Cancer Research UK response to the UK National Screening Committee consultation on modifying the NHS Cervical Screening Programme

Cancer Research UK (CRUK) welcomes the opportunity to respond to this consultation. In the UK, around 3,200 women are diagnosed with cervical cancer and over 850 women die from the disease each year. When diagnosed at its earliest stage, roughly 95% of women with cervical cancer will survive for 5 years or more. The cervical screening programme has led to major falls in both incidence and deaths, with roughly 2000 lives being saved each year through screening. Since virtually all cervical cancer cases are preventable, with the introduction of high risk HPV primary screening and uptake in the HPV vaccine programme, the rate of incidence and number of deaths from cervical cancer should continue to fall.

Key Points

- We support the recommendation to extend standard screening intervals from three to five years for HPV negative women as high risk HPV primary screening, will give longer lasting protection, so the likelihood of developing cervical cancer is highly unlikely in that time frame.
- We are supportive of the proposals for how women aged 64 and over exit the programme. But would like to address the inconsistencies between women with positive HPV results at their exit screen and other HPV positive women in the programme.
- Unless the inconsistencies can be justified through evidence, we suggest the process be the same for all HPV positive/cytology negative women, regardless of age.
- The lack of evidence on exiting the programme should not hinder the rollout of HPV primary testing; provided screen results and diagnostic pathways in older women are monitored for any adverse effects.
- There is a lack of evidence that self-sampling will be the most effective way forward in trying to increase screening numbers. We suggest a pilot on a larger proportion of the population to understand the effectiveness and cost-effectiveness of this intervention.
- Limitations of the current pilot include a lack of cost awareness and knowledge of why people do not attend screening, which will need to be addressed in further studies.

Further information

Issue 1: Screening intervals and surveillance intervals

HPV primary testing has stronger negative predictive power over cytology and is better able to pick up women with cell changes caused by HPV. Because of this, we agree that the screening interval can safely be extended to five years, as shown by several European trials. As the vaccinated population grows older, there may be an opportunity to increase screening intervals further. That said, Cancer Research UK has previously commented on suggestions that screening will no longer be necessary in the future, due to HPV vaccination making the risk of being infected so low. However, we concluded that for now, despite receiving protection from cervical cancer, either from the
screening programme alone, or in combination with HPV vaccination, it is still important to attend cervical screening.

We also support a 12-month surveillance interval for HPV positive, but cytology negative, women believed to be at intermediate risk. The Health Technology Assessment review found this increased the effectiveness of HPV primary screening under all the scenarios considered⁹.

We agree that women with persistent HPV infection and negative cytology should undergo two surveillance tests and if HPV positive at the second test, they should be referred to colposcopy irrespective of their cytology result. This strategy appears to be more cost effective and the absolute number of cancers diagnosed could be reduced due to more pre-cancerous changes being picked up and treated. In Scotland, where HPV vaccination has been shown to exceed 90%, there has been a 50% reduction in CIN2 and a 55% reduction in CIN3 associated with 3 doses of the bivalent HPV vaccination⁵. Further evidence from vaccinated women who are now reaching screening age, will thus be important to understand whether this will remain an effective strategy in terms of balancing harms, benefits and cost-effectiveness.

**Issue 2: Women aged 64 and over who are exiting the programme**

In general, Cancer Research UK supports the proposed exit programme recommendation for women aged 64 and over. We agree that the lack of evidence on this proposal should not hinder the rollout of HPV primary testing, provided screening results and diagnostic pathways in older women are monitored and audited to see if there are any adverse effects.

We recommend, in the absence of research, looking at the practices of other countries with comparable health systems to the UK which have already implemented HPV primary testing. For example, Australian guidance on exit screens vii.

In the proposed exit strategy, women with a positive HPV result at their exit screen are treated differently from other HPV positive women in the programme and we wish to highlight this inconsistency. Women in the programme who are HPV positive/cytology negative are recommended to undergo two annual surveillance tests before referral to colposcopy (see recommendation 1), but this is reduced to one for women at their final screen. Unless evidence can be used to justify the different treatment of older women, we would suggest that the process be the same for all HPV positive/cytology negative women, regardless of age.

We are concerned that, without clear evidence to guide either way, women who are HPV positive, but cytology and colposcopy negative will be discharged completely from the programme. These women could have a persistent HPV infection and so may be at higher risk of cervical cancer. We’d like the NSC to consider whether these women need to be managed differently and need to be offered further recall tests. It could be useful to analyse the proportion of women from HPV pilot sites who test HPV positive/cytology and colposcopy negative at their final screen, and their diagnostic pathways following this. We also advise that the audit of the cervical screening programme should be set up to monitor diagnostic pathways for these women.
Issue 3: Self-sampling as a strategy to address non-attendance for screening

We understand the potential that self-sampling could have in reducing the barriers to screening. However, Cancer Research UK supports the proposal that further studies for self-sampling are required. This would need to focus on certain practicalities, highlighted below.

We recommend that due consideration is given to the timing of when self-sampling is offered, to ensure that it is effective in reaching under-screened women, whilst not encouraging women who would normally attend screening to miss clinician appointments. Evidence suggests that the accuracy of HPV testing is lower in self-collected samples than in clinician-collected samples\textsuperscript{viii}. It is vital that women understand the comparative advantages of clinician-collected screening and that these are preferable to self-sampling. It is important to communicate, that only if they do not attend screening appointments, will self-sampling be offered as a screening option, to lessen the impact of women switching screening strategies. We argue that more research should be carried out and insight gathered, to guarantee individuals understand this choice.

If self-sampling is being considered as a failsafe for women who do not respond to screening invitations due to fear or embarrassment of the appointment, research needs to be carried out to ensure that fear of a cancer diagnosis or low understanding of HPV and cervical cancer does not similarly lead to a low uptake of self-sampling. Hence, there is a need to understand why women do not conduct clinician led screening or self-sampling and how best to combat this focusing on which women to target with self-sampling. Anecdotally, our nurse helpline is reporting high volumes of calls from women worried about an ‘HPV diagnosis’. Research has also demonstrated that in certain communities with lower uptake of screening, like some Asian groups, women report barriers around attributing the disease with sexually transmitted infections and promiscuity\textsuperscript{ix}. Fear of embarrassment and rejection from one’s own community could result in women not attending screening invitations or partaking in self-sampling. Thus, specific types of non-responders need to be targeted by self-sampling as the reasons for non-attendance between non-responders is quite diverse. Educational campaigns to generate better understanding of what HPV is, what causes it and how it is treated, is essential to make more impact.

The substantial economic cost that sending self-sampling kits to all women as a routine approach would require, when uptake is so low, attention. We suggest a further self-sampling pilot with a large study population to help build the evidence base and understand the impact self-sampling would have for non-responders across a national screening programme. Further information would be useful to establish the best possible pathways to increase informed uptake of screening, whether that be through self-sampling kits, or by sending individuals another invitation for clinician sampling. We would also like to see that the planned Public Health England campaign is thoroughly evaluated. Should a self-sampling pilot prove successful, an educational campaign would be vital in increasing understanding of what HPV is, what causes it and how it is treated and, run should run alongside the introduction of self-sampling screening. As well as raise greater awareness of clinician screening, health marketing campaigns could help reduce stigma and fear of the process and result in more individuals attending screenings or successful self-sampling being undertaken.
About us
Cancer Research UK is the world’s largest independent cancer charity dedicated to saving lives through research. We support research into all aspects of cancer and this is achieved through the work of over 4,000 scientists, doctors and nurses. In 2017/18, we spent £423 million on research institutes, hospitals and universities across the UK.

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