

# Mini-commentary on BJOG-20-1770.R1

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## Risk stratification of HPV positive women in routine cervical screening

High risk HPV primary screening is replacing organised cytology-based screening based on increased sensitivity to detect high grade intra-epithelial neoplasia and the very high negative predictive value which will allow extended screening intervals. The benefit of increased CIN detection and cancer prevention needs to balance against the disbenefits to screen positive women in over investigation not east the psychological impact. For colposcopy services, the English cervical screening programme reported a 80% increase in colposcopy referrals in the first round of screening, creating huge pressures on service capacity (Rebolj M et al BMJ 2019;364:l240). The lower positive predictive value also impacts on colposcopy performance with a different referral population wit proportionately less high grade CIN present. In this issue of BJOG, Gori M et al provide observational data from a large longitudinal study of routine primary HPV screening in an organised quality assured cervical screening programme in 3 regions of Italy. Whilst routinely collected data from real-world programmes will have limitations, they do provide an insight into disease detection and importantly impact on colposcopy provision. In a comparison of triage strategies, combined HPV genotyping for HPV16 and high-grade cytology offered an acceptable balance of risk of CIN3+ with number of colposcopies needed to detect one lesion. These results differ from the English pilot (Rebolj M et al 2019 BJC;121(6):455-463) where HPV16/18 genotyping detected only 1.2% more cases of CIN2+ with 5.9% additional colposcopies. Gori M et al did not combine HPV16/18 but they did report that HPV18 on genotyping was not as clinically useful at baseline or 12-month follow-up. Furthermore, 90% of women screened were aged over 35 years when HPV screening is more clinically effective whereas the English pilot started screening at age 25 years when HPV infection is more prevalent and less likely to be clinically significant. Longer follow-up, importantly at the next screening round, is not yet available when the relevance of non-HPV 16 types may be more apparent.

The impact of the Covid 19 pandemic on health services and in particular screening, has sharpened the argument of risk stratification following primary screen positive testing both for service providers and those in the target population. Ciavattini A et al (2020 Int J Cancer 30(8):1097-1100) reported on suspension or postponement of cervical screening programmes across Europe relevant to both routine screening and onward referral to colposcopy. As services have needed to adapt to Covid infection rates and health service capacity, the ability to triage effectively and avoid unnecessary hospital visits is critical. Clinicians and women need information on their risk to inform clinical practice and provide reassurance. In the current second wave, the suspension of screening implemented in the first wave is no longer acceptable. Whilst data, such as these from Gori et al, continue to emerge from national and regional screening programmes, Covid has highlighted the need to be responsive and adaptive to allow cancer prevention to continue.