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

Rebecca B. Perkins, MD, MSc,[1] Richard S. Guido, MD,[2] Philip E. Castle, PhD,[3] David Chelmow, MD,[4] Mark H. Einstein, MD, MS,[5] Francisco Garcia, MD, MPH,[6] Warner K. Huh, MD,[7] Jane J. Kim, PhD, MD,[8] Anna-Barbara Moscicki, MD,[9] Ritu Nayar, MD,[10] Mona Saraiya, MD, MPH,[11] George F. Sawaya, MD,[12] Nicolas Wentzensen, MD, PhD, MS,[13] and Mark Schiffman, MD, MPH,[14] for the 2019 ASCCP Risk-Based Management Consensus Guidelines Committee

The 2019 ASCCP Risk-Based Management Consensus Guidelines[1] represent a paradigm shift from using primarily results-based algorithms to using risk-based management based on a combination of current screening test results and past screening history. Screening using HPV testing or HPV/cytology co-testing provides superior risk stratification compared to cytology alone. Therefore, incorporating HPV testing into risk stratification and recommendations for surveillance following abnormal results was an important part of the 2019 guidelines. While the 2019 guidelines provide management recommendations for most results, 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[2] is acceptable. For 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[2] are recommended for management of abnormal results. Specifically, the 2012 guidelines recommend colposcopy for all cytology results of low grade squamous intraepithelial lesion (LSIL) or higher for individuals aged 25 and above.

The following clarifications specify management for additional scenarios. In cases where a colposcopy was previously recommended but not completed, if on repeat testing the patient has a persistent HPV-positive result and/or persistent cytologic abnormality (atypical squamous cells of uncertain significance, ASC-US, or higher), colposcopy is recommended. Colposcopy is also recommended if a patient has 2 consecutive HPV positive results and an exact risk estimate is not available. The management in these scenarios is based on the 2012 guidelines,[2] which recommend colposcopy when a follow-up HPV test is positive or cytology is ASC-US or worse following a result of HPV-positive with negative cytology. Arguably, the scenarios described above would be higher risk, and therefore colposcopy is warranted. Similarly, if a patient had a high-grade cytology result, including atypical squamous cells cannot exclude a high-grade squamous intraepithelial lesion (ASC-H) atypical glandular cells, (AGC) or high grade squamous intraepithelial lesion (HSIL), and did not receive a colposcopy, colposcopy is recommended. Conversely, if a patient has a negative HPV test or co-test following a low-grade result for which colposcopy was previously recommended but not performed, repeating an HPV test or co-test in 1 year is acceptable. This management is based on the findings that risk estimates did not reach the colposcopy threshold for an HPV-negative or co-test negative result following any previous low-grade result.[3]

From [1]Boston University School of Medicine/Boston Medical Center, Boston, MA; [2]University of Pittsburgh/Magee-Women's Hospital, Pittsburgh, PA; [3]Albert Einstein College of Medicine, New York, NY; [4]Virginia Commonwealth University School of Medicine, Richmond, VA; [5]Rutgers, New Jersey Medical School, Newark, NJ; [6]Pima County Health & Community Services, Tucson, AZ; [7]UAB School of Medicine, Birmingham, AL; [8]Harvard T.H. Chan School of Public Health, Boston, MA; [9]University of California, Los Angeles, CA; [10]Northwestern University, Feinberg School of Medicine-Northwestern Memorial Hospital, Chicago, IL; [11]Division of Cancer Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA; [12]University of California, San Francisco, San Francisco, California; [13]Division of Cancer Epidemiology and Genetics and Division of Cancer Prevention, National Cancer Institute, Bethesda, MD; and [14]Division of Cancer Epidemiology and Genetics and Division of Cancer Prevention, National Cancer Institute, Bethesda, MD

R.B.P. and R.S.G. contributed equally to the development of this manuscript and are co-first authors.

Disclosure of Financial Support: The guidelines effort received support from the National Cancer Institute and ASCCP. Participating organizations supported travel for their participating representatives. All participating consensus organizations, including the primary funders, had equal and balanced roles in the consensus process including data analysis and interpretation, writing of manuscript, and decision to submit for publication. No industry funds were used in the development of these guidelines. The corresponding authors had final responsibility for the submission decision.

Conflict of interest: The following listed authors have no conflicts of interest to disclose: Drs. Perkins, Chelmow, Garcia, Kim, Nayar, Saraiya, and Sawaya.

The following listed authors have conflicts of interest:

- Drs. Schiffman, Wentzensen: The National Cancer Institute (incl. Drs. Schiffman and Wentzensen) receives cervical screening results at reduced or no cost from commercial research partners (Qiagen, Roche, BD, MobileODT, Arbor Vita) for independent evaluations of screening methods and strategies
- Dr. Moscicki: Merck and GSK, Advisory Board member
- Dr. Guido: Inovio Pharmaceuticals DSMB, ASCCP Consultant
- Dr. Huh: Inovio Pharmaceuticals DSMB
- Dr. Castle has received HPV tests and assays at a reduced or no cost from Roche, Becton Dickinson, Arbor Vita Corporation, and Cepheid for research.
- Dr. Einstein has advised companies and participated in educational activities, but does not receive any honoraria or payments for these activities, In some cases, his employer, Rutgers, receives payment for his time for these activities from Papivax, Cynvec, Merck, Hologic, and PDS biotechnologies. He has been the overall PI or local PI for clinical trials from Johnson&Johnson, Pfizer, Iovance, and Inovio. Funding for these activities is for the research related costs of the trials.

Disclaimer: The conclusions, findings, and opinions expressed by authors contributing to this journal do not necessarily reflect the official position of the U.S. Department of Health and Human Services, the Public Health Service, the Centers for Disease Control and Prevention, or the National Cancer Institute.

DOI: 10.1097/LGT.0000000000000628

REFERENCES

1. Perkins RB, Guido RS, Castle PE, et al. 2019 ASCCP risk-based management consensus guidelines for abnormal cervical cancer screening tests and cancer precursors. *J Low Genit Tract Dis* 2020;24:102–31.
2. Massad LS, Einstein MH, Huh WK, et al. 2012 ASCCP Consensus Guidelines Conference. *J Low Genit Tract Dis* 2013 Apr;17(5 Suppl 1)):S1–S27.
3. Egemen D, Cheung LC, Chen X, et al. Risk estimates supporting the 2019 ASCCP risk-based management consensus guidelines. *J Low Genit Tract Dis* 2020 Apr;24:132–43.