

BREAST AND CERVICAL CANCER CONTROL PROGRAM
MEDICAL PROTOCOL

I INTRODUCTION

This protocol has been developed for use in the Title XV Michigan Breast and Cervical Cancer Control Program and addresses the provision of services related to breast and cervical cancer screening and follow-up care **only**. It is recognized that a BCCCP coordinating agency or its sub-contractor for clinical screening/follow-up services may or may not have the ability and willingness to screen for and manage health problems unrelated to breast or cervical cancer.

BCCCP coordinating agencies or its subcontractors, which have the ability and willingness to screen for and manage other health problems (STD testing, blood glucose testing, hemocult, etc.), may, at their own discretion, do so at the time of the woman's visit to the BCCCP.

However, Title XV funds cannot be used for the time and materials needed to assess and manage problems unrelated to breast or cervical cancer. The protocol for assessment and management of other health problems should be developed by the BCCCP coordinating agency and added to this core protocol.

The Michigan Cancer Consortium (MCC) Breast Cancer Advisory Committee (BCAC) and the Cervical Cancer Advisory Committee (CCAC) have developed guidelines for both breast and cervical cancer screening and follow-up care. These guidelines are incorporated as part of this BCCCP medical protocol.

The BCAC recognizes and promotes the use of the American Cancer Society (2003, 2007), American College of Radiology (2003), US Preventive Services Task Force (2002), NCCN (2007) and American College of Physicians (2007) breast cancer screening and follow-up guidelines.

The Cervical Cancer Advisory Committee recognizes and promotes the use of the American Society for Colposcopy and Cervical Pathology's (ASCCP) 2006 Consensus Guidelines for the Management of Women with Abnormal Cervical Cancer Screening Tests and 2006 Consensus Guidelines for the Management of Women with Cervical Intraepithelial Neoplasia or Adenocarcinoma in Situ. Guidelines are referenced in this document and may be found at <http://www.asccp.org/>

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II PROVISION OF BREAST AND CERVICAL CANCER SCREENING, FOLLOW-UP, AND TREATMENT SERVICES THROUGH THE BCCCP

The BCCCP provides the following breast and cervical cancer screening services: clinical breast exams, mammograms, Pap tests and pelvic exams. Screening is the attempt to detect unsuspected disease in average risk, asymptomatic women. Women identified with abnormal breast and/or cervical screening results are referred for appropriate diagnostic procedures to confirm or rule out a cancer diagnosis. In the event a breast or cervical cancer is diagnosed, the woman is assisted in obtaining necessary breast or cervical cancer-related services in a timely manner. A crucial component of the Michigan BCCCP is to ensure that women enrolled in the program receive timely and appropriate screening, diagnostic and treatment services.

III BREAST AND CERVICAL CANCER SCREENING RECOMMENDATIONS

A. Breast Cancer Screening Recommendations

1. Screening Tests

A clinical breast exam and mammogram should be used for routine breast cancer screening.

2. Recommendations for Breast Cancer Screening

| Screening Exam | Interval | Age to Begin | Additional Information |
|----------------------------|-----------------------|---|---|
| Breast Self Exam (BSE) * | Monthly | Age 20 and older | Women should report any breast change promptly to their health care providers |
| Clinical Breast Exam (CBE) | Every three (3) years | Asymptomatic women in their 20's and 30's | CBE should be part of a periodic health exam |
| | Annually | Women age 40 and older | |
| Mammography | Annually | Average risk women starting at age 40 | The American College of Physicians Practice Guidelines (2007) advises clinicians to tailor the decision to screen women on the basis of women's concerns about breast cancer, as well as their risk for breast cancer. Based on this review, the MCC recommends no change to the current recommendation of annual mammography for average risk women beginning at age 40. |

* No firm evidence has been identified that performing breast self-exam reduces the risk of breast cancer mortality. (Level of Evidence: The United States Preventative Services Task Force (USPSTF) found poor evidence to determine whether BSE reduces breast cancer mortality. The American Cancer Society concurs with this finding. The USPSTF found fair evidence that BSE is associated with an increased risk for false-positive results and biopsies. Due to design limitations of published and ongoing studies of BSE, the USPSTF could not determine the balance of benefits and potential harms of BSE.)

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NOTE: Magnetic Resonance Imaging (MRI) is not recommended for breast cancer screening of average risk women. BCCCP cannot reimburse for MRI of the breast.

3. Upper Age Limit for Screening
 - Annual mammography screening should continue regardless of age, as long as a woman does not have serious chronic health problems.
 - For women with serious health problems or short life expectancy, evaluate ongoing early detection testing.

NOTE: BCCCP women are eligible for breast cancer screening until age 64 unless they are ineligible for Medicare or have not purchased Medicare Part B

B. Cervical Cancer Screening Recommendations

1. Screening Tests
 - A Pap test and speculum exam should be used for routine cervical cancer screening.
 - Testing for cervical cancer is performed using either Liquid-Based Cytology or Conventional (slide) Pap Test.
2. Age to Initiate Screening:

Screening for cervical cancer should begin at age 21 or 3 years after the onset of sexual activity, **whichever comes first.**
3. General Information
 - a. The need for cervical cancer screening should not be the only basis for the onset of gynecological care.
 - b. Adolescents must be able to obtain appropriate preventative health care, including, but not limited to, an assessment of health risks, counseling for pregnancy and sexually transmitted disease (STD) prevention, contraception, and treatment of STD's; even if they do not need a Pap smear.

NOTE: BCCCP only provides follow-up diagnostic services to rule out cervical cancer for women under age 40.

- c. For the purpose of these guidelines an ADOLESCENT is defined as 20 years of age or younger
- d. Adolescents and young women who have received the HPV vaccine should continue cervical cancer screening according to the current guidelines.
- e. Clinical breast exam and yearly speculum and bimanual pelvic examinations should be provided even if no cervical cancer screening is performed.

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- f. In the absence of endocervical cells, if a Pap smear is satisfactory and negative, then regular screening should be continued.

4. Recommendations for Cervical Cancer Screening:

| Age to Begin | Screening Exam | Screening Interval |
|---|--|--------------------------|
| Age 21 or 3 years after the onset of sexual activity until age 29 | Conventional Pap Test OR | Annual |
| | Liquid Based Cytology (LBC) | Every two years |
| Age \geq 30* with three consecutive, negative cytology results | Conventional Pap Test OR Liquid Based Cytology | Every two to three years |

* HR-HPV (High-Risk Human Papillomavirus testing) as an adjunct to cervical cytology testing may be used for cervical cancer screening in women 30 years of age or older. If both tests are negative, testing occurs every three years. For abnormal results, follow-up guidelines may be found on <http://www.asccp.org/>.

NOTE: HR-HPV as an adjunct to cervical cytology testing cannot be reimbursed by the BCCCP.

5. Special Considerations:

- a. Women with a histologically-confirmed HSIL, whether or not they receive treatment - continue cervical cancer screening on a regular basis, for **20** years.
- b. Women who are HIV+, immunocompromised, or had *in utero* DES exposure – continue **ANNUAL** cervical cancer screening regardless of the testing method.
- c. For women whose cytology exam is satisfactory but obscured or partially obscured by inflammation – repeat the exam in 6 months. Refer for colposcopy if subsequent cytology is still interpreted as obscured, partially obscured or otherwise abnormal.
- d. Women whose cytology exam is unsatisfactory need a repeat cytology exam within the next 2 to 4 months.
- e. Per the ASCCP guidelines, adolescents and pregnant women are also given special consideration. See guidelines for details at <http://www.asccp.org/>.
- f. Treatment of pregnant women:
 - Endocervical curettage is unacceptable in pregnant women
 - Colposcopy may be deferred until the postpartum examination
 - Invasive cancer is the only indication for treatment during pregnancy

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6. **For Women Who Have Had a Hysterectomy:**
 - a. If the hysterectomy was for cervical cancer or cervical dysplasia - continue **ANNUAL** Pap testing.
 - b. For women who still have a cervix, continue testing as indicated by age, type of cytology test and Pap history.
 - c. Total hysterectomy for benign gynecological disease (no cervix present) - screening with vaginal cytology is **NOT** indicated; this does not preclude a pelvic exam.

7. **Upper Age Limit for Screening:**
 - a. Consider not screening after age 70 if the woman has had 3 documented negative Pap tests and no abnormal Pap tests in the last 10 years.
 - b. Consider continuing to screen if the woman is sexually active.
 - c. Women with comorbid illnesses may forego cervical cancer screening.
 - d. Continue screening if there is a history of cervical cancer, *in utero* DES exposure, or the woman is HIV + or immunocompromised.

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| <p>NOTE: BCCCP women are eligible for cervical cancer screening until age 64 unless they are ineligible for Medicare or have not purchased Medicare Part B.</p> |
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8. **Indications for Referral to a Qualified Colposcopist:**
 - a. Women age 20 and under requiring treatment for CIN2/3
 - b. Pregnant women with HSIL cytology.
 - c. Women with a significant cervical lesion in which “see and treat” may be indicated
 - d. Women desiring fertility who, after excisional treatment, have recurrent or persistent cervical dysplasia.
 - e. Women who have had two “unsatisfactory for evaluation” tests 2-4 months apart
 - f. Women with AGC (Abnormal Glandular Cells) or AIS (Adenocarcinoma in situ) on cytology. Management follows the algorithm found at <http://www.asccp.org/>
 - g. **Women with any gynecologic cancer should be referred to a Gynecologic Oncologist.**

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C. Provision of Screening and Diagnostic Services to Special Populations in the BCCCP.

NOTE: The following special populations are eligible to participate in the BCCCP as long as they meet the income requirements

1. Women < 40 identified in specified **Sexually Transmitted Disease (STD) clinics** who have not had a documented Pap test > 10 months are eligible for both cervical screening and diagnostic services if needed for follow-up of Pap test abnormalities.
2. Women <40 seen in any **Family Planning/Title X clinics** who have an abnormal Pap test result requiring immediate follow-up for the abnormality can be referred to BCCCP for diagnostic services **only** to confirm or rule out a cancer diagnosis.

NOTE: HPV testing should be discussed and recommended to the client; however, BCCCP funds cannot pay for HR-HPV testing for Family Planning clients with screening Pap test results of ASC-US

3. Women age 40-64 seen in either STD or Family Planning/Title X Clinics for cervical services may be referred to BCCCP for breast screening and diagnostic services (if needed).

III. CLINICAL HISTORY/EXAMINATION

- A. Clinical history should consist of the following:
1. Description of current breast and GYN (gynecological) symptoms
 2. Past history of breast problems (abnormal clinical breast exams, abnormal mammograms).
 3. Past history of abnormal Pap tests. (Hysterectomy history, if applicable, and reason for hysterectomy).
 4. Personal history of breast, cervical, ovarian, colorectal cancer
 5. Family history of breast/ovarian/colorectal cancer (both maternal and paternal, age at diagnosis).
 6. Smoking history: past, current, packs per day, and duration.
 7. Last mammogram date and result.
 8. Last Pap test date and result.

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- B. Physical exam
- a. Clinical Breast Examination
 - Sitting - inspection, palpation of axillary and supraclavicular nodes
 - Supine - inspection, palpation
 - b. External Genitalia examination
 - Inspection
 - Palpation
 - c. Internal examination
 - Inspection of cervix and vagina
 - d. Bimanual examination
 - Palpation of vaginal wall, cervix
 - Palpation of uterus and adnexae
 - e. Recto-vaginal exam
- C. Obtain Pap Smear (if indicated)

NOTE: BCCCP funds can only reimburse for SCREENING Pap tests according to the following guidelines. These guidelines DO NOT apply to women requiring Pap tests as follow-up for an ABNORMALITY.

Screening Pap test Guidelines

Conventional Cytology (Screening Pap tests) may be performed:

- **Annually** until three (3), consecutive normal/negative Pap tests are obtained within a 60-month (5-year period).
- **Then, once every (3) three years, for** women with (3) three, consecutive normal/negative screening Pap tests performed within a 60-month (5 year period).

Liquid Based Cytology (LBC) may be performed:

- Every **TWO** years until three (3), consecutive normal/negative Pap tests are obtained within a 60-month (5 year period).
- **Then, once every (3) three years, for** women with (3) three, consecutive normal/negative Pap tests performed within a 60-month (5 year period).

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D. Mammography Screening

1. Order the appropriate mammogram based on clinical breast exam findings:
 - **Screening mammogram** - performed on an **asymptomatic** woman to detect early, clinically unsuspected breast cancer.
 - **Diagnostic Mammogram** - performed on a woman with **clinical signs or symptoms** that suggest breast cancer or past history of a breast cancer or abnormality that requires ongoing monitoring.
2. Request films (if available) from last mammogram to be sent to referral mammography facility.
3. Forward results of CBE to mammography facility (if able).
4. Request copy of mammogram report. Review report to determine appropriate follow-up (if recommended by radiologist).
5. Send report of all clinical findings and follow-up recommendations (if any) to primary care provider.

E. Patient Education

1. Review physical exam components
 - a. Clinical Breast Exam
 - Discuss normal findings and variances.
 - **Emphasize that any time a woman detects a breast change or a palpable mass she should seek evaluation from a qualified health care provider (breast specialist).**
 - b. Pelvic Exam
 - Clinicians should educate all women about the components of the pelvic exam, including whether cervical cancer screening is performed and whether or not the woman is being tested for STDs, including HPV.
 - c. Discuss indications for notifying the provider about abnormal breast and/or cervical signs/symptoms that need evaluation.
2. Discuss the importance of breast and cervical cancer screening which includes:
 - Frequency of breast and cervical cancer screening is based on the woman's risk factors and past medical history.
 - Breast cancer screening tests include both a clinical breast exam and mammogram.
 - Cervical cancer screening tests include a Pap test. **(Frequency of Pap testing is dependent on previous Pap test results).**

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- Pelvic exams should be received **yearly**, whether or not a Pap test is needed based on risk factors and history.
 - Possible testing for STDs including HPV.
3. Discuss limitations of screening procedures
- Normal results on a screening exam do not necessarily indicate absence of disease.
 - No screening test is 100% accurate; therefore, some cases of the disease may be unavoidably missed.
 - Normal results never rule out the later development of the disease, which is why annual screening is so strongly recommended.
 - The detection of an abnormality does not mean the abnormality is cancerous. Only some of the women with abnormal screening results will, after further evaluation, be diagnosed with breast or cervical cancer.

**IV FOLLOW-UP OF NORMAL AND ABNORMAL BREAST AND CERVICAL
CANCER SCREENING RESULTS**

A. Reminder and tracking systems

Clinicians and agencies should develop and implement tracking systems which will:

- Remind women to schedule cancer screening testing **AND**
- Notify women of abnormal mammogram results or cervical cancer screening tests (which include positive HPV – High Risk test results) and follow-up diagnostic testing that is required.

B. Inability to contact a woman regarding abnormal results

Each local coordinating agency should establish its own protocol for women who cannot be contacted regarding abnormal results. The protocol should include:

- Contacting the woman by telephone and/or sending a certified letter
- Documentation of the above in the medical record

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C. Follow-up of Clinical Breast Exam Screening Results

| CBE Result | Type of Follow-up | Recommendation |
|---|---|---|
| 1. No Breast Abnormality (normal glandular tissue felt upon palpation) | No Follow-up | Refer for Screening Mammogram |
| 2. Benign Breast Condition (symmetrical thickening or area of thickened tissue palpated in the same location in both breasts; nodularity, irregularity or lumpiness that is <i>not</i> clinically suspicious): | No or Short-term Follow-up (3-7 months) | Refer for Screening* Mammogram *Based on the type of mammogram ordered and client's history, a diagnostic mammogram may be ordered. This mammogram is considered screening. |
| 3. Abnormal CBE Results that include any of the following: <ul style="list-style-type: none"> • New onset UNILATERAL breast pain, soreness or sensitivity not related to menstrual cycle changes • Clinically suspicious mass or asymmetrical thickening (including an area of density, a lump, or another area that stands out or is <i>discrete</i> from the surrounding tissue or an irregular, hard, fixed mass) • Nipple discharge (nonspontaneous multiduct discharge, or persistent, spontaneous, unilateral, single duct, serous, or sanguineous nipple discharge) • Observed skin or nipple changes (Peau d'orange, erythema, nipple excoriation, scaling, eczema) | Immediate Follow-up (within 1-2 months) to confirm or rule/out cancer | Refer for Diagnostic Mammogram AND additional follow-up procedures as indicated. See Michigan Cancer Consortium Recommendations for Follow-up of Abnormal Breast Cancer Screening Results |

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D. Follow-up of Mammogram Breast Cancer Screening Results

| Mammogram Result | Type of Follow-up | Recommendation |
|---|--|---|
| ACR 1 - Negative | No Follow-up | Annual screening unless CBE is abnormal – See E |
| ACR 2 – Benign Breast Condition | No or Short-term Follow-up (3-7 months) | Based on the type of mammogram ordered and client’s history, the radiologist may recommend a diagnostic mammogram or ultrasound. |
| ACR 3 – Probably Benign | Short-term Follow-up (3-7 months) | Refer for diagnostic mammogram and/or ultrasound based on radiologist recommendations. See Michigan Cancer Consortium Recommendations for Follow-up of Abnormal Breast Cancer Screening Results |
| ACR 0 – Assessment is Incomplete | Immediate Follow-up (within 1-2 months) to confirm or rule/out cancer | Refer for diagnostic mammogram and/or ultrasound based on radiologist’s recommendation. Based on result, additional referral to a breast surgeon/ specialist for evaluation may or may not be indicated. NOTE: If comparison films are requested, films should be obtained within 30 days. After review, radiologist will determine if no or additional follow-up is required. |
| ACR 4 – Highly Suggestive of Malignancy ACR 5 – Suspicious Abnormality | Immediate Follow-up (within 1-2 months) to confirm or rule/out cancer | See MCC Recommendations for Follow-up of Abnormal Breast Cancer Screening Results |

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E. Special Considerations

**ABNORMAL clinical breast examination, NORMAL mammogram results OR
ABNORMAL mammogram, NORMAL clinical breast exam**

1. Notify the patient of the results of her CBE and/or mammogram result and its implication. This information should include:
 - Explanation of the type of abnormality suspected/identified (on clinical breast exam and/or mammogram).
 - Additional diagnostic follow-up required based on the abnormality (i.e. ultrasound, surgical consultation, biopsy etc) as recommended by the radiologist/breast specialist/surgeon.
 - Implications for coverage by the BCCCP
2. Refer for additional diagnostic follow-up as indicated.

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| <p>NOTE: Radiologically confirmed breast cysts do not always require referral to breast surgeon/specialist. Additional follow-up is determined by size of cyst, patient history, and recommendation by the radiologist.</p> |
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3. Notify the patient's primary provider (if any).
 - The physical exam findings and mammogram/ultrasound test results
 - BCCCP role/action taken

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**Michigan Cancer Consortium
Recommendations for Follow-up of Abnormal Breast Cancer Screening Results
March 21, 2001**

| Abnormal Result | Primary Care Management | Indication for Referral |
|---|--|---|
| A. <u>Clinical Breast Exam:</u> <i>Nipple Discharge, no palpable mass</i> | | |
| 1. Bilateral Milky Discharge | Conduct Pregnancy Test | None |
| 2. Nonspontaneous Multiduct discharge | <i>Under age 40</i> - Educate and Observe | None |
| | <i>Over age 40</i> – Refer for Mammogram | Refer to Breast Specialist/ Surgeon for additional evaluation after mammogram |
| 3. Persistent, spontaneous, unilateral, single duct, serous, or sanguineous nipple discharge | Refer for diagnostic mammogram with guaiac or cytology (optional) | Refer to Breast Specialist/ Surgeon for additional evaluation after mammogram |
| B. <u>Clinical Breast Exam:</u> <i>Lump/Mass</i> | Under age 30 Refer for Ultrasound (preferred), needle biopsy, or if low risk, observe for 1-2 menstrual cycles to see if the mass resolves; | If lump/mass persists, refer to Breast Specialist/ Surgeon for additional evaluation |
| | Over age 30 Refer for mammogram and/or ultrasound | Refer to Breast Specialist/ Surgeon for additional evaluation after imaging |
| C. <u>Clinical Breast Exam:</u> <i>Thickening/nodularity/ asymmetry</i> | • Under age 30 Refer for ultrasound plus mammogram if indicated | Refer to Breast Specialist/ Surgeon for additional evaluation after imaging |
| | • Over age 30 Refer for bilateral diagnostic mammogram with or without ultrasound | Refer to Breast Specialist/ Surgeon for additional evaluation after imaging |
| D. <u>Clinical Breast Exam:</u> <i>Skin changes (Peau d'orange, Erythema, Nipple excoriation, Scaling, eczema)</i> | Refer for bilateral diagnostic mammogram with or without an ultrasound | Refer to Breast Specialist/ Surgeon for additional evaluation after imaging |
| E. <u>Mammogram:</u> BiRADS Category 3- ACR 3 Probably Benign | Refer for bilateral diagnostic mammogram at 6 months, then every 6-12 months for 2-4 years; may include biopsy if patient noncompliant or highly anxious | May need to refer to Breast Specialist/ Surgeon for additional evaluation after imaging (if indicated). |
| F. <u>Mammogram:</u> BiRADS Category 4 – ACR 4 Suspicious Abnormality Category 5 – ACR 5 Highly Suggestive of Malignancy | Refer to breast specialist/surgeon for FNA or Core biopsy with post-specimen radiography if microcalcifications or Needle localization excisional biopsy | |

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- F. Follow-up of Abnormal Cervical Cancer Screening Results
1. **ABNORMAL pelvic examination (abnormal gross appearance of cervix),
NORMAL Pap test**
 - a. Notify the patient of the results of her pelvic examination and its implication.
This information should include:
 - The nature of the suspected disease and differentiation between a cervical lesion or other pelvic abnormality (ovarian mass) and implications for coverage by BCCCP, etc.
 - Refer immediately for colposcopy with biopsy as indicated.
Do not rely on cervical cytology results alone.
 - b. Notify the patient's primary provider (if any).
 - The physical exam findings and screening test results
 - BCCCP role/action taken
 2. **UNSATISFACTORY cervical cytology specimen**
 - Repeat Pap smear in 2-4 months.
 - If second Pap test is unsatisfactory, refer for colposcopy.
 3. **ABNORMAL cervical cytology report**
 - a. Notify the patient of the results of the Pap test and its implications within 4 days of receipt of abnormal findings, including:
 - The nature of the suspected disease
 - What a precancerous lesion is and that it is 100% curable
 - The need for further testing for definitive diagnosis before treatment
 - Treatment options available, benefits and risks of each
 - b. Refer/arrange for repeat Pap test and/or diagnostic work-up and treatment based on Pap test results.
 4. **Follow-up of ABNORMAL CYTOLOGY RESULTS:**
 - a. The website <http://www.asccp.org/> contains algorithms on the:
 - Follow-up of ASC-US cytology results for all women

NOTE: BCCCP funds CAN REIMBURSE for HR-HPV testing for BCCCP clients (age 40-64) only as follow-up for screening Pap test results of ASC-US.

- Management of adolescent women with HSIL results, ASC-US or LSIL cytology
- Management of pregnant women with LSIL results
- Management of HSIL, ASC-H and LSIL cytology for all women
- Management and follow-up of AGC cytology.

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- b. A diagnostic excisional procedure is recommended for women with HSIL and an unsatisfactory colposcopy, except when pregnant.
- c. A diagnostic excisional procedure is recommended for adolescents and young women with HSIL when CIN of any grade is identified on ECC
- d. Ablation is unacceptable for HSIL cytology if:
 - No colposcopy was done
 - CIN 2/3 is not identified colposcopically
 - ECC identifies CIN of any grade
- e. In women less than 35 years of age with an AGC cytology result, an endometrial biopsy should be performed in the presence of, but is not limited to, the following conditions:
 - Dysfunctional uterine bleeding
 - At risk for chronic anovulation
 - A change in menstrual flow

5. **Management of Women and Adolescents with Histologically-confirmed Cervical Intraepithelial Neoplasm:**

The website <http://www.asccp.org/> contains algorithms on the management of:

- Women with histological results of CIN1, preceded by ASC-US, ASC-H or LSIL cytology
- Women with histological results of CIN1, preceded by HSIL or AGC-NOS cytology
- Adolescents, with a histological result of CIN1
- Women with a histological result of CIN2/3
- Women with AIS (Adenocarcinoma in situ) diagnosed from diagnostic excisional procedure.

6. **Appropriate follow-up for BCCCP Clients with Pap test results of HSIL with colposcopy results of CIN I, “not cancer”, or atypia**

- When the colposcopy is satisfactory, a review of cytology, colposcopy and histology results should be performed
- If there is a revised interpretation of either the Pap or the histology results, the clinical management should follow the appropriate guidelines as described in the BCCCP Medical Protocol
- If Pap results of HSIL are upheld, a diagnostic excisional procedure is preferred (either cone or LEEP).
- When the colposcopy is unsatisfactory, a review of cytology, colposcopy and histology results should be performed when possible.
- If there is a revised interpretation of either the Pap or the histology results, the clinical management should follow the appropriate guidelines.

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- If HSIL Pap is upheld, review is not possible, or biopsy-confirmed CIN1 is identified, a diagnostic excisional procedure is preferred (cone or LEEP)

NOTE: BCCCP can reimburse for either cold knife cone or LEEP procedure. Authorization MUST be obtained prior to the procedure being performed.

- Ablation is unacceptable
- If colposcopy suggests a high-grade lesion, initial evaluation using a diagnostic excisional procedure is acceptable management (“**see and treat**”)
- Testing for High-risk Human Papillomavirus (HPV) is not acceptable management as triage for HSIL

6. Management of Atypical Glandular Cells (AGC) or Adenocarcinoma In Situ (AIS)

a. Initial Evaluation:

- Colposcopy with endocervical sampling is recommended for women with all subcategories of atypical glandular cells (AGC) (AGC “not otherwise specified [NOS],” AGC “favor neoplasia”) and adenocarcinoma in situ (AIS).
- Performance of endometrial biopsy (EMB) should be considered as part of the initial evaluation for women age 35 or older.

NOTE: BCCCP can reimburse for endometrial biopsies in this situation only. Pre-authorization MUST be obtained prior to the procedure being performed.

- Management of women with initial AGC or AIS using a program of repeat cervical cytological testing is ***unacceptable***.

b. Subsequent Evaluation or Follow-up:

- If biopsy-confirmed CIN is identified during the initial workup of a woman with AGC (NOS), the woman should be referred to a qualified colposcopist for treatment.
- If invasive disease is not identified during the initial colposcopic workup, it is recommended that women with AGC “favor neoplasia” or endocervical AIS undergo a cold-knife conization or LEEP.

NOTE: BCCCP can reimburse only for a cold knife conization/LEEP. Pre-authorization MUST be obtained prior to the procedure being performed.)

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- If no neoplasia is identified during the initial workup of a woman with AGC (NOS), it is recommended that the woman be followed up using a program of repeat cervical cytological testing at 4- to 6-month intervals until 4 “negative for intraepithelial lesion or malignancy” results are obtained, after which the woman may return to routine screening.

QUESTIONS REGARDING THIS PROTOCOL MAY BE DIRECTED TO:

E.J. Siegl, MA, OCN, RN, BCCCP Nurse Consultant
Ann Garvin, MS, CNM, BCCCP Nurse Consultant
Washington Square Building
Cancer Prevention and Control Section,
109 Michigan Ave, 5th Floor, Lansing, MI 48913

517/335-8814
517/335-9087