OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Cervical Screening Test

(previously within guideline 'Vaginal Procedures')

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting (e.g. Visiting Midwifery Services, Community Midwifery Program and Midwifery Group Practice)

This document should be read in conjunction with this Disclaimer

Contents

Aim

Inform staff of cervical screening eligibility criteria, provide guidance on the procedure for collecting a Cervical Screening Test (CST)[a] and results management.

National Cervical Screening Program (NCSP) recommendations[2]

The NCSP National Cervical Screening Policy (external website) recommends:

- Cervical screening should be undertaken every five years in asymptomatic women and people with a cervix 25-74 years of age, using a primary human papillomavirus (HPV) test with partial genotyping and liquid-based cytology (LBC) triage if high risk HPV detected.
  - People who have ever had sexual contact (digital or penile) should commence cervical screening at 25 years of age.
  - Both HPV vaccinated and unvaccinated people are included in the NCSP.
- Anyone eligible for a CST under the NCSP will be given a choice of HPV testing either through self-collection of a vaginal sample or clinician-collection of a sample from the cervix.
  - Self-collection is not appropriate if the participant requires a co-test or is experiencing **symptoms** (such as abnormal vaginal bleeding, pelvic pain, pain with sexual intercourse, watery bloody vaginal discharge).
- Self-collection should be an option any time an HPV test is needed, including for follow-up HPV testing after an intermediate risk result.
- People in whom HPV is detected should be managed in accordance with the NCSP Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding (NCSP Clinical Guidelines) (external website) and the Cervical screening pathway (external website).

For a full list of recommendations, refer to the NCSP National Cervical Screening Policy (external website).

Women and people with a cervix of any age who have symptoms suggestive of cervical cancer require diagnostic testing and should be managed in accordance with the NCSP Clinical Guidelines (external website), regardless of their cervical screening history.

[a] CST: Cervical Screening Test- a clinician- collected cervical sample for HPV testing and reflex liquid-based cytology (LBC) when indicated, or a self-collected vaginal sample for HPV testing.

Transitioning participants to the renewed NCSP

- All women or people with a cervix aged 25-74 years should have now transitioned to the renewed NCSP. If they have not had a CST or follow-up test since their last Pap smear, they are now overdue.
- **Participants of any age** who are undergoing follow-up for abnormalities detected in the Pap smear program, should attend this follow-up when due.
- For further information, refer to the NCSP Clinical Guidelines (external website).

Cervical screening in specific populations

The NCSP Clinical Guidelines (external website) outline the management of women in specific populations. These groups, and where to access the relevant recommendations, include women and people with a cervix who:

- Are pregnant (external website)
- Have had a total hysterectomy (external website)
- Have abnormal vaginal bleeding (external website)
- Are immune-deficient (external website)
- Have been exposed to diethylstilbestrol (DES) in utero (external website)
- Experienced early sexual activity or have been victims of sexual abuse (external website)

Cervical screening information

For further information refer to the WNHS Cervical Screening: For Health Professionals website.

To access your patient's cervical screening history, contact the National Cancer Screening Register (NCSR) on 1800 627 701 or look up via the online NCSR Healthcare Provider Portal (external website).

Discussing CST options

Providing accurate and clear information about cervical screening can assist patients to make an informed choice. When talking with patients, key information to mention includes:

- The link between persistent HPV infection and cervical cancer, noting
  - HPV infections are usually cleared by the immune system in 1–2 years
  - if HPV infection persists, in rare cases it can lead to development of cervical cancer after about 10–15 years
  - Cervical cells can undergo a number of changes before cancer develops. Therefore, regular screening can detect these changes early and, if needed, treat them before cervical cancer develops.
- Cervical screening is based on HPV testing, and cells in the sample will only be studied for changes if HPV is detected.
- Patients have the choice to screen either through self-collection of a vaginal sample using a simple swab (unless a co-test is indicated), or clinician-collection of a sample from the cervix using a speculum.
  - Self-collection is an option any time an HPV test is needed, including for follow-up HPV testing 12 months after an intermediate risk result.
  - The NCSP Self-collection and the Cervical Screening Test (external website) fact sheet can be provided during a consultation to help discuss cervical screening options with patients.
  - NCSP Your choices explained (external website) is a video guide to help people from culturally and linguistically diverse communities understand the importance of cervical screening and the choices available.
- When deciding whether to self-collect a vaginal sample or have a clinician-collected cervical sample, patients must be given clear information about the possibility that HPV may be detected and, if so, what follow-up will be required.
  - A self-collected sample is from the vagina (not the cervix). It can only be tested for HPV and not for cytology (cervical cell abnormalities).
  - To be fully informed, participants should be advised that if HPV is detected on a self-collected vaginal sample, they will need to return for either a clinician-collected cervical sample for LBC analysis, or be referred directly for colposcopy. Follow-up care will be determined by the type of HPV detected.
  - Among those attending for routine screening, approximately 2% have HPV 16/18 detected and approximately 6% have HPV (not 16/18) detected, although the latter varies by age.
  - Over 90% of participants who have routine Cervical Screening Tests do not have any HPV detected and therefore are recommended to screen again in 5 years' time, unless symptomatic.
- Routine cervical screening is only indicated once every 5 years for patients who do not have HPV detected.

For more information on discussing cervical screening with patients, refer to Understanding the NCSP Management Pathway: A Guide for Healthcare Providers (external website).

Pathology tests for cervical and vaginal testing

Clinical information on pathology request forms assists pathology laboratories perform the right tests, match the right clinical recommendations and select the right MBS item(s). Practitioners will need to specify on the pathology request form:

- whether the collection is part of routine screening or is for clinical management or for screening symptomatic people **and**
- the tests required (refer to the NCSP Pathology test guide for cervical and vaginal testing (Pathology test guide) (external website)) **and**
- whether the sample was clinician-collected or self-collected **and**
- other relevant clinical information e.g. screening history, DES exposure **and**
- the patient's Aboriginal and/or Torres Strait Islander status.

The Pathology test guide (external website) provides guidelines for pathology testing.

Procedure: Clinician-collected cervical sample or self-collected sample

	Procedure	Additional information
1	**Preparation**	
1.1	Inform the patient of: • The importance of cervical screening and the risks of not participating • Both cervical screening options, including the follow-up required for positive and negative results: ➢ Self-collected vaginal sample OR ➢ Clinician-collected cervical sample	Prior to taking a clinician-collected sample ensure: • The patient has been provided with sufficient and suitable information to make an informed decision[3] • The patient has been offered both cervical screening options • Privacy is ensured[3] • The patient understands the role and benefits of the NCSR (see below) • Engage an interpreter if needed and consider using pictorial and translated resources with patients to explain the process.
1.2	Confirm patient's identification. Record the patient's name, date of birth and UMRN number on the specimen vial.	See WNHS policy: Patient Identification.
1.3	Ask the patient if they are of Aboriginal and/or Torres Strait Islander origin.	In accordance with the Australia Bureau of Statistics Indigenous Status Standard (external website), Aboriginal and/or Torres Strait Islander status may influence clinical management (e.g. those patients determined to be at intermediate risk).

	Procedure	Additional information
1.4	On the pathology request form record the following: • Patient identification (see 1.2 above) • Cervical screening and other relevant medical history (including gynaecological history) • Any cervical abnormalities visualised during the cervical examination • Aboriginal and/or Torres Strait Islander status • Country of birth; and • Main language other than English spoken at home (if applicable) • Clearly indicate that the sample was either clinician-collected or self-collected	Refer to the NCSP Pathology test guide (external website) for details what information to specify on the pathology request form. To access the patient's screening history contact the NCSR on 1800 627 701 or look up via the online Healthcare Provider Portal (external website). Where the form does not allow for Aboriginal and/or Torres Strait Islander status or culturally and linguistically diverse information to be collected, clearly write the information obtained in an appropriate space on the form.
1.5	**In addition to the above:** For **Clinician-Collected** sample: • Obtain verbal consent [3] • All women shall be offered a chaperone. The chaperone must be a NMHS-employed clinician. • Position the patient so they are comfortable. • Explain to the patient how the test will be taken	Refer to, and document (name, profession etc.) as per, NMHS Chaperone policy. A Chaperone Stamp is available in some areas. The NCSP – What happens when my healthcare provider collects my sample (external website) is a visual guide that can be given to patients to help them understand the process.

Role and benefits of the NCSR includes:

- maintaining a national database of cervical screening records
- inviting eligible people to commence cervical screening when they turn 25
- reminding participants when they are due and overdue for cervical screening
- providing participants' cervical screening history to laboratories to inform screening recommendations
- providing a 'safety net' for participants who are at risk and who have not attended further testing by prompting them to have follow-up tests.
- See NCSR (external website) for more details

Taking a clinician-collected cervical sample

Equipment

- Bi-valve speculum (plastic or metal)
- Cervex-Brush® / Cytobrush®
- Torch or extension light
- SurePath LBC collection vial
- Water based lubricating gel
- Kidney dish
- Sheet
- Examination gloves

Procedure (clinician-collected sample)

	Procedure	Additional information
1	**Preparation**	
	As per previous section 'Preparation'	
2	**Speculum insertion**	
2.1	Refer to section in Vaginal Procedures guideline: 'Speculum Examination'.	Provides instruction on performing a speculum examination.
3	**Taking the cervical sample**	
3.1	1. Insert the speculum. 2. Visually inspect the cervix. Note if the transformation zone is visible and whether the cervix appears normal, a variation of normal, or abnormal.	Offering the patient self-insertion of the speculum may help reduce feelings of vulnerability and powerlessness. Moisten and warm the speculum with warm water or a small amount of water-soluble and carbomer-free lubricant (taking care to avoid the tip of the speculum) (See WACCPP Use of Lubricants for Cervical Screening). Any abnormality noted on visual inspection of the cervix requires colposcopy referral.
3.2	If unable to locate the cervix: • Ask the patient to lift their buttocks and place a rolled towel under them or they can sit on their fists. • Withdraw the speculum and palpate the position of the cervix. Reinsert the speculum in the direction of the cervix. • Use a different size speculum.	If the lateral vaginal walls are bulging inwards, consider using: • A larger speculum; and/or • A condom over the speculum (cut off the reservoir tip of the condom).

Taking the cervical sample: GYNAECOLOGY	Taking the cervical sample: OBSTETRIC
Take the sample, ensuring the transformation zone is sampled when possible, using appropriate implement(s) (Cervex-Brush®, Cytobrush®). To capture adequate samples of both endocervical (glandular) and squamous cells), a Cytobrush® should be used in conjunction with the Cervex-Brush® in: • Women who have undergone surgery for a previous cervical abnormality • Women whose previous tests have shown no endocervical cells • Post-menopausal patients • Situations when the transformation is not visible (T3) The Cervex-Brush® is used to collect both endocervical and ectocervical cells and is the preferred implement for most women. An optimal cervical sample has: • Sufficient mature and metaplastic squamous cells to indicate adequate sampling from the transformation zone. • Sufficient numbers of endocervical cells, to ensure screening for glandular abnormalities.	1. Inform the woman that cervical screening can be performed in pregnancy.[1] 2. Collect the sample using the **Cervex-Brush®** as described below.  **Additional information:** Do **not** use the Cytobrush® in pregnancy.[1] Read REC14.11 and REC14.12 on next page. See also WNHS Flowchart for cervical screening in antenatal patients. **Note**: Cervical sampling should generally be delayed in cases of placenta praevia, vasa praevia and cervical insufficiency. If there is a strong clinical indication to collect in these pregnancies, it should be performed by a senior clinician.

Using the Cytobrush®	Using the Cervex-Brush®
• Gently insert the Cytobrush® into the cervical os. • Gently rotate Cytobrush® one quarter to one half of a turn in one direction. • Snap the head of the brush into the SurePath collection vial. **Additional information:** • Do not insert Cytobrush® out of vision • To reduce unnecessary bleeding, do not over rotate brush	• Insert the centre of the brush into the endocervical canal. • Rotate the brush five times in a clockwise direction, keeping bristles in contact with the ectocervix. • Use the interior rim of the SurePath collection vial to pull off the head of the brush and deposit into the SurePath vial. **Additional information:** If a large ectropion is present, ensure that a sample of cells is collected from beyond the border of this area as well.

	REC14.11: Cervical screening in pregnancy (external website) Routine antenatal and postpartum care should include a review of the patient's cervical screening history. Those who are due or overdue for screening should be screened. REC14.12: Cervical screening in pregnancy (external website) A patient can be safely screened at any time during pregnancy, provided that the correct sampling equipment is used. An endocervical brush should not be inserted into the cervical canal because of the risk of associated bleeding, which may be distressing.

Follow-up

Antenatal patients: Follow-up of results through antenatal team / clinician. See also WNHS Pathway for Cervical Screening in Antenatal Patients.

Gynaecology clinics / EC patients: Cytology Nurse manages the CST results. Advise the patient that a letter advising of the result and any follow-up needed will be sent to:

- The patient themselves; and
- The patient's General Practitioner (GP)

Oncology / Colposcopy: Test results for patients attending Oncology and Colposcopy services are reviewed and managed by the attending doctor.

Procedure: Facilitating a self-collected vaginal sample

Self-collection provides a level of control, choice and removes a significant barrier to participation in screening. There are some groups that are less likely to screen, including:

- Aboriginal and/or Torres Strait Islander peoples
- Culturally and linguistically diverse communities
- People who identify as LGBTIQ+
- People with disabilities
- People who have experienced sexual violence
- Post-menopausal people and
- People who have had previous negative cervical screening experiences.

Self-collection may be more acceptable to these groups.

For asymptomatic patients, there is strong evidence that HPV tests on self-collected vaginal samples and clinician-collected cervical samples have equivalent sensitivity when using a PCR-based HPV test.

Eligibility

Anyone eligible for a CST under the NCSP now has the choice to screen either through self-collection of a vaginal sample using a simple swab (unless a co-test is indicated), or clinician-collection of a sample from the cervix using a speculum.

Self-collection is not appropriate for patients who require a co-test, for example because they:

- are symptomatic (e.g. experiencing unusual vaginal bleeding, pain or discharge),
- are undergoing Test of Cure surveillance following treatment of a HSIL result or have been treated for a glandular abnormality,
- have had a total hysterectomy with a history of HSIL, and
- have been exposed to diethylstilbesterol (DES) in utero.

Self-collection of a vaginal sample needs to be ordered and overseen by a healthcare professional who can also ensure timely clinician-collected testing if required as part of follow-up assessment, and for Medicare reimbursement. However, within that framework, healthcare professionals have flexibility to develop models of screening in collaboration with other healthcare workers, in order to best meet the needs of their patients and communities.

Refer to FAQs for Providers (external website) for key self-collection updates within the NCSP Clinical guidelines.

Procedure (self-collected sample)

	Procedure	Additional information
1	**Preparation**	
	As per previous section 'Preparation'	
2	**Self-collection of a vaginal HPV sample**	
2.1	Provide the patient with: • Self-collection instruction sheet and talk through each step • Self-collection information sheet • A swab approved for use in self-collection	The self-collection instructions (external website) and information sheet (external website) can be downloaded, printed and provided to the patient. The self-collection instructions are a visual guide to help people understand how to collect their test. There is a visual guide (external website) to help people from culturally and linguistically diverse communities understand the test. There are also videos which explain how patients can take their own sample: • video (external website) • video (external website) for Aboriginal and Torres Strait Islander patients. The sample medium for a self-collected HPV test will vary between pathology laboratories, but for PathWest is the COPAN FLOQswab 552c (red top).
2.2	Provide the patient with a private space to collect their sample (e.g. behind a curtain or in the bathroom).	If patient not comfortable collecting their own vaginal sample, the sample may be collected by the healthcare provider. If this occurs, still request 'HPV test, self-collected sample' on the request form.
2.3	Place the self-collected sample and pathology request form in a specimen bag for transport to the laboratory.	
3	**Self-collection: OBSTETRIC**	
	Inform the patient that cervical screening can be performed safely in pregnancy	**Note**: Cervical sampling should generally be delayed in cases of placenta praevia, vasa praevia and cervical insufficiency. If there is a strong clinical indication to collect in these pregnancies, it should be performed by a senior clinician.

	Procedure	Additional information
	Pregnant patients are suitable self-collection	REC14.11: Cervical screening in pregnancy (external website) Routine antenatal and postpartum care should include a review of the patient's cervical screening history. Patients who are due or overdue for screening should be screened. See WNHS Pathway: Cervical Screening in Antenatal Patients REC14.13: Self-collection in pregnancy All patients who are due for cervical screening during pregnancy may be offered the option of self-collection of a vaginal swab for HPV testing.
4	**Follow-up**	
	As per follow-up processes for clinician collected samples	

WNHS pathway: Cervical screening in antenatal patients [NEW Nov 2022]

Review Antenatal Patient's Cervical Screening History at Booking Visit

>25 years old **AND** never screened or overdue for routine cervical screening

Requires a co-test for:

- Follow-up testing for previous abnormal test or following treatment of HSIL or glandular abnormality
- abnormal / unexplained PV bleeding or discharge, or symptoms

Offer clinician-collect or self-collect sample: provide CST information sheet and self-collect instruction sheet, if appropriate

Cervex-Brush

Encourage patient to obtain self-collect sample whilst on-site (behind curtain in consult room or in clinic toilet)

Use pre-printed CST path form

Clinician-collect sample using Cervex-Brush

Delay sampling if placenta praevia, vasa praevia, cervical insufficiency.
If strong clinical indication senior clinician to perform.

Cytobrush

At next medical appointment

Unsatisfactory HPV test → Retest HPV in 6–12 weeks

HPV not detected → Routine 5-yearly screening

HPV detected (16/18) → eReferral KEMH: Gynaecology→ Colposcopy

HPV detected (not 16/18) → Management as per routine cervical screening pathway

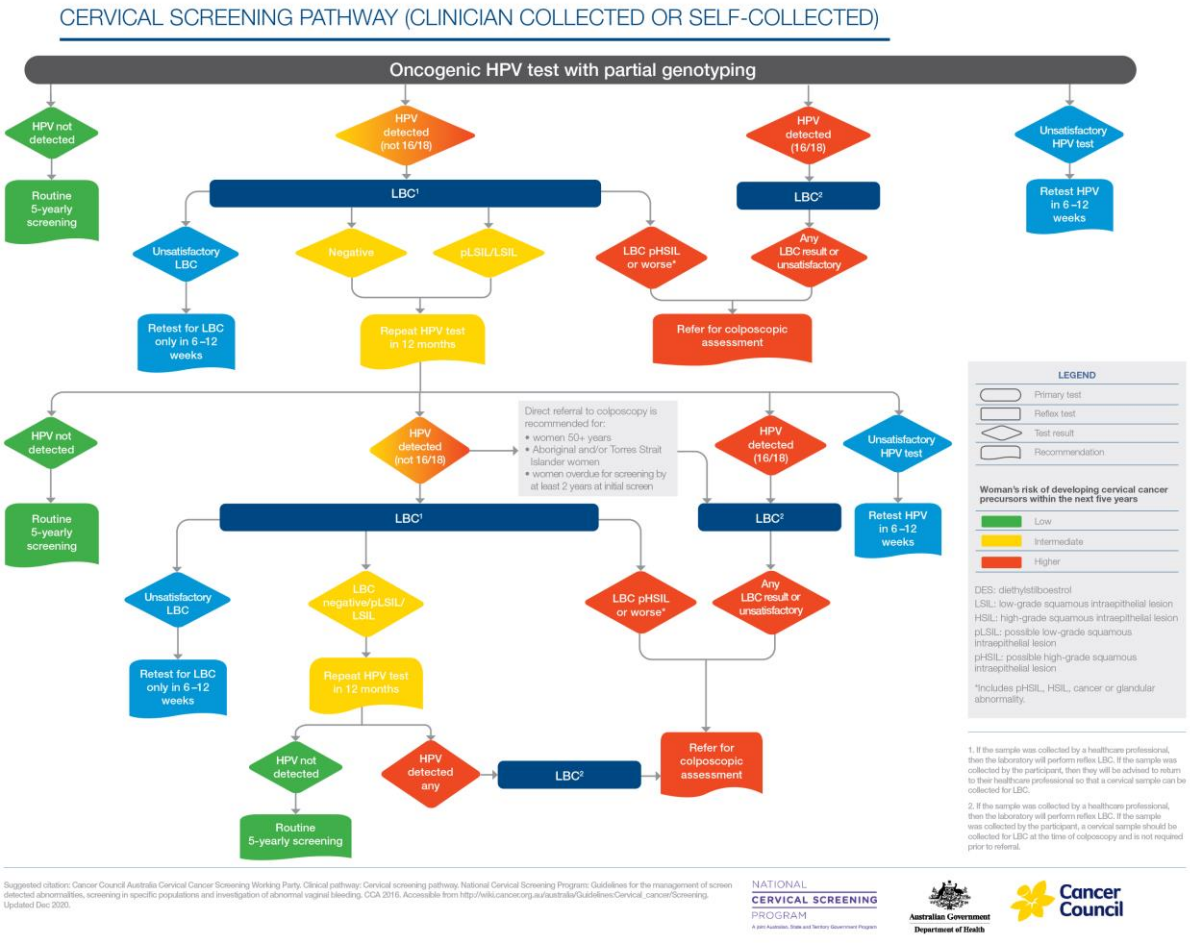
Interpreting results and management

The screening pathway

The Cervical Screening Test and pathway is a risk-based approach to the management of patients participating in the NCSP. Patients are managed according to their risk of developing significant cervical abnormalities. For more information about the risk-based approach refer to Understanding the NCSP Management Pathway: A Guide for Healthcare Providers (external website).

The screening pathway below and the results matrix (on next page) outline how the risk categories and management strategies are determined based on HPV and LBC (if performed) results.

Cervical screening pathway (clinician-collected or self-collected)



Acknowledgment: Cancer Council Australia Clinical Guidelines: Cervical Screening: Cervical Screening Pathway (PDF, 121KB, external website).

Results matrix: Cervical Screening Test results and LBC guidance – clinician-collected and self-collected samples

Risk of significant cervical abnormalities	HPV test result	LBC	LBC result	Recommended management
Low-risk result	HPV not detected	Not required	-	Return to screening in 5 years
Intermediate risk result	HPV detected (not 16/18)	Yes If self-collected recommend patient returns for clinician-collected LBC	Negative, pLSIL or LSIL	Repeat HPV test in 12 months
	HPV detected (not 16/18) (12 or 24 month repeat)	Yes If self-collected recommend patient returns for clinician-collected LBC	Negative, pLSIL or LSIL	Repeat HPV test in a further 12 months
Higher risk result	HPV detected (not 16/18)	Yes If self-collected, recommend patient returns for clinician-collected LBC	pHSIL, HSIL or any glandular	Refer to specialist (colposcopy)
	HPV detected (16/18)	Yes If self-collected, LBC collected at time of colposcopy, not required prior to referral	Any result	Refer to specialist (colposcopy)
-	Unsatisfactory	-	-	Collect new sample for HPV only in 6-12 weeks
-	HPV detected (not 16/18)	Yes If self-collected recommend patient returns for clinician-collected LBC	Unsatisfactory	Collect new sample for LBC only in 6-12 weeks

Acknowledgement: National Cervical Screening Program – Understanding the National Cervical Screening Program Management Pathway (external website). See 'Understanding the risk categories' (pp14-17) for a full explanation of strategies.

Risk categories

Low risk

Low-risk result means HPV was not detected. **Patients with a low-risk result should be invited to screen again in 5 years.**

Intermediate risk

An intermediate-risk result means HPV (not 16/18) was detected and on LBC, there

were either no cell changes or possible LSIL, or LSIL.

Patients with an intermediate risk result will be invited to return for a repeat HPV test in 12 months. This is to check if their body has cleared the HPV infection.

If the sample was self-collected and HPV (not 16/18) was detected the patient should be asked to return for a clinician-collected LBC sample.

12 months after intermediate risk result

The patient should have a follow-up HPV test, and will receive one of the following possible results:

- HPV not detected on follow-up: **The patient can now safely return to 5-yearly screening, if they remain asymptomatic.**
- HPV detected (not 16/18) on follow-up: LBC should be performed. **If the LBC showed negative or pLSIL/LSIL patient should return for a second follow-up HPV test in a further 12 months.**
- **Some groups of people may be at higher risk of a high-grade abnormality and should be referred to colposcopy if HPV (any type) is detected at the 12 month follow-up tests**, regardless of the LBC result. These include people who:
  - were overdue for screening by at least 2 years at the time of their initial CST which detected HPV (not 16/18) test result
  - identify as Aboriginal and/or Torres Strait Islander
  - are aged 50 years or older.

24 months after intermediate risk result (12 months after follow-up HPV test)

The patient should have a second follow-up HPV test, and will receive one of two possible results:

- HPV not detected: **The patient can now safely return to 5-yearly screening**, if they remain asymptomatic.
- HPV detected (any type): This result means that there is a persistent HPV infection (any type). **The patient should be referred for colposcopic assessment**.

Higher risk

Any patient who has received a higher risk result should be referred for colposcopic assessment.

On routine screening:

- HPV detected (16/18): **Patients should be referred directly for colposcopic assessment because they are at higher risk of cervical cancer.** A colposcopy will determine if a biopsy is needed and this will determine if treatment is required. LBC will inform the colposcopic assessment.

- If the LBC showed invasive cancer the **patient should be referred to a gynaecological oncologist or gynaecological cancer centre for urgent evaluation**, ideally within 2 weeks.
- If the LBC showed pHSIL/HSIL or any glandular abnormality, the **patient should be referred for colposcopic assessment at the earliest opportunity**, ideally within 8 weeks.

On second follow-up HPV test after an intermediate risk result:

- HPV detected (not 16/18): If HPV (not 16/18) is detected at the 12 or 24 month repeat HPV test, LBC should be performed.
  - If the LBC showed invasive cancer the **patient should be referred to a gynaecological oncologist or gynaecological cancer centre for urgent evaluation**, ideally within 2 weeks.
  - If the LBC showed pHSIL/HSIL or any glandular abnormality, the **patient should be referred for colposcopic assessment at the earliest opportunity**, ideally within 8 weeks.

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Related NMHS and WNHS policies, guidelines and procedures

NMHS Chaperone policy

WNHS Obstetrics and Gynaecology:

- Vaginal Procedures (including Chaperone and Speculum sections);
- Gynaecological (Oncology) : Link to Classification and Staging of Cervical Cancers

Useful resources and related forms

- Department of Health WA: Safety and Quality in Healthcare: Procedure Specific Information Sheets: NMHS: KEMH: Colposcopy and LLETZ OG13 (WA Health employees access through HealthPoint)
- National Competencies for Cervical Screening Providers (external site) – see Appendix F of the NCSP Quality Framework (external website)
- Sexual Health Quarters (formerly Family Planning WA): Certificate in Sexual and Reproductive Health (Nursing)- Cervical Screening (external website)

Additional resources (external websites)

Australian Government: National Cervical Screening Program:

- Consumer information: Self-collection instruction sheet (July 2022) and What happens when my healthcare provider collects my sample (July 2022)
- Healthcare provider information: Quick reference– Self-collected vaginal sample ; Understanding the National Cervical Screening Program management pathway and Changes to the clinical management of women at intermediate risk – FAQ
- General resources and toolkit

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Cancer Council Australia.

- Cervical Cancer Control Policy- Cervical Cancer: Causes. Sydney: Cancer Council Australia. 2018.
- FAQ for Providers: Self-collection udpates to the National Cervical Screening Program Clinical Guidelines. June 2022.

National Centre for Immunisation Research and Surveillance [NCIRS]

- Evaluation of the National Human Papillomavirus Vaccination Program Final Report. 2018.
- Fact Sheets and other resources- Human papillomavirus: Human Papillomavirus (HPV) Vaccines for Australians: Information for Immunisation Providers. 2020.

NPS MedicineWise. National cervical screening program. 2022. Available from https://learn.nps.org.au/mod/page/view.php?id=7804

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists [RANZCOG]. Guidelines: Guidelines for HPV vaccine: C-Gyn 18. 2019.

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Author / Reviewers:	Medical Consultant, Clinical Lead Colposcopy; Senior Registrar Obstetrics and Gynaecology; Senior Program Officer WACCPP		
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Version history

Version number	Date	Summary
1	Nov 2022	First version. **History**: Previously a chapter within the Vaginal Procedures guideline. Prior to 2017, was called 'Papanicolaou (Pap) Smear'. Contact OGD Guideline Coordinator for archived versions. **Changes** include: • National cervical screening program changed- Expansion of vaginal HPV sample self-collection option to all women eligible for CST (except if symptomatic, DES in utero, total hysterectomy with HSIL and/or undergoing test of cure). Read self-collection sections. • All CST sections updated and restructured format; New pathway for screening antenatal patients; Updated interpreting results section • Vaginal Procedures guideline separated into two- CST chapter removed to be stand-alone guideline • Inclusive language for women and people with a cervix

This document can be made available in alternative formats on request for a person with a disability.