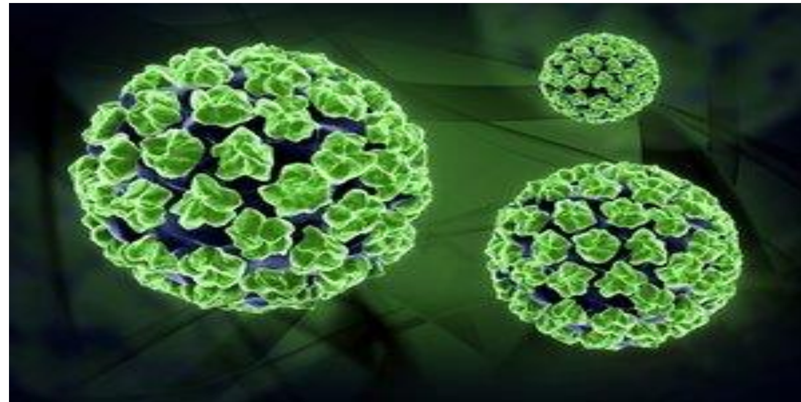
The Colposcopy Burden of HPV x3

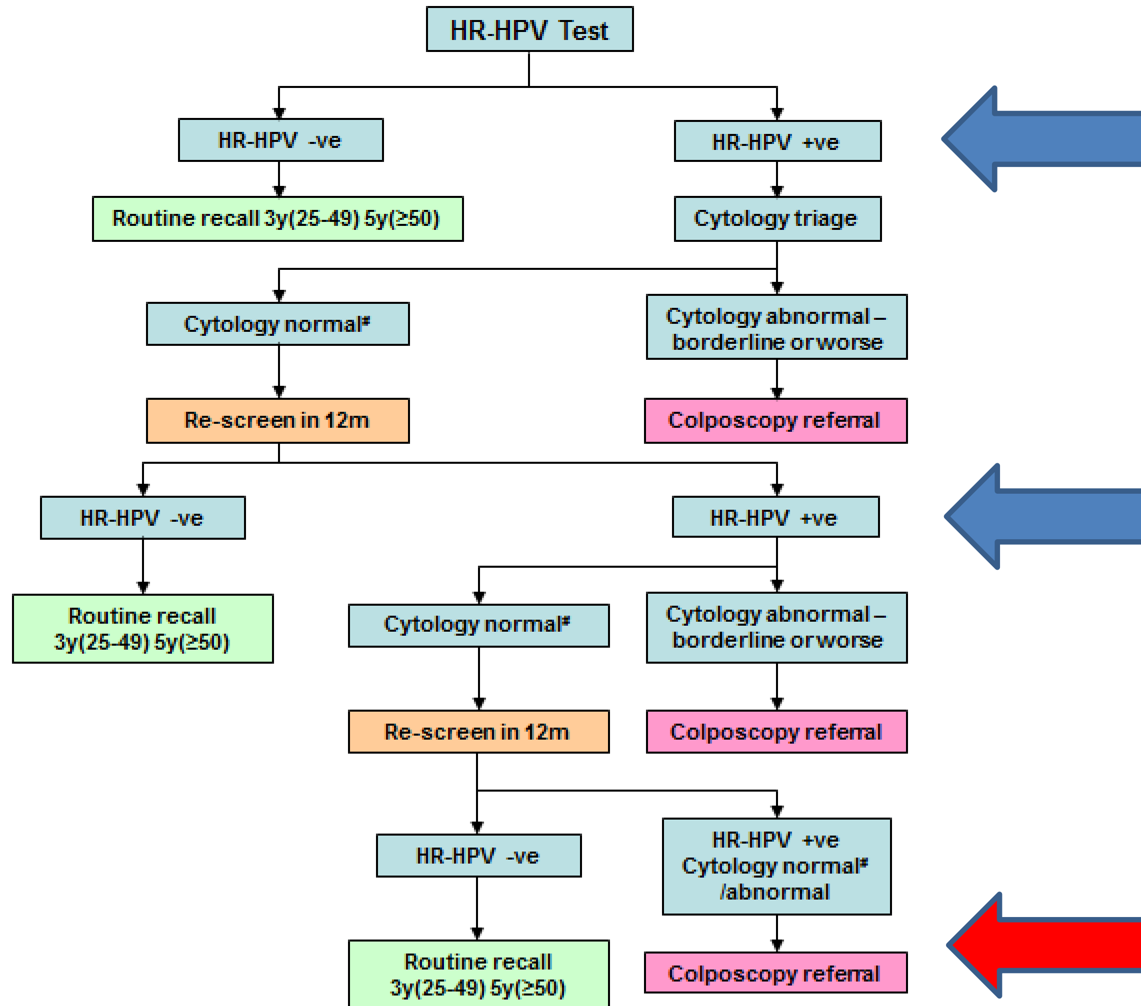


Southmead Cytology

- Started HPV primary pilot September 2013
- One third of our workload ~ 20,000
- 4 years worth of data
- This data starts October 2016 – YEAR 3!
- Rolled out for all samples 11th September 2017
- Currently refer to two Colposcopy clinics

HPV Primary Screening Pilot Protocol Algorithm

All women aged 25-64 on routine call/recall and early recall



HPV x3 – original data

- Time interval 11 months – October 2016 – September 2017 (new IT system only)
- 16947 HPV primary samples screened out of 55,000 samples overall
- 1% of all samples were third HPV cases (29S)
- In total 278 samples were HPV positive for the third time and referred to Colposcopy.

- In this time period 2550 samples were referred to colposcopy
- This 186 represents an extra 7.3%
- However this is for one third of the workload therefore you could predict that for a whole lab workload the colposcopy appointments could increase by 22% in year 3.

However!!!!!

- Year on year samples for the last two years have stayed fairly stable
- This year over the same time period we issued 2473 colposcopy referrals
- This year has a 3% overall increase in referrals increase – not 7% as the current figure seems to show

……..I would like to state at this point that I'm pretty poor at stats!!!!

Reasons?

- Screening the vaccinated population?
- Overall effect of 9 years of HPV testing?
- Just a different way of finding positives? – this will be explained in the diagnosis slides……

Never fear!

- We also need to take into account that this is the first three year round – the effect will/should decrease once we are screening all of the population.
- We had the same effect when we brought in HPV testing for BC/LG and TOCs
- As the vaccinated population enter the screening programme numbers should drop

……or maybe fear a bit!!

- There is quite a difference between HPV assay outcomes and LBC/HPV combinations
- Southmead uses Hologic Thinprep with Hologic Aptima HPV assay, these figures are purely from our data
- Between sites there are variances from 13% – over 20% positivity – depending on population/HPV test/LBC test/reporting thresholds.

Latest Data – a snapshot

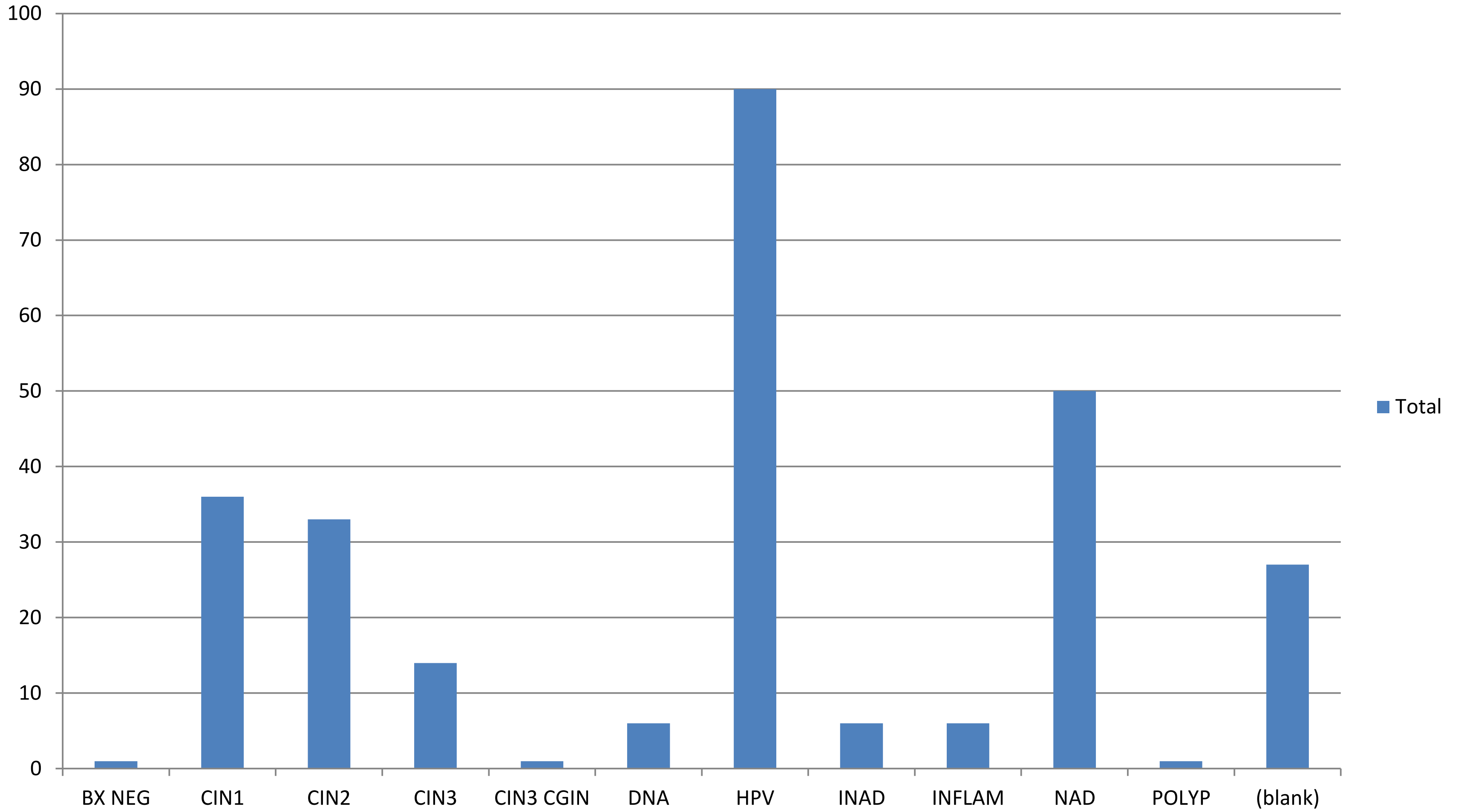
- Data taken from 1st October 2017 to 31st December 2017
- Within period of 100% HPV primary
- 13976 cases tested
- 83 HPV x3 – this equals just over 0.6%
- Quite a drop from the earlier data.

SO?...............

What were the outcomes?

Diagnosis includes all data

Colp/Histo outcome	Occurance	Percentage	Previous
No outcome	27	9.93%	
DNA colp	6	2.21%	
Nothing seen at Colp	50	18.45%	
Inflammation	6	2.21%	
Polyp	1	0.36%	
HPV only	90	33.21%	
Biopsy inadequate	6	2.21%	
Biopsy negative	1	0.36%	
CIN1	36	13.28%	13.5%
CIN2	33	12.17%	13.0%
CIN3	14	5.16%	3.75%
TOTAL	**271**	Rounded up	


Total
100
90
80
70
60
50
40
30
20
10
0
BX NEG
CIN1
CIN2
CIN3
CIN3 CGIN
DNA
HPV
INAD
INFLAM
NAD
POLYP
(blank)
Total

- 13 of the 47 cases which were high grade on first Colp visit (bx or LLETZ) were negative or LG on LLETZ
- Are we referring earlier – with very small lesions?
- ….or is the biopsy Histology being overcalled?
- Do we need to be cautious when treating these patients? – tend to be young.

Negative Cytology

- Where have the abnormal cells come from?
- All of these cases were referred with negative cytology – in fact 3 years of negative Cytology!
- if we reviewed these negative repeat and negative referral slides would they still be negative…………..

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- Very small lesions being missed on sampling?
- Small lesions producing very small numbers of abnormal cells on a slide?
- ? Psychological effect of knowing the patient is being referred anyway –in the original protocol there was no slide made at 3rd HPV – just a straight referral
- ……..but the screeners insist they screen these slides slower due to the psycological effect of HPV positivity!

- So is this just another way of finding referrals rather than an actual increase?

Finishing thoughts

- How will Colposcopy clinics fund extra clinic appointments?
- What effect will the vaccinated population have?
- How will the referral numbers be effected if HPV type 16/18 management is brought in?
- How will communication be maintained between Cytology labs, Histology labs and Colpscopy clinics which may be geographically very far apart?

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- There will be more histology samples being reported without access to the Cytology slides – MDTs will be essential.

- How will the referral numbers be effected if HPV type 16/18 management is brought in?
- What effect will recall extensions have?
- How will communication be maintained between Cytology labs, Histology labs and Colpscopy clinics which may be geographically very far apart?

- Overall the outcome of the referrals are very reassuring for the sensitivity of HPV testing and the National protocol
- As we roll out National data will be interesting

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ANY QUESTIONS?