Section 6: Management of those with a normal colposcopy and/or with a histologically confirmed low grade squamous abnormalities following HPV detected (any type) and negative, ASC-US or LSIL cytology

This section addresses the management of participants with HPV detected (any type), with negative, ASC-US or LSIL cytology, normal colposcopy and/or a histologically confirmed LSIL abnormality.

Management of participants is not stratified by age as more longitudinal data is required to inform follow up management algorithms, particularly in older participants. An observational study from a UK pilot implementing HPV testing into primary screening reported the proportion of persistently positive HPV participants did not vary substantially with age. Regression of HPV detected (any type) with negative cytology at 24 months was similar across age groups and estimated at 56.9%. [1] A US study examining the natural history of HPV infections reported 80% of HPV infections were no longer detectable within three years. HPV 16 persistence was strongly associated with progression to CIN3+. The duration of HPV persistence was the most important feature in regard to progression and age did not appear to modify risk. [2]

Please note *further data is being sought to guide the management of older participants with HPV persistence and negative cytology*

Normal colposcopic findings following HPV detected (any type) and negative, ASC-US or LSIL cytology results

With the change to the primary HPV screening programme and the increased sensitivity of the HPV test compared with cytology screening, there will be an increase in participants with normal colposcopic findings associated with negative, ASC-US or LSIL cytology. Evidence suggests the risk of high grade disease is low following a

normal colposcopy with negative, ASC-US or LSIL cytology and an HPV detected (any type) result. [3-5] Participants can be discharged to primary care for a follow up HPV test in 12 months. Data from the US shows that for any type of HPV detected (any type) result with negative, ASC-US or LSIL cytology, the 1-year risk of CIN3+ following a normal colposcopy and a biopsy result of less than CIN1, is below 0.60% (See Table 1).

Table 1. CIN3+ 1 year and 5-year risks upon receipt of colposcopy / biopsy result

Index referral result	Colposcopic biopsy result	n	CIN3+ 1-yr risk %	CIN3+ 5-yr risk %
HPV detected negative cyto	<CIN1	7082	0.56	2.65
HPV detected ASC-US	<CIN1	15601	0.49	3.18
HPV detected LSIL	<CIN1	7129	0.59	2.09

HPV detected = any type

Histologically confirmed LSIL following an HPV detected (any type) and negative, ASC-US or LSIL cytology results

Based on Lower Anogenital Squamous Terminology (LAST) the histology of low grade HPV-associated squamous lesions are reported as LSIL (CIN1). [6] The majority of LSIL abnormalities will resolve with time and do not require treatment [3] Current guidelines do not recommend treatment for histologically confirmed LSIL (CIN1) or lesser lesions because they are an expression of a productive HPV infection.

Participants who have an HPV detected (any type) and negative, ASC-US or LSIL cytology with a histologically confirmed LSIL abnormality can be discharged to primary care for a follow up HPV test in 12 months, evidence suggests the risk of high grade disease is very low. [3-5] Data from the US shows that for any type of HPV detected (any type) result with negative, ASC-US or LSIL cytology, the 1-year risk of CIN3+ following a normal colposcopy and a biopsy result of CIN1, varies between 0.53 and 0.74% (See Table 2).

Table 2. CIN3+ 1 year and 5 year risks upon receipt of colposcopy / biopsy result [5]

Index referral result	Colposcopic biopsy result	n	CIN3+ 1-yr risk %	CIN3+ 5-yr risk %
HPV detected Neg cyto x 2	CIN1	5,732	0.74	2.8
HPV detected ASC-US	CIN1	20,131	0.53	2.6
HPV detected LSIL	CIN1	18,254	0.74	2.3

*Immediate risk; HPV detected = any type

A new recommendation following a normal colposcopy or histologically confirmed low grade abnormality with an **HPV detected (any type)** and negative, ASC-US or LSIL cytology, participants can be discharged to their primary care provider. Participants should have a repeat HPV test in 12 months. This can be a vaginal swab or cervical sample.

Screen takers must explain the options available for a follow up HPV test with participants. **It is important for screen takers** to discuss the potential need for an additional visit when the follow up test is a vaginal swab, and the test is **HPV detected (any type).**

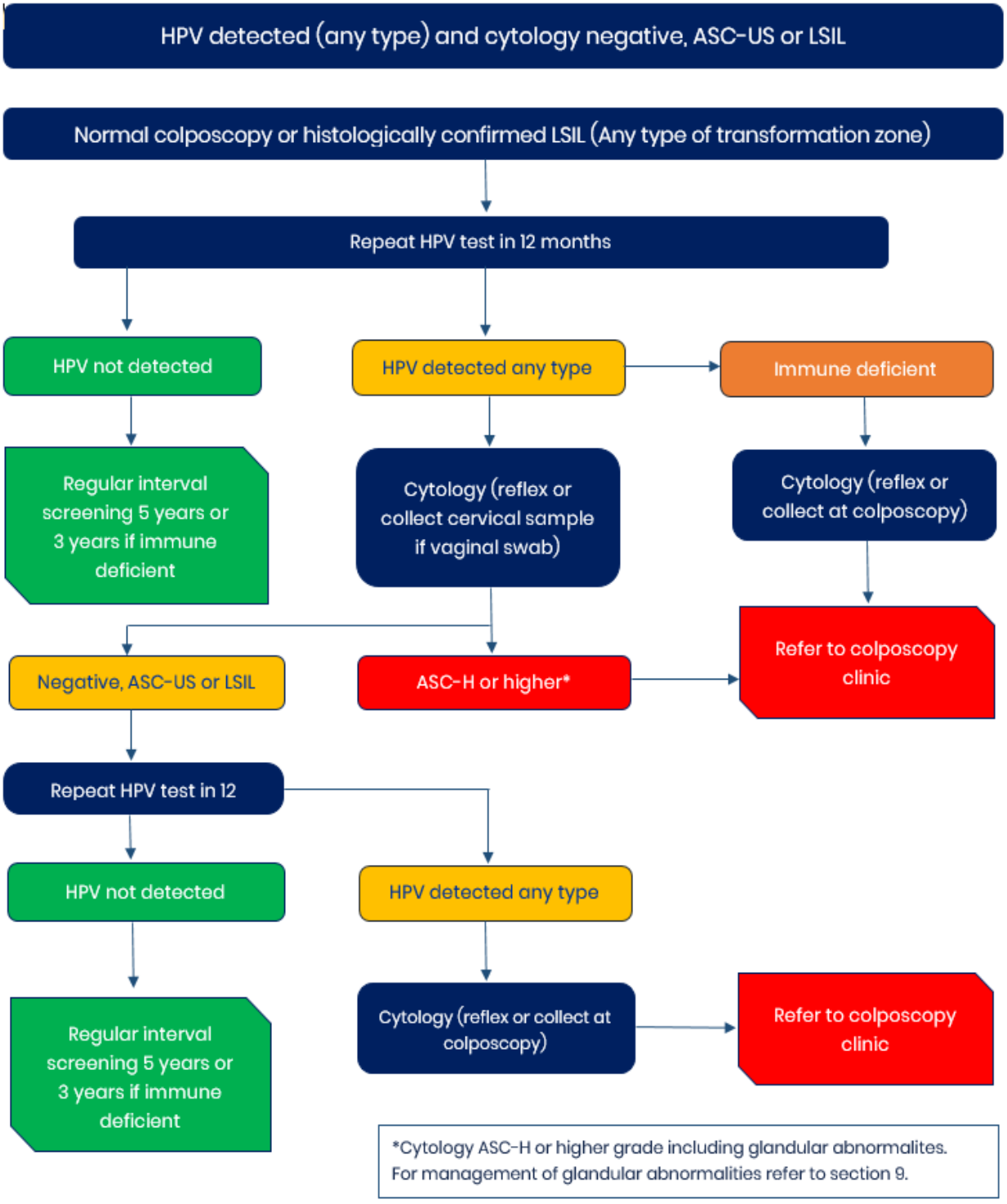
If the cervical sample reflex cytology or follow up cytology is negative, ASC-US or LSIL the participant should have a repeat HPV test in a further 12 months. If the cytology is reported as high grade the participant should be referred to colposcopy.

RECOMMENDATIONS – MANAGEMENT OF NORMAL COLPOSCOPY OR HISTOLOGICALLY CONFIRMED LSIL	
R6.01 Management of participants with a normal colposcopy or histologically confirmed LSIL following HPV detected (any type) and negative, ASC-US or LSIL cytology	**Evidence-based recommendation** Participants who have an HPV detected (any type) test result with a cytology report of negative, ASC-US or LSIL, and either a normal colposcopy or histologically confirmed LSIL should have a repeat HPV test in 12 months with their primary care provider. This includes participant with a type 3 transformation zone.

RECOMMENDATIONS – MANAGEMENT OF NORMAL COLPOSCOPY OR HISTOLOGICALLY CONFIRMED LSIL	
R6.02 HPV test 12 months after a normal colposcopy or histologically confirmed LSIL	**Consensus- based recommendation** If the repeat HPV test result at 12 months is: HPV not detected, the participant can return to regular interval screening. For participants with HPV detected (any type) on a vaginal swab they should be recalled for cytology within 6 weeks. Immune deficient participants should be referred to colposcopy. Direct referral can occur following an HPV Detected (any type) result on a vaginal swab and cytology can be collected at the time of colposcopy. Participants with HPV detected (any type) and a negative, ASC-US or LSIL cytology result should have a repeat HPV test in 12 months. Participants with HPV detected (any type) and high grade cytology should be referred for colposcopy. If suspected or definite invasion is reported on cytology, refer urgently to colposcopy.
R6.03 Management of follow up results in 24 months	**Consensus- based recommendation** If the repeat HPV test result at 24 months is: HPV not detected; the participant should be advised to return to regular interval screening Participants with HPV detected (any type) should be referred to colposcopy.
R6.04 Treatment of HPV test results or CIN1	**Consensus-based recommendation** Treatment is not recommended in participants with a normal colposcopy or histologically confirmed LSIL abnormality following an HPV detected (any type) test result and negative, ASC-US or LSIL cytology. Low grade lesions are an expression of a productive HPV infection.
R6.05 Treatment of HPV test results or CIN1 with a type 3 transformation zone	**Consensus-based recommendation** Treatment is not recommended for participants with a type 3 transformation zone with HPV detected (any type) and negative, ASC-US or LSIL cytology. The risk of treatment outweighs the benefits.

RECOMMENDATIONS – MANAGEMENT OF NORMAL COLPOSCOPY OR HISTOLOGICALLY CONFIRMED LSIL	
R6.06 Support for participants requiring a follow up HPV test or cytology	**Practice Point** Ask all participants / whānau whether they require assistance or support to attend for a follow up HPV test or cytology. Consider transport, cultural support and where appropriate offer referral to Support to Screening services.

Figure 1 - Management of participants with a normal colposcopy or histologically confirmed LSIL following HPV detected (any type) and a cytology result that is negative, ASC-US or LSIL



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