

Task Force to Study Cervical Cancer Prevention, Detection and Education December 20, 2005 Meeting

MEETING SUMMARY

Members in attendance: Senator Nancy Sullivan (co-chair), Representative Lisa Marrache (co-chair), Representative James Campbell, Dina Cole, Bob Downs, Sharon Jerome, Dr. Michael Jones, Evelyn Kieltyka, Janet Miles, Dr. James Raczek, Dr. Molly Schwenn, Dr. James Wilberg,

Members absent: Dr. Kolawole Bankole, Dr. Carrie Bolander, Dr. Susan Miesfeldt, Dr. Jonathan Fanburg.

1. Cervical Cancer Clinical Guidelines

- Dr. Raczek presented information regarding the current cervical cancer screening guidelines of the: (1) the American Cancer Society (ACS), (2) the U.S. Preventive Services Task Force (USPSTF), and (3) the American College of Obstetricians and Gynecologists (ACOG).
- See meeting handout: “Table 1. Cervical Cancer Screening Guidelines”

Key Points Made in Presentation/Discussion:

- The recommended starting point for screening is similar across the three groups (ACS, USPSTF, and ACOG). However, recommendations for how often to screen for cervical cancer and when to stop screening differ across the groups. These differences are not surprising given that each group had its own process and methodology for developing its guidelines.
- It is important to remember that cervical cancer is primarily a consequence of HPV; very different from breast cancer in which you see the risk goes up as age increases; for cervical cancer you need to consider that the risk is based on behavior, including the number of sexual partners (past and present), use of condoms, etc. ; you need to ask those questions to determine the risk
- It is important to look at the national guidelines and recommendations within the context of Maine. Also, what is critical is having guidelines and then applying them to individual patients and to one’s own practice.
- With regard to trying to eliminate cervical cancer – theoretically you can prevent it with adequate screening; the question is what is adequate screening?
- The Maine Cancer Registry is going to do a chart review of women diagnosed with cervical cancer, with a focus on what screening services the patient received over the prior 12 months.
- It is important to keep in mind that this Task Force is designed to look at cervical cancer prevention, detection and education for *all women* in Maine; its scope is much broader

than the Maine Breast and Cervical Health Program (MBCHP). The goal is to look globally at what we can do for all women in Maine through publicly provided programs (MaineCare, MBCHP), community-based programs, through the private health care system, etc.

2. Clinical and Technological Issues

- Dr. Jones presented information on several clinical and technological issues relating to cervical cancer prevention and detection, including: cervical cancer screening failures, the conventional Pap and the Thin Prep, the relationship between HPV and cervical cancer, and the development of HPV vaccines.
- See meeting handouts:
 - Dr. Jones PowerPoint slides (Page 1 has “Cervical Cancer Death Rate” and “Cervical Cancer Prevention”)
 - “Pap Test Rates for Maine Women Ages 18+” (see OPLA handouts packet)
 - “Status of Licensure for New HPV Vaccines” (see OPLA handouts packet)
 - “Human Papillomavirus, Infections Agents Cancer.” Copy of presentation by Diane M. Harper, MD, MPH, MS (see OPLA handouts packet)
 - “Attitudes about HPV Vaccination: Health Care Providers and Parents.” Copy of presentation by Jessica A. Kahn, MD, MPH (see handouts OPLA packet)

a. Cervical Cancer Screening Failures

Key Points Made in Presentation/Discussion:

- Given the existing screening technology, it is estimated that 95% of cervical cancer could be prevented under perfect conditions. In reality, 30% of cervical cancer cases are not prevented as a result of imperfections, or failures, in the screening system. Screening failures can be divided into two major types:
 1. *Insufficient screening.* Approximately 65-70% of screening failures are the result of women not being screened, including women who are never screened and women who are not meeting the recommended guidelines for onset and frequency of screening, and
 2. *False negative screening.* Approximately 30-35% of screening failures are the result of “false negative” screening, in which a woman is screened but still develops cervical cancer.
- There is a long latency period for cervical cancer; older women are at low risk for exposure to HPV but they may still be at risk of developing cervical cancer from exposure at a younger age
- Several members suggested that it is likely that lack of screening and rates of cervical cancer are likely to be higher in the rural areas of the state (see information request below)
- Important to target education and outreach efforts to those sub-populations with low screening rates

b. Screening Technology – Conventional Pap vs. ThinPrep

Key Points Made in Presentation/Discussion:

- A number of advantages of the ThinPrep technology were identified, including:
 - More effective than conventional Pap smear in detecting low-grade and high-grade lesions (specifically squamous intraepithelial lesions, or SILs)
 - Provides higher quality sample than conventional Pap smear; ease of sample collection is a contributing factor
 - The sample is good for 30 days and can be used for follow-up testing for Human Papillomavirus (HPV) without requiring the patient to return for another test
- Despite the advantages of the ThinPrep Pap test, it was noted that the test does cost significantly more than the conventional Pap test and given the current lack of scientific evidence as to whether the ThinPrep will result in reductions in cervical cancer mortality, it is still unclear whether the additional cost is warranted. Nonetheless, it is clear that practitioners are increasingly using the ThinPrep instead of the conventional Pap test.
- About 80% of the Pap tests received in the MaineMed lab are collected by ThinPrep

c. HPV and Cervical Cancer

Key Points Made in Presentation/Discussion:

- The prevalence of HPV peaks in the mid-20s age group and then declines over time, but the latency of cervical cancer leads to increasing cancer rates over time; for women under 30 years, there is a high prevalence of HPV but it does not manifest as disease; new exposure to HPV goes down as age increases.
- While HPV is known to lead to cervical cancer, it is important to note that most HPV infections are “transient” and will resolve on their own without medical intervention and will *not* develop into cervical cancer.
- Because most cases of HPV will not lead to cervical cancer, positive HPV test results provide less information (have less predictive value) than negative HPV test results.
- HPV testing is increasingly being used to further evaluate Atypical Squamous Cells of Undetermined Significance (ASCUS) results from a routine Pap test and determine whether to proceed to a colposcopy (visual examination of the outer portion of the cervix using a colposcope to magnify and illuminate the area).
- Other drivers behind the use of the HPV test include its relatively high sensitivity for detection of high-grade intraepithelial lesion (HSIL) and the opportunity it presents to extend the screening interval for women 30 years or older who have a negative HPV test result.

d. HPV Vaccines

Key Points Made in Presentation/Discussion:

- Vaccines may be prophylactic (prevent development of disease) or therapeutic (for use once disease has developed)

- It is anticipated that the introduction of HPV vaccines may significantly advance cervical cancer prevention. At the same time, it is important to recognize that there will be a significant lag period between the introduction of the vaccines and a reduction in cervical cancer mortality rates, due to the latency associated with this disease.
- Two prophylactic HPV vaccines are currently in the pipeline for licensure by the U.S. Food and Drug Administration (FDA): (1) Gardasil, being developed by Merck, and (2) Cervarix, being developed by GlaxoSmithKline(GSK).
- While these vaccines are expected to be highly effective, acceptance of the vaccines among health care providers, parents and patients is an important practical challenge that will need to be addressed to fully realize the potential of these vaccines.

3. “At Your Cervix” Program

- Sara Hayes, FNP, Clinical Director, Tri-County Health Services presented information regarding their new cervical cancer prevention program: At Your Cervix.
- See meeting handout: “At Your Cervix”

Key Points Made in Presentation/Discussion:

- Tri-County Health Services (TCHS) provides reproductive health services and education to residents of Androscoggin, Franklin and Oxford counties.
- With a two-year grant from the Maine Health Access Foundation, TCHS launched At Your Cervix in July 2005 to enhance and expand its cervical cancer prevention effort and to reduce barriers to follow-up care after an abnormal Pap
- As part of At Your Cervix, TCHS has been able to:
 - Switch from conventional Pap tests to liquid based Pap tests at no extra charge to clients
 - Provide HPV testing for all atypical Pap test results,
 - Provide significant discounts for colposcopy, cryosurgery and cervical biopsy procedures,
 - Purchase equipment to perform colposcopies in all three counties,
 - Train a clinician in the Loop Electrical Excision Procedure (LEEP), a procedure to remove tissue from the cervix, and
 - Initiate new community outreach services including providing information to local providers (gynecologists and family practice physicians), distributing At Your Cervix information along with heating assistance program applications and hiring a Somali outreach worker for the Lewiston-Auburn area.

4. MaineCare Coverage of Cervical Cancer Screening/Treatment

- Maura Howard, Office of MaineCare Services, Department of Health and Human Services presented information regarding MaineCare services and expenditures related to cervical cancer.
- See meeting handouts:
 - “Routine Diagnostic and Cancer Treatment Expenditures – SFY04”
 - “Total Expenditures By Procedure Code for Pap Smears – SFY04”

- “Summary MaineCare Enrollment under the Treatment Act – By Year of Enrollment”

Key Points Made in Presentation/Discussion:

- As summarized in the table below, DHHS provided claims and expenditure data organized by diagnosis code (the client’s diagnosis) and other data organized by procedure code (the clinical procedure performed).

**MaineCare Expenditures Related to Cervical Cancer
State Fiscal Year 2004**

	# Distinct Claims	# Distinct Members	Total Paid
By Diagnosis Code (ICD-9)			
Routine Pap/Gynecological exam	31,850	23,546	\$1,510,609
Treatment/Evaluation of Abnormal Pap	37,801	21,304	\$2,101,414
Human Papillomavirus (HPV)	1,517	1,256	\$131,101
Cervical cancer treatment or care	1,755	564	\$832,836
By Procedure Code			
Cytopathology for Pap smear	39,290	33,320	\$579,418
Colposcopy/Biopsy/LEEP	2,113	1,825	\$118,675
HPV testing	2,069	1,964	\$27,642

- Staff also provided a handout, “Summary MaineCare Enrollment under the Treatment Act – By Year of Enrollment,” related to MaineCare coverage for cervical cancer under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 (the Treatment Act).
- To be eligible for MaineCare under the Treatment Act provisions, a woman must be under age 65, not covered by credible health insurance, and have income less than 250% of the federal poverty level. MaineCare coverage under these rules is continuous for one year as long as the woman is receiving cancer treatment.
- Since 2001, 88 women with cervical cancer or a pre-cancerous cervical cancer condition have been enrolled in MaineCare under these provisions. Of these women, 64% entered MaineCare with a diagnosis of cervical cancer and 36% entered with a pre-cancerous condition.

5. Follow-up Information Requests

- What is the geographical distribution of women in Maine diagnosed with cervical cancer? What is the geographical distribution of women in Maine who are **not** getting screened at the recommended intervals? Can we get data by county of residence?
 - Molly Schwenn agreed to look into what data can be released; there are issues regarding confidentiality due to small absolute numbers of cases in Maine.
- In the MaineCare data, for the 564 members with a cervical cancer diagnosis, how many of these are “invasive”? Can we get a breakdown of the 564 case by 5-digit diagnosis code?

- Need to follow-up with DHHS
- Could we get data from the private insurers regarding cervical cancer screening and treatment related procedures and numbers of cases?
 - Bob Downs suggested requesting such information from the Maine Health Data Organization (MHDO); it should be included in the “paid claims” database

6. Initial Planning for Next Meeting

Task Force members identified the following three areas to address at its next meeting:

- Continue to monitor the development of cervical cancer vaccines and invite representatives from the U.S. Centers for Disease Control and pharmaceutical companies (Merck, GlaxoSmithKline) to brief the Task Force on the vaccines;
- Examine available data on the geographic distribution of women in Maine who are not receiving sufficient cervical cancer screening services (including follow-up services after an abnormal Pap) and discuss potential strategies to reach these women; and
- Examine available data from the Maine Health Data Organization on cervical cancer screening and treatment service utilization and expenditures in both public and private health care systems in Maine.

Future Meeting Dates

The Task Force will reconvene after April 25, 2006. The next meeting date has not yet been determined.

Staff as of January 1, 2006:

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