

Statement on HPV DNA Test Utilization

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Testing for carcinogenic or high-risk human papillomavirus (HPV) DNA has proven utility in cervical cancer screening and in many aspects of clinical management for cervical cancer prevention. However, inappropriate testing increases costs without benefit and potentially results in overtreatment of women. This statement was developed by the Cytopathology Education and Technology Consortium and has been endorsed by additional professional medical societies (listed at the end of the statement). It is intended as a concise, convenient summary of clinical indications for HPV DNA test utilization based on the American Cancer Society 2002 screening recommendations¹ and interim guidance² and the 2006 American Society for Colposcopy and Cervical Pathology (ASCCP) consensus management guidelines.³ Circumstances in which HPV DNA testing is considered appropriate and when such testing is generally not appropriate are outlined. This statement and **Table 1** are intended to

serve as an educational tool and reference to improve management of women and reduce inappropriate use of HPV tests.

1. High-risk (oncogenic) HPV DNA testing is appropriate in the following circumstances:
 - 1.1. Routine cervical cancer screening in conjunction with cervical cytology (dual testing or cotesting) for women 30 years or older:
 - 1.1.1. For women who are cytology-negative but HPV-positive, repeat both tests in 12 months. (As of March 2009, the US Food and Drug Administration approved an HPV-16/18 genotyping test; per ASCCP guidelines,³ HPV-16 positive and/or HPV-18 positive women 30 years or older are referred directly to colposcopy.)
 - 1.1.2. For women who are both cytology- and HPV-negative, repeat both tests only after a 3-year interval.

Table 1
Appropriate Uses of HPV Testing in Screening and Triage*

Age (y)	Routine Screening	Initial Triage				
		ASC-US	LSIL	ASC-H	AGC [†]	HSIL
≤20	2.1	2.3	2.3	2.3	2.3	2.3
21-29	2.1	1.2	2.4	2.5	2.5	2.5
30+	1.1 [‡]	1.2	2.4	2.5	2.5	2.5
Postmenopausal	1.1 [‡]	1.2	1.3	2.5	2.5	2.5

AGC, atypical glandular cells; ASC-H, atypical squamous cells, cannot exclude HSIL; ASC-US, atypical squamous cells of undetermined significance; HSIL, high-grade squamous intraepithelial lesion; HPV, human papillomavirus; LSIL, low-grade squamous intraepithelial lesion.

* Boldface type indicates HPV testing is appropriate. The numbers in the table cells refer to the text outline.

[†] Note that for AGC results, HPV testing is not to be used for triage to decide whether to refer to colposcopy; however, HPV testing may be done at the time of colposcopy to guide postcolposcopy management.

[‡] For women 30 years or older who are cytology- and HPV-negative, repeat both tests only after a 3-year interval.

- 1.2. Initial triage management of women 21 years or older with a cytologic result of ASC-US [atypical squamous cells of undetermined significance]
- 1.3. Initial triage management of postmenopausal women with cytologic result of LSIL [low-grade squamous intraepithelial lesion]
- 1.4. Postcolposcopy management of women of any age with initial cytologic result of atypical glandular cells (AGC)* or ASC-H [atypical squamous cells, cannot exclude high-grade squamous intraepithelial lesion (HSIL)] (when initial workup does not identify a high-grade lesion)
- 1.5. Postcolposcopy management of women 21 years or older with initial cytologic results of ASC-US or LSIL (when initial colposcopy does not identify a high-grade lesion)
- 1.6. Posttreatment surveillance
2. High-risk (oncogenic) HPV DNA testing is generally *not* appropriate in the following situations:
 - 2.1. Routine cervical cancer screening in women younger than 30 years
 - 2.2. Routine screening with HPV testing and cervical cytology more often than every 3 years for women 30 years or older whose tests were negative at last screen (see 1.1.2)
 - 2.3. Initial triage or management of adolescents (age 20 years or younger) with any abnormal cytologic result. Further, if HPV testing is inadvertently performed, the results should not be used to influence patient management.
 - 2.4. Initial triage of LSIL (except for postmenopausal women; see 1.3)
 - 2.5. Initial triage of ASC-H, HSIL, or AGC*/AIS [adenocarcinoma in situ] in women of any age
3. Repeat high-risk (oncogenic) HPV DNA testing should generally not be done in less than 12 months:
 - 3.1. Exceptions include follow-up to AGC NOS [not otherwise specified] when no pathology is found at initial workup, and follow-up after treatment for CIN [cervical intraepithelial neoplasia] 2 and 3. See ASCCP Guidelines for specific recommendations on testing intervals.³
4. Testing for *low-risk* (non-oncogenic) HPV types has *no* role in routine cervical cancer screening or for the evaluation of women with abnormal cervical cytology.

The intent of this summary is to facilitate provider education and to encourage appropriate utilization of HPV testing. Clinical judgment should always be used when applying a guideline to an individual patient because it is impossible to develop guidelines that apply to all situations. Links to the 2006 ASCCP Consensus Guidelines, as well as management algorithms, are available on the ASCCP Web site at <http://www.asccp.org/consensus/cytological.shtml>.

* Note that for AGC results, HPV testing is not to be used for triage to decide whether to refer to colposcopy; however, HPV testing may be done at the time of colposcopy to guide postcolposcopy management.

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