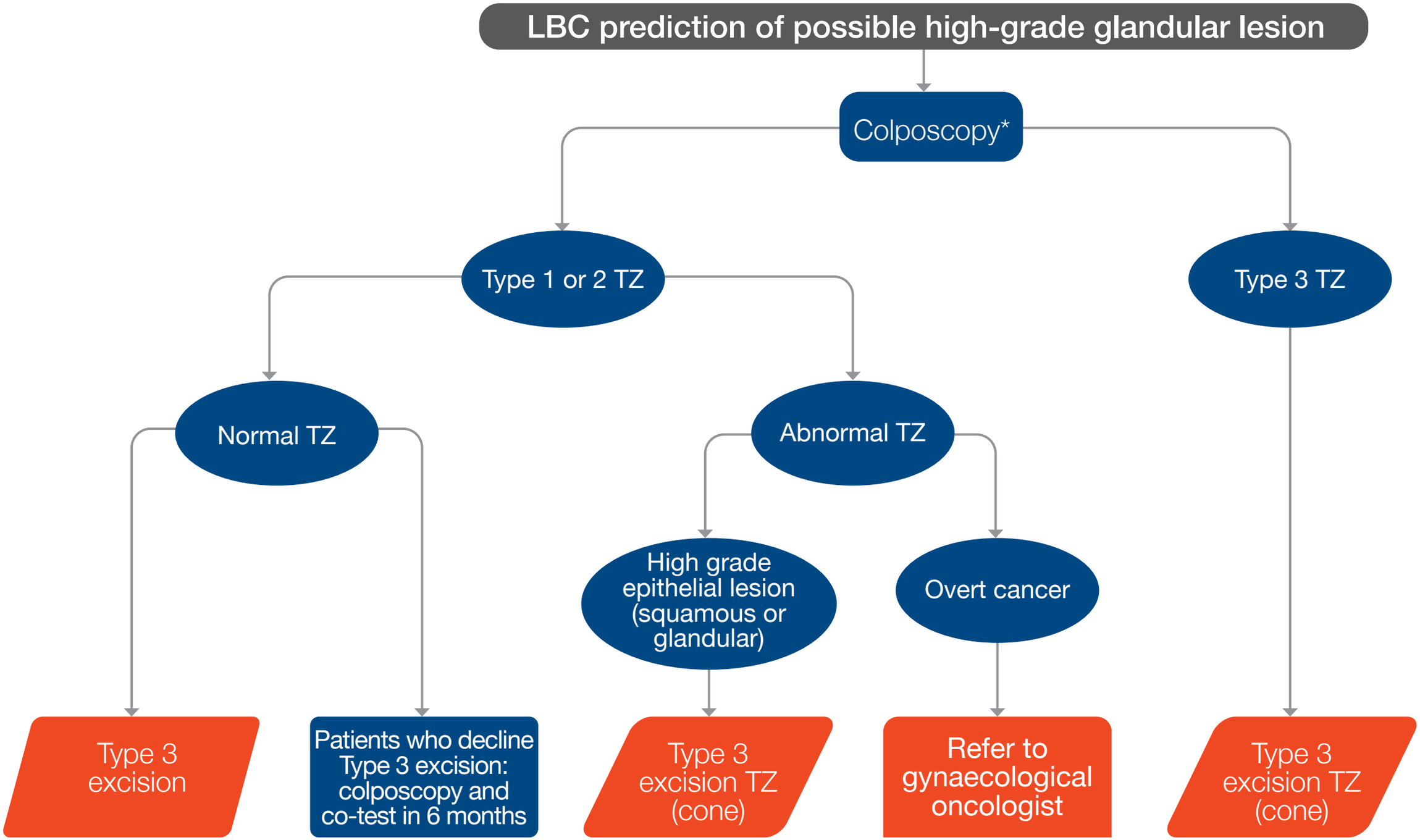
8.6: MANAGEMENT OF LBC PREDICTION OF A POSSIBLE HIGH GRADE GLANDULAR LESION



* by a gynaecologist with expertise in the colposcopic evaluation of suspected malignancies or a gynaecological oncologist

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Management of LBC prediction of a possible high grade glandular lesion. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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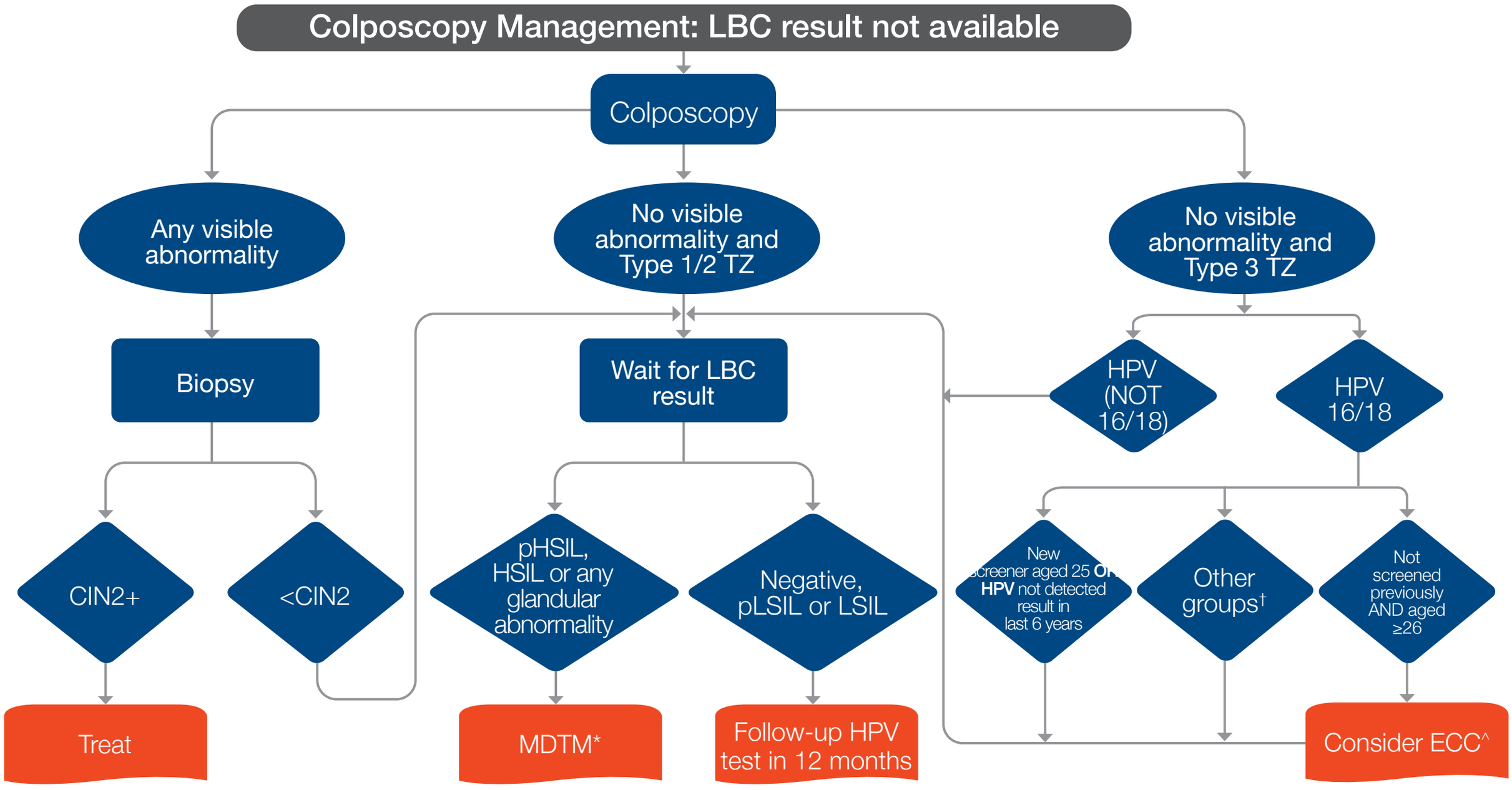
8.7: COLPOSCOPY MANAGEMENT WHEN LBC RESULT IS NOT AVAILABLE



ECC = endocervical curettage by those who are confident and trained in the technique and have appropriate equipment * Manage as per recommendations for people referred with these cytology results
MDTM: Multidisciplinary team meeting

† ECC could be considered for higher risk groups, including overdue (no negative cytology result in 5 years preceding HPV (16/18) result and no previous negative HPV test at all), previous HSIL or glandular abnormality.

^ ECC should be considered for this highest risk group based on NCSR data: CIN3+ risk in previously unscreened is around 15% and cancer risk is around 2% (excluding new screeners at 25). Cancer risk remains ~1.0% in those with negative LBC.

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Management of LBC predicting atypical glandular/endocervical cells of undetermined significance. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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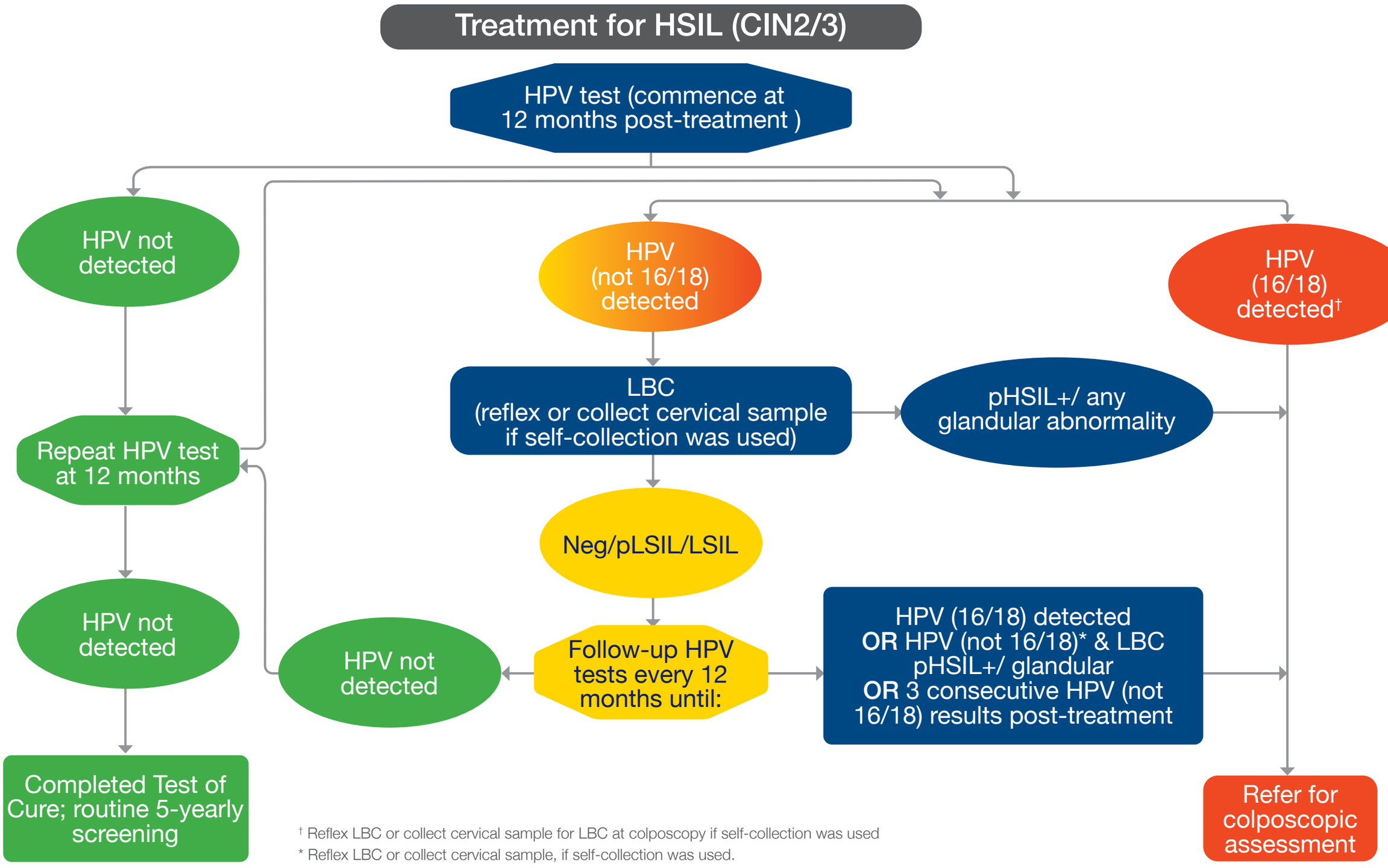
9.1: TEST OF CURE FOLLOWING TREATMENT FOR HIGH-GRADE SQUAMOUS ABNORMALITIES



† Reflex LBC or collect cervical sample for LBC at colposcopy if self-collection was used

* Reflex LBC or collect cervical sample, if self-collection was used.

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Test of Cure following treatment for high-grade squamous abnormalities. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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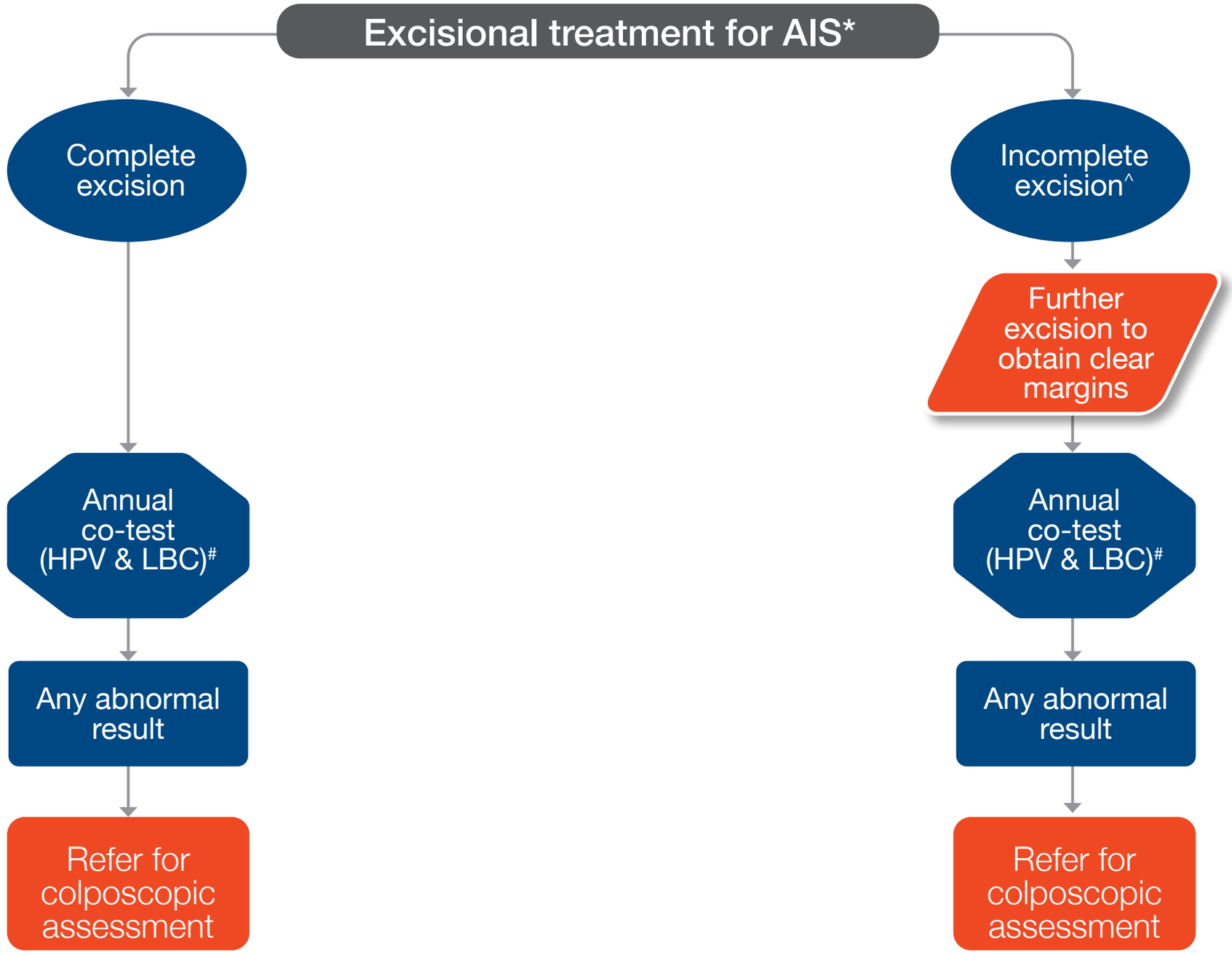
FOLLOW-UP AFTER EXCISIONAL TREATMENT FOR AIS



* AIS = Adenocarcinoma in situ

If all testing has been negative for 5 years, surveillance testing can be extended to every 3 years. If surveillance tests have been done for 25 years or more since the time of treatment and all tests are negative, people can be returned to routine screening. If they have already had a negative co-test when aged 70 years or older they can exit screening.

^ If margins are equivocal, review at MDT

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Follow-up after excisional treatment for AIS. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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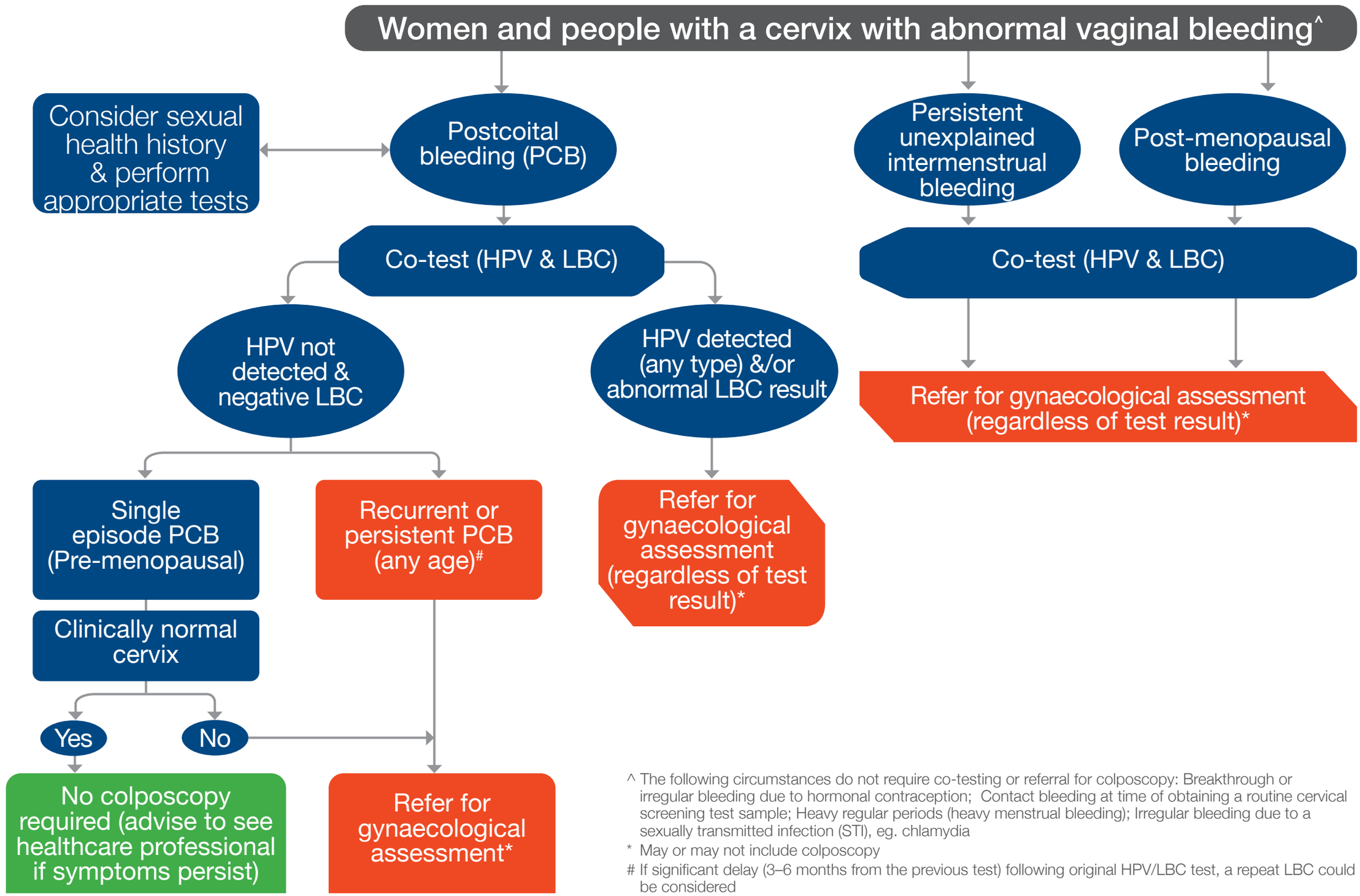
10.1: INVESTIGATION OF PEOPLE WITH ABNORMAL VAGINAL BLEEDING



^ The following circumstances do not require co-testing or referral for colposcopy: Breakthrough or irregular bleeding due to hormonal contraception; Contact bleeding at time of obtaining a routine cervical screening test sample; Heavy regular periods (heavy menstrual bleeding); Irregular bleeding due to a sexually transmitted infection (STI), eg. chlamydia

* May or may not include colposcopy

\# If significant delay (3–6 months from the previous test) following original HPV/LBC test, a repeat LBC could be considered

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Investigation of women with abnormal vaginal bleeding. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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