



November 29, 2011

Dr. Robert Cosby
United States Preventive Services Task Force
540 Gaither Road
Rockville, MD 20850

RE: Comments on Screening for Cervical Cancer - U.S. Preventive Services Task Force Recommendation Statement

Dear Dr. Cosby:

The National Women's Health Network (NWHN) is a nonprofit advocacy organization that works to improve the health of all women by developing and promoting a critical analysis of health issues to influence policy and support informed consumer decision-making. The NWHN aspires to a health care system that is guided by social justice and reflects the needs of diverse women. We believe that evidence should drive the services offered and the information that is made available to women to inform their health decision-making and practices.

Cervical cancer screening is a vital part of the reproductive health services a woman needs over her lifetime. In the United States, there is a fairly robust system in place that provides widespread access to cervical cancer screenings, giving many women access to the information and care we need to stay healthy. There are still, however, some groups of women for whom access to screening is inadequate and who, therefore, experience unacceptably high rates of cervical cancer. At the same time, there are harms associated with over-screening that women with good access to health care may be more likely to experience. These two realities – of under-screening for some and over-screening for others -- derive from the diverse circumstances of women's lives in this country as well as the vagaries of the U.S. health care system, and they pose a challenge to women and clinicians seeking to make the best decisions for each woman's reproductive health. The NWHN appreciates the United States Preventive Services Task Force's (USPSTF) commitment to providing women and the clinicians who care for them with screening recommendations based on a thorough review of the most up-to-date and highest quality evidence.

The NWHN agrees with the USPSTF's recommendation that cervical cancer screening should begin at age 21 and end at age 65, and that testing should occur every three years. We understand that screening and early detection lower the risk of dying from cervical cancer, and that in women with healthy immune systems the disease progresses very slowly, making this an effective interval for

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detecting cell changes long before they are even potentially life-threatening. We also recognize that the screening itself is associated with harms and that a woman should not be subjected to these potential harms more often than necessary to protect her from developing cervical cancer. The USPSTF's age and frequency recommendations adequately balance the benefits of screening and the possible harms women are exposed to by undergoing that screening.

We are concerned, however, with the Task Force's limitation of the recommendation for cervical cancer screening to women who have had vaginal intercourse. While vaginal intercourse is the most common way the HPV virus is transmitted during sex, there is reason to believe that the types of HPV that cause abnormal cell changes can also be spread by direct skin-to-skin contact during other sexual activities. In light of these risks, the NWHN believes that women who have not had vaginal intercourse but are sexually active should also be screened regularly for cervical cancer. We urge the USPSTF to broaden its recommendation to include those women, as its previous 2003 recommendation did. The current, narrow recommendation will give both clinicians and women the understanding that a woman who has not had vaginal intercourse is not at risk of developing cervical cancer, creating systemic, economic and educational barriers to screenings that are essential to protecting women's health.

The NWHN also agrees with the USPSTF's recommendation against screening for cervical cancer using HPV testing, alone or in combination with cytology, in women younger than 30 years of age. As the Task Force notes, the data show that although HPV testing generally has a higher sensitivity, it also has a lower specificity than cytology. This lower specificity, meaning more false-positive tests, was seen more among women younger than 30 years of age due to the higher prevalence of HPV but lower incidence of cervical cancer. Women should not be subjected to redundant procedures that increase their likelihood of undergoing unnecessary diagnostic colposcopies and biopsies, treatments, and the subsequent harms associated with those procedures and treatments without significantly reducing their chance of developing cervical cancer. Potential negative consequences for women include the direct harms of unneeded cervical biopsies as well as adverse pregnancy outcomes associated with treatment, such as preterm delivery and its negative effect on infant health. Additionally, we support the Task Force's finding that insufficient evidence exists to make a recommendation on HPV testing, alone or in combination with cytology, for screening for cervical cancer in women ages 30 years and older. The NWHN vigorously believes that evidence needs to be the foundation for recommendations on health services. Until there are adequate data to determine whether HPV testing reduces the risk of developing cervical cancer in this age group, we support the USPSTF's decision to refrain from making a recommendation.

The NWHN's position on HPV testing is guided by our belief that evidence-based health care produces both the best outcomes for the health of individual women and the best use of health care resources. In addition to exposing women to risk without sufficient evidence of benefit, the dual cytology-HPV testing puts an unwarranted burden on the healthcare system, leading healthcare providers to perform unneeded tests and fueling health care spending with unnecessary costs.

As noted above, women in underserved communities and those who face cultural and linguistic barriers to health care do not have adequate access to cervical cancer screening. This lack of adequate access has resulted in dangerously high rates of cervical cancer and consequential high rates of mortality. Vietnamese American women experience a five times higher rate of cervical cancer than that of white women, and Korean American and Latina women have twice the rate of white women. In addition, black women diagnosed with cervical cancer have twice the mortality rate as white women. These health disparities are due to lack of health insurance, lack of or misinformation about Pap smears and

lack of culturally and linguistically appropriate services, barriers that prevent women from obtaining timely cervical cancer screenings. We know cervical cancer rates, with timely screenings, can be significantly reduced - introducing screening programs to populations naïve to screening reduces cervical cancer rates by 60% to 90% within three years of implementation. We also know that without those screenings and early detection, women face dire consequences - 85% of women who die from cervical cancer were never screened. Health care resources need to be spent on eliminating barriers and expanding access for women so they can stay healthy, not on redundant testing of women who are already being screened.

Sincerely,

Cynthia Pearson
Executive Director