THE MINISTRY OF HEALTH,
WELLNESS,
SOCIAL TRANSFORMATION
& THE ENVIRONMENT
OF ANTIGUA AND BARBUDA

ANTIGUA AND BARBUDA

NATIONAL GUIDELINES FOR CERVICAL SCREENING & TREATMENT OF PRE-CANCER LESIONS

QUICK REFERENCE GUIDE

FIRST EDITION
2024

ANTIGUA & BARBUDA

Quick reference Guide

National guidelines for cervical screening and treatment of pre-cancer

MINISTRY OF HEALTH, WELLNESS, SOCIAL TRANSFORMATION AND THE ENVIRONMENT (MOHWSTE)

Cervical Cancer Elimination Program

February 2024

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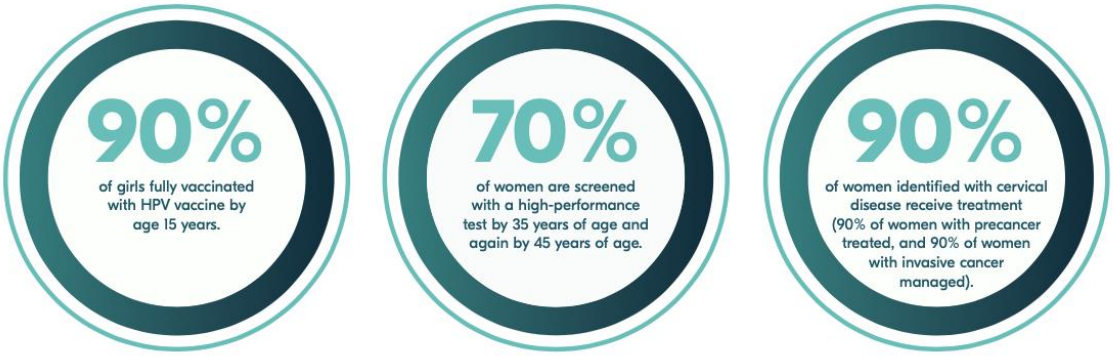
1.GLOBAL STRATEGY TO ELIMINATE CERVICAL CANCER

WHO has defined the threshold for elimination of cervical cancer as a public health problem as an age-standardized incidence rate of less than 4 cases per 100,000 women-years. To achieve elimination within a century, the following targets need to be met by 2030 and maintained beyond:

- 90% of girls fully vaccinated with the HPV vaccine by 15 years of age.
- 70% of women are screened with a high-precision test (HPV DNA test) at 35 and 45 years of age.
- 90% of women identified with cervical disease receive treatment and care (90% of women screened positive treated for pre-cancer lesions and 90% of invasive cancer cases managed).



WHO recommends the simultaneous implementation of these three pillars to achieve a maximum impact.

Countries can expect a decrease of cervical cancer mortality as access to treatment of invasive disease improves, coupled with a decrease of incidence resulting from implementation of population-based screening followed by treatment of the pre-cancerous lesions. Vaccination against HPV will offer protection against cervical cancer to future generations.

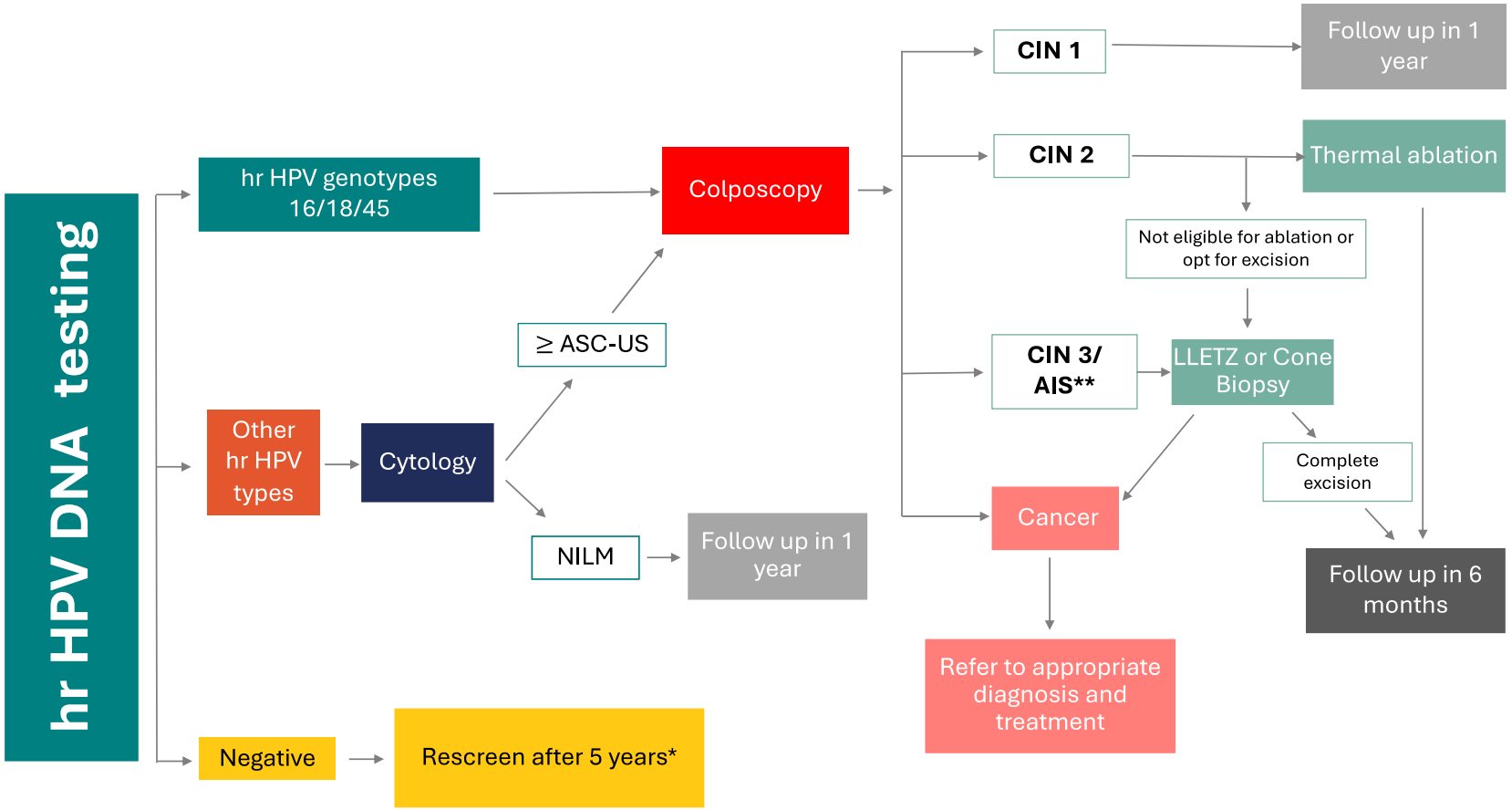
2. TARGET POPULATION, SCREENING FREQUENCY AND FOLLOW UP.

Target population groups for screening and screening frequency						
Target groups	**Age groups**	**Screening method**		**Screening frequency**		
		Primary	Triage	Negative screening	Positive screening NOT requiring treatment	Positive screening requiring treatment
General population	30-65 years	Hr HPV DNA	Cytology	5 years	1 year	6-12 months
	25-29 years	Cytology	Hr HPV DNA	3 years	1 year	6-12 months
WLHIV start at age 21 or within 2 years of sexual activity	21-24	Cytology	Hr HPV DNA	3 years	1 year	6-12 months
	25-65 years	Hr HPV DNA	Cytology	3 years	1 year	6-12 months

Hr HPV testing follow up of women with high grade lesions	
• Persons with CIN 2 preceded by hr HPV different than 16/18/45 (Hr HPV Type Others)	1 year
• Women living with HIV • Women treated for any high-grade lesions which was preceded by high-risk HPV 16/18/45. • Women who were treated for CIN 3	6 months
• Persons treated for high grade lesions require 3 negative tests before they return to the screening process.	HPV testing every 3 years for the next 25 years (ASCCP recommendation)

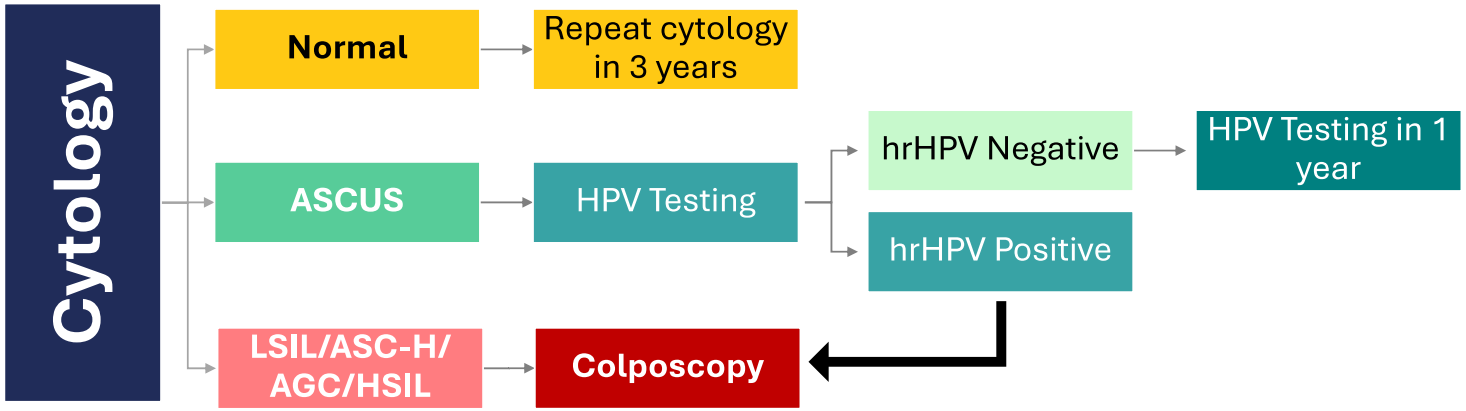
Possible complications of treatment of pre-cancer.	
Early warning signs (first 2-4 weeks)	**Late warning signs (1-3 months following the procedure)**
- Fever for more than two days - Severe lower abdominal pain, especially if you have fever. - Foul-smelling or pus-coloured discharge - Bleeding heavier than heaviest days of menstrual bleeding for more than two days - Bleeding with clots	- Later onset of lower abdominal pain with fever - Severe menstrual cramping with minimal or no menstrual bleeding - Leaking of urine or faeces through vagina

3. HIGH RISK HPV SCREENING ALGORITHM RECOMMENDED IN ANTIGUA.



NILM: Negative for intraepithelial lesion or malignancy
ASC_US: Abnormal Squamous Cells of Undetermined Significance
CIN: Cervical Intraepithelial Neoplasia
AIS: Adenocarcinoma in-Situ
*Immunocompetent women with normal screening history

4. CYTOLOGY SCREENING ALGORITHM RECOMMENDED IN ANTIGUA



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5. REFERRAL PROTOCOL.

After hr HPV DNA screening, refer positive cases as follows:

- Positive cases for hr HPV genotypes 16/18/45, refer to colposcopy.
    - If colposcopic biopsy confirms CIN1, follow up in 1 year.
    - If colposcopic biopsy confirms CIN2, CIN 3 or AIS, refer women for excision.
- Positive for other hr HPV subtypes, refer to cytology.
    - If cytology results indicate >/=ASC-US, refer women to colposcopy.
    - If cytology results not available at 4 weeks, refer women to colposcopy.
    - If colposcopic biopsy indicates CIN 2, refer for thermal ablation if eligible.
    - If colposcopic biopsy confirms CIN 3, AIS or a woman has CIN 2 but isn't eligible for ablation then refer for excision.
    - If cytology is negative (NILM), follow up with the woman in 1 year.
- If cancer is suspected at any moment, refer for appropriate diagnostic procedure and treatment.

Women can be referred to have the following specific services:

- **Cervical cytology** (Pap Smear): It is recommended in situations where the squamocolumnar junction (SCJ) cannot be visualized, which is common in postmenopausal women, in addition or after a positive hr HPV DNA positive for HPV subtypes different than 16/18/45 (hr HPV Type Others).
- **Colposcopy**: Colposcopy uses a special instrument (colposcope) that provides magnification and a strong light to visualize the cervix. It is typically used in conjunction with directed biopsies of abnormal appearing lesions of the cervix.
- **Biopsy**: Cervical biopsy is indicated when suspicious lesions are seen on the cervix on speculum examination.
- **Histology**: Histological diagnosis is always performed on biopsy and LLETZ tissue which is indicated for suspicious lesions or when lesions are beyond the indication for thermal ablation.

Symptoms which can be seen in cervical cancer.

Unusual vaginal bleeding such as: - heavier menses - vaginal bleeding in between periods - bleeding after sex
Changes in vaginal discharge which may be heavier or offensive
Pain during sex
Lower abdominal or pelvic pain
Back pain
Difficulty passing urine or stool
Feeling weak or tired especially associated with significant weight loss

6. KEY MESSAGES FOR CERVICAL CANCER OUTREACH AND EDUCATION.

Providing accurate, easy-to-understand information is the first step in helping women and families access services that can prevent cervical cancer. The following specific messages are the most important ones to convey within communities.

Who is at risk?

- Cervical cancer is a leading cause of cancer death in women.
- Women 30–49 years old are most at risk for cervical cancer. Women living with HIV or immunocompromised are at risk at earlier ages.
- Any woman who has had sexual relations is at risk of developing cervical cancer.

HPV infection:

- Cervical cancer is caused by infection with a virus called HPV. This virus is passed during sexual relations and is very common among men and women.
- Almost all men and women will be exposed to HPV in their lifetime. Most HPV infections go away in a short time without treatment.
- In some women, HPV infection persists and can slowly change the cells on the cervix. These changes are called pre-cancer. If not treated, they can develop into cancer of the cervix.

Cervical cancer is a disease that can be prevented with vaccination, early detection, and treatment of pre-cancerous lesions:

- There are tests to detect early changes in the cervix (known as pre-cancer).
- There are safe and effective treatments for pre-cancer. Without treatment, pre-cancer may lead to cancer.
- All women aged 25–65 years should be screened for cervical cancer.
- There is a vaccine for girls that can help prevent cervical cancer.

Vaccination:

- All boys and girls ages 9-14 years old should be vaccinated with the HPV vaccine, as well as a secondary group of 15-26 years.
- Vaccination with Gardasil 9 can be administered to women up to the age of 45 after discussion with their physician. It is important to note that vaccination at older ages is less effective and the focus should remain on screening and early detection of pre-cancer.
- Vaccination prevents the infection with the types of HPV that cause most cervical cancers.
- The HPV vaccines are safe and effective. Adverse reactions, when they occur, are usually minor.
- The HPV vaccine has no impact on a girl's fertility; it does not affect her capacity to become pregnant and have healthy children later in life.

- The HPV vaccine, to be most effective, should be administered in accordance with the number and timing of doses as advised in the manufacturer's instructions.
- Even after vaccination, all women aged 25–65 years will require cervical cancer screening, as the vaccine prevents most, but not 100% of cervical cancer cases.

Screening and treatment:

- There are cervical screening tests that can detect early changes of the cervix (pre-cancer).
- The screening tests for cervical pre-cancer are simple, quick, and do not hurt.
- If the screening test is positive, it means that there could be early changes (pre-cancer) that can be treated. A positive screening test outcome DOES NOT automatically mean cancer.
- To prevent cervical cancer, all women with positive screening tests should receive treatment.
- It is important to follow the recommendation of the health care worker as to when to return for screening.
- Women living with HIV are at higher risk for cervical cancer; they should start screening at the age of 21 years.

Signs and symptoms of cervical cancer:

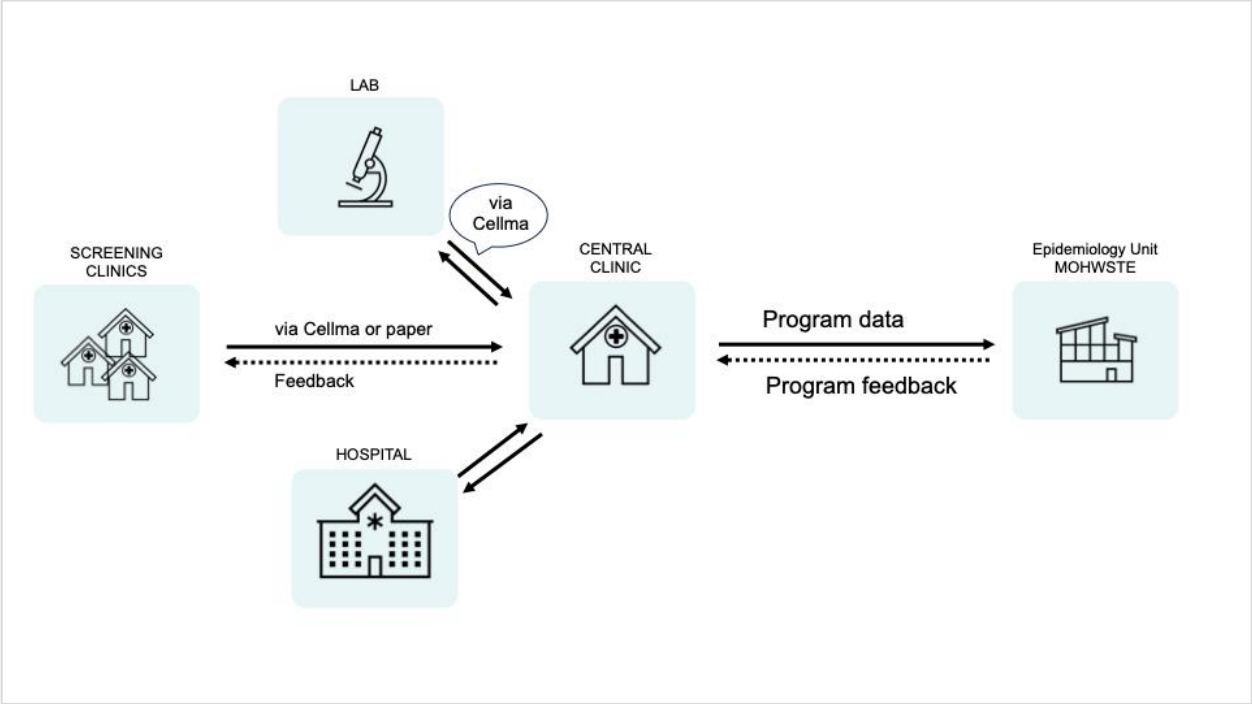
- There are no signs or symptoms for pre-cancer. Screening is the only way to determine if you have pre-cancer.
- Occasionally, cervical cancer (instead of pre-cancer) is detected during screening.
- In early stages, cervical cancer may not cause any symptoms and signs. For those who do have symptoms, they may include foul-smelling vaginal discharge, vaginal bleeding, bleeding after sexual intercourse, or any bleeding after menopause. These symptoms can present in other common gynaecologic conditions other than cervical cancer. Women with these symptoms should be carefully examined and referred for further evaluation.
- Women with these symptoms should be encouraged to seek medical care promptly.

Making decisions about health:

- Women have a right to make their own decisions about their health. To make
- informed decisions, women need correct information.
- Women may wish to involve their partners or families in their decision making.
- Although screening for cervical cancer and treatment of pre-cancer are highly
- recommended, women should understand that they are free to refuse any test or
- treatment.

7. FLOW OF STRATEGIC INFORMATION.

Reporting protocol from the service delivery point, where cervical cancer screening is conducted (health-facility level) to the national level.



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PAHO

Pan American Health Organization

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