COMMENTARY

No More Routine Pap Tests for Teens? It's About Time!

BY MICHAEL S. POLICAR, M.D.

At first glance, this latest American College of Obstetricians and Gynecologists' opinion on cervical cancer in adolescents is yet another reason for "guideline shock." The symptoms are familiar: New national guidelines are released before older ones are fully implemented, and as in this case, the recommendations appear to be the opposite of traditional practice.

In reality, this guideline is the result of an evolutionary process that has been in play since 2002, one in which the management of adolescent women, defined as those under age 21 years, has become much more conservative.

Before then, a national consensus guideline issued in 1989 recommended that women initiate cervical cancer screening with the onset of sexual activity, or by age 18 years even if a woman was a virgin.

In 2002, the American Cancer Society, relying on new studies of the natural history of human papillomavirus infections and consequent preinvasive cervical lesions, recommended that a woman delay her first screen until 3 years after her first episode of vaginal intercourse or to start screening at age 21 years, given the possibility that some women would not disclose their sexual history.

In the following year, ACOG and the U.S. Preventive Services Task Force issued similar guidelines.

In 2006, the American Society for Colposcopy and Cervical Pathology (ASCCP) took the next step by recommending that women under age 21 years not receive HPV-DNA testing under any circumstances and also sharply differentiated the management of abnormal cytology and histology results in adolescents, compared with adult women.

More recently in December 2009, the ACOG Practice Bulletin "Cervical Cytology Screening" flatly recommended that cervical cancer screening begin at age 21 years, regardless of the age of onset of sexual activity (Obstet. Gynecol. 2009;114:1409-20).

The newest ACOG guideline on this topic adds further advice for the management of adolescents who had abnormal Pap screening results in the "old system" and how they should be transitioned to the new.

The reason for this evolution in thinking is clearly stated in each of the guidelines. In younger women, most HPV infections are transient and not dangerous at the time of infection. If persistent infection with a high-risk type of HPV does result in the development of a high-grade lesion, it typically does so over a period of years or even decades, allowing ample time for the discovery of a preinvasive lesion once a woman starts screening at age 21 years.

In addition, invasive cervical cancer is exceedingly rare in adolescents, occurring at a rate of 1-2 cases per million women per year, and even some of these cases do not appear to have been preventable by screening.

Beyond the fact that screening of adolescents has no apparent benefit, the harms of screening are becoming better understood. Numerous studies have shown the negative psychological effects of screening, disclosure of abnormal results, and treatment, including effects on sexual function. Even more concerning are the findings that pregnancy outcomes following loop electrosurgical excision procedures (LEEP) show a significant increase in the rate of preterm birth.

Regrettably, there is no reason for optimism that this set of recommendations will be embraced quickly. As a number of studies have shown, clinicians have been slow to adopt the 2002 cervical cancer screening guidelines and consumers either don't know about the guidelines or believe that they are financially motivated. Providers are fearful of encountering a patient with an interval cancer and being sued for a missed diagnosis and also concerned that well-woman visits will be skipped if they are not tied to the need for a Pap test.

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There is also concern that sexually active adolescents will not receive annual Chlamydia screening and targeted screening for other sexually transmitted infections once they are informed at that annual screening pelvic examinations and Pap tests are no longer recommended. While these are legitimate concerns, they must be addressed in ways other than requiring a young woman to receive a test that is unnecessary and potentially harmful

For this guideline to be successfully implemented, a number of interventions are necessary. Most importantly, consumers must be educated and persuaded that the public health message of the last 60 years regarding the need for annual Pap screening in all women has been significantly modified for the purpose of improving quality of care and not just to save money. Second, providers must be convinced that the guideline is based on the best available evidence and are somehow motivated to follow it. Third, once these measures have been achieved, health plans should stop paying for cervical cytology in women under age 21 years, as many have done already for HPV-DNA tests.

While some clinicians will prefer to wait for updated guidelines produced by the USPSTF or the American Cancer Society before changing their practices, it is clear that the momentum of the evolutionary changes will continue in the direction that ACOG has taken. The bottom line is that by continuing to screen adolescents for cervical cancer, including those who are pregnant, we risk harming our patients rather than helping them. It's time to abandon this unnecessary practice. ■

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Perform Pap Smears in Girls With HIV, Immunocompromise

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"I think it makes it very clear for us as clinicians as to what we should be doing," she said

Dr. Gomez-Lobo said that waiting until age 21 to screen young women makes sense, given how rare cervical cancer is in that age group. "When we did screen a lot of teenagers, we were not preventing the few cancers that do happen in adolescents," she said. "Ultimately, many were having excisional procedures that put them at risk for preterm labor in the future."

The guidelines also specify how physicians should manage women younger than age 21 years who have already had Pap tests and who were found to have dysplasia. Periodic observation is generally safe for those with low- to high-grade precancerous lesions (Obstet. Gynecol. 2010; 116:469-72).

For those women whose Pap smear results showed improvement in dysplasia, it's acceptable to wait to rescreen until age 21, although annual screening is also okay.

In those younger women who were found to have cervical intraepithelial neoplasia 3 (CIN 3), however, treatment with cryotherapy, laser therapy, or loop electrosurgical excision is warranted as the natural history of CIN 3 has not been determined.

Adolescents should not be tested for human papillomavirus because the infection tends to resolve on is own most of the time, according to the guidelines.

Pregnancy in young women does not alter the recommendations, nor does a diagnosis of a sexually transmitted infection other than HIV. ■

Disclosures: *Dr. Gomez-Lobo reported that she has received an investigator-initiated grant from Merck and is studying the use of Gardasil in transplant patients.*

Pregnant Women Sought for Antipsychotics Registry

Pregnant women who are being treated with an atypical antipsychotic can enroll in a national registry that is evaluating the safety of these drugs during pregnancy, according to an announcement posted on the Massachusetts General Hospital's Center for Women's Mental Health Web site.

Women are eligible to enroll in the registry if they are pregnant and are between 18 and 45 years old and are currently being treated with one or more of the following antipsychotic medications: aripiprazole (Abilify), clozapine (Clozaril), ziprasidone (Geodon), paliperidone (Invega), risperidone (Risperdal), quetiapine (Seroquel), olanzapine (Zyprexa), and asenapine (Saphris). Once the participants have registered, they will be asked to participate in three brief phone interviews that will be conducted over an 8-month period.

The National Pregnancy Registry for Atypical Antipsychotics is collecting data to investigate the safety of atypical antipsychotics during pregnancy, when these agents are used to treat a wide range of mood, anxiety, or psychiatric disorders, according to the announcement from the hospital.

The main goal of the National Pregnancy Registry is to determine the frequency of heart defects, cleft lip, neural tube defects, and other major malformations in infants who are exposed to these medications in utero.

To register, or for more information about what participation in the registry involves, call 866-961-2388. The MGH Center for Women's Mental Health provides information on perinatal and reproductive psychiatry at www.womensmentalhealth.org.

—Elizabeth Mechcatie

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