this & that

10

OBGYN QUICK GUIDES · IF THIS, THEN THAT

NO.

Abnormal Cervical Screening

& colposcopy

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Obstetrics & Gynaecology

Triage & management

Verified against ASCCP · ACOG · ACS · NHS CSP · Canada · WHO — October 2026

Abnormal cervical screening & colposcopy

At a glance: the numbers to remember

≥4%	≥60%	0.55%	6 months	>7 mm
immediate CIN 3+ risk → colposcopy (ASCCP)	→ expedited treatment preferred (≥25 y, not pregnant)	5-year risk at or above this → repeat in 1 year	first HPV test after treatment; then 3-yearly for 25 y	excision depth, type 1 TZ (NHS CSP); aim <10 mm if fertility matters

US management follows the ASCCP 2019 risk-based guidelines and their 2023–2026 updates; the NHS Cervical Screening Programme (England) is set alongside where it differs, with society names marking each disagreement. Results are given in Bethesda terms with the UK equivalent in Section 2. **Abbreviations are listed in Section 13.**

01 Who, when and which test

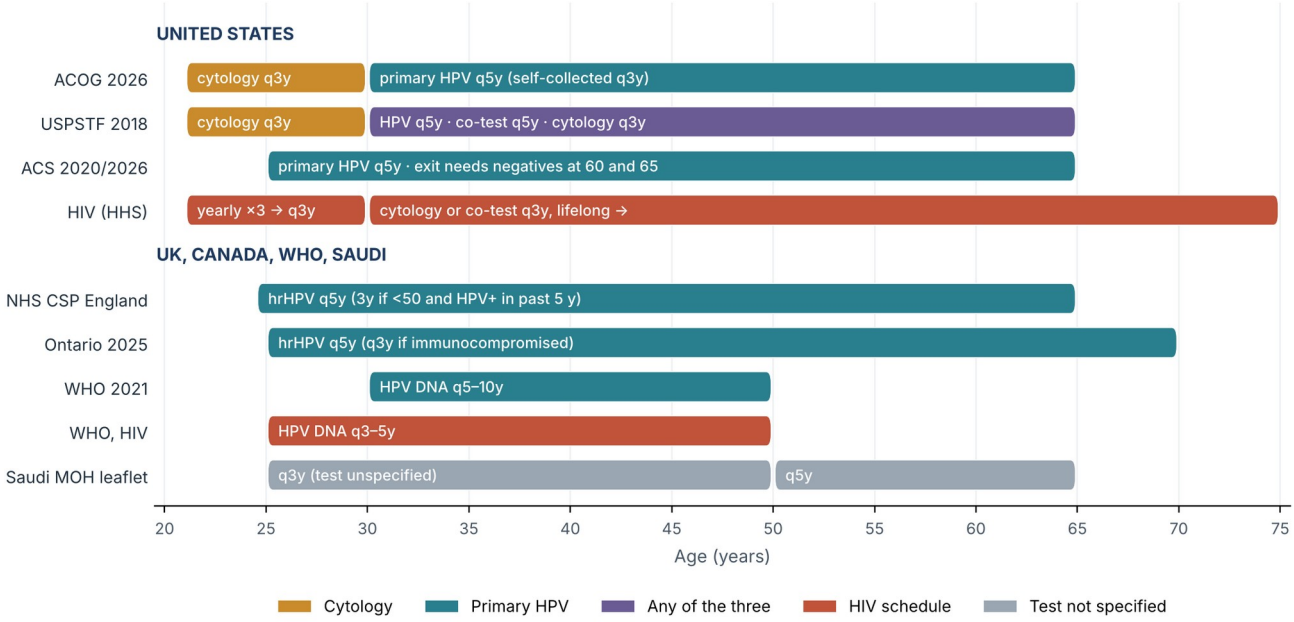


Figure 1. *Screening start, test and interval by society (average-risk, immunocompetent).*

IF	THEN
Under 21 (US) or under 25 (ACS, UK)	Do not screen, whatever the sexual history or vaccination status. Symptoms are examined, not screened.
21–29 (ACOG, USPSTF)	• Cytology every 3 y • Reflex HPV only to triage ASC-US • ACS: primary HPV every 5 y from 25
30–65 (ACOG 2026)	• **Primary HPV every 5 y** is the standard (clinician-collected) • Co-test every 5 y, or cytology every 3 y, only if primary HPV is unavailable or by patient choice • USPSTF 2018 (final) still lists all three as equal; its 2024 draft prefers primary HPV
Self-collected vaginal HPV sample	• HPV-negative → repeat in **3 y**, not 5 • HPV 16/18 → colposcopy; take cytology at the colposcopy visit • Other HR-HPV → clinician-collected sample for cytology (or dual stain) • Not for HIV/immunosuppression, DES exposure, symptoms or age <25

IF	THEN
Vaccinated against HPV	Screen exactly as the unvaccinated.
Saudi Arabia	No organised national call-recall programme confirmed. Saudi CPG 2016: HPV DNA or cytology, then colposcopy; cryotherapy or LEEP over cold-knife cone. MOH patient leaflet: 25–49 every 3 y, 50–64 every 5 y. MNGHA uses US-style rules (from 21; HPV or co-test from 30).
Postcoital or intermenstrual bleeding, visible or palpable cervical lesion	This is not screening: examine, biopsy any visible lesion and refer urgently. A normal recent screen does not exclude cancer. UK: suspected-cancer pathway (NICE NG12).
Total hysterectomy for benign disease, no CIN 2+ ever	Stop screening. Subtotal hysterectomy: cervix remains, so screen as usual.
Hysterectomy with CIN 2+ in the past 25 y	Continue vaginal HPV-based testing every 3 y until 25 y after the CIN 2+ diagnosis (ASCCP).
Age 65 (US)	• Stop if adequately screened: 2 negative co-tests or HPV tests, or 3 negative cytologies, in the past 10 y, the latest within 3–5 y, and no CIN 2+ in the past 25 y (ACOG, USPSTF) • ACS 2026: needs negative primary HPV tests (or co-tests) at **60 and 65** • Treated CIN 2+: continue to 25 y after treatment, even beyond 65 • HIV or immunosuppression: never exit

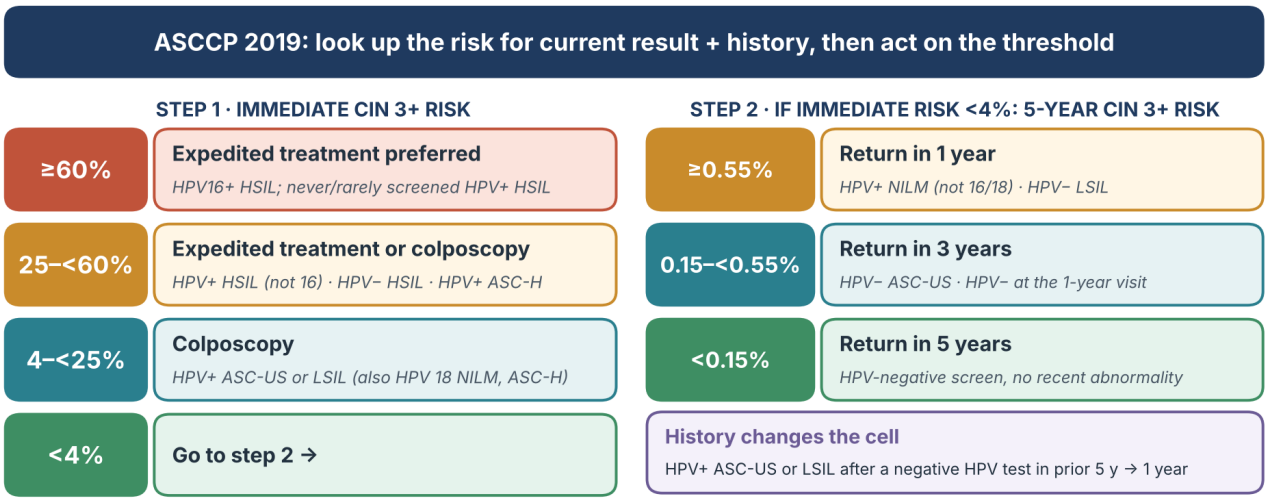
02 Reading the report

Bethesda (US)	UK (BSCC 2013)	Immediate CIN 3+ risk if HPV+ (ASCCP)	Usual next step (US)
NILM	Negative	2.1% (HPV 16+ higher)	1 y; colposcopy if 16/18+
ASC-US	Borderline change in squamous cells	≈4.4%	Colposcopy
LSIL	Low-grade dyskaryosis	≈4.3%	Colposcopy
ASC-H	No direct equivalent*	26%	Colposcopy (expedited treatment acceptable ≥25)
HSIL	High-grade dyskaryosis (moderate) / (severe)	49% (HPV 16+: 60%)	Expedited treatment or colposcopy
AGC / AIS	?Glandular neoplasia (endocervical / non-cervical); borderline change in endocervical cells	AGC: 26%	Colposcopy + ECC ± endometrial sampling
SCC / adenocarcinoma	?Invasive squamous carcinoma; ? glandular neoplasia	—	Urgent colposcopy, gynae-oncology

*UK laboratories report these cells within the borderline or high-grade categories. Histology uses LAST terms: LSIL (CIN 1), HSIL (CIN 2), HSIL (CIN 3). p16 immunostaining is used to settle a morphological CIN 2 call: block-positive supports HSIL, negative favours LSIL. UK glandular precancer is reported as CGIN or SMILE.

03 Triage of results: ASCCP risk-based

Each management step is set by the patient's **risk of CIN 3+**, estimated from the current result plus history (prior HPV, colposcopy and treatment). The ASCCP app or web tool does the look-up; the thresholds below are fixed.



Under 25, pregnant, immunosuppressed, AGC/AIS and post-treatment surveillance have their own rules (Sections 8–10)

Figure 2. *ASCCP 2019 action thresholds, with typical results in each band.*

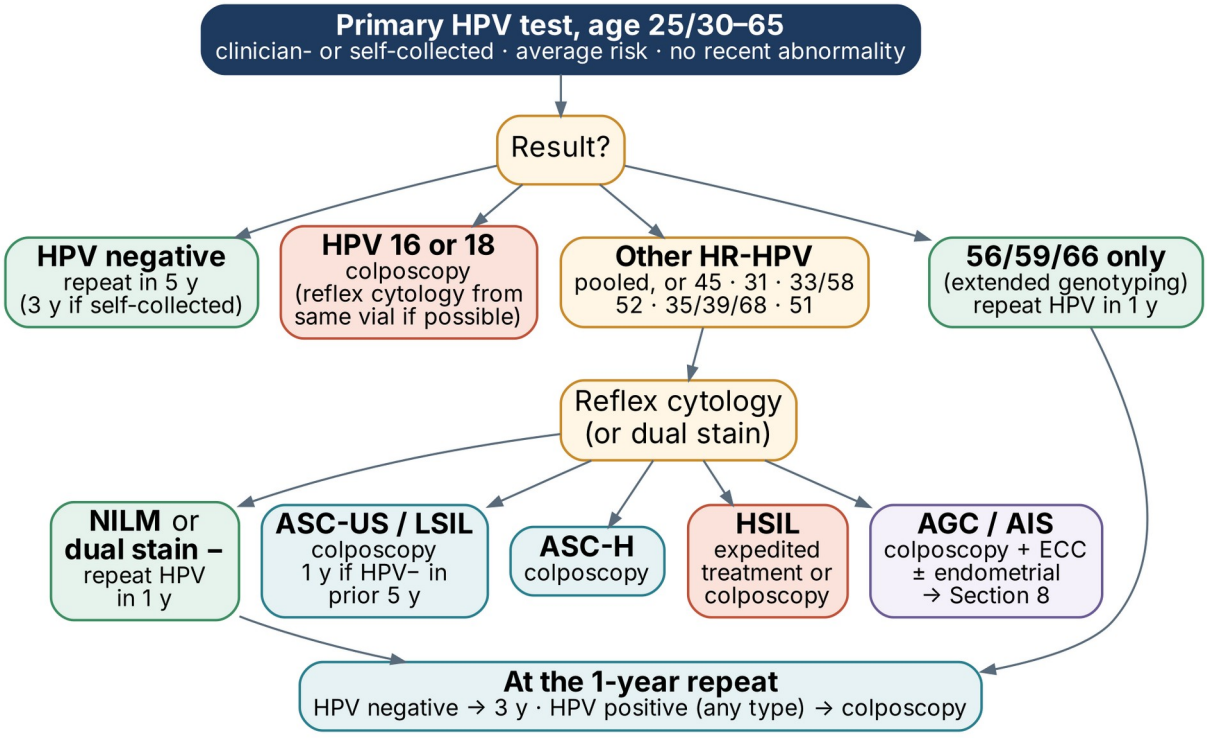


Figure 3. *Primary HPV screening result → next step (ASCCP 2019 with 2024–2025 genotyping and dual-stain updates).*

IF	THEN
HPV-negative, NILM (or no cytology)	Routine screening: 5 y (3 y if self-collected).
HPV-negative ASC-US	Repeat HPV-based testing in **3 y** (5-year risk 0.40%).
HPV-negative LSIL	Repeat in **1 y** (immediate risk 1.1%).
HPV-positive NILM, not 16/18	Repeat HPV-based testing in **1 y** (2.1%).
HPV 16 or 18 positive, NILM	**Colposcopy** (HPV 18 risk is only 3.0%, but its adenocarcinoma risk is disproportionate).

IF	THEN
HPV-positive ASC-US or LSIL	• **Colposcopy** • Exception: a documented negative HPV test or co-test within ≈5 y → repeat in 1 y (risk ≈2%)
ASC-H (any HPV result)	• **Colposcopy**; never triage with HPV • HPV+ ASC-H (26%): expedited treatment acceptable in non-pregnant ≥25
HSIL	• HPV 16+ (60%) or never/rarely screened (>5 y) HPV+ (64%): **expedited treatment preferred** if ≥25 and not pregnant • Other HPV+ (49%) or HPV-negative (25%): expedited treatment or colposcopy, by shared decision
AGC or AIS on cytology	Colposcopy + ECC, whatever the HPV result → Section 8.
Extended genotyping: 45, 31, 33/58, 52, 35/39/68 or 51	Triage with cytology or dual stain: NILM or dual stain negative → HPV in 1 y; ASC-US+ or dual stain positive → colposcopy (Enduring Guidelines 2025).
Extended genotyping: only 56, 59 or 66	Primary HPV: repeat in 1 y. Co-test with NILM, ASC-US or LSIL: 1 y; ASC-H, AGC or HSIL: colposcopy.
p16/Ki-67 dual stain	Positive → colposcopy. Negative → HPV-based test in 1 y, unless HPV 16/18 or high-grade cytology (→ colposcopy).
Unsatisfactory cytology	• HPV-negative or unknown: repeat age-based screening **within 4 months**; no HPV triage • HPV 16/18 positive: colposcopy • HPV-positive, not genotyped (co-test, ≥25): repeat in 2–4 months or colposcopy • Two consecutive unsatisfactory: colposcopy
Screened with cytology alone, ≥25	Use the cytology-only pathway below.
At the 1-year repeat	• HPV-negative (one test) → return in 3 y • HPV-positive again, any type → colposcopy • Three negative co-tests after low-grade + colposcopy <CIN 2 → 5 y

Expedited treatment

- Means excision (LEEP) without a preceding colposcopic biopsy. Use shared decision-making, especially when future pregnancy matters.
- Not for pregnancy, age <25, or when pregnancy concerns outweigh cancer concerns. Genotype rules do not apply after high-grade results or after treatment; use the 2019 tables.

When HPV testing is not available

ASCCP 2019 sends patients ≥25 screened by cytology alone back to the 2012 rules (kept in the 2023 update). Cytology misses more precancer than HPV testing, so every interval is shorter. Send cotesting or HPV reflex as soon as the laboratory can offer it.

IF	THEN
Screening schedule	• Cytology **every 3 y**, 21–65 (ACOG 2026 fallback when HPV is unavailable) • WHO 2021: cytology every 3 y from 30 until HPV DNA testing is running; stop after 50 if the last two are negative • Do not stretch cytology-only screening to 5 y
NILM, endocervical/TZ component absent	Routine 3-yearly cytology; an absent TZ component alone is not a reason to repeat early.

IF	THEN
Unsatisfactory	Repeat within 4 months; two in a row → colposcopy.
ASC-US, ≥25	• Send reflex HPV if any route exists (preferred) • Otherwise **repeat cytology at 1 y**: NILM → back to 3-yearly; ASC-US or worse → colposcopy
LSIL or ASC-H, ≥25	**Colposcopy.** (ASC-H never needs HPV triage anyway.)
HSIL, ≥25	Colposcopy, or expedited excision if not pregnant (2012: immediate LEEP or colposcopy).
AGC or AIS	Colposcopy + ECC ± endometrial sampling, exactly as in Section 8; HPV is not part of this work-up.
Age 21–24	Unchanged: ASC-US or LSIL → cytology at 1 and 2 y (Section 10).
Surveillance: the conversion rule (ASCCP 2019)	• Where ASCCP says HPV-based test **in 1 y** → cytology **every 6 months** • Where ASCCP says HPV-based test **every 3 y** → cytology **every year** • Any ASC-US or worse on surveillance → colposcopy
Example: <CIN 2 after ASC-US or LSIL	Cytology at 6 and 12 months instead of the 1-year HPV test; ASC-US or worse → colposcopy.
Example: after treatment of CIN 2+	Cytology 6-monthly in place of the 6-, 18- and 30-month HPV tests, then **annually** instead of 3-yearly, for at least 25 y.
UK (NHS CSP)	No cytology-only pathway: if a sample has no HPV result, repeat it after ≥3 months; two in a row → colposcopy (Section 4).

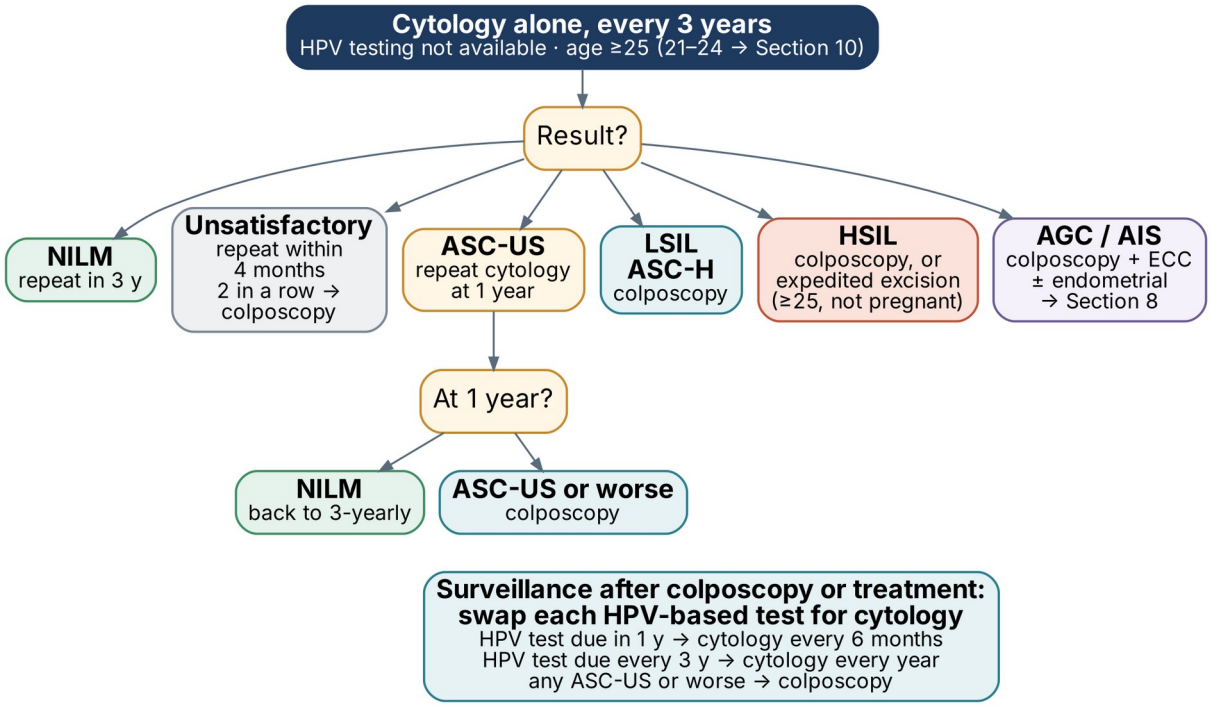


Figure 4. *Cytology-only screening and follow-up when HPV testing is unavailable (ASCCP 2012 rules as retained in 2019–2023; surveillance conversion from ASCCP 2019).*

04 The UK pathway (NHS CSP, England)

IF	THEN
Recall intervals (from 1 July 2025)	• First invitation at 24.5; HPV-negative → **5 y at every age** to 64 • Exception: <50 with an HPV-positive result in the past 5 y → 3 y until HPV-negative • Wales (2022) and Scotland (2020) already 5-yearly
Self-sample (England, from 25 August 2026)	• Offered to overdue people (first phase ages 30–65, press sources) • HPV-positive → clinician sample promptly for HPV + cytology; negative → 5 y • Not for early recall, test of cure, pregnancy or <3 months postpartum (London guidance)
HPV+, cytology negative	Repeat HPV at 12 months, then 24 months; **HPV-positive at 24 months → colposcopy** whatever the cytology. Borderline or worse at either repeat → colposcopy.
HPV+ with borderline or low-grade	Colposcopy within 6 weeks (US-style 1-year deferral does not exist).
High-grade dyskaryosis, ?invasion, ?glandular, borderline endocervical	**Colposcopy within 2 weeks.** Non-cervical ?glandular neoplasia → gynaecology.
Inadequate or no HPV result	Repeat no sooner than 3 months; two consecutive → colposcopy.
Normal colposcopy after low-grade referral	Community recall at 3 y; after HPV+/cytology− referral, 3 y from the referral result.
CIN 1	• Community test at 12 months (untreated CIN 1 pathway) • Persistent at 2 y: consider biopsy; annual surveillance or treatment by preference • Persistent HPV without CIN: do not treat
CIN 2 conservative management (no age limit)	• Colposcopy adequate, CIN 3 and invasion excluded, ≤2 quadrants • Histology and cytology reviewed at MDT • 6-monthly colposcopy + sampling; **treat if not resolved at 24 months**
CIN 3 or persistent high-grade	Treat within 8 weeks (unless pregnant); excision in ≥90%.
See-and-treat	Allowed for high-grade referrals (≥90% must show CIN 2+ or CGIN); not for HPV+/cytology−, borderline or low-grade referrals.
Ablation (UK extra criteria)	Histology within 3 months; no crypt involvement or postcoital/intermenstrual bleeding; age >50 only exceptionally; cryotherapy for low-grade CIN only (double freeze–thaw–freeze).
Exit	Automatically ceased after a normal result at ≥60 if on routine recall; anyone with a recent abnormality stays until follow-up is complete.

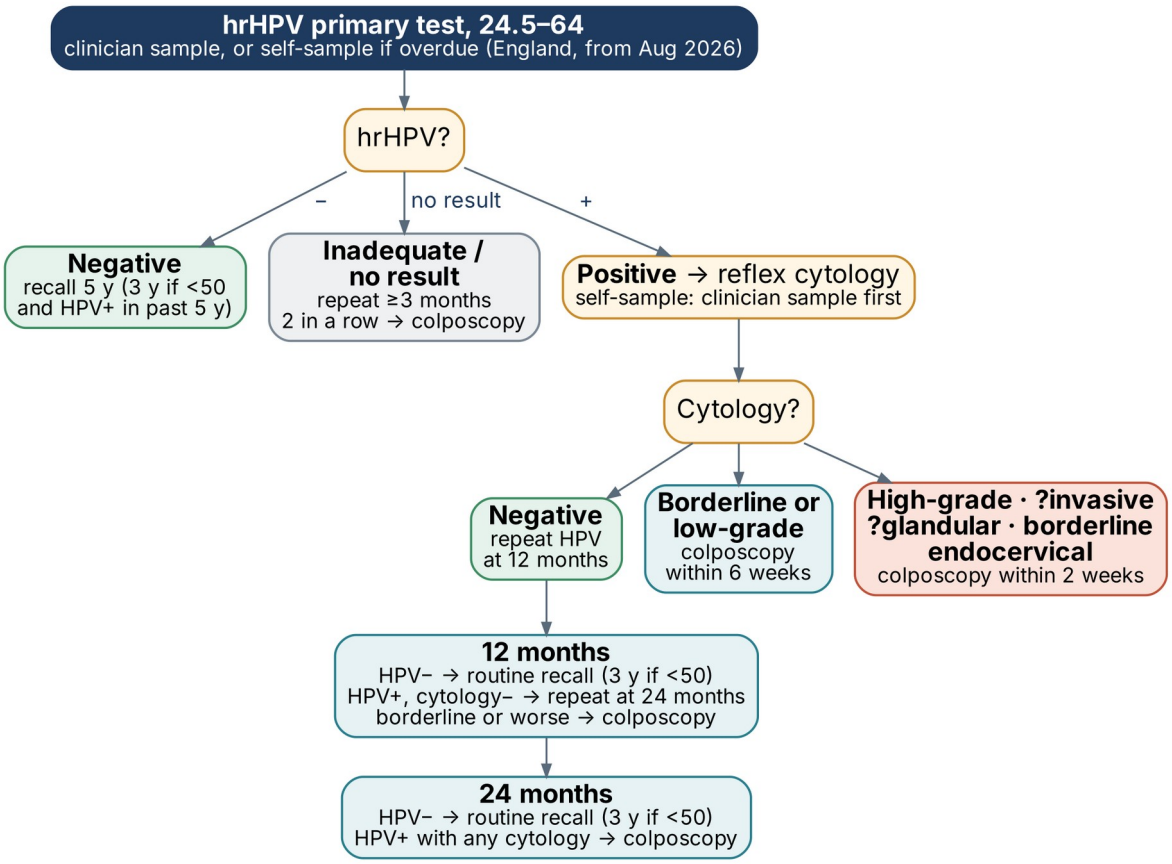


Figure 5. *NHS CSP (England) hrHPV primary screening pathway. No genotyping step.*

05 At the colposcopy

IF	THEN
Before starting	• Indication, prior results and treatments, LMP and contraception, pregnancy test if relevant, HIV and smoking status • Bimanual and speculum: a bulky, fixed or friable cervix is cancer until proved otherwise • Treat cervicitis, but do not delay for discharge or bleeding: both can be cancer
Technique	• Saline and green filter for vessels → **3–5% acetic acid** (allow ≈1 min) → Lugol's iodine if needed • Inspect the vagina and vulva as well, especially if HIV-positive or immunosuppressed
Document every time (ASCCP 2017; IFCPC)	• Cervix fully seen? **SCJ fully visible?** Transformation zone type 1, 2 or 3 • Acetowhitening and lesions: site (clock face), size (quadrants), extension into the canal or vagina • Impression: normal/benign, low-grade, high-grade, or cancer
High-grade features	Dense, opaque, slowly fading acetowhite; sharp straight borders; inner-border and ridge signs; coarse punctation or mosaic; cuffed crypt openings; iodine-negative.
Features of invasion	Atypical vessels, irregular or exophytic surface, ulceration, contact bleeding.
Biopsy	• **2–4 targeted biopsies** of all acetowhite areas, worst area first • Random biopsies not needed at the lowest risk: <HSIL cytology, not HPV 16/18, and a completely normal colposcopy • Punch biopsy under-grades about 1 in 5 lesions (Dewhurst)

IF	THEN
Endocervical sampling: recommended (ASCCP 2023)	HSIL, ASC-H or AGC cytology; HPV 16/18; dual stain positive; previous treatment; SCJ not fully visible; before choosing CIN 2 observation. Preferred in everyone ≥40.
Endocervical sampling: may omit / never	May omit in nulliparous <30 with ASC-US/LSIL, or when an excision is already planned. **Never in pregnancy.**
Atrophy hides the SCJ (postmenopausal)	A short course of vaginal oestrogen, then colposcopy about 2 weeks later, improves the view (Dewhurst); check contraindications.

06 After colposcopy: what the histology means

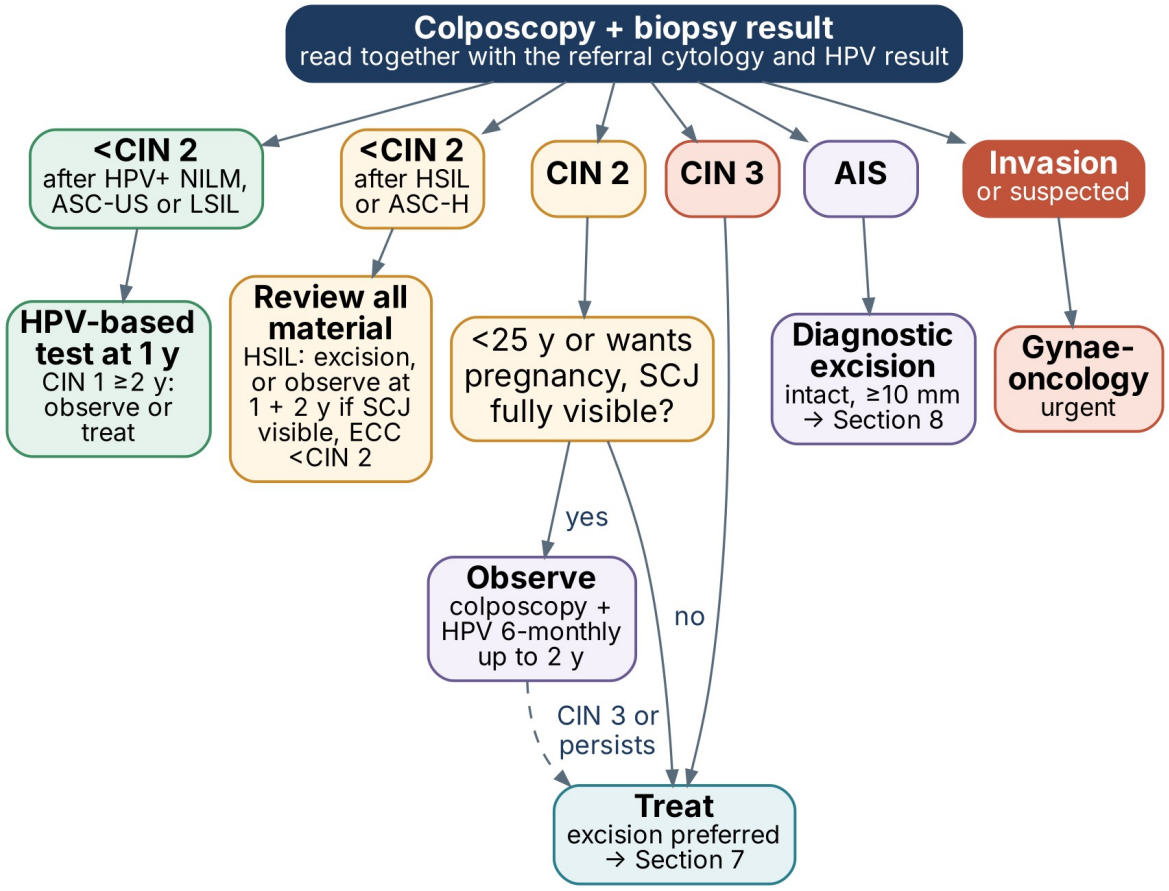


Figure 6. *Biopsy result, read with the referral result → next step (ASCCP 2019).*

IF	THEN
<CIN 2 after HPV+ NILM, ASC-US or LSIL	• HPV-based test in **1 y** (5-year risk 2–3%) • CIN 1 persisting ≥2 y: observation preferred; treatment acceptable (ablation only if SCJ and all lesions fully seen)
<CIN 2 after HSIL	• Review cytology, histology and colposcopy together first; manage by any revised diagnosis • Then either diagnostic excision or observation (HPV-based test + colposcopy at 1 and 2 y); neither is preferred • Observation only if SCJ and upper limit of lesion fully seen and ECC <CIN 2 • Excise if HSIL recurs at 1 or 2 y, or the SCJ is not fully visible
<CIN 2 after ASC-H	HPV-based test at **1 y**, no routine colposcopy; excision not recommended. Excise if ASC-H persists at 2 y.

IF	THEN
Negative at both 1- and 2-year visits	HPV-based testing in 3 y, then long-term surveillance.
CIN 2, age ≥25	• **Treat** (excision preferred) • If future pregnancy is a concern: observation is equally acceptable: colposcopy + HPV-based test every 6 months up to 2 y, if SCJ visible and ECC not CIN 2+ • Treat if CIN 3 appears or CIN 2 persists at 2 y; two negative rounds → annual testing
CIN 2, age <25	**Observation preferred**: colposcopy + cytology every 6 months. HSIL not further specified: observe or treat.
CIN 3 (any age, not pregnant)	**Treat.** Observation is unacceptable.
AIS on biopsy	Diagnostic excision → Section 8.
Microinvasion or invasion	Urgent gynae-oncology referral for staging; do not attempt local treatment first.

07 Treating CIN

IF	THEN
CIN 2+ needing treatment	• **Excision is preferred** (LEEP/LLETZ): it gives a specimen and margins • Ablation (cryotherapy, thermal ablation, laser) is acceptable only if every criterion below is met
Ablation allowed only if	• Lesion wholly ectocervical, SCJ and upper limit fully visible • ECC not CIN 2+ or ungradable; biopsies adequate and concordant • No glandular abnormality, no suspicion of invasion, no prior CIN 2+ treatment • Lesion ≤75% of the ectocervix and covered by the cryotip
Cold-knife cone instead of a loop	Suspected microinvasion; glandular lesion when an intact loop specimen is unlikely; large or deep lesion; very distorted anatomy. Needs general/regional anaesthesia and carries more bleeding and reproductive risk.
Depth of excision	• NHS CSP (≥95% of cases): **type 1 TZ >7 mm** (aim <10 mm in reproductive age) · **type 2 10–15 mm** · **type 3 15–25 mm** • Take only what the TZ needs: preterm-birth risk rises with each extra millimetre (Section 7, consent) • At least 80% of excisions should come out as a single specimen (NHS CSP)
Positive margins or ECC CIN 2+ (US, ≥25)	Repeat excision **or** observation, both acceptable; for observation an HPV-based test at 6 months is preferred. <25 or pregnancy concerns: observe.
Positive margins (UK)	CIN 2+ at the deep lateral or endocervical margin: no routine re-excision if <50 with no glandular disease or invasion; the 6-month HPV test of cure decides. ≥50 with CIN 3 at those margins and follow-up not assured: re-excise. CGIN at a margin, or stage IA1 with CIN at a margin: re-excise.
Recurrent CIN 2+	Repeat excision. Hysterectomy only if re-excision is not feasible or AIS/family complete; never as primary treatment for CIN 2/3.
Consent: early	Watery or blood-stained discharge for 2–4 weeks; primary bleeding (<1%) controlled with ball diathermy, Monsel's or silver nitrate; secondary bleeding at up to 2 weeks is usually infection (antibiotics). Avoid intercourse and tampons for 4 weeks.

IF	THEN
Consent: late	• Cervical stenosis (<6%); harder follow-up colposcopy • Preterm birth: 10.7% vs 5.4% untreated (RR 1.75); risk rises with depth: ≤10–12 mm RR 1.54, ≥20 mm RR 4.91; repeat treatment RR 3.78 (Kyrgiou, Cochrane 2017) • Fertility itself is not reduced
Timing and set-up	Ideally just after menses; exclude pregnancy; local anaesthetic with vasoconstrictor; insulated speculum, smoke evacuation; aim for one intact specimen.
HPV vaccine after treatment?	Not routine. Observational data suggested fewer recurrences, but RCTs (pooled RR 0.92; preliminary VACCIN and NOVEL results) show no reduction in CIN 2+ recurrence. Offer by the usual catch-up rules only.

08 Glandular abnormalities: AGC and AIS

IF	THEN
AGC (all subtypes except atypical endometrial cells)	• **Colposcopy + ECC**, whatever the HPV result • **Add endometrial sampling** if ≥35, or younger with risk factors (abnormal bleeding, anovulation, obesity) • HPV triage not recommended; repeat cytology unacceptable
Atypical endometrial cells	Endometrial and endocervical sampling first (preferred); colposcopy acceptable at the same time, and needed if both are negative.
Benign endometrial cells in a postmenopausal patient	Endometrial assessment. Premenopausal and asymptomatic: no evaluation.
AGC, HPV-negative, ≥50, work-up negative	Think beyond the cervix: endometrium, tube, ovary. ≈18% had an extra-cervical cancer in one series (Williams Gynecology); consider imaging.
AGC favour neoplasia, or AIS on cytology, no invasion found	**Diagnostic excision** with an intact specimen, plus endocervical sampling above the excision bed.
AGC-NOS with <CIN 2 at work-up	Co-test at 1 and 2 y; both negative → co-test in 3 y. Any abnormality → colposcopy.
AGC with CIN 2/3 only	Manage as for that squamous lesion.
AIS: excision technique	Single intact specimen, ≥10 mm long (18–20 mm if fertility is not wanted); LEEP and CKC equally acceptable; no "top-hat" second pass.
AIS, family complete	**Hysterectomy preferred** (simple, if margins negative). Positive margins → re-excise first, even if hysterectomy is planned.
AIS, wants fertility	Only with negative margins: co-test + endocervical sampling every 6 months for ≥3 y, then annually for ≥2 y (3-yearly from year 6 if all negative). Counsel: skip lesions mean negative margins are not fully reassuring.
UK: CGIN/SMILE	• MDT review for every case • Excise the whole TZ + **≥10 mm of canal** above the SCJ (fertility wanted, SCJ visible); **20–25 mm** if ≥50 or SCJ not visible • Margins clear: HPV test at 6 and 18 months; both negative → 3-year recall • Margins involved: re-excise; if declined or impossible, HPV at 6 and 12 months then annually for 9 y • Simple hysterectomy if fertility not required and invasion excluded; SMILE is managed as CGIN

09 After treatment: test of cure and follow-up

IF	THEN
Treated CIN 2+ (US)	• HPV-based test at **6 months**, whatever the margins • Then at 18 and 30 months; 3 consecutive negatives → every **3 y for at least 25 y**, beyond 65 if healthy • Any HPV-positive result → colposcopy
Only cytology available (US)	Every 6 months when annual HPV testing would be due, annually when 3-yearly would be due.
UK test of cure	• hrHPV test at **6 months** after CIN of any grade, whatever the margins; cytology is reflexed only if HPV-positive • Negative → recall at 3 y; negative again → routine 5-yearly • Positive → colposcopy · no result → repeat in 3 months • Stays in follow-up past 65 until the protocol is complete
After hysterectomy for CIN 2+ (US)	Vaginal HPV-based testing; ASCCP text: three annual tests, then every 3 y for 25 y. Palpate and inspect the vault for nodularity (occult invasion).
After hysterectomy with CIN (UK)	• CIN completely excised: **one** vault HPV sample at 6 months; negative → discharge; HPV+ → colposcopy • CIN 2/3 incompletely or uncertainly excised: 6 and 12 months, then 9 annual samples (CIN 1: 6, 12 and 24 months) • No CIN in the specimen: no vault sample; follow-up runs to 65 or 10 y after surgery, whichever is later
AIS treated conservatively	As Section 8: co-test + endocervical sampling 6-monthly ≥3 y.
Recurrent abnormality after treatment	Colposcopy, including the vagina (VaIN often extends from the vault or upper third).

10 Special populations

Age 21–24 (US)

IF	THEN
LSIL, ASC-US HPV+ or ASC-US untested	Cytology at 1 and 2 y; two negatives → routine screening. ASC-US with negative reflex HPV → cytology in 3 y.
Colposcopy if	ASC-H, HSIL, AGC or AIS at any time, or ASC-US or worse at 2 y.
ASC-H or HSIL	Colposcopy, **not** expedited treatment.
CIN 2 or HSIL	Observation preferred (colposcopy + cytology 6-monthly). CIN 3 → treat. SCJ not fully visible → excision.
Turns 25	Switch to risk-based management.

Pregnancy

IF	THEN
Screening due	• US: screen if due, by the non-pregnant rules • UK: defer routine screening until **12 weeks after delivery**; follow-up of a previous abnormality is not deferred

IF	THEN
Colposcopy indicated	• Same thresholds as outside pregnancy (ASCCP); the aim is to **exclude invasion** • Low-grade results may defer colposcopy to ≥4 weeks postpartum (ASCCP acceptable)
UK timing (NHS CSP)	Any abnormal referral: colposcopy late first or early second trimester. CIN 1 or less: may wait until after delivery. Suspected CIN 2/3: repeat colposcopy at the end of the second trimester, or 3 months postpartum.
Biopsy	Only if CIN 2+ or cancer is suspected; bleeding is brisker, but biopsy is safe.
Do not, in pregnancy	ECC, endometrial sampling, expedited treatment, or treatment of CIN.
CIN 2/3 found	Colposcopy + testing every 12–24 weeks (preferred), or defer to postpartum. No treatment unless invasion.
Invasion suspected	Diagnostic excision (wedge, cone or LEEP) in theatre with facilities for haemorrhage; joint gynae-oncology and MFM care.
AIS on biopsy	Gynae-oncology referral preferred.
Postpartum	Colposcopy no earlier than **4 weeks** after delivery (ASCCP); about **3 months** (NHS CSP).

HIV and other immunosuppression

IF	THEN
Living with HIV (HHS OI guideline)	• Start at **21** (2021 change; no longer "within 1 y of sexual debut") • <30: cytology at diagnosis, annually ×3, then every 3 y (no co-testing) • ≥30: cytology on that schedule or co-test every 3 y • Continue lifelong; no self-collection or primary HPV
Transplant, immunosuppressive drugs, other immunodeficiency	Follow the HIV schedule (ASCCP).
Results	• HPV+ ASC-US → colposcopy; ASC-US not HPV-tested → repeat cytology in 6–12 months • LSIL or worse → colposcopy, whatever the HPV result • Co-test NILM with HPV 16/18 → colposcopy; other HR-HPV → repeat in 1 y
At colposcopy	Inspect the whole lower anogenital tract (vulva, vagina, perianal). Ablation fails more often; prefer excision.
UK	• NHS CSP: **annual** screening, same age range (to 64), initial colposcopy if resources permit; results follow the national algorithm; <CIN 2 generally not treated • Before transplant: a screening sample within the previous year; dialysis: screen at diagnosis if not up to date • Chemotherapy, tamoxifen, biologics: no extra surveillance (local rules for long-term biologics)

11 Do not

- Screen under 21 (US) or 25 (UK), or treat a symptomatic patient's normal smear as reassurance.
- Triage ASC-H, HSIL or AGC with HPV testing, or repeat cytology for AGC.
- Use 5-year intervals after a self-collected negative test (3 y), after treated CIN 2+ (3-yearly for 25 y), or with cytology alone (3 y).
- Discharge a single ASC-US without HPV triage or a repeat cytology at 1 y.
- Apply genotype or dual-stain shortcuts after high-grade cytology, high-grade histology or treatment.
- Offer expedited treatment in pregnancy, under 25, or without shared decision-making.
- Treat CIN 1 after a low-grade referral, or observe CIN 3.
- Ablate when the SCJ is not fully visible, ECC shows CIN 2+, there is any glandular abnormality, or after previous treatment.
- Perform ECC or endometrial sampling, or treat CIN, in pregnancy.
- Use hysterectomy as primary treatment for CIN 2/3, or hysterectomy for AIS before a diagnostic excision.
- Excise more depth than the transformation zone needs: preterm-birth risk climbs with every extra millimetre.

12 Where the guidelines differ

Topic	ASCCP / ACOG (US)	NHS CSP (England)	WHO 2021 / 2026
Start and test	21 cytology; 30 primary HPV q5y (ACS: HPV from 25)	24.5 hrHPV, 5-yearly	30 HPV DNA, every 5–10 y
Self-collection	Any age in range; negative → 3 y	Overdue only; negative → 5 y	Acceptable alternative
Stop	65 if adequately screened (ACS: negatives at 60 and 65)	Ceased after normal result at ≥60 on routine recall	50, after 2 consecutive negatives
HPV+, cytology negative	1 y (HPV 16/18 → colposcopy)	12 and 24 months; colposcopy if still HPV+	Triage-negative → retest at 24 months
HPV+ ASC-US / LSIL	Colposcopy (1 y if HPV− in prior 5 y)	Colposcopy within 6 weeks	Triage by genotyping, VIA, colposcopy or cytology
Genotyping	16/18 → colposcopy; extended types triaged (2025)	Not used	2026: extended or limited genotyping suggested
Treat without biopsy	Expedited treatment for HSIL ≥25 (preferred if risk ≥60%)	See-and-treat for high-grade referrals	Screen-and-treat (ablation) allowed
CIN 2	Treat ≥25 (observe if pregnancy concerns); observe preferred <25	Conservative at any age if criteria + MDT; treat if unresolved at 24 months	—
Ablation	Acceptable with strict criteria; excision preferred	Criteria + histology ≤3 months; cryo for low-grade only	Thermal ablation or cryo if TZ visible and eligible
Positive margins	Re-excision or HPV at 6 months (≥25)	No routine re-excision <50; HPV test of cure decides	—
After treatment	HPV at 6, 18, 30 months; then 3-yearly for 25 y	HPV at 6 months; negative → 3 y, then 5 y	HPV at 12 months
Pregnancy	Screen if due; colposcopy ≥4 weeks postpartum	Defer screening to 12 weeks postpartum; colposcopy ≈3 months postpartum	—
HIV	From 21; cytology yearly ×3 then 3-yearly, or co-test q3y ≥30; lifelong	Annual, 25–64	From 25, HPV DNA every 3–5 y

Topic	ASCCP / ACOG (US)	NHS CSP (England)	WHO 2021 / 2026
Hysterectomy with CIN	Vaginal HPV-based testing for 25 y	One vault HPV sample at 6 months if excision complete	—
No HPV test available	Cytology q3y; ASC-US → repeat at 1 y; LSIL+ → colposcopy; surveillance cytology 6-monthly or yearly	Not applicable: repeat a sample with no HPV result after ≥3 months	Cytology (or VIA) q3y from 30 until HPV DNA is running

13 Abbreviations

Abbr.	Meaning	Abbr.	Meaning	Abbr.	Meaning
ACOG	American College of Obstetricians and Gynecologists	**HPV**	Human papillomavirus	**NILM**	Negative for intraepithelial lesion or malignancy
ACS	American Cancer Society	**HR-HPV, hrHPV**	High-risk HPV	**OHIP**	Ontario Health Insurance Plan
AGC	Atypical glandular cells	**HRSA**	Health Resources and Services Administration	**OI**	Opportunistic infections
AGC-NOS	AGC, not otherwise specified	**HSIL**	High-grade squamous intraepithelial lesion	**PB**	Practice Bulletin
AIS	Adenocarcinoma in situ	**IA1**	FIGO stage IA1 (invasion ≤3 mm deep)	**q3y, q5y**	Every 3 years, every 5 years
ASC-H	Atypical squamous cells, cannot exclude HSIL	**IFCPC**	Int. Federation for Cervical Pathology and Colposcopy	**RCT**	Randomised controlled trial
ASC-US	Atypical squamous cells of undetermined significance	**JLGTD**	Journal of Lower Genital Tract Disease	**RR**	Relative risk
ASCCP	American Society for Colposcopy and Cervical Pathology	**LAST**	Lower Anogenital Squamous Terminology	**SCC**	Squamous cell carcinoma
BSCC	British Society for Clinical Cytology	**LEEP**	Loop electrosurgical excision procedure	**SCJ**	Squamocolumnar junction
CGIN	Cervical glandular intraepithelial neoplasia	**LLETZ**	Large loop excision of the transformation zone	**SMILE**	Stratified mucin-producing intraepithelial lesion
CIN	Cervical intraepithelial neoplasia	**LMP**	Last menstrual period	**SOGC**	Society of Obstetricians and Gynaecologists of Canada
CKC	Cold-knife cone	**LSIL**	Low-grade squamous intraepithelial lesion	**TZ**	Transformation zone
CPG	Clinical practice guideline	**MDT**	Multidisciplinary team	**USPSTF**	US Preventive Services Task Force
CSP	Cervical Screening Programme	**MFM**	Maternal–fetal medicine	**VaIN**	Vaginal intraepithelial neoplasia
DES	Diethylstilbestrol (in utero exposure)	**MNGHA**	Ministry of National Guard Health Affairs	**VIA**	Visual inspection with acetic acid
ECC	Endocervical curettage or sampling	**MOH**	Ministry of Health	**WHO**	World Health Organization
HHS	US Department of Health and Human Services	**NHS**	National Health Service	**WPSI**	Women's Preventive Services Initiative
HIV	Human immunodeficiency virus	**NICE**	National Institute for Health and Care Excellence		

14 Sources

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Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.