



MANAGEMENT OF CERVICAL SCREENING AND HPV TESTING IN TYGERBERG HOSPITAL AND METRO EAST

- The incidence of cervical cancer cases in South Africa is 44.4/100 000.
- It is the second leading cause of female cancer in South Africa, the leading cause of cancer for females 15-44 and the most common cause of female cancer deaths in SA.
- The primary cause of cervical cancer is persistent infection with high-risk Human Papillomavirus (HPV), particularly types 16, 18, and 45.
- HPV is one of the most common sexually transmitted infections, affecting 70-80% of sexually active women at some point in their lives with at least one strain of the virus.
- There are also low-risk types that are not associated with cervical cancer. HPV 6 and HPV 11 cause genital warts (condyloma acuminatum).
- Cervical screening, in the form of HPV testing +/- cervical cytology (commonly referred to as a PAP smear), is used to identify women at high risk for pre-cancerous lesions.
- Once HR HPV is identified, intervention can be offered to prevent the development of cervical cancer.
- A patient with a macroscopic cervical lesion must have an urgent biopsy which must be sent for histology. Cervical cytology / HPV testing is an inappropriate investigation for these women.

WHO MUST GET CERVICAL SCREENING?

All healthy asymptomatic women without any pathology:

HIV negative: First HPV test at age 30 years and every 10 years if the result is HPV negative.

WLHIV: HPV test at 30 years and every 5 years if result is HPV negative.

20-30 years - Cytology at HIV diagnosis, NOT HPV test.

All new referrals to a gynaecology clinic must have an up-to-date cervical screen before referral.

SIGNS AND SYMPTOMS OF CERVICAL CANCER

- Abnormal vaginal bleeding between periods.
- Continuous vaginal discharge.
- Menstrual periods becoming heavier and lasting longer.
- Vaginal bleeding or pain during sexual intercourse.
- Increased urinary frequency.
- Vaginal bleeding after menopause.

WHAT TO LOOK OUT FOR WHEN DOING A CERVICAL SCREEN

Medical staff must do a full external and internal vaginal examination to look for any visible signs of sexually transmitted infections or any other pathology that will need attention. This includes genital warts, suspicious vaginal lesions or abnormal lesions on the cervix.

WHAT SHOULD WOMEN DO IN ORDER TO AVOID AN ABNORMAL SCREEN

Primary prevention

1. Young women should delay having sex.
2. Always use condoms.
3. General healthy lifestyle; stop smoking.
4. HPV immunization.

Secondary prevention

1. Have cervical screening every 10 years starting from the age of 30 to ensure early detection.
2. Seek medical help if signs and symptoms of infection or cervical cancer are present e.g. substantial and/or pungent vaginal discharges, lower abdominal pain, abnormal bleeding, etc.

HOW TO PERFORM A CERVICAL SCREENING

- Do the liquid-based HPV test with a cytobrush.
- Rinse the brush off thoroughly in supplied liquid medium (NOT formalin) for 15 seconds.
- Do not leave the brush head in the liquid medium container.
- On the cytology form under SPECIMEN TYPE - Tick or write HPV PCR screen/ Reflex cytology.

INTERPRETATION OF HPV TEST

- If HPV negative (low risk):
Next screen in 5 years for WLWH.
Next screen in 10 years for HIV-negative women.
- If HPV 16, 18, or 45 positive (high risk):
Patient should be referred to colposcopy for immediate treatment (LLETZ or thermal ablation).
Colposcopy with biopsy may be performed before treatment but is not mandatory. Follow-up HPV test in 12 months after treatment.
- If other hrHPV positive (non-16/18/45) (intermediate risk): See Table
Automatic reflex cytology will be done by NHLS.
If result is less than HSIL (e.g., ASCUS, LSIL): Follow-up HPV test in 12 months.
If result is ASC-H or HSIL: Refer to colposcopy for treatment (LLETZ or thermal ablation).
Follow-up HPV test in 12 months after treatment:

INTERPRETATION OF CERVICAL CYTOLOGY

	Other HrHPV positive / Cytology result	WHAT TO DO
LSIL	Low grade squamous intra-epithelial lesion	Repeat HPV test after 1 year; if second test positive and shows LSIL refer for colposcopy.
HSIL	High grade squamous intra-epithelial lesion	Refer for colposcopy ± LLETZ If pregnant: visualise cervix, if macroscopically normal, refer to a colposcopy clinic. If macroscopically abnormal, refer to the nearest gynae service for a biopsy.
AIS	Adenocarcinoma-in-situ	Refer to colposcopy clinic for urgent appointment
ASC-US	Atypical squamous cells of undetermined significance	Repeat HPV test after 1 year; if second test positive and ASCUS or LSIL refer for colposcopy.
ASC-H	Atypical squamous cells cannot exclude a high-grade lesion	Refer for colposcopy.
AGUS	Atypical glandular cells of undetermined significance	Refer for colposcopy and do endometrial sampling.
AGC	Atypical glandular cells (endocervical or not otherwise specified)	Refer for colposcopy and do endometrial sampling
SCC	Squamous cell carcinoma	If there is a cervical lesion the patient must be examined by a doctor immediately. A cervical biopsy must be done and then the patient should be discussed with the Gynae clinic the same day for further workup. If no identifiable lesion is visible please refer for an URGENT colposcopy.

Please refer patients to the closest colposcopy clinic. High risk lesions should ideally be referred within 3 months. The cervical cytology should not be more than 6 months old. If more than 6 months, the patient needs an examination of the cervix and a repeat cytology provided that the cervix looks normal.

Please attach the CERVICAL cytology/HPV result with a referral letter if any other concerns are noted

IF CTOLOGY RESULT SHOWS INFECTION

-Trichomonas infection: give 2g Metronidazole orally as a single dose to both sexual partners. Consider the full syndromic treatment for both, as there may be other underlying STI's as well (add Ceftriaxone 250mg IM as a single dose; and Azithromycin 1g, orally as a single dose).

-Candida infection: give clotrimazole vaginal cream daily (Give one tube)

-Gardnerella: (if the patient is symptomatic): give 2g Metronidazole orally as a single dose (not necessary to treat the sexual partner, as this is not a STI)

-It is not necessary to trace the patient for treatment if she does not return and the smear was normal

REFERRAL TO GYNAECOLOGY OUTPATIENTS

All patients referred for gynaecological problems should have an up to date cervical screening result available at referral; unless the patient has never been sexually active.

WHAT TO TELL THE PATIENT ABOUT THE REASON FOR COLPOSCOPY REFERRAL

- Please inform the patient about the findings of her HPV test and/or cervical cytology. Depending on what her individual cervical screening result is, she will be counselled and treated accordingly.
- For colposcopy the patient will be examined and counselled again before any procedure is performed.
- The patient must attend the clinic even if they are menstruating.
- The patient can eat and drink in the morning and should be encouraged to take all chronic medication as normal.
- The patient will go home the same day and will be able to go to work the following day.
- All forms of contraception should be continued and if the patient is pregnant, she must inform the medical staff on arrival.

FOLLOW UP AFTER LLETZ

If a patient has had a LLETZ procedure she will be given a copy of her notes and told to attend her local clinic in 6 weeks' time to check the results.

Result	What to do
CIN 1/HPV/ LSIL completely excised	Repeat HPV test in 1 year
CIN 1/ HPV/ LSIL incompletely excised	Repeat HPV test in 1 year
CIN II/III/ HSIL completely excised	Repeat HPV test in 1 year
CIN II/III/ HSIL incompletely excised	Repeat HPV test in 1 year
Carcinoma in situ completely excised	Refer to nearest Gynaecology OPD <ul style="list-style-type: none">- discuss hysterectomy
Carcinoma in situ incompletely excised	Refer to colposcopy urgently <ul style="list-style-type: none">- cold knife cone
Squamous cell carcinoma or moderately differentiated keratinizing carcinoma	Urgent referral to nearest referral hospital

- At the 12 month follow-up after the LLETZ procedure: repeat a HPV test and plan follow-up
- If the test is negative, the patient must have a repeat test in 5 years (if living with HIV) or 10 years if negative.
- Continue providing contraception
- If WLHIV please continue ARTs
- Advise the patient to stop smoking if she is smoking

FOLLOW UP AFTER HYSTERECTOMY FOR CIN LESIONS

After a hysterectomy for CIN the patient will be booked for follow-up at the gynae clinic at 6 weeks to review the result. If no cancer found, she will be down referred to the local clinic for a repeat HPV test in 12 months. Do a HPV test at local clinic in 12 months

- If negative, repeat in 5 years, if HIV positive, 10 years if HIV negative.
- If HR HPV – do reflex cytology
 - refer back to colposcopy clinic as per guideline

COMMUNICATION

THE LOCAL CLINIC:

All women must return for their Cervical screening results.

Make the appointment for colposcopy and inform the colposcopy clinic of name of the referring clinic and attach the relevant result with the referral letter.

THE COLPOSCOPY CLINIC:

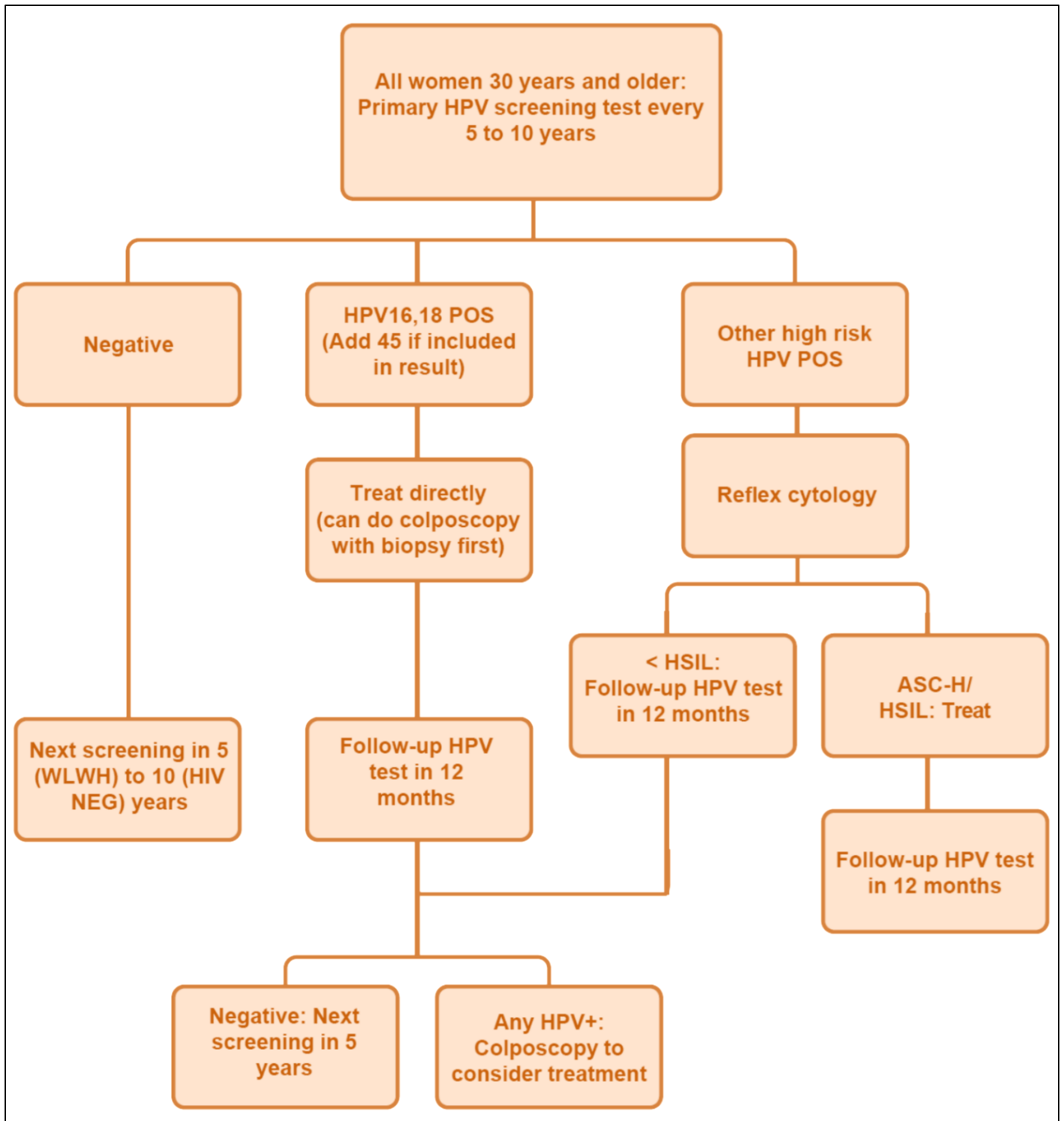
Supply the referring clinic with a copy of the written report of the procedure done.

COLPOSCOPY CLINICS AVAILABLE

Tygerberg Hospital: Clinics MONDAY, WEDNESDAY, THURSDAY	Ph 021 938 4428 Bookings will be taken after 11am
Khayelitsha Hospital: Clinic TUESDAY	Ph: 021 360 4548/4362
Helderberg Hospital: Clinic Alternate FRIDAY	Ph: 021 810 6668/6666
Karl Bremer: Clinic FRIDAYS	Refer via VULA
Paarl Hospital: TUESDAY and THURSDAY (and Outreach)	Ph: 021 860 2749
Worcester Hospital: TUESDAY and THURSDAY	Ph: 023 348 6453

Referrals as per gynaecology referral pathways.

HPV SCREENING ALGORITHM



Treat = Refer to colposcopy for LLETZ or Ablation

Abbreviations

- **AGC:** Atypical glandular cells (endocervical or not otherwise specified)
- **AGUS:** Atypical glandular cells of undetermined significance
- **AIS:** Adenocarcinoma-in-situ
- **ASC-H:** Atypical squamous cells cannot exclude a high-grade lesion
- **ASC-US:** Atypical squamous cells of undetermined significance
- **BSO:** Bilateral salpingo oophorectomy
- **CIN:** Cervical intraepithelial neoplasia
- **HIV:** Human Immunodeficiency Virus
- **HPV:** Human Papilloma Virus
- **hrHPV:** High risk HPV
- **HSIL:** High grade squamous intra-epithelial lesion
- **LLETZ:** Large Loop Excision of the Transformation Zone
- **LSIL:** Low grade squamous intra-epithelial lesion
- **NILM:** Negative for Intraepithelial Lesion or Malignancy
- **Pap smear:** Papanicolaou cervical smear
- **SCC:** Squamous cell carcinoma
- **STI:** Sexually Transmitted Infection
- **WLHIV:** Women living with HIV

Signed: Dr JL Butt



COMMITTEE RESPONSIBLE	Dr JL Butt; Dr M Bryan-Mc Innes, Prof S Gebhardt
ENQUIRIES	jbutt@sun.ac.za
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