Cervical Cancer Screening in Underserved Populations

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[Dr. Saraiya] Welcome to this CDC program on cervical cancer screening. I'm your host, Dr. Mona Saraiya. With me today is Dr. Lisa Flowers. Dr. Flowers is board certified in obstetrics and gynecology, a specialist in HPV-related diseases, and Director of Colposcopy at Emory University School of Medicine. Thanks for joining us, Lisa.

[Dr. Flowers] Thanks, Mona, for inviting me.

[Dr. Saraiya] Lisa, can you tell us what type of setting you work in?

[Dr. Flowers] I really love where I work. I'm very fortunate. I have a population that really reflects who I am. I am an African-American and Latino woman and my population is predominantly African-American, Latino, and other patients that are underinsured or uninsured.

[Dr. Saraiya] Lisa, can you tell me what kind of setting you work in?

[Dr. Flowers] I am a director of colposcopy at Grady Memorial Hospital, which is a county hospital that services predominantly African-American and Latino patients, as well as those that are underinsured and uninsured within the greater Atlanta region. I have a wonderful clinic that really involves different levels of practitioners - family practice physicians, nurse practitioners, PAs, as well as my residents in my OB/GYN department. And what's really wonderful is that it predominantly tries to serve and give care to those women who have abnormal Pap smears or have other HPV-related diseases, and it’s been a rewarding experience to really deal with those who have limited services because of their financial stress in their lives.

[Dr. Saraiya] Do you do HPV testing either as a reflex or cotesting in that clinic?

[Dr. Flowers] Oh absolutely. I perform reflexive high-risk HPV testing in women who are 21 and older, who have an ASCUS or atypical squamous cells Pap test, and I also do it in combination with the Pap test at the same time in women who are 30 and over.

[Dr. Saraiya] What do you like about the combined testing using the Pap and the high-risk HPV testing?

[Dr. Flowers] I like the combined testing using the Pap and the high-risk HPV testing because it reduces cost and minimizes overtreatment by screening women every three years if both are negative. In addition, the risk of CIN 2 in women with a negative combination test is 1 to 2 percent and their 10-year risk of getting cancer or CIN 3 is only 1 to 2 percent. So it's great.

[Dr. Saraiya] As a female physician, you are a role model to other women providers. In your opinion, do you think female providers are ready to get on the bandwagon to screen every three years?

[Dr. Flowers] Actually, what I've found among many of the female providers is that they are reluctant to use the combination testing for fear that the patient will not return for their annual pelvic exam and wellness visit.

[Dr. Saraiya] And what do you do to reassure the providers?

[Dr. Flowers] I explain to them that there are so many other issues that should be addressed annually with a patient and if they take the time and reassure the patient about the fact that there is unlikely a chance for them to develop cervical cancer in those three years and then concentrate on all the other issues, that being sexually transmitted infections, family planning, they can maintain that relationship so that the annual visit doesn't only get centered around the Pap smear but on all the important issues for women's health.

[Dr. Saraiya] OK. Well let's discuss the ASCCP guidelines, which I know you were very much involved in. What is the single most important change that has affected your practice?

[Dr. Flowers] The single most important change has been in the management of the young female patient under 21 years of age. First, I no longer perform reflexive high-risk HPV testing in a woman less than 21 years of age who has an ASCUS Pap. Second, I no longer routinely perform colposcopies in women less than 21 years of age with an LSIL Pap or an ASCUS Pap.

[Dr. Saraiya] So what would you do instead?

[Dr. Flowers] Well, what I usually do is follow them for two years with these low-grade cytological abnormalities and perform the Pap 12 months after that abnormal Pap and only proceed if their follow-up Pap returns high-grade.

[Dr. Saraiya] So you are saying you would only do colposcopy if their follow-up Pap returns as a high-grade Pap. Any other reasons?

[Dr. Flowers] Yes, sure. If the two-year observation period is over and they have a Pap after the two years and it continues to be abnormal, I'll do a colpo in that instance, or if they become 21 and older.

[Dr. Saraiya] Getting back to the cotesting, how do you think cotesting would impact the population that you currently see?

[Dr. Flowers] It would truly ease the burden on the system, especially with costs for annual Paps, which include labor and staffing, to manage over 50,000 Paps which are performed at Grady every year.

[Dr. Saraiya] OK. What will be the most challenging issue with patients?

[Dr. Flowers] I think the biggest challenge we have is that patients are really used to doing that Pap annually, and they'll have to get used to truly coming in for their pelvic exam but

understanding that the Pap test, along with the high-risk HPV test, will be done every three years, and they just need to be reassured. I find that if you spend that time reassuring the patient, they will no longer request that Pap every year. And I guess the other challenge would be convincing the practioner that the patient will be reassured and reassuring themselves, as well.

[Dr. Saraiya] Lisa, if a HPV test and a Pap test are done at the same time and they're negative, a woman does not have to be screened for at least three years. What about screening intervals at your institution?

[Dr. Flowers] Well currently, we are trying to institute the cotesting with the Pap and the high-risk HPV testing, which would be great because it would really delay the need for another screening test for both for another three years. Currently, it's a little bit of a struggle, but we're starting to win a lot of our practioners over.

[Dr. Saraiya] Would you feel better having conducted cotesting in the women you see?

[Dr. Flowers] Absolutely, because I already realize that my patient population has a challenge in returning back annually for their Pap tests. So this is a way for me as a practitioner and for the patient to be comforted with the fact that their risk for cervical cancer or high-grade disease is very low in light of the fact that both tests are negative.

[Dr. Saraiya] Lisa, we're going to just switch gears now to talk a little bit about the HPV vaccine. What kind of experience have you had with the HPV vaccine and the underserved populations you see?

[Dr. Flowers] Well, initially it was a really big challenge, largely because of these populations' understanding of HPV and the consequences of it and the transmission. I had to do a lot of education going into the communities—going into their environment—to really explain how this virus is contracted and how it's passed. Once the basic education about HPV and the foundation is laid, people understood that vaccines could actually help in reducing future disease incidence. So it's really been a lot easier now that I've spent the time educating about the disease.

[Dr. Saraiya] What are your thoughts about how the HPV vaccine will impact cervical cancer screening?

[Dr. Flowers] Well, I truly feel that we will see over next coming years, that we'll be able to stretch the interval of screening, as well as start the initiation of screening later in a woman's life. And I actually think that this will truly reduce health care costs, as well as being a benefit for the patient population. So for example, instead of us initiating screening after three years of sexual onset, I truly feel we'll be able to stretch it to five or 10 years after sexual onset and then afterwards every five or 10 years do a Pap test, but most likely we'll have to start with five years as our mark and then see what happens to the natural history and decide whether we can stretch it even farther.

[Dr. Saraiya] Thank you, Lisa, for coming today and contributing to the cervical cancer discussion.

[Dr. Flowers] Well I enjoyed it. Thank you very much for inviting me.

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