2022 – WOMEN'S HEALTH SCREENING – UPDATES

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1

DISCLOSURES

- Financial: paid consultant & content expert for the NBME
- Personal: I think health screening is exceedingly important.

2

Learning Objectives

- Identify individuals who require more detailed breast cancer screening and / or genetic counseling services.
- Consider current cervical cancer screening
  - *Primary HPV screening… is coming*
  - *Cessation of screening*
- Contraceptive updates
- Menopause & hormone therapy
- Bone density screening

3

Topics to be covered

- Breast health / cancer screening
  - *Personalized genomic approach*
  - *Cessation of screening*
- Cervical cancer screening
  - *Primary HPV screening… is coming*
  - *Cessation of screening*
- Contraceptive updates
- Menopause & hormone therapy
- Bone density screening

4

BREAST CANCER SCREENING UPDATES

5

What are the (2) most important details on a mammogram report?

- Risk assessment calculation (e.g. Tyrer-Cuzick/IBIS model)
- Breast density category
- Which radiologist read the study
- Ability to compare to prior studies
- BI-RADS category

- Did you know there is *legislation* for that?!?
  - *Yup – Iowa law tells us how to handle breast density categories*

6

Breast health / cancer screening

- Personalized genomic approach
- Improve the benefit-harm ratio of breast cancer screening programs
  - *Tyrer-Cuzick/IBIS*
  - *Breast Cancer Risk Assessment Tool*
    - allows health professionals to estimate a woman's risk of developing invasive breast cancer over the next 5 years and up to age 90 (lifetime risk)
    - validated for white women, black/African American women, Hispanic women and for Asian and Pacific Islander women in the United States.
  - *Gail model*

7

Breast health / cancer screening

- Cessation of screening
  - *There is growing recognition that among women aged 75 and older, the harms and burdens of routine mammography screening may outweigh the benefits…*
  - *CDC's recommendation: "…* the age to stop screening with mammography should be based on each woman's health status rather than an age-based determination. **In average-risk women aged 75 years or older or in women with a life expectancy of 10 years or less**, clinicians should discontinue screening for breast cancer.

8

Breast health / cancer screening

- Cessation of screening *(cont.)*
  - *USPSTF's recommendation:* The USPSTF recommends biennial screening mammography for women aged 50 to 74 years. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women aged 75 years or older.
  - *National Cancer Institute*
  - *NCCN*

9

CERVICAL CANCER SCREENING UPDATES

10

We need to STOP calling it a "Pap +/- smear"!!!

- Why??
  - *Because it's not a "Pap smear"*
    - We haven't "smeared" anything in years
    - Eponyms are out
  - *Because the term "Pap" triggers the idea of "annual" or "yearly"*
  - *Because it confuses patients*
    - Many many MANY females believe that the term "Pap" is describing a speculum exam.
  - *Because it bypasses a chance to highlight the uniqueness and importance of cervical cancer screening as a preventative measures*
  - *Because it wastes the opportunity to link cervical cancer screening to the high-risk HPV virus and, the HPV vaccine*

11

When were cervical cancer screening guidelines last updated?

- 2012
- 2018
- 2020
- 2021

- This is the 'screening' piece.
- Think of it as the point in time where you ask, "Do I need to do anything?"

12

Comparison Chart of recent cervical cancer screening guideline updates

	2020 ACS	2012 ACS	2018 USPSTF
Age 21–24	No screening	Pap test every 3 years	Pap test every 3 years
Age 25–29	HPV test every 5 years (preferred) HPV/Pap cotest every 5 years (acceptable) Pap test every 3 years (acceptable)	Pap test every 3 years	Pap test every 3 years
Age 30–65	HPV test every 5 years (preferred) HPV/Pap cotest every 5 years (acceptable) Pap test every 3 years (acceptable)	HPV/Pap cotest every 3 years (preferred) Pap test every 3 years (acceptable)	Pap test every 3 years, HPV test every 5 years, or HPV/Pap cotest every 5 years
Age 65 and older	No screening if a series of prior tests were normal	No screening if a series of prior tests were normal	No screening if a series of prior tests were normal and not at high risk for cervical cancer

13

USPSTF Recommendations for Routine Cervical Cancer Screening

Population*	Recommendation	USPSTF Recommendation Grade†
Aged less than 21 years	No screening	D
Aged 21–29 years	Cytology alone every 3 years‡	A
Aged 30–65 years	Any one of the following: • Cytology alone every 3 years • FDA-approved primary hrHPV testing alone every 5 years • Cotesting (hrHPV testing and cytology) every 5 years	A
Aged greater than 65 years	No screening after adequate negative prior screening results§	D
Hysterectomy with removal of the cervix	No screening in individuals who do not have a history of high-grade cervical precancerous lesions or cervical cancer	D

14

Your patient's cervical cancer screening returned with an abnormal result. Now what?

- When were the 'management' guidelines last updated?
  - 2009
  - 2012
  - 2019
  - 2022
- This is the 'diagnosis' or 'management' piece.
- If you find yourself at this step, there are more steps to come!

15

2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors

- What changed?
  - Recommendations are based on risk, not results.
  - Colposcopy can be deferred for certain patients.
  - Guidance for expedited treatment is expanded (*i.e.* treatment without colposcopic biopsy).
  - Observation is preferred to treatment for CIN 1.
  - Excisional treatment is preferred to ablative treatment for histologic HSIL (CIN 2 or CIN 3) in the United States.
  - Excision is recommended for adenocarcinoma in situ (AIS).

16

2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors

- What changed? *(cont.)*
  - Continued surveillance with HPV testing or cotesting at 3-year intervals for *at least* 25 years is recommended after treatment and initial post-treatment management of histologic HSIL, CIN 2, CIN 3, or AIS. Continued surveillance at 3-year intervals beyond 25 years is acceptable for as long as the patient's life expectancy and ability to be screened are not significantly compromised by serious health issues.

17

2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors

- What didn't…
  - "… certain situations do not have specific guidance. In such cases, using the 2012 updated consensus guidelines for the management of abnormal cervical cancer screening tests and cancer precursors is acceptable…"
  - "… individuals aged 25 or older screened with cytology alone, the 2012 updated consensus guidelines for the management of abnormal cervical cancer screening tests and cancer precursors are recommended for management of abnormal results…"
    - E.g. "… colposcopy for all cytology results of low grade squamous intraepithelial lesion (LSIL) or higher for individuals aged 25 and above…"

18

What is primary HPV screening going to look like?

- Surveillance with cytology alone is acceptable only if testing with HPV or cotesting is not feasible. Cytology is less sensitive than HPV testing for detection of precancer and is therefore recommended more often. Cytology is recommended at 6-month intervals when HPV testing or cotesting is recommended annually. Cytology is recommended annually when 3-year intervals are recommended for HPV or cotesting.

- All positive primary HPV screening tests, regardless of genotype, should have additional reflex triage testing performed from the same laboratory specimen (*e.g.*,reflex cytology).

19

What is primary HPV screening going to look like?

- Additional testing from the same laboratory specimen is recommended because the findings may inform colposcopy practice. For example, those HPV-16 positive HSIL cytology qualify for expedited treatment.

- HPV 16 or 18 infections have the highest risk for CIN 3 and occult cancer, so additional evaluation (*e.g.*, colposcopy with biopsy) is necessary even when cytology results are negative.
- If HPV 16 or 18 testing is positive, and additional laboratory testing of the same sample is not feasible, the patient should proceed directly to colposcopy.

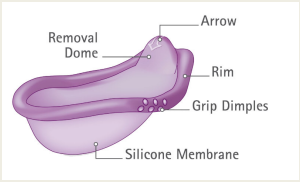
20

CONTRACEPTIVE UPDATES

21

Available, but unpopular…

- Caya diaphragm
  - *"Natural, safe, hormone-free birth control"*
  - *When to consider:*
    - Have health conditions that prevent you from using hormones
    - Are breastfeeding and prefer a natural birth control
    - Need backup contraception in the case of missed pills
    - Need protection from pregnancy only occasionally
  - *"Proper use includes using the diaphragm with a water-based spermicide or contraceptive gel."*
  - *Must remain in place for 6 hours after intercourse.*



22

What's new with "The Pill"

- Nextstellis (drospirenone and estetrol tablets)
- Estetrol: labeled as a "native estrogen with selective action in tissues", or NEST
- Benefits:
  - *a minimal first-pass metabolism*
  - *a reduction of impact on hemostasis parameters*
  - *half-life of 28 hours*
- Slynd (drospirenone tablets)
  - *24/4 regimen*
  - *MOA = ovulation suppression*
    - Norethindrone POPs work by thickening cervical mucus
  - *One study demonstrated that, even with multiple intentional 24-hour delays in tablet intake, ovulation suppression was maintained*

23

Pills, Patches and Rings – OH MY!!

- Twirla (levonorgestrel and ethinyl estradiol transdermal system)
  - *Lower daily amount of released ethinyl estradiol (30 mcg vs 35 mcg)*
  - *Used the same way the Xulane patch is used*
- EluRyng = generic NuvaRing
- Annovera (segesterone acetate and ethinyl estradiol vaginal system)
  - *One vaginal ring lasts one year (= 13 cycles)*
  - *Stored in a small case during the ring-free week each cycle*
  - *No data about ability to use continuously*
  - *97.3% efficacy in preventing pregnancy*

24

Last, but not least…

- Mirena (high-dose levonorgestrel) IUD is approved for 8 years by the FDA.
  - *For heavy menstrual bleeding, FDA approval is still only for 5 years*
- RCT in the NEJM demonstrated the the 52mg LNG IUD is not inferior to Cu IUD for emergency contraception!!
- Liletta (high-dose LNG) IUD is approved for 6 years of contraceptive benefit.
- Phexxi (lactic acid - citric acid.- potassium bitartrate prescription vaginal gel)
  - *Not a typical spermicide*
  - *Alters the vaginal pH when inserted in the vagina within an hour before sex*
  - *86% efficacy with typical use*
  - *Expensive*

25

MENOPAUSE & HORMONE THERAPY UPDATES

26

Which of the following is not a risk of using estrogen-only hormone therapy?

- Thromboembolic stroke
- Breast cancer
- Deep venous thrombosis
- Exacerbation of cirrhosis
- Pulmonary embolism

27

HOT off the press!!

- North American Menopause Society Updates Hormone Therapy Guidance – July 7th, 2022
  - *"NAMS recommends risk stratification by age and time since menopause."*
  - *"…* Benefits of hormone therapy outweigh the risks for most healthy symptomatic women aged younger than 60 years and within 10 years of menopause onset…"
    - This refers to *INITIATION*, not continuation, of hormone therapy.
  - "Transdermal routes of administration and lower doses of hormone therapy *may* decrease risk of VTE and stroke."
  - *"Shared decision-making remains key…"*

28

Hormone Therapy

- Different ways to slice the pie:
  - *Systemic vs. localized (i.e. vaginal)*
    - "… vaginal estrogen… or other non-estrogen therapies may be used at any age and for extended duration, if needed."
  - *Estrogen-only vs. Combined (i.e. estrogen + progestin)*
  - *Enteral vs. transdermal*
    - Progestins are not well-absorbed across epidermal skin
  - *Indications*
    - Systemic estrogens (+/- progestins, as indicated) treat vasomotor symptoms and mood lability
    - Topical estrogens treat atrophic vaginitis
      - *Minimal effect when applied to vulva*
    - Transdermal testosterone treats low libido

29

Hormone Therapy – the basics

- "… position statement emphasizes the role of hormone therapy as the most effective treatment for vasomotor symptoms (VMS) and genitourinary syndrome of menopause (GSM)…"
- "Breast cancer risk does not increase appreciably with short-term use of estrogen-progestogen therapy and may be decreased with estrogen alone."

30

Hormone Therapy (cont.)

- "Hormone therapy does *not* need to be routinely discontinued in women aged older than 60 or 65 years and can be considered for continuation beyond age 65 for persistent VMS, quality-of-life issues, or prevention of osteoporosis after appropriate evaluation and counseling of benefits and risks."
- "Compounded bioidentical hormone therapy presents safety concerns, including minimal government regulation, misadministration, lack of scientific efficacy and safety data, and lack of a label outlining risks."

31

THANK YOU!!!

Any questions?

32