ScreenSouth Canterbury and South Canterbury Screen-takers' Update November 2022

Questions and Answers

National Cervical Screening Programme

Questions	Answers
1. Can the kits be mailed out?	The initial implementation of HPV testing does not include a centralised mailout of the self-test kits. Self-test swabs will be available from Primary Care providers or at community events. A self-test can be completed at the location or taken home and returned later in agreement with the healthcare provider. Outreach services may deliver them to the participant's home. It is important that a conversation takes place between the clinician and the participant to get informed consent and to fulfil the first part of the clinical oversight process. Practices can mail kits after a clinical conversation with the patient. The swab needs to be processed within 28 days.
2. How will over-70s exit the programme?	Cervical screening is recommended from the age of 25 to 69. Those who are un/under-screened at age 69, should be offered an exit HPV test up to 74 years of age, to ensure they are HPV negative before exiting screening. In this age group, detection of HPV of any type should trigger referral to colposcopy for assessment.
3. Are over 70-year-olds who present with a dormant virus activating, as their immune systems age, potentially wise to self-test?	Older participants who are HPV positive are at risk of developing cervical abnormalities and potentially cancer, so need to be identified and followed up. Having a self-test is just as sensitive for detecting HPV DNA as having a clinician-taken sample, at any age. Having a speculum examination can be more uncomfortable for older participants because of epithelial atrophy and vaginal dryness so a self-test may be more acceptable for this age group. There is emerging evidence of reactivation of dormant HPV virus in a very small number of older women. However, the long-term risk of cervical cancer in a participant who is HPV negative at the age of 69 is minimal and no further testing is required.

4. Is there a plan to make HPV testing free?	At present, the model approved by Government for HPV primary screening does not provide for HPV testing to be free. Therefore, there is no change to the current service delivery model, including the setting of costs by individual health providers for the various elements of the services provided. Clinical oversight in the context of self-testing means: • providing advice and getting informed consent • providing, coordinating and receiving the test • ensuring all quality assurance measures are met • ensuring the lab request information is completed, and • ensuring the participant is told of the test result and ensuring the result is followed up. Accordingly, the clinical oversight remains the same, however for HPV testing no procedure is involved, so we would not expect a procedure cost to be charged. We are aware of continuing discussions about the potential for Government to fund free HPV testing. For the moment however, the current service delivery model will continue to apply.
5. What is the position regarding participants who want to screen more frequently than the programme advises?	A negative HPV test gives greater reassurance than a negative cytology test. There is robust evidence from large clinical trials in Europe and the UK, that the risk of developing cancer five years after a negative HPV test is very low, and is no greater than the risk three years after a negative cytology test. The screening interval is carefully chosen for clinical safety in the programme. Those who screen more frequently than is recommended, are using resources for very little benefit, that would be much better used elsewhere. To date, the NCSP has processed and reported any cytology samples taken in New Zealand, even if taken too frequently. This approach will continue in the new programme but as it is now much easier to take a sample for HPV testing, over-screening may be more of an issue, The NCSP will be monitoring this closely, and may need to limit inappropriate testing, if a significant number of early screens occurs.
6. How do you go about getting consent for people to be on the Register?	The new NCSP-Register will capture population-based data sourced from NHI, including currently enrolled participants and unenrolled who are with a Primary Care provider. Anyone who does not wish to be on the Register can choose to opt-off the Programme.

	Participants are automatically enrolled in the Register from NHI data. As part of the consent for the HPV test clinicians need to let participants know that they are on the Register unless they opt off.
7. We currently ask history/screening type questions before doing the screen, is there going to be any recommended screening questions done going forward?	The current practice of consent process and history taking remains important. The required symptom questions must be answered on the laboratory request form.
8. How would the screen-taker via cytology sampling be able to maintain their competency if there are reduced cervical smears required?	The annual minimum number of speculum-taken samples requirement for sample takers is being reviewed prior to go live.
9. Who makes the decision as to who won't be suitable for self-swabbing? And how will we tease these people out of our recall lists?	The clinician ordering the test will determine this. Those who have symptoms or are undergoing a test of cure will need a speculum exam and co-test (both LBC and HPV). The Register will show who is requires a Test of Cure.
10. Will current people (who have cytology now) be recalled on the three-year recall?	Yes. They will then be tested for HPV and if negative, will then go on to a five-year recall.
11. Will the screening ages remain the same?	Yes. Cervical screening is recommended from the age of 25 to 69.
12. Patients that have had total hysterectomies - should they have cytology or swab?	The section on hysterectomy and screening is quite detailed and it is only if there has been no prior history or a prior history that has been returned to normal screening with a complete hysterectomy that can stop screening.
13. What benefits are there for having the HPV vaccine for over-26s who were previously HPV positive but are now HPV negative?	The level of protection decreases after HPV infection has occurred. Protection will still occur for the HPV types that the individual hasn't been exposed to. HPV vaccination is not a therapeutic vaccine and cannot treat an HPV infection were previously HPV positive but now HPV negative?
14. What happens with women who are immunosuppressed, on yearly cytology screening? Are they able to have HPV swab screening? What will their screening interval be?	The screening interval for those who are immune deficient is three-yearly HPV screening compared with five-yearly screening for immune competent people. This reflects the higher level of risk of cervical lesions for those who are immune deficient.
15. Once women have completed TOC can they continue with HPV swab screening?	Those having a test of cure require HPV testing and cytology so will need an LBC sample taken. If it has returned to normal, and the test of cure has been completed, screening can revert to the normal five-yearly HPV testing interval.