Five myths about cervical screening that refuse to die

March 10 2017, by Terri Foran

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The online petition against changes to Australia's cervical cancer screening program has revealed more than 70,000 people (most of whom we could assume are women) are deeply concerned about what the upcoming changes mean.

Their comments also reveal a number of misconceptions about the new screening program, which will now be rolled out in December 2017, rather than in May as planned.

It seems that in concentrating on the science behind shifting away from Pap smears every two years to testing for the human papillomavirus (HPV) every five years, our medical authorities have failed to convince many Australian women this move will save lives.

Convincing women to come on board is, of course, critical to the success of the new screening program, which is forecast to improve cervical cancer detection rates by at least 15% and is good news for women.

So let's have a look at some common misconceptions and concerns about changes to the cervical cancer screening program raised by some of my patients and by the many people signing up to the change.org petition.

Myth #1: no more Pap tests means no more invasive examinations

Quite a few of my patients have thought the new screening program means the end of invasive examinations. And I say "unfortunately not." For most women the collection procedure will be exactly the same as before. This means you will still have to lie on a couch and a doctor or nurse will still insert the dreaded speculum. This instrument is needed to hold the vaginal walls gently apart so that the cervix at the end of the vagina can be seen.

Two small brushes are used to sample cells from both the outside of the cervix and from the opening which leads up to the uterus. Rather than the specimen being smeared on a slide (as with Pap smears), the two brushes are swizzled around in a preservative liquid, which separates out

most of the collected cells and any HPV, the virus responsible for at least 99.7% of cervical cancers.

But it's not until the specimen gets to the pathology lab that the process really changes.

First, the specimen is checked for HPV and only if HPV is present will cells be examined for signs of pre-cancer or cancer.

There is also the option for women who have previously avoided having Pap tests for cultural, religious or personal reasons to collect their own HPV sample. It is estimated that even if a woman has only one self-collected test at age 30 she reduces her risk of cervical cancer by about 40%.

Myth #2: the new test could miss types of cervical cancer not related to HPV

Almost 85% of cervical cancers are actually skin cancers, triggered not by the sun but by HPV. This type of cervical cancer usually takes about 15-20 years to develop. So, HPV testing gives us a chance to detect potential problems long before there is anything to see on a Pap test.

In the new program, women who carry the highest risk HPV types will then have their cells examined using a more sensitive test known as liquid-based cytology. They will also be automatically referred to a gynaecologist for further tests. If other kinds of HPV are found, a check whether the cells show any changes will guide whether the woman is referred for other tests or simply monitored more closely.

Some 15% of cervical cancers start in glandular cells. HPV also triggers these cancers but they are often beyond the reach of the little brushes

used to collect cells in a Pap test. They can hide away quietly, growing and spreading for many years before they are detected.

When you hear of someone diagnosed with cervical cancer after previously normal Pap tests it is almost always a glandular-type cancer.

The good news is that HPV testing should pick up this kind of cancer earlier and more reliably than a regular Pap test.

There are also some very rare cervical cancers (less than 1%) that start off from muscle, nerve or pigment cells deep within the cervix and are not related to HPV infection. It is true that the new screening program is not designed to detect these types of cancer but then they were also almost impossible to detect on a traditional Pap test as well.

Myth #3: young women will miss out on early detection if screening starts at 25

There are many online testimonies from women signing the change.org petition saying they had cervical cancer before the age of 25. It is more likely that most of these were pre-cancerous changes because cervical cancer in this age group is really rare – around 1.7 in 100,000 Australian women under 25.

Unfortunately, in the nearly 30 years our present screening program has been running there has been no significant impact on the numbers of cervical cancers reported in Australian women under 25.

Another complication in this younger age group is that cellular changes may look worse than they actually are because of a robust immune reaction to the HPV infection. Unfortunately this can lead to well-meaning advice to treat changes that are very likely to get better on their

own.

Myth #4: less cervical testing reduces the chances of picking up other cancers such as ovarian and uterine cancer

Pap tests were designed to pick up pre-cancerous changes in the cells of the cervix. They are absolutely useless at detecting endometriosis, polyps, ovarian cancer or sexually transmitted infections other than HPV. They occasionally pick up uterine cancer if it is advanced enough for the cells to be shedding through the cervix that day.

The important point here is that screening tests are only for women with no symptoms. If a woman develops symptoms, such as irregular bleeding, pain or abnormal vaginal discharge, she needs to see her doctor for advice regardless of when she had her last cervical screening test.

Myth #5: the government is motivated by a cheaper option and will shift the costs of the test to the woman herself

The new tests are more expensive than a traditional Pap test, but because they are so much more sensitive there is no need to do them as frequently.

They will be funded under Medicare just as the Pap test is now. Any out-of-pocket costs depend on whether health care providers bulk bill (as they often do with screening tests) or charge the scheduled fee.

Provided by University of New South Wales