

INFORMATION NOTE

**EUROPEAN GUIDELINES FOR QUALITY ASSURANCE OF
CERVICAL CANCER SCREENING AND DIAGNOSIS, 2nd
edition**

Background

Cancer of the uterine cervix primarily affects younger women, with the majority of cases appearing between the ages of 35 and 50, when many women are actively involved in their careers or caring for their families. In the European Union (EU) 34 000 new cases and over 16 000 deaths due to cervical cancer are reported annually. The burden of cervical cancer is particularly high in the new member states. The highest annual world-standardised mortality rates are currently reported in Romania and Lithuania (13.7 and 10.0/100 000, respectively) and the lowest rates in Finland (1.1/100 000).

Among all malignant tumours, cervical cancer is the one that can be most effectively controlled by screening. Detection of cytological abnormalities by microscopic examination of Pap smears, and subsequent treatment of women with high-grade cytological abnormalities avoids development of cancer (Miller, 1993). Cytological screening at the population level every three to five years can reduce cervical cancer incidence up to 80% (IARC, 2005). Such benefits can only be achieved if quality is optimal at every step in the screening process, from information and invitation of the eligible target population, to performance of the screening test and follow-up, and, if necessary, treatment of women with screen-detected abnormalities.

More than a decade has passed since publication of the first edition of the European guidelines for quality assurance in cervical cancer screening which was based on decades of experience in the EU Member States in implementation of regional and national cervical cancer screening programmes using the PAP test. The first edition of the European Guidelines for Quality Assurance in Cervical Cancer Screening established the principles of organised, population-based screening and was pivotal in initiating pilot projects in Europe. In the meantime, a number of countries have developed organised, population-based screening approaches, which are illustrated in the second guideline edition. It is hoped that this new guideline edition will have a greater impact on those countries in which opportunistic, rather than organised, population-based screening has been the preferred model in the past. Toward this end, considerable attention has been given to the essential aspects of developing an organised, population-based programme policy that minimises the adverse effects and maximises the benefits of screening. The current recommendations are also particularly relevant to planning new cervical cancer screening programmes in Europe. Different solutions fulfilling the recommended methodological standards need to be implemented in different countries and regions with diverse levels of resources and general healthcare infrastructure.

The current (second) edition has been developed by a multidisciplinary team of experts appointed by the European Commission from the former European Cervical Cancer Screening Network (ECCSN) established under the Europe Against Cancer Programme. In addition to the cytopathologists, epidemiologists, general practitioners, gynaecologists, histopathologists, virologists, and specialists in social science serving as editors and authors; experts from outside the ECCSN were also invited to write, review, and contribute to the development of the second edition. Besides the input of the 48

experts from 17 member states directly involved in the production of the guidelines, numerous comments and suggestions were provided by experts attending meetings held in Denmark, Finland, Greece, Hungary and Luxembourg from 2003 to 2006 by the ECCSN and the European Cancer Network (ECN) in which the former cancer screening networks have been consolidated in the current EU Public Health Programme.

Key aspects of EU guidelines

Quality assurance of the screening process requires a robust system of programme management and coordination, assuring that all aspects of the service are performing adequately. Attention must be paid not only to communication and technical aspects but also to qualification of personnel, performance monitoring and audit, as well as evaluation of the impact of screening on the burden of the disease.

Population-based screening policy and organisation conforming to evidence-based standards and procedures provide the overall programmatic framework essential to implementation of quality assurance and are therefore crucial to the success of any cervical cancer screening programme.

Establishment of screening registries and linkage of individual screening data with cancer registry data, taking into account appropriate data protection standards and methods, are essential tools of monitoring and evaluation.

The expanded (second) edition includes extensive updates on technical details and documentation, as well as assessment of new technologies, e.g.: liquid-based cytology, automated interpretation of Pap smears and testing for human papillomaviruses. The scope of the current guideline has also been extended to include comprehensive instructions prepared by a multi-disciplinary team of experts for general practitioners, gynaecologists and cytopathologists. Much more extensive recommendations on follow-up, diagnosis and management of women with positive cervical cytology have been added. This necessitated the incorporation in the second edition of a separate chapter on techniques and quality assurance in histopathology and, for the first time, detailed guidance for clinicians in dealing with abnormal cytology, including management according to the severity of cytological abnormalities and management of histologically confirmed cervical epithelial neoplasia.

A major further addition has been the inclusion of uniform indicators for monitoring programme performance and for identifying and reacting to potential problems at an early time. The indicators deal with screening intensity, test performance, and diagnostic assessment and treatment, and address aspects of the screening process that influence the impact, as well as the human and financial costs of screening. Standard tables have been provided for documenting screening policies, and for tabulating the person-based data used to generate the uniform performance indicators. The availability of these standardised tools will substantially improve data comparability and the exchange of experience and results between screening programmes in Europe. Such exchange, in turn, is essential to effective pan-European collaboration in implementing and continuously improving the quality and effectiveness of cervical cancer screening programmes.

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