RLAG's FOR PREVENTION & SCREENING OF CERVICAL CANCER

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FIGO RIO DE JANEIRO 2018 COMMITMENT

We declare:

We, the participants of the XXII FIGO World Congress of Obstetrics and Gynecology held in Rio De Janeiro between 14th and 19th October 2018, hereby declare that, we will work collaboratively to scale up interventions with the aim of eliminating cervical cancer as a public health concern.

In line with cervical cancer elimination priority actions:

- Introduce and scale up HPV vaccination to achieve high coverage among girls by 15 years of age
- Introduce and scale-up HPV screening tests for women from 30 years and above and ensure appropriate management
- Increase access to diagnosis and treatment of cervical cancer and ensure palliative care with financial risk protection.

We agree to:

Undertake in all countries, in our various individual and collective capacities, to support efforts to promote the following actions for impact for girls and women worldwide:

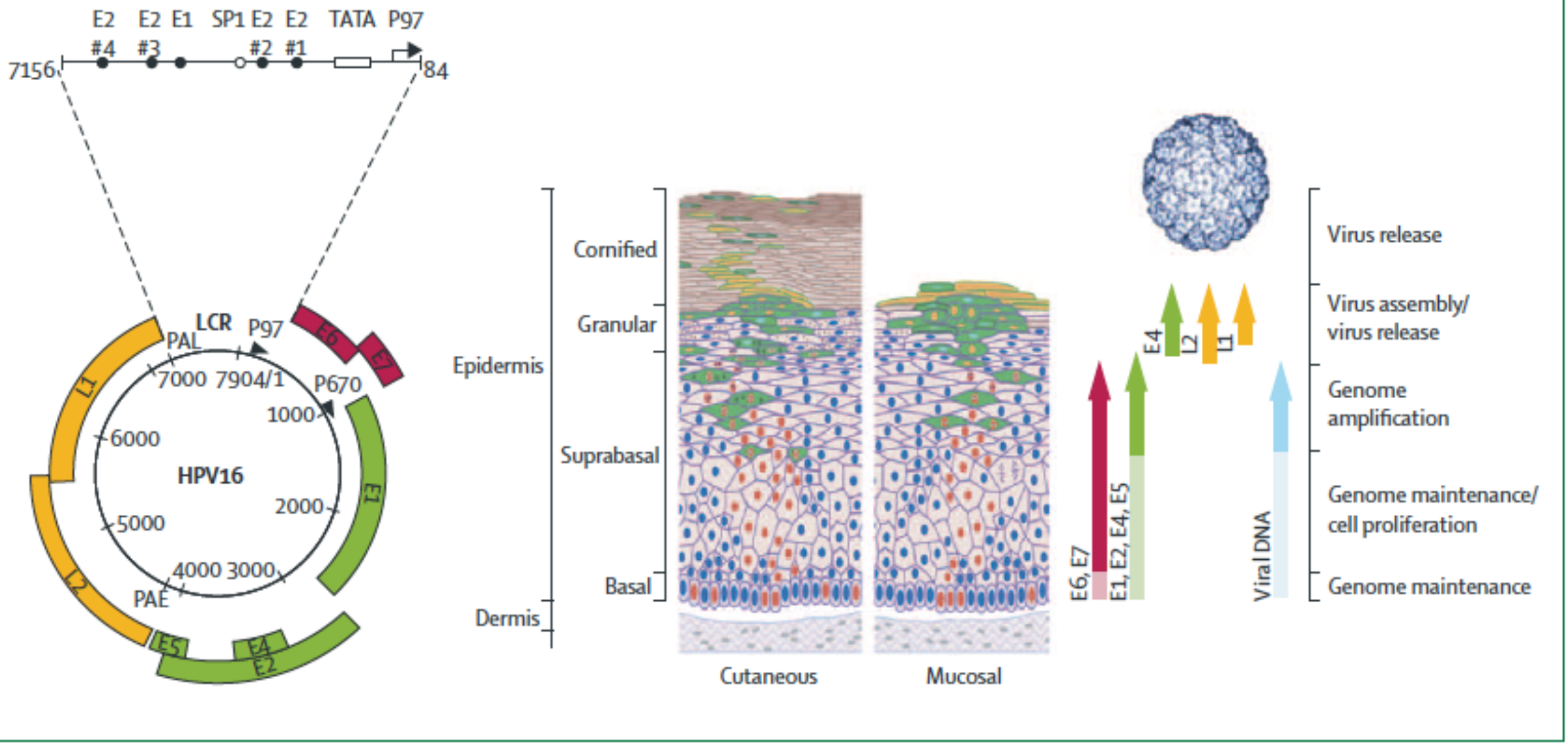
- Advocate for national cervical cancer strategies which align with the global call to elimination
- Establish capacity building efforts to expand the knowledge and skills of our membership to contribute to national elimination programmes
- Support countries in rolling out the HPV vaccine for adolescent girls and cervical cancer screening and adequate management for older women
- Ensure that FIGO quality of care and educational programmes promote and support regional and national elimination ambitions
- Contribute expertise to the emerging elimination programme of work, particularly supporting WHO and UNFPA updates of guidelines and technical guidance and their dissemination
- Harness FIGO collaborations and partnerships to promote cervical cancer elimination efforts in the context of overall wellbeing of women.

Rio De Janeiro 18 October 2018

End

BACKGROUND

- Cervical Cancer: preventable and treatable.
- WHO Cervical Cancer Elimination Initiative.
- Important disparity between countries: different outcomes.
- The role of HPV in this disease and the rationale in prevention.
- Lack of different health providers in some settings.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Dermis
Cutaneous
Mucosal
E6, E7
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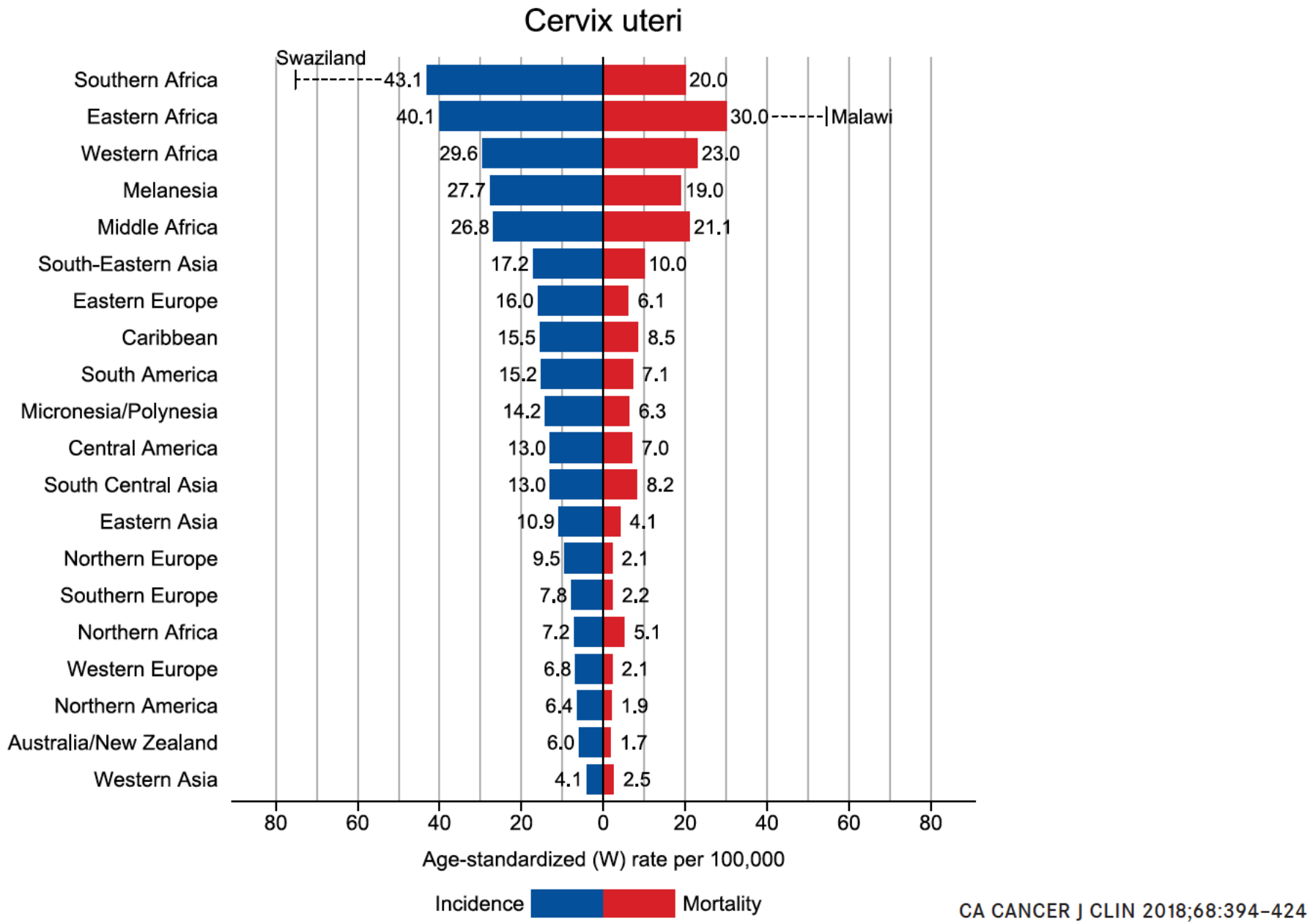
L1
Viral DNA
Virus release
Virus assembly/ virus release
Genome amplification
Genome maintenance/ cell proliferation
Genome maintenance



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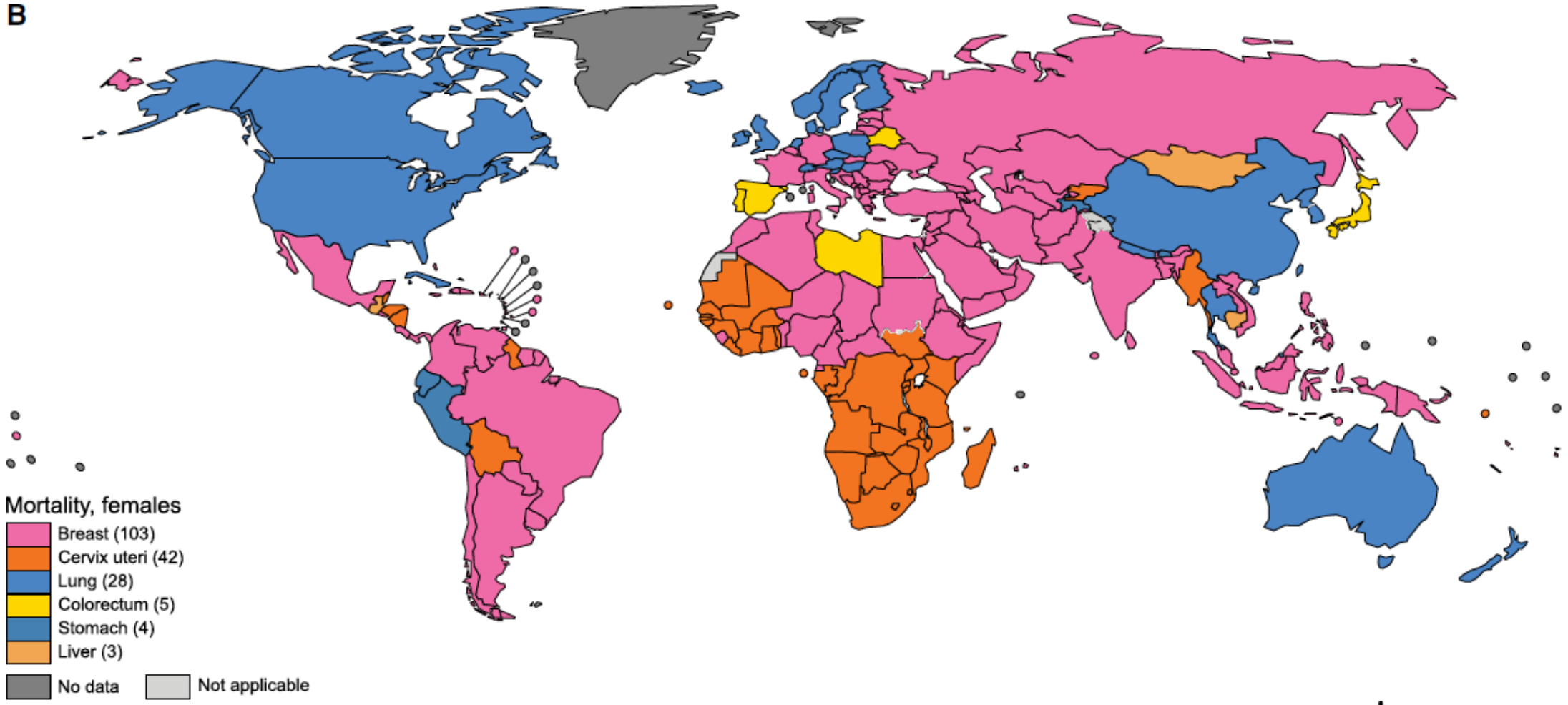


The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data source: Globocan 2018
Map production: IARC
World Health Organization

World Health Organization

special article

Primary Prevention of Cervical Cancer: American Society of Clinical Oncology Resource-Stratified Guideline

special article

Secondary Prevention of Cervical Cancer: ASCO Resource-Stratified Clinical Practice Guideline

RESOURCE STRATIFICATION

SETTING	DEFINITION
Basic	• Core resources or fundamental services that are absolutely necessary for any public health or primary health care system to function. • Single clinical interaction.
Limited	• Services that are intended to produce major improvements in outcome, such as incidence and cost effectiveness, and are attainable with limited financial means and modest infrastructure. • Services may involve single or multiple interactions.
Enhanced	• Resources or services that are optional but important. • Resources should produce further improvement in outcome and increase the number and quality of options and individual choice.
Maximal	• High Level or State of the Art. • Resources or Services that may be used or available in some high resource countries and/or may be recommended by high resource setting guidelines. • Do not adapt to resource constraints.

Anderdon BO & cols. Breast J 2006. Breast Health Global Initiative

PRIMARY PREVENTION: GUIDELINE QUESTION

WHAT IS THE OPTIMAL METHOD FOR PRIMARY PREVENTION OF CERVICAL CANCER IN EACH RESOURCE STRATUM?

PRIMARY PREVENTION: RECOMMENDATION

VACCINATION IS THE OPTIMAL STRATEGY FOR PRIMARY PREVENTION OF INFECTION BY SOME TYPES OF HPV THAT CAUSE CERVICAL CANCER IN THE TARGET POPULATION.

THERE IS NO OTHER PREVENTIVE STRATEGY FOR THIS MALIGNANCY.

PRIMARY PREVENTION: RESOURCE STRATIFIED

RECOMMENDATION	LIMITED RESOURCE SETTING	BASIC RESOURCE SETTING
WHICH COHORTS	• Girls as early as possible, between 9 – 14 yo.	• Girls as early as possible, between 9 – 14 yo.
NUMBER OF DOSES & INTERVALS	• Immune Competent Girls, 2 dose – regimen. • At least 6 months. • Up to 12 to 15 months.	• Immune Competent Girls, 2 dose – regimen. • At least 6 months. • Up to 12 to 15 months.
CATCH – UP FOR THOSE OUT OF THE PRIORITY GROUP	• Once have reached a minimum (>50%) for females who have received one dose and are >14 yo; additional doses or complete the series up to 26 yo.	• Once have reached a minimum (>50%) for females who have received one dose and are >14 yo; additional doses or complete the series up to 26 yo.
VACCINATION OF BOYS	• Not recommended if vaccination of girls >50%. • May be extended to boys if vaccination of girls <50% (Prev Cx Ca).	• Not recommended if vaccination of girls >50%. • May be extended to boys if vaccination of girls <50%. (Prev Cx Ca).

PRIMARY PREVENTION: SPECIAL POPULATIONS ALL SETTINGS

POPULATION	ALL SETTINGS
HIV (+) or IMMUNOSUPPRESSED	• Same ages recommendation. • Three doses.
PREGNANT WOMEN	• Not recommended.
WOMEN RECEIVING TREATMENT FOR PRECURSOR LESIONS	• Insufficient Data. • Not recommended.

SECONDARY PREVENTION: GUIDELINE QUESTION

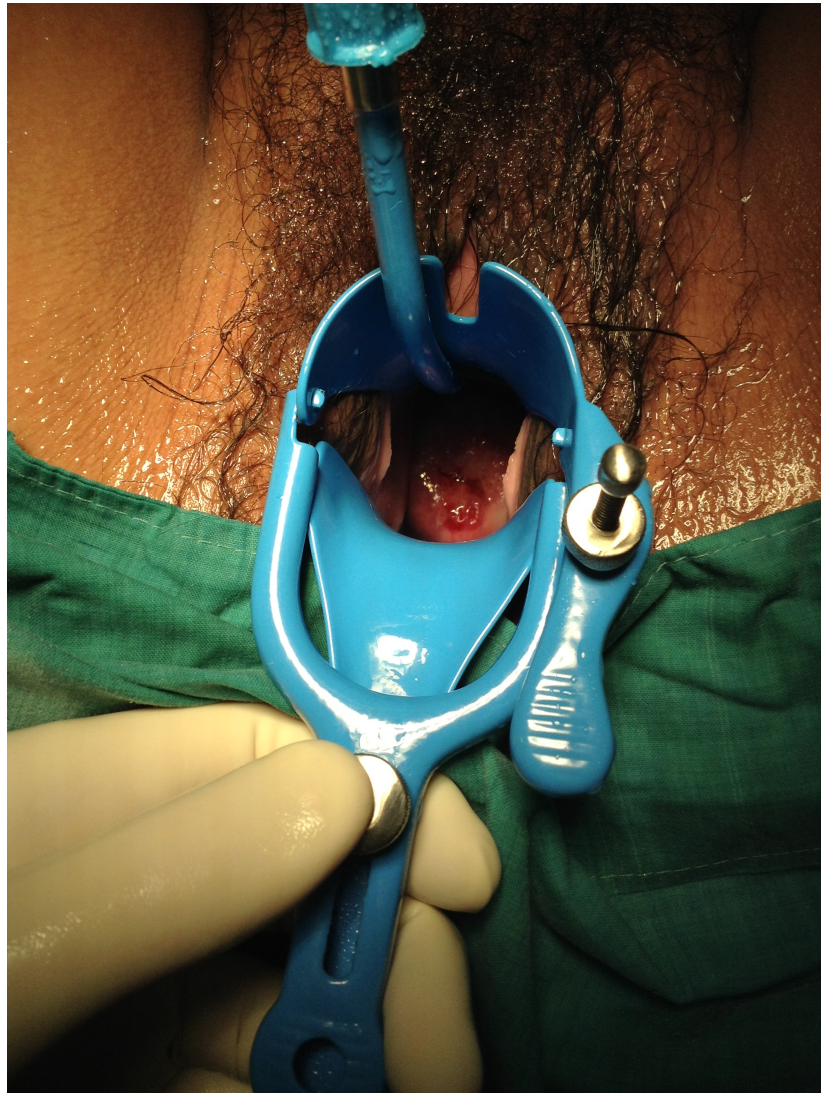
WHAT ARE THE OPTIMAL METHOD(S) FOR CERVICAL CANCER SCREENING AND THE MANAGEMENT OF WOMEN WITH ABNORMAL SCREENING RESULTS FOR EACH RESOURCE LEVEL?

SECONDARY PREVENTION: RECOMMENDATION

HPV DNA TESTING IS RECOMMENDED IN ALL RESOURCE SETTINGS.

SECONDARY PREVENTION: RESOURCE STRATIFIED

RECOMMENDATION	LIMITED RESOURCE SETTING	BASIC RESOURCE SETTING
PRIMARY SCREENING	• HPV DNA Testing.	• HPV DNA Testing. • VIA may be used.
AGE RANGES & FREQUENCY	• 30 – 49 yo. • Every 10 years.	• 30 – 49 years old. • 1 – 3 times per lifetime.
EXITING SCREENING	• <49 years.	• <49 years.
TRIAGE	• HPV Genotyping +/- Cytology.	• VIA if HPV DNA (+).
AFTER TRIAGE	• If (-) 12 months follow up. • If abnormal or (+), colposcopy if available or VIA if not available.	• If (-) 12 months follow up. • Treatment if there are abnormal or (+) results.
TREATMENT	• LEEP Procedure. • 12 month post treatment follow up.	• Cryotherapy. • LEEP Procedure. • 12 month follow up post treatment.
POSTPARTUM WOMEN	• Screening 6 months postpartum.	• Screening 6 weeks postpartum.



SECONDARY PREVENTION: SPECIAL POPULATIONS ALL SETTINGS

POPULATION	ALL SETTINGS
HIV (+) or IMMUNOSUPPRESSED	• HPV DNA as soon as diagnosed. • Frequency: twice as the general population. • Same treatment as the general population if (+) triage.
PRIOR HISTERECTOMY	• No need for screening unless the reason for the removal of the uterus was related to HPV/cervical dysplasia or cancer. • Normal screening if patient underwent subtotal hysterectomy.

UNANSWERED DILEMMAS

- Role of Self Collection.
- Recommended screening for women previously vaccinated.
- New technologies.
- Future directions.

TAKE HOME MESSAGES

REAL NEED FOR PRIMARY AND SECONDARY PREVENTION FOR CERVICAL CANCER.

SCREENING IS MANDATORY REGARDLESS WHETHER OR NOT GIRLS HAVE BEEN PREVIOUSLY VACCINATED OR NOT.

SCREENING REGISTRIES ARE CRUCIAL.

HUGE DIFFERENCES AMONG COUNTRIES AND AREAS.

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THANKS

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