

**MARYLAND COMPREHENSIVE CANCER PLAN
CERVICAL CANCER SUBCOMMITTEE
MINUTES OF THE MAY 15, 2002 MEETING**

Attendance:

Ann Klassen, PhD - Johns Hopkins University, School of Public Health- chair
Sandra Brooks, MD-University of Maryland
Michael Henry, MD- University of Maryland Medical Center
Niharika Khanna, MD - University of Maryland
Phyllis Smelkinson - American Cancer Society
Diane Solomon, MD – National Cancer Institute
Judy Trickett - Carroll County Health Department
Connie Trimble, MD - Johns Hopkins Medical Institutions
Helene O’Keefe - DHMH, Department of Maternal and Child Health

DHMH Staff

Bowie Little Downs –Cancer Council
Kate Shockley – Comprehensive Cancer Control Coordinator
Donna Gugel – Breast and Cervical Cancer Screening Program (BCCP) Director
Marsha Bienia – Director, Center for Cancer Surveillance and Control
Toni Brafa-Fooksman – BCCP Coalition Coordinator
Frank Ackers – Cigarette Restitution Funds Program Epidemiologist
Julia Mitchner – BCCP Clinical Services Coordinator
Pat Mulkey – Breast and Cervical Cancer Diagnosis and Treatment Program Manager

Introductions and Committee Membership- Donna Gugel

- Committee members and DHMH staff were introduced by name and organization.
- A committee roster was passed around. Members were asked to make corrections and add credentials and job titles.
- Member information, including name and organization, will be listed on the website and in the final published cancer plan. Members were given an opportunity to not have their name listed or ask questions. No members objected to the display of their information.

Overview/Evaluation - Bowie Little-Downs

- Comprehensive cancer control is the development of an integrated and coordinated approach to reduce the incidence, morbidity, and mortality of cancer through prevention, early detection, treatment, rehabilitation, and palliation.
- In September of 2001, the Maryland DHMH was awarded a 2-year cooperative agreement to develop a Comprehensive Cancer Control Plan.
- Currently there are 13 states funded to implement their Comprehensive Cancer Control plans. In addition, there are 7 states funded under the Planning phase and scheduled to update or rewrite their cancer plans.
- The Maryland Council on Cancer Control and key administrators within the DHMH/ Center for Surveillance and Cancer Control are charged with the oversight for this grant. An organizational chart for the planning process is included in the Committee Materials binder.

- To date, the Core Planning Team has been responsible for the planning and preparation that took place over the first 6-8 months. This team has now transitioned so that it will provide overall monitoring and guidance to all committees and sub-committees.
- From within this Core Planning Team there are 6 individuals that make up the Evaluation Committee. It is the responsibility of the Evaluation Committee to help guide the process by which each Sub-Committee operates.

The evaluation committee designed an evaluation tool to be used after all subcommittee meetings. The evaluation tool uses the CIPP Evaluation Model. CIPP is the acronym for **C**ontent, **I**nput, **P**rocess, and **P**roduct. The CIPP model is a process/satisfaction-oriented evaluation tool. It is essential that committee members complete the evaluation at the end of every meeting. The survey includes eight questions. Of particular importance are questions 1, 2, 4, and 8. If you don't have time to do complete the survey immediately following the meeting, it is available on line at www.marylandcancerplan.org. The comments will be compiled and shared with committee members at the beginning of each subsequent meeting. The tool is being considered for use by other Mid-Atlantic states with comprehensive cancer planning grants and by CDC for its "Best Practices" web page. The evaluation form is also available online for those not able to complete it at the end of the meeting (<http://www.marylandcancerplan.org/evaluation.html>).

Background Information - Kate Shockley

The new cancer control plan will expand upon previous plans developed in 1991 and 1996. The Core Planning Team hopes to increase community involvement in the development of the new plan by the formation of the subcommittees and through seven regional town hall meetings, which will be held July 15 - August 15. The notebooks contain a draft Table of Contents for the new plan. The committee was asked to review current literature, data, policies and programs and use this information to help formulate recommendations for the plan. Special attention should be paid to racial and cultural minorities and disparities in special populations. The committee will meet 4 times before October, 2002. At least one meeting will be held after the town hall meetings, so that public comments can be incorporated into recommendations. A statewide consensus conference will be held on October 16, 2002. The committee's recommendations will be presented at the conference.

Cervical Cancer Committee Notebook - Donna Gugel

Chapter 3 in the notebook contains a copy of the chapter on cervical cancer from the 1996 Maryland Cancer Control Plan. It also contains copies of the cervical cancer chapters from the 2001 North Carolina and the latest Michigan cancer control plans.

The next meeting of the Cervical Cancer Committee will include a review of current literature, as well as existing policies, mandated benefits and current health department programs offered through the Center for Cancer Surveillance and Control and the Center for Maternal and Child Health (Helene O'Keefe). If anyone would like to see specific data or other information, please let Donna Gugel or Toni Brafa-Fooksman know, so that it will be available at the next committee meeting.

A Committee Member Questionnaire was passed out and attendees were asked to list what they believe are the most important objectives for Maryland in order to decrease the burden of cervical cancer and to decrease racial disparities.

Donna Gugel presented information about cervical cancer programs in Maryland: The first low cost screening programs in the state were the hospital-based HSCRC programs. They were established in 1988 and ended in 1996. Through this program, twenty-three hospitals offered free clinical breast examinations and mammograms for uninsured, low-income women. Nine of these hospitals also offered pelvic examinations and Pap smears. In 1992, DHMH received a planning and implementation grant to start a breast and cervical cancer screening program (BCCP). Maryland was one of the first group of 12 states to start screening patients (in late 1992). Currently CDC is funding 70 programs. County programs are funded by grants from DHMH to the local health departments.

Data Review - Dr. Connie Trimble

Dr. Trimble reviewed the data for cervical cancer incidence and mortality in Maryland. She made several key points: (See Section 2 in the notebook for copies of the overheads.)

- Cervical cancer incidence and mortality rates in Maryland are similar to those for the United States.
- The cervical cancer incidence and mortality rates for African American women in Maryland are slightly lower than for women in the U.S. as a whole.
- For women 70 years of age and older, the incidence and mortality rates for cervical cancer is significantly higher for Maryland women than for the U.S. as a whole.
- In Maryland, the incidence of cervical cancer is highest in Baltimore City, on the Eastern Shore and in Western Maryland.
- In Baltimore City, the mortality rate is 3 times higher than the national average. It is also very high on the Eastern Shore.
- The Maryland cervical cancer mortality rate is 4 times greater for African American women than for white women.
- In 1998, 248 Maryland women were diagnosed with invasive cervical cancer and 74 women died from the disease.
- According to unpublished SEER data, 20% of the women over 65 years of age diagnosed with stage 3 or 4 cervical cancer do not receive any type of treatment
- The five year survival rate for cervical cancer did not change significantly from 1974-97.
- The five year survival rate is greater for white women than for African American women.
- A large number of women being diagnosed with invasive cervical cancer have seen a physician within the last year.

Dr. Trimble mentioned that she felt that the number of women who report ever having a Pap smear through the Behavioral Risk Factor Surveillance System (BRFSS) is over reported because it relies on respondents having a telephone.

Several questions were raised:

- Why are the survival rates for African American lower than for white women?

- Why are the survival rates for Maryland women who are 70 years of age lower than for younger women?
- Who is getting screened / diagnosed? Can we find out stage by age and ethnicity?
- What are the barriers for screening? For example at the Spanish Apostolate they have found illegal immigrants who refuse screening because they are afraid of being deported. Are there other groups of women not being screened and how does this affect Maryland data?
- Why are there discrepancies in survival?
- How can we improve access to care?
- What screening modalities are appropriate?

Issues identified for further examination and discussion:

- Can we find out from cytopathology labs how many women are being screened for cervical cancer? Can we get demographic information from them? (Dr. Henry stated that it may be possible to get the information from larger labs, but may not be possible from smaller labs.)
- How can we improve access to care?
- What screening modalities are appropriate? Which techniques are best for different age groups (e.g. HPV typing using urine screening in adolescents and young women)? How often?
- Eligibility rules for existing programs can be a problem if women don't meet them. There are pockets of unscreened women who are ineligible for free/low cost programs.
- Doctors are not aware of the programs.
- Low reimbursement rates may not equal the cost of the service.
- Older women may only see a primary care provider. Many primary care providers do not perform Pap smears.
- Very few resources are provided to clinics. Should use natural leaders (like the breast cancer model) to find, recruit, screen and follow-up unscreened women.
- Treat Baltimore City as a developing country.
- Decrease the number of visits women have to make to providers.

Bethesda, ALTS, ASCCP Recommendations - Dr. Diane Solomon

Dr. Solomon spoke about screening recommendations, the Bethesda System, the ASCUS Low –Grade SIL Triage Study (ALTS), the American Society for Colposcopy and Cervical Pathology (ASCCP) management of abnormal cervical cytology guidelines and new technologies for Pap smears. A copy of her presentation was distributed. Dr. Solomon made several key points during her presentation:

The first Bethesda Conference was held in 1988. Until this time, many different systems were used to report Pap test results. The conference resulted in a uniform reporting system and also addressed the issue of specimen adequacy. A second conference, held in 1991, reevaluated the reporting system and attempted to address what to do with women whose Pap tests indicated low level abnormalities. The ALTS trial resulted from this conference. A third conference was held in 2001 for the purpose of discussing the new technologies and how to incorporate them into cervical cancer screening policies and to look at the results of the ALTS trial.

- New technologies have affected screening and practice guidelines.

- Liquid-based technologies account for approximately 50% of the Pap smears done in the U.S.
- The ASCCP has established practice guidelines for the management of low grade cervical abnormalities (i.e. LSIL, ASCUS and glandular abnormalities.)
- HPV infections of the cervix are common among sexually active women. Most HPV infections resolve themselves. In a small percentage of cases the infection persists. These women are at high risk for developing precursor lesions, which if untreated, may eventually lead to invasive cervical cancer.
- Cervical cancer is an ideal model for a screening program because the cervix is easily accessible for examination and sampling; it has a precursor stage which can be recognized and is treatable; and there is evidence that screening reduces mortality.
- The consensus of current screening recommendations from numerous groups including the American College of Obstetricians and Gynecologists, the American Cancer Society, and the U.S. Preventive Services Task Force state:
 - Screening should begin at age 18 or when a woman becomes sexually active.
 - After three consecutive, annual Pap tests with normal results, the Pap smear can, at the discretion of the physician, be performed once every three years.
- There are several problems with the current screening recommendations:
 - Not all groups follow the screening recommendations that were agreed upon in 1987. Many groups still recommend annual screening.
 - The recommended age to begin screening is when women are most likely to have multiple, transient HPV infections which will resolve themselves. This can lead to over treatment. High grade lesions are most likely to occur when a woman is in her 20's and 30's and screening is occurring every three years.
 - The wording is vague. What does “at the discretion of the physician” mean?

For more information on the ALTS study please see:

Solomon D et al, Comparison of Three Management Strategies for Patients with Atypical Squamous Cells of Undetermined Significance: Baseline Results from a Randomized Trial, JNCI, Vol. 93, No. 4, February 21, 2001, 293-299.

Sherman M et al, Effects of Age and Human Papilloma Load on Colposcopy Triage: Data From the Randomized Atypical Squamous Cells of Undetermined Significance/Low-Grade Squamous Intraepithelial Lesion Triage Study (ALTS), JNCI, Vol. 94, No.2, January 16, 2002, 102- 107.

For more information on the Bethesda System and the ASCCP guidelines please see:

Solomon D et al, The 2001 Bethesda System Terminology for Reporting Results of Cervical Cytology, JAMA, Vol. 287 (16) April 24, 2002, 2114- 2119.

Wright TC et al, 2001 Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities, JAMA, Vol. 287 (16), April 24, 2002, 2120-2129.

- **Discussion/Recommendations:**
- CDC allows the BCCP to pay for liquid-based Pap tests, but at the same rate as for a conventional Pap. Donna Gugel reported that she expects CDC to recommend co-collection

for HPV testing, if needed. There was a discussion about possible problems with sample storage and tracking.

- Screening strategies need to consider sensitivity for detection of high grade CIN, specificity, cost in relationship to the number of cancers prevented, and acceptable risks.
- The USPSTF and ACS are looking at new recommendations for cervical cancer screening. These are expected by the end of the year.
- No matter what we do there are some cases of cervical cancer that won't be diagnosed.
- When postmenopausal women with LSIL are given estrogen, cervical pathology is similar to that of younger women. In unestrogenized women, diagnosis of cervical abnormalities is harder because of cervical atrophy.
- Condom use is not 100% effective in preventing HPV infection.
- There is a need to look at alternative screening techniques, time frames, etc. Can home test kits, similar to those used for colorectal cancer screening, be used to screen for cervical cancer? Is it better to use a less accurate test than to require a visit to the physician which may not occur? Will home test kits increase screening in women who aren't usually screened? Will older women who do not have routine cervical cancer screenings use a home test kit?
- How does the high rate of STDs affect the incidence of cervical cancer in Baltimore City?
- We need to look at the lack of providers doing colposcopy and the length of time it takes to go from screening to completion of the diagnostic workup. In Southern Maryland it can take up to four months to get an appointment for a colposcopy. Getting the results back from a routine Pap smear can take between 3-4 weeks. CDC requires that 75% of the women screened in BCCP complete their diagnostic work-up within 60 days. Currently only 44% of the women are completing work-up within this time frame.
- Would a colposcopy van be useful?
- Is it possible to obtain data as to why some women who have a positive screen do not complete diagnostic work-up or treatment? Why are some women diagnosed at late stages?
- The biggest impact to reduce cervical cancer is to screen unscreened women.
- There is a strong need to educate physicians that excessive testing leads to overtreatment.
- Self-sampling for Paps may be possible. Look at the colorectal model of using something like FOBT kits.
- Need to figure out how to get to target population in need.
- Conduct a look back study to determine why the system fails women who develop cervical cancer.
- Incidence data by census tract would be helpful.
- Many clinicians are performing HPV tests on women with LSIL and then giving them a LEEP. Physicians need to be educated about ASCCP guidelines.
- Look at literature to see if anyone has tried to measure # of Pap tests by looking at lab volume.

The next meeting of the cervical cancer committee will be on June 5th at 4:00 p.m. in the L-3 conference room. Additional meetings are also scheduled for August 12, September 11 and 18, 2002.