



XXVIII

SCIENTIFIC MEETING

QUEENSTOWN, NEW ZEALAND 2023

Towards Elimination: 90-70-90

Millennium Hotel Queenstown, New Zealand
19 - 21 July 2023



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The registration desk will be open throughout the conference to answer any questions you may have and is located in the Gallery Foyer outside the Galaxy III.

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See opening hours below:

Wednesday, 19th July 2023, 5.00pm – 6.00pm (*Observatory Restaurant*)

Thursday, 20th July 2023, 7.45am – 5.30pm

Friday, 21st July 2023, 8.00am – 5.00pm

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INVITED INTERNATIONAL SPEAKERS

A/Prof Elmar Joura (Austria)

Prof John Doorbar (UK)

A/Prof Emma Allanson (Australia)

ASCCP COMMITTEE OF MANAGEMENT

Simon Hyde, President

Annabelle Farnsworth, Immediate Past President

Lois Eva, Vice President

David Allen, Secretary

Trevor Tejada-Berges, Treasurer

Mary Sparksman, Society Manager

Committee Members:

Patricia Guzman, Antonia Jones,

Georgina McPherson, Selvan Pather,

Supuni Kapurubandara (Co-opted), &

Yee Leung (Co-opted)

SCIENTIFIC PROGRAM

WEDNESDAY 19TH JULY 2023

1700 - 1800 Registrations Open

1800 - 2030 Welcome Reception

Observatory Restaurant

THURSDAY 20TH JULY 2023

0745 - 0820 Registration Open - Arrival Tea and Coffee

0820 - 1005 **SESSION 1: The Route to Elimination**

Chair: Simon Hyde

Galaxy Ballroom 1 & 2

0820 - 0835 Welcome & Mihi Whakatau

0835 - 0905 90-70-90 - **Elmar Joura**

0905 - 0930 HPV Transmission, Disease Biology and the Likelihood of HPV Elimination –
John Doorbar

0930 - 0955 The Next Frontier – Barriers to Elimination - **Emma Allanson**

0955 - 1005 Discussion/Questions

1005 - 1035 Morning Tea

Galaxy Ballroom 3

1035 - 1230 **SESSION 2: Report from NZ**

Chair: Lois Eva

Galaxy Ballroom 1 & 2

1035 - 1100 Implementing HPV Primary Screening: The New Zealand Experience -
Jane O'Hallahan

1100 - 1125 He Tapu Te Whare Tangata: HPV Implementation Studies - **Bev Lawton**

1125 - 1150 Let's Test for HPV: Implementing HPV Screening in NZ Primary Care - A Pilot
Study - **Peter Sykes**

1150 - 1210 Auckland HPV Self-Testing Implementation Research – Lessons Learned and
Potential Futures - **Karen Bartholomew**

1210 - 1230 Discussion/Questions

1230 - 1330 Lunch

Galaxy Ballroom 3

SCIENTIFIC PROGRAM

1330 - 1500	SESSION 3: Vaccination <i>Chair: Patricia Guzman</i>	<i>Galaxy Ballroom 1 & 2</i>
1330 - 1350	Refining our Understanding of Cancer Development at the Cervical Transformation Zone - John Doorbar	
1350 - 1410	Update on HPV Vaccination in Australia: The Move to Single Dose - Julia Brotherton	
1410 - 1430	Global Vaccination - Emma Allanson	
1430 - 1450	Post-Treatment Vaccination Research - Elmar Joura	
1450 - 1500	Discussion/Questions	
1500 - 1530	Afternoon Tea	<i>Galaxy Ballroom 3</i>
1530 - 1720	SESSION 4: Current Research and Challenges in Cervical Screening <i>Chair: Trevor Tejada-Berges</i>	<i>Galaxy Ballroom 1 & 2</i>
1530 - 1550	Equity of Access for LGBTQ - Karen Benattar	
1550 - 1610	Urinary HPV Testing in a Transgender Population - Elmar Joura	
1610 - 1620	Discussion/Questions	
1620 - 1630	Diagnostic Outcomes for Women Seen after Detection of Oncogenic HPV (Non-16/18) Considered as Intermediate Risk with Cervical HPV Screening. - Annabelle Huguenin	
1630 - 1640	Outcomes in Women Aged 50years plus After Detection of Oncogenic Human Papillomavirus (HPV) at Cervical Screening - Antonia Jones	
1640 - 1650	Audit of Cervical Excision Depth of Large Loop Excision of the Transformation Zone (LLETZ) and the Relative Rate of Positive Endocervical and/or Stromal Margins - Jasmine Schuijers	
1650 - 1700	Rates of High-grade Histology in Women Over 30 Referred with Low-grade Cervical Cytology in Relation to Ethnicity and High-risk Human Papillomavirus (HPV) Status - Jessica Stanners & Matthew Sollis	
1700 - 1710	The Impact of HPV Vaccination for Women Undergoing Cervical Screening in New Zealand - Peter Sykes	
1710 - 1720	Scope2: A Clinical Validation of Self-collection Using Copan FLOQSwab and Rovers Viba-Brush Eluted in Copan MSwab Media - David Wrede	
1900	Faculty Dinner	

SCIENTIFIC PROGRAM

FRIDAY 21ST JULY 2023

0800 - 0830 Registration Open - Arrival Tea and Coffee

0830 - 1030	SESSION 5A: Australia <i>Chair: Annabelle Farnsworth AM</i> <i>Galaxy Ballroom 1</i>	SESSION 5B: New Zealand <i>Chair: Georgie McPherson</i> <i>Galaxy Ballroom 2</i>
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0830 - 0900	Elimination Strategies in Australia - Marion Saville AM	New Screening Guidelines - Lois Eva
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0900 - 0925	Self-Collect Report - Annabelle Farnsworth AM	Updated Colp Standards - Deralie Flower
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0925 - 0955	National Cancer Screening Register: Update and Program Participation - Dorota Gertig	Parliamentary Review - Georgie McPherson
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0955 - 1015	Quality Assurance in Colposcopy/Screening - Yee Leung	Working in the HPV Primary Screening Programme: What Colposcopists Need to Know - Margaret Sage
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1015 - 1030	Discussion/Questions	Discussion/Questions
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1030 - 1100	Morning Tea	<i>Galaxy Ballroom 3</i>
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1100 - 1230	SESSION 6: Challenges in Accessing Screening and Treatment <i>Chair: David Allen</i>	<i>Galaxy Ballroom 1 & 2</i>
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1100 - 1120	Why We Don't Treat HPV - John Doorbar
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1120 - 1140	Access to Colposcopy for Indigenous Australian - Lisa Whop
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1140 - 1200	Marae Based Colposcopy – Increasing Access to Colposcopy for Wāhine Māori - Judy Ormandy
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1200 - 1220	National Cancer Screening Register: Cervical Abnormalities Referred for Colposcopy - Dorota Gertig
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1220 - 1230	Discussion/Questions
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1230 - 1330	Lunch	<i>Galaxy Ballroom 3</i>
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1330 - 1505	SESSION 7: Can We Eliminate Cervical Cancer? <i>Chair: Supuni Kapurubandara</i>	<i>Galaxy Ballroom 1 & 2</i>
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1330 - 1350	Why We Should Eliminate Cervical Cancer - Sandra Morrison
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1350 - 1410	Where We Are Now - Global Approach to Elimination - Emma Allanson
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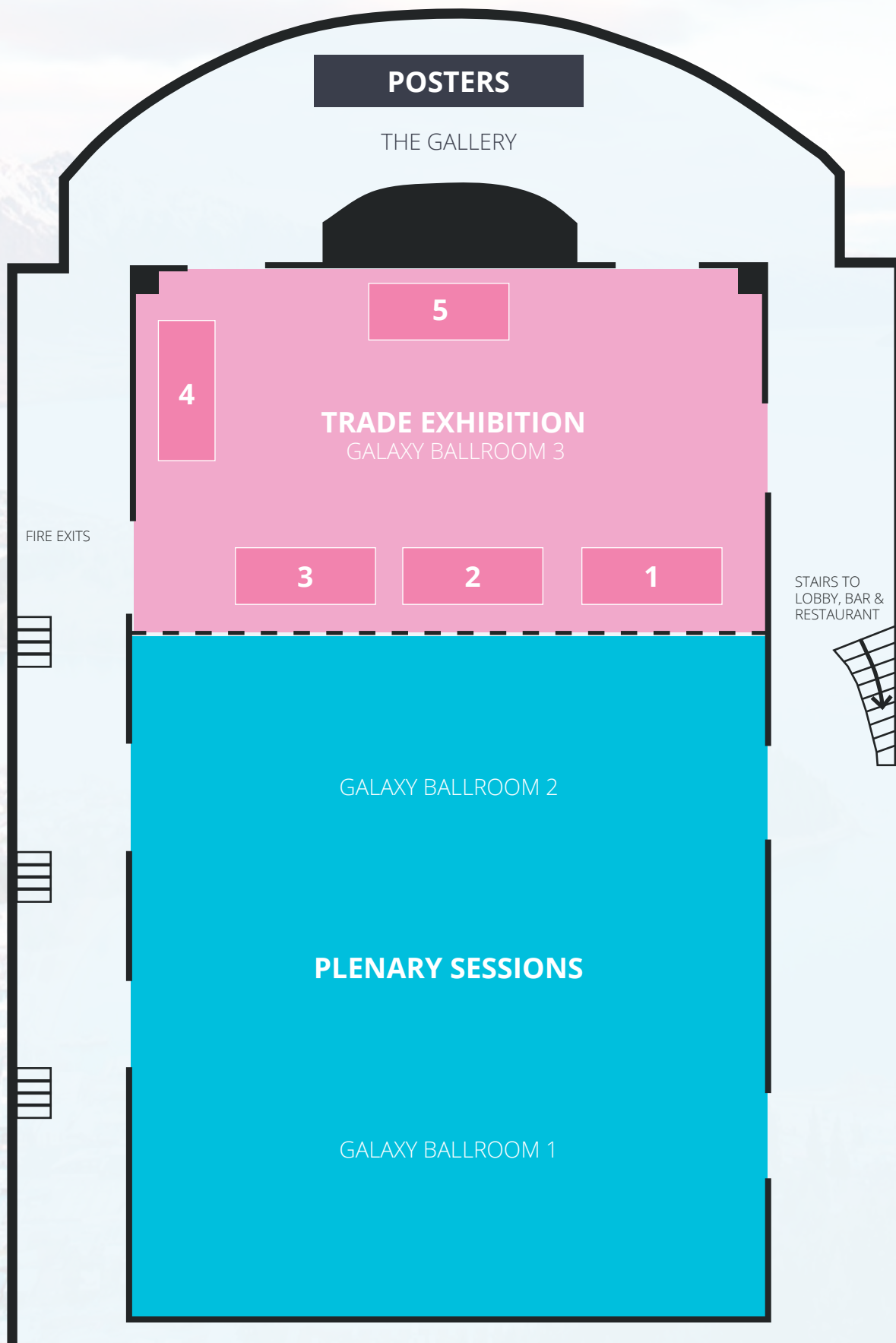
1410 - 1420	Discussion/Questions
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SCIENTIFIC PROGRAM

1420 - 1505	We Will Eliminate Cervical Cancer Debate Affirmative - Marion Saville, Emma Allanson, & Simon Hyde Negative - John Doorbar, Lois Eva, & Yee Leung	
1505 - 1535	Afternoon Tea	<i>Galaxy Ballroom 3</i>
1535 - 1650	SESSION 8: Case-Based Discussion <i>Chair: Toni Jones</i> <i>Panel: Elmar Joura, John Doorbar, Emma Allanson, Trevor Tejada-Berges, Patricia Guzman, Supuni Kapurubandara, Annabelle Farnsworth AM, & Georgie McPherson</i>	<i>Galaxy Ballroom 1 & 2</i>
1900 - 2300	Conference Dinner	<i>Eichardt's Grille</i>

**Program correct at time of publishing and subject to change without notice.*

FLOOR PLAN



POSTERS

- #1 A long way from home; anal cancer detected on cervical cytology - **Sophie Bittinger**
- #2 Self-sampling: What to expect utilising our previous experience with HPV16/18 positive CSTs? - **Rosemary McBain**
- #3 How can we measure the competency of diagnostic colposcopists? - **Niveditha Rajadevan**
- #4 Incidental diagnosis of endometrial cancer, prompted by routine cervical cytology. A retrospective case study - **Peter Sykes**
- #5 Knowledge of, and barriers to, HPV screening in selected general practices across New Zealand: A qualitative study - **Peter Sykes**
- #6 Cervical screening by HPV detection leads to earlier diagnosis of Adenocarcinoma in situ (AIS) - **David Wrede**

SOCIAL PROGRAM

Welcome Reception

Date: Wednesday 19th July 2023
Venue: Observatory Restaurant, Millennium Hotel
Queenstown
Time: 6.00pm – 8.30pm
Dress Code: Smart Casual

Conference Dinner

Date: Friday 21st July 2023
Venue: The Grille by Eichardt's Queenstown
Time: 7.00pm – 11.00pm
Dress Code: Cocktail

RESEARCH GRANTS

Submissions are open for 2023 ASCCP Research Grants. The aim of the ASCCP Research Grant is to fund small or pilot projects in any area of research relevant to the care of women with preinvasive or invasive cervical, vaginal, vulval or anal cancer undertaken by ASCCP members or their fellows as the principal researcher.

Submissions will close on **Friday 29th September 2023.**

For more information, please visit the ASCCP Website or contact the ASCCP Secretariat at asccp@yrd.com.au or +61 7 3368 2422.

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More details can be found on the [ASCCP Website](#).

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PROGRAM ABSTRACTS

THURSDAY, 20TH JULY 2023

SESSION ONE: THE ROUTE TO ELIMINATION / 0820 - 1005

Galaxy I & II

90-70-90

Elmar Joura

IN 2018 the WHO called to action to eliminate cervical cancer. A threshold of 4 cases/100,000women/year was set. The strategy to achieve this global goal is to vaccinate 90% of the girls under the age of 15 against HPV; test 70% of women at the age of 35-45 years twice for HPV and to treat 90%v of those being diagnosed for pre-cancer or cancer. The first country to achieve this will be Australia. The potential and various strategies of HPV vaccination will be discussed. HPV vaccination has the potential to prevent six cancers and disease related to HPV 6 and 11. HPV testing will replace cytology as a screening tool. Treatment is mostly assured in high income countries but not in low resource countries, where most of the cases occur.

HPV Transmission, Disease Biology and the Likelihood of HPV Elimination

John Doorbar

Vaccination has proved to be a remarkably effective way to control high-risk human papillomavirus infections. This success takes advantage of the particular vulnerabilities of the papillomavirus family, which are not shared by other viruses. The possibility of either HPV 'elimination' or 'eradication', which are distinct outcomes, can now be considered in the context of HPV diversity, ongoing virus evolution, and virus structure. The process of virus transmission and infection will be discussed, alongside the merits and limitations of a prophylactic-only vaccine that depends on the generation of long-term sterilising immunity. As human papillomaviruses are ubiquitous in the human population, preventative measures will need to be accompanied by improvements in treatment and therapeutics, and by ongoing advances in cervical screening.

The Next Frontier – Barriers to Elimination

Emma Allanson

Abstract not yet received.

SESSION TWO: REPORT FROM NZ / 1035 - 1230

Galaxy I & II

Implementing HPV Primary Screening: The New Zealand Experience

Jane O’Hallahan

Abstract not yet received.

He Tapu Te Whare Tangata: HPV Implementation Studies

Bev Lawton

HPV self-testing is coming to Aotearoa - soon. HPV self-testing is highly acceptable to wāhine. Self-testing will be key to the elimination of cervical cancer. We will report on a successful set of studies looking at HPV self-testing and ways of implementation. ‘Te Ara Waiora – Implementing HPV primary testing to prevent cervical cancer in Aotearoa New Zealand: a non-inferiority trial’ - conducted at primary care practices in Te Tai Tokerau/Northland, covering a diverse range of urban and rural areas. ‘He Tapu Te Whare Tangata - A model for empowering rural solutions to prevent cervical cancer’ - a randomised crossover trial conducted at rural primary care practices in Hawke’s Bay and Tairāwhiti. ‘Into the field’ - we take HPV self-testing outside of primary care practices and provide on-site testing and colposcopy at public events.

Let's Test for HPV: Implementing HPV Screening in NZ Primary Care – A Pilot Study

Peter Sykes

The lets test for HPV study is a ministry funded pilot study performed by the university of Otago. The aim of the study was to determine the impact of the introduction of HPV screening including the universal option of self testing. It was a pragmatic study involving a wide range of primary practice environments in several regions of NZ. We aimed to enroll 3000 women over a 6 moth period. The study enrolled over 3200 women from 17 general practices in 3 regions of NZ. We estimate 82% of eligible women took part in the study. Over 50% of women were more than 6 months overdue for their cervical screen. Almost 95% of screens performed were self tests and over 20% were performed at home. 13% of tests were HPV positive. While uptake appeared equitable there appear to remain inequitable barriers to cervical cytology and colposcopy. We conclude that the NZ HPV screening program will be the first predominantly self test program among wealthy nations. While this will improve access to testing it will introduce a number of unique challenges. We will share are preliminary data.

Auckland HPV Self-testing Implementation Research – Lessons Learned and Potential Futures

Karen Bartholomew

Abstract not yet received.

SESSION THREE: VACCINATION / 1330 - 1500

Galaxy I & II

Refining our Understanding of Cancer Development at the Cervical Transformation Zone

John Doorbar

Human papillomaviruses infect a diverse variety of epithelial sites, but typically cause cancers at only a subset of the sites that they infect. The cervical transformation zone lies between the stratified epithelium of the ectocervix and the columnar cells of the endocervix, and has an unusual epithelial structure which makes it particularly vulnerable to HPV-induced carcinogenesis. The way that HPV-associated cancers develop at this site will be considered in the context of this unique epithelial site, and our understanding of high and low-risk HPV biology. Our understanding of infection and disease progression at the cervix provides a general understanding of HPV-associated carcinogenesis at other sites, including the anal transformation zone and the oropharynx.

Update on HPV Vaccination in Australia: The Move to Single Dose

Julia Brotherton

Abstract not yet received.

Global Vaccination

Emma Allanson

Abstract not yet received.

Post-treatment Vaccination Research

Elmar Joura

HPV vaccination is most effective when given before the onset of sexual activity. However, it has been demonstrated that HPV vaccination before or soon after conization reduces the risk of subsequent or recurrent HPV related disease by more than 60%. Data are also available on benefits after HSIL of the vulva, the anus and genital warts. Data and potential mechanisms will be discussed.

SESSION FOUR: CURRENT RESEARCH AND CHALLENGES IN CERVICAL SCREENING /1530-1720

Galaxy I & II

Equity of Access for LGBTQ

Karen Benattar

In Aotearoa New Zealand 4.4% of the population aged 18 and over identified as being part of the LGBTQ+ population in 2021 (Stats NZ). Accurate population statistics for transgender and non-binary people are more difficult to find for Australia but 4% identified as being gay, lesbian or bisexual in 2020 (Australia Bureau of Statistics).

Local and international research studies repeatedly report reduced cervical screening uptake by people in the LGBTQ+ group.

Barriers to accessing care fall broadly into four themes:

Gaps in knowledge and awareness of both consumers and health providers.

Wider societal attitudes and providers' lack of cultural competency that result in stigma, discrimination and adverse healthcare experiences.

The type of examination required for cervical screening and colposcopy.

Systems designed for heterosexual cisgender women that fail to identify all people with a cervix, result in challenges to effective recall and provide unwelcoming resources and environments for the LGBTQ+ population.

The introduction of primary HPV screening offers an opportunity to improve access and acceptability of cervical screening for LGBTQ+ people. However improving access to cervical screening, colposcopy and treatment will require a broad approach informed by consultation with the community.

Urinary HPV Testing in a Transgender Population

Elmar Joura

Transpeople are an often medically underserved population. The majority of transmen has still a cervix in place and a low attendance for screening. The reason is that transmen feel uncomfortable with a screening for a gynecologic cancer, they experience the smear more painful as cis-women, but remain at risk. We decided to offer a screening which is gender-neutral and non-invasive. The present data from a study in 200 transpeople using the Colli-pee device for urinary sampling. The acceptance was high and we detected cases of HSIL of the cervix in this population. This technique offers opportunities for self-testing in otherwise underserved populations.

Diagnostic Outcomes for Women Seen after Detection of Oncogenic HPV (Non-16/18) Considered as Intermediate Risk with Cervical HPV Screening.

Annabelle Huguenin

1,978 women were seen at the Colposcopy Clinic, Royal Women's Hospital, Melbourne, from 1st December 2017 to 31st July 2020 with 'intermediate risk' HPV (non-16/18 types). There were 599 (30.3%) women with reflex cytology (LBC) Low grade (LSIL), 305 (15.4%) possible LSIL (pLSIL) and 1,074 (54.3%) with negative cytology.

225 women (11.4%) had histologically proven CIN2/3, there were no cases of Adenocarcinoma in situ or cancer, found up to 2 years from first colposcopy visit (FCV): 172 (76.4%) at FCV, 11 (4.9%) after cervical excision arranged when no CIN2+ was detected at initial colposcopy and 42 (18.7%) at subsequent reviews up to 2 years later.

Histological CIN2/3 was 16.9%, 11.5%, 8.3% and CIN3 was 6.3%, 3.0%, 3.5% when reflex LBC was LSIL, pLSIL and negative respectively.

Only 144 (7.3%) women were aged 50 and over, of these more had negative reflex LBC (68.8%) and less CIN2/3 (7.6%) compared with the younger cohort - 53.1% and 11.7% respectively.

More CIN3 was detected if seen for colposcopy after 1 intermediate risk HPV (7.9%) as compared to after 2 intermediate risk HPV (4.3%) or after 1 intermediate risk HPV with a prior LSIL cytology (3.9%). For those follow up to 2 years when there was no initial CIN2+, approximately 60% cleared the HPV infection.

The risk of CIN2/3 increases with the reflex LBC abnormality and inversely with patient age. We recommend ongoing audit to determine if women with non-16/18HPV and Low grade (LSIL) reflex LBC with a risk of 6.3% CIN3 would require earlier colposcopy than after 3 'intermediate risk' HPV.

Outcomes in Women Aged 50years plus After Detection of Oncogenic Human Papillomavirus (HPV) at Cervical Screening

Antonia Jones

464 women were seen in the Colposcopy Clinic at the Royal Women's Hospital from 1st January 2018 to 31st July 2020, with 292 (62.9%) positive for HPV16 or/and18 and 172 (37.1%) for HPV(not16/18). 54 (11.6%) had histologically proven CIN2+ including 7 cancers, up to 2 years after the First Colposcopy Visit (FCV):

48 (88.9%) detected at FCV or at excisional treatment ('Excision') arranged after no CIN2+ detected at FCV. There was no significant difference ($p=0.14$) in proportion of CIN2+ detected between the 2 groups, 'HPV16 or/and18' (9.9%) or 'HPV(not16/18)' (14.5%), nor within the different reflex cytology types. The positive predictive value (PPV) of high-grade impression at colposcopy was 63.6%. 243 (52.4%) had Type 3 transformation zone (TZ3) with 20 CIN2+ detected, 13 at FCV including all 3 cancers and 5 at 'Excision'. 214 (73.3%) with positive HPV16 or/and 18 had reflex negative cytology, of which seven had CIN2+ including 1 cancer but only 2 (1.4%) had CIN2+ when their repeat cytology at colposcopy was negative. Most CIN2+ was detected at first colposcopy or at subsequent excision.

We would encourage high biopsy rates at colposcopy and vigilance in selection for excisional treatment in TZ3 cases if there is no significant clinical or pathological suspicion of high-grade abnormality. There is a need to refine the algorithm for management of persistent HPV16 or/and18 infections with reflex negative cytology to reduce colposcopy referrals in women aged 50 and above.

Audit of Cervical Excision Depth of Large Loop Excision of the Transformation Zone (LLETZ) and the Relative Rate of Positive Endocervical and/or Stromal Margins

Jasmine Schuijers

Background

Excisional treatment of pre-malignant cervical disease is an effective strategy to prevent progression to invasive cervical cancer. LLETZ is the most commonly utilised cervical excisional method in Australia and has high rates of success. Incomplete excision, i.e., HSIL that extends to the endocervical or stromal margins, is a well-established risk factor for disease recurrence. This has subsequent impacts on oncological as well as pregnancy and psychosocial outcomes.

Objectives

To determine what proportion of LLETZ procedures were excised at the depth they were intended, to what degree this affected the presence of positive margins, and whether clinician experience influenced these results.

To compare clinicians' intended type of LLETZ with the actual depth of excision achieved, and analyse the rates of positive endocervical and stromal margins.

Standards

Public Health England (PHE) suggests that the depth of excision should be as intended in at least 95% of cases. In practice, the rate of incomplete excision after LLETZ procedures varies widely in the literature from around 5 to 25%. There is no national standard to guide the expected rate of complete LLETZ excision.

Methodology

Records from all LLETZ procedures performed between 1/6/22 and 8/12/22 at the Royal Women's Hospital (Melbourne, Australia) was retrospectively collected via the local electronic medical records system. Data collected included provider, intended type of excision (as per operation report), depth of specimen (as per pathology report), closest margin (endocervical and/or stromal), and confirmed pathological diagnosis.

Results

Data from 173 LLETZ were examined, the vast majority of which were undertaken by gynaecology oncology consultants. 77 (46.1%) were correctly performed, 64 (38.3%) were shallower than intended, and 26 (15.6%) were deeper than intended. Endocervical and/or stromal margins positive for HSIL or higher occurred in 21 (12.1%). 10 (47.6%) of these were excised correctly, 9 (42.9%) were too shallow, and 1 (4.8%) was too deep (the remainder was of unclear length). Consultants performed 51.8% of LLETZ at the depth they intended, compared to 32.4% of registrars. The rate of positive margins was 8.6% for consultants and 8.8% for registrars.

Conclusion

The majority of excisions were not performed at their intended depth. Those with positive margins were disproportionately type I excisions. Whether the excision was as intended or shallower resulted in comparable rates of positive margins. The rate of positive margins was also comparable between consultants and registrars.

Rates of High-grade Histology in Women Over 30 Referred with Low-grade Cervical Cytology in Relation to Ethnicity and High-risk Human Papillomavirus (HPV) Status

Jessica Stanners & Matthew Sollis

Background: New Zealand is commencing primary HPV screening in July 2023. As the upcoming recommendation for women with high risk HPV (non-16/18) and low-grade cytology is follow up testing at 12-24 months we wished to determine the burden of high-grade histology in a historical cohort of women with low-grade cytology by HPV status. We also wished to exclude the inequitable distribution of disease in this cohort of women.

Aims: Histological outcomes for women with low-grade cytology on initial smear, stratified by initial HPV result and ethnicity.

Materials and methods: A retrospective observational study of 789 women seen at Christchurch Women's Hospital Colposcopy Clinic from 1 January 2012 to December 31 2021. To achieve an equitable sample, all women of Māori, Pacifica, Asian, MELAA or unknown ethnicity were included, the number of European women were matched to wāhine-Māori.

Results: Of the study sample, 31.3% of women were referred with ASCUS and 68.7% with LSIL cytology. 11.8% of women were positive for HPV 16/18 and 48.1% positive for HPV non-16/18. HPV testing was unavailable for 12% of women. Of the women with HPV 16/18, 44.6% had histological CIN2 or above on subsequent biopsy, including CIN3, adenocarcinoma in situ and cancer. Of those with HPV non-16/18, 28% had histological CIN2 or above. Of those with histological HPV/CIN1 or above confirmed on biopsy, 23.2%, were wāhine-Māori, 25.9% European, 8.4% Pacifica, 30.0% Asian, 3.7% MELAA and 8.9% unknown ethnicity. Of women with histological CIN2 or above, 26.0% were wāhine-Māori, 27.7% European, 7.9% Pacifica, 26.6% Asian, 3.4% MELAA and 8.5% unknown ethnicity. 78 women (9.9%) did not receive a biopsy during any visits.

Conclusions: The majority of women with low-grade referral cytology will be positive for HPV non-16/18. Of women with HPV 16/18, the risk of CIN2 and above is greater than that of HPV non-16/18 and all cancers were confined to the HPV 16/18 group. However, the percentage of CIN2 and above in the HPV non-16/18 group is considerable. There did not appear to be any appreciable difference in rates of CIN2 or above histology between ethnic groups.

The Impact of HPV Vaccination for Women Undergoing Cervical Screening in New Zealand

Peter Sykes

The Nz HPV vaccination program utilising a 3 dose quadravalent vaccine (Gardasil) was introduced in 2008 for females up to the age of 25. Nz women are advised to undergo cervical cytology screening every 3 years. In 2019 the age of first screen increased from age 20 to 25. The benefits of cervical screening in New Zealand are however inequitable, screening coverage is greatest for European women and Maori have approximately double the risk of being diagnosed with cervical cancer.

The aim of this study was to link data from the National cervical screening register (NCSPR) and the National Vaccination register (NVR) to determine the impact of HPV vaccination particularly with regard to its impact on the occurrence of high grade cervical abnormalities and cancer.

This is a retrospective observational study. Data from the two registries was linked by NHI and then anonymised before being released to the authors. The data collected included demographic and encounter data for all women born from 1990 to 1999 and included cervical screening episodes up to Aug 2022.

When vaccination commenced in 2008 women born 1990 were 18 yrs old and women born 1991 were 17 and therefore were not eligible for vaccination at a younger age. Hence the age of vaccination drops by birth cohort until the cohort was young enough to be vaccinated as part of the school based program. The number of screening episodes decreases by successive birth cohorts.

The cumulative risk of both high grade cervical cytology and high grade cervical histology was reduced in women who had been vaccinated prior to the age of 18 compared to unvaccinated women.

Cervical cancer is rare in women under the age of 25 however we were able to demonstrate a marked reduction in cervical cancer histology in women vaccinated under the age of 18.

We were unable to demonstrate a reduction in the incidence of abnormalities by successive birth cohort in either vaccinated or unvaccinated women.

This study reports for the first time the prevention of cervical cancer by HPV vaccination in NZ and reaffirms the benefit of HPV vaccination for school age children. We also report a significant but more modest reduction in high grade cervical abnormalities.

It is important we continue to monitor the NCSPP and the NVR to ensure we optimise opportunities for cervical cancer prevention for all peoples from New Zealand.

Scope2: A Clinical Validation of Self-collection Using Copan FLOQSwab and Rovers Viba-brush Eluted in Copan MSwab Media

David Wrede

Introduction: The World Health Organization's Elimination Strategy includes the 2030 scale-up target of 70% of eligible people to be screened twice with a high - precision test. HPV-based cervical screening has created the opportunity for self-collection as a tool to increase access.

Methods: The Self-Collection or Practitioner-collection Evaluation 2 (SCoPE2) study recruited 400 participants attending for colposcopy. Participants who gave informed consent self-collected two samples, using a Copan FLOQSwab and a Rovers Viba-brush in random order, before a cervical specimen was practitioner-collected at colposcopy and eluted into a ThinPrep vial. The self-collected samples were shipped dry, stored for seven days then eluted in 5 ml of Copan MSwab media. All three specimens were tested on a range of clinically validated PCR-based HPV assays. Histological outcomes were available through to 6 months after recruitment.

Results: HPV positivity rates for the first 200 samples sets were 64.1% (mean across five HPV assays), 72.6% and 70.0% for the practitioner-collected, FLOQSwab and Viba-brush self-collected specimens. Preliminary data show the sensitivity for CIN2+ (n = 31) of HPV testing was 96%, 96% and 90% on practitioner-collected cervical and on self-collected FLOQSwabs and Viba-brushes; respectively. The average relative sensitivity estimates (self- vs practitioner samples) were 1.00 and 0.939, for FLOQSwab and Viba-brush, respectively.

Conclusion: Self-collection using cheap high-quality devices which can be transported dry are needed to increase accessibility both in low and middle-income countries and support screening in traditionally under- and never-screened populations in high-income countries. MSwab medium is cheap, non-toxic, does not contain alcohol and can be transported easily as it is not classified as a dangerous good. This validation demonstrates the clinical utility of two self-collection devices in combination with a non-toxic medium using a wide range of HPV assays.

FRIDAY, 21ST JULY 2023

SESSION FIVE A: AUSTRALIA / 0830 - 1030

Galaxy I

Elimination Strategies in Australia

Marion Saville AM

Abstract not yet received.

Self-collect Report

Annabelle Farnsworth AM

One of the most vital aspects of any publicly funded cancer screening programme is achieving a high level of participation in the program. Australia has had a successful cervical cancer screening programme for many years, but even before the introduction of HPV primary screening participation in the program was falling. Participation remains a significant issue in the renewed cervical screening programme and there is an acknowledged need for provision of this testing into marginalised groups, the ATSI, CALD and sexually diverse populations.

Universal self-collection was introduced into the Australian screening programme in July 2022 when all women eligible for routine screening could opt for a self-collect sample. The uptake of this as a collection method has been approximately 12% across Australia. Rates of detection of HPV have been significantly higher than in the clinician collected sample group in the DHM laboratory.

Although these results are promising numerous issues in implementation have arisen and highlight the need for significant increases in education amongst both the people presenting for cervical screening as well as the clinicians managing the self-testing protocol.

The importance of understanding of the pre analytical component of any pathology testing will be discussed. The significance of the collection method has been highlighted by data from the Dutch cervical screening programme. Self-collection was introduced when their HPV testing programme began in 2017. Analysis of the HPV detection rates in people who opted for self-collection showed lower rates than those with a clinician collected sample. Analysis of this information has highlighted a failure of the self-collection protocol, including the particular cell collection device. One of the issues remaining in the Australian

programme is the lack of validation of collecting devices in many laboratories throughout Australia.

In the Australian programme, self-testing is to be properly overseen by clinicians who understand the process, as it is vital that people with positive HPV on self-collect are managed appropriately. Follow-up return rates and issues with management will also be discussed.

National Cancer Screening Register: Update and Program Participation

Dorota Gertig

Abstract not yet received.

Quality Assurance in Colposcopy/Screening

Yee Leung

Abstract not yet received.

SESSION FIVE B: NEW ZEALAND / 0830 - 1030

Galaxy II

New Screening Guidelines

Lois Eva

On July 26th 2023 the long awaited move to primary HPV screening will occur. The new screening guidelines were published in June 2023 and we will discuss the sections of the guidelines with emphasis on key changes and potential impacts on colposcopy services in Aotearoa New Zealand.

Updated Colp Standards

Deralie Flower

Abstract not yet received.

Parliamentary Review

Georgie McPherson

HPV self-testing is coming to Aotearoa - soon. HPV self-testing is highly acceptable to wāhine. Self-testing will be key to the elimination of cervical cancer. We will report on a successful set of studies looking at HPV self-testing and ways of implementation. 'Te Ara Waiora - Implementing HPV primary testing to prevent cervical cancer in Aotearoa New Zealand: a non-inferiority trial' - conducted at primary care practices in Te Tai Tokerau/Northland, covering a diverse range of urban and rural areas. 'He Tapu Te Whare Tangata - A model for empowering rural solutions to prevent cervical cancer' - a randomised crossover trial conducted at rural primary care practices in Hawke's Bay and Tairāwhiti. 'Into the field' - we take HPV self-testing outside of primary care practices and provide on-site testing and colposcopy at public events.

Working in the HPV Primary Screening Programme: What Colposcopists Need to Know

Margaret Sage

Abstract not yet received.

**SESSION SIX: CHALLENGES IN ACCESSING SCREENING AND TREATMENT /
1100 - 1230**

Galaxy I & II

Why We Don't Treat HPV

John Doorbar

Current treatments for Human Papillomaviruses are relatively unsophisticated, and depend on lesion removal/destruction, or the modulation of the local immune response. Disease-recurrence is a major problem, particularly for genital warts. LLETZ treatment of HSIL is a more successful approach, but still has a 5% or so recurrence rate in the general population, rising to 30% or so in women living with HIV. The lack of specific antivirals, and the difficulties in developing therapeutic vaccines stand in marked contrast to the comparative ease with which papillomaviruses infection can be inhibited through prophylactic vaccination. Much of these recurrence difficulties can be understood by considering the biology of disease persistence, HPV immune evasion strategies, and HPV protein function. Our understanding of HPV molecular biology, is however providing new opportunities for targeted therapy, which should in due course impact the field.

Access to Colposcopy for Indigenous Australian

Lisa Whop

Abstract not yet received.

Marae Based Colposcopy – Increasing Access to Colposcopy for Wāhine Māori

Judy Ormandy

The introduction of HPV self-testing has the potential to increase access to primary cervical cancer screening in Aotearoa New Zealand. However, equitable access to colposcopy services is also needed if the benefit of HPV testing to reduce cervical cancer rates is to be realised.

This presentation will describe the piloting and establishment of a colposcopy service co-located at a mārae-based health clinic. The experiences of wāhine who attended the clinic were collated when they were invited to a kōrero / interview about their experiences of colposcopy.

The clinic was positively viewed by wāhine, particularly when compared with previous hospital experiences. Themes identified during the kōrero included

- Welcoming and friendly people
- Familiar, non-clinical environment
- Free, accessible parking
- The clinic was close to home
- Agency

Prioritising wāhine through the provision of culturally safe and accessible colposcopy has the potential to increase health equity. Community co-located clinics are a feasible alternative to hospital colposcopy services.

Wāhine: women

Kōrero: conversation, discussion

National Cancer Screening Register: Cervical abnormalities referred for colposcopy

Dorota Gertig

Abstract not yet received.

SESSION SEVEN: CAN WE ELIMINATE CERVICAL CANCER / 1330 - 1505

Galaxy I & II

Whakamaua kia tina...haumi...e hui e taiki e.

Our call to action to eliminate cervical cancer

Sandra Morrison

This session examines how the values and principles of Te Ao Māori can impact and encourage positive engagement between Māori women and the health sector thereby supporting the journey to eliminate cervical cancer. I draw on the experience of the SmearYourMea Charitable Trust founded by Talei Morrison which was established to prevent cervical cancer, a campaign that insisted on total whānau involvement to be successful. It is the journey of a whānau rather than the single individual. Despite Talei's passing in 2018, the work of the Trust continues and we continually advocate and assert the involvement of whānau, of manaaki through all levels of the system to whānau and to enhancing the rangatiratanga of the whānau for culturally safe care in order to eliminate cervical cancer.

Where We Are Now – Global Approach to Elimination

Emma Allanson

Abstract not yet received.

We Will Eliminate Cervical Cancer Debate

Affirmative – Marion Saville, Emma Allanson, & Simon Hyde

Negative – John Doorbar, Lois Eva, & Yee Leung

SESSION EIGHT: CASE – BASED DISCUSSION / 1535 - 1650

Galaxy I & II

Panel Discussion

Elmar Joura, John Doorbar, Emma Allanson, Trevor Tejada-Berges, Patricia Guzman, Supuni Kapurubandara, Annabelle Farnsworth AM, & Georgie McPherson



ASCCP Treatment Course 2023

2nd December 2023
Chris O'Brien Lifecare Sydney

[Registration open!](#)