

# **Taking Action Against Cervical Cancer Through Early Detection and Vaccination**

**Clinician Outreach and  
Communication Activity (COCA)  
Webinar  
November 20, 2014**

Office of Public Health Preparedness and Response  
Division of Strategic National Stockpile



## Objectives

**At the conclusion of this session, participants will be able to—**

- ❑ Describe the epidemiology, natural history, and clinical features of cervical cancer.
- ❑ Discuss current recommendations and rationale for HPV vaccination and cervical cancer screening in the U.S.
- ❑ Identify opportunities for screening and vaccination and share evidence-based practices for clinicians and health departments.

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## TODAY'S PRESENTER (1)



**Mona Saraiya, MD, MPH**

Associate Director of the Office of International Cancer Control  
Division of Cancer Prevention and Control  
National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention

## TODAY'S PRESENTER (2)



**George Sawaya, MD**  
Obstetrician-Gynecologist  
Professor in Obstetrics  
Gynecology and Reproductive Sciences  
San Francisco General Hospital Colposcopy Clinic

## TODAY'S PRESENTER (3)



**Francisco García, MD, MPH**  
Obstetrician-Gynecologist  
Director of Public Health  
Pima County Health Department - Arizona

## Today

- ❑ **Saraiya: Vital Signs and overview of HPV vaccination**
- ❑ **Sawaya: Cervical cancer screening and treatment**
- ❑ **Garcia: What doctors and communities can do to promote cervical cancer prevention**

## About



- ❑ Appears on the first Tuesday of the month as part of the CDC journal *MMWR*.
- ❑ Provides the latest data and information on key health indicators.

Cancer prevention	Alcohol use
Obesity	Cardiovascular health
Tobacco use	Teen pregnancy
Motor vehicle passenger safety	Health care-associated infections
Prescription drug overdose	Food safety
HIV/AIDS	Developmental disabilities

- ❑ For more information about *Vital Signs* and to subscribe, please visit <http://www.cdc.gov/vitalsigns/>.

# Cervical Cancer Incidence, Mortality, and Screening—United States, 2007–2012

**Mona Saraiya MD, MPH**

Associate Director, Office of International Cancer Control  
Division of Cancer Prevention and Control

Clinician Outreach and Communication Activity (COCA)  
November 20, 2014

National Center for Chronic Disease Prevention and Health Promotion  
Division of Cancer Prevention and Control



# Cervical Cancer Is Preventable— No woman should die of cervical cancer

- ❑ More than **4,000** women die of cervical cancer each year.
- ❑ As many as **93%** of cervical cancers could be prevented by screening and HPV (human papillomavirus) vaccination.
- ❑ In 2012, **8 million** U.S. women ages 21 to 65 have not been screened for cervical cancer in the last 5 years.



Vital Signs: Cervical Cancer Incidence, Mortality, and Screening—  
United States, 2007–2012

Source: <http://www.cdc.gov/vitalsigns/cervical-cancer/>

## Methods

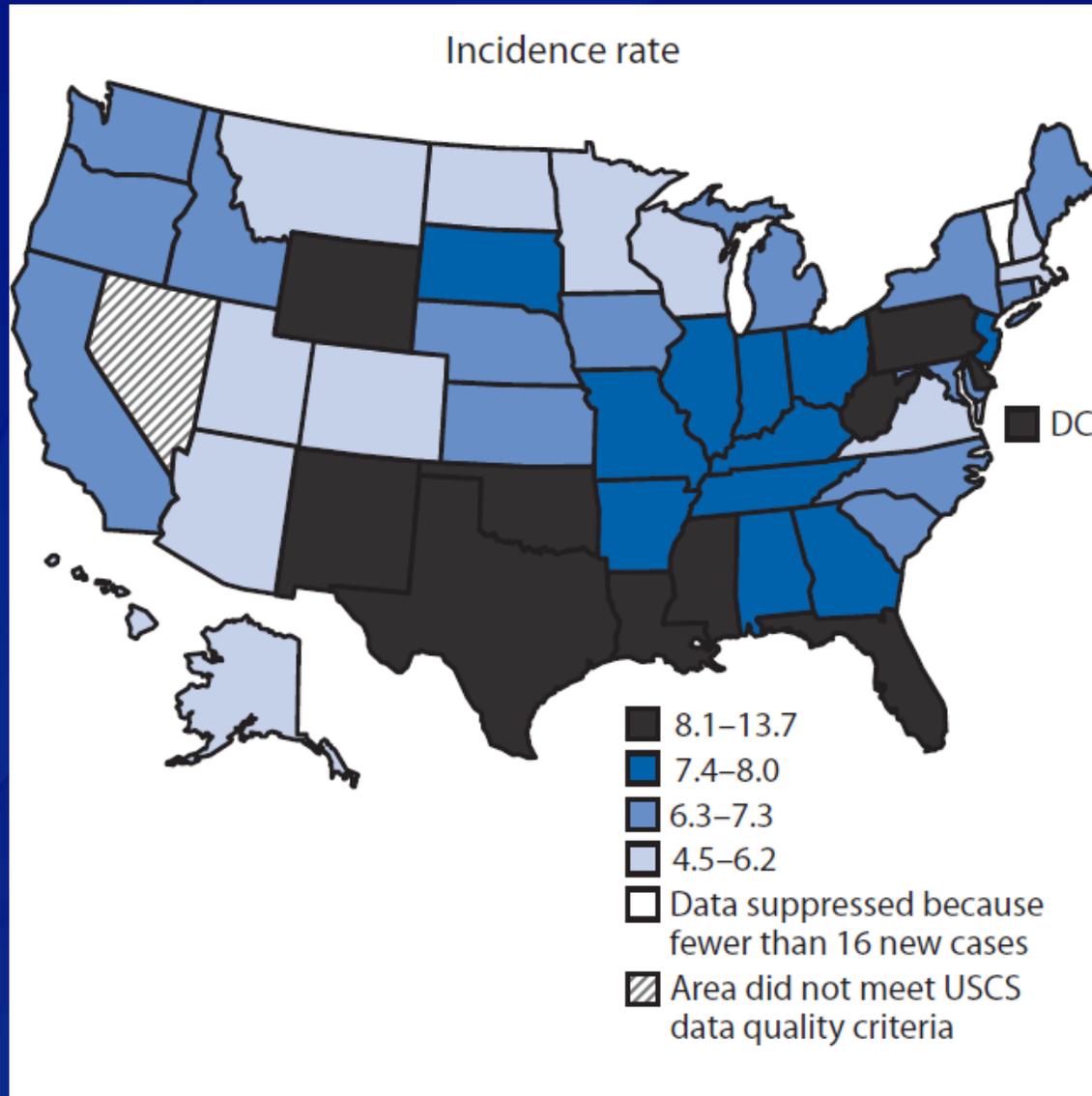
- ❑ **Behavioral Risk Factor Surveillance System (BRFSS), 2012**
  - Percentage of women who had not been screened for cervical cancer in the past 5 years
- ❑ **United States Cancer Statistics, 2007–2011**
  - Cervical cancer incidence rates by state, Census region, and U.S. overall
- ❑ **National Vital Statistics System, 2007–2011**
  - Cervical cancer incidence rates by state, Census region, and U.S. overall

## Percentage of Women Who Had Not Been Screened for Cervical Cancer in the Past 5 Years, BRFSS 2012

- ❑ 11.4% (8 million) women aged 21–65 had not been screened for cervical cancer in the past 5 years.
- ❑ 23.1% of women not screened did not have health insurance.
- ❑ 25.5% of women not screened did not have a regular health care provider.
- ❑ The proportion of inadequately screened women is higher among older women and Asian/Pacific Islanders.

Source: *MMWR* 2014;63.

# Cervical Cancer Incidence Rates—United States, 2011





# Screening, Incidence, and Death by State and Region

## ❑ Screening, 2012

- Range of not screened by state: 6.9% to 18.7%.
- South had the lowest percentage overall not screened (12.3%).

## ❑ Incidence rates, 2007–2011

- 62,150 cervical cancer cases.
- Overall 1.9% per year decrease in the United States.
- South had the highest incidence rate (8.5 per 100,000).

## ❑ Death rates, 2007–2011

- 19,969 cervical cancer deaths.
- Overall death rate did not change in the United States.
- South had the highest death rate (2.7 per 100,000).

Source: [www.cdc.gov/vitalsigns/cervical-cancer/](http://www.cdc.gov/vitalsigns/cervical-cancer/)

## Cervical Cancer Deaths in the U.S., 1975–2011

- ❑ Widespread use of the Pap test has resulted in dramatic decreases in cancer deaths.
- ❑ Death rates did not change from 2007–2011.

### No woman should die of cervical cancer

Screening leads to fewer deaths



Source: [www.cdc.gov/vitalsigns/cervical-cancer/](http://www.cdc.gov/vitalsigns/cervical-cancer/)

## What Can Be Done to Address Cervical Cancer?

Doctors, nurses, and health systems can:

- ❑ Help women understand what screening tests are best for them and when they should get screened.
- ❑ Screen or refer all women as recommended at any visit.
- ❑ Make sure patients get their screening results and the right follow-up care quickly.
- ❑ Use reminder-recall systems to help doctors, nurses, and patients remember when screening and HPV vaccination are due.
- ❑ Strongly recommend that preteens and teens get vaccinated against HPV.

Source: [www.cdc.gov/vitalsigns/cervical-cancer/](http://www.cdc.gov/vitalsigns/cervical-cancer/)

# HPV / HPV Vaccine Basics

# Human Papillomaviruses

## ❑ Double-stranded DNA virus

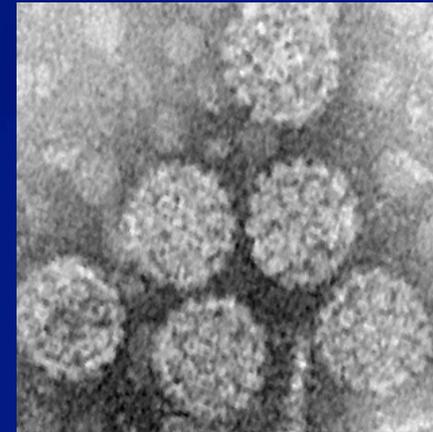
- More than 120 closely related viruses
  - Types numbered in order of discovery

## ❑ HPV infection confined to epithelium

- Begins in base of epithelium, cells proliferate and are not killed

## ❑ Humoral and cellular immune responses identified

- Antibodies detected in less than 70% of females infected



# HPV Types Differ in Their Disease Associations

~40 Types

**Mucosal/genital sites of infection**

**Cutaneous sites of infection**

~ 80 Types

**High-risk (oncogenic)  
HPV 16, 18**

**Low-risk (non-oncogenic)  
HPV 6, 11**

**Cervical cancer  
Vaginal, vulvar, penile, anal,  
oropharyngeal, ?oral cavity  
High-grade precancers --  
Low-grade cervical disease**

**Genital warts  
Laryngeal papillomas  
Low-grade cervical disease**

**"Common" hand  
and foot warts**

## Genital HPV Infection

- ❑ **Most common sexually transmitted infection**
- ❑ **≈14 million new infections in U.S. each year**
- ❑ **Acquired around sexual debut**
  - 40% infected within 2 years
- ❑ **Most sexually active persons infected at some point**
- ❑ **Infection usually transient, asymptomatic**
  - 90% clear or become undetectable within 2 years
- ❑ **Persistent infection with some types can lead to disease**

# Evolution of Recommendations for HPV Vaccination in the United States

Quadrivalent  
Routine, females 11 or 12 years\*  
and 13-26 yrs not previously vaccinated

Quadrivalent or Bivalent  
Routine, females 11 or 12 years\*  
and 13-26 years not previously  
vaccinated

Quadrivalent  
May be given,  
males 9-26 years\*

Quadrivalent  
Routine, males 11 or 12 years\*  
and 13-21 years not previously  
vaccinated  
May be given, 22-26 years\*\*

June

October

2006 2007 2008 2009 2010 2011 2012

Quadrivalent (HPV 6,11,16,18) vaccine; Bivalent (HPV 16,18) vaccine

\*Can be given starting at 9 years of age

\*\*For MSM and immunocompromised males, quadrivalent HPV vaccine through 26 years of age

## **ACIP Recommendation for HPV Vaccine**

- ❑ Routine HPV vaccination recommended for both males and females ages 11–12 years**
- ❑ Catch-up ages 13–21 years for males; 13–26 for females**
- ❑ May vaccinate at ages 9–10 years for both males and females; 22–26 for males**

## **HPV Vaccine Recommendation for Females**

- ❑ **Either bivalent HPV vaccine (Cervarix) or quadrivalent HPV vaccine (Gardasil) recommended for girls at age 11 or 12 years for prevention of cervical cancer and precancer**
  - Also for girls 13 through 26 who haven't started or completed series
  - Only quadrivalent HPV vaccine (Gardasil) also for prevention of vaginal, vulvar, and anal cancers, as well as genital warts.

## HPV Vaccine Recommendation for Males

- ❑ **Quadrivalent HPV vaccine (Gardasil) recommended for boys at age 11 or 12 years for prevention of anal cancer and genital warts**
  - Also for boys 13 through 21 who haven't started or completed series
  - Young men, 22 through 26 years of age, who identify as gay or bisexual
  - Young men, 22 through 26 years of age, who are immunocompromised

## HPV Vaccination Schedule

- ❑ **ACIP recommended schedule is 0, 1–2, 6 months**
  - Following the recommended schedule is preferred
- ❑ **Minimum intervals**
  - 4 weeks between doses 1 and 2
  - 12 weeks between doses 2 and 3
  - 24 weeks between doses 1 and 3
- ❑ **Administer IM**

## **HPV Vaccine Duration of Immunity**

- ❑ **The vaccine appears to have good long-term protection duration after a complete 3-dose schedule**
- ❑ **Available evidence indicates protection for at least 8–10 years**
  - Multiple cohort studies are in progress to monitor the duration of immunity



You're  
not  
opening  
the door  
to sex.

● You're  
closing  
the  
door to  
cancer.

**HPV vaccine is  
cancer prevention.**

Talk to your child's doctor about  
vaccinating your 11-12 year old  
against HPV.

[www.cdc.gov/vaccines/teens](http://www.cdc.gov/vaccines/teens)



U.S. Department of  
Health and Human Services  
Centers for Disease  
Control and Prevention



If there were a  
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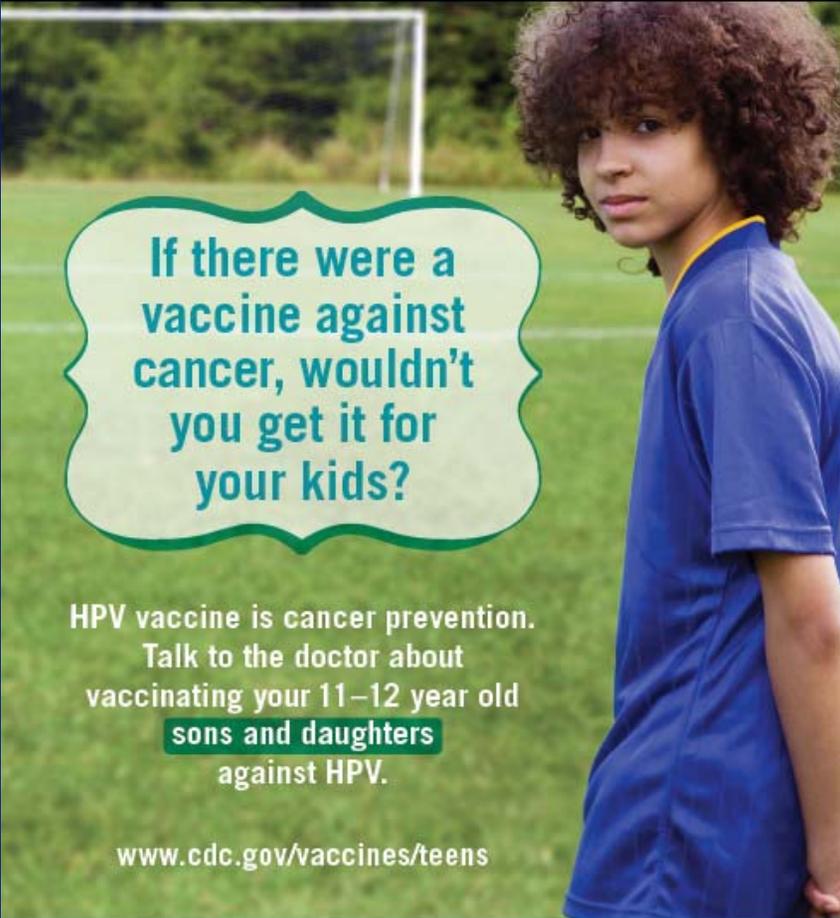
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**YOU** ARE THE KEY TO HPV  
CANCER PREVENTION

Distributed by:



# Thank You

[www.cdc.gov/cancer](http://www.cdc.gov/cancer)

**For more information, contact:**

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## **Centers for Disease Control and Prevention**

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Web: <http://www.cdc.gov>

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

# **Updates on Cervical Cancer Screening**

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**Professor**

**Department of Obstetrics, Gynecology and Reproductive Sciences**

**Department of Epidemiology and Biostatistics**

**University of California, San Francisco**

**Director, Cervical Dysplasia Clinic, San Francisco General Hospital**

# From virus to cancer



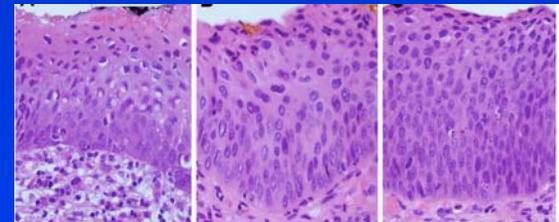
Source: Saslow et al., *American Journal of Clinical Pathology*, 2012.

# Precancerous lesions

Cervical intraepithelial neoplasia (CIN)

Graded based on proportion of epithelium involved

- CIN 1: indicates active HPV infection; high spontaneous resolution: treatment discouraged
- CIN 2: most treated, but *about 40% resolve over a 6-month period*; treatment may be deferred in young women
- CIN 3: proximal cancer precursor
- Adenocarcinoma *in situ* (rare)



# Treating precancerous lesions: 3 main modalities



<b>Freezing or Laser</b>	<b>Destroying</b> abnormal cervical changes by freezing with a very cold instrument (cryotherapy) or by vaporizing them with a laser beam
<b>LEEP or Cone biopsy</b>	<b>Removing</b> abnormal cervical changes with a hot wire (LEEP) or with a scalpel (cone biopsy)
<b>Hysterectomy</b>	<b>Removing</b> the cervix and uterus entirely

## 2012 Cervical Cancer Screening Guidelines for Average-risk Women

US Preventive Services Task Force, American Cancer Society/American Society for Colposcopy and Cervical Pathology/American Society for Clinical Pathologists, American College of Obstetricians and Gynecologists

<b>Age to begin screening</b>	21
<b>Screening methods and intervals, by age</b>	Ages 21-65: cytology every 3 years or Ages 21-29: cytology every 3 years Ages 30-65: cytology plus HPV testing (for high-risk or oncogenic HPV types) every 5 years
<b>Age to end screening</b>	65 If 3 consecutive negative cytology results or 2 consecutive negative cytology plus HPV tests within 10 years before cessation of screening, with the most recent test performed within 5 years
<b>Screening after hysterectomy with removal of the cervix</b>	Not recommended

Guidelines do not apply to immunocompromised women (HIV+), those with *in utero* DES exposure and those with prior CIN 2 or 3 or cervical cancer.  
Vaccinated women are screened the same as unvaccinated women.

# Ending screening: regardless of age

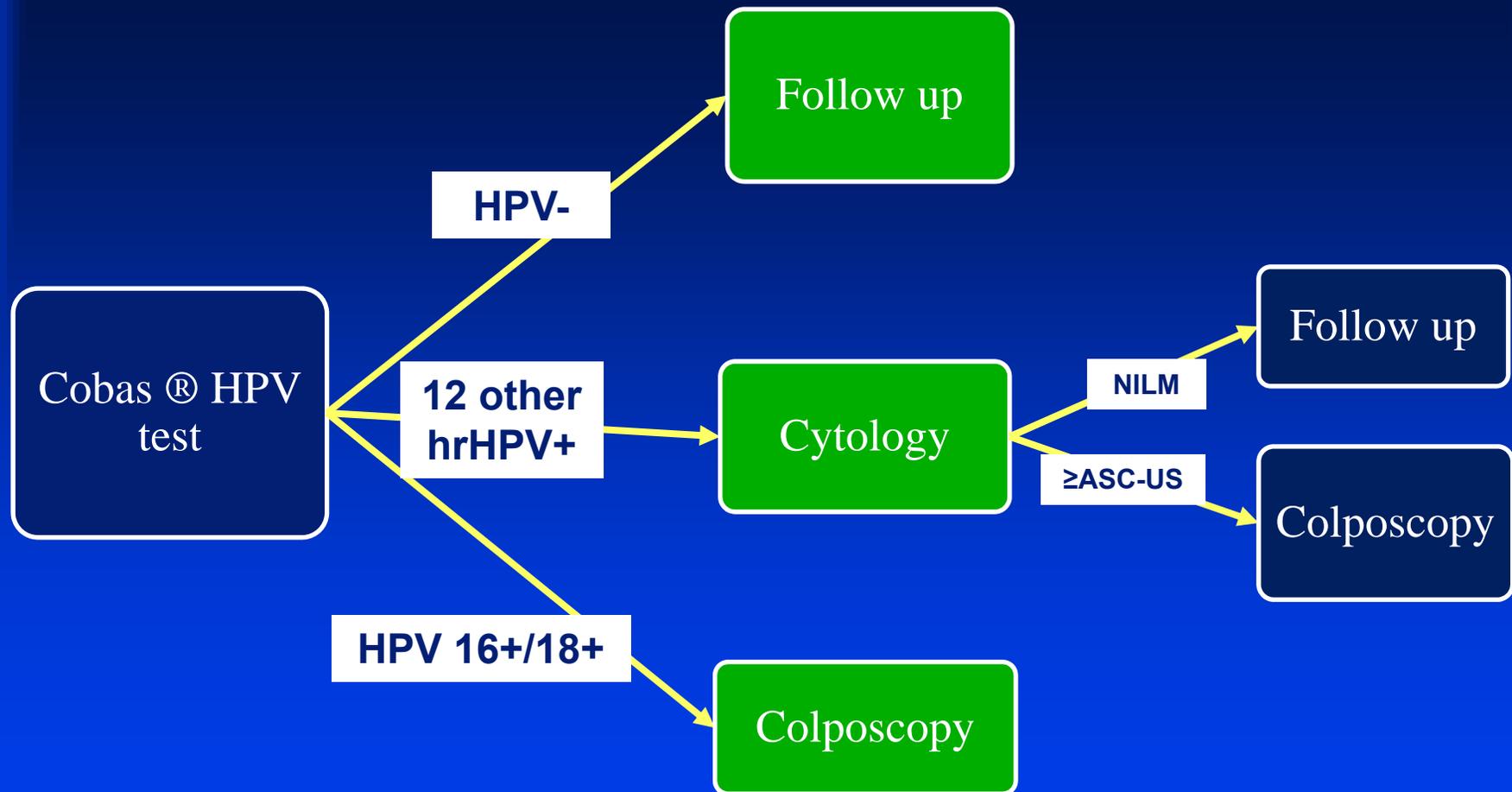
- **ACOG, ACS and USPSTF:** all agree that screening following total hysterectomy with removal of the cervix for benign disease is not indicated.  
USPSTF: “D” recommendation
- **ACOG (2003):** If hysterectomy for CIN 2 or 3, may stop screening after 3 normal tests.
- **ACOG (2012):** Continued routine screening (cytology ever 3 years) recommended for 20 years.

# Rationale

- **Beginning at age 21**  
cervical cancer precursors and cancers: rare  
abnormal tests: common  
concerns: false-positive testing, unnecessary invasive procedures, possible preterm delivery risk with excisional procedures
- **Screening every 3 years with cytology alone**  
average time from CIN 3 to cancer: 10 years  
concerns with annual testing: false-positive testing, invasive procedures
- **Screening every 5 years with cytology plus HPV testing**  
decision analysis: similar benefits (cancers, cancer deaths prevented) and harms (colposcopies, false-positive tests) as cytology every 3 years  
USPSTF: apply only to “women who want to lengthen the screening interval”  
ACS: co-testing “preferred” but based on a “weak” recommendation
- **Ending screening at age 65**  
cervical cancer uncommon among well screened older women but potential for harms (false-positive testing, invasive procedures)

# On the horizon

Cobas HPV test (14 HR types): FDA approved as a primary screening test beginning at age 25 years



Currently not endorsed by any major guideline group

# Community Cervical Cancer Prevention: Missed Opportunities

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*Francisco A. R. García, MD, MPH*

*Director & Chief Medical Officer*

*Distinguished Outreach Professor of Public Health*



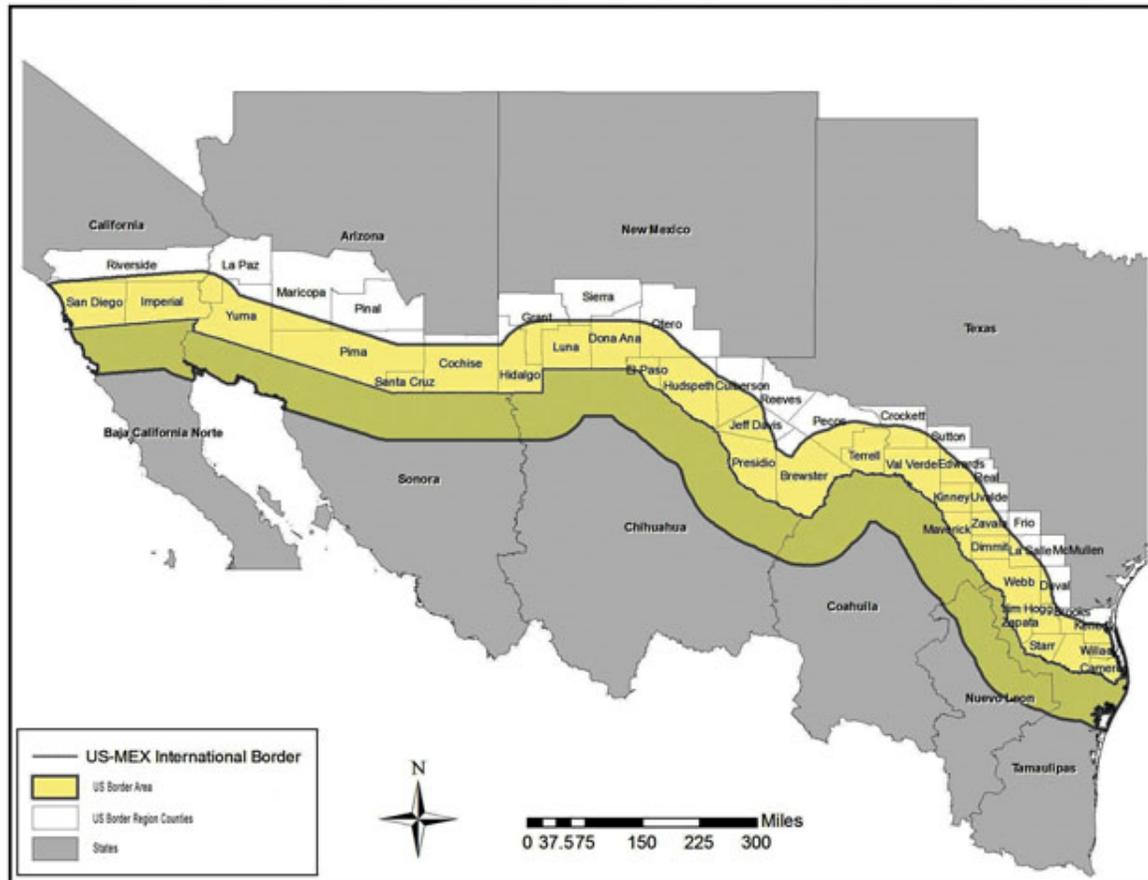
**PIMA COUNTY**  
HEALTH DEPARTMENT

**A Healthy Pima County**  
Every **one**. Every **where**. Every **day**.

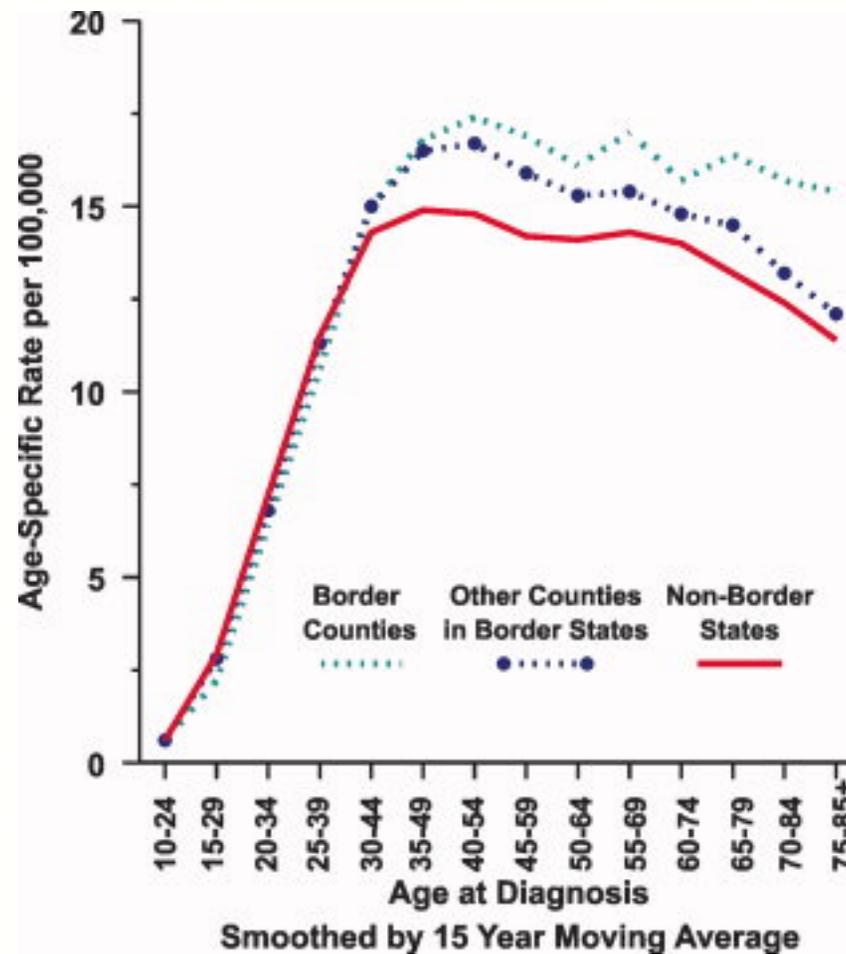
# Faculty Disclosure

- I have no personal financial interests or affiliations to disclose

# US-Mexico Border



# Cervical cancer incidence in the United States in the US-Mexico border region, 1998–2003



Cancer

Volume 113, Issue S10, pages 2964-2973, 3 NOV 2008 DOI: 10.1002/cncr.23748

<http://onlinelibrary.wiley.com/doi/10.1002/cncr.23748/full#fig2>

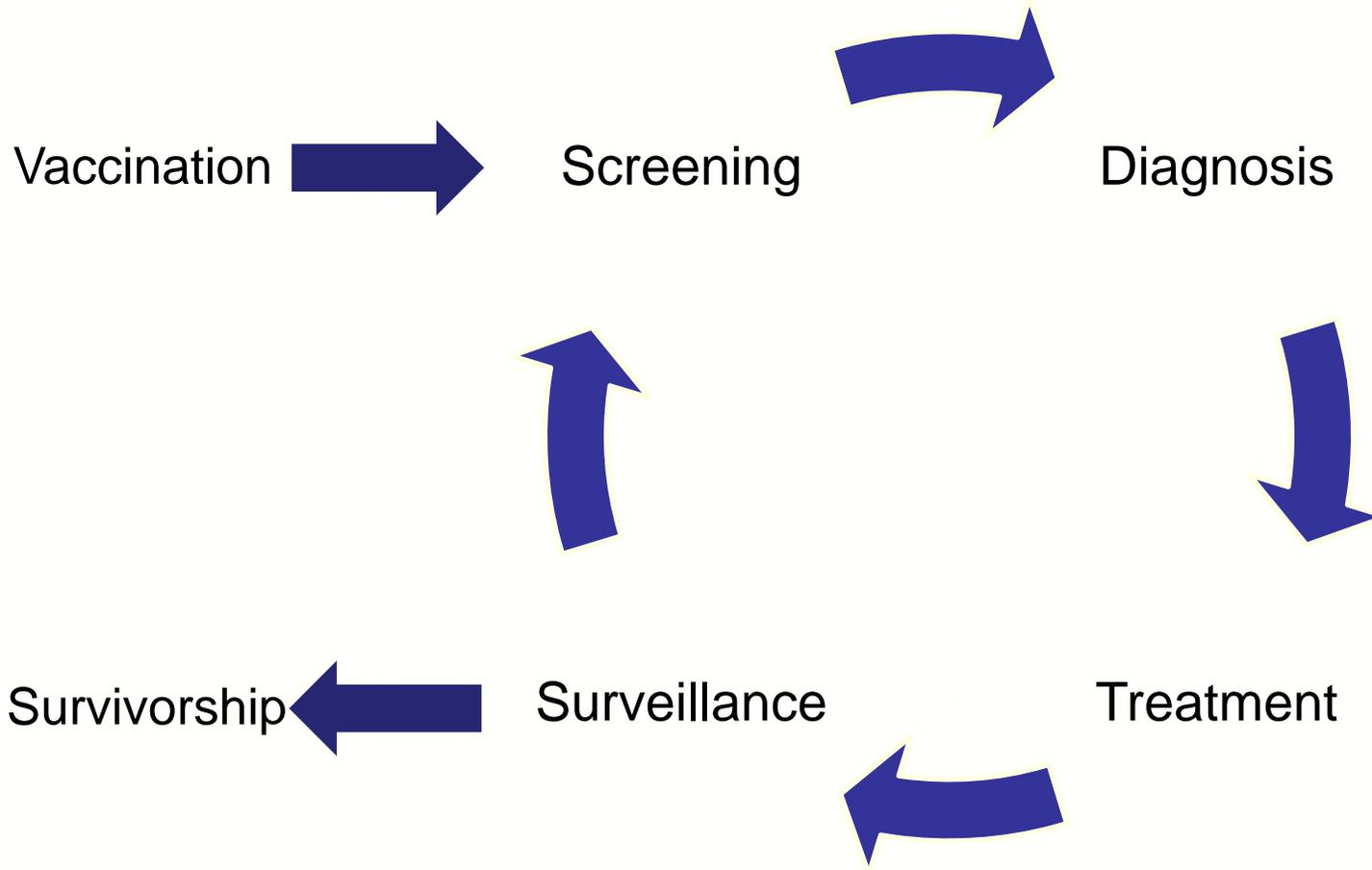
# Cancer Screening in Border Communities: BRFSS 1999-2000

	Never Pap		Pap >3 years	
	Hispanic	Non-Hispanic	Hispanic	Non-Hispanic
Border Counties	14.9%	3.8%	26.4%	11.7%
Non-Border Counties	8.7%	5.4%	16.7%	15.4%
US	8.7%	5.3%	15.9%	15.0%

*Factors Positively Associated with Pap <3 years:* Younger age, non-Hispanic ethnicity, lower parity, non-rural residence, physician visit past year & insurance.

S. Coughlin. Fam Community Health 2003

# Comprehensive Cervical Cancer Prevention in Vulnerable Communities



# Missed Opportunity: Coverage & Access

## 8m Un/Under Screened women (21-65 years)

Percent Estimate	n	Insured	Health Care Provider
70%	5.6m	+	+
10%	0.8m	+	-
10%	0.8m	-	+
10%	0.8m	+	-

# Cervical Cancer Screening Utilization: Yuma Project

- Cross-sectional population based study (n=504)
- Post menopausal ( $\geq 50$ ) women in Yuma County
- Mexican-born, US-born Hisp, White/Non-Hisp
- Cancer screening & utilization

	<b>Total</b>	<b>Mex Born Hispanic</b>	<b>US Born Hispanic</b>	<b>White Non-Hisp</b>
Pap w/in 3 years	73%	75%	64%	72%

Nuno, Castle & Garcia J Women's Health 2011

# Missed Opportunity: Tapping into Existing Social Networks

Yuma *Promotora* Intervention, 3-year follow-up

Pap	n (%)	OR	95% CI
			p=0.007
Usual Care (n=116)	87 (75%)	1.0	
Intervention (n=104)	93 (89%)	2.8	(1.3-6.0)

# Missed Opportunity: Post Screening Loss to Follow-up

California (Tabnak. CCC 2010)

- 12.3% lost post screening
- 8% lost post colp diagnosis

Quebec (Franco. Prev Med 2007)

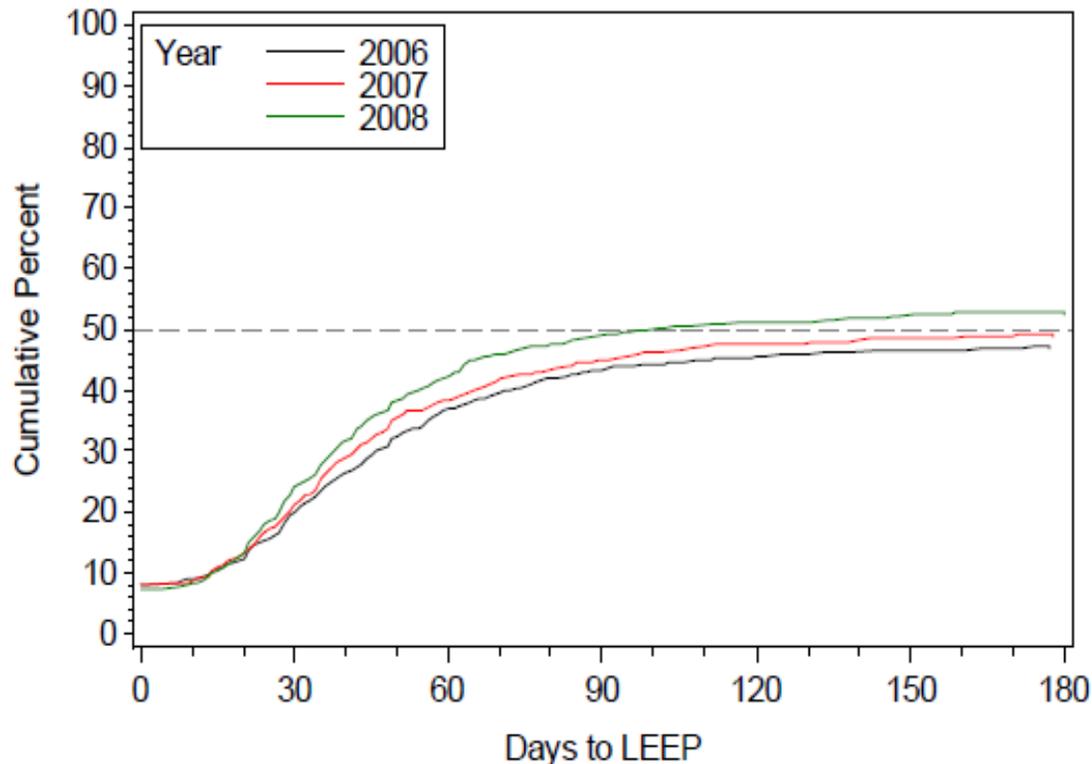
- 12% loss post screening

Pima County (Garcia)

- 15% loss post screening

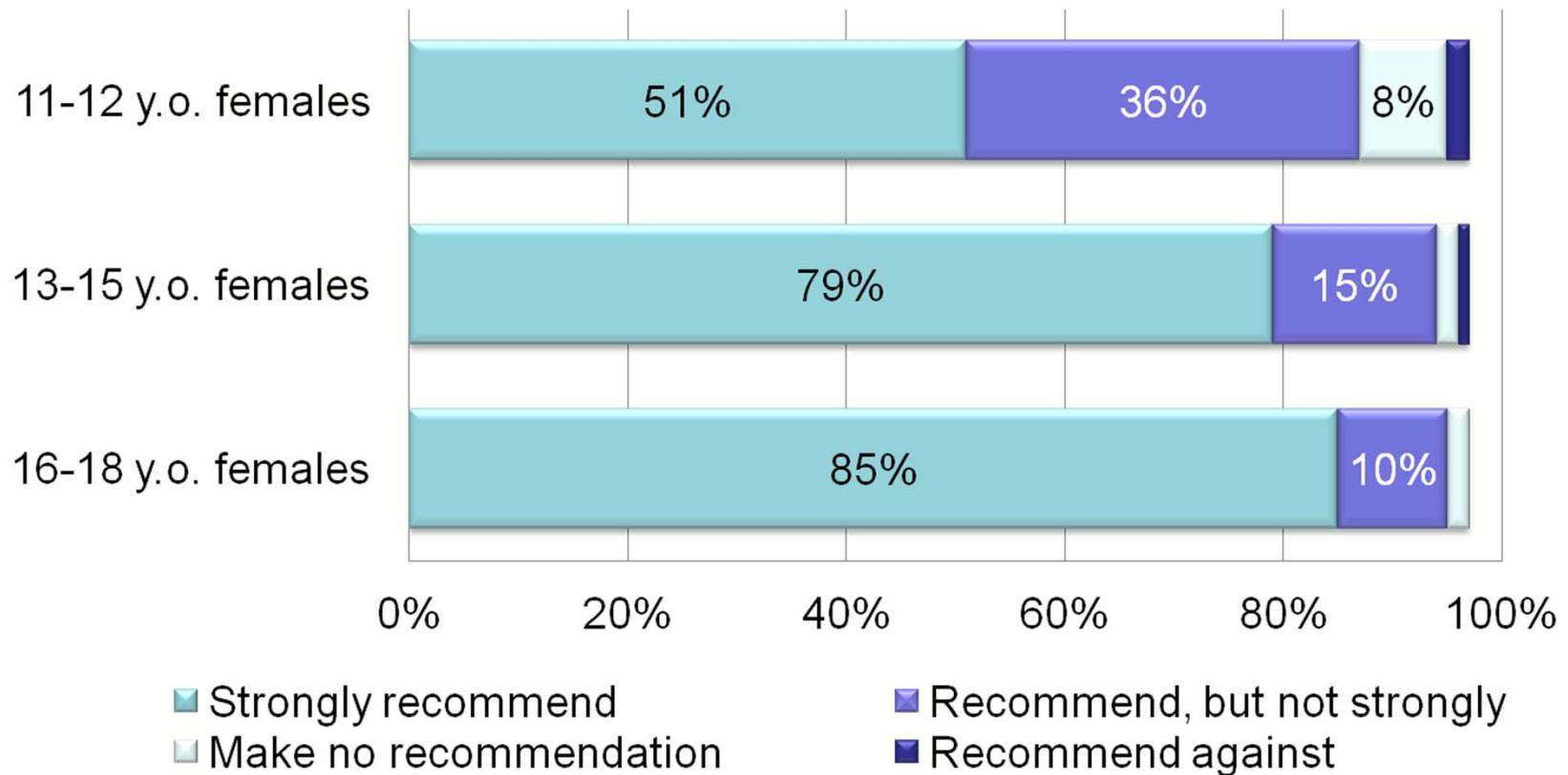
# Missed Opportunity: Timely Treatment

Cumulative percent of women receiving LEEP after a diagnosis of CIN2+  
By year of diagnosis (unpublished Wheeler et al. 2010)

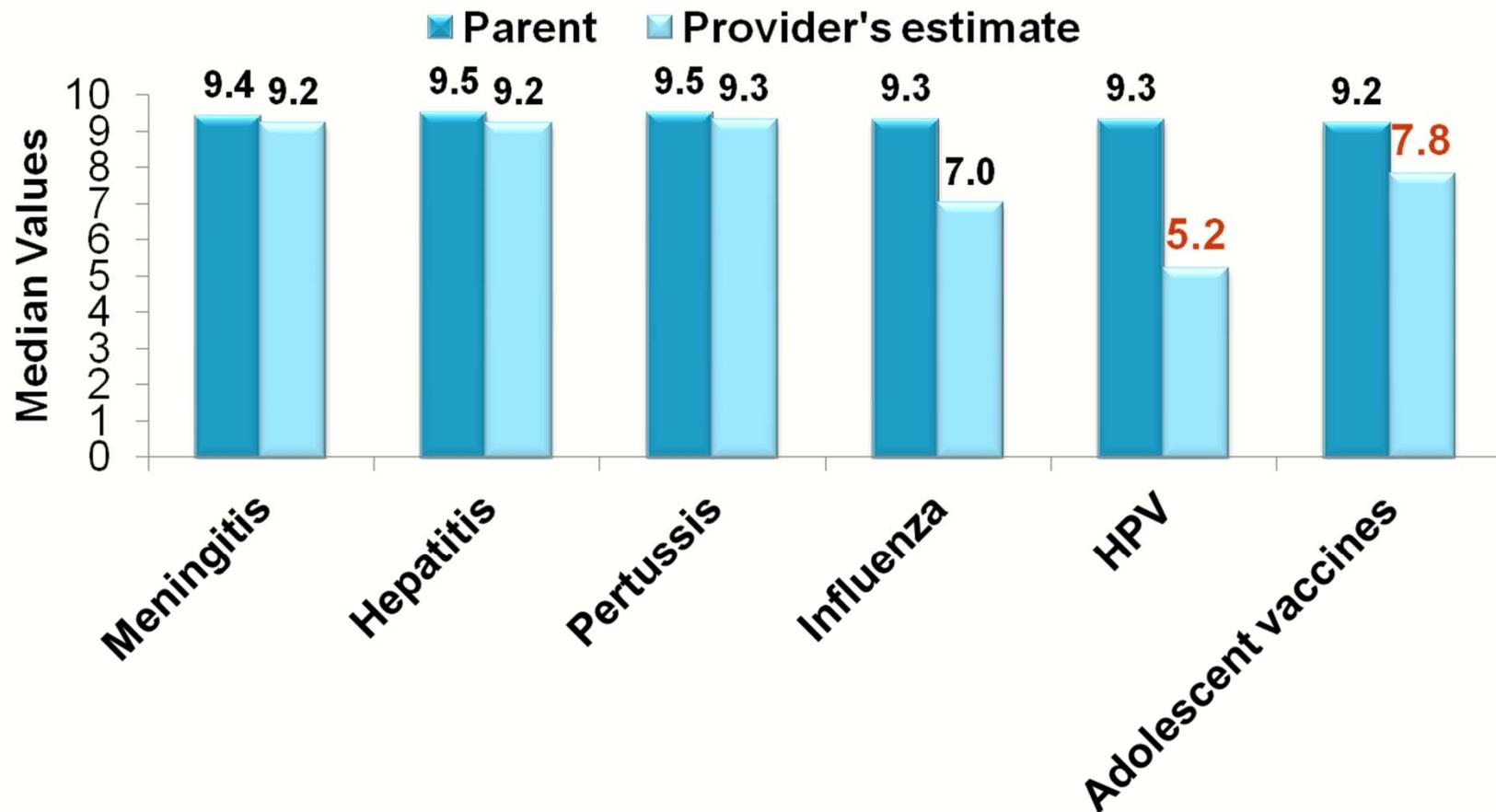


Note: The diagnosis of CIN2+ is from a cervical biopsy that is at least one year after any previous biopsy. Population ~275,000 women screened/yr. Approximately 82% of women had a referral Pap smear ascertained by the NM HPV Pap Registry. The intercept on the vertical axis indicates that about 7% had a LEEP at the same time that the diagnosis of CIN2+ was made.

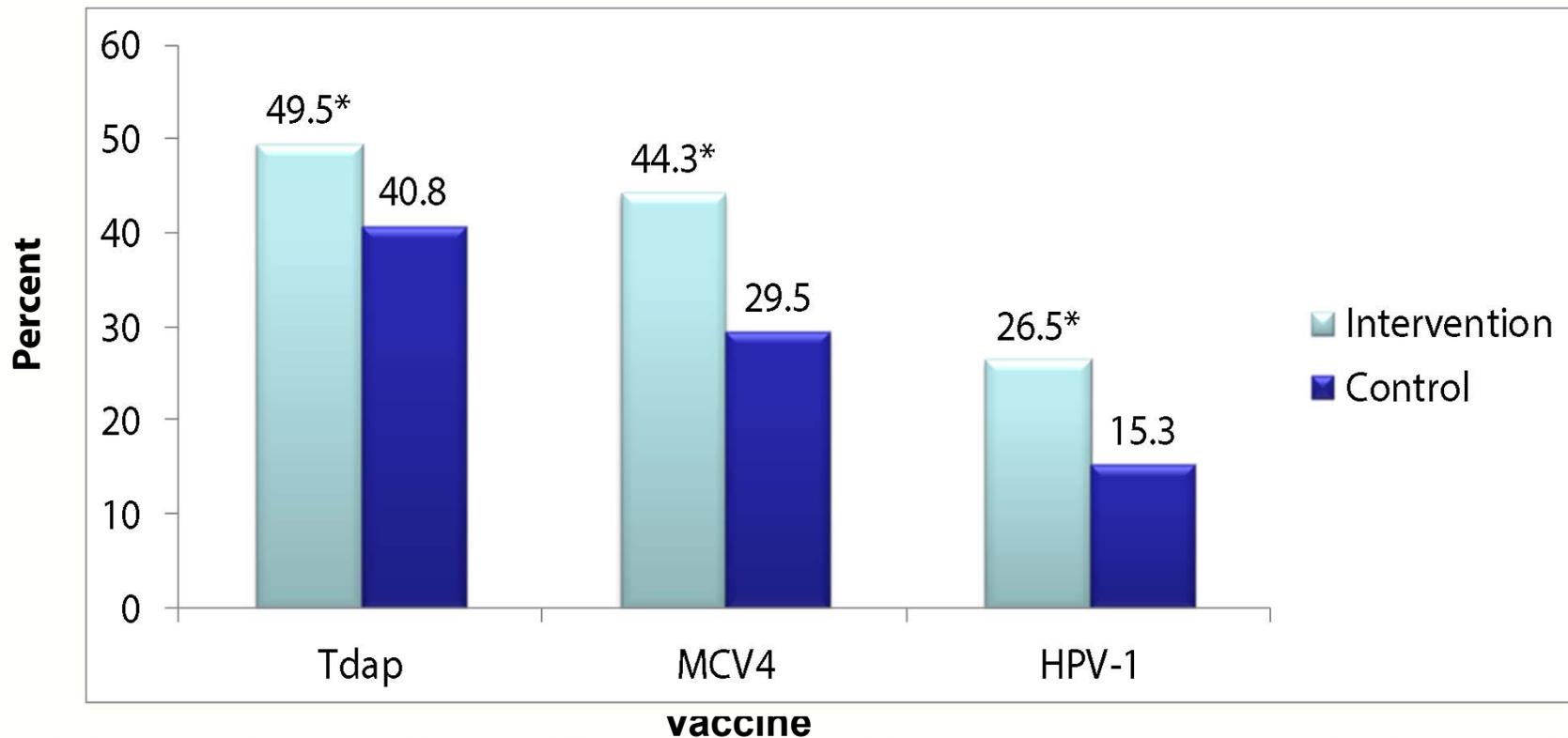
# Most clinicians wait too long to make strong recommendations for HPV vaccine



# Clinicians underestimate the value parents place on HPV vaccine

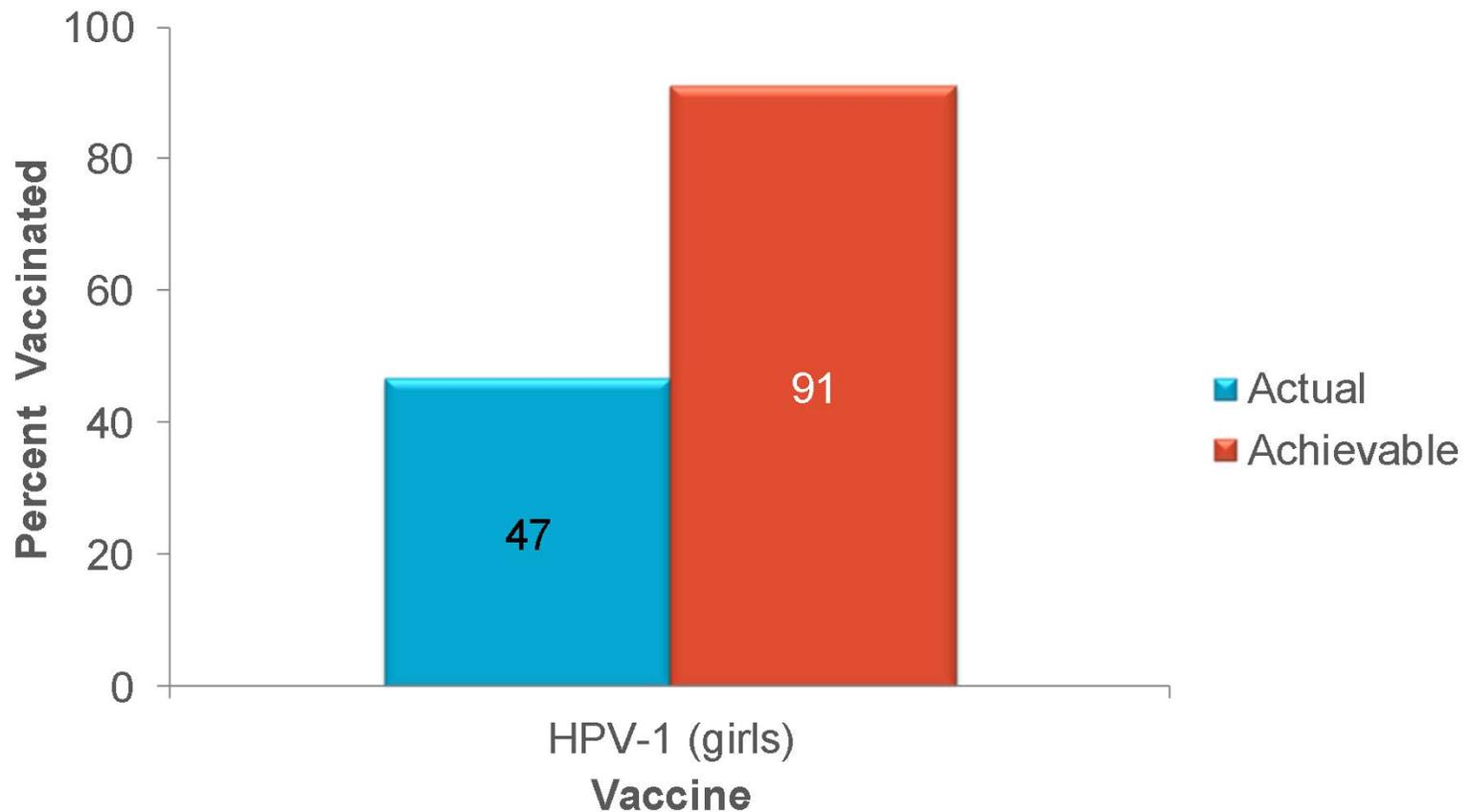


# Missed Opportunity: Reminder/Recall Impact on Vaccination



# Missed Opportunity: Optimizing Vaccination Visits

## Impact of Eliminating Missed Opportunities by Age 13 Years in Girls Born in 2000

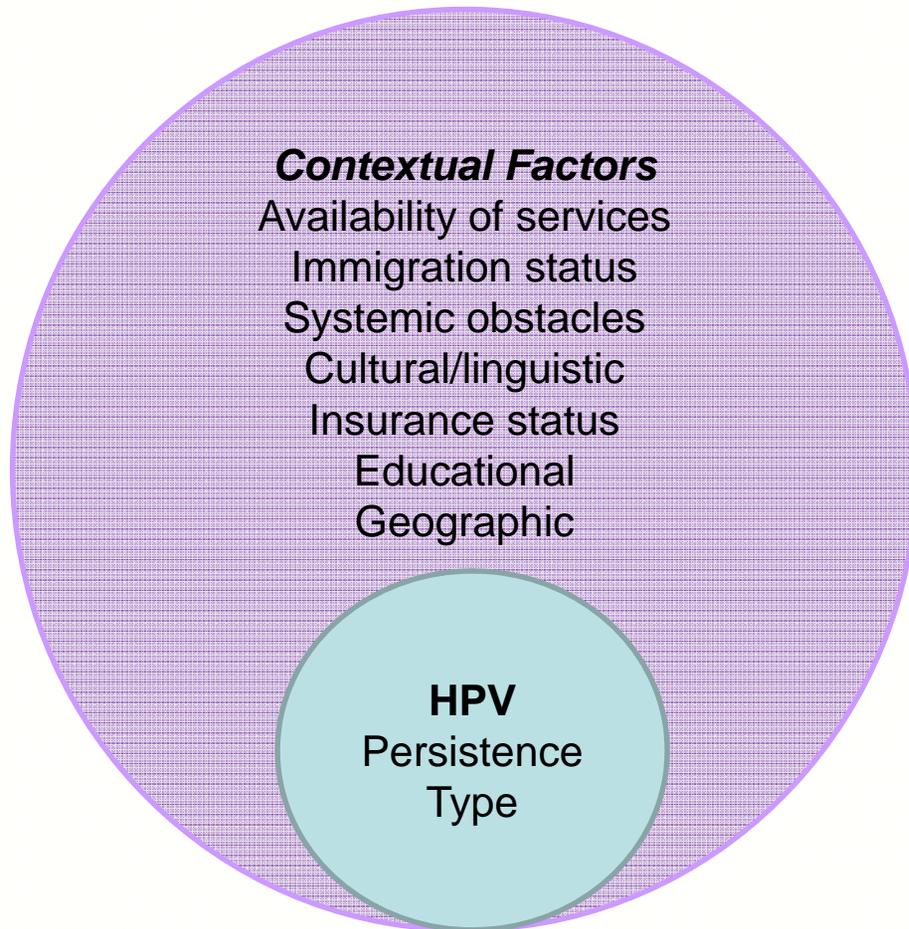


Missed opportunity: Healthcare encounter when some, but not all ACIP-recommended vaccines are given.

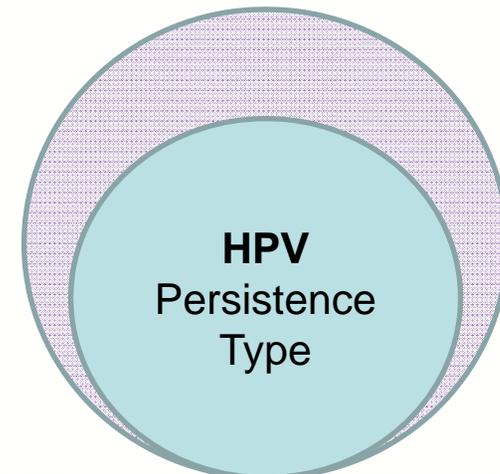
HPV-1: Receipt of at least one dose of HPV.

MMWR. 63(29);620-624.

# Relative Role of Host and Contextual Factors



**Vulnerable Population**



**Resilient Population**

# Minimize missed opportunities!

- Know your community
- Tap into existing resources
- Every clinical encounter is an opportunity to review screening/vaccination history
- Provide effective follow-up
- Optimize insurance coverage

# How to Ask a Question

## ❑ Using the Webinar System

- Click the Q&A tab at the top left of the webinar toolbar.
- Click in the white space.
- Type your question.
- Click **Ask**.

## ❑ On the Phone

- Press star (\*) 1 to enter the queue to ask a question.
- State your name.
- Listen for the operator to call your name.
- State your organization and ask your question.

**Thank you for joining!**  
**Please send questions to [coca@cdc.gov](mailto:coca@cdc.gov)**



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**Atlanta, Georgia**

Clinician Outreach and Communication Activity (COCA)

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## Continuing Education Credit/Contact Hours for COCA Calls/Webinars

Continuing education guidelines require that the attendance of all who participate in COCA conference calls be documented properly. All continuing education credits/contact hours (CME, CNE, CEU, CECH, ACPE, and AAVSB/RACE) for COCA conference calls and webinars are issued online through CDC's Training and Continuing Education Online system ([www.cdc.gov/TCEOnline/](http://www.cdc.gov/TCEOnline/)).

Those who participate in COCA conference calls and wish to receive CE credit/contact hours and will complete the online evaluation by **December 21, 2014** will use the course code **WC2286(SC)**. Those who wish to receive CE credits/contact hours and will complete the online evaluation between **December 22, 2014** and **November 19, 2015** will use course code **WD2286(SC)**. CE certificates can be printed immediately upon completion of your online evaluation. A cumulative transcript of all CDC/ATSDR CEs obtained through CDC's Training and Continuing Education Online system will be maintained for each user.

# Join Us on Facebook

Visit CDC's Facebook page for health partners! Like our page to receive COCA updates, guidance, and situational awareness about preparing for and responding to public health emergencies.

[www.facebook.com/  
CDCHealthPartnersOutreach](http://www.facebook.com/CDCHealthPartnersOutreach)



The screenshot shows the Facebook profile for CDC Health Partners Outreach. The profile picture features a group of diverse healthcare professionals. The page name is "CDC Health Partners Outreach" with 3,758 likes and 105 people talking about this. The bio identifies it as a Government Organization and provides a link to the CDC Emergency Risk Communication Branch. The page includes a "Status" section with a link shared on April 24, a "Recent Posts" section with several posts from "Art Leather" about chronic pain, and an "Ads Manager" sidebar on the right.